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FINAL REPORT

An Evaluation of the Bureau of Justice Assistance

Mental Health Court Initiative

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An Evaluation of the Bureau of Justice Assistance

Mental Health Court Initiative

EXECUTIVE SUMMARY

An important new development in court administration and diversion programs for defendants with mental illness is the mental health court (MHC, Petrila, 2003). MHCs are criminal courts based on the notion of therapeutic jurisprudence (Winick & Wexler, 2003) that hear cases of individuals with mental illness charged with crimes. They are often proposed as a strategy to stop the revolving door of repeated cycling through the criminal justice system of people with mental illness (CMHS, 1995). Moreover, they were developed in response to the large numbers of persons with severe mental illness incarcerated in jails, their special needs while incarcerated, the difficulties courts face in effectively addressing mental illness issues and the strains that involvement with the criminal justice system places on individuals with mental illness and their families.

Despite little to no empirical data that MHCs are successful in obtaining their goals, the courts are proliferating at a fast rate (Steadman, Davidson, & Brown, 2001). Today, there are 100 MHCs in the United States whereas only one existed in 1997 (GAINS Center, 2004). The dearth of research on the outcomes of mental health courts relative to their proliferation is not surprising. The growth in the number of courts reflects the broader trend in court administration towards problem-solving specialty courts such as drug courts, domestic violence courts and community courts (Petrila, 2003). In addition, the emergence of mental health courts reflects the frustration of the criminal justice system in processing more persons with serious mental illness and seeing some of the same mentally ill persons continually reappearing before the criminal courts.

In the present report, we describe our evaluation of seven mental health courts. Our goal in this evaluation was to advance the knowledge base that can inform communities searching for alternatives to the unnecessary incarceration of people with serious mental illness. The courts were partially funded by the 2002 Bureau of Justice Assistance funds for MHCs and were the seven courts that were operational at the time we began the evaluation. The evaluation, which focused on the processes of mental health courts (as opposed to outcomes), included both qualitative and quantitative portions.

Overview of Present Research

In 2002, the Bureau of Justice Assistance announced their first round of funding for mental health courts. Twenty-three courts were funded. Under National Institute of Justice support, we conducted a process evaluation of the seven courts that were operational at that time. The remainder of the courts used the BJA funds to initiate their MHCs and thus were not suitable for evaluation. The overall goal of our project was to learn and provide heretofore-never-reported information on multiple mental health courts, courts that aim to improve the lives of persons with mental illness. Our process evaluation consisted of two stages: 1) qualitative stage, involving site visits to the courts, and 2) a quantitative stage, involving data collection on the characteristics of referrals and court disposition decisions over three months. The qualitative evaluation was a necessary first step in developing and conducting the quantitative evaluation.

The seven MHCs are located in: 1) Santa Clara County, CA; 2) Orange County, NC; 3) Allegheny County, PA; 4) Washoe County, NV; 5) Brooklyn, NY; 6) Bonneville County, ID; and 7) Orange County, CA.

Qualitative Evaluation: Site Visits

Methodology

Over a four-month period in 2003 (June – September), two-person teams (comprised of the PI, the Project Director, and three senior consultants) conducted site visits of the courts. A set of fifty questions was developed a priori building from the previous MHC comparison work of Goldkamp & Irons-Guynn (2000) and Griffin et al. (2002), and answers were obtained during the site visits.

Results

Our first step in analysis was to systematically describe the seven courts across four dimensions. We found that 1) all of the courts accept felony cases, 2) all but one utilize post-adjudication models, 3) the majority are comfortable placing persons in jail as a sanction when necessary, and 4) there is a preponderance of reliance on internal supervision (i.e., internal to the criminal justice system).

Our next step was to compare and contrast the seven MHCs that we studied with other MHCs that have been previously studied and described in the literature. We proposed that a second generation of MHCs was developing, based on notable differences between the descriptions of older courts and those developed within the past three years. We supported this proposition by comparing eight established mental health courts (what we referred to as the 'first generation') previously addressed by Griffin, Steadman, and Petrila (2002) with the seven newer BJA-funded MHCs (what we referred to as the 'second generation').

Although we noted numerous similarities between first- and second-generation MHCs, we also noted that the two generations of courts differed on the four dimensions of charge type, adjudication model, use of jail as a sanction, and supervision model. We also found that the first

three dimensions that distinguished the generations are relevant to the front end of mental health court operations. The day-to-day, back-end operations after participant enrollment have changed little. After enrollment dispositions are made, participants attend hearings in front of a judge, treatment mandates are issued, and some level of supervision is rendered; because these courts accept defendants charged with felonies, the supervision is more likely to involve probation officers rather than be left solely to community mental health providers. Rather, what has seemingly changed is how potential persons are selected for enrollment, the front end of the court.

A key component of the qualitative site visits was determining the best way to proceed with the qualitative portion of our evaluation. What information on mental health courts was lacking? Although there is still much to be learned about MHCs in general, we felt that there was a dearth of knowledge concerning how defendants came to enroll in the courts. And, as noted, main differences between first- and second-generation MHCs concerned the front-end operations of the courts. Thus, the quantitative portion of our evaluation was designed to examine the front-end processes of referral and disposition decision-making of mental health courts.

Quantitative Evaluation: Referral and Disposition Processes

Our research questions concerned 1) how cases were referred, processed and disposed of by the courts and 2) whether there were factors that distinguished cases *accepted* by the court from cases *referred* to the court. We were also especially interested in whether mental health courts, like the majority of other jail diversion programs (Naples & Steadman, 2003), would have older, White women disproportionately represented in comparison to their numbers in the criminal justice system as a whole.

Methodology

Data were collected on all "formal referrals" to the seven courts. Court staff completed a one-page questionnaire for every formal referral between November 1, 2003 and January 31, 2004. The questionnaire had three parts: 1) identification of the referring agent, 2) characteristics of the referred person, and 3) the disposition decision.

Results

Over the three study months, 285 persons were referred to the seven courts varying from 15 to 91 referrals per court. In regard to the referring agent, five of the seven courts listed the Public Defender's Office as either their primary or secondary referral source. Another common source of referrals was another judge or magistrate in the court system. Six of the seven courts processed their MHC cases post-adjudication, thereby allowing other judges to make referrals to the mental health courts. In regard to the characteristics of referrals, we did find that the mental health court referrals in our sample were more likely to be older, White, and women. Four of the seven courts had participant rates age 35 or older that were substantially higher than the national rate (Bureau of Justice Statistics, 2002), one court had a similar rate, and two courts had rates that were lower. The percentage of men referred to the mental health courts ranged from 45% to 72% with an overall mean of 60%. In the U.S. jails and prisons, men make up 90 to 94% of all inmates. In terms of ethnicity, there was wide variability, which may have reflected the geographic diversity of the courts (for example, in Bonneville County, ID the overwhelming majority population of the county is White). Proportions of Whites referred to the courts ranged from 8% to 93%. Again, when compared to jail and prison populations, which are comprised of 63% minorities, whites are overrepresented in most of the courts. One exception is Brooklyn, where the majority of persons referred were non-White.

Across the seven courts there was no clear pattern on mental health characteristics of the participants. Generally the three most common diagnoses were schizophrenia/ schizoaffective disorder, bipolar disorder, and depressive/mood disorders. Most courts maintained a clear misdemeanor/felony distinction. That is, for four courts, the majority of referrals had felony charges, whereas for two courts, most referrals had misdemeanor-only charges. In the Washoe County, NV MHC, the number of referrals with felony charges and with misdemeanor-only charges was nearly split 50-50. Six of the seven courts had referrals with violent (e.g., aggravated assault, arson, robbery) charges.

In regard to disposition decisions, the proportion of all referrals ultimately accepted by the courts ranged from 20% to 100%. Rates of the defendant opting out before a decision was made were universally low (5%), as were rates where no decision was made. The length of time from referral to disposition varied widely, ranging from an average of one day to more than 45 days. Most of the referrals accepted by the MHC team also agreed to enroll in the court. In five of the seven courts, 100% of those offered acceptance into the mental health courts enrolled.

While people were rejected for a variety of reasons, a primary reason accounting for 30% of all rejections (but ranging from 5 to 100% across courts) was that the referred person was ineligible because of mental health status. More specifically, this could mean that the person 1) did not have a mental disorder, or 2) did not have a mental disorder consistent with the court's eligibility requirements (e.g., did not have an Axis I diagnosis). Another common basis for rejection was that the person was ineligible for reasons relating to current or past criminal charges, accounting for approximately one-fifth of the rejections.

We were also interested in whether persons who were accepted into the courts differed from those referred. Because of small sample sizes, we were precluded from examining the data

for each site separately. Thus, for the analyses described below, we first collapsed data across six of the seven courts (data from the Orange County, NC MHC have been excluded because they did not reject anyone). We performed a logistic regression, which included six of the seven courts and predicted differences between those accepted (n = 130) and those rejected (n = 97). The model was significant, χ^2 (5) = 37.71, $p < .001$, Nagelkerke $R^2 = .21$, and 69% of participants were correctly classified. Age was not a significant predictor of acceptance decisions. The difference between the mean age of those accepted, $M = 35.12$, and those rejected, $M = 36.49$, was not significant, F (1, 237) = 0.92. The rates of acceptance for men and women also did not differ. Overall, of those accepted for enrollment, 42% were women. In addition, being White was not predictive of acceptance decisions (overall, 56% of those accepted were White).

In terms of mental health status, a large significant effect emerged. Not surprisingly, persons who did not have a mental illness or persons whose mental illness status was unknown were more likely to be rejected than accepted. In addition, persons with violent charges were no more or less likely to be accepted than those without similar charges.

Conclusions

One of our research questions was whether the participants in these mental health courts would reflect the nearly universal pattern of other types of jail diversion programs where older, White women are overrepresented as compared to their proportions among all arrestees. This was confirmed by our data. The finding that mental health jail diversion programs are disproportionately composed of older, White women is consistent enough to warrant further investigation. Do these three characteristics increase (or are perceived to increase) the probability of favorable outcomes (i.e., less recidivism, increased treatment engagement)?

Our descriptive data on referral patterns and case processing provide insight into how mental health courts operate as new forms of jail diversion for persons with serious mental illness. However, this is only an initial step to approaching the core question: for whom do such courts work and why? Between the previously published research and data reported here, we can see that despite wide variations, mental health courts can be arrayed across some key dimensions. For example, much about how cases are processed and ultimately supervised in the community depends on the ratio of felony to misdemeanor cases handled by the court (see Redlich et al., in press). Both the length of supervision and the available sanctions for non-compliance vary considerably by whether the charges are felonies or misdemeanors. Likewise, whether charges are dropped, continued, or a guilty plea is required can determine whether community supervision with reports back to the court is primarily the responsibility of the criminal justice system via probation departments or the mental health system via case managers (Griffin et al., 2002).

Problem solving courts have become a major force in reshaping court administration across the U.S. In most cases, these innovations emerge from judicial and community frustration with the justice system's inability to stem the tide of recidivism and violence. Unfortunately, most of these innovations proceed far in advance of the empirical evidence to inform their structures, clientele, policies, procedures and overall operations. In the case of mental health courts, history is repeating itself. The data reported here and the limited amount of other available research suggests there is a lack of standardization, no assurances that the people targeted for diversion are the optimum candidates, and great uncertainty about best models for supervision and monitoring. It may be advisable for communities to slow the tide of new mental health courts until the specified effectiveness of current ones can be demonstrated.

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ABSTRACT

An important new development in court administration is the mental health court (MHC). MHCs are criminal courts based on the notion of therapeutic jurisprudence that divert persons with mental illness from incarceration to outpatient treatment. Despite little to no empirical data that MHCs are successful, the courts are proliferating. Today, there are 100 MHCs in the United States whereas only one existed in 1997. In the present report, we describe our process evaluation of seven MHCs. The courts were partially funded by the Bureau of Justice Assistance. The seven MHCs are: 1) Santa Clara County, CA; 2) Orange County, NC; 3) Allegheny County, PA; 4) Washoe County, NV; 5) Brooklyn, NY; 6) Bonneville County, ID; and 7) Orange County, CA.

Our evaluation consisted of a qualitative and a quantitative stage. The qualitative stage involved site visits to the courts, for which standardized reporting and summary forms were created. We noted four dimensions that characterized the courts: 1) the type of charges the court accepts; 2) the type of adjudication model the courts follow; 3) sanctions employed in the court, and 4) supervision of MHC participants. Based on notable differences between the descriptions of older courts and those we evaluated which were more recently established, we proposed that a second generation of MHCs had developed.

The quantitative evaluation was designed to examine the front-end court processes of referral and disposition decision-making. Data collection consisted of a one-page questionnaire completed on every court referral (n = 285) during a three-month period. We found that the MHCs varied substantially in how they managed cases from referral to the decision to accept or

reject the person for MHC admission. We also found that older, White women were more likely to be referred to the courts, which is similar to the practices of other types of diversion programs.

Our evaluation data on the seven courts provide insight into how mental health courts operate as new forms of jail diversion for persons with mental illness. The data reported here and the limited amount of other available research suggests there is a lack of standardization across MHCs and no assurances that the people targeted for diversion are the optimum candidates. It may be advisable for communities to slow the tide of new mental health courts until the specified effectiveness of current ones can be demonstrated.

An Evaluation of the Bureau of Justice Assistance

Mental Health Court Initiative

FINAL REPORT

One of the most important developments in court administration in the past decade is the mental health court (MHC, Petrila, 2003). MHCs are criminal courts based on the notion of therapeutic jurisprudence (Winick & Wexler, 2003) that hear cases of individuals with mental illness charged with crimes. They are often proposed as a strategy to stop the revolving door of repeated cycling through the criminal justice system of people with mental illness (CMHS, 1995). Moreover, they were developed in response to the large numbers of persons with severe mental illness incarcerated in jails, their special needs while incarcerated, the difficulties courts face in effectively addressing mental illness issues and the strains that involvement with the criminal justice system places on individuals with mental illness and their families. Despite little to no empirical data that MHCs are successful in obtaining their goals, the courts are proliferating at a fast rate (Steadman, Davidson, & Brown, 2001). Today, there are 100 MHCs in the United States whereas only one existed in 1997 (GAINS Center, 2004), and Congress recently appropriated seven million dollars to the development of new MHCs (Public Law 106-515, 2000).

In the present report, we describe our evaluation of seven mental health courts. The courts were partially funded by the 2002 Bureau of Justice Assistance funds for MHCs and were the seven courts that were operational at the time we began the evaluation. The evaluation, which focused on the processes of mental health courts (as opposed to outcomes), included both qualitative and quantitative portions. Before describing our methods and findings, we provide a brief background of mental health courts.

Mental Health Courts

Mental health courts emerged as one response to the relatively large number of persons with mental illness involved in the criminal justice system (Ditton, 1999). It has been surmised that the deinstitutionalization of persons with mental illness from hospitals that occurred in the second half of the past century created a situation in which these released persons in the community are now being arrested and re-institutionalized in jails and prisons. This phenomenon has been labeled the "criminalization" of persons with mental illness (see Torrey et al., 1992). Recent responses to this phenomenon include jail- and court-based diversion programs and governmental action and funding.

In 2004, The Mentally Ill Offender Treatment and Crime Reduction Act was enacted authorizing grants to states and localities to develop collaborative mental health and criminal justice responses, including jail diversion programs, for people with mental illness in the criminal justice system. These federal grant programs receive further credibility from the President's New Freedom Commission on Mental Health report (2003), which recommended "widely adopting adult criminal justice and juvenile justice diversion and reentry strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness" (p. 43-44).

Many programs have emerged in recent years to divert individuals with mental illness from jail to community-based treatment and support services. In 1992, a national survey of jail diversion programs estimated that only about 52 jails in the U.S. had diversion programs for persons with mental illness (Steadman, Barbera, & Dennis, 1994). Today, the TAPA Center for Jail Diversion reports there are over 300 jail diversion programs nationally (Steadman & Naples,

2005). Similarly, MHCs have grown rapidly. In 1997, there were two mental health courts; today, there are more than 100 courts (Redlich et al., in press).

Mental health courts have been described as idiosyncratic (Goldkamp & Irons-Guynn, 2000; Steadman et al., 2001). However, there are at least five commonalities that operationally define mental health courts. First, MHCs are criminal courts with separate dockets exclusive to persons with mental illness. Some MHCs are exclusive to persons with serious and persistent mental illness (SPMI, Axis I disorders). Other MHCs have less stringent criteria and only require "demonstrable mental health problems" (as opposed to diagnoses). Additionally, some MHCs focus on misdemeanants, whereas others focus on felons.

Second, MHCs were developed as a mechanism to divert persons with mental illness from jail into community mental health treatment, and to therefore reduce the detrimental cycle of revolving in and out of jail (CMHS, 1995; Torrey et al., 1992). Empirical outcome data from specific courts are just beginning to emerge (Boothroyd, Poythress, McGaha, & Petrila, 2003; Trupin & Richards, 2003) indicating that MHCs can be somewhat successful in 1) getting participants to engage in treatment and 2) lessening recidivism. However, whether MHCs will be as successful as their predecessors and exemplars--Drug Treatment Courts--in improving client outcomes and quality of life remains to be seen.

Third, all MHCs mandate and monitor community mental health treatment. Main requirements are that participants engage in treatment and take prescribed medications. Some MHCs have written contracts that participants must sign before being allowed to enroll (Goldkamp & Irons-Guynn, 2000). Although most MHCs state that they do not force participants to take their medications, participants are often disallowed from continuing in the MHC if they do not comply. That is, because a requirement of MHCs is taking prescribed medications, not

taking them is grounds for dismissal. To gain compliance, there are usually incentives in place, such as having the initial charges dropped or reduced or the conviction vacated (in addition to avoiding jail/prison). There are numerous other requirements attached to MHCs and these vary from court to court and from defendant to defendant. A usual first step for the courts is to set up individualized treatment plans at the onset of defendants' participation (see Goldkamp & Irons-Guynn, 2000); complying with treatment plans is central to graduating from MHCs. Other requirements include, but are not limited to, desisting criminal behaviors, attending scheduled court review hearings, meeting with vocational training officers, finding and maintaining employment, and more idiosyncratic mandates (e.g., physical exercise, keeping one's home clean, moving from a certain location).

All MHCs monitor participants' compliance, of which the intensity of supervision can depend on the court and on the defendant. In this context, supervision refers to the responsibility of ensuring MHC participants stay engaged in community treatment (e.g., go to therapy sessions, take their medication) and otherwise follow the court's orders. Courts may have dedicated personnel responsible for supervision and reporting back to the judge (e.g., specialized probation officers, court monitors), may rely on community treatment providers indirectly linked to the court, or may use some combination of court and community providers (Griffin, Steadman, & Petrila, 2002).

Fourth, MHCs offer praise and encouragement for compliance and impose sanctions for non-compliance. MHCs clearly work under the model of therapeutic jurisprudence (Winick & Wexler, 2003), and as such tend to recognize small and large successes. It is common for MHC judges to congratulate participants at status review hearings for accomplishments such as going to scheduled clinic appointments and adhering to their treatment plans. These review hearings

may be weekly, bi-weekly, monthly, or even quarterly. It is also common for the entire courtroom to applaud participants' efforts. After sustained periods of success and stability, participants graduate from MHC, which is the point when the original charges may be dropped or the conviction vacated and when connection with the criminal justice system ends.

In contrast to offerings of praise and encouragement for compliance is the utilization of sanctions for non-compliance. Commonly used sanctions include admonishments from the judge, increases in supervision and in the number of status hearings, and when necessary, returning people to jail. Courts differ on their use of jail as a sanction, but it is becoming more common as MHCs accept more felons. If non-compliance is ongoing, participants can be dismissed from the MHC and returned to regular criminal court processing and/or to their sentence of jail or prison. But, it should be noted that perfect performance is not expected in mental health courts. Graduated sanctions are common with jail usually as a later option when other penalties have failed. Thus, although most MHCs have lenient policies regarding noncompliance, all courts have mechanisms in place to counter noncompliance.

Fifth, a precondition across all MHCs is that they are voluntary, referring to the fact that potential participants must choose to enroll in the court on their own accord. There is little knowledge available on how (or if) the courts ensure decision-making is indeed voluntary.

Gaps in the Knowledge Base of Mental Health Courts

As mentioned above, mental health courts have grown rapidly in the U.S. from one in 1997 to 100 today (GAINS Center, 2004). However, research on these specialty courts has not kept pace with their growth. To date, the multi-site studies that exist are descriptions of the structures and operations of the courts (e.g., Goldkamp & Irons-Guynn, 2000; Griffin et al., 2002). The most ambitious research projects published have been single-site outcome studies in

Broward County, FL and Santa Barbara, CA. The Broward study has produced a series of papers on the operation of the court (Petrila, Poythress, McGaha, & Boothroyd, 2001; Poythress, Petrila, McGaha, & Boothroyd, 2002), and the characteristics and service use of the participants (Boothroyd et al., 2003), with analyses on participant outcomes now being conducted. The Santa Barbara study was a randomized control trial comparing a MHC participant sample and a treatment-as-usual (control) sample (Cosden, Ellens, Schnell, Yasmeen, & Wolfe, 2003). Both samples had been referred and found eligible for the MHC, but were randomly assigned into their respective groupings. The authors found that the experimental and control groups had similar rearrest rates and days in jail over the first year, but the MHC subjects were more often rearrested for technical violation of probation while the controls were rearrested for more serious charges.

The dearth of research on the outcomes of mental health courts relative to their proliferation is not surprising. The growth in the number of courts reflects the broader trend in court administration towards problem-solving specialty courts such as drug courts, domestic violence courts and community courts (Petrila, 2003). In addition, the emergence of mental health courts reflects the frustration of the criminal justice system in processing more persons with serious mental illness and seeing some of the same mentally ill persons continually reappearing before the criminal courts. Mental health courts have not grown based on an empirical database demonstrating that they have had a positive impact (Steadman et al., 2001).

In many ways, the mental health court movement sharply contrasts that of drug courts. For example, whereas early on, drug courts had a strong, federally supported model from which to draw, mental health courts tend to be locally driven reflecting the styles and values of founding judges. What the drug and mental health courts share is a prolific growth. The first drug

court was established in Dade County, FL in 1989. Today there are 1,823 drug courts. This widespread enthusiasm reflects a response to the need for a therapeutic alternative to the stringent sentencing schemes for drug crimes enacted in the 1980's. This option, when combined with early federal support for a model for the structure of drug courts that required a standard training procedure for all recipients of federal grants via heavily funded technical assistance centers, fueled adoption in jurisdictions across the country. Moreover, research suggested positive outcomes for drug court clients (Belenko, 1999; Gottfredson, Najaka, & Kearley, 2003).

No such context currently exists for mental health courts. To date, the only federally supported technical assistance for these courts is the center operated by the Council of State Governments funded in 2003 in support of the 37 mental health courts funded by the Bureau of Justice Assistance in 2002 and 2003. Other than an initial grantee meeting in January 2004, there are no training requirements for these courts' personnel. Nor has the federal government promulgated either a specific or general model for the core characteristics of MHCs. Rather, communities have been left to their own devices to devise programs that will best serve their needs. No federal dollars have been appropriated for mental health courts in 2004. Whether the research on mental health courts can inform program development at the same pace as drug courts remains to be seen.

Our goal in this evaluation was to advance the knowledge base that can inform communities searching for alternatives to the unnecessary incarceration of people with serious mental illness. The present study was designed to examine the referral and disposition decision-making processes of mental health courts (MHCs). Given that mental health courts have emerged without reference to a standard model, it is important to begin to understand the characteristics not only of those who enter the court's jurisdiction, but also to understand the characteristics of

those *referred* for possible entry to the court and the processes by which communities make such decisions.

Overview of Present Research

In 2002, the Bureau of Justice Assistance announced their first round of funding for mental health courts. Twenty-three courts were funded. Under National Institute of Justice support, we conducted a process evaluation of the seven operational courts. The remainder of the courts used the BJA funds to initiate their MHCs and thus were not suitable for evaluation. Our process evaluation consisted of two stages: 1) qualitative stage, involving site visits to the courts, and 2) a quantitative stage, involving data collection on the characteristics of referrals and court disposition decisions over three months. The qualitative evaluation was a necessary first step in developing and conducting the quantitative evaluation. We also note that all data collection procedures were approved by Policy Research Associate's Human Subjects Committee.

The seven courts are described below.

1) *Santa Clara County, California*. Santa Clara County is a large county both in terms of population (1,682,000 residents) and geography. The major city is San Jose, a hub of Silicon Valley. The Santa Clara County MHC grew directly from the county's Drug Treatment Court, and the MHC is a dual-diagnosis court. That is, the MHC in this county focuses on clients who have mental health issues as well as substance abuse issues. However, the Court does not restrict eligibility to only those with co-occurring problems. Rather, the court casts a broad net and accepts nearly all referrals. It is one of the largest MHC we have seen with over 600 participants and a calendar that meets a full day and a half per week.

2. *Orange County, North Carolina*. This court, named the "Community Resource Court," originated in May 2000. The idea for the Court was initiated by a local National Alliance for the

Mentally Ill (NAMI) member. Orange County has 118,000 residents and is home to Chapel Hill and Hillsborough. Court is held twice a month in two locations. When we visited the court in August 2003, there were 65 cases combined for the two dockets.

3. *Allegheny County, Pennsylvania.* Allegheny County, whose major city is Pittsburgh, has nearly 1.3 million residents. The first referral to the court was in July 2001. The court holds both plea and reinforcement hearings, which are held alternately once a week. The plea hearings are the first-time appearances for new defendants. The reinforcement hearings, which are characterized by MHC personnel as positive (e.g., praise for treatment adherence) or negative (e.g., threat of sanctions for treatment non-adherence) and are dependent on progress and compliance, are first held every 30 days and later every 90 days as participants advance through the MHC process. At the time of our site visit to the court, there were 120 active cases and 36 people who had successfully graduated.

4. *Washoe County, Nevada*. Washoe County is in Northern Nevada. The larger cities there are Reno and Sparks, and the county is home to nearly 500,000 residents. The MHC began accepting referrals in November 2001 and from its inception, approximately 225 participants have enrolled in the court. At the time of our visit, there were 37 cases on the docket. The Court meets weekly and is one of several specialty courts in the county.

5. *Brooklyn, New York*. Brooklyn is home to 2.5 million people. This court started as a pilot program in March 2002 and at the time of our visit, approximately 40-50 people had participated. The court meets weekly and status hearings are held with decreasing frequency as the participant progresses through the court. Like many mental health courts, Brooklyn's court was sparked by its drug treatment court. This MHC is part of a larger array of forensic programs for persons with mental illness.

6. *Bonneville County, Idaho*. The hub of Bonneville County, which is home to approximately 85,000 residents, is Idaho Falls. Its MHC began in August 2002 and is small relative to other mental health courts. One reason for its small size is the court's integration with an Assertive Community Treatment (ACT) team. All MHC clients are served by the ACT team. By their nature, ACT programs are intensive and the ratio of clients to staff is low. In this MHC, no more than 20 clients at one time can participate; at the time of our visit, there were 13 active clients. Court is held once a week.

7. *Orange County, California*. Orange County is a large California county in the southern part of the state. Although the county has 2.8 million residents, the MHC serves only a specific region of the county, which has a population of 800,000 people. Like the other California MHC in Santa Clara County, this MHC is a dual-diagnosis court. All participants must be enrolled via the California Proposition 36 track, which is "The Substance Abuse and Crime Prevention Act." This initiative allows for treatment alternatives to incarceration for first-time and second-time nonviolent drug possession offenders and is the primary funding mechanism for the Orange County MHC. At the time of our visit, there were 47 active participants enrolled.

Qualitative Evaluation: Site Visits

Methodology

Over a four-month period in 2003 (June – September), two-person teams (comprised of the PI, the Project Director, and three senior consultants) conducted site visits of the courts. A set of fifty questions was developed a priori building from the previous MHC comparison work of Goldkamp & Irons-Guynn (2000) and Griffin et al. (2002), and answers were obtained during the site visits. This form is attached (Appendix A). Soon after the site visit was completed, the two-person team who had conducted the visit completed a follow-up site visit report. This report

represented a summary of the answers to our site visit questions, as well as any additional information gleaned over the course of the visit. Attached in Appendix B are the site visit reports for all seven courts.

Results

Our first step in analysis was to systematically describe the seven courts. We noted four dimensions that succinctly characterized the courts: 1) the type of charges the court accepts (felony versus misdemeanor); 2) the type of adjudicative model the courts follow (pre- versus post-adjudication); 3) sanctions employed in the court (specifically the expressed willingness to use jail as a sanction), and 4) supervision of MHC participants (mental health versus criminal justice professionals).

Table 1 describes the seven MHCs on these four dimensions. As discussed in detail below: 1) all of the courts accept felony cases; 2) all but one utilize post-adjudication models; 3) the majority are comfortable placing persons in jail as a sanction when necessary; and 4) there is a preponderance of reliance on internal supervision (i.e., internal to the criminal justice system).

Table 1

Characteristics of the Seven BJA-NIJ Mental Health Courts

	Types of Cases Accepted	**Type of Adjudication Model**	**Jail as a Sanction?**	**Type of Supervision**
Santa Clara County, CA	Mostly felonies	Post-plea	Comfortable using it, but used with discretion	Team TYPE 3
Orange County, NC	Misdemeanors and felonies	Mostly pre-plea	Comfortable using it, but used with discretion	Treatment staff (most cases) TYPE 1
Allegheny County, PA	Misdemeanors and some property felonies	Post-plea	Rarely used	Probation TYPE 2

Washoe County, NV	Misdemeanors and felonies	Post-plea	Comfortable using it, but used with discretion	Team TYPE 3
Brooklyn, NY	Non-violent felonies; few misdemeanors	Post-plea	Rarely used	Court case managers TYPE 2
Bonneville County, ID	Misdemeanors and felonies	Post-plea	Comfortable using it, but used with discretion	ACT team and Probation TYPE 3
Orange County, CA	Felony- Substance	Post-plea	Comfortable using it, but used with discretion	Probation TYPE 2

After identifying these dimensions, we found that an appropriate way to proceed was to compare and contrast the seven MHCs that we studied with other MHCs that have been previously studied and described in the literature. More specifically, based on our prior knowledge of mental health courts, the authors of this report and the three senior consultants believed that from our site visits, mental health courts were in a state of evolution. Thus, a comparison with established and already-studied courts seemed an effective way to test our beliefs about the possible changing nature of mental health courts. A paper on this topic, which includes the qualitative evaluation analysis of the seven BJA-funded MHCs, is now "in press" in *Psychology, Public Policy and the Law* (Redlich, Steadman, Monahan, Petrila, & Griffin, in press). In this article, we proposed that a second generation of MHCs was developing, based on notable differences between the descriptions of older courts and those developed within the past three years. We supported this proposition by comparing eight established mental health courts (what we referred to as the 'first generation') previously addressed by Griffin, Steadman, and Petrila (2002) with the seven newer BJA-funded MHCs (what we referred to as the 'second generation').

First-Generation Mental Health Courts. Griffin et al. (2002) examined eight well-established MHCs. The first four were formerly investigated by Goldkamp and Irons-Guynn (2000) and are located in 1) Broward County, Florida, 2) King County, Washington, 3) San Bernardino, California, and 4) Anchorage, Alaska. Griffin and her colleagues then "identified the four longest-running mental health courts other than those studied by Goldkamp and Irons-Guynn" (p. 1286) as MHCs in 5) Santa Barbara, California, 6) Clark County, Washington, 7) Seattle, Washington, and 8) Marion County, Indiana. These eight courts began in the mid- to late-1990s.

Table 2 lists characteristics of the eight first-generation courts as described by Griffin et al. (2002). At the time, six of the eight only accepted defendants with misdemeanor charges, and often times restrictions were placed on the misdemeanors these courts were willing to accept. For example, four of the courts excluded defendants with charges of driving under the influence. However, since the Griffin et al. article was published, four of the six courts that had only accepted persons charged with misdemeanors will now consider persons charged with felonies on a case-by-case basis (see GAINS Center, 2004).

Table 2

Characteristics of First-Generation Mental Health Courts

	Types of Cases Accepted	**Type of Adjudication Model**	**Jail as a Sanction?**	**Type of Supervision**
Broward County, FL	Misdemeanors	Mostly Pre-Plea	Extremely Rare	Community Treatment Providers TYPE 1
King County, WA	Misdemeanors	Mostly post-plea	Sparingly	Probation (special) TYPE 2
San Bernardino, CA	Misdemeanors and low-level felonies	Post-plea	Used liberally	Team: Probation and MH staff TYPE 3

Anchorage, AL	Misdemeanors	Mostly post-plea	After repeated attempts and still non-compliant	Court monitor TYPE 1 AND 2
Santa Barbara, CA	Misdemeanors and some felonies	Mostly post-plea	Occasional use	Team: Probation and MH staff TYPE 3
Clark County, WA	Misdemeanors	Pre-plea and post-plea (depending on jurisdiction)	Avoids unless there is a new violent charge	Community Treatment Providers (most cases) TYPE 1
Seattle, WA	Misdemeanors	Mostly pre-plea	Rarely and conditional	Probation (special) TYPE 2
Marion County, IN	Misdemeanors	Pre-plea	Rarely	Community Treatment Providers TYPE 1

In terms of the type of adjudication model the eight courts followed, Griffin et al. (2002) described three models: 1) Preadjudication model; 2) Postplea-based model; and 3) Probation-based model. The second and third models are post-adjudication models in that convictions are in place, but sentences may or may not be imposed. Four of the eight used a pre-adjudication model for most or all of their cases. Under this agreement, a plea of guilty may be required but the case is not adjudicated. Often, the prosecutor holds the charges in abeyance and this is what is used as leverage to motivate the participant to comply with mental health treatment and other orders of the court. Three of the courts used post-adjudication for most or all of their cases, and for one court (Clark County, Washington), the use of the pre- and post-adjudication models depended upon where in the county the crime was committed.

All of the eight first-generation MHCs reported using a variety of sanctions when compliance with court-ordered conditions was less than perfect. Sanctions included hearings before the judge (where participants usually receive reprimands from judge), changes in treatment plans, and community service. Jail was available as a sanction but most courts reported using it very rarely. One court, San Bernardino, CA, however, reported using jail as a sanction more liberally.

As reported in Griffin et al. (2002), the eight courts follow one of three supervision models. In this context, supervision refers to the responsibility of ensuring MHC participants stay engaged in community treatment (e.g., go to therapy sessions, take their medication) and otherwise follow the court's orders. Type 1 is a model in which community treatment providers are primarily responsible for MHC participant supervision but also report back to the court on a regular basis and/or when difficulties arise. In the Type 2 model, recurring supervision is provided by court staff or probation/parole officers. Sometimes, the court staff person or probation officer has a dedicated position or caseload and works exclusively with MHC participants. The Type 3 model is when mental health staff and probation work together. Four of the first-generation courts followed Type 1 supervision model, three followed Type 2, and two courts followed Type 3. (Note that the Anchorage, AL MHC used both Type 1 and 2 supervision models depending on which court program the participant was in.)

Overall, based on descriptions provided by Goldkamp and Irons-Guynn (2000) and Griffin et al. (2002), the majority of first-generation mental health courts focused on misdemeanants. As such, the courts were in better positions to accept cases without requiring convictions and to rely more heavily on supervision external to the MHC (i.e., community mental health providers).

Similarities and Differences between First- and Second-Generation MHCs

First- and second-generation MHCs have clearly descended from the same ancestors. Indeed, there are likely to be more similarities between the generations than differences. For example, all of the courts we evaluated are problem-solving courts and based on the premise of therapeutic jurisprudence (Winick & Wexler, 2003). In addition, court processes are generally informal and non-adversarial.

Goldkamp and Irons-Guynn (2000) described three common factors of early MHCs. First, the courts are designated as specialty courts; that is, courts that have special dockets and, in the case of mental health courts, only accept participants with mental health problems or diagnoses. Of the eight examined by Griffin et al., this was clearly the case. Of the seven more recent courts presented here, at least one will accept clients without mental health problems and includes those with physical health problems, such as AIDS or Hepatitis C. This is most likely to be an exception to the rule, however. We would still generally describe the second generation of MHCs as those that primarily serve persons with mental illness.

The second common feature of MHCs noted by Goldkamp and Irons-Guynn (2000) was that most have dockets restricted to nonviolent misdemeanants. Although we discuss this more in depth below, we did not find this standard across the newer courts. The third common feature was that mental health courts attempt to divert people into community treatment instead of jail or prison. This was also a goal of the seven more recent courts; a goal that is unlikely to change over time and with the creation of even newer courts. Indeed, the first and third features are integral to the *definition* of mental health courts, whereas the second feature serves better as a *description* of individual courts. Mental health courts, as generally understood, are specialty courts for persons with mental illnesses charged with crimes (the first feature) and are designed

to mandate people into treatment instead of incarceration (the third feature). The second feature—restriction to nonviolent misdemeanants—is a feature that is alterable without necessarily changing the definition of a mental health court. This second feature is also our first dimension distinguishing first- from second-generation courts.

Dimension One: Type of charges accepted. In the Griffin et al. (2002) study, seven of the eight first-generation courts *focused* on misdemeanor crimes, and only two courts (San Bernardino and Santa Barbara) included felony crimes. Updated information (GAINS Center, 2004) on these eight courts informs us that now only two courts will not consider felony defendants. Of the seven second-generation courts, all accept felonies. Three of the seven can be described as focusing on felonies or those that only accept felonies. Of the four that accept both misdemeanants and felonies, we would describe only one (Allegheny County, PA) as focusing on misdemeanor crimes with an occasional acceptance of persons charged with felonies on a case by case basis (see Tables 1 and 2).

A related feature is whether courts will accept offenders charged with violent offenses or those with violent histories. From our observations, the seven second-generation courts were also more relaxed on this issue, although this is not to say that these courts were unconcerned with public safety as they clearly made it a priority. In the eight first-generation courts, two courts allowed for charges of domestic violence or battery and sometimes only with the victims' consent. Of the seven second-generation courts, restrictions concerning violent charges and histories still exist, but most courts were also willing to apply a "totality of the circumstances" approach and examine the circumstances surrounding the crime, the person, and the overall situation before making a decision of acceptance or rejection. For example, one of the courts accepted two women with mental illness accused of killing their children. Another court enrolled

a person charged with taking a saw to a female neighbor's door. In this latter case, an exception was made because court-related personnel were familiar with the potential client and believed the MHC was in the participant's and in society's best interest. Similarly, the Bazelon Center (2003) reported in their analysis of 20 mental health courts that 80% were willing to consider persons charged with violent acts.

Dimension Two: Type of Adjudication Model. Of the eight courts studied by Griffin et al., although six have mechanisms for post-plea adjudication, four of the eight relied primarily on pre-plea models. Using information from the National GAINS Center (2003) report, it would seem that the eight courts have not changed their adjudication procedures with one exception. The Marion County, IN court appears to have changed to a deferred-sentence model and thus processes cases post-adjudication. In contrast to some of the first-generation courts, of the seven second-generation courts, six only allow for post-plea enrollment. The seventh (Orange County, NC) is primarily deferred prosecution (pre-plea) but approximately 25% of their cases are post-plea/post-conviction.

An ancillary component to the more frequent utilization of post-plea adjudication models in the second-generation courts is that potential MHC participants are being referred much further down the criminal justice pipeline. For the eight first-generation courts, Griffin et al. wrote "Each court identifies possible participants within the first 24 to 48 hours of arrest" (p. 1286). Generally, we did not find this to be the case for the seven second-generation courts. Persons are either not being identified shortly after arrest during initial detention or, if they are identified shortly after arrest, are not enrolled in the MHC until much further into the adjudication process. Time from referral to first MHC appearance ranged from 0 to 129 days with an average of 28 days across the second-generation courts (Steadman, Redlich, Griffin,

Petrila, & Monahan, 2005). Potential referents are often identified by other judges and court personnel later in the criminal justice process. For example, in one of the seven newer courts, participants are convicted and sentenced before MHC consideration. The original sentencing judge is the final decision maker of whether persons are allowed to enter the MHC and if they replace their sentences with mandated community treatment. The implications of persons being referred much further down the criminal justice pipeline could suggest that persons are spending more time in jail than compared to earlier MHCs. Because diversion should be swift, an important research question is determining where referred MHC clients are spending their time between case initiation and MHC enrollment—in jail or in the community.

Dimension Three: Type of Sanctions Used. Within this dimension, we focus on the use of jail as a sanction. All of the fifteen (first- and second-generation) courts utilize a cadre of sanctions, such as mandating community service and reprimands from the judge. Griffin et al. noted that six of the eight first-generation courts reported rarely using jail as a sanction for non-compliance with the courts' orders. Of the second-generation courts, our impression was that jail appeared to be used with more regularity. At least five of the seven seem to be comfortable using jail as a sanction, although all reported using jail as a later (but not necessarily last) resort when earlier, less punitive sanctions had not induced treatment engagement. Moreover, all of the seven courts reported some flexibility in regard to non-compliance; that is, perfect performance was recognized as a futile goal. Many of the courts also acknowledged that whereas jail was an effective solution to gaining compliance for some participants, for others, jail had a detrimental and opposite effect. Thus, jail as a sanction was used with discretion.

Nevertheless, from what we observed, our perception was that the second-generation courts were more willing to place people in jail than previously studied MHCs, a consequence

perhaps of the fact that these more recent courts accept persons charged with felonies. For example, the Santa Clara County, CA MHC reported being comfortable using jail under the following circumstances: 1) as a "wake-up" call, 2) for medical detoxification, 3) as a result of new charges, or 4) for failure to keep appointments with their probation officers. Another common mechanism among several of the courts for jail time was "dirty" urinalyses, which is similar to their predecessors, Drug Treatment Courts. In its report on 20 mental health courts, the Bazelon Center (2003) found that 64% were willing to place people in jail for non-compliance, but the frequency of use was not specified. Empirical data is sorely lacking on the use of jail as a sanction (such as average numbers of jail days), as well as on all types of MHC sanctions.

Dimension Four: Type of Supervision. As described above, Griffin et al. denoted three types of supervision models for their eight first-generation courts. Type 1 was supervision by existing community mental health providers who reported back to the MHC either when there are difficulties or on a regular basis. Type 2 was regular supervision by dedicated MHC staff (e.g., Court Monitor, mental health staff) or probation/parole officers. Type 3 was regular supervision from a combination of probation officers and community or court mental health workers. For the second-generation courts, we found that the courts fit one of these three models but the majority of MHCs relied on supervision by personnel directly linked to the court.

As shown in Table 1, four of the courts rely on either probation solely or MHC staff (Type 2 model) to supervise clients in the community. Two courts utilize a team approach (Type 3) in that probation officers jointly supervise clients with either court staff or community mental health providers. Only one court—Orange County, NC--relies primarily on community mental health staff (Type 1) who then report back to the MHC. Although this court does have the option of probation supervision, it is not commonly used because in most circumstances it does not

apply (i.e., 75% of their clients are diverted pre-adjudication and are therefore not subject to probation). Thus, whereas the types of supervision employed by the first- and second-generation courts are similar, the frequency with which they are used differs. That is, while four of the first-generation courts relied solely on community treatment providers for supervision of participants, only one second-generation court did so. For the newer courts, it was more common to see court personnel and/or probation responsible for supervision.

It is clear that these four dimensions distinguishing first- from second-generation courts are related to one another. That is, because the courts now accept more felony defendants, the number of courts relying on post-plea adjudication models increased, as did the use of jail as a sanction and the use of criminal justice mechanisms of supervision. Since felony crimes, by definition, are more serious than misdemeanor crimes, prosecutors and others involved in the MHC more often require that potential participants plead guilty (with or without a conviction) to enroll in the MHC. This is also true for the increased use of jail as a sanction. In their report, the National Drug Court Institute (2000) noted that the leverage of jail is commonly used in drug treatment courts, which tend to handle felonies.

Moreover, the first three dimensions are relevant to the front end of mental health court operations. The day-to-day, back-end operations after participant enrollment have changed little. After enrollment dispositions are made, participants attend hearings in front of a judge, treatment mandates are issued, and some level of supervision is rendered; as noted above, because these courts accept defendants charged with felonies, the supervision is more likely to involve probation officers rather than be left solely to community mental health providers. Rather, what has seemingly changed is how potential persons are selected for enrollment, the front end of the court.

The precise reasons for the changes in how MHCs refer and select participants for inclusion in the courts are not known. We have several suppositions, however. One has to do with funding mechanisms for the courts. The two California courts, Santa Clara and Orange Counties, are linked to Proposition 36 funds. As noted earlier, this initiative allows first- and second-time, non-violent, simple drug possession offenders the opportunity to receive substance abuse treatment in the community instead of incarceration. As a result, both are dual-diagnosis courts and focus on felony defendants. One aim of Proposition 36 is to divert people from state prisons rather than local jails (a goal of many misdemeanor MHCs), and, as such, felons are a more appropriate target for these courts. It is also possible that localities have made policy decisions to not focus on misdemeanants because of uncertainty regarding the effectiveness of such a focus and reliance on alternative strategies for diversion. The Bazelon Center (2003) acknowledged that MHCs were becoming increasingly likely to accept felony defendants, but argued that misdemeanants are ill-suited for MHCs because they should be diverted from the criminal justice system entirely (e.g., pre-booking diversion programs). The Center's report states "To avoid becoming the entry point for people abandoned by the mental health system, mental health courts should close their doors to people charged with misdemeanors" (p. 7). If the trends we have noted from the first to second-generation courts continue, third- or fourth-generation courts may indeed be exclusive to felony defendants. And, finally, with an increase in the number of pre-trial/pre-arrest diversion and Crisis Intervention Training (CIT) programs for persons with mental illness (Naples & Steadman, 2003), it may be that the need has diminished for mental health courts to accept misdemeanants in localities with alternative forms of diversion. Some local jails will not accept misdemeanants (primarily because of overcrowding), regardless of mental health status.

Conclusions

The above is meant to generate thought and discussion concerning the differences between well-established and newly established mental health courts. It is not intended as an exhaustive catalogue of all of the current U.S. MHCs. We only examined fifteen courts over two studies, which is less than one-fifth of the mental health courts that exist in the U.S. Furthermore, we did not directly re-evaluate the eight first-generation courts, and thus their current practices may not match exactly what was described in the literature reporting on their operations up to 2002. We must also emphasize that we did not compare the efficacy of what we have labeled first- and second-generation courts and are not suggesting that second-generation courts are superior to first-generation courts. Lastly, we use the term "generation" to represent a cohort of courts, but, of course, there were some exceptions to the rule. That is, there were first-generation courts that may today have many of the characteristics of second-generation courts, and vice versa. However, our goal was to describe what was common among the courts and not pigeonhole courts into any one label.

Do the four dimensions—increased acceptance of felony charges, post-plea adjudication models, increased use of jail as a sanction, increased use of criminal justice supervision—challenge the intent of therapeutic jurisprudence? Are second-generation courts an improvement upon first-generation or simply a distinct type of mental health court? In the future, will the trend we noted with second-generation courts continue and will mental health courts limit their jurisdiction to felonies? What is the impact of the use of sanctions on compliance with court-ordered conditions? Some of these questions have been raised elsewhere (Griffin et al., 2002; Steadman et al., 2001), and as the characteristics of MHCs become more clear, it is to be hoped

that research will begin to address these questions along with the many other substantive issues that such courts raise.

Quantitative Evaluation: Referral and Disposition Processes

A key component of the qualitative site visits that we conducted was determining the best way to proceed with the quantitative portion of our evaluation. What information on mental health courts was lacking? Although there is still much to be learned about MHCs in general, we felt that there was a dearth of knowledge concerning how defendants came to enroll in the courts. And, as noted, main differences between first- and second-generation MHCs concerned the front-end operations of the courts. Thus, this portion of our evaluation was designed to examine the front-end processes of referral and disposition decision-making of mental health courts.

To our knowledge, there is only one prior study of case processing, which occurred in the Marian County, IN, Psychiatric Assertion Identification and Referral (PAIR) Program (Luskin, 2001). Luskin's case study of this court-based diversion program found that a history of felony convictions, a current charge of a crime against a person and being male decreased chances for diversion. In contrast, older males and younger females were advantaged for diversion.

Our research questions concerned 1) how cases were referred, processed and disposed of by the courts and 2) whether there were factors that distinguished cases *accepted* by the court from cases *referred* to the court. We were also especially interested in whether mental health courts, like the majority of other jail diversion programs (Naples & Steadman, 2003), would have older, White women disproportionately represented in comparison to their numbers in the criminal justice system as a whole. That is, the number of older, White women involved in the justice system is low, but individuals with these three characteristics—separately and combined—make up significant portions of the persons diverted from the criminal justice system

to community-based mental health treatment. The design of the present study allowed for determinations of whether this overrepresentation is a product of the diversion referral or acceptance process.

Methodology

Data were collected on all "formal referrals" to the seven courts during a three-month period. A formal referral was identified slightly differently for each court, but generally it was a person who had passed through that court's pre-defined referral process.

Court staff completed a one-page questionnaire for every formal referral between November 1, 2003 and January 31, 2004. The questionnaire (Appendix C) had three parts: 1) identification of the referring agent, 2) characteristics of the referred person, and 3) the disposition decision. For the referring agent, a list of potential agents was supplied (e.g., Public Defender's Office, Other Judge/Magistrate), as well as an "other" option. Characteristics of the referred person included demographic information (age, gender, race/ethnicity), criminal charge information (most severe current charge, number of misdemeanor and felony charges), and mental health/substance abuse information (diagnosis if available, presence of substance abuse problems). Information on the disposition decision included the date of disposition, whether the referred person had been accepted or rejected for entry into the court, or whether a decision had not been made (either because the defendant opted out of consideration or another reason). If the referred person had been accepted, information was collected on whether the person actually enrolled. If the person was rejected, reasons for rejection were obtained.

Generally, one person at each court completed the questionnaire. Depending upon the size of the court, the role of the person within the court differed. For example, in some of the

larger courts where resources for a "data" employee were available, this person completed the forms. In order to allow time for disposition of all referred cases, data collection ran five months.

Results

Over the three study months, 285 persons were referred to the seven courts varying from 15 to 91 referrals per court: Santa Clara County, CA: 36; Orange County, NC: 18; Allegheny County, PA: 91; Washoe County, NV: 73; Brooklyn, NY: 28; Bonneville County, ID: 15; and Orange County, CA: 24.

Referring Agent

As seen in Table 3, five of the seven courts listed the Public Defender's Office as either their primary or secondary referral source. Another common source of referrals was another judge or magistrate in the court system. Six of the seven courts processed their MHC cases post-adjudication, thereby allowing other judges to make referrals to the mental health courts. Finally, nearly one-third of referrals to the Brooklyn, NY MHC originated from competency to stand trial examination orders. All persons referred for competency exams in Brooklyn are required to be referred to this MHC.

Table 3

Main Referring Agents

	Primary Referring Agent	**Secondary Referring Agent**
Santa Clara Co., CA	Other Judge/Magistrate (58%)	Public Defender's Office (28%)
Orange Co., NC	Public Defender's Office (78%)	District Attorney's Office (17%)
Allegheny Co., PA	Forensic Diversion Program (33%)	Public Defender's Office (29%)
Washoe Co., NV	Court Officials (34%)	Other Judge/Magistrate (30%)
Brooklyn, NY	Public Defender's Office (43%)	Competency Examination Order (29%)

Bonneville Co., ID	Public Defender's Office (80%)	Probation (13%)
Orange Co., CA	Mental Health Court Judge (58%)	Other Judge/Magistrate (42%)
Overall	Public Defender's Office (29%)	Other Judge/Magistrate (20%)

Characteristics of Referrals

In comparison to persons in jails and prisons (see Beck, Karburg, & Harrison, 2002), mental health court referrals in our sample were more likely to be older, White, and women. As seen in Table 4, the mean age of referral for five of the seven courts was mid-30s, and percentages of those 35 and older ranged from 20% to 71%. The Bureau of Justice Statistics (Beck et al., 2002) reports that only 39% of all inmates are age 35 and older, whereas in our overall sample 53% were age 35 and older. Four of the seven courts had participant rates age 35 or older that were substantially higher than the national rate, one court had a similar rate, and two courts had rates that were lower.

The percentage of men referred to the mental health courts ranged from 45% to 72% with an overall mean of 60%. In U.S. jails and prisons, men make up 90 to 94% of all inmates (Beck et al., 2002). Thus, proportionally, at least in these courts, women are much more likely to be referred to these seven mental health courts than men. In terms of ethnicity, there was wide variability, which may have reflected the geographic diversity of the courts (for example, in Bonneville County, the overwhelming majority population of the county is White). Proportions of Whites referred to the courts ranged from 8% to 93%. Again, when compared to jail and prison populations, which are comprised of 63% minorities, whites are overrepresented in most of the courts. One exception is Brooklyn, where the majority of persons referred were non-White.

Table 4

Characteristics of referrals

	CA 1	**NC**	**PA**	**NV**	**NY**	**ID**	**CA 2**	**Overall**
Demographic Characteristics								
Mean Age in years	36.7	36.2	38.5	36.4	29.3	26.3	34.7	35.8
% 35 years and older	54.5	47.1	71.4	60.3	26.1	20.0	41.7	52.5
% Men	72.2	61.1	67.0	45.2	71.4	53.3	54.2	60.4
% White	55.6	50.0	52.3	75.3	7.7	93.3	70.8	58.4
% African American	19.4	38.9	45.5	11.0	61.5	0	8.3	28.7
Mental Health Characteristics								
No/Unknown Mental Illness	19.5	11.1	6.6	20.6	17.9	20.0	16.6	14.7
% Schizo spectrum	38.9	27.8	27.5	35.6	17.9	20.0	16.7	28.8
% Bipolar	5.6	11.1	27.5	21.9	17.9	26.7	0	18.9
% Depression/Mood	19.4	16.7	28.6	16.4	32.1	6.7	25.0	22.5
% Personality	0	5.6	0	1.4	0	13.3	0	1.4
% Anxiety	2.8	11.1	4.4	4.1	0	13.3	4.2	4.6
% Substance-related	11.1	0	1.1	0	3.6	0	37.5	5.3
% Other Diagnoses	2.8	16.7	4.4	0	3.6	0	0	3.2
Criminal Charge Characteristics								

% Felony Charges	69.4	16.7	6.6	46.6	89.3	93.3	100	46.1
% Drug-related	74.2	5.9	10.2	13.7	23.1	33.3	100	28.5
% Minor offenses	0	29.4	21.6	15.2	3.8	0	0	13.1
% Property	16.1	29.4	22.7	39.7	11.5	33.3	0	24.5
% Crimes Against Persons	0	11.8	15.9	2.7	7.7	0	0	7.3
% Violent	5.6	17.7	28.4	23.3	50.0	20.0	0	22.9
% Other Charges	2.8	5.9	1.1	5.5	3.8	13.4	0	3.6

Notes. CA 1 = Santa Clara Co., CA; CA 2 = Orange County, CA

Across the seven courts there was no clear pattern on mental health characteristics of the participants. Generally the three most common diagnoses were schizophrenia/ schizoaffective disorder, bipolar disorder, and depressive/mood disorders. In the Orange County, CA MHC, which is a dual-diagnosis court with funding drawn from appropriations for substance abuse treatment, a substantial number of referrals had been diagnosed with substance-related disorders, such as methamphetamine dependence and drug-induced psychosis. Many of the other courts noted that they were unwilling or unable to take on such cases, sometimes due to limitations in the types of cases community mental health services were allowed to consider. Finally, about 20% of the referrals from five courts were described as not having a mental disorder after further screening and assessment or it was unknown if the person had a mental disorder. In the other two courts, rates were lower at 7% (PA) and 11% (NC).

Most courts maintained a clear misdemeanor/felony distinction. That is, for four courts, the majority of referrals had felony charges, whereas for two courts, most referrals had

misdemeanor-only charges. In the Washoe County, NV MHC, the number of referrals with felony charges and with misdemeanor-only charges was nearly split 50-50.

In terms of the types of charges, in the two California MHCs, which were both dual-diagnosis courts and partially funded by California Proposition 36 Funds (i.e., a mechanism allowing for treatment alternatives to incarceration for first-time and second-time nonviolent drug possession offenders), the majority of referrals had drug-related charges as their most serious current charge. In the Orange County, CA court, 100% of the charges were drug-related, which was a requirement of the court. Across all courts, minor offenses, such as disorderly conduct, did not account for the preponderance of charges, although we only asked for the most serious current charge. Importantly, six of the seven courts had referrals with violent (e.g., aggravated assault, arson, robbery) charges.

Disposition Decisions

The proportion of all referrals ultimately accepted by the courts ranged from 20% to 100% (see Table 5). The Bonneville County, ID MHC had the lowest rate of 20%, most likely because this court is linked to an ACT team that has a maximum capacity of 20 participants. Orange County, CA had a similar acceptance rate. Three courts had approximately 50% acceptance rates, whereas the remaining two courts accepted all or nearly all of their referrals. Rates of the defendant opting out before a decision was made were generally low (5%), as were rates where no decision was made, with one exception. Specifically, in slightly less than one-third of their referred cases, Washoe County, NV ended up not having to make a decision of acceptance or rejection because the referred person had been let out of jail on “time served.”

Table 5

Disposition Decisions

	CA 1	**NC**	**PA**	**NV**	**NY**	**ID**	**CA 2**	**Overall**
Disposition Decisions								
% Accepted	88.9	100	44.0	49.3	50.0	20.0	20.8	51.9
% Rejected	11.1	0	46.2	19.2	39.3	73.3	62.5	34.0
% Defendant Opted Out	0	0	7.7	4.1	7.1	6.7	8.3	5.3
% Decision Not Made	0	0	2.2	27.4	3.6	0	8.3	8.8
Time from Referral to Disposition								
Mean in days	1.19	10.9	47.3	18.8	25.3	20.6	36.2	27.5
Mode in days	0	0	*	5	14	*	42	0
Acceptance Results								
% Defendants Enrolled	100	100	82.5	100	100	33.3	100	93.9
Primary Rejection Reasons								
% Ineligible: Mental Disorder	100	NA	4.8	14.3	36.4	36.4	86.7	29.9
% Ineligible: Crime	0	NA	23.8	21.4	9.1	18.2	13.3	18.6
% DA Declined	0	NA	40.5	0	0	0	0	17.5
% Incompetent/Unstable	0	NA	0	14.3	45.5	0	0	7.2

Notes. CA 1 = Santa Clara Co., CA; CA 2 = Orange County, CA. * = cannot be calculated, multiple modes.

The length of time from referral to disposition varied widely, ranging from an average of one day to more than 45 days (Table 3). The most common time period (mode) across the seven courts was 0 days (occurring 39 times, 14%), i.e. the decision was made on the day of referral, but this was driven by the Santa Clara County, CA and Orange County, NC MHCs (accounting for 33 of the 39 times). Of the remaining five courts, all but one (Allegheny County, PA) had made at least one disposition decision the same day the person had been referred (i.e., had a score of 0 on the measure of time between referral and disposition). Interestingly, of the 39 cases in which the referral and disposition occurred on the same day, 35 of them had been accepted, but again, this is because the Santa Clara County, CA and Orange County, NC courts accepted all or nearly all of their referrals. When the 39 cases of same day referral-disposition decision are excluded, the average length of time across courts was 32 days.

Most of the referrals accepted by the MHC team also agreed to enroll in the court. In five of the seven courts, 100% of those offered acceptance into the mental health courts enrolled. In the Bonneville County, ID court, the rate of one-third enrollment is somewhat misleading. The Bonneville County MHC accepted three persons, and of those, one enrolled. Of the two remaining, one was supposed to enroll after getting out of prison (this court is a post-conviction MHC) and the other had been extradited to Wisconsin. In the Allegheny County, PA MHC, seven persons who had been accepted did not enroll: one person chose not to enroll, one person was considered too unstable to enroll, and the five remaining could not be located. Interestingly, for these seven individuals, the lag time between referral and acceptance was quite long: for the person who declined enrollment, 64 days; for the person who was unstable, 129 days; and for the five who could not be found, 70-80 days.

While people were rejected for a variety of reasons (Table 5), a primary reason accounting for 30% of all rejections (but ranging from 5 to 100% across courts) was that the referred person was ineligible because of mental health status. More specifically, this could mean that the person 1) did not have a mental disorder, or 2) did not have a mental disorder consistent with the court's eligibility requirements (e.g., did not have an Axis I diagnosis). Another common basis for rejection was that the person was ineligible for reasons relating to current or past criminal charges, accounting for approximately one-fifth of the rejections. In one court—the Allegheny County, PA MHC—a significant portion (41%) of referrals were rejected because the DA declined to permit the case to proceed to MHC. The primary reason (46%) for rejection in the Brooklyn MHC was that the referred person was considered incompetent or too unstable at that time to make the decision to enroll and to participate in the court's proceedings. As noted above, a large portion of Brooklyn's referrals originated from competency examination orders from other criminal courts. Only one other court (Washoe County, NV) cited incompetence to proceed as a reason for rejection. Finally, other less common rejection reasons included that other parties or agencies (i.e., defense attorney, probation, mental health care system) declined (6.2%); that the person was considered unmotivated/too hostile (3.1%); or that the person was deemed more appropriate for another specialty court, such as a drug or pre-booking diversion court (5.2%).

Characteristics of Persons Accepted

In the section above, we discussed the characteristics of persons *referred* to the seven mental health courts. Of major interest is whether persons who are accepted into the courts differ from those referred. Because of small sample sizes, we were precluded from examining the data for each site separately. Thus, for the analyses described below, we first collapsed data across six

of the seven courts (data from the Orange County, NC MHC have been excluded because they did not reject anyone). Second, to examine whether the results we found across the six courts held for two of the courts individually, we re-conducted separate analyses with data from the Allegheny County, PA and Washoe County, NV MHCs. These two courts were the only ones to have sufficient numbers of accepted and rejected persons to conduct reliable analyses (see Table 5). Because we were unable to conduct analyses separately for each of the seven courts, these findings should be viewed with caution, but as providing preliminary insight into an important, understudied area.

For demographic characteristics, we focused on age and gender. For mental health characteristics, we focused on no or unknown mental illness versus mental illness versus serious mental illness (i.e., schizophrenia, schizoaffective, and bipolar disorders). For criminal characteristics, we focused on percent accepted/rejected with violent charges. We performed logistic regressions predicting characteristics of persons who were accepted into the courts compared with persons who were rejected. Persons who opted out or for whom no disposition decision was made were excluded. Lastly, we examined whether the time lag between referral and disposition was shorter for persons who had been accepted versus rejected.

The logistic regression, which included six of the seven courts and predicted differences between those accepted (n = 130) and those rejected (n = 97), was significant, χ^2 (5) = 37.71, $p <$ .001, Nagelkerke R^2 = .21, and 69% of participants were correctly classified. As shown in Table 6, age was not a significant predictor of acceptance decisions. The difference between the mean age of those accepted, M = 35.12, and those rejected, M = 36.49, was not significant, F (1, 237) = 0.92. The rates of acceptance for men and women also did not differ. Overall, of those accepted

for enrollment, 42% were women. In addition, being White was not predictive of acceptance decisions (overall, 56% of those accepted were White).

In terms of mental health status, a large significant effect emerged (Table 6). Not surprisingly, persons who did not have a mental illness or persons whose mental illness status was unknown were more likely to be rejected than accepted. However, a total of five persons (seven if NC is included) were accepted into a MHC without a known mental disorder. Moreover, persons with schizophrenia, schizoaffective, and bipolar disorders (i.e., SMIs) were much more likely to be accepted than rejected. Of those referrals with a serious mental illness, 76% were accepted. Persons with other types of mental disorders (e.g., depression, substance-related disorders) were approximately equally likely to be accepted or rejected (i.e., 44% were accepted). Another area of interest concerned acceptance/rejection rates of those with violent charges. Persons with violent charges were no more or less likely to be accepted than those without similar charges.

Next, we conducted logistic regressions to determine if the results we found overall (excluding NC) held for the Allegheny County, PA and Washoe County, NV courts. Separate regression analyses were conducted and both were significant, χ^2s (5) $\geq$ 15.39, *ps* < .01, Nagelkerke R^2s = .29 for PA and .38 for NV. For the PA and NV MHCs, respectively, 71% and 80% of participants were correctly classified. Results concerning age, being White, and severity of mental illness did not change (see Table 4). Specifically, age and being White did not influence acceptance-rejection decisions, but degree of severity of mental illness positively predicted acceptance decisions. In regard to gender, women were more likely to be accepted (69%) than men (38%) in the PA court, but for the NV court, men (74%) and women (70%) were accepted at equivalent rates. In regard to violent charges, results remained non-significant.

Table 6

Predictors of Acceptance Decisions

	All MHCs except NC			**PA**			**NV**		
	B	*Wald (1)*	*p*	*B*	*Wald (1)*	*p*	*B*	*Wald (1)*	*p*
Age	-.01	0.25	.62	.01	0.05	.83	-.07	2.58	.11
Gender (0 = Male, 1 = Female)	.51	2.58	.11	1.44	6.05	.01	-.41	0.21	.64
White (0 = No, 1 = Yes)	-.18	.36	.55	.24	0.19	.67	.75	0.52	.47
Mental Illness (0 = No MI, 1 = MI, 2 = SMI)	1.30	28.37	.001	1.34	7.93	.01	1.75	8.38	.01
Violent Charges (0 = No, 1 = Yes)	-.48	1.73	.19	-.68	1.38	.24	-0.28	0.08	.78

Notes. MI = mental illness; SMI = serious mental illness.

Lastly, we conducted an analysis of variance (ANOVA) to determine if the mean time between referral and disposition differed significantly between those who were accepted and those rejected. When data from all of the MHCs were entered, except North Carolina, the main effect of time was significant, F (1, 222) = 4.11, $p < .05$. Decisions for persons who had been accepted, M = 25.43 days, were made in shorter periods of time than for those who had been rejected, M = 32.95 days. However, when data from Pennsylvania and Nevada only were entered into separate ANOVAs, the time between referral and disposition decision for those accepted and rejected was non-significant, Fs (1, 47/80) $\leq$ 1.75.

Conclusions

Prior research has shown that there is no single model for the structure of U.S. mental health courts. Similarly, the case processing data presented here show that there is no standard way in which cases are managed from referral to the decision to accept or reject the person for admission to the MHC. The parties that make initial referrals to the mental health courts are fairly similar. Public Defender offices were either the primary or secondary reference in five of seven of the courts studied. At the same time, there are few commonalities concerning the characteristics of those referred. Mean age of referrals varied from 26 to 38 years. The proportion of cases that were male ranged from 45% to 72%. Ethnicity was highly variable from 0% African American to 62%. Similarly, mental health diagnoses varied widely as did criminal charges—felonies ranged from 7% to 100%. The time from referral to court decisions averaged from 1 to 47 days. But, the courts were quite similar in that almost all individuals who were offered mental health court as an alternative to normal criminal processing accepted.

One of our research questions was whether the participants in these mental health courts would reflect the nearly universal pattern of other types of jail diversion programs where older, White women are overrepresented as compared to their proportions among all incarcerated persons. Should this be the case, because we had referral data, we would be able to determine if this was the result of screening after referral or the referral pattern itself.

In general, differences between referrals and those accepted by the courts were non-significant for these three demographic factors. However, in the Allegheny County, PA MHC, gender was influential in acceptance decisions: women were more likely to be accepted than men. In this court, women accounted for one-third of referrals (which, as noted above, is substantially higher than national rates of 6-10% of women in jail/prison populations), and of the

women referrals, more than two-thirds were accepted. In the Marion County, Indiana MHC, Luskin (2001) reported similar results such that younger (but not older) women were advantaged for diversion into treatment. For whatever reason, we found that individuals in our sample referred by the public defenders, other judges, and the other referral agents were more likely to be older, White and female than individuals incarcerated. The finding that mental health jail diversion programs are disproportionately composed of older, White women is consistent enough to warrant further investigation. Do these three characteristics increase (or are perceived to increase) the probability of favorable outcomes (i.e., less recidivism, increased treatment engagement)? A prospective, multi-site mental health court study will help to distinguish whether successful outcomes are largely a product of the type of people in the court or a product of the court mandates themselves.

Our descriptive data on referral patterns and case processing provide insight into how mental health courts operate as new forms of jail diversion for persons with serious mental illness and co-occurring substance use disorders. However, this is only an initial step to approaching the core question: for whom do such courts work and why? Between the previously published research and data reported here, we can see that despite wide variations, mental health courts can be arrayed across some key dimensions. For example, much about how cases are processed and ultimately supervised in the community depends on the ratio of felony to misdemeanor cases handled by the court (see Redlich et al., in press). Both the length of supervision and the available sanctions for non-compliance vary considerably by whether the charges are felonies or misdemeanors. Likewise, whether charges are dropped, continued, or a guilty plea is required can determine whether community supervision with reports back to the

court is primarily the responsibility of the criminal justice system via probation departments or the mental health system via case managers (Griffin et al., 2002).

In order to develop a meaningful sampling strategy for an outcome study, it was essential to provide basic descriptive work on the characteristics of such courts. It is now time for the field to conduct both single- and multi-site studies that follow mental health court participants into the community, measure the services and supervision they receive, and collect outcome data on clinical, satisfaction, quality of life, and social policy indicators, including recidivism, violence, hospitalization, as well as cost data that can assess the effectiveness and the cost-effectiveness of mental health courts. More specifically, what types of detainees are most likely to profit from which of the various types of mental health courts that are proliferating across the U.S., and at what price? Ultimately, the question is a broader one of whether mental health courts are the preferred public policy option for jail diversion.

Implications for Criminal Justice Practice and Policy

Problem solving courts have become a major force in reshaping court administration across the U.S. In most cases, these innovations emerge from judicial and community frustration with the justice system's inability to stem the tide of recidivism and violence. Unfortunately, most of these innovations proceed far in advance of the empirical evidence to inform their structures, clientele, policies, procedures and overall operations. In the case of mental health courts, history is repeating itself. The data reported here and the limited amount of other available research suggests there is a lack of standardization, no assurances that the people targeted for diversion are the optimum candidates, and great uncertainty about best models for supervision and monitoring. It may be advisable for communities to slow the tide of new mental health courts until the specified effectiveness of current ones can be demonstrated.

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APPENDIX A:

SITE VISIT REPORTING FORM

NIJ Mental Health Courts Site Visits

Court _____
Date _____
Site Visitors _____
Recorder _____

Meeting Group _____
Attendees _____
_____
_____
_____

HISTORY (1-6)	
1. Court Start Date (1st Referral)	_____
2. What were the catalysts?	_____ _____ _____ _____
3. Process for its development?	_____ _____ _____ _____
4. Volume (Annual)	_____ _____ _____ _____
5. Key Successes	_____ _____ _____ _____

6. "Bumps in the Road"	

CURRENT STRUCTURE (7-26)	
7. Current Supervising Judge(s)	
8. How and why was this particular judge chosen for the court?	
9. Key Collaborating Agencies	
10. Current Mental Health Court Goals	
11. Current Criminal Eligibility Criteria	

12. Current Mental Health Eligibility Criteria	_____ _____ _____ _____
13. Exceptions? When? Why?	_____ _____ _____ _____
14. Frequency of Court Sessions	_____ _____ _____ _____
15. Courtroom Team	_____ _____ _____ _____
16. Mental Health Team Treatment/Services	_____ _____ _____ _____

17.	Any special criteria for assignment to the court? • Judge(s) • PD (Dedicated?) • Prosecutor (Dedicated?)	
18.	Is the assignment time-limited or can it be indefinite?	
19.	Any special training associated with assignment to the MHC? • Judge • Public Defender • Prosecutor	
20.	Any Drug Court – relationships	
21.	Amount of appropriations?	

22.	Source of appropriations?	_____ _____ _____ _____
23.	What do appropriations pay for?	_____ _____ _____ _____
24.	Special leverage or priority to access treatment services?	_____ _____ _____ _____
25.	Future funding prospects	_____ _____ _____ _____
26.	What is demanded of court to justify its continued funding?	_____ _____ _____ _____
CASE PROCESSING (27-46)		

27. Stage(s) of Identification	
28. Referral Source(s)	
29. Initial Screening • Where? • How? • By Whom?	
30. Time from Referral to Mental Health Court Appearance	
31. Final Eligibility Decision-Maker	

32. Competency Evaluation Done by MHC? Where? By Whom?	
33. Disposition of Charges	
34. Treatment Begins	
35. Length of Treatment & MH Court Supervision	
36. Supervision	
37. Frequency of Status and Review Hearings	

38. Effect of Request for Trial	
39. Sanctions for Non-Compliance	
40. Incentives for Compliance	
41. Successful Termination	
42. Components of success? (i.e., What do you have to accomplish to graduate?)	
43. Unfavorable Termination	

44.	Does the Court have the authority to initiate civil commitment exams?	
45.	Does the court have the authority to initiate a competency to stand trial exam?	
46.	Does the court have jurisdiction to rule on medication issues and issue an order to force medication?	
	DATA SYSTEMS (47-52)	
47.	Is there a specific data system devoted to the MHC?	
48.	What are its characteristics?	

49.	Who maintains it?	
50.	Is it linked to other data sets within the jurisdiction?	
51.	Can the court query other data sets regarding previous psychiatric history?	
52.	Are local data systems integrated in any other ways?	
RESEARCH (53-54)		
53.	Any current or planned research on court?	

54.	Has your court ever been evaluated? By whom? When?	_____ _____ _____ _____
FUTURE (55)		
55.	Are there any major changes for the MHC likely in the near future? If yes, what? Why?	_____ _____ _____ _____ _____ _____

Additional Information: _____

_____

_____

_____

_____

_____

_____

APPENDIX B:

SITE VISIT SUMMARY REPORTS

Mental Health Court Site Visit Report

Location: Allegheny County Mental Health Court

Dates: August 27-28, 2003

Team: H. Steadman & J. Petrila

History

- First referral was July, 2001
    - 4 years ago meeting occurred with Allegheny County HHS/Probation/NAMI/providers – group visited Broward County and Seattle (King County) MHCs – went to Chief Administrative Judge Bigley to sanction a MHC Task Force—catalysts for creation of the court included dissatisfaction on the part of Allegheny forensics in dealing with multiple judges; concern also with "revolving door" defendantsState OMH issued a Forensic Services RFP from which county got $180,000 for 3 years – went to group of local foundations for additional funds
- Reported that without new money, could not have gotten court off the ground because would not have gotten in kind contributions needed from DA & PD
- As of 8/27/03:
    - 120 Active cases (i.e. Accepted + Dispositions + Reinforcements)
    - 36 graduates
- Key successes:
    - 7% recidivism rate
    - Collaboration between DA/Judge/PD
    - Less time spent in jail
    - Perception that treatment compliance has increased

Bumps in the road: Initial difficulty in establishing individual sentences in open court; went to closed pre-hearing conferences to enable each party to be frank in its opinion; also the judge is trying to be "more realistic" in imposing costs on defendants which are imposed routinely but are not expected to be collected.

Current Structure

A. Funding

- State OMH $180,000 – 3rd year of 3
- Local foundations $282,500 over 2 years
- BJA - $150,000

(attached budget shows expenditures)

B. Staff

- Judge Robert Colville – former DA (22 years) & Police Chief
- Mental Health Court Monitor (Jill Tarr) – does all assessments and coordinator
- Forensic Mental Health Specialists (Lynsey & Steve)
- Dedicated PD (Michelle Lee Bailey)
- Dedicated ADA (Nicola ?)
- Probation Liaison (Clyde ___) – key to community supervision
  - Goes to first Probation appointment

C. Staff Selection/Training

- Judge Colville volunteered to Administrative Judge who originally heard all cases on condition that he would get all of them – no special training
- Dedicated PD & ADA on all cases – no special training
  - PD had prior experience with MH law
  - ADA had prior experience with District Judges and Forensic Division Team
  - No limit on how long judge or attorneys are assigned to the court

D. Eligibility

- Misdemeanor cases with occasional property felonies
  - Have had one robbery & one arson
  - Victim consent required in assault cases (ADA discusses case with victim); written notice to victims in property cases
- Certain cases excluded based on state sentencing guidelines
- Axis I – no exceptions

E. Processing

(See attached flow chart)

- All referrals assessed by Jill Tarr, MHC Monitor
- All referrals then go to review by MCH Monitor/PD/ADA
  - 30% acceptance—judge is *not* involved in this initial screening decision
  - Avg. = 53 days from referral to disposition
- Thursday morning for hearings – alternate weeks for new cases and reinforcement hearings. Cases are heard in open court and other non mental health cases are on the docket as well. Usually mental health cases are heard at the end of that morning's session.
- All final decisions made in chambers on Thursday morning before court when PD/ADA/FMH Specialist recommend/negotiate and Judge makes final decision
- Cases plead guilty or nollo and get probation
  - Charges not expunged at end of successful probation term
- Defendants sign a multi-point treatment plan
- There is no relationship with the local drug court

F. Length/Type of Supervision

- 1 or 2 years probation for almost all cases
- 30 – 60 (optional) – 90-90-90 day Reinforcement Hearings
- Probation Department with Probation Liaison (Clyde) do monitoring – compile "positive" and "negative" reinforcement hearing report

G. Sanctions

- Extend term of probation
- Jail
- Only specific incentive is no 60-day Reinforcement Hearing
- Court has a "no failure" policy so it appears impossible to be removed from this court's jurisdiction because of treatment failure/non-compliance

H. Data System

- County ECAPS has a MHC module
- Jill & Clyde do data entry – only on individuals already in system
- Can get all county service use data for 75% (est.) that are already in – could run Medicaid claims data from Data Warehouse

I. Key Points from Providers

- Meeting included only Forensic Liaisons to County Base Service Units
- MHC clients get no special access to services, but are followed more closely ("there are more hands in the mix" – "there are more people invested in their well being")
- Forensic system = additional supports when there is a crisis – helps to get ICM ("keeps them from getting lost")
- Court agreement makes them legally bound – approach = "I'm here to help you meet those agreements"
- Providers describe court as giving the provider extra leverage in dealing with clients

J. Summary Comments

- Allegheny County not nearly as resources–strapped as most places
- County has very stable population, i.e. few transient homeless and mentally ill who are usually previously identified
- Amy Kroll – County Director Forensic Services = dynamic force in everything forensic
- Big emphasis in program successes is on the level of coordination that has been achieved ("doing whatever it takes")
- Original and Reinforcement Hearings are very perfunctory compared to other courts - Line up all new cases in front of judge and do all together - 15 Reinforcement Hearings from 9:50 – 10:15 a.m.
- Our interpretation = judge not interested in developing a relationship with defendants to the level of other MHCs – also very careful to get all legal right information on the record to avoid appeals

PD – “MHC is about creating critical pathways in the system” – “avoids ‘ad hocing’ cases”

- Competency issues: Competency to stand trial can be an issue. If the person is judged incompetent, after he/she is restored to competency then the offer of the mental health court as a disposition will be made again.

Mental Health Court Site Visit Report

Location: Brooklyn Mental Health Court

Dates: June 16-17, 2003

Team: H. Steadman and J. Monahan

History

- First case on March 27, 2002 (MDI Part)
- Chief Judge Kage, Brooklyn DA J. Hines, and Dept. DA Ann Swern plus Center for Court Innovation (CCI)
- CCI put together the team – Judge Matthew D'emic was "last piece"
- As of 6/11/03:
  - 131 referrals
  - 36 participants
  - 28 pending
  - 67 non-participants (ineligible/DA wouldn't accept/opted out)
  - 5 defendants came through again (i pending)
- 1st graduate projected for 7/1/03

Current Structure

A. Funding

- $275,000 renewable annual grant from NYS OMH
- $90,000 amendment – 2 year evaluation
  - contracts with Center for Court Innovation
- TANFF – partly funds Case Managers
- $150,000 BJA (100% to CCI)
- Pays for staff and computers

B. Staff

- Project Director (Carol Fisler)
- Clinical Director (Lucille Jackson)
- Judge (Matthew D'emic)
- Psychiatrists (n=2 PT) – evaluators
- Social Worker (Nancy Frost)
- Case Managers (n=2)
- Evaluator (Kelly ____)

C. Staff Selection/Training

- Judge self-selected
- ADA & PP's dedicated
- No special training except series of breakfast meetings between Clinical Director, Judge D'emic and Legal Secretary on clinical issues
- Assignments indefinite

D. Eligibility

- Non-violent Felons (some rule outs; rape, subway pushers)
- Few misdemeanors taken – jurisdictional issues for Supreme Court
- SPMI
- Exceptions on case-by-case (e.g., 2 moms who killed newborns considered)

E. Processing

- Referrals
  - All returned fitness evaluations and restorations (730's)
  - DA & PD referrals
- Screening
  - Psychiatrists/Clinical Director
  - Done in jail or in community, if on bail
- If eligible, treatment plan developed – presented to ADA & PD – if agree to keep it in MDI Part, DA makes offer – if accepted, sign contract – plead guilty – judge = final decision-maker
- Usually takes 3-4 weeks – key variable is finding treatment and housing in the community
- Court has no competing determination

F. Length/Type of Supervision

- 18 – 24 months usual
- 2 cases = 36 months
- Contract signed
- Status hearings weekly, then alternate weeks, then monthly and sometimes every other month
- Case managers (court's) complete a 2-page report card for the judge
  - Also may be done by ICM in community
- Success = completion without being dropped – could be rearrested, missed appointments, etc., but could be retained
  - None yet – 1st expected July, 2003

G. Sanctions

- Sentence improved
- No unfavorable terminations yet

H. Data System

- Sophisticated system adapted by Center for Court Innovation staff from their Domestic Violence Court System
- Two systems
  - Court information with dates and judges notes
    - Court Clerk maintains
  - Evaluation data entered by MHC Team
- Trying to get Medicaid #'s for all cases to permit linkage to external claims information systems

I. Key Points from Providers

- "Court gives us leverage" – There is a "power differential" in clinical relationship with court contract
  - "mandates are like another level of clinical support – "mandation"
- Removal Orders (AOT) vs. Bench Warrants – "they know the latter"
- Willingness of Clinical Director to visit treatment sites as needed is very valuable
- MHC staff are supportive as opposed to Probation & Parole staff – can call back to MHC staff and get a response
- "We're in this together"
- Give and take with MHC staff on adapting treatment plans – not formally changing court contracts

J. Summary Comments

- Very strong staff throughout
- Project Director, Carol Fisler, is a strong potential speaker for TAPA/GAINS events
- Evaluation unusually well funded and competently done
- MIS systems (court and evaluation) exceptionally well structured
- Judge D'emic said court should not be "judge-driven", but it is and, like all MHC, will be sorely tested whenever he departs
- As a felony court, most everything about its terms of supervision is different than with the usual misdemeanor MHC's
- ADA, David Kelly's observation of how this works in prosecutor's office very interesting – "If we have a sucky case, we try to 'program it out'."
- Court cases given no priority in service system because "OMH [funder] doesn't want criminals jumping to the front of the line."
- OASIS pays higher rate for court-mandate cases than regular ones, but OMH does not want this

Mental Health Court Site Visit Report

Location: Bonneville County, ID Mental Health Court

Dates: August 7, 2003

Team: P. Griffin and A. Redlich

History

- First case on August 15, 2002
- ACT leader, Eric Olsen, was the first to propose the idea to Judge Moss. Started in this county because of available resources
- Catalysts: people failing in DTC
- As of 8/7/03:
    - 13 participants (38% males)
    - Capacity of 20, set by ACT team
    - 61 screened so far for court
- Key successes:
    - Wide support from collaborating agencies
    - The team itself and its collaborative nature
- Bumps in the road:
    - Eric's report: Initially ACT team was not so supportive and had concerns about their already heavy workload and because the people were "criminals.
    - Poor public transportation system. ACT staff drive their clients around.

Current Structure

A. Funding

- Mainly incur the cost themselves
- $150,000 BJA
    - Halfway Drug and Alcohol program provided by Alcohol Recovery Program
    - Transportation,
    - Medications
    - Medical medications and physician visits for non-psychiatric purposes,
    - Nighttime and weekend med monitoring,
    - Breathalyzer, and

        - Employee training (e.g., Certified Drug and Alcohol Counselor certification, visits to other MHCs).
- NAMI contributes some, such as the candy
- $35 fee/month for Court paid by clients
- Monthly payments for probation supervision
- ACT services and other treatment costs supported by Idaho Dept of Health and Welfare (although these are existing funds rather than new funds for MHC).
- Significant local and state support for problem solving courts.
    - 14 of 18 local judges have problem solving court caseloads.
    - Chief of Idaho Supreme Court has visited court and included two paragraphs about it in her annual judiciary address.

B. Staff

- Judge Brent Moss and Judge St. Clair (rotate every other week)
- Burt Butler, Court Administration
- Eric Olson, MHC Coordinator and ACT Team Supervisor
- Tracy ? (Eric's supervisor),
- Lisa Gifford, State Probation
- Larry Wright, County Probation
- Rocky Wixom, Asst PD
- ACT team members including Lynn Allen, Rebecca …. , psychiatrist, nurse, camping coordinator, transporter, etc
- Bruce Pickett, Asst DA
- Dave Doten, Bonneville County Jail MH Services
- Robert ? and Tamara ?, Idaho Dept. of Vocational Rehabilitation
- Tom ?, Idaho Dept. of Corrections (Lisa's supervisor)
- Valerie Gardener, Criminal Court Supervisor for DTC, MHC, and Misdemeanor Probation

C. Staff Selection/Training

- Eric Olsen selected Judge Moss. Moss selected St. Clair
- Two dedicated probation officers (one for felonies and one for misdemeanors)
- Chief Administrative Judge supports Judge Moss' involvement as long as he wants to do it. Assignment appears to be indefinite.
- ADA used to be Asst PD in Reno and involved in their DTC APD given choice of three problem solving courts and chose MHC.

o Training

    - No formal training for MHC but attended drug court training offered by Drug Court Program Office.
    - Visited other existing MHCs.

        - Receive informal training from the "round table" discussion of cases
    - Judge Moss also presides over a DTC court. He sees them as two distinct populations. Judge St. Clair does not preside over a DTC. Neither ADA nor APD involved in DTC.

D. Eligibility

- Felonies and misdemeanors. Generally non-violent but allow some participants with history of violence—use a "totality of the circumstances" approach.
- Probation violation that is grounds for incarceration.
- As a rule, sex offenders are not allowed (treatment issues).
- Axis I mental disorder, with or without co-occurring substance use disorder.
    - Schizophrenia, schizoaffective, or bi-polar.
    - Must meet criteria for ACT team.
- Takes into account history of psychiatric hospitalizations, jail time, or any one of seven specific areas.
- State priority population guidelines
- Case by case exceptions after examining totality of offenses and history.
    - Willing to take persons with history of violence if ACT team knows the person well.
    - For example, one defendant took a saw to a female neighbor's door because he wanted to talk to her and was also in the possession of guns. The team was familiar with him and thought him appropriate for the MHC and made an exception re: violent behavior.

E. Processing

Referrals

- No formal initial identification process. Jail mental health staff, Pre-Trial Services, defense attorney, family member, community treatment provider, sentencing judge, etc, could identify potential participants.
- All seem to refer to Public Defender's Office to assist defendant in making application to MHC. 99% of formal referrals come from PD's office (there are 5 APDs). Occasionally from private defense attorneys or probation office
- PD submits application to Eric (We have copies) after assuring defendant understands the processing of the case and ramifications of entry to MHC.

Screening

- After Eric receives application, he obtains the mental health history, the probation LSI scores, and the criminal histories to determine if the person is suitable. Application includes client's agreement to making records available (although the application explicitly states that their information cannot be used in prosecution of new crimes).
    - Most have substance abuse screening already in their mental health files.
- Eric sits down individually with potential MHC clients and explains the process, review MHC handbook, and determines if the person wants to be a part of it.
- Potential MHC participants watch the court in action before making decision to enroll. May also talk with current MHC participants.
- MHC team reviews at weekly team meeting. Complete consensus is required for admission.
- Judge reviews talks with potential applicant at following MHC session and confirms he/she wants admission to MHC.
    - Judge signs Order of Acceptance, which is forwarded to sentencing judge.
    - Two week "back-out period" begins from date of next scheduled MHC appearance.
- Sentencing Judge is final decision maker, but rarely denies entry
- Time from arrest to first appearance depends on if person is in jail
- Disposition of Charges
    - Post conviction and sentencing: Probation agreement.
        - Assigned to one of MHC dedicated POs.
        - Participants also sign a statement of "General Conditions of Release".
    - There was some discussion by the probation officers of withheld judgment vs. suspended sentence dispositions.
        - However, none of the 13 current participants has either disposition. All are on probation.
        - ADA: More experienced courts try to intervene earlier in the criminal justice process and provide incentives for opting into courts. He expects MHC to develop a disposition that intervenes earlier in the process as the court matures.

F. Length/Type of Supervision

- Minimum of 14 months

- ACT and Probation do supervision; coordinated but separate
- Status hearings are Phase dependent. At first, once a week, then three times a week, and then every other week

G. Sanctions

- Jail time (could be a day or more depending upon what seems to work for each individual).
- Community service (Such as janitorial, copying, or washing cars at probation office; Cleaning other ACT clients' homes, etc.).
- More intensive probation monitoring.
- Work release to day treatment followed by nights in jail.
- Writing thinking reports.
- Reprimands from judge.
- Remarks made about how sanctions used in MHC are not present in other courts. Also, refusing UA is acceptable in other courts, not in MHC.

- Successful completion
    - Referral back to sentencing judge for final disposition with indication that participant has successfully completed MHC.
    - Successful termination hasn't happened yet so this hasn't been completely worked out among the MHC team.
    - At this point, there does not seem to be a real incentive such as dismissal of charges or reduction in fines although the following options were discussed:
        - Felonies: Withhold judgment on felony and dismiss their case. Not treated as a felony conviction.
        - Misdemeanors: Can apply after successful completion of probation (and no violations) to have charges dismissed.
    - Unfavorable termination
        - Modification or revocation of probation with return to sentencing judge
        - May send defendant to prison.
        - Can reapply (MHC team doesn't want to give up on anyone).

H. Data System

- Access data system.
- Includes information from
    - Recdivisim
    - Reasons for denials
    - LSI probation scores

        - Number of times applied to MHC
    - Eric Olsen maintains it

I. Key Points from Providers

- "It has been easier and more effective to serve their (i.e., community agencies) clients who were already receiving services in their system, but who were a frustration to them for lack of treatment options."
    - Goals:
        - Teach clients about their MI, importance of their meds, how to manage their mental illness and stay out of jail and hospitals, stay substance free; and generally how to live their lives beyond MHC.
        - Reduce recidivism by providing structure and accountability. Alternative to penitentiary
    - Idaho Dept. of Vocational Rehabilitation counselor assigned to team and active member. Provides job coaching, assistance seeking jobs, etc. Jobs are an important and real focus.
        - Robert: MHC clients have a higher rate of successful "closure" than his other clients; "MHC makes it easier for us."
        - ACT staff: "Clients that work do better."
    - Peer to peer support program (Developed with one of the MHC successful clients).
    - Parenting education and support offered by NAMI
    - Independent housing (only one participant is in sheltered care).
- "MHC clients have more resources available to them than non-MHC clients because of the BJA money"
- Easy access to treatment in jail; "Jails will never be full, always open to MHC and DTC clients"

J. Summary Comments

- Plans to start a diversion MHC by Judge Linda Cook that would look at pre-sentence defendants.
    - She has begun sitting in on team meetings and court sessions but has no specific plans for start up.

Allison's comments

- Interesting and positive to see Vocation Rehabilitation and Jail Mental Health Services so involved. Patty remarked how this is unusual for MHCs.

- Remark made about how the clients do not sabotage themselves towards the end of their participation in MHC (as seen in DTC) because the ACT team will still be there for them—which is distinct from the Santa Clara Court.
- MH staff are also involved in other specialty courts (e.g., DTC and Family Court). This is helpful to the MHC as well because they are there to say that this person is appropriate (or not) for MHC.
- Felt the Court was somewhat coercive. Examples: views about forcing meds (and sanctions for not taking), polygraphs, mandating physical exercise and cleaning house, views about UAs.
- In court:
    i. Close physical contact with the judge --- participants step right up to the bench.
    ii. DA and PD do not participate.
    iii. Judge did not repeat opening rules re: confidentiality as in the Santa Clara Court, which may be even more appropriate here given the small community.
- Court's success seems somewhat dependent on the size of the community and the people they let into the program. On the one hand, they take the more difficult challenging cases (e.g., have failed DTC, problematic in the past), but on the other hand, they only take clients who would do well under ACT, close supervision. They don't want APD, Borderline, Sex offenders, etc. because they know they would not respond to the type of treatment they provide. The judge in Santa Clara would see this as "cherry picking." However, they are starting a diversion MHC which would take MH clients other than schizophrenics and bipolar.

Patty's comments:

- The combination of a MHC seeing most participants weekly along with an ACT team will make it difficult to sort out what is coercion on the court's part versus the typical intensive (some say "intrusive") nature of an ACT team.
- This is a small intensive MHC (max caseload of 20) using an evidence-based treatment modality as contrasted to the large, less intensive MHC in Santa Clara (caseload of approximately 600) that refers to available community treatment.

Mental Health Court Site Visit Report

Location: Orange County, CA Mental Health Court

Dates: August 5-6, 2003

Team: P. Griffin and J. Petrila

History

- First case on October 29, 2002
- Judge Wendy Lindley convened the team. Used funds from Prop 36
- Catalysts: people failing in Prop 36 track and being placed in prison
- As of 8/6/03:
  - 47 participants (53% males)
  - 11 pending
  - Capacity of 70, set by Probation Officer
  - 1 graduate so far; 8 months in court (appears probation ran out)
- Key successes:
  - individual client success,
  - avoiding state prison days,
  - expanded dual diagnosis resources and expertise
- Bumps in the road:
  - confidentiality (Initial reluctance of providers to share information);
  - DA not supportive of this court or other collaborative courts

Current Structure

A Funding

- Prop 36 funds. Exact amount unknown.
  - Controlled by County HCA
  - 95% of participants have treatment paid for by Prop 36
  - also funds PD and DA's office but not for specific MHC positions
- $150,000 BJA
  - residential treatment
  - 15,000 for evaluation
  - 5500 for sweat patches

B. Staff

- Court Manager (Teresa Risi)
- Daily Operations Manager (Lynn Fenton)
- Judge (Wendy Lindley)

- Court MFT (Jeff Blanks; assigned to Court)
- ADA (Stephanie….)
- APD (Katya Giritsky)
- Probation Officer (Gina….)
- County Health Care (Linda Hartung)
- Evaluators (Libby Deschenes, Chris Kleinpeter, Corey Lepage; Cal State)

C. Staff Selection/Training

- Judge self-selected (long-term drug court judge)
- No special dedicated assignments
- No special training but training conference scheduled for Sept.
- Asst PD has 10 years experience with MH issues (conservatorships and insanity pleas)
- Assignments 2-years is general rule, but not fixed
- Most of the major players are new except the judge

D. Eligibility

- Non-violent Felons with a substance related charge
- No violent charge or history
- Substance use disorder plus SMI (Axis I is the focus)
- Few exceptions because too few slots available.
- Exclude those with Axis II co-occurring because of lack of slots and also poor prognosis for improvement

E. Processing

- Referrals
    - Those arrested for drug-related offenses are referred for assessment and end up in 1) diversion/education, 2) Prop 36; or 3) drug court
    - Most often end up in this court after failing in prop 36 track
    - Jail personnel, community providers, DA & PDs, probation officers
    - The gate into the court is the 60-day assessment for eligibility
- Screening: 3 levels
    - Initial health screen
    - Preliminary MH screen to determine if full assessment is needed
    - Assessment of 60 days
    - Done in jail or ambulatory setting
- Assessment
    - Has requisite mental illness
    - Person a good candidate for complying with treatment regimen
- Usually about ½ of those assessed are eligible and recommended to the court. Most often reason for rejection is Axis II dx.
- Judge is final decision maker (in consultation with court team)
- Time from arrest to first appearance can be lengthy

- Disposition of Charges
    - Plead guilty and placed on probation
    - Guilty plea withdrawn upon graduation. Charges reduced to a misdemeanor and then dismissed. Records cleared.

F. Length/Type of Supervision

- Minimum of 18 months, which no one has reached yet
- Probation and Court liaison (Jeff) do supervision
- Status hearings every two week in the beginning. May be one, two, four, or six weeks depending on progress and difficulties

G. Sanctions

- Reprimand, essay, day in court, increase in 12-step program, increased testing, increased probation supervision
- Jail with a positive test (usually 3 days)
- Probation violation (being in jail doesn't mean an automatic violation)
- Termination
    - Commission of violent offense or something involving public safety
    - DUI or drug offense while under court's jurisdiction
    - Imposition of sentence, consistent with plea

H. Data System

- Stand alone system separate from DTC
- Includes information from
    - HCA brief screening
    - Probation
    - Court mandated info (new warrants, charges)
    - Progress reports
    - Lynn Fenton maintains it

Libby Deschenes is working with court on development of database for her evaluation

I. Key Points from Providers

- Expanded expertise among providers. "Renewed energy and enthusiasm for this population" Receive training on dual diagnosis issues
- Substance abuse staff provide the treatment.
- Psychiatric time also contracted for by the Drug and Alcohol agency
- Expedited access to psychiatric evaluations, med assessments and med clinic.
- "Treatment providers are sensitive to mental health court status"
- The court and team gives treaters additional leverage with their clients

J. Summary Comments

- Appear to be no appreciable services provided by the public mental health system
- This court appears to function as a probation-monitoring court and is heavily influenced by the fact that it developed out of the process and with the judge who created the drug court.
- Because pleas are heard by another court, this court receives cases further "downstream" than do many MHCs that also take the initial plea

Mental Health Court Site Visit Report

Location: Orange County, NC Mental Health Court

Dates: August 28-29, 2003

Team: P. Griffin and A. Redlich

History

- First case in May 2000
- Local NAMI president, Bill Mead, approached a law professor (Don P.) about the idea of a MHC who introduced him to Judge Buckner
- As of 8/28/03:
  - 65 active cases in two courts (Chapel Hill and Hillsborough)
  - Closed approx. 50 cases this year with a 50% success rate
- Key successes:
  - Engaging people in treatment even after they graduate from CRC
  - Increases demand for treatment but offers opportunities to increase leverage
    - Leverage is now open and above board
  - CRC dedicated staff allows greater attention to regular clinic clients that have not been successful in treatment
  - Dedicated liaisons from shelters, police, etc. enhances community mental health services and increases their sense of collaboration and teamwork
- Bumps in the road:
  - Different timelines for judicial and mental health systems: Court lasts 6 months and tx wasn't always finished within 6 mos.
  - Difficulties in wrestling with co-occurring mental health and substance abuse
  - Bringing more people into the tx system and not having the tx resources. More need than services
  - Limited judge time available. Dockets keep expanding but time for longer dockets isn't available

Current Structure

A. Funding

- NC Dept of MH: $67,000 for two years (split across the two years)
    - CRC case manager who acts as liaison, pre-screener, links to treatment providers, and reports compliance to CRC

In-kind and existing resources

- BJA funds, 150K
    - Second CRC case manager who will focus on Hillsborough participants and provide more clinical services
        - The hope is to use current CRC case manager to focus on majority of spmi participants and be involved in more "street time" coordination
    - Local trainings for CRC team and legal community
    - Mileage reimbursement and supplies
    - Mentoring site visit to a MHC
    - Client assistance funds

B. Staff

- Judge Joe Buckner (Chapel Hill) and Judge Pat Devine (Hillsborough)
- Jeffrey DeMagistris, CRC Program Coordinator, Orange-Person-Chatham Area Program (OPC) (local mh/sa/dd authority) case manager supervisor
- Tim Williams, Director, OPC
- DC Rhyne, CRC Case manager , OPC, Adult MH services
- Marie Lamerauex, District Court Projects Coordinator
- Tim ……, Asst. Public Defenders
- Karen Murphy and Glen Vliet, Contracted private defense attorneys
- Jacqueline Perez—ADA (ADA Beverly Scarlett, the more involved and senior ADA, was on vacation)
- Vicki ……, Probation
- Matt Sullivan, Police Social Worker, Chapel Police Department
- Michael Norton, ACT team supervisor, OPC
- Jefferson Parker, Housing Coordinator, OPC
- Senga Caroll, TASC, OPC

C. Staff Selection/Training

- Retired law professor sought out Judge Buckner and Judge Buckner chose Judge Devine
- Judge Buckner: Interest in therapeutic courts; Judge Devine: Son with serious mental illness
- Asst PD (dedicated): No special criteria. Asst DAs: No special criteria. Both were prior defense attorneys

- Designated private attorneys: Judge Buckner chose because one does civil commitment hearings and that other has experience in a secure mental health unit
- Indefinite assignment for all. Judge Buckner would prefer to switch the roles of the defenses attorneys so that the two designated private attorneys would handle the bulk of the cases with the Asst PD handling the "due process" (conflict of interest) cases: In that way he could keep the private attorneys with the court for years and not be affected by the rotations of Asst. PDs though the court
- Training
  - A team of 10 (including Judge Buckner, one of the Asst DAs, one of the Asst PDs) attended the training offered by the federal Drug Court Program Office which was coordinated through the state's Drug Court Office
  - Semi-annual local training sessions for CRC team
  - Judge: Some training on therapeutic court models for drug treatment courts

D. Eligibility

- Misdemeanor or felony charges
  - Violent charges possible if victim agrees, which most do
  - H and I felonies "technically" but this is not a strict adherence.
- District Attorney's Office must agree (public safety is paramount)
- Mental illness, mental health history, or developmental disability
  - Those with severe mental illness receive priority and case management from OPC
- May also have substance abuse problems
- Case by case exceptions after examining totality of offenses and history.
  - Sometimes DA will insist that the case be a post-plea in CRC (as opposed to deferred prosecution) allowing more leverage by having the plea in place.

E. Processing

- Referrals
  - Police, judges, attorneys, court officials, community mental health, ACT, magistrates, pretrial services, family members, and private citizens
    - Approximately 50% of referrals come from attorneys
    - Judge receives referrals directly
  - DA screening on regular court date

        - Defense attorneys provide a preview of treatment alternatives to defendant
        - Defense attorneys discuss with DAs prior to or on court date
    - CRC case manager provides prescreening, orientation to CRC, has participant sign consent, and makes referral appointments during CRC court session
- Screening
    - Informal screening first done by DA (sniff test)
    - Legal screening: DA and/or Defense determine is offense sheet is appropriate for CRC. Interviews prosecuting witness or law enforcement regarding allegations
    - Clinical Screening: OPC/CRC case manager. Administers screening questionnaire
    - DC (OPC case manager) has main conversation with potential client to determine interest and to explain rights and procedures of Court.
- DA is final decision maker, but usually a team decision
- Time from arrest to first appearance varies up to 30 days
- Disposition of Charges
    - Deferred prosecution --- Pre-plea
        - About 75% of cases
        - Probation can supervise pre-plea cases
        - Have consent order (which is agreeing to not commit any new offenses, follow recommended tx plan, take any prescribed meds, and an 'other'
    - Prayer for Judgment Continued --- Plea but final conviction is suspended
        - About 12% of cases
    - Suspended sentence --- Conviction is entered but sentence is suspended; CRC could be a condition of probation for this alternative
        - About 12% of cases

F. Length/Type of Supervision

- Minimum of 6 months but try to keep clients engaged longer
- Supervision
    - Treatment staff: Participants with severe mental illness: CRC case manager, CRC Program Coordinator/ case manager supervisor (also carries a small caseload), ACT staff. Participants with primarily substance abuse problems : TASC and DWI staff

- Probation officer if participant on probation. Currently only one CRC client is supervised by a dedicated probation officer
- Court meets once a month in each location.

G. Sanctions

- Warnings, threats, stern lectures, and expressions of disappointment from judge (from grant proposal)
- Jail
- Deferred prosecution may be extended for:
    - Periods of non-compliance with treatment
    - Periods of inpatient treatment
    - If treatment provider recommends, that in the best interests of the defendant, continued court monitoring will increase compliance with treatment and enhance defendant's stability (from consent order signed by participant)
  - Termination and return to regular criminal court processing
  - People who did not show up for Court, a warrant was issued for their arrest
- Successful completion
    - For deferred prosecution: Case is dismissed (guilty plea is withdrawn)
    - For prayer for judgment continued: Final conviction remains suspended
    - Suspended sentence: Probation is terminated and there is a final discharge

Unfavorable termination

- Return to regular criminal court processing for trial and sentencing
- No prejudice attached (i.e., they're not punished for not succeeding in CRC)
    - What occurred in CRC is not used against them in regular court. A fresh start; "Firewall" with DA's Office
- Nothing worse than regular criminal process

H. Data System

- Excel data system (not too sophisticated but a start).
- Client Outcomes Inventory --- Jail Diversion data for participants served by CRC case manager (required by funding source, NC Dept of MH)
- Excel db includes information on: Name, DOB, Race, Gender, Monitoring Source, Treatment Type, Case Disposition, Outcome (e.g., opted out, never engaged, graduated)
- CRC case manager maintains it

I. Key Points from Providers

- Goals:
  - Venue to focus on people with criminal charges for which there is an indication that mental health problems are the primary contributors to the criminal offenses
  - Engagement in treatment (mental health and substance abuse)
  - Becoming more visible in the community (e.g., talking to the defense bar and letting others know they exist)
- Special access to treatment
  - CRC case manager position provides case management for CRC clients: Otherwise, CRC participants wait in line along with everyone else
- BJA funds will be used to hire a specialized clinician for CRC participants
  - Tx providers expressed concerns that their attention had to be focused on the CRC clients

J. Summary Comments

- Ginny Aldige Hiday and her graduate student, Marlee Guerra are currently working on an evaluation (observational study and descriptive study)
  - Observing team meetings, court sessions, and accompanying CRC case manager in his work
  - Asking participants for consent to look at medical records (but many have refused)
  - Interviewing major players
  - Examining pre and post arrest (1 year)
- Statewide changes to mh/dd/sa system requiring local authority to contract out all services by 2007
  - Considering keeping CRC staff under local authority or contracting out or placing under court system or other options
- Judge does most of the talking in the courtroom, “the voice of the team”; During team meeting, he’ll often ask: “What do you want me to say?”
  - Defendants talk little also
  - Somewhat formal, clients stand away and have to have permission to approach judge

- Age of adulthood for Judicial System is 16, Age of Adulthood for MH Services is 18—this has created a conflict. Now have to work with youth mental health services (who actually have a lot more resources available to them).

Mental Health Court Site Visit Report

Location: Santa Clara County, CA (San Jose) Mental Health Treatment Court

Dates: July 24-25, 2003

Team: P. Griffin and A. Redlich

History

- Court Start Date (1st Referral)-- First funding for mental health staff in Spring 1999. There is no single, clear date because the court developed as the result of a Drug Treatment Court (DTC) beginning to shift defendants with mental illness to a Friday morning docket.
- DTC staff noticed that a number of their clients had mental health problems, tended to fail, and not graduate from DTC so began to schedule those cases together on a separate day.
- Judge also observed that defendants with co-occurring substance use problems and mental illness were excluded from services/treatment. He noted the fragmented systems, turf wars, separate funding, and eligibility restrictions occurring between county Dept of MH and Dept of Alcohol and Drug Services (DADS). Judge brought everyone together, including the county executive and announced, "I'm starting a MHTC."
- Volume: 600 plus or minus 30 on any day's caseload; County jail census is 8500
- About 10 new cases a month
- Approximately 4 graduations a month
- Considers itself the first MHC in California and the largest MHC in the world.

Current Structure

A. Funding

- CSAT—$1.2 million from a new grant; Partly money for prescriptions
- OJP: $150,000/year for 2 years. Two part-time psychiatrists, 9 supervised housing beds
- County funding — 2.5 FTE MH staff from County Dept of MH; MH and D&A services; Bus tokens from DADS
- Proposition 36
- CA Drug Court Treatment Partnership Act

- Local Law Enforcement Grant --- Small amount
- BJA: Court will contract and hire one "Corrections" employee. PALS supervisor of Custody MH staff interviewing now.
    - Connections will be an off-shoot of PALS program to serve MHTC participants with less severe mental illness but having difficulty succeeding in the court.
- Aggressive pursuit of grants and other funding.

B. Staff

- Court Coordinator (Kelly Simms)
- Judge (Stephen Manley)
- ADA (David Angel)
- APD (Bernardo Saucedo)
- Mental Health Workers (n=2.5 FTE) (Khanh Dang, Tracy Fleming, and Sue Sidel)
- Probation Officers (n=4 dedicated)
- Data Manager (Nick Raby; soon to be replaced, Erica ___)

C. Staff Selection/Training

- Judge self-selected (and started MHTC)
- ADA & APDs assigned to court
- No special training
- Assignments indefinite (although DA and PD can rotate them out at any point)
    - Current ADA and APD have been with the court a number of years
    - When this APD rotated off, six APDs rotated through in the two years before he returned

D. Eligibility

- Non-violent felons and misdemeanants (some rule outs such as rape)
    - As of 7/24/03—73% of clients have felony charges.
    - Currently seeking out felons since California state government provides fiscal incentives to reduce prison costs. As a result, getting a lot more felony cases.
- Must be dually-diagnosed with substance problem
- Not clear what happens to those with mental illness only but, given this judge, they would probably be included in the MHTC.
    - Many exceptions
        - Deaf
        - HIV & AIDs, Hepatitis C

        - Antisocial
        - "Goofy"
        - Brain Injury
        - Mentally retarded
        - Dementia

E. Processing

- Referrals, Multiple sources:
    - Other judges (90 judges in county)
    - DA's office
    - DTC process
        - ID'd in meetings
        - Along with those not succeeding in that setting
    - County Jail MH, probationers, anyone can call or email judge
- Screening
    - 4-6 assessments per week by MH staff of MHTC
    - Usually takes 10 days, per grant proposal

- Disposition of charges:
    - Plead guilty, convicted, and placed on probation.
        - Felony probation cases also have suspended prison sentence.
- Prosecuting ADA is final decision-maker, not ADA assigned to MHTC
    - MHTC ADA sees this as a check and balance when he isn't the one to advocate a defendant to be placed in the MHTC
        - Concerns about public safety
    - Cases where guilt is clear and person is willing to cede this
        - Part of the motivation is limited time and money to investigate these cases.

F. Length/Type of Supervision

- 18 months average; some 2 ½-3 years
- Probation is often extended (as opposed to terminating clients)
- Probation officers are responsible for supervision
- Contract signed
- Status hearings as clinically needed and/or as court docket allows
- Success
    - Note of successful completion of probation and treatment requirements
    - Felony charges reduced to misdemeanors (for felons)
        - Per Section 17, California Penal Code
    - Withdrawal of guilty plea
    - Dismissal of misdemeanors

- Clearance of criminal records, in accordance with California Penal Code 1210

- Termination: Very few; Prefer to extend probation instead

G. Sanctions

- Remand into custody for short periods of time
  - MHTC is comfortable using jail for:
    - Wake up call
    - Medical Detox
    - Result of new charges
    - Failure to keep appointments with probation officer
- Admonishments from judge with encouragement to do better in the future
- Revised treatment requirements:
  - Increased frequency of participation in treatment
  - Increased attendance at AA/NA/Dual Recovery Anonymous meetings (Often "90/90": 90 days, 90 meetings for those who relapse to substance use)
- Bench warrants issued for those who fail to appear in court

H. Data System

- Archaic system
- Have criminal justice data (sentences, days served, credits earned), but only now trying to keep hard copy folders of MH data (treatment services, where, what)
- Plans to get new system up and running in near future
- MH staff have access to public MH records through MIS terminal locked in an office on same floor as MHTC

I. Key Points from Providers

- "Judge Manley" beds (9) at emergency shelter specializing in serving people with mental illness (Julian Street Inn)
  - Average stay is about 90 days, range is two days to a few months
  - Can have other MI issues; Axis I dx is not necessary
  - Other beds there —Max stay is 60 days and you have to have Axis I dx.
  - Also have nine Prop 36 beds there

- PALS program is a bridge from jail to community for successful transition

  - Run by Sherry Johnson
    - Allison: She spoke well and could potentially be a GAINS speaker (attended SF GAINS conference)

- Funded by Mentally Ill Offender Crime Reduction Grant (MIOCRG)

- BJA funding new program, Connections, that will be more tightly linked with the MHTC and will not limit itself to SMI.

Summary Comments

PATTY

- A true problem solving court
- Strongly a dual diagnosis court which operates in larger context of drug court
  - Flexibility accepting people from drug court
  - Shared formal graduation ceremonies so stigma avoided in these public events
  - Constant emphasis on sobriety
    - Motto: Joy, Serenity, Sobriety
- Judge:
  - Does not require medication although he encourages and asks participants to give it a chance
    - Does require them to participate in treatment
  - Shows a clear understanding of substance use issues and mental illness
  - Strong desire to get people the help they need despite diagnoses, service limitations, etc.
    - Advocacy for his clients and their access to the services they need
    - Considers it a "crusade"
  - Sense of humor and obvious respect for his team members and the clients themselves
  - Clear persistence in achieving his goals
  - Clear rituals
    - Opening comments re the specialness of the court, his rules, and his encouragement
    - Docket starts with the successful folks who act as role models for others
    - Asking how long they've been clean and sober "honestly"
    - Invariably positive response
      - Leading applause
      - Congratulations for that accomplishment, no matter how small
    - Congratulations upon successfully completing the court's requirements:
      - Asks participant to share any words of wisdom
      - Comes off the bench to give the person a hug
      - "Good luck and stay in the boat!"
    - While clearly the center of the court, he doesn't monopolize the discussion or appear to need to be the center of everything

- Judge reads out both what participants are agreeing to as part of being placed on probation and his final rulings (see above) at time of successful completion of the MHTC
- Very strong sense of teamwork
    - Many members on the court team whose input is much appreciated and expected
        - Judge humorously prods tx folks when they put up barriers to care
        - Acknowledgment of how much help this population needs and persistence in seeking out various systems' assistance
    - Almost choreographed interactions
        - Everyone has a clear role to play
        - Interesting to watch especially since the court has so few formal structures such as a mission statement, policies and procedures, etc.
    - Strong roles for asst prosecutor and asst public defender (along with other defense attorneys); Flexible but still take care of their traditional responsibilities
        - For instance:
            - Asst DA still concerned about public safety and accountability but not intent on punishment as the means to get there
            - Asst PD advocates for his clients but does not insist on protecting rights that get in the way of success in the court or in making a better life for the defendants
                - While a strong advocate, does not object to extension of probation on a knee jerk basis
    - Asst PD uses a green forms to get information from his clients prior to the court hearings
        - He organizes each session's docket
        - Asks participants "who wants to go last?" And then puts them on early as a reward
- Creative development of resources
    - Community service and volunteer activities (to pay off fees and fines)
    - Adding Connections program based on successful track record of PALS
    - Family of Friends peer support group through probation
    - Dedicated beds from an emergency shelter focused on people with mental illness
    - Willingness to share positions with other agencies in order to gain resources
        - For instance, positions supervised by Custody MH staff but working in court
        - Dedicated mh staff now spend a day and a half each working in the main community mh clinic seeing MHTC clients in order to be able to bill for services
            - Also allows staff to be more integrated into the community mh system and help their clients become more comfortable attending treatment after MHTC's jurisdiction ends
    - Solicited private practitioners to volunteer to take MHTC participants with trauma issues for individual therapy

ALLISON

- Little distinction between MHTC and DTC
    - Staff say DTC process is more formal

- Judge said that jail is renting MH beds to other counties because of success of MHTC. No data provided.

- Appears to be another MHC in the County. Those clients who do not have substance problems? However, by all accounts, there is no follow-up. Judge issues treatment orders and that is the end of the case. Did not get judge's name.

    - Sounds like a disposition court that makes referrals to treatment rather than a court that mandates to treatment, makes referrals, and continues to supervisise participants.

- Recently, the Municipal Courts merged with the Superior Courts. Court employees are currently neither state or county employees. Judge Manley was a Municipal Court judge until merger.

- County is a managed care county.

- Judge speaks around the country about the MHTC. Much of Nick's time is devoted towards getting stats for the judge's presentations. Quickly glanced at some exit survey stats for those who had successfully completed MHTC:
    - 78% have family contact
    - 70%(?) better able to recognize relapse
    - 55% learned to solve problems
    - 13% completed GED
    - 38% employment (from 22% before MHTC)

- Judge: "When someone murders someone, the program [MHTC] will die as well"

- Judge has been on bench for 25 years. Unclear how court will sustain when he retires.
    - MHTC is extremely judge-driven. He is reluctant to go on vacation because he knows other judges aren't willing to do what he does in terms of caseload, informality, etc.

- Discussed with Kelly the type of information we'll want to collect so she can start thinking about it now. Currently do not keep track of referrals and things of that nature; Will have to be a special effort on their part, which they seem willing to do.

- Follow-up: get hard copies of forms (put in request 7/28)
  e.g., Clients have to sign an agreement when enter MHTC

Mental Health Court Site Visit Report

Location: Washoe County, NV Mental Health Court

Dates: September 3-4, 2003

Team: P. Griffin and A. Redlich

History

- First case in November 2001
- Grew from the success of the drug court model as a judicial problem-solving mechanism designed to address the root causes that contribute to criminal involvement
- NAMI member, Rosetta Johnson, put together a one day conference
- MHC Planning Committee, convened by District Court Judge David Breen, was established in December 2000
    - Included judges from Reno and Sparks (District Court, Justice, & Municipal Courts), Court Services (alternative sentencing), state legislator, and representatives from District Attorney, Public Defender, state Attorney General, private defense bar, county jail, state Parole and Probation, state and local mh and substance abuse treatment programs, child welfare, advocates, and family members
    - Produced Report and Recommendations for legislative session in Feb 2001
- 2001 Legislature approved language for the multi-jurisdictional MHC (SB 366/SB 6 of the special session) authorizing:
    - A district court to establish an appropriate program for the treatment of mental illness and provides that a justice court may transfer original jurisdiction to the district court,
    - The court may suspend judgment of conviction, suspend further proceedings and place the defendant on probation,
    - The court may also accept defendants who have been placed on probation with a condition they participate in MHC, and
    - No state funds were appropriated during first year although approximately $680,000 appropriated the second year
        - Partnership of Representative Sheila Leslie and Senator Randolph Thompson
- As of 8/28/03:
    - 37 active cases

    - Get 5 referrals a week
    - Have graduated 9 people to date
- Key successes:
    - Intensely focus existing resources on individuals in the criminal justice system
    - Encouraging the revision of existing policies to make it easier for all mentally ill persons to access the mental health system
    - Hook MH services, probation, CJS all into together.
    - Make the system work for these people; facilitate recovery
    - Medication compliance
- Bumps in the road:
    - Lack of a specialized case manager to perform the intensive follow-up work needed to ensure clients make progress on their court-ordered treatment plan between court sessions
    - Lack of more intensive data regarding previous arrests, jail time, and personal client histories to build a case for cost savings and ongoing funding from local and state resources
    - Difficulties identifying appropriate clients who have the best chance of success
    - Addressing systemic issues that involve barriers to treatment, finding the staff time to work with difficult and complex individual cases that need intensive follow-up, sometimes on a daily basis,
    - Lack of funding for supportive client services
    - Difficulties between MH and SA determining diagnosis and who's responsible. Particularly for meth related cases (major problem in this area)
    - Lack of resources to address those with head injuries
    - DA opting out
    - Culture shock for some clinicians. Did not like the Judge telling them their business, although has changed. Also confidentiality issues and providing records
    - Did not get the money the first time around
    - The Attorney General did not think the judge could order people to do things. The AG is the lawyer for the state MH hospital (not the forensic hospital)
    - Issues of aftercare and trying to ensure people stay engaged with tx

Current Structure

A. Funding

- Existing and in-kind resources: Estimate more than $500,000 over course of 2 year grant
    - NNAMHS: MH Division: Medications, hospitalization when necessary, a portion of outpatient case management
    - Restart: Case management, housing assistance
    - Court: Legal services, staff time, and judge time
- BJA
    - MH Court Services Officer to provide the court with a focused, individualized effort to ensure compliance with court-ordered treatment plans while also providing the staff support needed to collect program data to be analyzed and incorporated into future internal and external funding requests
        - Hope position will allow MHC to expand to 60 active cases per month
    - Required travel
    - Support for training
    - Client Assistance Fund (e.g., bus passes)
    - Operating costs
    - Computer/printer support
- State appropriations: 680,000. A line item in Carlos' budget all to MHC, which Washoe County is the only one
        - Establish a consistent, fair, and reliable funding stream through a $7 increase in the assessment placed on all misdemeanor fines in justice and municipal courts in Nevada (estimated 1 million/yr)
        - Funding would be earmarked for the use of Specialty Courts, with specific allocations within judicial districts
        - Went into effect July 1, 2003

B. Staff

- Judge David Breen, District Courts
- Sheila Leslie, Specialty Courts Coordinator (Also elected state representative; Appropriations Committee; Democrat)
- Debbie Gant, MHC Court Services Officer (Not a clinician but transferred from Court Services Office to fill BJA funded position)
- EJ Maldordo, Northern Nevada Adult MH Services (state community mental health services)
- Michelle, Harry, and Linda, Project Restart (private mh provider)

- David Spitzer, MHC Defense Attorney
- Will Arange, Parole and Probation
- JC Palmer, County Child Protective Services
- Mary Ann …., County Adult Social Services
- Tom ……., Sierra Regional Center (state center for developmentally disabled)
- Other interested persons
    - Carlos Brandenburg, Administrator, Nevada Division of MH and Developmental Disabilities
    - Senator Randolph Townsend (State senator, Chair of Commerce and Labor Committee, Republican)

C. Staff Selection/Training

- Judge Peter Breen
    - Drug court judge
    - Most senior judge in the state therefore willing to take more risks
    - Attended Rosetta's conference, turning point for Judge
- Asst PD (dedicated contract): No special criteria. Asst DAs: NA b/c opted out.
- Indefinite assignment
- Training
    - No special training. Attend Annual DTC conventions. Share interesting articles with each other (e.g., Time article about bi-polar). Looking at cross-training for all specialty courts

D. Eligibility

- Pending charge (misdemeanor, gross misdemeanor, or non-violent felony)
- Case by case review of those with violent histories
- Mental illness must be demonstrable and must have likely contributed to their criminal involvement (although this has proven hard to demonstrate, and thus is not considered too often)
- Typical charges include defrauding an innkeeper, solicitation of prostitution, trespassing, petit larceny, and probation violations
- Originally required agreement from prosecuting attorney that transfer to MHC is appropriate however DA "opted out' of MHC (and drug court) for reasons of:
    - Limited staff resources
    - Conflicts with judges when DA staff were over-ruled by judges
- Major psychiatric diagnosis (bi-polar, schizophrenia, severe depression) and mental retardation. (69% are active substance abusers; 75% have a diagnosis of a co-occurring disorder)

- MH system says ‘no’ to brain injured persons
  - Over time, they’ve become more willing to take those with more serious charges
  - As wide a gate as possible

E. Processing

- Referrals
  - Screening Committee reviews referrals prior to MHC contact with defendant to determine if referral is appropriate
  - Interviewed by counsel to determine if their interest in the program and participation is on a voluntary basis
  - Public defenders, parole and probation, judges, and court services personnel at the jail, Sierra Regional, Restart doesn’t refer too often
  - Insistent on referral form.
- Screening
  - Screening Committee consists of specialty courts coordinator, defense counsel, parole and probation, treatment providers from the state and community-based programs
  - Defense attorney explains rights to them
  - Sometimes done at video (CCTV) arraignment
- Judge is final decision maker, but has never turned anyone down
- Time from arrest to first appearance is on average 2 weeks
  - Sometimes Court cannot act fast enough after they receive a referral—the person has already left jail on time served.
  - Sometimes won’t accept people until they are stabilized on their meds
- Disposition of Charges
  - Any of the eight justice or municipal courts operating in the 2nd Judicial District may transfer original jurisdiction to the district court
  - District court (i.e., MHC) suspends judgment of conviction, suspends further proceedings, and places the defendant on probation

F. Length/Type of Supervision

- Expect 12-24 months but some may need 36 months
- Supervision
  - MH staff
  - Probation

- Status hearings: Weekly in the beginning, diminishing to bi-monthly or monthly as participant progresses

G. Sanctions

- Yelled at by the judge
- use jail time when necessary
- "Perfect or else" policy
- Places you under contempt (mechanism into jail)

- Successful completion
  - Court may discharge him and dismiss the proceeding against the participant without adjudication of guilty

Unfavorable termination

- Go back to regular Court or DTC.
- Criminal docket—stays with Judge Breen, proceeds to sentencing

H. Data System

- Starting a new one, using SCOTIA software. Judge will eventually have SCOTIA on his bench (just the summary screen)
- Sheila maintains an excel file that is pretty good for the referral process. Is also willing to add more of what we want (e.g., diagnoses). We have a copy of this excel file.
- Sheila and Debbie maintains excel file for referrals

I. Key Points from Providers

- Goals:
  - Provide comprehensive mental health services to eligible defendants
  - Protect public safety
  - Reduce recidivism and re-incarceration
- Special access to treatment
  - Special walk in hours to NNAMHS after Court. MHC clients receive priority
  - Mill St. apartments, MHC clients have priority but currently not exclusive to them
  - Judge demands that the system responds because they are in-crisis/high-risk

- "Don't have to take meds if they don't want to, but they can't be in the MHC" "Take your meds or go to jail" All but one MHC client were on meds
- Just hired a new liaison between the Court and the public MH system. This is the 3rd one. Others felt it created deterioration in the therapeutic relationship; lack of trust.

J. Summary Comments

- Much more funding coming in. Should allow them to expand and provide more resources (like housing)
- Estimated that over 90% of their clients were not involved in the public mental health system prior to the MHC. Thought they would be seeing the same people, but this has turned out not to be the case.
- Fasting growing state

APPENDIX C:

REFERRAL AND DISPOSITION DECISION

DATA COLLECTION FORM

NIJ-BJA Mental Health Court Evaluation Study
Referral Data Sheet

1. Study ID: _1_/ ___ ___ ___ ___ ***Site/ ID#*** **2. Date of Referral: __ __/__ __/__ __ (*mm/dd/yy*)**

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

1. ☐ Mental Health Court Judge
2. ☐ Police/Law Enforcement
3. ☐ Jail Mental Health Staff
4. ☐ Public Defender's Office
5. ☐ Defense Attorney (Private)
6. ☐ Community Mental Health
7. ☐ Competency Examination Order
8. ☐ Other Judge/Magistrate/Speciality Court Judges
9. ☐ District Attorney's Office
10. ☐ Probation
11. ☐ Court Officials
12. ☐ Private Citizen/Family Member(s)
13. ☐ Self-Referral
96. ☐ 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. ☐ Caucasian
1. ☐ African American
2. ☐ Asian
3. ☐ Hispanic
4. ☐ Other *specify* _____
9. ☐ 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)***
13b. ☐ Rejected for the MHC (2) ***(skip to 15)***
13c. ☐ Defendant opted out of consideration (3)
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. ☐ Defendant enrolled in MH court
0. ☐ Defendant DID NOT ENROLL in MH Court *(check only one)*
   - ☐ defendant declined to enroll (1)
   - ☐ defendant could not be found (2)
   - ☐ defendant was not stable (3)
   - ☐ defendant homeless (4)
   - ☐ other (5); *specify*: _____

15. IF REJECTED: *Reason (check only one)*

1. ☐ Ineligible because of mental disorder (e.g., only substance problem or does not have a SPMI)
2. ☐ Ineligible because of current criminal charges or past criminal history (e.g., violent offense)
3. ☐ District Attorney's office declined
4. ☐ Public Defender's office or private defense attorney declined
5. ☐ Judge declined
6. ☐ Probation declined
7. ☐ Mental health providers declined
8. ☐ Other; *specify*: _____
9. ☐ Unknown

**********DO NOT WRITE BELOW THIS LINE**********

Date received: __ __/__ __/__ __ Date entered: __ __/__ __/__ __ Date verified: __ __/__ __/__ __

INSTRUCTIONS FOR COMPLETING REFERRAL DATA SHEETS

From **NOVEMBER 1, 2003 UNTIL JANUARY 31, 2004**, please complete a Referral Data Sheet on EVERY referral into your Court. One sheet reflects data on one referral. Thus, if you have 35 referrals during the three months, please complete 35 sheets (even if the same person was referred more than once).

We are only interested in completed data sheets on persons **formally** referred into your Court. Although this may vary from Court to Court, a formal referral can include persons with a written application to the Court, or persons for whom a screening and/or assessment was conducted, etc.

1. Study ID: Your site number is already filled in. Please fill in 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.

FOR QUESTIONS: PLEASE CALL ALLISON REDLICH AT 518-439-7415, EXT. 232.
Send forms to Allison Redlich, Policy Research Associates, 345 Delaware Avenue, Delmar, NY 12054

In press, Psychology, Public Policy, and the Law

The Second Generation of Mental Health Courts

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Abstract

Mental health courts (MHCs) generally began to appear in 1997. Today, more than 80 courts exist in the US. In the present paper, we argue that the second generation of mental health courts has arrived. We compare eight previously described courts (Griffin, Steadman, & Petrila, 2002) with seven newer courts that have not been previously described in the psycholegal literature. We identify four dimensions distinguishing first- from second-generation courts: 1) the acceptance of felony versus misdemeanant defendants, 2) pre- versus post-adjudication models, 3) the use of jail as a sanction, and 4) the type of court supervision. Potential reasons for the evolution of a second generation are discussed.

Between 1998 and 2003 the number of mental health courts (MHCs) in the U.S. increased from fewer than 10 to over 80 (National GAINS Center, 2003). Empirical data—both evaluative and outcome—remain sparse despite their growth. There have been informative articles written on individual courts (e.g., Petrila, Poythress, McGaha, & Boothroyd, 2001; Cosden, et al., 2003) and on the comparison of multiple courts (Bazelon Center, 2003; Trupin & Richards, 2003), but non-descriptive studies are generally lacking.

One issue relates to defining mental health courts. Previously, mental health courts have been described as those that 1) are criminal courts, 2) have separate dockets exclusive to persons with mental illness, 3) divert defendants from jail and/or prison into community mental health treatment, and 4) monitor mental health treatment and potentially impose sanctions for non-compliance (Steadman, Davidson, & Brown, 2001). Based on the MHCs described by Goldkamp and Irons-Guynn (2000) and Griffin and colleagues (2002), a number of MHCs fit these common descriptions. However, in this article, we propose that a second generation of MHCs is developing, based on notable differences between the descriptions of older courts and those developed within the past three years. We support this observation by comparing eight established mental health courts (what we refer to as the 'first generation') previously addressed by Griffin, Steadman, and Petrila (2002) with seven newer MHCs (what we refer to as the 'second generation') we are evaluating as part of the 2002 Bureau of Justice Assistance Mental Health Court Program.

One definition of the word "generation" is descent from a common ancestor. Clearly, the first and second generations of MHCs descend from similar sources, and because of this they have numerous overlapping characteristics. There are also important differences, however, that we believe warrant the title of second generation. We are not claiming that the second generation

of courts is superior to, or an improvement upon, the first. There are no empirical data to support such a claim. Rather, our assertion is that the second generation of MHCs differs from the first on four meaningful dimensions that must be considered in planning needed research. The four dimensions are: 1) the type of charges the court accepts (felony versus misdemeanor); 2) the type of adjudicative model the courts follow (pre- versus post-adjudication); 3) sanctions employed in the court (specifically the expressed willingness to use jail as a sanction), and 4) supervision of MHC participants (mental health versus criminal justice professionals). Because of these differences, the conceptualization of what is a mental health court should be fundamentally altered.

For the work reported here we did not re-evaluate the eight first-generation courts. It is possible that one or more of these eight courts have evolved over time in their procedures, eligibility criteria, sanctions used, etc. and may have shifted into a court we would consider a second-generation court. Our intent is to depict two cohorts of courts based on previous descriptions provided in the literature and from recent data we have collected, and to support the idea that a new generation of MHCs is present which is distinguishable from the original cohort of courts.

First-Generation Mental Health Courts

Griffin et al. (2002) examined eight well-established MHCs. The first four were formerly investigated by Goldkamp and Irons-Guynn (2000) and are located in 1) Broward County, Florida, 2) King County, Washington, 3) San Bernardino, California, and 4) Anchorage, Alaska. Griffin and her colleagues then "identified the four longest-running mental health courts other than those studied by Goldkamp and Irons-Guynn" (p. 1286) as MHCs in 5) Santa Barbara,

California, 6) Clark County, Washington, 7) Seattle, Washington, and 8) Marion County, Indiana. These eight courts began in the mid- to late-1990s.

Table 1 lists characteristics of the eight first-generation courts as described by Griffin et al. (2002). At the time, six of the eight only accepted defendants with misdemeanor charges, and often times restrictions were placed on the misdemeanors these courts were willing to accept. For example, four of the courts excluded defendants with charges of driving under the influence. However, since the Griffin et al. article was published, four of the six courts that had only accepted persons charged with misdemeanors will now consider persons charged with felonies on a case-by-case basis (see National GAINS Center, 2003).

In terms of the type of adjudication model the eight courts followed, Griffin et al. (2002) described three models: 1) Preadjudication model; 2) Postplea-based model; and 3) Probation-based model. The second and third models are post-adjudication models in that convictions are in place, but sentences may or may not be imposed. Four of the eight used a pre-adjudication model for most or all of their cases. Under this agreement, a plea of guilty may be required but the case is not adjudicated. Often, the prosecutor holds the charges in abeyance and this is what is used as leverage to motivate the participant to comply with mental health treatment and other orders of the court. Three of the courts used post-adjudication for most or all of their cases, and for one court (Clark County, Washington), the use of the pre- and post-adjudication models depended upon where in the county the crime was committed.

All of the eight MHCs reported using a variety of sanctions when compliance with court-ordered conditions was less than perfect. Sanctions included hearings before the judge (where participants usually receive reprimands from judge), changes in treatment plans, and community

service. Jail was available as a sanction but most courts reported using it very rarely. One court, San Bernardino, CA, however, reported using jail as a sanction more liberally.

As reported in Griffin et al. (2002), the eight courts follow one of three supervision models. In this context, supervision refers to the responsibility of ensuring MHC participants stay engaged in community treatment (e.g., go to therapy sessions, take their medication) and otherwise follow the court's orders. Type 1 is a model in which community treatment providers are primarily responsible for MHC participant supervision but also report back to the court on a regular basis and/or when difficulties arise. In the Type 2 model, recurring supervision is provided by court staff or probation/parole officers. Sometimes, the court staff person or probation officer has a dedicated position or caseload and works exclusively with MHC participants. The Type 3 model is when mental health staff and probation work together. Four of the eight courts followed Type 1 supervision model, three followed Type 2, and two courts followed Type 3. (Note that the Anchorage, AL MHC used both Type 1 and 2 supervision models depending on which court program the participant was in.)

Overall, based on descriptions provided by Goldkamp and Irons-Guynn (2000) and Griffin et al. (2002), the majority of first-generation mental health courts focused on misdemeanants. As such, the courts were in better positions to accept cases without requiring convictions and to rely more heavily on supervision external to the MHC (i.e., community mental health providers).

Second-Generation Mental Health Courts

In 2002, the Bureau of Justice Assistance announced their first round of funding for mental health courts. Of those that applied, 23 courts were funded. Under National Institute of Justice support, we are conducting a process evaluation of the seven operational courts. (The

remainder of the courts is using the BJA funds to initiate their MHCs and thus was not suitable for evaluation.) Over a three-month period in 2003, two-person teams (comprised of the authors) conducted site visits of the courts. A set of fifty questions was developed a priori building from the previous MHC comparison work of Goldkamp & Irons-Guynn (2000) and Griffin et al. (2002), and answers were obtained during the site visits. The seven courts are described below.

1) *Santa Clara County, California.* Santa Clara County is a large county both in terms of population (1,682,000 residents) and geography. The major city is San Jose, a hub of Silicon Valley. The Santa Clara County MHC grew directly from the county's Drug Treatment Court, and the MHC is a dual-diagnosis court. That is, the MHC in this county focuses on clients who have mental health issues as well as substance abuse issues. However, the Court does not restrict eligibility to only those with co-occurring problems. Rather, the court casts a broad net and accepts nearly all referrals. It is one of the largest MHC we have seen with over 600 participants and a calendar that meets a full day and a half per week.

2. *Orange County, North Carolina.* This court, named the "Community Resource Court," originated in May 2000. The idea for the Court was initiated by a local NAMI member. Orange County has 118,000 residents and is home to Chapel Hill and Hillsborough. Court is held twice a month in two locations. When we visited the court in August 2003, there were 65 cases combined for the two dockets.

3. *Allegheny County, Pennsylvania.* Allegheny County, whose major city is Pittsburgh, has nearly 1.3 million residents. The first referral to the court was in July 2001. The court holds both plea and reinforcement hearings, which are held alternately once a week. The plea hearings are the first-time appearances for new defendants. The reinforcement hearings, which are characterized by MHC personnel as positive (e.g., praise for treatment adherence) or negative

(e.g., threat of sanctions for treatment non-adherence) and are dependent on progress and compliance, are first held every 30 days and later every 90 days as participants advance through the MHC process. At the time of our site visit to the court, there were 120 active cases and 36 people who had successfully graduated.

4. *Washoe County, Nevada.* Washoe County is in Northern Nevada. The larger cities there are Reno and Sparks, and the county is home to nearly 500,000 residents. The MHC began accepting referrals in November 2001 and from its inception, approximately 225 participants have enrolled in the court. At the time of our visit, there were 37 cases on the docket. The Court meets weekly and is one of several specialty courts in the county.

5. *Brooklyn, New York.* Brooklyn is home to 2.5 million people. This court started as a pilot program in March 2002 and to date, approximately 40-50 people have participated (36 are currently enrolled). The court meets weekly and status hearings are held with decreasing frequency as the participant progresses through the court. Like many mental health courts, Brooklyn's court was sparked by its drug treatment court. This MHC is part of a larger array of forensic programs for persons with mental illness.

6. *Bonneville County, Idaho.* The hub of Bonneville County, which is home to approximately 85,000 residents, is Idaho Falls. Its MHC began in August 2002 and is small relative to other mental health courts.. One reason for its small size is the court's integration with an Assertive Community Treatment (ACT) team. All MHC clients are served by the ACT team. By their nature, ACT programs are intensive and the ratio of clients to staff is low. In this MHC, no more than 20 clients at one time can participate; at the time of our visit, there were 13 active clients. Court is held once a week.

7. *Orange County, California.* Orange County is a large California county in the southern part of the state. Although the county has 2.8 million residents, the MHC serves only a specific region of the county which has a population of 800,000 people. Like the other California MHC in Santa Clara County, this MHC is a dual-diagnosis court. All participants must be enrolled via the California Proposition 36 track, which is "The Substance Abuse and Crime Prevention Act." This initiative allows for treatment alternatives to incarceration for first-time and second-time nonviolent drug possession offenders and is the primary funding mechanism for the Orange County MHC. Currently, there 47 active participants enrolled.

Table 2 describes the seven second-generation MHCs using the same variables as in Table 1. As discussed in detail below: 1) all of the courts accept felony cases; 2) all but one utilize post-adjudication models; 3) the majority are comfortable placing persons in jail as a sanction when necessary; and 4) there is a preponderance of reliance on internal supervision (i.e., internal to the criminal justice system).

Similarities and Differences between First and Second Generation MHCs

As stated above, first and second generation MHCs have clearly descended from the same ancestors. Indeed, there are likely to be more similarities between the generations than differences. For example, all of the courts we evaluated are problem-solving courts and based on the premise of therapeutic jurisprudence (Wexler & Winick, 1992). In addition, court processes are generally informal and non-adversarial.

Goldkamp and Irons-Guynn (2000) described three common factors of early MHCs. First, the courts are designated as specialty courts; that is, courts that have special dockets and, in the case of mental health courts, only accept participants with mental health problems or diagnoses. Of the eight examined by Griffin et al., this was clearly the case. Of the seven more

recent courts presented here, at least one will accept clients without mental health problems and includes those with physical health problems, such as AIDS or Hepatitis C. This is most likely to be an exception to the rule, however. We would still generally describe the second generation of MHCs as those that primarily serve persons with mental illness.

The second common feature of MHCs noted by Goldkamp and Irons-Guynn (2000) is that most restricted their docket to nonviolent misdemeanants. Although we discuss this more in depth below, we did not find this standard across the newer courts. The third common feature was that mental health courts attempt to divert people into community treatment instead of jail or prison. This was also a goal of the seven more recent courts; a goal that is unlikely to change over time and with the creation of even newer courts. Indeed, the first and third features are integral to the *definition* of mental health courts, whereas the second feature serves as a *description* of individual courts. Mental health courts, as generally understood, are specialty courts for persons with mental illnesses charged with crimes (the first feature) and are designed to mandate people into treatment instead of incarceration (the third feature). The second feature—restriction to nonviolent misdemeanants—is a feature that is alterable without necessarily changing the definition of a mental health court. This second feature is also our first dimension distinguishing first- from second-generation courts.

Dimension One: Type of charges accepted. In the Griffin et al. (2002) study, seven of the eight first-generation courts *focused* on misdemeanor crimes, and only two courts (San Bernardino and Santa Barbara) included felony crimes. Updated information (National GAINS Center, 2003) on these eight courts informs us that now only two courts will not consider felony defendants. Of the seven second-generation courts, all accept felonies. Three of the seven can be described as focusing on felonies or those that only accept felonies. Of the four that accept both

misdemeanants and felonies, we would describe only one (Allegheny County, PA) as focusing on misdemeanor crimes with an occasional acceptance of persons charged with felonies on a case by case basis (see Tables 1 and 2).

A related feature is whether courts will accept offenders charged with violent offenses or those with violent histories. From our observations, the seven newer courts were also more relaxed on this issue, although this is not to say that these courts were unconcerned with public safety as they clearly made it a priority. In the eight Griffin et al. courts, two of the courts allowed for charges of domestic violence or battery and sometimes only with the victims' consent. Of the seven newer courts, restrictions concerning violent charges and histories still exist, but most courts were also willing to apply a "totality of the circumstances" approach and examine the circumstances surrounding the crime, the person, and the overall situation before making a decision of acceptance or rejection. For example, one of the courts accepted two women with mental illness accused of killing their children. Another court enrolled a person charged with taking a saw to a female neighbor's door. In this latter case, an exception was made because court-related personnel were familiar with the potential client and believed the MHC was in the participant's and in society's best interest. Similarly, the Bazelon Center (2003) reported in their analysis of 20 mental health courts that 80% were willing to consider persons charged with violent acts.[1]

Dimension Two: Type of Adjudication Model. Of the eight courts studied by Griffin et al., although six have mechanisms for post-plea adjudication, four of the eight relied primarily on pre-plea models. Using information from the National GAINS Center (2003) report, it would seem that the eight courts have not changed their adjudication procedures with one exception. The Marion County, IN court appears to have changed to a deferred-sentence model and thus

process cases post-adjudication. In contrast to some of the first-generation courts, of the seven second generation courts, six only allow for post-plea enrollment. The seventh (Orange County, NC) is primarily deferred prosecution (pre-plea) but approximately 25% of their cases are post-plea/post-conviction.

An ancillary component to the more frequent utilization of post-plea adjudication models in the second-generation courts is that potential MHC participants are being referred much further down the criminal justice pipeline. For the eight first-generation courts, Griffin et al. wrote "Each court identifies possible participants within the first 24 to 48 hours of arrest" (p. 1286). Generally, we did not find this to be the case for the seven second-generation courts. Persons are either not being identified shortly after arrest during initial detention or, if they are identified shortly after arrest, are not enrolled in the MHC until much further into the adjudication process. Time from referral to first MHC appearance ranged from 7 to 60 days with an average of 29 days across the seven newer courts. Potential referents are often identified by other judges and court personnel once further in the criminal justice process. For example, in one of the seven newer courts, participants are convicted and sentenced before MHC consideration. The original sentencing judge is the final decision maker of whether persons are allowed to enter the MHC and if they replace their sentences with mandated community treatment.

Dimension Three: Type of Sanctions Used. Within this dimension, we focus on the use of jail as a sanction. All of the fifteen (first- and second-generation) courts utilize a cadre of sanctions, such as mandating community service and reprimands from the judge. Griffin et al. noted that six of the eight first-generation courts reported rarely using jail as a sanction for non-compliance with the courts' orders. Of the second-generation courts, our impression was that jail appeared to be used with more regularity. At least five of the seven seem to be comfortable using

jail as a sanction, although all reported using jail as a later (but not necessarily last) resort when earlier, less punitive sanctions had not induced treatment engagement. Moreover, all of the seven courts reported some flexibility in regard to non-compliance; that is, perfect performance was recognized as a futile goal. Many of the courts also acknowledged that whereas jail was an effective solution to gaining compliance for some participants, for others, jail had a detrimental and opposite effect. Thus, jail as a sanction was used with discretion.

Nevertheless, from what we observed, our perception was that the second-generation courts were more willing to place people in jail than previously studied MHCs, a consequence perhaps of the fact that these more recent courts accept persons charged with felonies. For example, one MHC reported being comfortable using jail under the following circumstances: 1) as a "wake-up" call, 2) for medical detoxification, 3) as a result of new charges, or 4) for failure to keep appointments with their probation officers. Another common mechanism among several of the courts for jail time was "dirty" urinalyses, which is similar to their predecessors, Drug Treatment Courts. In its report on 20 mental health courts, the Bazelon Center (2003) found that 64% were willing to place people in jail for non-compliance, but the frequency of use was not specified. Empirical data is sorely lacking on the use of jail as a sanction (such as average numbers of jail days), as well as on all types of MHC sanctions.

Dimension Four: Type of Supervision. As described above, Griffin et al. denoted three types of supervision models for their eight first-generation courts. Type 1 was supervision by existing community mental health providers who reported back to the MHC either when there are difficulties or on a regular basis. Type 2 was regular supervision by dedicated MHC staff (e.g., Court Monitor, mental health staff) or probation/parole officers. Type 3 was regular supervision from a combination of probation officers and community or court mental health

workers. For the second-generation courts, we found that the courts fit one of these three models but the majority of MHCs relied on supervision by personnel directly linked to the court.

As shown in Table 2, four of the courts rely on either probation solely or MHC staff (Type 2 model) to supervise clients in the community. Two courts utilize a team approach (Type 3) in that probation officers jointly supervise clients with either court staff or community mental health providers. Only one court—Orange County, NC--relies primarily on community mental health staff (Type 1) who then report back to the MHC. Although this court does have the option of probation supervision, it is not commonly used because in most circumstances it does not apply (i.e., 75% of their clients are diverted pre-adjudication and are therefore not subject to probation). Thus, whereas the types of supervision employed by the first- and second-generation courts are similar, the frequency with which they are used differs. That is, while four of the first-generation courts relied solely on community treatment providers for supervision of participants, only one second-generation court did so. For the newer courts, it was more common to see court personnel and/or probation responsible for supervision.

It is clear that these four dimensions distinguishing first- from second-generation courts are related to one another. That is, because the courts now accept more felony defendants, the number of courts relying on post-plea adjudication models increased, as did the use of jail as a sanction and the use of criminal justice mechanisms of supervision. Since felony crimes, by definition, are more serious than misdemeanor crimes, prosecutors and others involved in the MHC more often require that potential participants plead guilty (with or without a conviction) to enroll in the MHC. This is also true for the increased use of jail as a sanction. In their report, the National Drug Court Institute (2000) noted that the leverage of jail is commonly used in drug treatment courts, which tend to handle felonies.

Moreover, the first three dimensions are relevant to the front end of mental health court operations. The day-to-day, back-end operations after participant enrollment have changed little. After enrollment dispositions are made, participants attend hearings in front of a judge, treatment mandates are issued, and some level of supervision is rendered; as noted above, because these courts accept defendants charged with felonies, the supervision is more likely to involve probation officers rather than be left solely to community mental health providers. Rather, what has seemingly changed is how potential persons are selected for enrollment, the front end of the court.

The precise reasons for the changes in how MHCs refer and select participants for inclusion in the courts are not known. We have several suppositions, however. One has to do with funding mechanisms for the courts. The two California courts, Santa Clara and Orange Counties, are linked to Proposition 36 funds. As noted earlier, this initiative allows first- and second-time, non-violent, simple drug possession offenders the opportunity to receive substance abuse treatment in the community instead of incarceration. As a result, both are dual-diagnosis courts and focus on felony defendants. One aim of Proposition 36 is to divert people from state prisons rather than local jails (a goal of many misdemeanor MHCs), and, as such, felons are a more appropriate target for these courts. It is also possible that localities have made policy decisions to not focus on misdemeanants because of uncertainty regarding the effectiveness of such a focus and reliance on alternative strategies for diversion. In its report on 20 mental health courts, the Bazelon Center (2003) acknowledged that MHCs were becoming increasingly likely to accept felony defendants, but argued that misdemeanants are ill-suited for MHCs because they should be diverted from the criminal justice system entirely (e.g., pre-booking diversion programs). The Center's report states "To avoid becoming the entry point for people abandoned

by the mental health system, mental health courts should close their doors to people charged with misdemeanors" (p. 7). If the trends we have noted from the first to second-generation courts continue, third- or fourth-generation courts may indeed be exclusive to felony defendants. And, finally, with an increase in the number of pre-trial/pre-arrest diversion and Crisis Intervention Training (CIT) programs for persons with mental illness (Naples & Steadman, *in press*), it may be that the need has diminished for mental health courts to accept misdemeanants in localities with alternative forms of diversion. Some local jails will not accept misdemeanants (primarily because of overcrowding), regardless of mental health status.

Conclusions

The present article is meant to generate thought and discussion concerning the differences between well-established and newly established mental health courts. It is not intended as an exhaustive catalogue of all of the current U.S. MHCs. We have only examined fifteen courts over two studies, which is approximately one-fifth of the mental health courts that exist in the U.S. Furthermore, we did not directly re-evaluate the eight first-generation courts, and thus their current practices may not match exactly what was described in the literature reporting on their operations up to 2002. We must also emphasize that we did not compare the efficacy of what we have labeled first- and second-generation courts and are not suggesting that second-generation courts are superior to first-generation courts. Lastly, we use the term "generation" to represent a cohort of courts, but, of course, there were some exceptions to the rule. That is, there were first-generation courts that may today have many of the characteristics of second-generation courts, and vice versa. However, our goal was to describe what was common among the courts and not pigeonhole courts into any one label.

Do the four dimensions—increased acceptance of felony charges, post-plea adjudication models, increased use of jail as a sanction, increased use of criminal justice supervision—challenge the intent of therapeutic jurisprudence? Are second-generation courts an improvement upon first-generation or simply a distinct type of mental health court? In the future, will the trend we noted with second-generation courts continue and will mental health courts limit their jurisdiction to felonies? What is the impact of the use of sanctions on compliance with court-ordered conditions? Some of these questions have been raised elsewhere (Griffin et al., 2002; Steadman et al., 2001), and as the characteristics of MHCs become more clear, it is to be hoped that research will begin to address these questions along with the many other substantive issues that such courts raise.

Footnote

1. The Bazelon Center did not provide a list of the 20 mental health courts that they studied, and thus it is unknown what proportion of the courts are newly established as opposed to older courts (e.g., pre-2000 versus post-2000).

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Table 1

Characteristics of First-Generation Mental Health Courts

	Types of Cases Accepted	**Type of Adjudication Model**	**Jail as a Sanction?**	**Type of Supervision**
Broward County, FL	Misdemeanors	Mostly Pre-Plea	Extremely Rare	Community Treatment Providers TYPE 1
King County, WA	Misdemeanors	Mostly post-plea	Sparingly	Probation (special) TYPE 2
San Bernardino, CA	Misdemeanors and low-level felonies	Post-plea	Used liberally	Team: Probation and MH staff TYPE 3
Anchorage, AL	Misdemeanors	Mostly post-plea	After repeated attempts and still non-compliant	Court monitor TYPE 1 AND 2
Santa Barbara, CA	Misdemeanors and some felonies	Mostly post-plea	Occasional use	Team: Probation and MH staff TYPE 3
Clark County, WA	Misdemeanors	Pre-plea and post-plea (depending on jurisdiction)	Avoids unless there is a new violent charge	Community Treatment Providers (most cases) TYPE 1
Seattle, WA	Misdemeanors	Mostly pre-plea	Rarely and conditional	Probation (special) TYPE 2
Marion County, IN	Misdemeanors	Pre-plea	Rarely	Community Treatment Providers TYPE 1

Table 2

Characteristics of Second-Generation Mental Health Courts

	Types of Cases Accepted	**Type of Adjudication Model**	**Jail as a Sanction?**	**Type of Supervision**
Santa Clara County, CA	Mostly felonies	Post-plea	Comfortable using it, but used with discretion	Team TYPE 3
Orange County, NC	Misdemeanors and felonies	Mostly pre-plea	Comfortable using it, but used with discretion	Treatment staff (most cases) TYPE 1
Allegheny County, PA	Misdemeanors and some property felonies	Post-plea	Rarely used	Probation TYPE 2
Washoe County, NV	Misdemeanors and felonies	Post-plea	Comfortable using it, but used with discretion	Team TYPE 3
Brooklyn, NY	Non-violent felonies; few misdemeanors	Post-plea	Rarely used	Court case managers TYPE 2
Bonneville County, ID	Misdemeanors and felonies	Post-plea	Comfortable using it, but used with discretion	ACT team and Probation TYPE 3
Orange County, CA	Felony-Substance	Post-plea	Comfortable using it, but used with discretion	Probation TYPE 2