



# A Guide to Collecting Mental Health Court Outcome Data



DATE_ARRESTED	DATE_HEARING	PRIOR_ARREST?	NUM_PRIORS	DAYS_TREATMENT	ON_MEDICATION
01-01-2004	01-12-2004	Y	1	20	N
01-08-2004	01-12-2004	Y	1	85	N
01-13-2004	01-20-2004	N	0	12	N
01-19-2004	02-04-2004	N	0	104	Y
01-27-2004	02-04-2004	N	0	17	N
02-03-2004	02-10-2004	N	0	34	N
02-04-2004	02-10-2004	Y	2	21	Y
02-11-2004	02-19-2004	Y	3	63	Y
02-17-2004	02-19-2004	Y	1	90	Y
03-09-2004	03-12-2004	N	0	24	N
03-15-2004	03-20-2004	Y	1	14	N
03-18-2004	03-20-2004	N	0	56	Y

# A Guide to Collecting Mental Health Court Outcome Data

A publication of the Council of State Governments, prepared for the Bureau of Justice Assistance

## About the Bureau of Justice Assistance (BJA)

The Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system. BJA provides leadership, services, and funding to America's communities by emphasizing local control; building relationships in the field; developing

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## About the Office of Justice Programs (OJP)

The Office of Justice Programs, US. Department of Justice, was created in 1984 to provide federal leadership in developing the nation's capacity to prevent and control crime, administer justice, and assist crime victims. OJP carries out this mission by forming partnerships with other federal, state, and local agencies, as well as national and community-based organizations. OJP is dedicated to comprehensive approaches that empower communities to address crime,

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## About the Council of State Governments

The Council of State Governments (CSG) is a nonprofit, nonpartisan organization that serves all three branches of state government. Founded in 1933, CSG has a long history of providing state leaders with the resources to develop and implement effective public policy and programs. Owing to its regional structure and its constituency—which includes state legislators, judges, and executive branch officials—

CSG is a unique organization. Comparable associations operate only on a national level and target one branch of state government exclusively.

The development of this guide was overseen by staff of the Criminal Justice Program of CSG's Eastern Office, which also coordinates the Criminal Justice/Mental Health Consensus Project.

## About the Criminal Justice/Mental Health Consensus Project

Coordinated by the Council of State Governments (CSG), the Criminal Justice/Mental Health Consensus Project is an unprecedented national effort to improve the response to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. The landmark Consensus Project Report, which was authored by CSG and representatives of leading criminal justice and

mental health organizations, was released in June 2002. Since then, the Consensus Project has continued to promote practical, flexible approaches to this issue through presentations, technical assistance, and information dissemination. This includes providing technical assistance to the Bureau of Justice Assistance Mental Health Courts Program.

# A Guide to Collecting Mental Health Court Outcome Data

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# The recent and rapid expansion

of mental health courts across the country has been driven by the creativity of local and state officials responding to the growing number of individuals with mental illnesses who become involved in the criminal justice system. As is the case with many new innovations, the impact of these courts has not yet been documented by empirical evidence. Little research has been undertaken concerning mental health courts in general, and many of the courts have struggled to incorporate data collection into their program designs.

The purpose of this guide is to help both well-established and newly operating courts develop practical, feasible, and effective strategies for collecting outcome data. After a brief discussion of key assumptions and target population and goals, the guide suggests strategies for:

- Determining which data to collect
- Obtaining the data
- Evaluating the data
- Comparing the data
- Collecting qualitative data
- Overcoming common challenges

Outcome data can be of enormous value to courts in their efforts to demonstrate the initial promise of their approach and can help to attract researchers interested in conducting a more rigorous evaluation. Mental health courts usually receive initial funding based on their potential for positive impacts. They are funded (or not) in subsequent years based on their ability to demonstrate results.



## diverse people, diverse terminology

Many different terms are used to describe people involved with the mental health system and the criminal justice system. In this guide, we have chosen to use the following:

**Individual or person with a mental illness**—someone with a mental illness

**Consumer**—someone receiving mental health treatment

**Defendant**—someone appearing in court

**Inmate**—someone who is detained or incarcerated in jail or prison

# Key assumptions of this guide

**THE IDEAS OFFERED IN THIS GUIDE** assume several things about mental health courts and the task of collecting data:

Mental health courts have allocated **very little money** to collecting outcome data.

Mental health court administrators and program staff are **not experts** in data collection.

Collecting outcome data is **not a one-time research endeavor**; it is an ongoing effort to understand the mental health court's impact over time, assessed periodically for budgeting, publicity, a meeting presentation, or to justify the court's existence.

**There are more resources** (i.e., brain power, interest, and willingness) available to a mental health court trying to collect outcome data than may be apparent initially.

# Identifying target population and goals

**THE CORE QUESTION IN** evaluating mental health courts is not, “Do mental health courts work?” but rather, “What works, for whom, under what circumstances?” No intervention will work for everyone. Mental health courts should determine the type of defendants on which the court can have the most positive impact in terms of the individual, public health, and public safety.

Before collecting any outcome data, or even accepting participants, a mental health court should have a clear idea of its target population.<sup>1</sup> Outcome data can then be used to determine which segment of this population seems to respond most positively to the mental health court intervention. These data should provide some insight on the need to revise the parameters of the target population over time, or the need to alter the services delivered to, or activities required of, the program participants.

Each mental health court should also specify its goals with regard to the participants, the criminal justice system, and the community in order to measure its success.<sup>2</sup> These goals need to be both realistic and measurable. For example, it



is reasonable to expect that participation in the mental health court would reduce the incidence of arrest during program participation, and arrests can be measured easily and reliably. However, it is not realistic to expect that the mental health court program would reduce the overall crime rate or alleviate jail overcrowding, as both of these are influenced by a myriad of other factors beyond the control of the

mental health court program.

Specific program goals should be set during the planning phase of the court and should have a logical connection to the type, intensity, and duration of services provided. Agreement among stakeholders (including the evaluators) on the explicit meaning of goals and how they should be measured is essential.



# Determining which data to collect

**MENTAL HEALTH COURTS CAN OBTAIN A** general sense of their results by collecting a relatively limited range of data. In some cases, producing a single statistic will require collecting several pieces of information. For example, determining the average length of stay in the program will require information about the date that each participant entered the program and the date each participant's case was resolved.

Although most evaluation findings are presented using aggregate-level data (i.e., statistics about how the group of mental health court clients performed as a whole; for example, only 20 percent of court participants were rearrested during the time that their case was active), individual-level data are needed to construct these statistics. Thus, simply counting the number of defendants accepted by the court is not sufficient. Instead, a range of information needs to be collected for each defen-

dant so that statistics can be calculated for the group as a whole. This volume of data is far too cumbersome to be hand-tabulated and requires a database that is customized to capture the items of local interest. This database need not be sophisticated—often a simple spreadsheet is sufficient. It is critical, however, that the people responsible for collecting and entering the data receive training to ensure the data elements are interpreted consistently by all staff and entered in a format that will be easy to analyze.

Below are the four main categories of data a mental health court should consider collecting, along with key data elements within each category. This list is not meant to be comprehensive, and mental health court planners should determine appropriate data elements based on the structure and goals of their particular program.



## Participants

*How many people did the court serve, and what are their characteristics?*

- Number of individuals screened
- Number of individuals eligible (according to program criteria)
- Number of individuals accepted
- Relevant characteristics of the individuals who were eligible but not accepted (including demographics, charges, prior criminal history, diagnosis)
- Reasons not accepted (including legal or clinical reasons)
- Relevant characteristics of the eligible defendants who decline to participate
- Reasons for declining to participate (e.g., requirements too strict, supervision time too long)
- Relevant characteristics of those who were accepted into the court (e.g., demographics, charges, prior criminal history, diagnosis)
- Length of time between key decision points (e.g., screening to acceptance, acceptance to case termination)
- Reasons for termination (e.g., drop-out, completion, revocation)

## Services

*What services/what type of services did the court participants receive? How often did they receive them (e.g., once a week)? For how long did they receive them (e.g., six months)? These services might include:*

- Assessment
- Case management
- Medication appointments
- Outpatient treatment
- Intensive outpatient treatment
- Psychosocial rehabilitation
- Housing
- Residential substance abuse treatment
- Integrated treatment for co-occurring disorders
- Supported employment, other vocational or employment training
- Education, GED preparation and testing
- Self-help groups
- Enrollment in Medicaid, Supplemental Security Income (SSI), and Social Security Disability Income (SSDI)
- Other locally important services

## Criminal Justice Outcomes

*What were the effects of these services on participants' criminal justice involvement?*

- Number of arrests during program participation and subsequent to participation
- Type of charge (e.g., violent, property, drug, etc.)
- Number of admissions to jail or prison during program participation and subsequent to participation
- Reason for admission (e.g., new charge, technical violation)
- Number of days in jail or prison for new crimes
- Number of days in jail because of sanctions for nonadherence to court conditions

## Mental Health Outcomes

*What were the effects of the services on participants' mental health symptoms and overall functioning?*

- Number of inpatient hospitalizations and length of stay
- Number of emergency room admissions and type of treatment received
- Changes in symptoms (using, for example, the Modified Colorado Symptom Index)<sup>3</sup>
- Number of days homeless
- Number of victimizations (e.g., domestic violence, assault, robbery)
- Level of satisfaction with services offered
- Changes in quality of life (using, for example, Lehman's Quality of Life Interview)<sup>4</sup>
- Number of days clean/sober, or number of positive urinalysis tests
- Number of days employed or in school during a specified period (e.g., 10 out of the last 30 days)
- Level of compliance with psychotropic medication plan

# Obtaining the data

**FINDING A RELIABLE SOURCE OF INFORMATION** for each of these data elements can be difficult. Usually, programs rely on a combination of data extracted from official agency records and information collected from participant interviews. When should a court rely on self-reported data rather than official agency records? There is no right answer to this question. Clearly, for data on the flow of participants through the program, such as the number and characteristics of people served, agency records are necessary. For information on services received, electronic records of public sector services recorded for reimbursement purposes by providers are optimum, but self-reported data from consumers on the services they received is better than no information at all. For some outcomes (e.g., rates of homelessness), both agency records (criminal justice and mental health) and self-reported information are needed. For other measures, such as service system satisfaction, data must be obtained directly from the participants using interviews or surveys.

To develop a successful data collection plan, all of the stakeholders involved in the operation of the court will need to agree on 1) what data elements will be collected; 2) what the source will be for each data element; 3) who will enter the data; and 4) where the data will ultimately be stored. This conversation must take place early in the development of a data collection plan and with the input of staff from the various partner agencies who have knowledge and expertise in the kinds of data their agencies can provide.

Policy Research Associates created a Mental Health Court Case Processing Form for its evaluation of seven BJA Mental Health Courts. It can be a useful point of reference for developing local data collection procedures. See Appendix on page 18.





## collecting qualitative data

In addition to collecting quantitative data, developing one or two *case studies* of mental health court participants can add depth and dimension to what is known about the impact of the court and how it has helped to improve participants' lives. Case studies should be constructed in the early stages of program operation to ensure that the court is ready to respond to any high-profile relapses or program failures that may be publicized by the media.

A survey of court officials (prosecutors, defense attorneys, judges) and other criminal justice and mental health staff who are involved in the court can distill their perceptions of the program to be used in proposals to sustain funding. In some jurisdictions, positive responses to these kinds of surveys have helped to convince policymakers of the value of a program even before empirical evidence was collected.<sup>5</sup>

# Evaluating the data

**THE DATA DESCRIBED PREVIOUSLY REPRESENT** the raw materials that mental health courts will need to understand the court's process and impact on participants. Once sufficient data are collected, the courts must develop a strategy for analyzing the data. Analysis may be prompted by the need to submit annual reports, to apply for continued funding, or simply to review the progress of the program. Whatever the impetus, the process of analyzing the data will likely require time and expertise beyond what the court personnel possess. In some larger jurisdictions, the mental health court may be able to rely on staff within the court or mental health system to analyze the data. In many jurisdictions, the court may need to contract for outside assistance. Either way, someone with the expertise to analyze the data should be identified early in the planning process.

Two types of evaluations are needed to fully understand the mental health court's impact. First, a process evaluation examines how the court operates and provides essential information on the characteristics of the intervention itself. Second, an outcome evaluation assesses the effectiveness of the intervention. In other words, an outcome evaluation tells you if it worked, and a process evaluation tells you what "it" is.

## Process Evaluations

Some mental health courts (and other new programs for that matter) overlook the importance of a process evaluation. Recognizing that administrators, funders, and community members are most interested in the impact of the mental health court, many courts do not focus specifically on the way the court operates. But understanding the court's operation is an essential prerequisite to an outcome analysis: without examining the court process, it is impossible to know why or how the mental health court had the impact it did, or why some participants did better than others. Process evaluations determine whether the court operated according to its original design and provide valuable insights to whether a program adapted from another jurisdiction properly replicated key elements. Process-related information tends to be descriptive in nature, but is still quantitative. Typical process-related questions include:

- How many defendants were referred to, screened for, and accepted into the mental health court?
- How did these numbers compare to expectations?





- For what reasons were participants not accepted?
- What agencies or individuals referred potential participants?
- How long did court participants wait before being accepted into the program?
- What kinds of diagnoses did court participants have?
- How long did participants remain in the program?
- How did program duration compare to expectations?

The Mental Health Courts Case Processing Form in the Appendix is one example of a useful data collection tool for process evaluations.

### Outcome Evaluations

An outcome evaluation answers the essential question of effectiveness. As discussed in the first section of this guide, specific outcome-related research questions should be based on the specific goals of the mental health court. Some research questions will require data to be collected only after the program is completed, while others

will require information to be gathered during program participation as well. Typical outcome-related questions include:

- How often were mental health court participants arrested?
- How many days did mental health court participants spend in jail?
- What kind of services did participants receive in the community?
- How often did they receive those services?
- How many participants were eligible for benefits (e.g., Medicaid, SSI/SSDI) and of those, how many were connected to benefits?
- How did participants' quality of life change during participation in the program?
- What were the rates of substance use among participants?

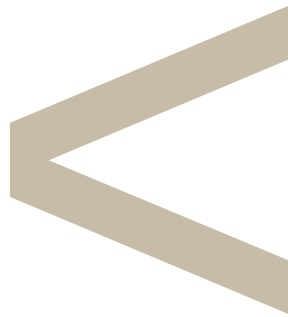
# Comparing the data

## THE CRUCIAL QUESTION IN THE ANALYSIS

of outcome data is: “Compared to what?” That is, the court can only understand its impact in terms of a comparison, either to different points in time or to different groups of people. Most often, resource and practicality issues require courts to find comparisons for each case within itself, focusing on how court participants perform during their involvement in the mental health court program compared to how they were doing during the period just prior to their admission into the mental health court (e.g., one year prior to admission).

From a purely scientific standpoint, the effects of any intervention are difficult to determine if the only participants studied are those who receive the intervention. Ideally, a second study group is available, consisting of defendants with the same characteristics as those who received the intervention, but who received standard or traditional services. Both groups are tracked

for the same length of time, during the same time period, and are measured against the same outcome measures. The *experimental group* includes defendants receiving services through the mental health court. Their outcomes are contrasted to those of the *comparison group* that receives services via the traditional court process. Any differences in the key outcome measures can be attributed to the intervention, since the two groups were similar on all other significant factors; the only difference is that one group received the services of the mental health court and one did not. If the two groups had different characteristics (e.g., different offenses or diagnoses), any differences in their outcomes could be attributed to these characteristics rather than to the intervention.



In practice, evaluations with good comparison groups are very difficult to accomplish.

First and foremost, they are much more expensive, roughly doubling the cost of data collection, since they require an additional study group equal in size to the experimental group. Second, in a single community, a sufficient number of similarly situated people to form both an experimental and a comparison group are often hard to find. Third, ethical standards requiring that all research participants receive equally effective treatment may deter a community from using a comparison group.

So while comparison groups may be desirable from a scientific standpoint, for most mental health courts with limited time and resources

for data collection and evaluation, using court participants as their own “control group” is a reasonable compromise that helps the courts to determine their impact on program participants. If this type of comparison demonstrates promising results, it can attract researchers and funders who may be able to undertake a more rigorous experimental design.

This is not to say that comparison group studies are unimportant. They are essential for ensuring that empirical knowledge about mental health courts grows along with their numbers, and mental health court administrations should consider strategies for obtaining interest and funding for such studies. However, courts without a research budget are not likely to be able to undertake that level of analysis.



# Overcoming common challenges

**MENTAL HEALTH COURTS THAT HAVE SUCCEEDED** in obtaining quality data and evaluating their results have encountered a wide range of challenges. Some of the most common challenges are listed below, along with suggestions for overcoming them.

## **CHALLENGE:**

Securing funds for evaluation

## **SOLUTIONS:**

- **Approach local foundations**
- **Involve local college students who need internships/theses/dissertations**
- **Assign time-consuming data collection tasks to mental health court program staff, conserving available funds to contract for analysis**
- **Collaborate with other mental health courts (e.g., share database development and data entry costs)**

Locally based philanthropic foundations are often very interested in documenting local success stories, especially when leadership comes from the judiciary. Students of community colleges and those in masters and doctoral programs often need access to programs in order to collect data for thesis and dissertation research. Many students also need semester-long internships, usually low-paid or unpaid, which can be used for targeted data collection. Data collection is often the most time-consuming of the tasks involved in evaluating program outcomes. If program staff are trained to collect data in a systematic fashion, the costs for securing outside analytical expertise can be reduced.

1



2

**CHALLENGE:**

Constructing a realistic evaluation plan

**SOLUTIONS:**

- Do less, but do it well
- Get pro bono evaluation guidance

Being realistic in terms of what can be accomplished by program staff is a good starting point when planning data collection. Few mental health courts have staff with the expertise required to conduct a rigorous evaluation of program outcomes. However, their knowledge about program operations and staff workload is essential for devising efficient data collection strategies. Ultimately, a thorough job on a smaller set of questions is more useful than a half-baked attempt at a huge project. Good advice about what may be manageable within existing resources can often be obtained pro bono from local universities and colleges. Another way to narrow the focus of an evaluation is to identify the key concerns of funding sources and other key stakeholders, and target only those issues for data collection. A basic but well-structured set of data elements is adequate for getting a general sense of the program's operation and is also an excellent starting point for researchers who may be contracted to do a more rigorous evaluation of program outcomes.

3

**CHALLENGE:**

Documenting treatment services

**SOLUTIONS:**

- Accomplish #1 and #2, above
- Negotiate data sharing agreements with community treatment providers
- Work hard

Documenting the services received in the community is often the most difficult part of the data collection effort. Unfortunately, these data are the most important. The "intervention" must be clearly defined in terms of the type, intensity and duration of services provided. If a court does not know the characteristics of the intervention actually provided, it cannot determine which service components produce the most positive outcomes. Asking for help from students and universities, as discussed above, is especially important in this domain, as is negotiating data-sharing agreements with service providers and/or their funding sources at the outset of program planning. Data sharing among organizations will require participants to sign a waiver during the mental health court admission process.<sup>6</sup>

## Overcoming common challenges *continued*

4

**CHALLENGE:**

Planning for outcome data collection soon enough

**SOLUTIONS:**

- **Just do it**
- **Line up a local evaluation ally**

The earlier in the planning and operation phases that the data questions are addressed, the better off a court will be when the program must be justified to potential funding sources. On the front end, courts should obtain agreement on program goals, evaluation questions, and the data needed to answer them while lining up the criminal justice, mental health, substance abuse, housing, health, and other partners in the court's operation. In addition, courts should enlist the cooperation of a local evaluation allies (e.g., students, university, or research organization) at the outset of program planning so that the researchers can begin to think through the evaluation questions while the court's implementation is being planned.

5

**CHALLENGE:**

Collecting data on the cost of intervention and cost savings

**SOLUTION:**

**Use a sophisticated method, or do not attempt to collect cost-based data**

Cost data, usually structured to show savings, are very complex data to gather correctly. Cost studies done "on the cheap" easily backfire, showing short-term costs that are dramatically higher for mental health court participants than inmates with mental illnesses who are housed in the jail. This occurs for several reasons. First, most cost studies underestimate the actual jail costs for these high-need inmates: incarcerating individuals with mental illnesses, who require treatment and more intensive supervision and stay longer in jail, does not cost the same as the "average" inmate. Second, mental health courts are designed to connect defendants to comprehensive (and thus costly) mental health and related services; many of the participants have not been consistently engaged in services prior to their involvement in the court, so their use of services often increases substantially. This initial outlay of treatment resources may eventually result in reduced criminal justice costs and improved functioning for participants, but savings are most likely to accrue over an 18-month period or longer.

6

**CHALLENGE:**

Maintaining privacy and confidentiality

**SOLUTIONS:**

- Review state and federal regulations
- Consult local evaluation advisor

In today's world of careful attention to the rights of prisoners to participate in research, data collectors need to give prominent and explicit consideration to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 42 of the Code of Federal Regulations (for persons with co-occurring substance abuse disorders), and human subject protections for research. The specifics of these issues are very complex and beyond the scope of this guide, but must be flagged for careful consideration.<sup>7</sup> Because confidentiality laws differ among states, a local evaluation advisor should be enlisted to review data collection plans and release of information forms and provide general guidance on protecting the rights of participants involved in the research.

7

**CHALLENGE:**

Collecting reliable data

**SOLUTIONS:**

- Establish specific data sharing agreements to extract data from existing administrative datasets (e.g., police, jail, prison, employment).
- Train all staff responsible for gathering and entering data

When data are extracted from existing administrative databases, their structure and format must be amenable to analysis. Local evaluation advisors can provide useful guidance to courts drafting data sharing agreements. Researchers and information system managers share a common language and can ensure that the data extracted meets the needs of the analysis.

For new data entered into the mental health court's database, mental health courts should train those responsible for data entry and build as many automatic edits as possible into the electronic data entry system. Specific discussions with the person responsible for analyzing the data are needed to ensure that the data are structured, coded, and entered in a way that is useful for analysis. These preparations can save both time and money once sufficient data has been collected for an analysis of outcomes.

# Technical assistance

**AS THIS GUIDE SUGGESTS, CRITICAL SOURCES** of evaluation-related expertise may be available to mental health courts within their own communities. Readers may also want to consult the section of the Criminal Justice / Mental Health Consensus Project Report on “Measuring and Evaluating Outcomes,” available at [www.consensusproject.org](http://www.consensusproject.org).

In addition, the Council of State Governments (CSG) provides technical assistance for the BJA Mental Health Courts Program, and is available to help both Mental Health Court Program grantees and nongrantees develop data collection strategies to meet their local needs and resources.

CSG, with the help of the GAINS Center for Evidence-Based Practices, has provided guidance to numerous courts in determining outcome measures, establishing data collection procedures, synthesizing data collection strategies across multiple courts, and other issues related to measuring the impact of their programs.

Jurisdictions interested in such assistance should visit the Mental Health Courts Program Web site,

[www.consensusproject.org/mhcourts](http://www.consensusproject.org/mhcourts)

to download the technical assistance request form, or contact:

Council of State Governments  
40 Broad Street, Suite 2050  
New York, NY 10004  
(212) 482-2320  
[mhc-assistance@csg.org](mailto:mhc-assistance@csg.org)



# References

1. For more information on defining the target population, see the companion to this document, *A Guide to Mental Health Court Design and Implementation*.
2. For more information on program goals, see the companion to this document, *A Guide to Mental Health Court Design and Implementation*.
3. Conrad, K.J., J.R. Yagelka, M.D. Matters, A.R. Rich, V. Williams, and A. Buchanan. "Reliability and Validity of a Modified Colorado Symptom Index: A National Homeless Sample." *Mental Health Services Research*. September (3):141-53, 2001.
4. Russo, J., P. Roy-Byrne, D. Reeder, M. Alexander, E. Dwyer-O'Connor, C. Dagadis, R. Reis, D. Patrick. "Longitudinal assessment of quality of life in psychiatric inpatients: reliability and validity." *Journal of Mental and Nervous Disease*. March (3):166-75, 1997.
5. The Connecticut Department of Mental Health and Addiction Services conducted such a survey of a pilot jail diversion program. The program was subsequently expanded statewide. See Solnit, Albert J. "The Costs and Effectiveness of Jail Diversion: A Report to the Joint Standing Committee of the General Assembly Having Cognizance of Matters Pertaining to Judiciary, Public Health, and Appropriations." Hartford, CT: Department of Mental Health & Addiction Services. February 1, 2000.
6. For more information on confidentiality issues, see the companion to this document, *A Guide to Mental Health Court Design and Implementation*.
7. The U.S. Department of Health and Human Services offers extensive guidance for complying with HIPAA through its Web site, <http://www.hhs.gov/ocr/hipaa/>. The National Institute of Justice offers guidance on the use of human subjects in research through its Web site, <http://www.ojp.usdoj.gov/nij/humansubjects/index.html>. The site also includes links to the Code of Federal Regulations and to sample consent forms and protocols. You can also find an article on HIPAA on the National Drug Courts Initiative Web site, <http://www.ndci.org/admin/docs/confid.pdf>.



# Appendix: NIJ-BJA Mental Health Court Evaluation Study Referral Data Sheet

## NIJ-BJA Mental Health Court Evaluation Study Referral Data Sheet

1. Study ID: \_\_\_\_\_ 2. Date of Referral: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yy)  
 ID#

3. Referring Agent (Agency) (if more than one referent, check the primary one)

1. <input type="checkbox"/> Mental Health Court Judge	8. <input type="checkbox"/> Other Judge/Magistrate/Speciality Court Judges
2. <input type="checkbox"/> Police/Law Enforcement	9. <input type="checkbox"/> District Attorney's Office
3. <input type="checkbox"/> Jail Mental Health Staff	10. <input type="checkbox"/> Probation
4. <input type="checkbox"/> Public Defender's Office	11. <input type="checkbox"/> Court Officials
5. <input type="checkbox"/> Defense Attorney (Private)	12. <input type="checkbox"/> Private Citizen/Family Member(s)
6. <input type="checkbox"/> Community Mental Health	13. <input type="checkbox"/> Self-Referral
7. <input type="checkbox"/> Competency Examination Order	96. <input type="checkbox"/> Other; specify _____

4. Age: \_\_\_\_\_ years 5. Gender: 0.  Male 1.  Female

6. Racial/Ethnic background (Check all that apply if more than one race/ethnicity)

0. <input type="checkbox"/> Caucasian	3. <input type="checkbox"/> Hispanic
1. <input type="checkbox"/> African American	4. <input type="checkbox"/> Other specify _____
2. <input type="checkbox"/> Asian	9. <input type="checkbox"/> Unknown

7. Most Serious Current Criminal Charge: \_\_\_\_\_

8. Number of Current Criminal Charges: \_\_\_\_\_ misdemeanors; \_\_\_\_\_ felonies

9. Major Mental Disorder (Axis I): 1.  Yes 0.  No 9.  Unknown (skip to 11 if "no" or "unknown")

10. Primary Axis I Diagnosis (If known): \_\_\_\_\_  
 DSM-IV code: \_\_\_\_\_

11. Substance Use Problem(s)? 1.  Yes 0.  No 9.  Unknown

\*\*\*\*\*

12. Date of Referral Disposition (or removal from Court's referral list): \_\_\_/\_\_\_/\_\_\_ (mm/dd/yy)

13a.  Accepted for the MHC (1) (skip to 14)  
 13c.  Defendant opted out of consideration (3)

13b.  Rejected for the MHC (2) (skip to 15)  
 13d.  NA (4), the referral was neither accepted nor rejected for the Mental Health Court (e.g., the person was released from jail on "time served" before a decision could be made).

14. IF ACCEPTED:

1. <input type="checkbox"/> Defendant enrolled in MH court	15. IF REJECTED: Reason (check only one)
0. <input type="checkbox"/> Defendant DID NOT ENROLL in MH Court (check only one)	1. <input type="checkbox"/> Ineligible because of mental disorder (e.g., only substance problem or does not have a SPMI)
<input type="checkbox"/> defendant declined to enroll (1)	2. <input type="checkbox"/> Ineligible because of current criminal charges or past criminal history (e.g., violent offense)
<input type="checkbox"/> defendant could not be found (2)	3. <input type="checkbox"/> District Attorney's office declined
<input type="checkbox"/> defendant was not stable (3)	4. <input type="checkbox"/> Public Defender's office or private defense attorney declined
<input type="checkbox"/> defendant homeless (4)	5. <input type="checkbox"/> Judge declined
<input type="checkbox"/> other (5); specify: _____	6. <input type="checkbox"/> Probation declined
	7. <input type="checkbox"/> Mental health providers declined
	8. <input type="checkbox"/> Other; specify: _____
	9. <input type="checkbox"/> Unknown

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## INSTRUCTIONS FOR COMPLETING REFERRAL DATA SHEETS

One sheet reflects data on one referral.

1. Study ID: This space can be used to establish a unique four-digit # for each person.
2. Date of Referral: Enter the date the referral was made. You can estimate, if necessary.
3. Referring Agency: Check the primary agency or agent who referred the person to your attention. If a common referent is not there, specify "other" (e.g., forensic diversion program).
4. Age: Enter the person's age in years.
5. Gender: Enter the person's gender, male or female.
6. Racial Background: Enter the person's racial background. Check all boxes that apply. If you do not know the racial background, check the "unknown" box.
7. Most Serious Current Criminal Charge: Enter the most serious current criminal charge *at the time the referral was made*. Please be as specific as possible.
8. Number of Current Criminal Charges: Enter the number of current criminal charges (misdemeanors and felonies) *at the time the referral was made*.
9. Major Mental Disorder (Axis I): Enter 'yes,' 'no,' or 'unknown' for whether the person has an Axis I disorder (e.g., schizophrenia, bi-polar disorder, major depression).
10. Primary Axis I diagnosis: If known, enter the primary, or most severe, Axis I diagnosis. If available, also enter the five digit DSM-IV code.
11. Substance Use Problems(s): Enter 'yes,' 'no,' or 'unknown' for whether the person has known substance use problems.
12. Date of Referral Disposition (or removal from Court's referral list): Enter the date in which a decision was made to either accept or reject the referral for the Mental Health Court. If a decision was not rendered, enter the date the referral was removed from your list or from your consideration.
- 13a-d. Disposition of Referral: Check whether the person was A. ACCEPTED for enrollment into the MHC [skip to #14]; was B. REJECTED for enrollment into the MHC [skip to #15]; C. DEFENDANT OPTED OUT of consideration (that is, if the defendant was initially uninterested in the MHC and/or opted out of the evaluation); or D. NA: If none of these options is applicable (e.g., the decision was taken out of your hands because the person was released from jail).
14. **If Accepted:** If the person was accepted for enrollment into the MHC, check whether the person voluntarily enrolled in the Mental Health Court or not. If the person did not enroll, check the most appropriate reason why the person did not enroll or specify another reason.
15. **If Rejected:** If the person was rejected for enrollment into the MHC, check the reason why the person was denied enrollment into the MHC. Note that if the DA declined because the person was charged with a violent crime, please check #3 (DA's office declined), not #2 (Ineligible because of criminal charges). #2 should be checked if, for example, the reason for rejection was a program decision or an automatic ineligibility factor.











## About the Mental Health Courts Program

The Bureau of Justice Assistance administers the Mental Health Courts Program (MHCP), which has awarded grants to 37 mental health court projects nationwide since 2002. The MHCP funds projects that seek to improve the response to adult and juvenile offenders with mental illnesses through continuing judicial supervision and the coordinated delivery of mental health and related services. [www.ojp.usdoj.gov/BJA/grant/mentalhealth.html](http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html)

The program also provides technical assistance, coordinated by the Council of State Governments (CSG), to grantee courts and other jurisdictions. As part of its technical assistance efforts CSG has developed four publications to aid communities considering or implementing a mental health court:

### THIS GUIDE:

**A Guide to Collecting Mental Health Court Outcome Data** provides practical strategies to both well-established and newly operating courts for deciding which data to collect; obtaining, evaluating, and comparing the data; and overcoming common challenges.

### OTHER GUIDES IN THE SERIES:

**What Is a Mental Health Court?** introduces the mental health court concept, including the reasons why communities establish such courts, how they differ from drug courts, recent research, and concerns that these courts have raised.

**A Guide to Mental Health Court Design and Implementation** provides detailed guidance on issues such as determining whether to establish a mental health court, selecting the target population, ensuring confidentiality, and sustaining the court. Examples from existing mental health courts illustrate key points.

**Navigating the Mental Health Maze: A Guide for Court Practitioners** offers a basic overview of mental illnesses, including their symptoms, diagnosis, and treatment, and discusses the coordination of treatment and court-based services.

**The Bureau of Justice Assistance (BJA)**, Office of Justice Programs, U.S. Department of Justice, supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system. BJA provides leadership, services, and funding to America's communities by emphasizing local control; building relationships in the field; developing collaborations and partnerships; promoting capacity building through planning; streamlining the administration of grants; increasing training and technical assistance; creating accountability of projects; encouraging innovation; and ultimately communicating the value of justice efforts to decisionmakers at every level.

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**The Council of State Governments (CSG)** is a nonpartisan, public, nonprofit organization that provides information, research, and training to state officials in all three branches of government in every state and U.S. territory.

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**The Criminal Justice / Mental Health Consensus Project** is an unprecedented national effort to improve the response to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system.

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