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King County District Court

Mental Health Court

Phase I Process Evaluation Report

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King County Advisory Group
Mental Health Court Evaluation

MEMBERS

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King County District Court Mental Health Court

Phase I Process Evaluation and Early Outcome Analyses

EXECUTIVE SUMMARY

A team of researchers from the University of Washington and the Washington Institute for Mental Illness Research and Training (WIMIRT), led by Dr. Eric Trupin, conducted the first phase of program evaluation of the King County District Court Mental Health Court (MHC), a court designed to address the unique needs of mentally ill misdemeanants. This phase of the evaluation focused on program fidelity to goals, efficiency of functioning during the first year of operations, and the analysis of preliminary outcome data on defendants referred to the court. Sections on qualitative findings, quantitative findings, and integration/recommendations organize the report.

Methods

The evaluation relied on four methods of data collection:

1. Intensive structured interviews were conducted with key informants within the MHC, the County council, the State legislature, the judiciary, the office of the county executive, county agencies, and treatment providers.
2. An anonymous survey was administered to key informants from involved agencies.
3. Evaluators informally observed MHC process and role performance of key MHC staff.
4. Archival data was collected and analyzed from the District Court, the County Department of Adult and Juvenile Detention (DAJD), and the County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) information systems.

Qualitative Findings

Qualitative process-related findings from an anonymous survey, confidential structured interviews, and researcher observations indicate that:

1. The MHC is currently providing adjudication services to the target population of individuals charged with misdemeanor offenses and identified as suffering from a significant mental illness. Mental illness is defined broadly to include developmental disabilities and brain injuries, or general psychiatric symptoms of at least moderate severity.

2. The MHC team is coherently organized, well managed, and routinely applies specialized knowledge and expertise to the adjudication of mentally ill defendants. Consistency and teamwork of core staff and increased intensity of supervision and monitoring of clients are essential components of the MHC model.

   - Although the MHC functions as a Judge-centered team, the unique roles of the Court Monitor and Program Manager were viewed by almost all informants as critical to the success of the court.

   - Because of the recognized importance of teamwork among MHC core staff, turnover has become an issue of concern.

3. Stakeholders and agencies in operational contact with the MHC indicated high regard for the MHC leadership and staff. Expressed stakeholder and agency support for the program was high.

4. Key stakeholders and members of the MHC share a common understanding of the MHC as a problem solving court that administers justice for mentally ill defendants by pursuing value-laden objectives. Among these objectives are:

    a. Preventing the criminalization of the mentally ill through informed legal case management;
    b. Improving the defendant's well-being and ability to conform to the requirements of the law by engaging the defendant in needed treatment and providing linkage to other needed resources;
    c. Managing cases to insure public safety; and
    d. Supporting the defendant's personal autonomy through the exercise of personal responsibility and legitimate prerogatives.

1. MHC team members, like the larger stakeholder group, differed in their views about how the balance should be struck, both in principle and in specific cases, among shared objectives.

    - In a significant minority of cases, differing views of priorities contributed to an intensification of the adversarial model, as opposed to the MHC's usual teamwork approach.

    - An adversarial approach combined with the broadly defined roles of mental health core staff have contributed to inefficiencies in gathering and sharing information.

2. The MHC has enhanced communication between systems and agencies that previously worked in relative isolation and has increased awareness among key stakeholders of the needs of mentally ill misdemeanants.

3. Linkage of defendants to mental health and other resources has been significantly increased by MHC activities.

    - Limited availability of appropriate housing and the absence of a full continuum of integrated substance abuse services for the mentally ill remain significant obstacles to improving community management of participants.

4. The MHC routinely provides specialized, intensive community supervision and responds rapidly to changes in the mental health or compliance status of participants.

5. The decision to opt for participation in MHC is strongly impacted by the advice of the defense attorney and prosecutorial recommendations, which in turn is influenced by the severity of the alleged offense, the defendant's criminal history, and the type and severity of psychiatric symptoms.

    - Defendants with insight into their psychological symptoms or who are already engaged in mental health services are more likely to opt into MHC than individuals with less insight or paranoid symptoms.

6. MHC is more likely to grant deferred sentences and deferred prosecutions than other courtrooms.

    - Deferred or suspended sentences are more likely if clients are making proactive efforts in treatment and/or if criminal history appears related to mental illness.

Quantitative Findings

Quantitative analysis was conducted on available archival data for the first 246 defendants seen in the MHC. These data were provided by the MHC and from the information systems of the District Court, DAJD, and MHCADSD. When possible, defendant mental health and detention histories were compared before and after contact with the MHC. These analyses indicate that:

- The MHC population is fairly representative of the detention population in terms of gender and ethnicity. The average age of participants was 37 years, with a range of 18 to 81 years of age.

- 41% of referred defendants opted to participate in the MHC (Opt-Ins) versus 31% who declined participation (Opt-Outs).[1]

- 85% of those referred were diagnosed with severe mental disorders such as psychotic disorders, bi-polar disorder, major depression, and organic brain dysfunction, suggesting that the program was successful in targeting mentally ill defendants.

- When compared to Opt-Out defendants, Opt-In defendants were almost three times more likely to have a new treatment authorization request made on their behalf during the study period, indicating that the MHC was successful in linking offenders to treatment services.

- Opt-In defendants received significantly more hours of treatment after contact with the MHC, when compared to both their previous treatment histories and to Opt-Out defendants, indicating that the MHC was successful in engaging patients in treatment and establishing a greater measure of compliance to treatment regimens.

- Clinician ratings indicated that only defendants opting into MHC experienced significant improvements in adaptive functioning following MHC contact.

Quantitative analysis of detention data for 77 participants over the one-year period prior to the formation of the MHC through its first year of operation led to the following key findings:

- Several quantitative analyses indicated that defendant involvement with the MHC resulted in increasing the amount of treatment received and decreasing problems with the criminal justice system. This impact was greatest for Opt-In defendants.

- For both Opt-Out and Opt-In defendants, lower motivation to deal with alcohol and substance use problems was associated with an increase in new bookings.

[1] Approximately 7% are screened-out as inappropriate or ineligible, and 13% of cases are disposed of before an Opt-In, Opt-Out decision. At any given time about 9% were pending a decision to participate.

- For both Opt-Out and Opt-In defendants, as the number of treatment episodes increased, time in detention decreased. This relationship was strengthened after defendants had contact with the MHC.

- After contact with the MHC, Opt-In defendants on average spent fewer days in detention than Opt-Out defendants.

- The rate of new bookings after contact with the MHC decreased significantly for Opt-In participants, but did not for those who chose not to participate.

Recommendations

The following recommendations are offered in the context of findings that are highly supportive of the MHC and which indicate a successful first year of operation. Several of these recommendations involve program enhancements or program expansion. Their implementation may require additional resources. Other recommendations are aimed at preserving program integrity and are achievable within currently available resources.

7. In response to this report, the MHC should review its mission with the goal of establishing a working consensus concerning priorities among its objectives.

8. Role clarification and refinement should be supported through the submission of written work content and process descriptions to the Judge and Program Manager for review, revision, and discussion in team meetings.

9. Team meetings should remain a high priority, and some portion of each meeting should be documented in minutes that can serve as the basis for ongoing review of the team's process.

10. Standardized assessment instruments should be adopted for use in clinical monitoring.

11. A formal process for assessing risk for future dangerousness should be adopted. This process should rely on validated risk assessment instruments administered by appropriately trained staff.

12. Stronger judicial oversight of the provision of treatment should be established by setting the expectation that detailed treatment plans will be reviewed by MHC. The type and methods of treatment referred to in the plans should be available to the MHC in sufficient detail to determine the appropriateness of the treatment to mentally ill defendants.

13. Protective payee arrangements and the establishment of a flexible fund for minor expenses should be considered as ways to increase contingent incentives for participant success.

14. If resources are made available to manage the additional caseload, the MHC should be empowered to accept cases from additional municipal courts and to adjudicate some less serious felonies.

15. The need for additional staff time for each role in the MHC, and for administrative support, should be reviewed.

16. Guidelines should be established to specify the conditions under which diversion of cases from the criminal justice system should be considered.

17. For some refractory cases, outpatient commitment proceedings may be an appropriate outcome of repeated decompensation and reoffending. A review of the use and appropriateness of the current statute for this purpose and the treatment system's ability to support this process should be conducted by a body that is independent of the MHC, such as a Task Force.

18. A Community Advisory Committee should be established that would include a wide range of knowledgeable and concerned citizens.

19. A review of possible early course "model drift" is in order, given the completion of this preliminary study, turnover in the MHC, the loss of the program's novelty, and potential challenges to its resources.

INTRODUCTION

The newly formed King County Mental Health Court (MHC) was the product of the King County Mental Health Court Task Force (1998) in response to the perceived need of community leaders for increased services and better coordination of services for mentally ill misdemeanants. The task force recommended a single court with jurisdiction over supervision of mentally ill offenders (MIOs). Recommendations included a greater emphasis on delivery of treatment, increased follow-up of treated MIOs, and ultimate reduction of contacts with the criminal justice system. Despite the fact that court-mandated and monitored treatment has been found effective for mentally ill misdemeanants, there are very few diversion programs in the United States designed for such individuals and very little evaluation data available for the existing programs (Lamb & Weinberger, 1998).

The King County District Court MHC began hearing cases on February 17, 1999. Differences from regular District Court courtrooms include a single core team of professionals, linkage to mental health treatment, and increased court supervision. The King County District Court MHC, including the core team approach, is modeled after the country's first MHC in Broward County, Florida. Unlike Broward County, where most assistant public defenders and prosecuting attorneys are assigned to specific courtrooms and judges, King County's MHC requires special arrangements to facilitate the core team process. The philosophy behind the core team approach is that MHC team members will become familiar with defendants and their individual legal, mental health, and other treatment needs (Cayce & Burrell, 1999).

MHC core staff consists of a single judge, program manager, court monitor, social worker, prosecuting attorney, and a public defense attorney who is assigned only MHC cases. Two probation officers are assigned exclusively to MHC for the purpose of increased supervision. The court monitor position is unique to MHC and, similar to Broward County, is designed to facilitate linkage of defendants with mental illness in the criminal justice system with mental health and other treatment services. The program manager, a primarily administrative position, is also unique to the King County MHC.

Defendants may be referred to MHC from several sources including the King County Jails, judges and attorneys from other courtrooms, police officers, and family members. Once referred, the Court Monitor screens individuals for symptoms of mental illness, provides information to the Court, and facilitates linkage to appropriate mental health or other services. MHC is considered voluntary and defendants may choose to "opt in" or "opt out." Opting in involves waiving a right to trial and expressed willingness to comply with a supervised treatment plan. Once a defendant has opted in, he or she may be assigned to one of the MHC probation officers who will meet with that individual on a regular basis, with more intensive supervision than standard probation. Another difference from regular District Court is that MHC clients are expected to attend regularly scheduled and relatively frequent review hearings, (e.g. every 30, 60, or 90 days) for increased case monitoring.

The Present Study

The present study assessed the overall efficacy of the MHC in King County's District Court, a court designed to address the unique needs of mentally ill misdemeanants. The objectives of the Phase I Assessment of MHC were: (1) to evaluate MHC in relation to the original goals established by the Mental Health Court Task Force; (2) to make organizational adjustment recommendations to MHC; and (3) to set the stage for a longitudinal, (Phase II) empirical assessment of MHC. The following goals developed by the Mental Health Court Task Force are addressed in this report:

20. expedition of case processing;
21. development of greater linkages between the criminal justice system and the mental health system;
22. reduction of actual jail time and improved access for treatment of mentally ill offenders; and
23. reduction of the number of times mentally ill offenders come into contact with the criminal justice system.

Method

Because of the expectation that MHC will decrease jail time via increased linkage of criminal justice and mental health resources, measurable decreases in cost are unlikely to be demonstrated in a short amount of time. Therefore, the usual and dichotomous "Does it work?" approach to program evaluation would be inappropriate for an early stage assessment (Bogdan & Taylor, 1994). For the present study, we adopted the approach of conducting a qualitative description of the program, including conceptual and organizational issues, combined with a parallel quantitative description and exploratory analysis of available data. Structured confidential interviews, an anonymous survey, and direct informal observation of the MHC by members of the research team provided the basic data for the qualitative aspect of the study. Quantitative analyses, including some related to preliminary outcomes, were conducted on data provided by the MHC, DAJD, and DMHCADS. Qualitative and quantitative approaches to evaluation result in divergent findings, leading to different conclusions and recommendations. Also, the validity and usefulness of findings from these two assessment approaches are themselves evaluated by different criteria. For these reasons, this report is organized into qualitative and quantitative sections and concludes with an integrative section with recommendations

QUALITATIVE SECTION

Subjects

Semi-structured interviews were conducted with MHC staff, mental health service providers, and the legal community. Appendix A contains the complete list of interviewees, including title and position. The University of Washington's Evaluation Team and the MHC Evaluation Advisory Committee collaboratively developed and approved the lists of interview questions and key informants.

Instruments

A semi-structured interview (Appendix B) designed specifically for the purposes of this evaluation was used to gather qualitative data. Interviews primarily focused on the structure of the court, not on specific subject data. For example, interviews were directed toward examining how defendants are processed and efficiency of processing, including whether mental health services are timely and appropriate. Interviewees were asked to evaluate the degree to which services for mentally ill defendants have been coordinated and the degree to which MHC staff have contributed to providing greater linkages between the criminal justice system and the mental health system. Interview questions also focused on the court's primary goals, population, referral and case processing, staff, probation, and treatment services. In addition to interviews, a survey was conducted using a questionnaire with similar item content to many of the issues investigated in the interviews (Appendix B). Individuals who were directly involved in the day-to-day operation of the court and of services provided to the court were administered the survey anonymously. Response sheets were coded for groups relevant to the MHC, such as MHC Staff, Mental Health Jail Staff, etc.

Procedures

Four types of semi-structured interviews were carried-out: 1) MHC core staff interviews, 2) key stakeholder interviews, 3) mental health treatment provider interviews and 4) follow-up interviews. MHC core staff interviews were conducted with MHC core staff and other agency and system representatives working in close proximity to the day to day operations of the court's referral and case processing, probation and/or treatment services. Key stakeholder interviews were conducted with selected representatives of organizations and agencies related to MHC operations. Mental health treatment provider interviews were conducted with selected mental health case managers and other clinical staff who had worked with MHC defendants. One interview was scheduled for each provider agency. Follow-up interviews were used when necessary to provide informants additional time to respond to selected questions from the first interview.

Interviewees were asked to read and sign a consent form, which explained the voluntary nature of the interview and included a request for permission to audiotape (Appendix C). A primary interviewer conducted interviews with, when possible, an additional assessment team member. Interviews were audiotaped when possible and with interviewee consent to ensure accuracy. No defendant interviews were conducted for the retrospective study. Interviews for each category of informants were guided by an identical list of questions. Information specific to individual MHC clients was prohibited during key informant interviews. Although most questions required unstructured responses, several required ratings or numeric responses. Frequencies for responses to rating or numeric questions can be viewed in detail in Appendix D. Evaluation team member(s) recorded interview responses. In addition to the interviews, evaluation team members observed court proceedings periodically to gain general understanding of the MHC process and staff roles.

Analyses

Evaluation team members read interviews while identifying themes and issues, which were later coded for tabulation. Responses to rating scales used within the structured interviews (pertaining to the expedition of case processing, linkage to mental health services, time in detention, perception of recidivism, etc.) were also coded for aggregation. Direct quotes and anecdotal descriptions were extrapolated when identified as illustrative of a particular theme. Interview questions requiring a rating or numeric response (e.g. percent in need of housing) and the anonymous survey were analyzed using descriptive statistics such as means, standard deviations, percentages, and frequencies. Survey responses were incorporated in the discussion of interview findings as supplementary information, rather than being addressed in a separate results section. Appendix E contains the survey items and aggregated results.

Results

Staff Roles

The following staff role descriptions are a compilation of interviewee responses. Interviewees were asked to highlight how these roles were unique to MHC in comparison to other courtrooms (if applicable).

Judge: The Judge takes an objective stance as in other courtrooms, weighing the potential for release to community treatment versus public safety, and is not an advocate for either defense or prosecution. There was the shared perception among interviewees of leadership, sensitivity, and credibility conveyed by the current judge. One interviewee noted that the current judge is more traditional [than the MHC judge in Broward County] and has a different view of therapeutic jurisprudence that preserves the traditional judicial role with a strong focus on public safety. The Judge also handles issues of public relations, community education, political coordination, and is the final decision maker for MHC. The Judge is aware of relevant issues and allows mental health information to be part of decisions.

Program Manager: The MHC Program Manager is an administrative position with no active courtroom duties. Much of the focus is on planning and communication between systems. The Program Manager is also involved with program development, public relations, community outreach, and relations with partner agencies including mental health agencies and jail. This position also involves supervisory and internal administrative duties, including supervision of the two staff Probation Officers and facilitating team meetings and other interdisciplinary communication between staff. Other tasks include grant writing, trouble-shooting system problems, and coordinating information system development. The Program Manager often takes the lead on program implementation issues. One example given was when the MHC Judge wanted to implement changes in the design and writing of probation reports. The Program Manager met with staff and communicated the new requirements that were then implemented by the Probation Officers. The Program Manager position was perceived as critical to the coordination of MHC processes at all levels.

Court Monitor: The Court Monitor provides an initial assessment of MHC clients that involves a release of information and description of psychological symptoms and treatment needs. The Monitor provides linkage through referral to appropriate mental health or chemical dependency treatment providers, as well as supervision of defendants prior to opting into MHC. These findings, as well as available community resources, are presented to the Court at the client's first appearance when possible. This position also involves acting as a knowledge base of mental health information for the Judge. The apparent objectivity of these assessments and recommendations may at times pre-empt the traditional fact finding process that relies more on advocacy of attorneys.

The Court Monitor also helps to coordinate mental health system issues with the Court, via a contract between MKCADSD and United Behavioral Health (UBH), with language referring specifically to MHC. For example, MHC has a current treatment resource problem with Cedar Hills, (a residential chemical dependency program) severely restricting beds available to unstable or psychotic MIOs. The Court Monitor has been working with this agency regarding their client criteria to address the problem. The Court Monitor seems to act more as a case liaison between systems and people and often is involved in follow-up with case manager and family members, encouraging them to attend hearings. Some of these duties may be done by the defense team in other courtrooms, which seemed to result in some territorial disagreements among the core staff. Additionally, one interviewee perceived this role as overly allied with the prosecution in its current focus on public safety.

Court Clerk: The Court Clerk has essentially the same responsibilities as in other courtrooms and is responsible for maintaining official court files and the docket (which is maintained electronically), and reporting court outcomes. The Clerk maintains the court calendar.

Public Defender: The MHC Public Defender represents the client and advocates for the client's position in Court. The main differences in MHC are the difficult and needy population of mentally ill defendants, and the need for the defense attorney to be very knowledgeable about mental health issues and resources. At times the Public Defender and the Court Monitor will need to pool their knowledge to access appropriate treatment resources for a client. Despite the obvious team approach of the MHC staff, it is still an adversarial system and the defense attorney has a perceived obligation to zealously represent clients and the prosecutor to protect the public. The MHC Public Defender carries only MHC cases.

Social Worker: The MHC Social Worker works directly for the public defense agency that represents MHC clients. The majority of the MHC core staff had unclear perceptions as to the role of the social worker. Some saw the position as duplicating much of the assessment and community resource linkage performed by the Court Monitor. This perception may be due to the need for the defense to carefully consider sharing client information in criminal cases. For example, most interviewees perceived very little involvement of MHC client families (between 5% - 50% of cases), whereas the social worker estimated that families played an active role in 60-75% of cases and reported that he/she often facilitated this involvement. One stakeholder was concerned about this lack of communication and the fact that the Social Worker may be working to develop plans for clients that are in conflict with the Court Monitor's plan. The main difference between the Social Worker role and that of the Court Monitor is that the Social Worker works for the MHC client via the defense team and is more invested in the client's stated interest than the goals of the Court.

County Prosecutor: The general role of the prosecutor is similar to that in other courtrooms: to represent the community, public safety, and accountability for crimes. The philosophy seems to be somewhat unique in that the goals are more long-term and focus is on treatment compliance, as opposed to jail time with no treatment, as a better mechanism to improving public safety. The prosecutor may consult with the Court Monitor in an attempt to understand the dynamics of a particular case. Turnover in this position has been perceived as somewhat of a hardship for MHC, as prosecutors tend to lose the perspective of watching cases progress over time. The MHC prosecutor carries cases in other courtrooms and has supervisory responsibilities in addition to MHC and therefore has limited time allocated to MHC cases.

Probation Officers: MHC began with one Probation Officer and another was added as caseloads grew. It has been suggested that a third position will become necessary as MHC continues to grow. The Probation Officers' duties are similar to that of other officers in that they monitor compliance. However,

both of the MHC Officers have extensive backgrounds in mental health that allow for a better understanding of treatment compliance, medication, and treatment issues. The MHC Probation Officers supervise clients closely, often checking in with them weekly or even daily, attend hearings with clients, and seem to have a stronger relationship with clients than would be expected in other courtrooms. MHC probation caseloads are currently 40-50 clients per officer, as compared to as high as 300 in the regular system. Probation Officers receive updates from treatment providers regarding treatment compliance and relay this information to the Court. They were described as often acting as client advocates in contacting case managers and treatment providers who often have extremely large caseloads.

Key Variables in the Functioning of the Mental Health Court

1. Increased Communication Between Systems

Several interviewees mentioned a pattern of enhanced communication between previously segregated systems. Some of this communication existed out of necessity to expedite treatment plans for MHC clients. For example, a client referred by the King County jail would involve communication between the jail, MHC staff, and treatment providers. The Court Monitor is based at UBH and has numerous contacts and links to MHC treatment providers. The MHC Probation Officers also keep in close contact with treatment providers. One of the Officers asks treatment providers to regularly fill out a form on MHC clients and fax it to Probation for review. The form provides a summary of the client's recent attendance, participation, and medication compliance.

Other communication has occurred between systems because of the mutual interest in mentally ill individuals in the criminal justice system. Interest in the court is shared by organizations such as The Washington Alliance for the Mentally Ill (WAMI), the county jail, and treatment providers, as well as policy makers and other government officials. Although a clear lack of treatment resources exists for mentally ill offenders (and the indigent mentally ill in general), several interviewees noted that the presence of the mental health court facilitated increased awareness of this lack of resources among key stakeholders and across systems. For example, although the criminal defense team was acutely aware of the lack of mental health resources available to their clients, the prosecutors also became increasingly aware of the issue because it was repeatedly addressed in the courtroom. One stakeholder interviewee noted that the MHC has brought systems together to develop programs for mentally ill defendants and has increased public awareness both nationally and locally. A local example cited was that of that of meetings between MHC core staff and DESC which resulted in increased MHC client access to respite beds.

Some recommendations made by interviewees about further strengthening the inter-system communication were to form clear agreements with other courts with respect to communication and transfer of cases, and to better distribute information to other courtroom judges. Another recommendation was to develop more connection between MHC and County Designated Mental Health Professionals (CDMHPs) who make assessments for civil commitment and sometimes have information to make MHC referrals. One staff member suggested that known mentally ill defendants who may appear in other courtrooms be "flagged" so that the possibility of transfer to the MHC can be addressed.

MHC has developed and is in the process of implementing an information system application to capture client data for mental health court. This will allow for even more shared information between MHC, treatment, and detention staff. One difficulty with the database is securing additional resources to input the MHC data, design reports, and maintain the system. The information to be gathered for the database is currently located in six different systems.

24. Mental Health Court Core Staff and Teamwork

Consistency and teamwork among core staff were mentioned repeatedly as essential components of the MHC model. As mentioned by one core staff member, "We have a team of people who deal with these cases. They are not dealing with different judges and prosecutors. They get to know these individuals." The Court staff meets on a weekly basis to discuss and problem solve case processing issues. Team meetings have become less consistent as the Court has become more busy. On the individual case level, collaboration is more problematic. Because of the judge and defense attorney's inability to discuss specific cases off the record and without clients present respectively, cases are not discussed in the team meetings.

In the case of a client who fails to appear (FTA), the Probation Officer often knows the client well enough to provide the Court with information and, at times, to make arguments in support of holding an order (e.g. because of issues related to illness). A warrant may be ordered and remain unsigned by the Judge for one week prior to issuance. If a warrant is issued and the defendant then shows up to Court or contacts Probation, the Judge will often hear a case right away and may quash (dispose of) the warrant. Because of the frequent required appearances in MHC, more warrants may be issued due to FTA. However, because of the flexibility of MHC in handling FTAs, MHC clients tend to come into Court to address the warrants, resulting in warrants being quashed. Currently the King County Sheriff's Office does not serve misdemeanant warrants. However, one staff member noted two cases in which safety was a concern, and the Court would have preferred the serving of a warrant. Fewer warrants and jail time sanctions are used for failures to comply with conditions than in other courts. These seem to be dealt with more via increases in the intensity of supervision and monitoring.

Because of the recognized importance of teamwork among MHC core staff, inevitable turnover has become an issue of concern. The two MHC attorneys have turned over several times and a judicial change might occur. Another staff member stated, "I think that consistency is the most important thing about the model. It is important to have a public defender, prosecutor, and judge that really know the case inside and out. They are not just guessing looking at a thick file, they know what they have to do based on history and direct knowledge of the defendant and the case."

25. Supervision/Monitoring

Another theme that emerged among interviewees was the observation that increased supervision and more intense monitoring of cases by MHC and Probation resulted in perceived better outcomes for defendants (e.g. engagement in treatment, no new arrests). Supervision by probation is substantially more intensive than in the regular system, as MHC probation caseloads are currently 40-50 clients per officer, as compared to up to 300 in the regular system. Lower case loads allow MHC probation officers to see clients weekly for the first six months, and even daily if deemed necessary.

MHC conducts regular reviews of cases and receives reports directly from agencies. Both the Court Monitor and probation have regular contact with agencies to monitor treatment progress. Several interviewees attributed the success of clients to intensive supervision and threat of sanction. One staff member went on to state that the critical role of intensive supervision and looming sanctions might be due to the fact that no individual outpatient dual diagnosis treatment is currently available. "We either have inpatient or once per week groups. Once you're out we have nothing in between." In this respect, judicial oversight by the MHC may be filling a great gap in community treatment resources.

Balancing the immediacy of consequences with due process was another concern, as noncompliant defendants now get a week's notice to appear in Court. Consequences for noncompliance may therefore

lose effect as time passes. The Court does not currently monitor the specific approaches used by treatment providers. One staff member was concerned that the Court would lose objectivity if it began monitoring treatment providers and dictating treatment plans. Other observed differences between MHC and other courtrooms were: in MHC fines are not used unless mandatory, there are rarely probation fees (due to the indigent status of the population), most defendants receive mental health treatment conditions, and many have additional drug and alcohol treatment.

The Court Monitor also seems to alter the dynamics of the traditionally adversarial criminal justice process. This person provides information to the Court on client assessment, symptomatology, treatment needs, dangerousness, and other concerns. At times there has been conflict between the Court Monitor and defense attorney, who perceived an overlap in roles. For example, the defense attorney has at times interpreted the Court Monitor's information as legal recommendations to the Court.

26. The Court Monitor: Linking Defendants with Services

The Court Monitor position was mentioned in several interviews as a key component in the MHC's success. The Court Monitor provides a historically important but recently missing communication link between systems (jail, court, and mental health) that may be the single most important variable in working towards the other goals of MHC. In fact, it was pointed out by one stakeholder that, with the presence of an individual dedicated to providing mental health assessment and linkage to services, the MHC as a whole may not be essential in facilitating greater linkages between the criminal justice system and the mental health system. As stated by another stakeholder, "Maybe three court monitors in jail could be as effective as MHC as a whole." Although this point underlines the importance of linkage services, it fails to address the other goals of MHC, including providing incentives to comply with treatment, expediting case processing, and providing intensive supervision. The Court Monitor position seems to work well because of the contractual relationship with UBH, the managed care provider. Because of this systemic approach, case managers have been brought into close contact with the criminal justice system providing a stronger continuum of care than has existed in the past. It was further suggested by a MHC core staff member that this linkage could be further enhanced with more efficient utilization of the Court's social worker position.

Challenges to the Functioning of the Mental Health Court

1. Variability in Perception of Goals of the Mental Health Court

Perception of the main goals of the court varied among both key stakeholders and MHC core staff. Some of the listed goals were: (1) saving money (n=3); (2) helping the mentally ill get well (n=3); (3) linking MIOs to treatment or better services (n=11); (4) reducing fear and/or increasing public safety (n=8); (5) decreasing MIO recidivism (n=9); (6) reducing MIO jail time (n=3); and (7) reducing criminalization of the mentally ill by providing diversion or alternatives to jail time for MIOs (n=2). Expedition of case processing was viewed as a secondary goal by only one interviewee. Public safety was listed as a primary goal by 6/14 of the staff and operational players interviewed. The enhancement of public safety was perceived as an expected secondary benefit of MHC by one interviewee, who remarked that public safety has become more of a focus over time. One might expect this confusion over MHC goals to result in conflict among core staff members who would pursue different steps to achieve their different primary goals. For example, if public safety was established as top priority, the MHC Judge may act more conservatively in sentencing than if linkage to treatment was of primary concern. Despite the disparity in perception of MHC goals, 10 out of the 14 interviewees rated the MHC's balance between linkage of defendants to treatment with public safety as appropriate, and a shared vision among MHC staff was

endorsed by 11/14. Most (12/14) of the survey respondents also perceived a proper balance between treatment and public safety needs.

2. Lack of Treatment Resources for Mentally Ill Offenders

The majority of survey respondents (13/15) agreed or tended to agree with the statement that MHC has demonstrated a commitment to seeking appropriate resources for defendants with mental illness. A significant lack of available treatment resources was identified for the following sub-populations of mentally ill defendants: dually diagnosed, brain injured, women, and personality disordered. The most often mentioned treatment resource shortage was integrated treatment (either inpatient or outpatient) for clients with co-occurring chemical dependency and mental illness (i.e. dual diagnosis). Such integrated treatment would benefit the majority of this population. Other listed resource shortages included housing, (including but not limited to respite and crisis beds) and transportation (to court and treatment). There seems to be an especially large gap of services between inpatient care and infrequent outpatient group treatment.

Several staff members suggested a link between the lack of available services (especially inpatient dual diagnosis treatment) and jail time. The reported recent decision of Cedar Hills to reduce available beds to serve unstable or actively psychotic individuals has cut services even further, and clients have to be matched with the best available outpatient treatment, "…or they may have to stay in custody until they are stabilized". Defendants are less likely to be held in custody because of housing concerns, and transitional housing can often be secured before release. Although most interviewees noted that the lack of resources was not MHC's responsibility, one stakeholder suggested a blended funding approach to address these resource deficiencies as, "no one system can pick up all the needs."

Because of growing caseloads and long lengths of court supervision, the need for an additional MHC defense attorney and a full-time prosecutor was also noted by several members of the core staff. As there are often several cases on the calendar, additional staff would allow the defense attorney time to consult with clients while other cases being heard. MHC is currently contracted to one law firm for public defense. One interviewee suggested that increased competition between firms would provide information on the impact of different styles of defense in MHC.

3. Need for Standardized Assessment Procedures

Currently, no standardized assessment or screening protocol for MHC defendants has been established. Additionally, six out of the 14 interviewees perceived MHC's ability to identify client specific psychosocial needs before the first appearance as sufficient only for a minority of defendants. The lack of standardized assessment may result in inconsistent or biased treatment recommendations and referrals. There also seems to be some difficulty in assessment of out of custody MHC clients, when the reason for referral is unclear. One staff member suggested that clients with histories of violence should be given priority in housing placement. A full and standardized risk assessment performed by highly qualified individuals would be a more objective and accurate way of determining risk for the purpose of housing and treatment options. Several interviewees noted the current lack of a single point of contact at the county jail that existed in the earlier days of the MHC, as no single Psychiatric Evaluation Specialist (PES) is assigned as liaison to the program. Apparently this position provided consistency in screening and subsequent referrals to MHC, as well as a centralized source of jail information regarding MHC clients.

4. Need to Increase Opportunities for Diversion

Criminal defense staff noted that the lack of diversion options offered by the prosecution, along with the unwillingness to reduce charges, have significantly reduced the incentive to opt into MHC, which may result in MHC "missing a substantial portion of the target population because of disincentives." It is the opinion of the defense that individuals should be given the opportunity to opt into MHC without pleading guilty. One stakeholder remarked that the Seattle Municipal Mental Health Court is more likely to focus on diversion, whereas the MHC is more likely to use probation to supervise treatment. This divergence was also cited by the defense agency as one of the main differences between King County and Broward County's MHC, which primarily uses diversion. Other interviewees noted that the King County MHC prosecution is currently moving more in the direction of offering more diversionary choices that will result in dismissal of charges. Still others observed that the defense itself rarely asked for or worked to establish sufficient justification for diversion in specific cases.

MHC does seem more likely to grant deferred sentences and deferred prosecutions than other courtrooms. As stated by a core staff member, "In the regular system, it would be rare to grant a deferred sentence in any case other than the defendant's first conviction and many deferred sentences occur in MHC where the defendant has a prior history of convictions." In MHC, the clients are likely to get deferred or suspended sentences if they are making proactive efforts in treatment and/or if any existing criminal history appears related to a treatable mental illness.

5. Multiple Cases

Another identified difficulty with MHC is that defendants often come in with other cases that can not be transferred into MHC (e.g. felony cases, cases in other jurisdictions). As one interviewee pointed out, "It's the norm rather than the exception that they will have multiple cases in different jurisdictions." The interviewee went on to say that this aspect of MHC could only be improved with a unified court system. One difficulty is that MHC (District Court) defendants may have felony charges in Superior Court that cannot be transferred into a court of limited jurisdiction.

6. Other Themes

Referral Process

Referral sources included mostly jail psychiatric staff, other judges, defense or prosecuting attorneys, and family members. If the referral is made by the jail and it is a new booking, a case can be diverted directly to the MHC calendar. If the defendant authorizes release of information, the PES staff provides a brief report to MHC describing mental health issues, symptomatic behavior, current enrollment in services, and other relevant issues, such as competency or housing concerns.

If a client is in custody on an older booking or out of custody, the referral process is somewhat different and the referral source may be another judge (who will transfer the case to MHC for a review), attorney, probation, or a family member request. In these cases little information exists about mental illness, and hearings may have to be delayed for the purposes of collecting information. Once a referral is made, staff determines if it is a District Court case and contacts the court to inquire about transfer to MHC. One barrier mentioned concerning the referral process is the lack of familiarity with MHC in other courtrooms, which may result in some defendants appropriate for MHC not being identified.

Opt-in Decisions

Interviewees consistently reported that individuals with insight into their illness or those already engaged in mental health services were more likely to opt into MHC. The most commonly listed reasons for opting out were observed by staff as: (1) desire to pursue a trial; (2) lack of insight or recognition of having a mental illness; (3) recommendation of the prosecutor; (4) advice of defense attorney (e.g. the defense attorney may recommend not opting in because of the likelihood of noncompliance); and/or (5) paranoid symptoms. Some other variables mentioned as possibly related to defendant's decision to opt-in were the Court Monitor's presentation of desirable treatment options and the defendant's readiness for change. One staff member also reported a few instances where individuals with antisocial personality traits felt they could manipulate the system by opting into MHC. One concern noted was that some severely impaired defendants might not fully understand the consequences of opting in. These consequences include a potentially lengthy period of probation that, in turn, presents the possibility of a probation violation and the imposition of sanctions that can extend to a return to detention. Defendants who do not opt-in and decide to have their cases heard in the regular court may, nonetheless, receive referrals for treatment from the Court Monitor.

Most defendants are referred to MHC post-arraignment. Either before or at the time of the client's first appearance hearing, the defense attorney explains the MHC process, and the client is introduced to pertinent staff. If she has been able to see the client, the Court Monitor presents a summary assessment to the Judge. This procedure can be held up at times if the client refuses to sign a release of information (e.g. at the advice of defense). Some clients choose to opt-in at the time of first appearance.

Target Population

The target population of the MHC seems to have changed over time. Initially, there was the requirement or expectation of some connection between the individual's mental illness and charges. Several interviewees noted that the criterion has expanded and that mental health symptoms are addressed in the context of how they will affect probation or supervision, rather than in regard to the cause of the instant offense. The Court also accepts defendants with what it considers "less serious" disorders than was first expected. The current target population is individuals charged with misdemeanor offenses who have a significant mental illness. Mental illness is defined broadly at this time and may include developmental disabilities and brain injuries, or as one staff member described it, the definition my include "… anyone that has some sort of psychiatric symptomatology." MHC also now accepts cases at any point in the life of the case (e.g. probation status).

Status Hearings

The term "status hearing" can be applied to hearings that focus primarily on eligibility for MHC and for the opt-in/out decision process. Pleas and issues related to speedy trial are also dealt with in these early hearings. Interviewees indicated that at the current time more emphasis is placed on the opt-in decision during these hearings than in earlier in the formation of MHC, when more time was spent on determining the appropriateness of the defendant for participation in the program.

Review Hearings

Core staff members perceived reviews hearings as the court dates set to monitor compliance and treatment progress (e.g. every 30, 60, or 90 days) once a defendant has opted in, as well as to reinforce such compliance. No clear reward schedule exists for compliance at this time. Other purposes of these

hearings were listed as: (1) a reminder to defendants of probationary status; (2) to problem solve non-compliance issues; and (3) to assess need for or intensity of continued monitoring.

Need for Outcome Data

Several key stakeholders suggested the need for outcome data to guide the future of the MHC, as well as other specialty or "boutique" courts. One stakeholder stated, "We need to be able to go beyond the anecdotal. There is a need for more quantitative evaluation of costs." Long-term empirical evaluation that addresses such variables as jail time and recidivism among MHC clients was suggested to assess the efficacy of these models. One interviewee suggested a qualitative comparison with the Seattle Municipal Mental Health Court. Another suggested that future investigation involve interviews with MHC clients regarding their experiences in MHC and other courtrooms.

Safety

The majority of interviewees did not feel the need to take additional safety precautions while working with this population. Despite this shared perception, it was noted by staff that court security is present for higher percentages of time in MHC than has been experienced in other courtrooms.

Training

MHC has sponsored several training events for its staff since its inception, and the MHC staff has acted as a valuable resource for training and informing interested individuals in many venues. There was a positive response to the recently added mental health training sessions provided by the University of Washington. The sessions have included topics such as Dual Diagnosis, Malingering and Competency, and Risk Assessment. However, several individuals commented as to the variability in mental health backgrounds among staff members. Another stated, "We all have different jobs and may need different training." The training has been especially beneficial for those with a primarily legal background. In fact, the MHC judge interviewed reported that his improved level of mental health understanding has made a difference in some bench decisions.

Goals of Mental Health Court

Expedition of Case Processing;

MHC allows for a significant amount of courtroom time and the expediency of case processing seems to depend on the individual needs of the defendant. Of the 14 interviewed, seven regarded the MHC process as more or much more expedient than would have been experienced in another courtroom. As stated by one staff member, "We are pretty speedy in getting them on. We can put them on tomorrow or the next day rather than the next month in the regular court." One MHC core staff member commented that addressing the needs of the mentally ill in district court involves slowing down the process to have sufficient time to address their needs, including linkage to necessary treatment resources.

Much of the timeliness of case processing seems to hinge on the initial assessment process. In the case where a referral is made by the jail, MHC staff receive e-mail notification regarding the referral, and the Court Monitor initiates the process of collecting information on the individual. This process may involve contact with case managers, treatment facilities, and/or the jail staff. The Court Monitor then visits the individual at the jail for an assessment of mental health, chemical dependency, psychiatric history, and social issues (e.g. housing). If the defendant agrees to sign a release, the information is collected and

compiled into a report to be shared with MHC staff. The report may be faxed in the morning before court or passed out during court in the afternoon. The Court Monitor is unable to share information if the defendant refuses to sign a release. Because of the additional courtroom time allotted through regularly scheduled hearings, the defendants are allowed time to work through issues with their attorney.

Development Of Greater Linkages Between Criminal Justice And Mental Health Systems

In rating the degree to which MHC has facilitated greater linkage to mental health services, the majority of interviewees (9/14) endorsed a "medium to high" or "high" degree of linkage. Additionally, the results of the anonymous survey suggest that MHC has made mental health services more accessible to this special population. However, the ability of treatment providers to link defendants to integrated mental health and substance abuse treatment was perceived as insufficient by most (8/14) interviewees. It seems that one difference the MHC has made is getting mentally ill defendants out of custody and into treatment programs more rapidly. With the assistance of the Court Monitor, defendants are reportedly often out of jail and linked to treatment within 1-2 days of booking. Because of the interaction of the Court Monitor, Probation Officers, and treatment providers, the mental health and court systems must communicate at every hearing. This linkage became problematic at times only due to insufficient community resources for smooth transitioning of clients into the community (e.g. from jail or inpatient treatment).

Reduction Of Actual Jail Time And Improved Access For Treatment Of Mentally Ill Offenders

This issue is dealt with in more detail in the quantitative portion of the report. Referring to the inception of the court, one stakeholder remarked, "Numerically, the jail is still one of the biggest treatment facilities in Seattle. Jail is not conducive to getting well, so this incarceration of the mentally ill is still a legitimate concern."

Several interviewees were concerned that the county jail is "used too often as a placement." Others remarked that individuals who would have been released if resources were readily available are sometimes held in jail. One interviewee was concerned that the Court's emphasis on public safety was related to defendants being held in jail when outside services were unavailable, in order to get them stabilized on medication. Assessment and subsequent release may also be delayed if the defendant is ordered to undergo involuntary treatment or treatment for restoration of competency. Another staff member reported that jail time between booking and getting linked to treatment can take longer if the client is deciding whether to opt into MHC.

Reduction Of The Number Of Times Mentally Ill Offenders Come Into Contact With The Criminal Justice System In The Future.

This issue is addressed primarily in the quantitative analysis. However, several interviewees observed that MHC clients are spending more time on probation, but are rarely being arrested for new charge

QUANTITATIVE SECTION

Samples and Comparison Groups

Throughout this quantitative section of the Phase I report, the term population will refer to the 246 individuals seen in the MHC for a first appearance hearing. Several samples from the population will be referred to in the report. Several factors lead to the formation of these sample groups. Most importantly, limitations in resources required prioritizing cases for data capture. 85 individuals were identified for this purpose, primarily with the criteria of preferring individuals with cases originating in the MHC, as opposed to those transferred from other courts on probation. Another priority was to include individuals who had participated for at least six months after a decision to Opt-In or Out of the MHC process. Various aspects of detention data collection reduced this pool of 85 persons to 77. For example, some cases were never jailed during the period of observation. These cases were not included in analyses of re-booking data, since their inclusion would have made these analyses less generalizable to MHC clients as a whole, the majority of whom were in detention at the time of the first appearance hearing. Of the remaining 77 defendants, 15 Opt-Out subjects were observed for less than 5 months after their first mental health court hearing. These 15 subjects are included or excluded from analyses based on whether the goal of the analysis was to maximize power and generalizability or to maximize the validity of between group comparisons. The samples routinely used in this report and the reasons for using one sample rather than another, are described in Table P1 below. Often an analysis will be repeated with more than one sample to clarify relationships.

Participation Status and Population Demographics

246 individuals were identified as having been referred to the mental health court and subsequently processed at a first hearing in the court. Defendants were characterized as being in one of five mutually exclusive participation status categories:

1) Screened-out as not having a significant mental health problem;
2) Eliminated for some other reason (such as not having State filed charges);
3) Pending a participation decision;
4) Opt-In as a participant in the program; and
5) Opt-Out, having decided not to participate in the MHC program.

Table P2 shows the breakdown of this population by participation status. The majority, 75.8%, of participants was male. Participation status did not vary significantly by gender. 29.7% of the Opt-Out group was female as compared to 22.0% Opt-In group, a difference that is not statistically significant. The population had a mean age of 37.6 (10.95)[2]. 25% of the population was under 30 years of age, 50% were under 38, and 25% were over 43 years of age. The youngest participant was 18.5 years old, and the oldest was 81 years old. On average the Opt-Out defendants were older than the Opt-In participants. The average age of the Opt-Out defendants was 40.91 (11.10) years, whereas the Opt-In group average age was 35.6 (10.62) years, the mean difference of 5.24 years was statistically significant[3]. The ethnic and racial characteristics of the population from the MHCADSD information system are contained in Table P3. 63.8% of the population identified as Caucasian. Participation status groups did not differ by ethnicity.

[2] Throughout the text and tables, standard deviations will be enclosed in parentheses following their respective means.

[3] $t(172)=3.228$, $p<.001$, two-tailed.

TABLE P1. SAMPLES USED IN ANALYSES

Sample	N*	Composition	Purpose
Population	N=246	5 status groups	Description of the entire population. Mapping Estimating generalizability of analyses.
Priority Sample	N=77	46 Opt-In and 31 Opt-In	Maximizing repersentativeness of cases. Maxi of detention data. Maximizing exploration of r variables to CJ factors.
Closest comparison Sample	N=62	31 Opt-In and 31 Opt Out	Maximizing validity of closest comparisons be Opt-In statuses, especially on variables that are time observed, such as rates, or sums over vari
Status Group: Opt-In or Opt-Out	N= 31 or 46	Opt-In or Opt-Out, independently	Explore relationships that might be different in strength, or direction between two groups. Exa change between groups when variables for clos are not available.

Note: N's in specific analyses may vary due to missing data.

TABLE P2. PARTICIPATION STATUS OF 246 REFERRALS AS OF 3/31/00

Participation Status	N	%	Cum %
Screened out	18	7.3	7.3
Other elimination	33	13.4	20.7
Pending	21	8.5	29.3
Opt-Out	74	30.1	59.3
Opt-In	100	40.7	100
Total	246	100	

TABLE P3. ETHNIC COMPOSITION OF REFERRED DEFENDANTS.

Ethnic Group	Frequency	Percent
Caucasian	157	63.8
African American	38	15.4
Native American	27	11.0
Asian	6	2.4
Mixed	6	4.9
Unknown	12	4.9
Total	246	100%

Mental Health Data

Collection of Mental Health Data

Mental health data was requested for download from the KMHCADSD data system for all persons identified as seen by the court. The period examined was from August 1, 1998 through March 31, 2000. Data elements drawn from the information system appear in Appendix F.

Treatment Authorization Requests

Treatment cannot be received if it is not requested. Although some defendants were provided services by private providers, the Veterans Administration, or in other counties, informants concurred during process evaluation interviews that the majority of defendants received services primarily through KMHCADSD funded agencies. We viewed new requests for service as an indicator of treatment initiation or a request for additional services for an individual already engaged in treatment. Of 246 cases, 148, or 60.2% individuals recorded a treatment authorization request within the 19-month period observed for treatment services. Table T1 contains the breakdown of treatment authorization requests by participation status. The proportion of persons for whom treatment was initiated varied significantly across the status groups.[4] Subsequent analyses revealed that this difference was primarily due to increased requests for treatment in the Opt-In group. This difference remained significant for the closest comparison sample (N=62), where 54.8% of the Opt-Outs had no request for treatment on record as opposed to only 16.1% of the Opt-In group.

[4] ($\chi(4)= 43.436$, $p<.0001$, two-tailed.)

TABLE T1 TREATMENT AUTHORIZATION REQUESTS BY STATUS GROUP

NEW REQUEST	STATUS GROUP					
	Screened Out	Other Elimination	Pending	Opt-Out	Opt-In	Total
YES						
Count	17	16	6	38	21	98
% of Group	94.4	48.5	28.6	51.4	21.0	39.8
NO						
Count	1	17	15	36	79	148
% of Group	5.6	51.5	71.4	48.6	79.0	60.2

- Fewer records of diagnosis and treatment existed for individuals in the Opt-Out group, suggesting lower rates of treatment initiation and engagement over time.

- In proportion to their numbers, past requests for authorization of treatment were made more frequently for the Opt-In group, members who were almost 3 times more likely to have treatment initiated during the study period.

Diagnosis

Diagnoses for Axis I primary focus of treatment were available for 113 cases, or 45.9% of the population. The largest category of diagnosis was that of psychotic disorders, such as Schizophrenia, followed by Bi-Polar Disorder, Major Depression, and Organic Brain Syndrome. Table T2 contains the breakdown of diagnoses on Axis I for the entire population.

TABLE T2 AXIS I DIAGNOSES BY CATEGORY FOR REFERRED DEFENDANTS

Diagnostic Category	**N**	**Percent**
Psychotic	51	45.1
Bi-Polar	29	25.7
Major Depressive	12	10.6
Organic Brain Dysfunction	6	5.3
Other	15	13.3
Total	113	100.0

- The majority of those cases seen by the MHC were diagnosed with severe mental disorders such Schizophrenia and Bi-Polar Disorder.

When data for the Opt-Out and Opt-In subjects were compared, the two groups appear to have similar proportions of psychotic disorder. A trend was seen toward the Opt-In group having a higher proportion of Bi-Polar disorder diagnoses. However, these differences are unreliable due to missing data. Among the Opt-Out subjects, 66% were missing diagnostic data, whereas 39% of the Opt-In subjects had no Axis I diagnosis recorded. Differences between the Opt-In and Opt-Out subjects in the various sample groups are difficult to establish because of large between group differences in missing data. Differences in missing

diagnostic data may quite possibly be related to differences in treatment-seeking behavior (and, therefore, receiving a diagnosis) which in turn may be linked to motivation for choosing to participate in the MHC. Both high levels of psychopathology-- notably paranoia or denial of illness-- and better relative mental health resulting in a correct assessment of less need may result in less treatment seeking behavior. Therefore no confident extrapolation can be made from these data to diagnostic differences between the Opt-Out and Opt-In groups.

Quantity of Treatment

Several measures were developed to examine the quantity of treatment received. The names and definitions of these appear in Table T3. Table T4 shows the means, standard deviations, and significant differences tested by means of t-tests for a convenience sample of 100 subjects for whom there was at least one treatment episode on record. Statistical tests revealed that the Opt-In group had significantly more treatment after contact with the MHC and statistically more treatment episodes over the 19-month period. The MHC Opt-In clients did not have significantly more treatment hours before contact with the mental health court, suggesting that involvement with the court is responsible for their higher number of hours of treatment after their first hearing. In fact the Opt-In group increased on average by a significant 15.29 hours of treatment during the 19 months observed.[5] Global Assessment of Functioning Scale (GAF) scores are used to assess client functioning at multiple junctures of treatment. GAF Scale scores range from 100 to 1. The highest scores indicate superior functioning in all or most areas and no psychiatric symptoms. Lowest scores indicate extreme dysfunction in all or most areas, with dangerousness to self or others and with severe psychiatric symptoms.

TABLE T3. MENTAL HEALTH VARIABLES AND DEFINITIONS

Variables in Sets	Definitions
Diagnostic/Service Variables	
TX PRE	Hours of treatment recorded before contact with MHC
TX POST	Hours of treatment recorded after contact with MHC
Total TX	Total of Hours recorded over 19 months
Episodes	Total number of episodes of treatment over 19 months
Psych Severity	Contrast of psychotic versus other diagnosis
PD	Contrast of personality disorder present or not
Global Assessment of Functioning Scores *	
GAF PRE	Global Assessment of Functioning scale Pre MHC
GAF POST	Global Assessment of Functioning scale Post MHC
GAF Total	Global Assessment Scale: Average for 19 Months
Alcohol and Substance Abuse	
XRTC	Mean Readiness to Change Level*

*Lower scores indicate higher levels of motivation for change.

TABLE T4. TREATMENT RECEIVED BY PARTICIPATION GROUP, N=100.

Variable	Sample	Opt-Out	Opt-In
Treatment Hours Pre MHC	8.21 (37.10)	6.62 (4.91)	8.90 (43.36)
Treatment Hours Post MHC	18.49 (56.40)	5.20 (9.00)	24.19 (66.49) [1.]
Total Treatment Hours	26.71 (89.00)	11.817 (21.67)	33.09 (105.02)
Episodes of Treatment	103.23 (107.58)	71.10 (82.89)	117.00 (114.35) [2]

Note: Sample N=100, Opt-Out N=30, Opt-In N=70.

- t (74.78) = -2.340, p < .025, two-tailed.
- t (98) = -1.984, p=.05, two-tailed.

TABLE T5. TREATMENT RECEIVED BY PARTICIPATION GROUP, N=77.

Variable	Sample*	Opt-Out	Opt-In
Treatment Hours Pre MHC	10.67 (42.03)	4.32 (12.39)	20.10 (63.97)
Treatment Hours Post MHC	24.02 (63.32)	3.39 (7.65)	54.63 (91.93) [1]
Total Treatment Hours	34.69 (100.19)	7.71 (18.30)	74.72 (148.85) [2]
Episodes of Treatment	112.77 (102.50)	61.05 (78.49)	152.08 (102.50) [3]

* Sample total N=77, Opt-Out N=30, Opt-In N= 70

- t (30.28) = 3.097, p< .005.
- t (30.612) = 2.494, p < ,020.
- t (41.52) = 4.521 p<.001.

Findings from the analyses of the largest available convenience sample of Opt-Outs and Opt-In subjects are contained in Table T6. The one significant difference in the table between groups is that for GAF prior to contact with the mental health court. Subjects in the Opt-In group had significantly lower GAF scores prior to MHC contact than those for the Opt-Out group. However, at the Post MHC comparison the Opt-In subjects had improved slightly but not significantly, whereas the Opt-Out defendants had dropped in functioning, although not significantly. Interpreting these mean differences is difficult due to differences in the N's across the pre to post comparison. The increase in N over these two periods may suggest that individuals in both groups were more engaged in treatment and were therefore being assessed more frequently.

- Opt-In defendants appear to have had lower functioning relative to Opt-Out defendants prior to their contact with the MHC. This difference was no longer significant after contact with the court.

[5] (t (69) =5.8388, p<.003, two-tailed).

TABLE T6. GAF SCORES BY PARTICIPATION GROUP

Variable	Sample*	N	Opt-Out	N	Opt-In	N
GAF Pre	23.27 (12.69)..	79	28.65 (14.46)	27	20.48 (10.79)	19 [1]
GAF Post	22.70 (13.26)	86	19.74 (14.68)	52	23.53 (12.83)	67
GAF Total	34.78 (10.30)	109	34.8112.02	33	34.759.55	76

- t (77) = 2.835, p < . 006, two-tailed.

Alcohol and Substance Abuse Indicators

Alcohol and substance abuse characteristics of participants were not readily available from the KMHCADSD data provided. However, individuals seen at the Harborview Crisis Triage Unit (CTU) were assessed for their readiness to change alcohol and substance abuse problems (RTC). The RTC rating indicates the clinician's impression of the client's readiness level in a model that conceptualizes clients as potentially moving from pre-contemplation of change through contemplation, taking action and maintenance of recovery. The scale used by County providers appears in Table T7, with higher scores indicating less readiness to change. RTC data was available for 10 individuals in the Opt-Out group and for 31 individuals in the Opt-In group. Table T8 contains descriptive statistics for he average RTC rating, the most recent RTC rating, and for the highest rating contained in the KMHCADSD data set. Although the Opt-Out clients had lower average RTC scores, indicating greater readiness to change on all three measures, these differences were not statistically significant, probably due to the very small sample size.

TABLE T7. READINESS TO CHANGE SCALE (RTC) CATEGORIES.

Stage of Change Level	Rating
Drug Abuse Not an Issue	0
Maintenance-Abstinent and active in recovery activities	1
Action-Engaged in recovery activities and treatment	2
Preparation-Has taken some steps toward change	3
Contemplation- Considering the need for change	4
Precontemplation- Not actively considering change	5
Precontemplation- Does not accept problems	6

TABLE T8. RTC SCORES BY PARTICIPATION GROUP, N=41.

Readiness to Change	Opt-Out	Opt-In
Average	1.96 (2.38)	2.73 (2.94)
Current	1.80 (2.44)	2.94 (2.28)
Highest on Record	2.50 (2.51)	2.98 (2.40)

Note: Out-Out N=10. Opt-In N=31.

Detention Data.

Periods of Observation and Sample Construction

Limitations in resources required us to prioritize cases for data capture. 85 individuals were identified as priority cases for collection of DAJD booking data from the Subjects in Process Data System (SIDS). An attempt was made to optimize the number of Opt-In defendants with at least six months of full participation (after their opt-in decision) during the study interval. a number of factors caused a reduction in the originally identified priority pool. For example, several individuals were removed because they had no booking in SIDS during the interval under investigation, and thus provided a poor for comparison to other subjects, most of whom had multiple bookings. Data was obtained for 77 individuals from this pool for the 27-month interval of January 1, 1998 through March 31, 2000.[6] This interval allowed the capture of detention histories for subjects for a full year prior to the advent of the MHC and for a full year after the court's inception.

Approach

In addition to making comparisons between defendants based on their ultimate participation status (Opt-Out versus Opt-In), we planned to compare each defendant's detention history prior to MHC contact at a first hearing with their detention history after MHC contact. We chose the first hearing as a critical event because it marked a point in time when treatment and legal services that may have not previously been available could have been initiated. Whether or not the defendant chose to participate in the MHC, such services could reasonably be expected to have the potential to affect the defendant's future mental health and detention status.

To facilitate these comparisons, the following variables were calculated for each subject:

1. Number of days outside of the detention facility on a temporary release during this period. These days were removed from other counts of detention days.
2. Total number of jail days during the 27-month study interval.
3. Number of jail days served before the defendant's MHC first hearing.
4. Number jail days served after the defendant's first MHC hearing.
5. Annualized rates of detention for each subject for the three time periods described above.

Several of these variables are based on each individual's actual experience during the months before and after each individual's first hearing in the mental health court. However, this approach was problematic. The number of months before and after MHC first hearings varied considerably from case to case. Defendants were processed for first hearings throughout the interval from 2/17/99 through 3/31/00. Also, the average number of months pre or post MHC contact could potentially vary by group, since the rate of defendants' choosing to opt-in or opt-out was potentially variable. This variability was due to a number of factors, including factors related to our sampling criteria. Upon inspection, the median date for the MHC first hearing for the opt-out subjects was 09/29/1999, whereas the median first MHC hearing was 05/14/1999. Table J1 displays the distribution of average months of observation pre and post the first MHC hearing for the 77 priority group subjects. Opt-Out defendants were observed for 7.71 months (3.9) after

[6] A 30 day month was used rather than calendar months, resulting in 27.33 months of observation

their MHC first hearing, compared with an average of 10.75 months (2.13) for the opt-in group. This difference was statistically significant[7].

TABLE J1. AVERAGE MONTHS OF OBSERVATION PRE /POST FIRST MHC HEARING

	OPT OUT	OPT-IN
Months Pre MHC	19.62 (3.90)	16.59 (2.13)
Months Post MHC	7,72 (3.90)	10.75 (2.13)

**(t (75)=-4.389, p<.0001).

The problems with generalizing from rates based on short and variable periods of observation are easy to demonstrate. For example, an individual whose first MHC hearing was on 01/20/00 who was booked once after that date (after 2.37 months of observation) would have an annualized booking rate after contact with the court of 5.14 bookings per year. This rate is lower than an individual with 2 bookings observed over six months, whose annualized booking rate would be 4.0 bookings per year post MCH contact. Although a rate-based approach would utilize more of the available data on re-offending, it could potentially lead to distortions resulting from outliers who by chance were booked close to their first appearance date. To avoid this kind of distortion, we limited analyses using rate data to those cases that had been observed for at least five months after their first mental health court hearing. This criterion resulted in dropping 15 cases from the Opt-Out group that had fewer than 5 months post MHC hearing observation time, and the formation of the closest comparison group of 62, consisting of 31 Opt-Out defendants and 31 Opt-In defendants. Statistics for both groups will be presented in the following sub-section, since some analyses were appropriate for the larger priority sample, and other comparisons (especially those involving rates) were appropriate only for the smaller closest comparison sample. We also did not limit our analyses to those based on sums and rates, but utilized techniques such as correlational and nonparametric methods to explore hypotheses.

Basic Statistics And Results For Sum-Based And Ratio-Based Variables

Table J2 contains basic statistics on sum-based variables for the 77 person priority sample. 214 bookings were found for the 77 priority group defendants during the study interval, an average of almost three bookings per defendant. One jail day was counted if an individual was booked and released on the same day, resulting in a total of 5220 jail days. This figure is exclusive of 295 days spent by defendants outside of the detention facility on temporary release with a jail hold, most often in treatment or evaluation settings. The mean number of days of detention was 24.98 (SD=66.27), and the median for the distribution was 6 days, with a range of 1 to 487 days. The mode of days spent in jail per booking was one day, which was the length of stay for 24% of all bookings. This table indicates a significant difference between groups in the annualized rate of jail days after contact with the MHC. However, this difference can only be taken as suggestive, since it is based on rates extrapolated from different average months of observation. The Opt-Out group was observed on average for approximately 8 months after MHC contact versus approximately 11 months for the Opt-In group, making the Opt-Out group rates less "realistic".

[7] (t (75)=-4.389, p<.0001).

TABLE J2. BASIC STATISTICS FOR SUM AND RATE VARIABLES, N=77.

Variable	Sample*	Opt-out	Opt-in
Sum Variables			
Total Bookings	2.78 (2.26)**	2.91(2.67)	2.58 (1.50)
Bookings post MHC	3.91 (3.97)	3.98 (4.50)	3.81 (3.10)
Total Jail Days	67.79 (109.42)	78.72 (132.33)	51.58 (60.09)
Days out of Detention	3.83 (14.22)	3.18 (46.21)	4.81 (10.79)
Jail Days pre MHC	26.29 (53.43)	29.17 (64.46)	22.00 (31.11)
Jail Days post MHC	41.51 (78.78)	49.54 (94.27)	29.58 (46.34)
Annualized Rates			
Annual Rate: Bookings	1.24 (1.18)	1.29 (1.18)	1.15 (.67)
Bookings Post MHC	3.39 (3.97)	3.98 (4.50)	3.81 (3.10)
Total Jail Rate	30.18 (48.71)	35.04 (58.91)	22.96 (26.75)
Annual Rate Pre MHC	18.07 (36.64)	18.84 (43.06)	16.92 (24.87)
Annual Rate Post MHC	71.78 (112.52)	94.30 (132.61)	38.35 (61.34) ***

* Sample N=77. Opt-Out N=46. Opt-In N=31.
**Figures in parentheses are standard deviations.
*** Significant difference t (67.85)=2.493, p>.015, two tailed, mean difference 55.96.

Table J3 contains basic statistics on the 62-person closest comparison sample. These 62 persons accounted for 179 bookings, 52 of which occurred after contact with the MHC. These bookings accounted for 4386 jail days, 2664 of which occurred after contact with the MHC. These defendants spent 263 days outside of custody over the 27-month observation period. Table J4 shows the breakdown of temporary release days for each group. The related Chi-Square statistic shows a trend toward the Opt-In group defendants being more likely to be in the high use (>5 day) category, and more likely to spend time out of custody. A follow-up table on booking after contact with the mental health court, Table J5, revealed no significant difference between groups when tested by means of the Chi-square test. The closest comparison sample did not significantly differ by group on the average number of months observed before and after a MHC first hearing. [8] Rate comparisons between groups in this sample are, therefore, more "realistic" than those in the larger sample. None of the between-group comparisons were significantly different when tested by t-tests, despite the large size of some of the differences. The absence of any significant differences might be due to the very large within-group variability reflected in the large standard deviations, and the fact that most of these variables are not normally distributed.

The MHC was designed to break a pattern or cycle of re-incarceration. One way of describing this cycle is that the number of bookings a person had in the past can be used to predict the number of future bookings. We examined whether the number and rate of bookings after contact with the MHC could be predicted from prior booking experience. Also, we were interested in testing whether the two status groups in the closest comparison sample differed in predictability of future bookings, since a difference in predictability, could point to a change or alteration of patterns in one or both groups.

[8] (t (60) =1.391, p<.170, two tailed, NS)

TABLE J3. BASIC STATISTICS FOR SUM AND RATE VARIABLES, N=62.

Variable	Sample*	Opt-out	Opt-in
Sum Variables			
Total Bookings	2.89 (2.33)	3.19 (2.93)	2.58 (1.50)
Bookings post MHC	.84 (1.09)	1.00 (1.18)	.68 (.97)
Total Jail Days	70.74 (119.06)	89.90 (156.37)	51.58 (60.09)
Jail Days pre MHC	27.77 (56.92)	33.56 (74.50)	22.00 (31.11)
Jail Days post MHC	42.97 (86.32)	56.35 (112.39)	29.58 (46.34)
Annualized Rates			
Annual Rate Total	1.27 (1.02)	1.40 (1.28)	1.13 (.66)
Annual Rate Post MHC	1.10 (1.58)	1.41 (1.93)	.79 (1.07)
Annual Rate Total	31.44 (52.92)	39.96 (69.50)	22.93 (26.71)
Annual Rate Pre MHC	19.64 (39.06)	22.56 (49/83)	16.69 (24.53)
Annual Rate Post MHC	53.81 (101.21)	69.80 (129.00)	37.82 (60.50)

Sample N=62. Opt-Out N=31. Opt-In N=31.

TABLE J4. DEFENDANTS BY DAYS ON TEMPORARY RELEASE (TR), N=62.

		Opt-Out	Opt-In	Sample
Days	0	27	24	51
	1 thru 5	3	1	4
	> 5	1	6	7
Total		31	31	62

? (2)=4.7848, p=.093.

TABLE J5. DEFENDANTS BY NUMBER OF BOOKINGS POST MHC CONTACT

		Opt-Out	Opt-In	Sample
New Bookings	0	13	17	30
	1	11	10	21
	2	3	2	5
	3	2	1	3
	4	2	1	3
Total		31	31	62

χ (4) =1.884, p=.836 NS

Correlational Analyses: Predicting Future Bookings From Prior Booking History.

Strength of predictability (the degree of relationship between bookings pre and post MHC contact) was measured by means of the bivariate correlation coefficient, r. The unsigned value of r ranges from 0 to 1, with larger values indicating stronger relationships. A positive r indicates that two variables increase or decrease together. A negative r indicates that as one variable increases in magnitude, the other tends to decrease. We anticipated a significant but small positive correlation between bookings pre MHC contact and booking post MHC contact. Across all 62 subjects in the closest comparison sample, the correlation between bookings before and after MHC contact was significant (N=62, r=. 265, p=. 037), indicating that an individual's number of bookings prior to MHC contact predicted his/her number of bookings after the first hearing in the expected way.

However, when the same test was conducted for the two study groups separately, a different pattern between the two groups emerged. Although both groups had decreased in number of bookings significantly, the correlation between pre and post bookings was very different in the two groups. For the Opt-Out group the significant correlation between pre and post bookings was moderate and significant (N =31, r =. 372, p =. 039). In contrast, for the Opt-In group the correlation was miniscule and not significant (N =31, r =. 001, =. 996, NS). Since the two groups were on average not different in the number of months of observation in the pre and post periods, rate variables were used to more exactly determine changes in booking experience for the two groups. The correlation magnitudes and between group differences in correlations for the booking rate variables were similar to those for the raw sum variables.[9] However, the pre and post booking rates for the Opt-Out group were not significantly different, having changed by less than a tenth of a booking per year, or 6.8% of that group's standard deviation, whereas the pre-post booking rates for the Opt-In group indicated a significant decrease in rate of about approximately .6 bookings per year, or about 75% of that group's standard deviation. [10]

These analyses taken together suggest that the groups are different in two ways. The first difference is in the change of rate in new bookings: the rate decreased for the Opt-In group, but not for the Opt-Out group. The second difference, that of the non-predictability of new bookings for the Opt-In group, may be more important. Two major types of hypotheses may account for this difference. The first type, which is impossible to definitively refute without random assignment to groups, is based on the assumption that one or more fixed between-group differences preceded contact with the MHC. For example, possibly the two groups consisted of individuals with different causes for their criminality, as would be the case if the vicissitudes of mental health factors influenced the amount of criminal justice contact in one group and not the other. Arguing against this hypothesis is the fact that members of both groups were assessed to have major mental illnesses, and some anecdotal evidence that mental illness was sometimes more severe in defendants who chose to Opt-Out.

The second type of hypothesis posits change after contact with the MHC for the members of one group, but not the other. Possibly a process (e.g., more treatment, different relationship with the criminal justice system) that took place for most Opt-In subjects after contact with the MHC changed the relationship of past booking experience to future booking experience, making it impossible to predict the number of new bookings from old bookings. This process did not have take place for the Opt-Out subjects, who had predictable post MHC contact bookings. This hypothesis necessitates reasoning that 1. since the purpose of the MHC is to change patterns, and 2. since the bulk of resources and efforts toward doing so were applied to Opt-In defendants, it is more reasonable to assume that the Opt-In defendants have changed than to assume that contact with the MHC changed the pattern of future booking for the Opt-Out defendants.

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[9] . For Opt-Out group, r=.381, p<.035, two tailed; For Opt –In group, r=.019, p=.918, two-tailed, NS.
[10] (t (31) =2.450, p>.025).

Given the number and extent of preexisting differences and unforeseen change processes that are needed to support alternative hypotheses, we believe that the scenario of change in the Opt-In group is more likely than scenarios generated by other hypotheses.

- The rate of bookings after contact with the MHC decreased significantly for the Opt-In group, but not for the Opt-Out group.

- Contact with the MHC removed the relationship that allows prediction of new bookings from previous booking experience for Opt-In defendants, but not for Opt-Out defendants. To a statistically significant extent, the participation in the MHC appears to appears to have "broken the cycle" for some defendants.

Analysis of Charge Severity

Each charge associated with a booking was coded for severity utilizing a category scheme previously developed for a study of misdemeanants. The frequency distribution of offenses by category and by group for the population appears in Table J6. The Chi-Square test associated with group differences between expected versus actual occurrences in this table was significant. The means for charge severity for three periods observation are contained in Table J7. When the means of the average severity rating for charges in the two groups were compared using a t-test, a slight but non-significant trend existed towards a higher mean charge severity rating for the Opt-Out group. However, when the charges were divided between those that occurred before and after MHC contact, the Opt-In group had a significantly higher ($p<.05$) mean severity for charges before contact with the MHC, but the difference in severity ratings charges that occurred after contact with the MHC was not significantly different between the two groups. This finding could be because some defendants were more motivated to participate in the MHC because they were facing more serious offenses, whereas some defendants were less likely to choose to participate because their charges were not perceived as serious, and the benefits of having an alternative court process were less convincing. This assortative process could not affect charges made after the first MHC hearing.

Across groups, the relationship between seriousness prior to MHC involvement and seriousness after MHC contact was negative and significant (N=242, $r= -.546$, $p<.001$, two-tailed). This pattern of association was true for each group, although the correlation was somewhat higher in for the Opt-Out subjects (N=134, $r= -.614$, $p<.001$, two-tailed) versus the Opt-In subjects (N=108, $r= -.473$, $p<.001$, two-tailed). This finding could indicate that over time, defendants were being booked for less serious offenses. If this were the case, the change may be due to greater appreciation of the risk that mentally ill misdemeanants may pose to public safety following the murder of Captain Stevenson and initiation of changes, such as those that led to the creation of the MHC. However, it remains possible that the suggested lower threshold for booking is the result of defendants having more criminal history after their contact with the MHC or being more likely to have an outstanding warrant at the time of coming into contact with the police.

- Changes in charge severity over time suggest that mentally ill defendants are being booked for less serious offenses.

TABLE J6. CHARGE SEVERITY CATEGORIES BY PARTICIPATION GROUP.

Score	SERIOUSNESS CATEGORY		p Opt-Out	Opt-In	Total
1	NVOL, Littering, etc.	Actual	5	1	6
		Expected	3.6	2.4	6.0
2	DWLS3, Alcohol & Drug offenses, etc.	Actual	12	11	23
		Expected	13.6	9.4	23.0
3	DWLS2, Criminal Trespass, etc.	Actual	49	18	67
		Expected	39.7	27.3	67.0
4	Reckless Driving, Theft, etc.	Actual	16	16	32
		Expected	19.0	13.0	32.0
5	DWLS1, Domestic Violence, etc.	Actual	5	10	15
		Expected	8.9	6.1	15.0
6	DUI, Assault, etc.	Actual	41	32	73
		Expected	43.3	29.7	73.0
	Total				

Note: All FTA charges have been removed.
χ (5,216)=12.863, p<. 025.

Nonparametric Analysis: The Wald-Wolowitz Test of Rank Differences

As was stated earlier, many factors make detecting differences between the Opt-Out and Opt-In groups difficult in this preliminary phase of outcome evaluation. Among these factors are the short period of observation, the departure from normality of sum and rate variables, large within-group variability, and between group differences in variability. We resorted to the use of the Wald-Wolfowitz Test, a nonparametric test that is less sensitive to these problems, to investigate differences in jail days after contact with MCH. We chose the closest comparison sample of 62 subjects for this test, both because of its equal numbers of subjects in each status group and because in this sample the status groups are not statistically different in the number of days observed after contact with the MHC. This test combines subjects across groups, rank orders the cases, and eliminates matches between the groups. A statistic with a Z distribution is then calculated to test the likelihood that non-matched subjects from both groups are equally dispersed among the ranks of the new combined-sample. The obtained test value for the Opt-Out and Opt-Out group comparison was significant, such that the Opt-In group had a lower ranking in days of detention after contact with the MHC than did the Opt-Out group (Z =-2.817, p=. 002).

- After contact with the MHC, Opt-In defendants on average had significantly lower rankings in number of detention days served.

To summarize, the finding from the Wald-Wolfowitz Test and others notwithstanding, overall, the differences between the Opt-Out and Opt-In group on these variables are small relative to the large within-group variations. The absence of random assignment to groups, or detailed criminological and clinical matching of subjects makes any statement tentative. Nevertheless, several indications were found for a positive impact on defendants for MHC involvement, confined primarily to the Opt-In subjects.

- Despite large within group differences, several quantitative analyses point to a positive impact of MHC involvement, primarily concentrated in defendants who opted for the alternative court process.

TABLE J7. MEAN CHARGE SEVERITY RATINGS BY OBSERVATION PERIOD.

Observation Period	Opt-Out	N	Opt-In	N	Sample	N
Severity: All Charges	3.99 (1.56)	128	4.35 (1.51)*	88	4.14 (1.55)	216
Severity: Pre MHC	3.94 (1.59)	102	4.43 (1.48)**	70	4.14 (1.56)	172
Severity: Post MHC	4.19 (1.47)	26	4.06 (1.63)	18	4.14 (1.52)	44

* $t(214)=-1.686$, $p=.093$.
*$t(170) = -2.030$, $p<.05$.

Relationship Between Mental Health Factors And Detention History

Examining Patterns of Correlations

One premise of the MHC is that mental health factors, especially participation in appropriate treatment services, are significantly related to criminal conduct. This premise could be called the "treatment works--pathology hurts" premise. We used correlational analyses to investigate whether hypotheses generated from this premise could be supported by the available mental health and detention data. We translated the "treatment works—pathology hurts" premise of the MHC into two primary expectations concerning correlations. Increased treatment was expected to decrease bookings and jail days (expectation of a negative r), whereas increased psychopathology or decreased motivation to change a substance use problem was expected to result in increased bookings and jail time (expectation of a positive r). Relying on this premise, we predicted that these relationships might change after contact with the MHC. For example, increased psychopathology reflected in a diagnosis of a psychotic disorder might result in more jail days served prior to contact with MHC, but this relationship might be decreased or become non-significant after involvement with the MHC.

To represent these constructs (treatment, psychopathology, and readiness to change), we chose a set of 12 mental health variables. The six diagnostic and service variables were: hours of treatment before contact with the MHC, hours of treatment after contact with the MHC, total hours received, number of treatment episodes, presence of a psychotic disorder diagnosis, and presence of a personality disorder. The three Global Assessment of Functioning (GAF) variables were: average GAF prior to MHC contact, average GAF after MHC contact, and average GAF for the full period of observation. The three Alcohol and Substance Abuse Readiness to Change (RTC) variables were: mean readiness to change, maximum readiness to change, and the most readiness to change level. These variables were previously defined in Table T3.

Because of the preliminary nature of this phase of study, and because the expected direction (positive or negative correlation) of these relationships could be described in advance from our understanding of the "treatment works--pathology hurts premise", we set two criteria for considering a correlation to be of sufficient magnitude to be of useful. First, the correlation must have an associated probability of $p < .05$, for a one-tailed test, i.e. the obtained correlation must be likely to occur by chance at the rate of less than five out of 100 randomly drawn samples. Secondly, the correlation must be based on valid (non-missing) data for at least 20 defendants. For Opt-Out and Opt-In within-group correlations, this second criterion was lowered to having valid data for 15 defendants (N=15). Only correlations that met these criteria are presented and discussed in the text. To simplify the presentation and discussion, and to maximize the potential to identify group differences that may be present, only the analyses for the priority group of 77 subjects for whom both jail data and mental health data was collected is presented.[11]

Table J8 displays the resulting significant correlations. GAF scores were dropped from the table, due to the absence of correlations meeting our criteria. Before discussing the correlations in the table it is important to acknowledge and address a statistical problem with drawing conclusions from this kind of correlation matrix. The significant correlations in Table J8 represent the outcomes of up to 99 tests (11 CJ variables by 9 MH variables). When so many tests are performed, some are expected to be significant by chance. Since we set our criterion for considering a correlation at .05 for a single tailed test (a test that predicts the direction of relationship and the positive or negative sign of the correlation), the likelihood of a correlation without regard to sign appearing in the table could be as high as .10, meaning 10 out of 100 could be chance findings. We therefore applied the binomial test to the omnibus hypothesis that the finding of 24 out of 99 tests could be significant by chance if the rate of chance significant findings was 10 in 100 tests. The resulting binomial probability based on a Z approximation was significant at the .000 level, indicating that it was extremely improbable that this many significant correlations could be obtained by chance. This test does not protect us from error on viewing any individual correlation as being significant, but it does indicate that the overall pattern of findings is not due to chance.

- The obtained pattern of correlations between mental health and detention variables was highly unlikely to be due to chance.

In this table and the one that follows, correlations that fall roughly into interpretable clusters have been placed in boxes and numbered. The strongest relationships in the Table J8 are the 6 positive correlations (average $r = .422$) in Cluster 1 indicating that lower levels of the three measures of readiness to Change (RTC) are related to higher numbers of bookings in all three intervals observed. RTC's are reverse keyed, meaning lower values indicate higher readiness to change and motivation to participate in treatment. This relationship may reflect the difficulties that mentally ill offenders with substance use disorders have in avoiding attention from the criminal justice system, despite the effectiveness of both the criminal justice system and treatment system to motivate them. Several within status group analyses that follow may help to shed light on these correlations.

Cluster 2 consists of three positive correlations (average $r = .357$), indicating that increases in treatment hours received over 19 months are associated with increases in bookings. Although this relationship is less pronounced after defendants have had contact with the MHC (.388 in the pre MHC

[11] Limiting the exploration of these relationships to the N=62 closest comparison group would have resulted in many correlations not meeting our criteria for number of subjects in an analysis. Also, because of the higher frequency of missing data for Opt-In defendants, the N=62 sample would tend to represent Opt-In defendants. Choosing to focus on the N=77 priority sample limits the validity of between group but improves both power and generalizability.

period versus .265 in the post period.), the difference between the two correlations is probably not significant. In Cluster 3, three negative correlations (average r = .281) indicate that increases in the number of treatment episodes are related to decreases in the number of jail days and bookings. The decrease in total jail days appears to be primarily due to decreases in detention after contact with the MHC. Having a personality disorder is associated with increased bookings overall in the Pre MHC period but not in the Post MHC period.

So far we have discussed correlations as if the causal relationship was always from MH variables to CJ variables. However, it is possible to interpret the positive relationship between episodes of treatment with charge severity and the positive association of treatment hours to bookings previously described, as cases of causality in the other direction. CJ involvement may in itself cause increases in some MH variables, as would be the case when treatment is coerced by the CJ system during competency restoration. The positive relationship could also be due to variables not measured here but related to both CJ and MH variables, such as treatment hours received that are solely related to substance abuse problems services received in inpatient rather than outpatient settings. To summarize across the sample without attention to potential group differences, the following points are supported by these data:

- Available data indicate that treatment factors are significantly related to defendant detention histories.
- Lower motivation to deal with alcohol and substance abuse problems is associated with increased bookings.
- Having a personality disorder was associated with more bookings prior to, but not after MHC contact.
- The overall pattern supports the pathology hurts—treatment works premise.
- Defendants with more bookings also received more minutes of treatment over 18 months.
- As the number of treatment episodes increased, time spent in detention decreased. This relationship was particularly strong after defendants had contact with the MHC.

Table J9 has the same correlations as in the previous table, but in addition those cells of the grid contain text labels indicating significant correlations based on a single status group analyzed separately. Examining this table helps to clarify the relationships in the previous table. For values that were significant for the full sample, a significant correlation for one group in the sample but not for the other may indicate a between-group difference impacting the overall relationship. Significant group correlations that stand alone, without a significant finding for the larger group, also suggest between-group differences. The one cell of this table that contains a significant correlation for the larger sample and for both groups taken separately indicates that PD (presence of a personality disorder) is a particularly consistent and strong predictor of increased bookings prior to MHC contact.

Examining this table using the clusters described for the previous table, Cluster 1, which links substance use variables with booking variables, shows an apparent between-group difference in the relationship between mean RTC and Bookings after MHC contact, but not before MHC contact. This between-group difference suggests that Opt-In defendants experienced a greater positive impact from substance abuse treatment on the Opt-Out defendants relative to Opt-In. However, among other alternative

explanations is the possibility Opt-Out defendants participated in substance abuse treatment at a higher rate after MHC contact than they did before their contact with the MHC, thus increasing the ability of RTC to significantly predict new bookings simply because of the larger number of subjects in the analysis.

For Cluster 2 it appears that among Opt-Out defendants, more treatment was associated with more bookings in all three time periods, but that this relationship was not present for the Opt-In group. The finding that treatment was associated with more bookings in only one group may be primarily due to differences between the groups in amount and variability of treatment received. The Opt-In group on average had more treatment hours, and therefore less variability in treatment among its members, than the Opt-Out group. Another alternative hypothesis is that the Opt-Out group contained a larger percentage of individuals who were unresponsive to treatment, or even negatively reactive to treatment, resulting in the positive relationship between bookings and treatment for this the Opt-Out group, but not for the Opt-In group. This pattern may be related to higher levels of lack of insight and denial of illness in Opt-Out defendants (see quantitative findings). It may also be related to the effects of feeling coerced into treatment.

The Opt-In group appears to be the primary contributor to the correlations of Cluster 3 that indicate that increases in treatment episodes are associated with reductions in new bookings, Finally, two new clusters can be identified, those in the boxes with broken lines. Cluster 4 identifies substance abuse factors as more predictive of charge severity for the Opt-Out subjects. The reversal in sign for substance abuse factors with charge severity pre and post MHC contact may be due to resistance to engagement in substance abuse treatment among the members of this group with less severe charges, and higher motivation to be involved in substance abuse treatment among those with more severe charges, perhaps due to the consequences of noncompliance. Cluster 5 identifies the importance of personality disorder in predicting new arrests in this population.

Although between group differences cannot be definitively determined from this kind of analysis, the available data support the possibility of following between-group differences:

- Prediction of new bookings from substance abuse indicators was possible for the Opt-Out group independently, but not for the Opt-In group. This and other findings are suggestive of a greater importance for substance abuse factors among the Opt-Out defendants and of the possibility of a greater positive impact of substance abuse treatment.

- Increases in hours of treatment received were linked to increases in new bookings only in the Opt-Out group. This counter-intuitive finding may be due to a larger number of Opt-Out defendants who were unresponsive or negatively reactive to treatment.

- Increases in treatment episodes prior to involvement with the MHC were more strongly associated with decreases in new bookings after contact with the MHC for the Opt-In subjects than for the Opt-Out subjects. This finding may be due to a higher proportion of treatment responsive patients and a lower proportion of treatment reactive patients among Opt-In subjects.

Table J8. Significant Correlations of MH Variables with CJ Variables, N=77.

	TX PRE	TX POST	TOTAL TX	EPISODES	PSYCHOTIC	PD	MEAN RTC
Total Jail Days				-.317			-.377
Jail Days Pre MHC					**Cluster 3**		
Jail Days Post MHC				-.274			**Cluster 1**
						.296	
Bookings		**Cluster 2**	.419	-.251			-.384
Booking Pre MHC			.388			.313	
Bookings Post MHC			.265				-.413
Mean Charge Severity		.293		.358	-.296		
Severity Pre MHC	.240			.264			
Severity Post MHC							
Max Severity Pre MHC		.259					
Max Severity Post MHC	-.465						

Note: All correlations are for the entire sample (N=77) and are significant at p<.05 or higher for a one tailed test, with
**RTC variables are scored with 1=low motivation to 6=high motivation.

LEGEND: Cluster 1: Substance abuse readinesses to change variables are negatively associated with booking var
Cluster 2: Total hours of treatment over 27 months are positively associated with bookings.
Cluster 3: Total episodes of treatment over 27 months are negatively associated with jail days and boo

Table J9. Significant Single Group and Combined Sample Correlations (N=77).

	TX PRE	TX POST	TOTAL TX	EPISODES	PSYCHOTIC	PD	MEAN RTC
Total Jail Days				-.317			-.377
Jail Days Pre MHC					**Cluster 3**		
Jail Days Post MHC				-.274	OUT		
Bookings	**Cluster 2**		.419 OUT	-.251-IN		.296 OUT	-.384
Booking Pre MHC			.388 OUT	-IN		.313 OUT/IN	
Bookings Post MHC			.265 OUT			OUT	-.413 OUT
Mean Charge Severity		.293	OUT	.358	**New Cluster 5**		
Severity Pre MHC	.240		-OUT	.264	-.296		OUT
Severity Post MHC							-OUT
Max Severity Pre MHC		.259					
Max Severity Post MHC	-.465						**New Cluste**

Note: All correlations given specific figures are for the entire sample (N=77) and are significant at p<.05 or higher for
**RTC variables are scored with 1=low motivation to 6=high motivation.

LEGEND: OUT = Significant for the Opt-Out group, with N>=15. IN = Significant for the Opt-In group, with N>=1
sub-group designation (OUT or IN) indicate directions of a significant correlation. New Cluster 4: For the Opt-Out gr
indicators are positively related to charge severity prior to contact with the MHC and negatively after contact with the
Personality Disorder is positively related to booking independently in both Opt-Out and Opt-In groups.

RECOMMENDATIONS

Although the findings from the current study are considered preliminary, both the qualitative and quantitative data have demonstrated that the MHC has made significant progress towards its original objectives. The MHC has clearly made a significant impact on linking mentally ill defendants with treatment services and subsequently decreasing tier jail time. A longitudinal study will be necessary to make a more definitive statement regarding recidivism; however the data strongly suggest that the MHC is effective in "breaking the cycle" for re-offending and re-incarceration for mentally ill misdemeanants who have come under its jurisdiction.

The following recommendations are offered in the context of findings that are highly supportive of the MHC, and which indicate a successful first year of operation. Several of these recommendations involve program enhancements or program expansion. Their implementation may require additional resources. Others recommendations are aimed at preserving program integrity and are achievable within currently available resources.

Shared Mission, Procedural Guidelines, and Contingency Plans

Key stakeholders and members of the MHC share a common understanding of the MHC as a problem solving court that administers justice for mentally ill defendants by pursuing value-laden objectives. Among these objectives are (1) preventing the criminalization of the mentally ill through informed legal case management; (2) improving the defendant's well-being and ability to conform to the requirements of the law by engaging the defendant in needed treatment and providing linkage to other needed resources; (3) managing cases to insure public safety; and (4) supporting the defendant's personal autonomy through his/her exercise of personal responsibility and legitimate prerogatives.

MHC team members, like the larger stakeholder group, differed in their views about how the balance should be struck between shared objectives, both in principle and in specific cases. In a significant minority of cases, differing views of priorities have contributed to an intensification of the adversarial model, as opposed to the MHC's usual teamwork approach. An adversarial approach combined with the broadly defined roles of mental health core staff have contributed to inefficiencies in information gathering information sharing.

Goals and objectives of MHC should be revisited in response to this report and clearly stated and communicated to staff, stakeholders, referral sources, treatment providers, and the public. Divergence in the relative importance of MHC goals in any given case and in principle may not be undesirable. However, unspoken dissent from the basic working principles of the MHC could emerge if effort is not put into gaining a working consensus on general priorities among goals and objectives. Procedural guidelines and contingency plans for dealing with routine dilemmas of the Court should be documented and available to MHC staff and stakeholders. For example, the issue of informed consent to provide authorization for release of information could be addressed explicitly within the team. Guidelines could be established concerning methods of assuring that the defendant receives legal advice prior to the request for release or information, or alternatively, that the defense counsel will have some ability to limit the information considered by the Judge if the release is made prior to the provision of legal advice.

Clearly Defined Roles

Although clear role definitions exist for most members of the MHC team, two positions, that of the Court Monitor and the Social Worker, are less clearly defined and contain considerable overlap in task

performance. Several informants perceived the Court Monitor as allied primarily with the prosecution and as carrying the banner of public safety, whereas the social worker position was explicitly part of the defense team. Some informants perceived the Court Monitor as a non-neutral presenter of information to the MHC stems in part from complexity of the position. In the absence of a formal risk assessment process, an informal risk assessment process exists that relies heavily on information collected by the Court Monitor. Also, the Court Monitor, by virtue of personal diligence or quick access to the jail, was often the first MHC member to see a defendant. In many occasions this resulted in the Court Monitor requesting and obtaining an authorization for release of information (covering mental health records and the Court Monitor's interview findings) prior to the first meeting of the defense counsel with the referred defendant. This practice gives the appearance of pre-empting the opportunity for counsel to advise the defendant at a critical juncture. The practice of soliciting authorizations for release prior to the defendant's first contact with counsel may also raise questions concerning some defendant's mental competence to authorize a release of sensitive mental health information in the context of a criminal proceeding.

As a problem-solving court, sharing of all available information consistent with roles and responsibilities of MHC staff is of utmost importance. Legal advice from the defense team is the first step in setting the stage for open communication and more efficient case processing. This step should take place prior to assessment that will be presented in court. Initial contact by the Social Worker may fulfill this obligation of the defense team; however, this and any other paralegal duties of the social worker should be clearly described and communicated to other MHC staff to avoid duplication of efforts.

Enhanced redefinition and consensus on the Social Worker and Court Monitor roles would be extremely helpful in maximizing the unique contributions of these personnel by demarking aspects of role performance between the two positions that should be separate because of legal considerations (i.e., the need for the defense to protect the client's legal rights and options) from aspects of assessment and clinical planning that could be shared, coordinated, and not duplicated. Clear role definitions would also prevent disruption when staff turnover occurs.

Role definition of all MHC staff should be specifically defined via a series of meetings between MHC core staff and pertinent supervising agencies. In order to generate comprehensive and specific job descriptions, each core staff member could compose a work content and process description to be presented to the MHC judge and program manager for review and revision prior to discussing it at a team meeting. Once completed, abbreviated versions of these role descriptions could be made available to involved individuals and agencies, to promote understanding and efficiency.

Team Meetings

Team meetings should occur on a regularly scheduled basis, with all MHC core staff required to attend. Because of the importance of systemic and programmatic collaboration, the weekly meeting should take priority over other obligations. All team members should be invited to add to the team meeting agenda (e.g. by e-mail to the program manager) their particular issues, concerns, or suggestions. Minutes of these meetings should be kept and distributed to staff, stakeholders, and Community Advisory Committee.

Standardized Assessment

Accurate assessment of mentally ill defendants, especially those with co-occurring substance abuse, is one of the most difficult aspects of working with such individuals (RachBeisel, Scott, & Dixon, 1999). A standardized assessment protocol, which includes instruments with established validity and reliability, would allow for more accurate and consistent assessment of symptomatology, treatment needs, dangerousness, and malingering. It would also allow for a more comprehensive quantitative program evaluation in the future. The

future utilization of empirically derived, specialized forensic assessment instruments should be emphasized (Melton, Petrila, Poythress, & Slobogin, 1997). Standardization of assessment procedures may require an increase in resources, including the involvement of a doctoral level psychologist to perform or supervise assessments.

Formal Assessment for Risk for Future Dangerousness.

An impressive technology currently exists for assessing risk for future dangerousness in both mentally ill and normal offenders (Rice & Harris, 1997, Bonta & Hanson,1998). Utilizing this technology requires both appropriately trained professional staff and a formal procedure for the consideration of the findings of such assessments. It is recommended that the MHC evaluate the feasibility of implementing the use of available standardized risk assessment instruments and of routinely incorporating this information in its deliberations.

Judicial Oversight in the Provision and Monitoring of Treatment Services.

Currently, the MHC is actively involved in linking participants to services and monitoring their level of compliance with treatment recommendations. An equally important issue is the appropriateness and adequacy of planned interventions and the integrity with which they are delivered. This study's counter-intuitive finding of a moderately strong positive relationship between number of treatment hours received and number of new bookings is not unexpected if one considers the large and growing literature supporting the view that inappropriate treatment of offenders, including those with mental disorders, results in increased, rather than decreased reoffending (Rice & Harris, 1997).

Routine review in the MHC of detailed treatment plans proposed by providers would ensure that such plans exist and that they have a reasonable chance of being appropriate to the participant. Descriptions of programs, modules, and individual therapy contacts intended to address the needs of the participant should be made available to the MHC and reviewed for adequacy, perhaps relying on a consultant with expertise in this area. Another benefit from this process would be the increase of knowledge on the part of the MHC staff without over-reliance on formal didactic training sessions that do not address specific cases before the court. Also, some treatment providers interviewed wanted more intimate engagement in with the MHC, especially in regard to planning and delivery of services. The level of oversight envisioned here is not one of the Judge directing or managing treatment services. Rather, he/she should set a standard of accountability for providers that is consistent with MHC participant needs, and may not be reflected in the most basic requirements of a provider contract.

Use of Positive Incentives

Sanctions are often utilized in criminal justice programs to provide incentives for compliance. However, the process findings of this study confirm that sanctions are often less appropriate for mentally ill offenders, who may be unmindful of consequences and who may view sanctions in a different light from drug offenders. For example, drug offenders view less frequent reporting as highly desirable. Less contact with MHC staff or treatment providers is not necessarily rewarding to all or most defendants in the MHC. Mentally ill individuals typically have deficits in the ability to achieve legitimate social, interpersonal, and material rewards, and may substitute drug abuse or negative attention getting behaviors to fill this vacuum. Positive reinforcements or rewards should be central to any intervention approach for individuals with severe psychosocial and psychiatric disabilities. A clear reward system for compliance with supervisory conditions would help MHC clients to consolidate treatment gains and provide them with concrete, positive incentives for change. A more deliberate behavioral approach should be implemented to make clients aware of the sanction, and more importantly reward contingencies. This approach would both help to ensure their engagement in treatment and provide a consistent schedule of reinforcement for desired behavior.

Three ways are recommended for MHC to increase the use of positive reinforcement: (1) the establishment of flexible funds to provide immediate rewards for compliance with MHC expectations; (2) the presentation of certificates or tokens to MHC clients for reaching designated "steps" in MHC status; and (3) the use of protective payee arrangements to make defendant access to government provided funds contingent on compliance. Flexible funds could be established through several means, including as an item in the provider contract, as a grant from County or State government, or through donations solicited under the auspices of the Citizens Advisory Committee. An example of active incentives would be to provide a symbolic reward when a client graduates from having required hearings every 30 days to every 60 days because of treatment and probation compliance, as is the practice in 12 step groups when participants achieve longer periods of abstinence. The criteria for obtaining contingent positive incentives should be clearly established and explained to the defendant at the onset of MHC engagement.

Eliminate Obstacles to Centralized Case Management

At the moment, MHC is missing an important portion of the mentally ill defendant population because of its limitation to misdemeanor cases and to only those not originating in incorporated municipalities in the County. Several informants proposed expanding the jurisdiction of the MHC to include some felonies and cases from some of the County's municipalities. It is recommended that the Court take a somewhat conservative and scientific approach to this expansion, however, and begin with accepting only lower level, non-violent felony cases with continuous empirical assessment. Addressing this issue as soon as possible could result in much more efficient management of cases and could prevent a confusing set of responsibilities and occasionally unnecessary incarcerations or service of warrants for mentally ill individuals already involved with the MHC. Expansion to a larger pool of potential participants should be contingent on the resources available to the MHC to provide for the larger caseload.

Assess the Need for Increased Resources

Several of the members of the MHC have large and growing caseloads, as well as complex tasks that are made more difficult by the disabilities, limitations, and needs of the population that the MHC serves. Several recommendations offered here would require additions to these workloads. The Court Monitor function may be currently at capacity, and probation officers have a finite number of cases that can be carried at the appropriate level of intensity. Because of the length of time individuals are involved with the court and the already limited time of the staff attorneys, a detailed assessment of the need for additional MHC defense attorney and prosecution resources would also be recommended. The MHC prosecutor position is now only present on a part-time basis and has experienced a significant amount of turnover. As turnover seems to be an issue, the Court should explore mechanisms to retain staff attorneys and other members for a minimum amount of time (e.g. one year).

Evaluation of Charge Severity

We found that new bookings for defendants seen in the MHC have been for increasingly less severe offenses. If this pattern is confirmed, it has important implications for public policy, especially in regard to the criminalization of the mentally ill. Since this issue goes beyond the MHC and may be applicable to misdemeanant arrests in general, a pilot study of trends in severity of misdemeanant bookings over the last three years would help clarify this issue.

Preventing Criminalization: Diversion and Outpatient Commitment

Several recommendations bear on preventing the criminalization of individuals with mental illness. Establishing guidelines that specify the conditions under which diversion should be formally considered would provide a way to make these considerations less of an exception. Being faced with powerful negative incentives to plead guilty to criminal charges without a trial creates a dilemma that has serious legal, social, and sometimes ethical consequences for the defendant, his family, and his advisors. Outpatient mental health services often adequately address the issues that bring individuals to the attention of the courts and do not carry a heavy burden of stigma in modern urban society. One key informant suggested that it was time to examine the appropriate role of outpatient commitment for individuals who are initially incompetent to stand trial, or who repeatedly find themselves in the revolving door due to non-compliance to voluntary treatment recommendations. Although a limited outpatient commitment authority exists in the State statutes, the legal parameters may be neither adequate nor appropriate for addressing the need to provide treatment under coercion outside the walls of a hospital. Any unwanted treatment, but especially one under civil court order, is unlikely to be successful without the understanding and engagement of the treatment community. This engagement is most successfully fostered by incentives contingent on success.

The legal and legislative considerations concerning outpatient commitment and for the clinical support needed for its successful implementation even on a trial basis may need to be reviewed through a formal process such as a Task Force. However, it is important to recognize that consumers and their advocates are unlikely to support the use of outpatient commitment as the first resort for mentally ill persons who come into repeated contact with the criminal justice system. Support will not be forthcoming in the face of systemic evidence that voluntary treatment is not available when voluntarily requested, tends to be inappropriate, and is not monitored in a way that provides meaningful and timely feedback to consumers. Given concerns about undermining or failing to improve the voluntary treatment system, as well as other civil libertarian considerations, the use of outpatient commitment may be applicable to only a small number of defendants who might otherwise intermittently require commitment to inpatient facilities

Identification and Engagement of Key Stakeholders

To further enhance the inter-system communication and encourage more involvement, support, and resource development, a clear identification of MHC key stakeholders is also recommended. These individuals will be key in the identification of treatment resource needs and the securing of additional funding to meet these needs. It is also recommended that MHC form a Community Advisory Committee to include family members of consumers and mental health providers. Other members of the community to consider including are community business owners, police officers, and members of the Stevenson family. Meetings of this committee should occur regularly, be co-chaired by a community member and the MHC or District Court Presiding judge, with minutes kept and distributed to MHC staff and stakeholders.

Distribution of Information

Public relations and general distribution of information pertaining to MHC will be crucial to its success. The public's awareness of the importance of linking mentally ill defendants to treatment, especially with empirical support, will help to increase future support and funding. A broad selection of media should be used to distribute the findings of this report, including press releases and published and national presentation of the research findings. A link to the report on the MHC website would allow for even broader distribution of information.

The Dangers of Success

The MHC has experienced a climate of enthusiasm and hope surrounding its inception. Many hopes appear to have been realized, at least for those individuals who Opt-In and participate in the MHC for a reasonable period of time. Calls for the expansion of MHC are reasonable, given its success with many defendants and the high level of internal stakeholder and public support. Expansion without sufficient resources would in itself be a challenge to the future integrity of the MHC model. However, we found possible early warning signs of model drift and loss of enthusiasm at this juncture. Among these signs was the decision to disperse the MHC-Jail Services Liaison position among all the PES staff, rather than centering this function in one individual who is accountable for ongoing awareness of MHC issues and informing the MHC of critical details.

A second possible early warning sign was some informants' concern about the continuing viability of the MHC beyond the tenure of its first presiding Judge. This concern contains a strong endorsement of the current leadership of the MHC, but raises the doubt about the institutionalization of MHC within the District Court or the agenda of County government. A third set of warning signs might be seen in the areas of program documentation and information. Many files reviewed in during this evaluation did not contain the expected information or reports. Some reports or forms were only partially completed due to the demands of the MHC daily grind. In the last days of the final review process for this evaluation, the possibility emerged that the MHC information system application may be scrapped, due to a change requiring the contractor, UBH, to maintain future data systems. Additional clerical support and some minor programmer assistance might be required to maintain the MHC application after this change.

These may be indicators of a need for quality assurance and performance reviews of basic tasks and for reassessing work methods and the need for additional manpower, inclusive of administrative and clerical support. They also are calls for vigilance in dealing with threats that may flow from the early and partial success of a new model.

ISSUES IDENTIFIED FOR STUDY IN PHASE II

Warrants

The use of warrants for Failure to Appear should be evaluated in Phase II. Specifically, the number of warrants issued, reason for warrants, percentage of warrants quashed, and relation to future compliance. It would be important to make a comparison of warrants issued in a regular misdemeanor courtroom.

Recidivism

Because of the findings in the literature pertaining to the necessary timeframe to assess recidivism, it is recommended that this variable be examined in the context of a longitudinal study.

Comparison to Other Courts

Possible comparisons for Phase II include the Seattle Municipal Mental Health Court, the King County Drug Court, and other District Courts (e.g. in other Washington counties) serving mentally ill misdemeanants. Having similar courts for comparison would be an important step toward assessing the relative impact of various components of the MHC, such as the Court Monitor, dedicated probation supervision, etc.

Evaluation of Charge Severity

Our findings related to charge severity suggest that new bookings for defendants seen in the MHC have been for increasingly less severe offenses. In the next phase of study, the issue of charge severity should be examined more closely. If this pattern is confirmed, some review of the causes and desirability of this trend should be conducted.

Factors Influencing the Decision to Participate

A range of variables such as offense characteristics, defendant psychological characteristics, legal advice, type of offer made by the prosecution, and experience in detention should be used to determine factors that shape the decision to opt in or out of MHC participation. Understanding the decision making process of defendants will require a significant amount of assessment and interview time with them and very careful structuring of informed consent and confidentiality arrangements.

Defendant Perception of the MHC Process

How defendants and their families view the goals and objectives and operation of the MHC, and its impact on their legal cases and lives should be investigated through interviews and self-report measures.

Cost Benefit Analysis

Because of the short-term nature of this process study, a comprehensive cost-benefit analysis could not be completed. Such an analysis will be more appropriate in a longitudinal evaluation.

REFERENCES

Bogdan, R. & Taylor, S.J. (1994). A positive approach to qualitative evaluation and policy research in social work. In Sherman, E., & Reid, W.J. (Eds.). Qualitative Research in Social Work. New York: Columbia University.

Bonta, J.L. & Moira, H. K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. Psychological Bulletin, 123, 2, 123-142.

Bureau of Justice Assistance. (2000), Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage (NCJ 182504), Washington D.C.: National Institute of Justice.

Cayce, J.D. & Burrell, K. (June 1999). King County's Mental Health Court: An innovative approach for coordinating justice services. Washington State Bar News, 19-23.

Lamb, H.R. & Weinberger, L.E. (1998). Persons with severe mental illness in jails and prisons: A review. Psychiatric Services, 49, 483-492.

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogis, C. (1997). Psychological evaluations for the courts. New York: Guilford.

Murry, C., Polissar, N., & Bell, M. M. (1999). The Misdemeanant Study: Misdemeanors and Misdemeanor Defendants in King County, Washington. Report to the King County Council.

RachBeisel, J., Scott, J., & Dixon, L. (1999). Co-occurring severe mental illness and substance use disorders: A review of recent research. Psychiatric Services, 50, 1427-1434.

Rice, M. E. (1997). Violent offender research and implications for the criminal justice system. American Psychologist. 52, 4, 414-423.

Rice, M.E. & Harris, G. T. (1997). The treatment of mentally disordered offenders. Psychology, Public Policy, and the Law. 3, 1, 126-183.

Winick, B.J. (1997). The jurisprudence of therapeutic jurisprudence. Psychology, Public Policy, and Law, 3, 184-206.

Appendix A
MHC Phase I Evaluation Interviewees

MHC PHASE I EVALUATION INTERVIEWEES	
INTERVIEWEE	TITLE
CORE STAFF & JAIL STAFF	
James Cayce	MHC Judge, past Presiding Judge (term ended 12/1/99), KCDC
Kari Burrell	Program Manager, KCDC
Daniel Gross	Public Defense Attorney, TDA
Susie Rozalsky	Court Monitor, UBH
Roger Rogoff	MHC Prosecuting Attorney, OPA
Susan Butler	Mental Health Specialist Probation Officer, KCDC
Kymber Walton	Mental Health Specialist Probation Officer, KCDC
Dianne Morton	Public Defense Social Worker, TDA
Sandra Lampe	Court Clerk, KCDC
Kari Peterson	Jail Psychiatric Assistant Nursing Supervisor, County Dept of Public Health
Larry Smith	Administrator, Jail Psychiatric Services, DAJD
TREATMENT PROVIDERS	
	CPC
	Valley Cities
	Seattle Mental Health
KEY STAKEHOLDERS	
Barbara Gletne	Director, DCHS (Dept of Community and Human Services)
Joanne Asaba (Margaret Smith)	Manager, MHCADSD (Program Analyst, MHCADSD)
David Wertheimer	Systems Integration Administrator, DCHS
Steve Thompson	Director, DAJD (Dept of Adult and Juvenile Detention)
Pat Steele	Director, Office of the Budget
Beth Goldberg	King County Policy Analyst
Larry Gossett	King County Council Member
Doug Stevenson	Legislative Lead Analyst, County Council
Clif Curry	Senior Legislative Analyst, County Council
Ron Sims	King County Executive
Steve Nolen	Criminal Justice Senior Policy Advisor
Bob Boruchowitz	Executive Director, The Public Defender

MHC PHASE I EVALUATION INTERVIEWEES	
INTERVIEWEE	TITLE
	Association
KEY STAKEHOLDERS	
Floris Mikkelsen	Misdemeanant Unit Supervisor Public Defender Association
Norm Maleng	King County Prosecuting Attorney
Mark Larson	Chief Criminal Deputy, Office of the Prosecuting Attorney (OPA)
David Steiner	Presiding Judge, KCDC
Darrell Phillipson	Judge, KCDC (past RJC jail judge)
Senator Long	Washington State Senator
Justice Utter	
Stevenson Family	
Eleanor Owen	WIAMI, Executive Director

APPENDIX B
SEMI-STRUCTURED INTERVIEW
King County District Mental Health Court
Semi-structured Interview Process

Interviewee Code:_____
Interview Date:_____
Interview Starttime:_____
Interview Endtime:_____
Interviewer:_____
Process Related Comments:

Questions

General

G1. What are the MHC's primary goals?

G2. Please rate to what extent the court is accomplishing these goals?
a. (Low accomplishment)
b. (Low to substantial accomplishment)
c. (Substantial to high accomplishment)
d. (High accomplishment in all goal areas)
e. (Do not know/not sure)

G3. How would you recommend changing or modifying the MHC's primary goals?

G4. What are the strengths of the MHC?

G5. What are the weaknesses of the MHC?

Referral/Population

R1. Who is the target population? Has it been consistent throughout the MHC's operation? Please explain.

R2. How does the target population compare with the current population?

R3. In your opinion, are the criteria for referral to the MHC too restrictive, not restrictive enough, or just right? Please explain.

R4. Please describe the general referral process for each primary referral source.

R5. Please identify any existing barriers to the referral process.

R6. What patterns or characteristics (e.g. demographics, symptomatology, charges) have you noticed among opt-in defendants? Opt-out?

R7. How would you assess MHC's participation rates?

a. (Poor)
b. (Fair)
c. (Good)
d. (Excellent)
e. (Do not know/not sure)

R8. How would you recommend improving MHC's participation?

R9. Have you needed to take additional safety precautions when working with the MHC defendants as compared to defendants in other courts of lower jurisdiction?

Case Processing

C1. Please describe the general case process.

C2. How has the case process changed over time?

C3. What would you recommend modifying to improve the effectiveness and/or efficiency of the Court's case process?

C4. Please rate the court's ability to identify defendants' specific psycho-social needs before the first appearance hearing.

a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

C5. What are the objectives of the MHC's first appearance hearings?

C6. How would you recommend changing the first appearance hearing process and/or procedures?

C7. What factors are or appear to be influential in the decision to grant deferred sentences or suspended sentences?

C8. What are the objectives of the MHC's status hearings?

C9. How would you recommend changing the status hearings?

C10. What factors appear to be influential in defendants' decision to either opt-in or opt-out of the MHC?

C11. What are the objectives of the MHC's review hearings?

C12. How would you recommend changing the review hearing process and/or procedures?

C13. How would you compare MHC's case processing expediency with how its cases would have been processed in other courts of limited jurisdiction (Please note that changes in the law in 1998 --SB 6214 – have impacted the way competency issues are processed)?

a. MHC is much less expedient
b. MHC is less expedient
c. MHC is about the same
d. MHC is more expedient
e. MHC is much more expedient
f. Do not know/not sure

C14. Has MHC allowed extra courtroom time to process cases? If yes, in your opinion, has there been an impact case outcomes? Please explain.

C15. How are issues of FTA (failure to appear), FTC , pre-sentence and post-sentence warrants handled by the MHC?

C16. How can these issues (FTA/warrants) be mitigated?

C17. How would you rate the MHC's overall performance with respect to reducing defendants' time spent in-custody?

a. (Low)
b. (Fair)
c. (Good)
d. (Excellent)
e. (Do not know/not sure)

C18. How could this performance be improved (reducing jail time for MHC clients)?

C19. Please rate MHC's ability to balance transitioning defendants into the community with public safety.

a. (Insufficient concern for community safety)
b. (Appropriate amount of concern for community safety)
c. (Excessive concern for community safety)
d. (Do not know/not sure)

C20. How are defendants' obligations in other courts managed by the MHC – how would you recommend improvements in this area?

C21. In what percentage of cases do families play an active role the MHC process? How can greater family involvement be achieved?

C22. How effective is the use of sanctions in changing the behavior of MHC participants? (Rate on 1-5; 1= not effective; 5 = extremely effective; 6 = do not know)

1 2 3 4 5 6

C23. How could the use of sanctions be improved?

MHC Staff

S1. Please describe the primary roles and responsibilities of the following MHC positions (referred to below as MHC core staff) with an emphasis on how the roles and responsibilities differ from those in other courts of limited jurisdiction.

a. Judge

b. Program Manager

c. Court Monitor

d. Court Clerk

e. Public Defender

f. Social Worker

g. County Prosecutor

h. Probation Officers

S2. How would you recommend modifying the primary roles and responsibilities of MHC core staff (Judge, Program Manager, Court, Monitor Court , Clerk, Public Defender, Social Worker, County Prosecutor, Probation Officers) or the configuration of staff to improve the effectiveness and/or efficiency of the MHC?

S3. Please rate the extent to which there is a shared vision among the different MHC core staff.

a. (Low)
b. (Low to Med)
c. (Med to High)
d. (High)
e. (Do not know/not sure)

S4. Under what circumstances is collaboration among the MHC core staff desirable?

S5. How would you rate the extent to which the MHC core staff collaborate in these circumstances

a. (Low)
b. (Low to Med)
c. (Med to High)
d. (High)
e. (Do not know/not sure)

S6. How could collaboration be improved among MHC core staff?

S7. How are program implementation issues (e.g., case processing problems) handled within the MHC? Who is involved and how are decisions carried out? Please provide an example.

S8. How are issues of system development handled (i.e., system issues outside the court's jurisdiction that impact the court)? Who is involved? Please provide an example.

S9. Please rate the level of collaboration that takes place between the MHC core staff and jail staff?

a. (Low)
b. (Low to Medium)
c. (Medium to High)
d. (High)
e. (Do not know/not sure)

S10. How would you recommend improving collaboration between MHC core staff and jail staff?

S11. The MHC is premised on the idea that a consistent group of court staff will better serve mentally ill defendants. In your opinion, has the consistency of the core team of professionals improved case processing? Please explain.

S12. Has the MHC provided training for its core staff? If yes, how many hours and what type? Is training needed? If yes, how much and what type?

S13. Over the course of implementation, how much has the court's core staff improved their level of understanding in relation to mental health issues?

a. No improvement
b. Low level of improvement
c. Substantial level of improvement
d. High level of improvement
e. Do not know/not sure

S14. If the levels of understanding have improved: To what extent has improved levels of mental health understanding impacted the staff's behavior/work performance?

a. No impact
b. Low level of impact
c. Some impact
d. High level of impact
e. Do no know/not sure

S15. Describe how the MHC monitors treatment providers' performance following referral/enrollment?

Probation

P1. Describe the levels of court supervision defendants receive from their MHC probation officers?

P2. Are the conditions of probation for MHC defendants different from those in a regular court? If so, how?

P3. When a defendant is not following the conditions of his/her probation, what types of responses are carried out to foster compliant behavior prior to recommending revocation?

P4. What are the formal and/or informal protocols guiding POs' decisions to recommend probation revocation?

P4. How would you recommend changing the probation and court supervision process for defendants on review status?

Treatment

T1. Please describe the treatment services provided to MHC defendants/clients.

T2. Please describe and rate the timeliness of mental health treatment services (time between initial referral for treatment and the first day of treatment).
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T3. Please describe and rate the engagement strategies used by MHC defendants' mental health treatment providers.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T4. Please describe and rate the frequency of treatment and case management interventions implemented by MHC defendants' mental health treatment providers.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T5. Please describe and rate the intensity of mental health treatment and case management services provided for MHC defendants.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T6. Please describe and rate the collaboration that takes place between the court core staff and the mental health treatment providers.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T7. Please describe and rate the collaboration that takes place between the jail staff and the mental health treatment providers.

a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T8. Please describe and rate the MHC/mental health treatment providers' ability to link defendants to medical and financial assistance.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T9. Please estimate the proportion of MHC defendants who are in need of housing upon referral to the court.

T10. Please describe and rate the MHC/mental health treatment providers' ability to link defendants in need of housing to appropriate housing.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T11. Please describe and rate the MHC/mental health treatment providers' ability to provide or link defendants to integrated mental health/substance abuse treatment services – for those in need.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T12. Please describe and rate the coordination that takes place (among court staff, jail staff, mental health treatment providers, housing providers, substance abuse treatment, medical/financial assistance, family etc.) on behalf of MHC clients.
a. (Insufficient for all cases)
b. (Sufficient for the minority of cases)
c. (Sufficient for the majority of cases)
d. (Sufficient for all cases)
e. (Do not know/not sure)

T13. In your opinion, what parts or elements of the MHC have had the most impact on treatment outcomes? How has the overall MHC process affected clients' treatment outcomes?

T14. Please identify sub-populations for whom providing necessary treatment services have been especially challenging.

T15. In what proportion of court review hearings and other court sessions are mental health case managers present?

T16. How are MHC mental health treatment services (including treatment monitoring) different for those defendants already enrolled in the public mental health system upon referral to the MHC court?

T17. How does the MHC monitor defendants' treatment progress?

T18. In general, how can mental health treatment and other necessary services be improved for MHC clients?

Overall

O1. How would you rate the organizational and contractual structure of the MHC?

a. (Low)
b. (Low to Medium)
c. (Medium to High)
d. (High)

O2. How would you modify the organizational and/or contractual structure of the MHC to improve its effectiveness and/or efficiency?

O3. Please describe and rate the degree to which the MHC has facilitated greater overall linkages between the criminal justice system and the mental health treatment provider system.

a. (Low)
b. (Low to Medium)
c. (Medium to High)
d. (High)
b. (Do not know/not sure)

O4. Please recommend changes in the way information is collected in order to fully assess the MHC.

05. What legislative or policy changes would you recommend in order to improve the effectiveness/efficiency of the MHC?

O6. Do you believe the MHC program in its present form represents a wise use of public resources? Why or why not?

Mental Health Treatment Provider Questions

1. Please describe and rate the frequency of communication you have experienced with:

MHC Court Monitor	No Communication 1 2 3 4 5 Very Frequent
MHC Probation Officers	No Communication 1 2 3 4 5 Very Frequent
MHC Social Worker	No Communication 1 2 3 4 5 Very Frequent
Defense Attorney	No Communication 1 2 3 4 5 Very Frequent
Prosecuting Attorney	No Communication 1 2 3 4 5 Very Frequent
Jail Staff	No Communication 1 2 3 4 5 Very Frequent

2. Please describe and rate the effectiveness of communication – in terms of providing coordinated services for your clients -- you have experienced with:

MHC Court Monitor	Not Effective 1 2 3 4 5 Very Effective
MHC Probation Officers	Not Effective 1 2 3 4 5 Very Effective
MHC Social Worker	Not Effective 1 2 3 4 5 Very Effective
Defense Attorney	Not Effective 1 2 3 4 5 Very Effective
Prosecuting Attorney	Not Effective 1 2 3 4 5 Very Effective
Jail Staff	Not Effective 1 2 3 4 5 Very Effective

2. Please describe your level of participation in your MHC clients' review hearings.

3. Please describe how, if at all, MHC clients -- as a group -- are different from other clients on your caseload.

4. Have you needed to take additional safety precautions in working with MHC clients as compared to your other clients?

5. What parts or elements of the MHC have had the most impact on you clients' therapeutic process? Generally speaking, how has the MHC impacted your clients' therapeutic process?

6. What obstacles exist in meeting the treatment needs of MHC clients?

7. Please identify and describe what elements or strategies have proven effective in engaging and treating MHC clients and ultimately improving their stability and well-being in the community.

8. Services typically provided to MHC clients

- ☐ *risk assessment*
- ☐ *medication management*
- ☐ *case management services*
- ☐ *home visits*
- ☐ *housing assistance*
- ☐ *assistance obtaining financial assist*
- ☐ *assistance obtaining medical assist*
- ☐ *assistance with other benefits*
- ☐ *referral for health issues*
- ☐ *crisis intervention*
- ☐ *group therapy*
- ☐ *individual therapy*
- ☐ *day treatment*
- ☐ *behavior therapy*
- ☐ *referral for other therapy*
- ☐ *substance abuse (outpatient)*
- ☐ *substance abuse (inpatient)*
- ☐ *protective payeeship*

- ☐ *money management*
- ☐ *family therapy*
- ☐ *other (specify)*

8. Please recommend ways to improve the MHC in general and specifically its coordination with mental health treatment providers.

9. How many hours of cross-training (criminal justice/mental health) has you received? What areas and levels of training would you recommend mental health treatment staff serving MHC client receive in the future?

KEY STAKEHOLDER QUESTIONS

1. How has the Mental Heath Court been brought to your attention since its inception?

2. Has the existence of the Mental Health Court impacted the way you think about the mental health and criminal justice systems? If so, how?

3. Do you believe the MHC program in its present form represents a wise use of public resources? Why or why not?

4. What have been the strengths of the Mental Health Court?

5. In what areas, if any, would you recommend the Mental Health Court improve?

6. How would you suggest Mental Health improve its support among key stakeholders and the public?

1. What legislative or policy changes, if any, would you recommend in order to improve the efficacy of the Mental Health Court?

Appendix C

UNIVERSITY OF WASHINGTON
MENTAL HEALTH COURT EVALUATION

CONSENT FORM

Investigators: Principle Investigator: Eric Trupin, Ph.D., Professor and Vice-Chair, Psychiatry and Behavioral Sciences, University of Washington; (206) 526-2162; *trupin@u.washington.edu*.

Co-Investigators: Henry Richards, Ph.D., Peter Wood, M.P.A., Barbara Lucenko, M.S., Victoria Harris, Ph.D., Gregg Gagliardi, Ph.D., Richard Almbaugh, Ph.D.

INVESTIGATORS STATEMENT

The purpose of this consent form is to give you the information you will need to help you decide whether or not to be interviewed as a part of the Mental Health Court Evaluation. Please read the form carefully.

PURPOSE AND BENEFITS

We would like to evaluate the King County District Court. If you decide to take part in the evaluation, we would like for you to provide your impressions of how the Mental Health Court has been implemented. We hope the results of study will help to improve the Mental Health Court in the future. You may not directly benefit from being in the evaluation.

PROCEDURES

If you choose to participate in the evaluation, we would like to ask you a series of questions. The interview will take between 1-3 hours, including breaks. We will ask you to identify your perceptions of how the Mental Health Court has been implemented. For example, we will ask you to identify the strengths and weaknesses of the Mental Health Court's structure and implementation. We will also ask you to rate the extent the Mental Health Court Core Staff collaborate effectively and efficiently. It is possible that you may not have enough information or knowledge to answer some of the questions. You do not have to answer every question.

We would like for your responses to be completely and accurately understood and written down by the interviewer. We would like to audiotape your interview to ensure that our notes accurately reflect your responses. Audiotaped interviews will only be replayed so that the interviewer and/or another member of the University Evaluation Team can check the accuracy of the notes taken during the interview. Audiotapes will be stored in a locked filing cabinet on the campus of the University of Washington. Audiotapes will be destroyed within 21 days following the recording date. Please indicate below whether your give your permission to be audiotaped.

❒ I give my permission for my Mental Health Court Evaluation Interview to be audio-taped.

❒ I do NOT give my permission for my Mental Health Court Evaluation Interview Process to be audiotaped.

RISKS, STRESS, OR DISCOMFORT

Some people feel that providing information for evaluation projects of this kind is an invasion of privacy. Some people feel uncomfortable about being audio-taped.

OTHER INFORMATION

Participation in this study is voluntary. You can stop at any time. Information you provide for the Mental Health Court Evaluation is confidential. Information is coded. The link between your name and the code is kept in a locked filing cabinet on the campus of the University of Washington. This document linking the code with your name or other identifiers will be destroyed by August 30, 2000.

Subject's Statement

The study has been explained to me, and I voluntarily consent to participate. I have had an opportunity to ask questions. I understand that future questions I may have about the research will be answered by one of the investigators listed above. If I have questions about my rights as a subject, I may call the University of Washington Human Subjects Division at (206) 543-0098. I will receive a copy of this consent form.

_____

Signature of subject Date

APPENDIX D
INTERVIEW RATING AND NUMERIC RESPONSES

Please rate to what extent the MHC is accomplishing its goals

goals

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	low to substantial	3	21.4	21.4	21.4
	substantial to high	7	50.0	50.0	71.4
	high in all	2	14.3	14.3	85.7
	DK/Not sure	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

How would you assess the MHC's participation rates?

participation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Fair	2	14.3	14.3	14.3
	Good	7	50.0	50.0	64.3
	Excellent	1	7.1	7.1	71.4
	DK/Not Sure	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Please rate the MHC's ability to identify defendants' specific psycho-social needs before the first appearance hearing.

assessment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	6	42.9	42.9	42.9
	Sufficient for majority	4	28.6	28.6	71.4
	DK/Not Sure	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Compare the MHC's case processing expediency to how its cases would have been processed in other courts of limited jurisdiction.

expedienc

		Frequenc	Percen	Valid	Cumulativ Percen
Valid	Much less	1	7.1	7.1	7.1
	less	1	7.1	7.1	14.3
	about the same	2	14.3	14.3	28.6
	more	2	14.3	14.3	42.9
	much	5	35.7	35.7	78.6
	DK/Not	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Rate the MHC's overall performance with respect to reducing defendant's time spent in-custody.

in-custody

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	2	14.3	14.3	14.3
	Fair	2	14.3	14.3	28.6
	Good	5	35.7	35.7	64.3
	DK/Not Sure	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Rate the MHC's ability to balance transitioning defendants into the community with public safety.

balance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Appropriate	10	71.4	71.4	71.4
	Excessive	3	21.4	21.4	92.9
	DK/Not Sure	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Rate the extent to which there is a shared vision among the different MHC core staff.

vision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low to Med	1	7.1	7.1	7.1
	Med to High	7	50.0	50.0	57.1
	High	4	28.6	28.6	85.7
	DK/Not Sure	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Rate the extent to which the MHC core staff collaborate under

circumstances in which collaboration is desirable.

collaborate

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	1	7.1	7.1	7.1
	Med to High	7	50.0	50.0	57.1
	High	3	21.4	21.4	78.6
	DK/Not Sure	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Rate the level of collaboration that takes place between the MHC core staff and jail staff.

with jail

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low to Med	6	42.9	42.9	42.9
	Med to High	3	21.4	21.4	64.3
	High	2	14.3	14.3	78.6
	DK/Not Sure	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

How much has the court's core staff improved their level of understanding in relation to mental health issues?

insight

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No improvement	1	7.1	7.1	7.1
	Low level of improvement	1	7.1	7.1	14.3
	Substantial improvement	6	42.9	42.9	57.1
	High level of improvement	2	14.3	14.3	71.4
	DK/Not Sure	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

To what extent has improved understanding impacted staff behavior/work performance?

impact

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No improvement	1	7.1	7.1	7.1
	Low level of improvement	1	7.1	7.1	14.3
	Substantial improvement	4	28.6	28.6	42.9
	High level of improvement	4	28.6	28.6	71.4
	DK/Not Sure	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Rate the timeliness of mental health treatment services (from referral for Tx to first day of Tx).

timely?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	5	35.7	35.7	35.7
	Sufficient for majority	5	35.7	35.7	71.4
	Sufficient for all	1	7.1	7.1	78.6
	DK/Not Sure	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Rate the engagement strategies used by MHC defendants' treatment providers.

engagement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	4	28.6	28.6	28.6
	Sufficient for majority	3	21.4	21.4	50.0
	Sufficient for all	2	14.3	14.3	64.3
	DK/Not Sure	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Rate the frequency of treatment and case management interventions implemented by providers.

frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	5	35.7	35.7	35.7
	Sufficient for majority	6	42.9	42.9	78.6
	DK/Not Sure	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Rate the intensity of treatment and case management services.

intensity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	7	50.0	50.0	50.0
	Sufficient for majority	2	14.3	14.3	64.3
	DK/Not Sure	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Rate the collaboration that takes place between the MHC core staff and treatment providers

with MHC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Insufficient for all	1	7.1	7.1	7.1
	Sufficient for minority	4	28.6	28.6	35.7
	Sufficient for majority	4	28.6	28.6	64.3
	Sufficient for all	2	14.3	14.3	78.6
	DK/Not Sure	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Rate the collaboration that takes place between MHC core staff and treatment providers.

jail/MH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sufficient for minority	5	35.7	35.7	35.7
	Sufficient for majority	1	7.1	7.1	42.9
	Sufficient for all	1	7.1	7.1	50.0
	DK/Not Sure	7	50.0	50.0	100.0
	Total	14	100.0	100.0	

Rate the ability of MHC treatment providers to link defendants to medical and financial assistance

medical finace

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Insufficient for all	1	7.1	7.1	7.1
	Sufficient for minority	4	28.6	28.6	35.7
	Sufficient for majority	8	57.1	57.1	92.9
	DK/Not Sure	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Rate the ability of providers to link defendants to appropriate housing.

link housing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Insufficient for all	3	21.4	21.4	21.4
	Sufficient for minority	11	78.6	78.6	100.0
	Total	14	100.0	100.0	

Rate the ability of treatment providers to link to integrated mental health/substance abuse treatment services.

link MH/SA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Insufficient for all	6	42.9	42.9	42.9
	Sufficient for minority	2	14.3	14.3	57.1
	Sufficient for majority	4	28.6	28.6	85.7
	Sufficient for all	1	7.1	7.1	92.9
	DK/Not Sure	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Rate the coordination that takes place (in multiple systems) on behalf of MHC clients.

system coord.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Insufficient for all	1	7.1	7.1	7.1
	Sufficient for minority	7	50.0	50.0	57.1
	Sufficient for majority	5	35.7	35.7	92.9
	DK/Not Sure	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Rate the organizational and contractual structure of the MHC.

structure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	1	7.1	7.1	7.1
	Low to Med	2	14.3	14.3	21.4
	Med to High	5	35.7	35.7	57.1
	High	1	7.1	7.1	64.3
	DK/Not Sure	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Rate the degree to which the MHC has facilitated greater overall linkages between the CJ and MH provider systems.

linkages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	1	7.1	7.1	7.1
	Low to Med	3	21.4	21.4	28.6
	Med to High	5	35.7	35.7	64.3
	High	4	28.6	28.6	92.9
	DK/Not Sure	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Items requesting estimates of percentages and items that utilized continuous, non-categorical rating scales.

	N	Minimum	Maximum	Mean	SD
% Families involved	10	5	75	42.00	22.88
Effectiveness of sanctions*	11	2	5	3.45	.82
% Needing housing	13	25	90	62.31	17.27
% case workers at hearings	5	2	50	17.60	19.31
Communication: Court Monitor**	3	4	5	4.33	.58
Communication: PO	3	4	5	4.33	.58
Communication: Defender SW	3	1	5	2.67	2.08
Communication: P. Defender	3	1	2	1.67	.58
Communication: Prosecutor	3	1	2	1.33	.58
Communication: Jail Staff	3	2	3	2.67	.58
Effectiveness: Monitor***	3	4	5	4.33	.58
Effectiveness: PO	3	4	5	4.33	.58
Effectiveness: Defender SW	3	1	5	3.33	2.08
Effectiveness: P. Defender	3	1	4	2.33	1.53
Effectiveness: Prosecutor	3	1	4	2.33	1.53
Effectiveness: Jail Staff	3	1	4	2.67	1.53

*Sanctions: Effectiveness of sanctions was rated on a scale of 1=not effective to 6=extremely effective.

**The amount of communication with various members of the court was rated by mental health providers on a scale of 1=No Communication to 5=Very Frequent Communication.

*** The effectiveness of communication with various members of the court was rated by mental health providers on a scale of 1=Not Effective to 5=Very Effective.

Appendix E
ANONYMOUS SURVEY

Evaluative Survey

As you likely know, the University of Washington has been contracted by the King County District Court to carry out a process evaluation of the King County District Mental Health Court. IN summary, the evaluation is designed to describe how the Mental Health Court has been implemented since it began, with an eye toward improvement. In order to gain a better understanding of how the Court has been implemented, semi-structured interviews and an evaluative survey will be administered.

Survey Administration Protocol

Please return your survey directly to Henry Richards at the following fax number: 206-937-6358. Your survey will be dealt with anonymously in aggregate with others and will not be identified separately in any report.

Part A

My impression of the mental health court is that it:

1. More efficiently addresses the combined mental health and legal issues in criminal cases (when compared with a non-specialized court).

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

2. Has decreased congestion in the criminal division court dockets.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

3. Has tailored treatment as an alternative to punishment when appropriate.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

4. Has made mental health care more accessible to this special population

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

5. Has provided a proper balance between treatment needs and public safety needs.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

6. Requires reasonable accountability for criminal behavior.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

7. Has enhanced compliance with treatment.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

8. Has increased public safety.

   (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

9. Humanely deals with individual with mental disorders.

   (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

10. Adequately addresses the complex problems of defendants with mental disorders in its courtroom.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

11. Welcomes complexity in its cases.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

12. Overcomes traditional limitations.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

13. Expects innovation.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

14. Has <u>not</u> considered the jail as the focal point for treatment.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

15. Does <u>not</u> promote incarceration as a preferred method for restoring mental health

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

16. Fully utilities the knowledge and experience of the professionals who serve the court.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

17. Recognizes that those with developmental disabilities require individualized attention.

    (N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

18. Recognizes that those with co-occurring substance abuse disorders require individualized attention.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

19. Has demonstrated a commitment to seeking appropriate resources for its defendants with mental illnesses.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

20. Has demonstrated a commitment to forming community alliances to meet the unique needs of its defendants

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

Part B.

1. There is clearly a shared vision among the different primary player in the Mental Health Court.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

2. The Mental Health Court's core staff collaborates effectively together.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

3. The mental Health Court's core staff collaborates effectively with the jail's Psychiatric Evaluation Specialist (PES) staff.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

4. The Mental Health Court's core staff collaborates effectively with the Department of Public Health's Jail Health Services medical staff.

N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

5. The Mental Health Court's staff collaborates effectively with community treatment providers.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

6. The array of community services available to the mental health Court clients is adequate to meet their needs.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

7. The quality of community services provided to the Mental Health Court clients is adequate to meet their needs.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

8. Well-integrated mental health and substance abuse treatment services are readily available to Mental Health Court clients.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

9. Adequate housing is readily available for Mental Health Court clients.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

10. The contracts and agreements related to the operation of the Mental Health Court are adequate to meet its needs.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

11. The overall administration of the Mental Health Court is adequate.

(N) Do not know/not sure (1) Agree (2) Tend to agree (3) Tend to disagree (4) Disagree)

ANONYMOUS SURVEY RESULTS

Anonymous Survey Conducted on April 3, 2000. Informants were 15 individuals involved with the court:

Grouping of anonymous survey informants

	Frequency	Percent
treatment players	1	6.7
jail	6	40.0
MHC staff	8	53.3
Total	15	100.0

The MHC more efficiently addresses the combined mental health and legal issues in criminal cases (when compared with a nonspecialized court).

A1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Agree	9	60.0	60.0	80.0
	Tend to Agree	3	20.0	20.0	100.0
	Total	15	100.0	100.0	

The MHC has decreased congestion in the criminal division court dockets.

A2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	6	40.0	40.0	40.0
	Agree	1	6.7	6.7	46.7
	Tend to Agree	5	33.3	33.3	80.0
	Tend to Disagree	3	20.0	20.0	100.0
	Total	15	100.0	100.0	

The MHC has tailored treatment as an alternative to punishment when appropriate.

A3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	1	6.7	6.7	6.7
	Agree	9	60.0	60.0	66.7
	Tend to Agree	4	26.7	26.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC has made mental health care more accessible to this special population.

A4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	1	6.7	6.7	6.7
	Agree	10	66.7	66.7	73.3
	Tend to Agree	4	26.7	26.7	100.0
	Total	15	100.0	100.0	

The MHC has provided a proper balance between treatment needs and public safety needs.

A5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	7	46.7	46.7	60.0
	Tend to Agree	5	33.3	33.3	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC Requires reasonable accountability for criminal behavior.

A6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	5	33.3	33.3	33.3
	Agree	5	33.3	33.3	66.7
	Tend to Agree	5	33.3	33.3	100.0
	Total	15	100.0	100.0	

The MHC has enhanced compliance with treatment.

A7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Agree	5	33.3	33.3	53.3
	Tend to Agree	6	40.0	40.0	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC has increased public safety.

A8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	5	33.3	33.3	33.3
	Agree	4	26.7	26.7	60.0
	Tend to Agree	4	26.7	26.7	86.7
	Tend to Disagree	2	13.3	13.3	100.0
	Total	15	100.0	100.0	

The MHC humanely deals with individuals with mental disorders.

A9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	10	66.7	66.7	80.0
	Tend to Agree	3	20.0	20.0	100.0
	Total	15	100.0	100.0	

The MHC adequately addresses the complex problems of defendants with mental disorders in the courtroom.

A10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	1	6.7	6.7	6.7
	Agree	3	20.0	20.0	26.7
	Tend to Agree	10	66.7	66.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC welcomes complexity in its cases.

A11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	6	40.0	40.0	53.3
	Tend to Agree	7	46.7	46.7	100.0
	Total	15	100.0	100.0	

The MHC overcomes traditional limitations.

A12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Agree	4	26.7	26.7	46.7
	Tend to Agree	7	46.7	46.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC expects innovation.

A13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	4	26.7	26.7	26.7
	Agree	5	33.3	33.3	60.0
	Tend to Agree	6	40.0	40.0	100.0
	Total	15	100.0	100.0	

The MHC has not considered jail the focal point for treatment.

A14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Agree	9	60.0	60.0	80.0
	Tend to Agree	3	20.0	20.0	100.0
	Total	15	100.0	100.0	

The MHC does not promote incarceration as a preferred method for restoring mental health.

A15

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	8	53.3	53.3	66.7
	Tend to Agree	5	33.3	33.3	100.0
	Total	15	100.0	100.0	

The MHC fully utilizes the knowledge and experience of professionals who serve the court.

A16

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	6	40.0	40.0	53.3
	Tend to Agree	7	46.7	46.7	100.0
	Total	15	100.0	100.0	

The MHC recognizes that those with developmental disabilities require individualized attention.

A17

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	4	26.7	26.7	26.7
	Agree	7	46.7	46.7	73.3
	Tend to Agree	4	26.7	26.7	100.0
	Total	15	100.0	100.0	

The MHC recognizes that those with co-occurring substance abuse disorders require individualized attention.

A18

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	1	6.7	6.7	6.7
	Agree	6	40.0	40.0	46.7
	Tend to Agree	8	53.3	53.3	100.0
	Total	15	100.0	100.0	

The MHC has demonstrated a commitment to seeking appropriate resources for its defendants with mental illnesses.

A19

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	10	66.7	66.7	80.0
	Tend to Agree	3	20.0	20.0	100.0
	Total	15	100.0	100.0	

The MHC has demonstrated a commitment to forming community alliances to meet the unique needs of its defendants.

A20

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	11	1	6.7	6.7	6.7
	DK/Not Sure	3	20.0	20.0	26.7
	Agree	3	20.0	20.0	46.7
	Tend to Agree	7	46.7	46.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

There is clearly a shared vision among the different primary players in the MHC.

B1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	5	33.3	33.3	33.3
	Agree	2	13.3	13.3	46.7
	Tend to Agree	7	46.7	46.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC's core staff collaborates effectively together.

B2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	2	13.3	13.3	26.7
	Tend to Agree	10	66.7	66.7	93.3
	Tend to Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC's core staff collaborates effectively with the jail's Psychiatric Evaluation Specialist (PES) staff.

B4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	4	26.7	26.7	26.7
	Agree	2	13.3	13.3	40.0
	Tend to Agree	5	33.3	33.3	73.3
	Tend to Disagree	3	20.0	20.0	93.3
	Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The MHC's core staff collaborates effectively with community providers.

B5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	4	26.7	26.7	26.7
	Agree	3	20.0	20.0	46.7
	Tend to Agree	8	53.3	53.3	100.0
	Total	15	100.0	100.0	

The array of community services available to the MHC's clients is adequate to meet their needs.

B6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Tend to Agree	4	26.7	26.7	46.7
	Tend to Disagree	3	20.0	20.0	66.7
	Disagree	5	33.3	33.3	100.0
	Total	15	100.0	100.0	

The quality of community services provided to MHC clients is adequate to meet their needs.

B7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Tend to Agree	5	33.3	33.3	53.3
	Tend to Disagree	3	20.0	20.0	73.3
	Disagree	4	26.7	26.7	100.0
	Total	15	100.0	100.0	

Well-integrated mental health and substance abuse treatment services are readily available to MHC clients.

B8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	4	26.7	26.7	26.7
	Agree	1	6.7	6.7	33.3
	Tend to Agree	1	6.7	6.7	40.0
	Tend to Disagree	5	33.3	33.3	73.3
	Disagree	4	26.7	26.7	100.0
	Total	15	100.0	100.0	

Adequate housing is readily available for MHC clients.

B9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	3	20.0	20.0	20.0
	Tend to Agree	1	6.7	6.7	26.7
	Tend to Disagree	3	20.0	20.0	46.7
	Disagree	8	53.3	53.3	100.0
	Total	15	100.0	100.0	

The contracts and agreements related to the operation of the MHC are adequate to meet its needs.

B10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	9	60.0	60.0	60.0
	Agree	1	6.7	6.7	66.7
	Tend to Agree	2	13.3	13.3	80.0
	Tend to Disagree	2	13.3	13.3	93.3
	Disagree	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

The overall administration of the MHC is adequate.

B11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DK/Not Sure	2	13.3	13.3	13.3
	Agree	5	33.3	33.3	46.7
	Tend to Agree	8	53.3	53.3	100.0
	Total	15	100.0	100.0	

Appendix F.

KMHCADSD DATA DICTIONARY ELEMENTS FOR MHC EVALUATION

TTRIBUTE	**TRANSACTION**	**current**	**Pre MHC**	**Post MHC**	**within interval**	**End MHC**	**Spec.**
ducational Status	Activity Status	x	x	x		X	
mployment Status	Activity Status	x	x	x		X	
ther Activity Code	Activity Status	x	x	x		X	
dmint/Discharge Flag	Alcohol Drug Abuse				x		CTU
lcohol or Drug (AOD)	Alcohol Drug Abuse				x		CTU
urrent Intoxication	Alcohol Drug Abuse				x		CTU
ate Last Used	Alcohol Drug Abuse				x		CTU
lonths of Sobriety	Alcohol Drug Abuse				x		CTU
eadiness to Change	Alcohol Drug Abuse				x		CTU
everity	Alcohol Drug Abuse				x		CTU
ate of Assessment	Authorization Request		x	x			
enefit/Program Requested	Authorization Request	x	x	x			
enefit Change Code	Authorization Request				x		
ate of Birth	Client Demographics	x					
thnicity	Client Demographics	x					
ender	Client Demographics	x					
ispanic Origin	Client Demographics	x					
terpreter required	Client Demographics	x					
anguage Code	Client Demographics	x					
exual Minority Status	Client Demographics	x					
iagnosis Axis (I)	Diagnosis	x					
iagnosis Axis (II)	Diagnosis	x					
iagnosis Axis (V) GAF	Diagnosis	x	x			X	
xis Subtype (I)	Diagnosis	x					
xis Subtype (II)	Diagnosis	x					
iagnosis Code (I)	Diagnosis	x					
iagnosis Code (II)	Diagnosis	x					
iagnosis Code (V) GAF	Diagnosis	x	x			X	
dmt/Discharge Flag	HMC Crisis Data Scale		x		x		CTU
MC Scale	HMC Crisis Data Scale		x		x		CTU
ubstance Type	Drug Use History		x		x		CTU
ank of Use	Drug Use History		x		x		CTU
urrent IV Drug Abuse	Drug Use History		x		x		CTU
amily Size	Income Category	x					
come Indicator	Income Category	x	x	x	x	X	

ATTRIBUTE	TRANSACTION	Current	Pre MHC	Post MHC	Within Interval	End MHC	Spec.
CSO Identifier	Medicaid Coverage	x					
Date of Event	Notice of Exit	x	x	x		X	
Reason for Termination/Cancellation	Notice of Exit	x	x	x		X	
Priority Code	Priority	x	x	x		X	
Priority Code	Priority	x	x	x		X	
PSS A Health Status	Problem Severity Summary	x	x	x		X	
PSS B Depressive Symptoms	Problem Severity Summary	x	x	x		X	
PSS C Anxiety Symptoms	Problem Severity Summary	x	x	x		X	
PSS D Psychotic Symptoms	Problem Severity Summary	x	x	x		X	
PSS E Dissoci. Symptoms	Problem Severity Summary	x	x	x		X	
PSS F Cognitive	Problem Severity Summary	x	x	x		X	
PSS G dangerous Behavior	Problem Severity Summary	x	x	x		X	
PSS H Socio-legal	Problem Severity Summary	x	x	x		X	
PSS I Negative Social Beh.	Problem Severity Summary	x	x	x		X	
PSS J Self-Care	Problem Severity Summary	x	x	x		X	
PSS K Community Living	Problem Severity Summary	x	x	x		X	
PSS L Social Withdrawal	Problem Severity Summary	x	x	x		X	
PSS M Response to Stress	Problem Severity Summary	x	x	x		X	
PSS N Sustained Attention	Problem Severity Summary	x	x	x		X	
PSS O Physical	Problem Severity Summary	x	x	x		X	
County Code	Residential Arrangement	x					
Zip Code	Residential Arrangement	x					
Acute Indicator	Service Detail				X		
Minutes of Service Event	Service Detail				X		
Service Code	Service Detail				X		
Service Focus	Service Detail				X		
Service Location	Service Detail				X		
Service Transaction ID	Service Detail				X		
Start Date of Service Episode	Service Detail				X		
Count (Lifetime)	Service System History	x	x	x		X	
Count (Past Year)	Service System History	x	x	x		X	
Service System Type	Service System History	x	x	x		X	
Current/Previous Status	Service System Status	x	x	x		X	
Service System Type	Service System Status	x	x	x		X	
Service Delivery	Triage Services				X		CTU
Service Type	Triage Services				X		CTU

Note: Date specifiers collected for all variables.

Column Key:
Pre-MHC= closest measure prior to MHC referral date. Post MHC= closest measure after six months of participation. Within Interval = captured for every event in the interval from six months prior to MHC referral through current. Spec. = Only applies to events in a specialized program, such as CTU admission.