MENTAL HEALTH COURTS: A THEORY-DRIVEN PROGRAM EVALUATION

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MENTAL HEALTH COURTS: A THEORY-DRIVEN

PROGRAM EVALUATION

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Abstract: Mental Health Courts (MHCs) represent a potential solution to the interconnected social issues of mass incarceration and the criminalization of mental illness. MHC programs remove mentally ill offenders from regular judicial processes and into community-based therapeutic treatment.

The purpose of this research is to evaluate current MHC practices, organization, and environments to uncover variations in program assumptions and determine to what extent and manner MHCs adhere to the *10 Essential Elements of Mental Health Courts* (Thompson, Osher and Tomasini-Joshi 2008). The research uses a mixed-methods study design within a program - theory framework using survey and a collection of relevant MHC documents. Data was analyzed utilizing descriptive statistics and content analysis for a sample of twenty-seven adult MHC programs from eighteen states. Results were used to create program-theory logic models, identify issues, offer insights into the possibility of novel *Essential Elements*, and suggest new evaluation questions and methods for future research.

The research revealed six key findings: 1. MHCs are largely experiencing expansion from predominate emphasis on meeting clinical treatment needs to inclusion of a variety of services/activities aimed to meet identified dynamic criminogenic needs, 2. MHCs do not place as much emphasis on sanctions and incentives as an intervention required for program success as originally assumed, 3. Despite identified evolution in program assumptions and expanded variety of program activities, MHC goals are largely the same as originally outlined in the *Essential Elements*, 4. Client transportation acts as major barrier to program success, 5. The *10 Essential Elements* continue to largely encompass what court teams assume makes a successful MHC, restorative justice, however, may merit future consideration for inclusion, and 6. MHCs largely feel their programs impact the level of social organization in their communities, thus, community-level impacts are a viable source for methodological pursuit in future program evaluation.

This research is significant because it outlines a new method of MHC evaluation. Proper evaluation of the impacts of MHCs is imperative because MHCs have the capacity to promote access to care, diminish fear and stigmatization of the mentally ill, and reduce societal burdens caused by the criminalization of the mentally ill.

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LIST OF ABBREVIATED TERMS

Absent without leave (AWOL)

Affordable Care Act (ACA)

Alcoholics Anonymous (AA)

American Psychological Association (APA)

Bureau of Justice Statistics (BJS)

Continuum of Care (CoC)

Driving while Intoxicated (DWI)

Emergency Solutions Grant (ESG)

Global Positioning System (GPS)

Mental Health Courts (MHCs)

Narcotics Anonymous (NA).

National Alliance of Mental Illness (NAMI)

National Association of Drug Court Professionals (NADCP)

National Institute of Mental Health (NIMH)

Post-Traumatic Stress Disorder (PTSD)

Self-Help groups (SHG)

Substance Use Disorders (SUD)

United States Interagency Council on Homelessness (USICH)

CHAPTER I

INTRODUCTION

Mental health courts (MHCs) are a type of problem-solving diversionary court program that aim to reduce criminal recidivism through proper treatment of offenders with mental illnesses within the community rather than in jails (Almquist and Dodd 2009). These court programs are typically structured as tiered-step programs that include regular judicial interactions, behavior compliance monitoring, and a variety of sanctions and incentives to encourage program mandate compliance. A court team comprised of legal, treatment, and law enforcement professionals monitor program adherence, mental health, and social needs to help connect clients to needed mental and substance abuse treatment, counseling, and a variety of other services assumed to encourage healthy behaviors and reduce criminal involvement.

Problem-solving courts, and more specifically, MHCs arose as a reaction to the overpopulated and underfunded criminal justice system that failed to properly address social problems like drug addictions and mental illness' relationships to crime. Since the 1980s, mental illness became ostensibly "criminalized" and the mentally ill came to encompass a large portion of offenders in jails and prisons (Abramson 1972). Large numbers of offenders in the regular system are mechanically shuffled through the criminal justice system as fast as possible with no regard to the root causes of their criminal behaviors and sanctioned primarily based on structured,

mandatory sentences. Without addressing root causes of criminality, these types of offenders frequently find themselves returning to criminal activity and the justice system time and time again (Denckla and Berman 2001).

MHCs are theoretically purported to work through use two related theories of justice, therapeutic jurisprudence and restorative justice. Therapeutic jurisprudence is a lens by which one can look at the criminal justice system to find and address its "anti-therapeutic" components (Winick and Wexler 1996). MHCs aim to be therapeutic courts that make interactions with the judicial process an experience that promotes positive psychological functioning (Watson, Hanrahan, Luchins and Lurigio 2001). Restorative justice is a related theory used in MHCs. In line with this theory, offenders with mental illness can make amends for their wrong-doing and be re-accepted into the wider community (Garner and Hafemeister 2003).

MHC effectiveness is typically evaluated through process or outcome evaluations. Process evaluations show that MHCs vary in program organization, program structure and available resources, and have evolved over time to accept a wider variety of clients and use different sanctions and incentives (Redlich, Steadman, Monahan, Robbins and Petrila 2006; Griffin, Steadman and Petrila 2002). Outcome evaluations research MHC ability to affect client compliance, cognitive functioning, recidivism rates, and also function cost effectively compared to regular judicial and incarceration processes. Generally, studies indicate positive results when evaluated upon these outcomes (Linhorst and Dirks-Linhorst 2015). Positive initial outcomes facilitated their rapid proliferation in the years following the first MHC, which opened in 1997.

Due to wide variation in program organization, implementation, and resources used in the now nearly 400 MHCs in operation, empirical research struggles to keep up. Recently, researchers began to question whether the reductions in recidivism rates for MHC clients are due to mental health treatment components or other factors (Frank and McGuire 2010). Research has

also not yet addressed MHCs' core assumptions or adherence to the "*Essential Elements of a Mental Health Court*, a guide originally created by key stakeholders and legal scholars to organize creation and implementation of MHCs (Thompson, Osher and Tomasini-Joshi 2008). As MHCs continue to expand in usage across the United States, answers to *why* and *under what conditions* MHCs generate positive outcomes is essential to ensuring continued funding and proliferation of these alternative court programs (Fisler 2015).

MHCs serve as a potentially effective community-based alternative to the counter-productive practice of using overburdened and underfunded jails and prisons as institutional proxies for psychiatric hospitals. Historical analysis of Western society shows a perpetual cycle of growing public fear of the mentally ill, institutionalization of the mentally ill in jails or institutions, limited funding and abysmal treatment of mentally ill in those institutions, society's moral panic against the mistreatment of the mentally ill in the institutions, and deinstitutionalization of the mentally ill without proper knowledge or context for proper reintegration (Foucault 1988; Novella 2010a; Laberge and Morin 1995). Without addressing the fundamental contradiction between society's desire for proper, ethical treatment of the mentally ill within the community and society's fear/stigma of mental illness, society is doomed to repeat this cycle yet again. MHCs' current success in reducing criminal involvement of mentally ill offenders could serve as an end to this unproductive cycle. Therefore we must seek out and understand the principles and assumptions upon which these courts operate and how those assumptions and principles relate to various resources, activities, goals, and community impacts.

The purpose of this research is to evaluate current MHC practices, organization, and environments to uncover the variations in assumptions guiding MHCs and determine to what extent and manner MHCs adhere to the guiding MHC document, the *10 Essential Elements of Mental Health Courts* (Thompson, Osher and Tomasini-Joshi 2008). This research aims to address three core hypotheses related to uncovering MHC assumptions and practices:

1. MHCs vary in their assumptions, goals, and interpretations of the *Essential Elements.*

2. Transportation serves as a necessary MHC resource for program success.

3. MHCs can be evaluated through analysis of community-level impacts

This research utilizes a mixed-methods convergent research design within the framework of a theory-driven program evaluation (Chen 2006). Using survey and related court documents, MHC program theories and practices are identified. This collection of data reveals to what extent differences exist among MHC assumptions of how the program is supposed to work and what goals they aim to achieve. The data also reveals variations in program practices, structure, and interpretation of the *10 Essential Elements*. Results revealed issues encountered by MHCs, informed creation of program-theory logic models, and helped to suggest evaluation questions and methods for future evaluations (Chen 2006; Greene and Caracelli 1997).

As research points to other criminogenic factors being more predictive of criminal recidivism than mental illnesses and suggests program alterations, MHCs must quickly come to understand the specific mechanisms by which their court programs largely produce positive effects (Fisler 2015). I posit that uncovering MHC assumptions and practices is of vital importance to understanding the relationships between practices and outcomes and also ensuring MHC programs are logically structured to best achieve their identified goals. I argue that MHCs reduce recidivism not only by giving clients access to needed mental health treatments, but also by integrating their clients back into the community. MHCs connect clients with peers, promote the reduction of mental illness stigma within the court and the community, and provide essential resources for clients to reintegrate back into pro-social society. Essentially, by putting these clients back into the community- instead of jails and prisons- and giving them the resources they need to succeed in social life, they become more integrated into the community which promotes increased social control and reduced community fears of crime and mental illness. I believe MHC effects like these can be evaluated through community-level impacts.

This research is significant because it outlines a new method of MHC evaluation, identifies common program issues, and offers new suggestions on how to evaluate the impact of MHC programs. Validation of the impact of MHCs is important. MHCs have the capacity to help promote access to care, diminish fear and stigmatization of the mentally ill, and reduce societal burdens caused by the criminalization of the mentally ill.

CHAPTER II

LITERATURE REVIEW

The National Alliance of Mental Illness (NAMI) defines mental illness as “a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning” (National Alliance on Mental Illness 2018). Currently, diagnosable disorders fall into categories related to neurodevelopment cognition, anxiety, mood, stress and trauma, dissociations, somatic symptoms, sleep, conduct, personality, and eating disorders. Mental illnesses vary widely in cause, symptoms and proper treatment.

Societal reaction to the mentally ill cycles through periods of criminalization (Abramson 1972), total institutionalization (Goffman 1961), moral panic over poor treatment and living conditions (Cohen 1972), and deinstitutionalization (Grob 1983). Each phase transition indicates gradual progress towards a rational-legal society that pushes for further logical, scientific understanding of mental illness and appropriate legal decision-making (Weber 1947).

However, progress has not been made without mistakes. Failure to understand the fundamental contradictions and historical contexts upon which previous phases of treatment, rehabilitation, and legal decision-making were made results in conflicts, dilemmas, and ultimately, a lack of solutions to social problems related to mental illness (Chambliss 1979, Grob 1983). Fear and stigma of the mentally ill largely stunts rational progress. The following literature review details the lengthy history of mental illness treatment, social perceptions, legal-decisions, advocacy, and social problems. This history helps us understand the context of the evolution of mental illness and society as to better inform the current MHC movement and avoid previously made mistakes.

MENTAL ILLNESS TREATMENT OVER TIME

While disputed (Porter 1990), Foucault (1998) places the first "Great Confinement" of the mentally ill in Europe during the mid-17th century. He states that lunatics, homeless people, and beggars who could not contribute to the workforce were forcibly put in confinement by police. However, in Europe and America through the mid-19th century, families more often took care of mentally ill family members at home. If family members could not take care of their wards themselves, the town would contract care to community members or the church (Grob 1994). Treatment in this period was nonexistent, even home-based relatives were often locked in rooms (MacDonald, 1981a; 1981b; 1982a; 1982b). Those without care would wind up in jails and poorhouses, frequently naked, unfed, and chained like wild beasts (Osborn 2009; Foucault 1988).

While asylums did exist in Europe in prior centuries, public outcry during the Enlightenment Period resulted in additional asylums. Institutionalization of the insane in asylums was considered the ethical option compared to abusive jails and poorhouses. The first U.S. private institution was the Quaker-ran Pennsylvania Hospital, founded in 1752. The first state-run institution, the Eastern Lunatic Asylum of Virginia began in 1773. Around the same time in Europe, Phillipe Pinel and William Tuke advocated use of private asylums with moral therapy

treatment. Moral therapy included a regular routine and a pleasant environment, typically on the grounds of a physician's private residence. These private psychiatric facilities were a great alternative to the growing abysmal conditions of public psychiatric asylums, but only for those who could afford it (Holtzman 2012).

In 1840, social reformer Dorothea Dix began evaluation of the treatment of the mentally ill in a number of U.S. states, Canada, and Europe. She found overwhelming numbers of cases of abuse, neglect, and mistreatment wherein mentally ill community members were left in jails, poor houses, on the street, or within cages (Dix, 1843). Advocating for creation of state-operated mental asylums based on moral and ethical treatment, she helped create state legislation for thirty-two state-ran psychiatric hospitals. Quickly, however, the growing institutionalized population overburdened the existing asylums. Budgets were slashed, treatment moved from the moral therapy model to basic custodial care, and subsequent abuses proliferated (Grob 1994). The mounting horrific mistreatment of the mentally ill was notably illustrated in Nellie Bly's 1887 scathing exposé of the Women's Lunatic Asylum on Blackwell's Island. Posing as mentally ill, Bly uncovered mistreatment and unpleasant housing conditions experienced by institutionalized women in New York and helped advocate for funding (Bly 1887). By 1890, largely due to Bly's advocacy, each U.S. state had one or more mental institutions.

Over time, families became more willing to place mentally ill family members in institutions. Families also became more reliant on state, and then, later, federal funding to fund costs of care for their ill family members (Mechanic and Grob 2006). Treatment in the early 20th century included the development of psychiatry (known then as "alienism") and Freudian "talking cures". These methods were more frequently delivered to the rich in private mental institutions or home-based therapy sessions. The more egregious forms of treatment available at the time, lobotomies, insulin-induced comas, and electro-shock therapy, were used more commonly among

the lower class within public mental institutions and those with the most symptomatic and disruptive illnesses (Hollingshead and Redlich 2007; Holtzman 2012).

In 1946, spurred by the high number of mental health problems encountered by veterans returning from WWII, Harry Truman signed the National Mental Health Act and created the National Institute of Mental Health (NIMH). The act created legislation to fund assessment, treatment, medication development, and prevention of mental illnesses. By 1955, institutionalization in America reached its apex. Approximately 560,000 individuals resided within public mental hospitals (Mechanic 2014). Mirroring the historical troubles from the prior asylum movement, as patient numbers increased in mental hospitals the quality of care decreased. Once again, the public touted institutions for being overburdened, underfunded, and prolifically mistreating patients. A number of controversial reports harkened upon these issues and various human rights violations (Mechanic and Olfson 2016; Novella 2010b).

Labeling Theory and the Anti-Psychiatry Movement

Sociological studies of mental illness were numerous in the 1950s and 60s. "Labeling theory", which posits that people act in response to labels, or identities, placed upon them, was then at its height in sociological popularity (Lemert 1951; Becker 1963; Erikson 1964). Sociologists tested labeling theory in relation to how mental diagnoses were used as negative labels. Sociologists posed as mentally insane to gain admission to psychiatric hospitals, but, after admission, returned to normative behaviors to expose how doctors perceive anything an institutionalized person does as a symptom of mental illness (Goffman 1961, 1968).

Other sociologists studied public reactions and stereotypes about mental illness. Scheff (1974) found that negative stereotypes of mental illness are formed in childhood and are continuously reaffirmed through social interactions. Scholars studied a variety of negative values, fears, and judgements placed upon people with mental illness (Star 1952; Crocetti, Spiro, and

Siassi 1974; Gove 1982). The public connected characteristics like "unpredictable" and "dangerous" to the mentally ill (Star 1952). Negative stigmas were found attached to wives of institutionalized husbands (Yarrow, Clausen, and Robbins 1955) and psychiatric professionals (Star 1952). Family members denied existence of a loved one's mental illness due to incompatibility of their symptoms to the known mental illness stereotypes (Sampson et al. 1964).

Some anti-psychiatric scholars went as far as to posit that mental illness was a "convenient myth" used to obscure the fact that social life is stressful and problematic. Szasz (1960) said mental illness serves as a socially constructed label. He felt the mentally ill label fit with the growing reliance on science and medicine to explain the world and human behaviors. The medical model of illness gives others the ability to blame human disharmony upon those who deviate from medically defined "normal" societal behaviors (Szasz 1960, 1961).

However, labeling theory, and the "anti-psychiatric" models of mental illness were heavily critiqued. Scholars critiqued labeling theory due to its inability to explain mental illness causation as well as the lack of empirical evidence supporting secondary deviance (Gove 1970). Additionally, major pharmaceutical advances in the mid-1950s created antipsychotic drugs like chlorpromazine, lithium, and reserpine, antidepressants like imipramine, as well as new psychodynamic and psychosocial intervention approaches which showed marked support for the "reality" of mental illness through medical treatment and symptom improvement. Success of new medications also gave hope for the idea of treatment of mentally ill individuals outside the confines of total institutions (Goffman 1961).

Deinstitutionalization

The "community care" model became the overwhelming psychiatric agenda for the mentally ill starting in the mid-1950s. Thanks to new medications, psychological treatment method advancements, and mounting negative press against mental institutions, the

institutionalized population decreased 15% from 1955 to 1965 (Mechanic 2014). By the late 1950s and 60s, state psychiatric institutions were nicknamed “snake pits” due to the known poor quality of facilities, treatment, personnel, prolific abuse, and lack of proper funding (La Fond and Durham 1992).

In response to numerous abuses, President Kennedy signed the Mental Retardation Facilities and Community Health Centers Construction Act of 1963. This act aimed to reduce the number of psychiatric residents within facilities and encourage the closing of numerous state hospitals in favor of therapeutic treatment within communities such as community mental health centers, supervised residential homes, and use of community-based psychiatric teams (Novella 2010a). The goals of the 1963 legislation included a 50% decrease in the institutionalized population by 1973 and creation of a comprehensive community-oriented health care system (Butler and Windle 1977; *Public Law 88-164 (1964*). Concurrent legislation mandated only individuals who posed an imminent threat to themselves and others should be institutionalized. Additionally, Medicare and Medicaid legislation were passed in 1965. The health care services did not federally fund adult mental facility care, but did provide funding for care in general hospitals and nursing homes (Grobb, 1991; 2001). The largest decrease in institutionalized population, 65%, occurred from 1965 to 1985 (Mechanic 2014). About half of the population of the mentally ill from ages 18 to 65 were sent to live with their families in the community (Minkoff 1978) and half of the elderly mentally ill were transferred from psychiatric hospitals to nursing homes (Kiesler and Sibulkin 1987). Most early community mental health facilities focused primarily upon providing psychotherapy to individuals with emotional and personal problems, but not so much on aftercare for those with long term mental illnesses (DeLeon et al 2010).

Loss of the Rehabilitative Ideal

The late 1960s and 1970s saw dramatic shifts in both mental health and criminal justice policies. Fueled by rising crime rates and increased use of law-and-order politics (Blumstein and Beck 2005), the fervor for rehabilitative institutions for criminal offenders declined (Tonry 2005; Garland 2001). Martinson's (1974) pivotal study assessed the outcomes of numerous studies on correctional system rehabilitative measures like intensive supervision, parole, probation, and other community intervention strategies and found limited support for their role in crime prevention. Widely interpreted as "nothing works", the work became the empirical foundation for the shift from a rehabilitative approach to a more punitive, deterrence-based policy system which had rippling effects on the mentally ill.

CHANGES IN CRIMINAL JUSTICE

Mass Incarceration

Crime and incarceration rates rose in the 1970s (Blumstein and Beck 2005). Nixon claimed that welfare strategies perpetuated crime and began the "War on Drugs" (Western 2006). Notable drug laws include the Federal Anti-Drug Abuse Act of 1968, which famously created a 100:1 sentencing disparity between powder and crack cocaine, and the Omnibus Crime Control Rockefeller Drug Laws (Reitz 2011; NRC 2014). Crime rates and prison populations grew to historic highs during this period as crack cocaine entered the black markets and police made increasingly numerous arrests off of mandatory possession charges of drugs and weapons (Dubber 2001).

Tough on Crime legislation enacted since the 1970s, including mandatory minimum sentences, three strikes laws, truth-in-sentencing, and War on Drugs laws had major consequences for America. The most major consequence was the 450% increase in prison population by 2010, with three-quarters of that increase occurring between 1980 and 1995, producing "mass incarceration" (Garland, 2001; Campbell Vogel and Williams 2010). Prison

expansion began in 1972 and continued up through 2002, due mostly to the increase in drug crime incarceration, even as crime rates fell in the 1990s. By 1996, a quarter of all state prisoners were incarcerated due to drug crimes and, as of 2010, the percentage only decreased by about 5.5%. (Zimring and Hawkins 1991; Blumstein 1999; NRC 2014). The most consequential effects fell upon young black men (Petit and Western 2003), but incarcerated women rapidly increased in prevalence, outpacing the growth rate of incarceration for men (Daly 1989; Wakefield and Uggen 2010; NRC 2014). As the War on Drugs created more arrests, prosecutor decisions and plea bargaining became a "prosecution complex" pushing more offenders through the system at an unprecedented rate (Simon 2007).

Shift in Mental Health Policies

The 1970s saw the expansion of the civil rights for the mentally ill that aimed to keep individuals in the least restrictive environments possible and avoid unnecessary civil commitments (Appelbaum 1994; Mechanic et al. 2013). Federal attention was paid to mental health in 1977 when Jimmy Carter signed the President's Commission on Mental Health (DeLeon et al. 2010). The Commission resulted in the passage of the *Mental Health Systems Act* in 1980 which aimed to provide health care and psychotherapy in community settings (Grob, 1994)

By the1980s, a major turn occurred in public opinion towards mental health and the punishment of mentally ill offenders. The turn was due to the shift towards a tough-on-crime rational for punishment, decreased faith in rehabilitation, increased attention to drug use, and an economic downturn in the early 80s. The 1981 *Omnibus Budget Reconciliation Act* repealed many of the aims from the 1980 *Mental Health Systems Act*. Mandates for community health care access that stayed in place were severely federally underfunded due to the recession.

At this time, legislation changed to ensure the mentally ill were held criminally responsible for crimes and expanded allowances for forced psychiatric hospitalizations. Changing

public and political opinion helped to repeal laws related to sexual psychopathology rehabilitation, diminished capacity, and the allowance of post-sentencing extension of sentences for incarcerated individuals with “dangerous” mental illnesses (Lamb and Weinberger 1998).

FAILURE OF THE COMMUNITY MENTAL HEALTH CARE SYSTEM

The goals outlined by the *Mental Retardation Facilities and Community Health Centers Construction Act of 1963* failed in implementation (Dowell and Ciarlo 1983). The NIMH advocated for “comprehensive community support system” in the development of the community mental health centers. They realized that the mental health system could not support the mentally ill on their own. They needed “system linkages” on local, state, and federal levels to facilitate relationships between other social services like transportation, public health, medical care, social services, income maintenance, employment, housing, and vocational rehabilitation (Butler and Windle 1977). Unfortunately, those ideas were not realized due to poor conceptualization of community in program planning, federal oversight, and budget cuts to the NIMH and other federal programs.

In 1977, Comptroller of the General Accounting Office released a study to Congress called *Returning the Mentally Ill to the Community: Government Needs to Do More.* The study found evidence that the community mental health system was not implemented appropriately. They found that some people who could be treated in the community were still residing within institutions. Additionally, evidence was growing that the mentally ill experienced exclusion, neglect, and abuse in the community.

Critics felt that federal lack of the cultural understanding of communities ensured program failure (Hunter and Riger 1986). Federal planners decided to locate community mental health centers in “catchment areas”, geographic locations with populations with 75,000 to 200,000 residents (Butler & Windle 1977). Community mental health centers were often placed

in areas comprised of a variety of racial, ethnic, and cultural groups. In both rural and urban areas, groups did not identify as a singular community, some groups even had histories of non-interaction or conflict. Thus no one group developed a sense of ownership of the community health center. Additionally, the federal oversight and bureaucratization of the centers did not allow for development of community-specific or culturally-targeted programs that best suited the needs of the groups nor allowed for existing community resources to properly collaborate (Heller et al. 1984). Due of a lack of sense of community ownership, when federal funding to the centers was cut in the 1980s, the public did not push for continuation of services paid by local and state funding and taxes (Lamb 1994). Community centers were forced to compete with other social service agencies for limited funding in a period of time marked by the lack of social and political support for public safety net programs (Heller et al 2000). Existing community mental health centers altered primary focus from mental illness to substance abuse treatment. Underfunded treatment centers resulted in less service utilization and poorer quality of care for people who needed long-term care for chronic and severe mental health conditions. The failings of community treatment were due to the lack of proper community planning and community engagement, community resistance to mental health centers due to fear of the mentally ill, and a lack of state-funding for community mental health services. Mentally ill individuals were without treatment and vulnerable within the community.

Research indicates that the deinstitutionalization movement of the mentally ill, legislative changes in civil commitment mandates, (Fulwiler, Grossman, Forbes et al. 1997, Belcher 1988) and the patient rights movement made individuals with mental illness more likely to be out in the community instead of in institutions (Teplin 1984). By 1980, there were approximately only 130,000 individuals residing in psychiatric institutions. The goal of deinstitutionalization was largely achieved. However, community mental health centers that aimed to serve as a more ethical alternative to institutions were underfunded, overcrowded, and available predominately in

unsafe neighborhoods. Zoning laws, regulatory requirements, and public fears of the mentally ill being drawn to community health centers and making communities unsafe prevented their establishment and expansion (Heller et al. 2000).

Growing Fear

By the 1980s, the tough-on-crime rhetoric resonated with Americans. Politicians blamed historical overreliance on social support systems for the growing social problems of homelessness, drug use, and crime (Beckett 1997; Jacobs and Jackson 2010). Fear of crime was a successful tactic perpetuated by the media and used by politicians to garner major support for legislative changes in the criminal justice system (Scheingold 2011; Simon 2007). These same fear tactics linking mental illness and various social problems were used to affect changes in legislation specifically dealing with the mentally ill.

Due to deinstitutionalization, the mentally ill were exposed within communities. Then, the failings of the community mental health initiatives ensured lack of proper treatment and increased symptomology of the mentally ill, making them more likely to get arrested (Teplin 1984; 1991). The mentally ill, more vulnerable to economic downturns, were hit hard by 1981 economic recession. More ended up homeless and thus even more unable to afford or access treatment, medications, and insurance. Frequently homeless and untreated, these individuals were then even more exposed to the public eye, especially in urban areas. Televised accounts of urban crime, riots, and victimization (Simon 2007) coupled with negative and violent depictions of the mentally ill in the media perpetuated public fears and stigma (Wahl 1997).

Studies since the 1950s find that the public generally fears the mentally ill (Starr 1952) and associates violence with mental illness, especially in discussions of psychosis (Phelan, Link, Stueve and Pescosolido 2000; Phelan and Link 1998; Steadman 1981; Corrigan and Watson 2002; Wahl 1997; Wahl 1987; Link, Phelan, Bresnahan et al. 1999). Despite increased scientific

understanding and broadening definitions of mental illness over time, evidence shows that fear of the mentally ill as perpetrators of crime has only increased (Phelan and Link 1998; Martin, Pescosolido, and Tuch, 2000).

The public assumption that the majority of homeless people are mentally ill (Lee, Jones, and Lewis 1990; Arumi et al. 2007) and that the mentally ill homeless are dangerous (Snow 2013; Struening, Moore, Link, et al 1992) furthers the lack of access to and use of mental health treatment for homeless individuals due to multiple sources of stigma (Corrigan, Druss and Perlick 2014). In one qualitative study, homeless individuals seeking mental health care were denied services due to service providers assuming they were faking symptoms to gain housing on a cold night (Bhui, Shanahan, and Harding, 2006). Public fears about mental illness, homelessness, assumptions of dangerousness, and fear of crime coalesced with a general tough-on-crime rhetoric, loss of trust in rehabilitative treatment measures, and economic downturn to create a perfect setup for tough-on-mental illness changes in legislation. Tolerance for the mentally ill in the community was low and desire for punishment among the public and politicians was high (Lamb and Weinberger 1998). During the Neoconservative era of the early 1980s, public opinion swayed to believe treatment, of any sort, was not to be funded or tolerated for criminals, mentally ill or not (Fond and Durham 1992; Lamb and Weinberger 1998). People believed mental illness and the insanity defense were being abused so that offenders could avoid incarceration (Petersilia 1987; Perr 1985; Johnson 1985).

Homelessness

Deinstitutionalization and the lack of community treatment options, compounded with the early 1980s economic downturn, lack of affordable housing, and other anti-welfare policies, ensuring many mentally ill individuals became homeless. Homelessness was estimated to affect 500,000-600,000 individuals on any given night in the U.S. in March of 1987 (Burt and Cohen 1989a). Approximately 20 to 25% of homeless individuals in America suffer from a severe

mental illness compared to 6% of the general population (National Institute of Mental Health 2009).

Despite the improvement of the economy by 1983, the issue of homelessness did not improve. Between the 1980s and 1990s, chronic homelessness caught the attention of Americans as a societal problem. Chronic homeless is defined as "an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months" (U.S. Department of Housing and Urban Development 2017). As of January 2017, 24% (86,962 of 369,081) of surveyed homeless individuals experience a chronic form of homelessness (The U.S. Department of Housing and Urban Development 2017).

Research shows that a major majority of those who experience chronic homelessness overwhelmingly suffer from mental and physical disabilities as well as substance use issues, making them a difficult and expensive population to provide services to and get out of cycles of homelessness. Stressors like uncertainty, victimization, and rape encountered by people who are homeless serve to trigger onsets of mental illness, worsen symptoms, facilitate substance dependencies, creating increased difficulties for homeless individuals who are more likely to experience longer and more frequent stretches of homelessness and experience more problems during episodes of homelessness (Lippert and Lee 2015).

Out of 549,900 homeless individuals interviewed in 2016, an estimated 202,297 people also experience a severe mental illness or a chronic substance use disorder (Annual Homelessness Assessment Report 2017). Other studies confirm high rates self-reported abuse of drugs and/or alcohol amongst the homeless (Burt, Aron, and Valente 2001; Wright, Rubin, and Devine 1998; Johnson et al. 1997). Chronically homeless individuals cycle in and out of emergency rooms, inpatient beds, detox programs, jails, and psychiatric institutions, and can each cost tax payers

between $30,000 to $50,0000 annually (United States Interagency Council on Homelessness, 2017).

Recent legislation aimed at ending homelessness began with the *McKinney–Vento Homeless Assistance Act of 1987*. The Act federally funds homeless shelter programs, the Continuum of Care (CoC) program and the Emergency Solutions Grant (ESG) and helped begin what is now known as the United States Interagency Council on Homelessness (USICH). The USICH produced the first federal strategic plan to end homelessness in 2010 with goals of ending homelessness. The plan has been amended and rereleased in 2012 and 2015. President Obama cited budget concerns as the underlying reason for pushing back the goal of ending chronic homelessness from 2016 to 2017. Despite an 18% decrease in the overall number of the chronically homeless since 2010, the goal is still unmet (USHUD 2017).

Access to Health Care

Those with mental illnesses are less likely to be able to afford health care, treatment, and preventative care for both mental and physical disorders. Even if they do receive treatment, people with mental illnesses tend to receive less and lower quality treatment and be subject to stigmatization while interacting with health care providers (Corrigan, Druss and Perlick, 2014; Mechanic 2002; 2008). Additionally, negative internalized mental illness stigmas discourage help-seeking and treatment utilization by those with mental illnesses, especially among racial minority groups who face additional cultural stigmas and different conceptualizations of mental illness and treatments (Clement, Schauman, Graham, et al. 2015; Schomerus and Angermeyer 2008; Corrigan, 2004; Snowden and Cheung 1990; Conner, Copeland, Grote, Koeske, Rosen, Reynold and Brown 2010).

People with serious mental health problems such as, schizophrenia, bipolar disorder, schizoaffective disorder, and major depressive disorder have drastically higher morbidity and

mortality rates linked to physical health problems than individuals with the same physical health problems without mental illnesses even in countries where the healthcare system is considered good (Hert, Correll, Bobes, Cetkovich-Bakmas, Cohen, Asai, Detraux, Gautam, Möller, Ndetei, Newcomer, Uwakwe, Leucht 2011). These disparities are linked to problems of accessing health care, properly utilizing health care, and lack of quality care from health care providers. Disparities are also linked to the negative side-effects of psychotropic medications and risky lifestyle factors (Hert, Crrell, Bobes, et al. 2011). Doctors are found to misattribute physical health symptoms to mental illness and fail to provide needed physical health services (Jones, Howard, and Thornicroft 2008). Stigma felt from healthcare providers and lack of interconnected mental health and physical health services can also produce inequalities in access and quality of care (Lawrence and Kisely 2010).

Racial and socioeconomic disparities impact access to mental health treatment and quality. African Americans are found to suffer a greater "disease burden from mental illness" (Patient Protection and Affordable Care Act 2010). African Americans, especially older African Americans, are less likely to receive treatment for mental illness, more likely to undergo emergency psychiatric hospitalization, and more likely to receive less quality treatment compared to white Americans (Office of the Surgeon General 2001). Racial and mental health discrimination occurring during experiences of mental health and substance abuse treatment impede desire for further treatment and can ultimately impact health outcomes (Mays, Jones, Delany-Brumsey, Coles and Cochran 2017).

Mental Health Care and Insurance

The lack of available and affordable health care for mental health services is cited as an underlying issue for the over-representation of individuals with mental illnesses in the criminal justice system. Those without insurance are more ill, receive less quality care and die at a younger age (McWilliams 2009). Individuals with mental illnesses are less likely to be insured than those

without a mental illness (McAlpine and Mechanic 2000; Garfield, Zuvekas, Lave, and Donohue 2011)

Quadagno (2004) aimed to understand why America has been historically so resistant to health care reform and universal health insurance coverage citing "American exceptionalism", Anti-statist values, fear of the government (Jacobs 1993), diffusion of political authority (Steinmo and Watts 1995; Hacker 1998), lack of organization of the labor-based political parties and the working class (Navarro 1989), and the organized oppositional interests of physicians and political groups like the American Medical Association (Poen 1979). These interest groups and cultural values worked together to ensure any healthcare reform legislation was either not passed or resulted in federal action that created an increasingly bloated market-based, commercial insurance industry (Quadagno 2004).

The *Emergency Medical Treatment and Active Labor Act of 1986* aimed to ensure that patients without insurance would still be treated, but the Act is criticized for its lack of instituted funding for the policy mandate. From 1993 to 2003, there was a 26% increase in emergency room visits by the uninsured and the closure of 425 emergency departments and trauma centers due to underfunding (Garcia, Bernstein and Bush 2010). The population frequenting emergency rooms and trauma centers was increasingly comprised of those with mental illnesses and substance use disorders. For example, from 2006 to 2013, there were increases of 55.5% in emergency department visits for depression, anxiety or stress reactions, 52% for psychoses or bipolar disorders, and 37% for substance use disorders (Weiss, Barrett, Heslin, and Stocks 2006). Homeless individuals with mental illnesses and substance use disorders are very prevalent amongst the uninsured and frequent emergency room visitors (Cheung, Somers, Moniruzzaman, Patterson, Frankish, Krausz and Palepu 2015; Kushel, Vittinghoff , Haas 2001; Kushel, Perry, Bangsberg, Clark , Moss 2002). Most of the increases in emergency care visits come from predominately low-income populations. Many visits could have been avoided with proper

outpatient care. Between 2006 and 2013, the discrepancy between uninsured patients and patients with private insurance decreased, while use of Medicaid and Medicare increased (Weiss, Barrett, Heslin, and Stocks 2016), perhaps thanks to legislation expanding Medicare programs like the 1988 Medicare Catastrophic Coverage Act, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the 2003 Medicare prescription drug benefit. However, in the early 2000s, about 1/6th of the population was still without health insurance (Quadagno 2004).

The Mental Health Parity Act of 1996, which banned caps on mental health care services that exceeded general medical care costs, was expanded in the passage of the *Mental Health Parity and Addiction Equity Act of 2008*. This Act mandated equal benefits coverage for mental health and substance use disorders as for medical or surgical benefits for group health plans with more than 50 employees. Despite fears, there have not been any statistically significant increases in health care expenditures and better mental health and substance use benefits can serve to reduce out of pocket spending (McConnell Gast, Ridgely, Wallace, Jacuzzi, Rieckmann, McFarland, McCarty 2012).

The *Mental Health Parity and Addiction Equity Act of 2008* was further expanded in the *Affordable Care Act* (ACA) of 2010. The 2010 Act mandated not only that equal mental and physical health benefits coverage be offered by private insurers, but also by federal insurers like Medicare and Medicaid. The ACA also extended Medicaid coverage to apply to individuals whose annual income fell below 133% of the poverty line. In 2010, 24.1% of the community-dwelling, nonelderly adult Medicaid beneficiaries had a mental disorder (Garfield, Zuvekas, Lave, and Donohue 2011). The ACA aimed to extend reach of insurance coverage to an estimated 3.7 million additional individuals with mental health issues and cover traditionally uncovered services like comprehensive care management, care coordination, social support, transition care, collaborative care, and other evidence-based interventions (Mechanic and McAlpine 2010). During the first round of ACA legislated expansion in 2013-2014, 7.3 million people obtained

insurance (Pear 2014). The largest demographic increase in insured individuals were African American and Hispanic minorities, young adults, rural dwellers, and those from the lowest SES backgrounds (Quealy and Sanger-Katz 2014). Homeless individuals with severe mental illnesses enrolled in ACA were found to have increased use of outpatient mental health services, more days in housing, and higher reported quality of life (Gilmer et al. 2010; Mechanic and Olfson 2016).

Following the 2014 ACA expansion, Medicaid-based insurance coverage and mental health treatment increased, but substance treatment did not increase among adults with mental and substance use disorders (Saloner, Bandara, Bachhuber, and Barry 2017). Increasing the treatment rate and service utilization is still a primary concern for the ACA. Research is working towards identifying and solving issues of insurance acquisition and service under-utilization amongst predominately minority and low-income individuals (Thomas and Snowden, 2001; Snowden, 2012). Additionally issues of poorer quality services, lack of treatment providers for specialized services, and a lack of culturally and ethnically sensitive treatment options in both general and behavioral health treatment for low-income, minority folks needs to be addressed (Adepoju, Preston, and Gonzales 2015; Mechanic and Olfson 2016). So far, 27 states and the District of Columbia have expanded Medicaid services under ACA legislation, however, advocates fear that states that chose to not expand Medicaid services will fall even further behind in services, treatment, and health outcomes for low-income, minority individuals without access to insurance.

To date, more than 20 million Americans acquired health insurance after the passage of the ACA. In 2017, 8.8 million customers signed up for ACA insurance coverage by the December deadline, only a slight decrease in coverage from 9.2 million in 2016 despite new cuts touted by current president Donald Trump. Trump claims to desire to revoke ACA legislation, but, so far, the ACA has only seen shortened length of enrollment periods, reduced outreach and advertising

budgets, and legislation passed that repeal fines imposed on uninsured individuals which starts in 2019 (Mangan 2017; Sommers, Gawande and Baiker 2017). At this point, it is unclear whether estimates of 1.15 million new users of mental health services will be achieved by the original 2019 full ACA implementation date or whether lack of presidential and legislative support, changes in the program, and lack of state expansion will severely alter both insurance coverage and health outcomes.

THE CRIMINAL JUSTICE SYSTEM AND MENTAL ILLNESS

The Criminalization of Mental Illness

The "criminalization of mental illness" describes the theory that individuals who would historically have been treated in mental institutions or community health centers are now more likely to wind up in the criminal justice system (Abramson 1972). Although disputed (Steadman and Ribner 1980; Teplin 1983; Hiday and Moloney 2014), most scholars find growing evidence that jails and prisons have recently serve as new mental hospitals for individuals with mental health issues due to their overrepresentation within the jail and prison populations (Lamb and Weinberger, 1998; Teplin, 1990; Teplin, Abram, and McClelland, 1996; Blumstein and Beck 1999). Individuals with severe mental illness are more likely to be incarcerated than hospitalized (Morrissey, Meyer, and Cuddeback 2007; Hafemeister and George 2012).

Legal scholar Donald Black (1977) says as one social control institution loses its socialization power, other institutions must assert more power to control behaviors. State psychiatric hospital beds had decreased from 339 per 100,000 citizens in 1955 to 22 per 100,000 in 2000 (Lamb and Weinberger 2005). I assert that moral panic over mistreatment and abuse facilitated the shift of the socially undesirable, mentally ill population first from jails and poorhouses to asylums, then from asylums to mental health institutions, next from mental health institutions to community mental health care, and most recently, from community health care

back to jails and prisons. Laws are used to enforce social control over this population and facilitate the shift from one total institution to the next.

Sociologists examine laws from a social control perspective to discuss how certain victimless crimes are used by the government to assert control over socially undesirable individuals and put them in jails and prisons. Although disputed (Adler 1989), Chambliss (1964) depicts early vagrancy laws as a method of social control of the underclass. He states that drug and weapon possession charges, and their related policing methods, give police the legal authority to remove these people from the general population. While drug and weapons laws continued to grow during this time as well, the 1980s saw laws shift to also heavily criminalize behaviors of the homeless (Amster 2003) as well as the behaviors of the mentally ill (Abramson 1972).

Without treatment, mentally ill individuals are susceptible to crime perpetration and often find themselves in the criminal justice system (Lamb et al. 1998; Lamb and Weinberger 2001; Sigurdson 2000; Perez, Leifman and Estrada 2003). Chances of arrest and incarceration are only further multiplied when paired with tough-on-crime policies, War-on-Drugs legislation, reduced sentencing discretion, and shifts to proactive policing styles (Simon 2007; Walker 1993; Wilson 1978). Mentally ill individuals are often found homeless and unemployed. Employing negative coping methods like drugs and alcohol abuse due to inability to access proper medications and treatment for mental disorders (Draine, Salzer, Dennis, Culhane, and Hadley 2002; Abram and Teplin 1991; Kessle, Nelson, McGonagle, Edlund, Frank and Leaf 1996). What follows is that many individuals with mental illnesses are picked up for low-level, non-violent charges like drug possession, loitering, vagrancy, petty theft, and other public nuisance violations. Drug possession and trafficking are commonly the most serious offenses among inmates with mental illnesses, accounting for more than half of inmates in federal prisons (James and Glaze 2006).

Thanks to the criminalization of homelessness (Amster 2003), the mentally ill homeless population is additionally vulnerable to being picked up by police and charged with violations due to their exposure within the community and to the police (Kupers 1999). In 1998, mentally ill state prison inmates were more than twice as likely to experience homelessness the year prior to arrest than those incarcerated without a mental illness (Ditton 1998).

Mental Health and Violence

The media and legal system promotes fear through the false idea that *all* individuals with mental illness are violent. A larger overall percentage of *severely* mentally ill individuals do commit a higher rate of violent acts compared to the overall non-mentally ill population (Silver and Teasdale 2005; Swanson 1993; Swanson, Holzer, Ganju 1990), but only a small percentage of severely mentally ill individuals commit such violent crimes (Fazel and Grann 2006; Corrigan and Watson 2005). Individuals with co-occurring diagnoses and substance abuse issues are the most likely to commit violent acts within the mentally ill violent population. For example, Silver and Teasdale (2005) found that individuals with a substance use disorder had higher rates of violence (19.2%) than those with a major mental disorder (8.3%). Those with minor mental disorders had rates of violence (2.2%) comparable to those without any mental disorders (2.1%) (N= 3,438). Gun violence, although commonly attributed to mental illness, is largely due to other factors (Swanson, Holzer, Ganju, and Jono 1990). Counter to common conceptions, severely mentally ill individuals are much more likely to be victim of violent crime than the general public (Teplin, McClelland, Abram and Weiner 2005). Additionally, other factors like age and gender are more found to be more predictive of violent acts than mental illness (Corrigan and Watson 2005). However, a large proportion, 52.9%, of the quarter million mentally ill in prisons in 1998 were incarcerated for a violent offence (Ditton 1999).

Police and the Mentally Ill

Violent or not, behaviors of the mentally ill are frequently construed as illegal, disruptive, and dangerous. These associations promote fear among the populace who respond with increased calls for police intervention (Bonovitz and Bonovitz 1981; Menzies 1987; Teplin and Pruett 1992). Changes in policing style from order maintenance to law enforcement that took place during the War-on-Drugs movement ensured police encountered more mentally ill people and had less discretion in their decisions of formal or informal intervention (Goldstein and Hill 1990; Skolnick and Bayley, 1988; Wilson and Kelling 1982; Simon 2007; Wilson 1978) Also, in dealing with this population, law enforcement came to believe that placement of disruptive, mentally ill individuals into jails and prisons was a quicker, more efficient alternative than the mental health system in its then current state (Lamb, Weinberger and Gross 2004; Laberge and, Morin 1995; Jemelka, Trupin, and Chiles 1989). Some scholars found evidence of "mercy booking" of the mentally ill for issues that did not typically merit arrest so they might find some treatment within the confines of the criminal justice system (Lamb and Weinberger, 1998:488). Though the idea is subject to debate (Engel and Silver 2001), police are more likely to arrest those who show signs of mental illness than not (Hafemeister and George 2012; Teplin 1984). The mentally ill are more likely to be arrested multiple times (Steadman Vanderwyst and Ribner 1978; Ditton 1999) and 40% come into contact with the criminal justice system every year (Kim 2015; Hafemeister and George 2012).

Mental Illness in Jails and Prison

Deinstitutionalization of the mentally ill has not been attributed as the sole cause of mass incarceration (Steadman et al. 1984), but it, coupled with a lack of community mental health alternatives and legislative changes, set the stage for the criminalization of mental illness. By 2000, there were more mentally ill individuals in jails and prisons than in state hospitals (Sigurdson 2000). Estimates of up to 20% of inmates had a mental health disorder (Walsh and

Holt 1999; Ditton 1999); 75% of the mentally disordered also suffered a co-occurring substance disorder (Steadman et al., 1999). Less than half of inmates suffering from mental illnesses and co-occurring substance issues received treatment while incarcerated (Teplin, Abram, and McClelland 1997; Veysey, Steadman, Morrissey, and Johnsen 1997, Walsh and Holt 1999; Perez, Leifman and Estrada 2003).

In 2006, the BJS found that over half of jail and prison inmates had some form of mental illness (James and Glaze 2006). The most recent BJS estimates from 2011-2012 estimated that nationally, 26% of jail inmates and 14% of prisoners met the threshold for serious psychological distress in the past 30 days of the study. Major depressive disorder was the most common disorder among previously diagnosed mentally ill prisoners (24%) and jail inmates (31%) (Bronson and Berzofsky 2017; Fuller Sinclair and Snook 2016). While Americans with schizophrenia and severe bipolar disorder combined make up approximately 3% of the population, they make up estimates as high as 20% of jail and 15% of prison inmates with 7.2% of males and 15.6% of females in state prisons' solitary confinement (Association of State Correctional Administrators and The Arthur Liman Public Interest Program 2016: Torrey, Zdanowicz, Kennard, Lamb, Eslinger, Biasotti, and Fuller 2014; Fuller, Sinclair and Snook 2016). It is known that the mentally ill spend more time in jail (Ditton 1999), are less likely to earn probation (Steinberg Mills and Romano 2015), recidivate sooner and more often than their non-mentally ill counterparts, (Feder 1991, Wilson, Draine, Hadley, Metraux, Evans 2011; Bales, Nadel, Reed and Blomberg 2017) and typically return due to parole violations or other low-level offenses (Lovell, Gagliardi and Peterson 2002). However, data is still difficult to collect on service utilization and costs. Room for improvement exists in assessment measures for high needs populations and improving communication between local jurisdictions, state, and federal jails, and prisons to get more accurate accounts of mental illness, costs, and treatments (Fuller, Sinclair and Snook 2017).

Problems in Prison

Scholars hypothesize to what extent rates of mental illness diagnoses increased due to increasing ability to diagnose a large range of mental health conditions (Lamb and Weinberger, 1998) and to what extent increasing numbers of mentally ill individuals in jails and prisons could also be due to the issues that deteriorate mental health and aggravate existing mental health conditions. Approximately, one in five incarcerated people have a mental health problem. However, a third of jail inmates and about half of inmates in federal prisons do not receive treatment (Bronson and Berzofsky 2017).

Due to mass incarceration rates, prisons are overcrowded and housing conditions are frequently poor. Overcrowding reached its peak in jails in 2007 at 95% average operating capacity. By 2016, jails operated at 80% operating capacity (Zeng 2018). Federal prisons reached peak incarceration rate in 1997 at 450 prisoners per 100,000 U.S. residents (Gilliard and Beck 1998). By 1998, federal prisons averaged operation at 27% above capacity. By 2016, fourteen state and some federal prisons were operating at or over facility capacity and 27 state and federal prisons had more prisoners than beds (Carson 2018). Overcrowding is stressful and the possibility of negative interaction with violent inmates perpetuates anxieties over future attacks (Haney 2006). Traumatic experiences like rape, suicide, and exposure to communicable diseases are prevalent among this population (Kupers 1999; Travis 2005). The stress process literature says that stress and stigma can contribute to negative mental and physical health problems (Pearlin 2013; Thoits 2010). Minorities face additional stressors of racism and increased stigma both inside and outside the prison contributing to health issues (Wakefeld and Uggen 2010).

Disorderly mentally ill inmates become troublesome for correctional personnel as well as for their incarcerated cohorts (Gibbs 1983). Disciplinary issues occur frequently among mentally ill inmates (Ditton 1999). An uncooperative inmate who refuses to leave his cell may be subject to “cell extractions” which are forcible, frequently violent interventions with correctional staff to

remove the uncompliant inmate from their cell (Kupers and Touch 1999). Medicated inmates may be doubly punished due to medication's side-effects. Some medications cause slow response time. In cases where the inmates are demanded to drop to the floor or comply with other orders, a slow response time could result in a Tasing or physical intervention. Some antidepressant and psychotropic medications also lower the ability of a body to withstand electric shock, so a Tasing could cause seizures (Pisani, Oteri, Costa, Di Raimondo, Di Perri 2002) or death (White and Ready 2009).

As a problematic population in jail, mentally ill inmates are also frequently subject to solitary confinement as a safety or punitive measure. The negative effects of even short stays in solitary confinement on psychiatric and psychological health have been overwhelmingly confirmed (Smith 2006). Regardless of whether a person is diagnosed mentally ill prior to confinement, one's mental health deteriorates in solitary confinement thereby increasing the likelihood of future disruptive behaviors meriting placement in solitary confinement yet again. "[Solitary confinement] was first used in the United States in the early 18th century, but was abandoned, only to be reborn in the "law and order" era of the 1980s, when rehabilitation ceased to be an active goal of corrections." Today, approximately 80,000 individuals in the U.S. are in solitary confinement at any point in time (Shelton 2018).

The Texas case of *Ruiz v. Estell* (1980) states that overcrowding, abuse by correctional officers, and lack of mental health care is a violation of inmates' 8th amendment protections against cruel and unusual punishment. The case mandated standards of mental health care in correctional facilities and initiated the *Congressional Prison Litigation Reform* in 1996 to limit increasing litigation brought forth by inmates. *Jones v. Bock* (2007) helped to decrease the difficulty for inmates to bring suit against mistreatment in prison. Regardless of mandated standards of mental health care in the criminal justice system, medical, mental, and drug issues that exist prior to incarceration may be made worse by a stay in prison and ultimately contribute

to recidivism (Travis, Western, Redburn 2014). Psychiatric problems intensified or worsened by prison stay creates "revolving door phenomenon" whereby mentally ill offenders return to prison again and again (Hafemeister and George 2012).

THE NEED FOR ALTERNATIVES

The mentally ill experience more numerous and frequent social problems before and after incarceration. Mental illness serves to cause and/or exacerbate concurrent issues faced by those with mental illness and increase likelihood of arrest. These risk factors include: low education, foster home involvement, childhood abuse, sexual abuse, unemployment, homelessness, minority status drug use, poverty, and low levels of prosocial attachments (Kessler, Foster, Saunders el al. 1995; James and Glaze 2006; Bonta, Kaw, Hanson 1998; Greenberg and Rosenheck 2008; Fisher et al. 2006**).** The stress and trauma related to experiencing these types of social issues are linked to decrease in self-efficacy and coping resources which, in turn, can increase the likelihood of developing a mental illness and increased symptomology of mental illnesses (Thoits 2010). Essentially, these issues cumulate disadvantage in a reciprocal manner that makes both mental illness and social problems harder to deal with and increase likelihood of initial and subsequent arrest.

America now incarcerates more people than any other country. The tough-on-crime policies, drug laws, and resultant system of mass incarceration have become critical issues that need to be addressed. Imprisonment of those who commit minor infractions impacted American incarceration rates and largely helped to sweep up mentally ill offenders into the imprisoned heap. We have largely come to understand that many of our incarceration policies are harmful. Evidence has shown that prisons and jails as institution of choice for mentally ill offenders are unethical due to lack of treatment, abuse, and rehabilitative assistance. We find ourselves, once again, in moral outrage and panic, against a total institution holding the mentally ill. Jails and prisons are unable to support the sheer amount of offenders it contains, let alone afford and

provide proper treatment for the mentally ill and reduce recidivism. We now look to find alternatives to incarceration for a variety of offenders to help stem the tide of mass incarceration and the inability of jails and prisons to act as the newest form of institutionalization for the mentally ill. However, we are doomed to repeat the cycle if society's treatment of the mentally ill does not learn from our history of ill-informed policies and implementation failures.

Problem-solving courts

The problem-solving court movement arose as a potential solution to the problems created from the tough-on-crime criminal justice strategies seen since the 70s. By the time the first problem-solving court, a drug court, opened in 1989, police reported nearly 1.5 million drug offences to the FBI (McCoy 2003; Wilson, Mitchell MacKensie 2006). A great portion of these offenders were low-level, non-violent drug offenders who repeatedly cycled through the "revolving door of justice" (Deckla and Bermen 2001). Through mandatory sentences and other sentencing guidelines, judges moved large numbers of offenders through the sentencing process, but little attention was paid to underlying needs and addiction issues. "The McDonaldization of Justice" plays a fundamental roll in high recidivism rates for low-level offenders (Berman 2000; Ritzer 1983).

Problem-solving courts used mounting evidence that traditional courts processes and jail produced anti-therapeutic, even criminogenic, responses due to stigmatizing criminal labels that pressure individuals towards deviant subcultures. To avoid disintegrative shaming, problem-solving courts give second chances to conceptually rational offenders who can learn from mistakes, be given resources to make needed changes, and successfully reintegrate into society through rehabilitation and individualized justice. The court program does not undermine the law, but rather, uses the law to promote successful societal reintegration (Braithwaite 1989).

The problem-solving court model is typically structured as a tiered-step program. Clients progress through an individualized treatment plan including a variety of treatment and counseling services, restricted and mandated behaviors, community engagements, and frequent interactions with court team members (Berman and Feinblatt 2001). The problem-solving court team is made up of judicial actors, law enforcement, counselors, and program managers who collaborate to oversee clients' program progress. Counter to traditional adversarial court roles that quickly apply standardized forms of punishments to deter and incapacitate deviants, the judge and the court team get to know individual client to encourage social control through individualized punishments and rewards. The core team member is the judge (Castellano 2011). Problem-solving court judges are tasked with dual roles of coach and traditional judge (Wales, Hiday, Ray 2010). While judges promote adherence to program mandates through the power to apply formal punishments, problem-solving court judges can also facilitate compliance informally by building relationships. Judges may act as disappointed parents, moralizing social control through the process of reintegrative shaming (Braithwaite 1989). The noncompliant client feels shame for disappointing the judge who took an interest in their wellbeing. The client desires to earn back their approval. This dual role is further enhanced by the court team who can use these same formal and informal control mechanisms to build relationships, encourage compliance, closely monitor behaviors, and recommend the fairest punishments, mandates, and rewards to the judge (Erickson et al 2006).

Problem-solving court program mandates start off very strict. Clients must agree to frequent court visits, treatment and counseling appointments, drug tests, surveillance mechanisms, and court orders against certain social interactions. Restrictions are placed against meeting with certain people, places, and times if the court team deems them interactions that likely promote deviance, e.g. curfews and restrictions against bars and liquor stores (Ray 2014).

Bolstered by developing psychological and addiction research, relapse was viewed as a normative part of recovery, mistakes and drug use do not automatically trigger program dismissal and return to traditional judicial processes (Hora, Schma and Rosenthal 1998). However, to promote deterrence, sanctions become more severe as offenses are repeated. Sanctions also increase in severity as clients' progress to higher program levels because high-level clients are considered more capable of rational choices against deviant behaviors. Sanctions vary. They typically take graduated forms of severity, and might include (but are not limited to): stalled program progression, increased supervision methods (e.g. alcohol or GPS monitors), additional interactions with court team (Redlich, Hoover, Summers and Steadman 2010), community service, jail time, or program dismissal (Griffin, Steadman, Petrila 2002).

Additionally, the program can mandate attendance in vocational and/or educational programs, children and family counseling, and community service events to promote reintegration into society. These mandates are based off the idea that reducing contact with negative social networks and promoting pro-social ones additionally encourages social control through informal social networks and helps facilitate successful reintegration into society post program completion (Erickson, Campbell, Lamberti 2006). As clients show successful progress, externally applied mandates and control mechanisms frequently applied because adherence is thought to be better internalized. However, if clients do not follow the guidelines, more severe controls are applied as sanctions (Steadman et al. 2011).

Finally, rewards are doled out on a graduated basis. As clients progress in the program, they earn rewards, some tangible and some in the form of less restrictions (Griffin, Steadman Petrila 2002). The ultimate reward is program completion that might include sentence revocation or reduction. Program lengths vary widely and completion time is highly dependent on each individual client. Graduates of the program are often rewarded with a ceremony to mark their successful reintegration back into society.

Drug Courts

The first problem-solving court, a drug court, opened in 1989 in Dade County Florida. Drug courts aim to help divert drug offenders away from the already overburdened prison system and into effective treatment for drug and alcohol abuse issues. In drug court, offenders are diverted from jails and prisons through pre-trial/plea sentencing diversion; others use a post-plea/sentencing program wherein, upon successful program completion, the original charges are revoked or reduced (Marlowe 2011). Drug court clients work their way through a tiered-step program with mandates for meetings with the drug court judge and court team, mandated sobriety, counseling and treatment, and supervision methods. Drug court programs take, on average, a year to complete. Negative drug/alcohol test results proves adherence to program mandated sobriety. By 1997, drug court advocates developed a model for what they hypothesized made a drug court successful and created the *10 Key Components of Drug Court* (Table 1).

Drug Court Outcomes

Outcome studies of drug courts showed positive effects in terms of reduced drug use and recidivism rates, and improved cost-effectiveness compared to regular court processes (Marlowe et al 2012, 2014). Meta-analytic studies to date show that drug courts reduce recidivism rates among graduates on average up to 15% (Wilson et al. 2006; Latimer et al. 2006; Shaffer 2006; Lowenkamp et al. 2005; Aos et al. 2006). Drug court prolongs the length between offenses from 3 to 14 years (Gottfredson et al. 2005, 2006; Turner et al. 1999; Finigan et al. 2007). Drug courts are shown to reduce heavy alcohol and drug use (Rossman, Green and Rempel 2009) and helped to ensure better family connections and employment (Marlowe 2010), all while more cost effective than traditional court processes (Belenko et al. 2005; (Bhati et al. 2008). Drug courts were found to have the greatest outcomes for young, high-risk participants with multiple prior felony convictions, with antisocial personality disorder, and with no prior success in less intensive programs (Lowenkamp et al. 2005; Fielding et al. 2002; Marlowe et al. 2006, 2007;

Festinger et al. 2002). Originally hypothesized as a set of potentially effective components of a drug court, each of the *10 Key Components of Drug Courts* was validated as a vital part of the complete effective drug court model (Marlowe 2010; National Association of Drug Court Professionals 2013).

Expansion of Problem-Solving Court Model

Rapidly, adaptions to the drug court and therapeutic jurisprudence framework appeared across the U.S. Adapted models included driving while intoxicated (DWI) courts, family courts, mental health courts, veteran courts, tribal courts and adapted versions for juveniles. Underlying all these related "problem-solving courts" was the framework of therapeutic jurisprudence. Regular court processes mechanically shuffle offenders through the court process, relatively little attention is paid to underlying issues so that offenders are thrown into jail or prison only to recidivate once released. Using the framework of therapeutic jurisprudence, drug courts and related program adaptions allow judges and court employees to form relationships with the court participants, create a network of accountability, and utilize professionals who focus on rehabilitating offenders through counseling, drug rehabilitation, education and other programs so participants recidivate less. Backed by growing empirical research pointing to decreases in recidivism, increases in time before first recidivism, and greater cost-effectiveness compared to traditional court processes, the field of "problem-solving" courts continues to grow (Huddleston III, Marlowe and Casebolt 2008, Kuehn 2007, Shaffer 2011). As of June 2014, 3416 problem-solving courts exist in every state in the United States and internationally.

MENTAL HEALTH COURTS

The first official mental health court (MHC) began in Broward County, Florida in 1997, in response to the overwhelmingly positive response to drug courts. MHCs vary enormously in structure, composition, and judicial processes, but share common goals: "to improve public safety

by reducing the recidivism rates of people with mental illnesses, to reduce corrections costs by providing alternatives to incarceration, and to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system" (Almquist and Dodd 2009). In MHCs, the assumed root of the offenders' problems is mental illness. When properly addressed, offenders can learn to manage their mental illness, cope with addiction issues, and effectively end cycles of untreated illness, crime, homelessness, court involvement, and incarceration.

Redlich, Steadman, Monahan, Robbins, and Petrila (2006) described key features of MHCs observed in the United States. They describe MHCs as voluntary criminal courts with separate dockets for people with mental illnesses. Instead of regular incarceration processes, MHC clients receive mandated "community-based mental health treatment, medications, and other requirements". The clients are continually supervised using courtroom-based status review hearings and other "direct supervision methods in the community". MHCs utilize "principles of therapeutic jurisprudence by offering sanctions and incentives to encourage compliance" (Redlich, Steadman, Monahan, Robbins, and Petrila 2006). MHCs utilize a team of legal and treatment actors from a variety of backgrounds to implement the program. MHC team members vary, but all incorporate "a judge, representatives from the defense bar and the district attorney's office, probation/parole officers, and case managers and/or representatives from the mental health system" (Almquist and Dodd 2009: vi).

Early MHCs used various adjudication models such as a pre-adjudication model, probation-based model, and post-adjudication models (Griffin, Steadman, and Petrila 2002). The "second generation" of MHCs appeared to favor the post-adjudication model. Pre-adjudication models do not require an individual to admit guilt to their crimes before inclusion into the program, while post-adjudication models require a guilty plea/conviction (Redlich, Steadman,

Monahan, Petrila and Griffin 2005). However, both models, upon program completion, allow for reduced/removed sentences or completely expunged charges (Almquist and Dodd 2009).

Target Population

MHCs evolved over time. In the early years of development, only individuals with non-violent misdemeanors could participate. However, newer programs adapted to include felony offenders and, more recently, even some violent offenders (McNiel, Sadeh, Delucchi, and Binder 2015; Almquist and Dodd 2009). MHCs work to facilitate effective treatment for offenders, they do not give offenders a "free pass" from criminal culpability. MHC participation is a form of punishment. However, MHCs aim to rehabilitate their clients so they understand the consequences of their actions and learn to prevent future criminal behaviors. MHC judges structure the judicial process of the program in various ways to compensate for the complicated nature of the served offenders. MHCs conduct competency evaluations to ensure potential clients voluntarily and knowingly enter the program (Redlich 2005; Redlich, Hoover, Summers and Steadman 2010; Stafford and Wygant 2005).

Treatment Support and Services

MHC participants are eligible for a number of mental health treatment methods and support services. Treatment methods vary from court to court and are commonly modified for individuals' specific needs. Some of the most common treatment includes medication services, benefits, housing, crisis intervention, peer supports and case management (Thompson et al. 2008b). Case managers are typically responsible for connecting clients to their needed services and supports. The types and levels of support can change as the client progresses through the program and as new needs present.

Major components of treatment include services offered by one or more treatment facilities. The types of classes, counseling, and treatment methods vary widely based on the

facility(s) used. Many facilities offer mental health and drug addiction assessments, outpatient and inpatient counseling, rehabilitative services, group and individual counseling, psychosocial rehabilitative services, and Assertive Community Treatment (ACT) and other therapeutic methodologies (Cosden, Ellens, Schnell, and Yamini-Diouf 2005). Clients can work with facilities inside or outside the courthouse. Some clients are eligible to work with the Veterans Administration (VA) or tribal centers for additional support based on veteran status or Native American heritage. MHC coordinators and service providers also aim to create better lives for clients. Some offer housing assistance, childcare, transportation aid, education programs, and job placement programs depending on the needs of the clients and the services available in the area. MHCs work with many facilities in order to benefit their clients in connecting them to needed social supports and health services.

Sobriety and Treatment

Mental illness and substance abuse often go hand in hand. In 2010, approximately 9.2 million American adults had co-occurring alcohol and substance use disorders, also known as dual-diagnoses (Health and Services 2011). According to a study in the Journal of the American Medicine Association, nearly 50% of persons with severe mental disorders are also affected by substance abuse. 37% of alcohol abusers and 53% of drug abusers have one or more serious mental illness and 29% of all mentally ill individuals abuse drugs and/or alcohol (Regier et al. 1990). Common diagnoses in MHCs include schizophrenia/schizoaffective disorder, bipolar disorder, and depressive/mood disorders (Steadman et al. 2009).

MHCs assist offenders to improve their lives by implementing mandated sobriety as part of treatment plans. Similar to drug courts, MHC clients submit to random, frequent drug and alcohol tests. A treatment goal is to treat new clients at least twice a week on a random basis (Peters and Peyton 1998). Frequent, random drug testing is needed because 75% to 80% of MHCs clients are also diagnosed with substance use disorders (Blenko, 2001; Almquist and Dodd

2009). While abstinence from drugs and alcohol serves as an important requirement of MHC programs, relapse is considered part of the recovery process. MHC clients with co-occurring substance abuse are therefore also likely to use drugs and alcohol during their time in the MHC program as well. Drug court best practices indicate that substance abuse treatment is not there to reward or punish behaviors or serve other non-clinical goals. Substance abuse treatment in drug courts implements a continuum of care which includes services like detoxification, residential, sober living, day treatment, intensive outpatient, and outpatient services. MHCs mirror these services when needed in order to help participants adhere to sobriety mandates (NADCP 2013).

Co-occurring mental health issues and substance use issues make treatment more difficult. Clients with co-occurring issues tend to have more trouble succeeding in alternative court programs like MHCs. For optimal success for clients, mental health and substance abuse treatment must integrate into one program such as a co-occurring treatment court. If this is not available, the currently existing MHC or drug court must alter programs in order to see success in clients with co-occurring issues (Steadman et al. 2013). Although helpful, a mental health issue does not go away through sobriety and sobriety does not cure mental illnesses. Research on completely integrated substance use disorder (SUD) treatment and mental health treatment shows mixed results (Mills et al. 2012; Foa et al. 2013). Research pointing to the effectiveness of integrated mental health and substance use treatment points to the many barriers in implementing an effective program (Drake et al. 2001). However, some research indicates the absolute necessity of integrated dual-diagnosis. One example found that integrated treatment reduced Post Traumatic Stress Disorder (PTSD) symptoms through SUD and PTSD treatment, but SUD treatment alone did not reduce PTSD symptoms (Back 2010, Hien et al. 2010). In some cases, the symptoms of PTSD will worsen with SUD treatment especially during early stages of abstinence. Trauma-informed MHC practitioners and policy reform appears helpful in problem-solving courts. Its use should be implemented in judicial practices to improve client outcomes (Wells and

Urff 2013). Research continues to help determine how to best support MHC clients with integrated drug and alcohol treatment and trauma-informed policies.

12-step self-help programs

Another method in which MHCs help clients' abstinence from drugs and alcohol is through mandated 12-Step Self-Help groups (SHG) like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). MHC clients attend sobriety treatment options like these to supplement their therapy, counseling, and other treatment options. In SHGs, clients learn how to get off substances and avoid relapsing back into the cycle of drug and alcohol abuse while interacting with other members of the MHC and, potentially, other members of their community. The clients can attend the mandated program through the court, treatment providers, or another community-based program like those held in schools or churches (Castillo et al. 2007).

Research is mixed as to whether dual-diagnosed individuals with mental illness and SUDs will do well in the programs and remain abstinent from drugs and alcohol. Some research indicates that "people with difficulty thinking, concentrating, or controlling emotions are not able to successfully participate in standard therapeutic groups or 12-step programs" (Mueser et al. 2003:1). Research also points to individuals with different mental illness diagnoses and level of symptom severity to correspond to various levels of program success. Specifically, dual-diagnosed individuals with mental illnesses related to social anxieties and depression have trouble bonding with other participants that can limit successes and progress in program (Kelly, McKellar and Moos 2003). Dual-diagnosed individuals would do better in a modified SHG specifically for individuals with mental illnesses and SUDs (Moos and Timko 2008). Modified SHGs also allow participants to continue taking prescribed medications, an often misunderstood or prohibited practice in regular SHG programs ((Hatfield 2002). Research is limited on the efficiency of SHGs on MHC clients specifically. Some MHCs mandate all clients to participate in SHGs, even if clients are not diagnosed with a SUD (Bullard 2014).

Monitoring Adherence to Court Requirements

The use of sanctions and incentives are a vital component of MHC programs. MHC judges should give out sanctions and incentives during status hearings. MHC programs should include a variety of sanctions and incentives from which to choose and all sanctions and incentives should be individualized to the person receiving them. Sanctions and incentives serve to encourage client compliance to program mandates. Typically, judges dole out graduated sanctions and incentives to program clients based on specific behaviors or level in program. Incentives and sanctions may vary due to funding, program structure, and desires of court team members (Thompson, Osher and Tomasini-Joshi 2008). Some MHCs mirror drug courts in implementing a sanctions and incentives matrix. Matrixes ensure clients understand the consequence associated with certain behaviors. As offenses are repeated, the corresponding punishment becomes more severe. Understandably, these matrices are often adapted considerably based on individual's needs and level of understanding. Some MHCs forgo the use of matrixes altogether in favor of completely adaptable sanctions and incentives.

MHCs participants earn incentives through program compliance. Incentives act to encourage compliance through recognition of good behavior (Thompson et al. 2008a). The court team mandates clients to individualized treatment plans incorporating things like court appearances, therapy, treatment, and required medications, among others. Reduced or completely dropped criminal charges and avoidance of jail time present themselves as the seemingly most important incentives (Redlich 2005). However, throughout the program, the court teams offer other, smaller, incentives to encourage continued compliance and reward good deeds. Common incentives include public recognition, verbal accolades from the judge, "honor roll" status boards, snacks, gift certificates, certificates of acknowledgment, plaques, t-shirts, program level completion, reduction in supervision, and program graduation.

Sanctions vary based on program level, prior sanctions, and severity of infraction. Sanctions can include increased supervision methods like additional drug testing, GPS or sobriety monitors, additional home visits, office visits, status hearings, or treatment meetings. Other sanctions can include inpatient treatment options, verbal warnings, removal from "Rocket Docket", community service, jail time, demotion in program level, or additional time in current program level (Van Vleet et al. 2008). A study of 20 MHCs found that 36% adjusted treatment services, 27% used reprimands and increased status hearings, 18% considered client expulsion, and 64% used jail sanctions to enforce client/defendant compliance (Bernstein and Seltzer 2003).

Jail sanctions

One of the most debated sanctions for MHCs is the use of jail time. Those who use jail time as a sanction indicate that it should be used only as the most intensive sanction in the program and only as a "last resort", when other sanctions fail to provide a change in undesirable behaviors (Thompson, Osher and Tomasini-Joshi 2008). Advocates indicate that jail is a good method of supervision when other methods of supervision, like home visits, GPS/alcohol monitors, and probation officers, are unavailable. Others state that jail serves as a good option whenever the staff deems the client as a risk for becoming absent without leave (AWOL) from the program or potentially harming themselves and others if not under constant supervision. Jail sanctions are more common in MHCs today than at the beginning of MHC implementation (Redlich 2005).

Opponents of the use of jail time indicate that it is unfair to send people with mental illnesses to jail because mental illness is to blame for rule violations (Griffin, Steadman and Petrila 2002). These and other opponents also indicate the stressful nature of jails, jail time's counterintuitive nature against the MHC goal of jail diversion and the deteriorating effect it can have on the improvements MHC clients make outside of jail (Dodd & Almquist 2009). A study of 11 Oklahoma MHCs indicated drawbacks to jail sanctions (Bullard 2014). Jail staff would

often let clients out of their jail sentences early without MHC team approval or refuse to allow clients to serve sanctions if the jail was currently at capacity. Others indicated that MHC clients in jail did not receive proper medications, gained access to illegal drugs, and missed important treatment groups, meetings, and status hearings (Bullard 2014).

A study by Callahan and colleagues (2013) of four U.S. MHCs found that three out of four courts used jail as a sanction. While specific primary diagnosis had no effect on whether MHC clients would receive a jail sanction, participants with drug/alcohol disorders were more likely to receive jail sanctions. Also, clients who committed drug/alcohol offenses were more likely to serve jail sanctions than those who committed "person crimes" such as assault or domestic violence. In 2006, a survey of 90 MHCs found that only eight never used jail as a sanction. Only 2% of the 90 MHC used jail sanctions with over 50% of their clients (Allison et al. 2006). In a study of 11 Oklahoma-based MHCs, all used jail as a sanction (Bullard 2014). While research on the effectiveness of sanctions and incentives is still extremely limited, initial research seems to point to the necessity of finding a standard for what sanctions and incentives work best for MHC clients, and to what extent, if any, jail sanctions can be used to effectively encourage compliance.

Drug Testing

MHC clients are tested regularly to ensure adherence to mandated sobriety from drugs and alcohol through random, frequent drug tests. The current "gold standard" on drug testing frequency is two times a week for new clients (Peters and Peyton 1998). While hair, breath, sweat and saliva serve as drug testing specimens, urine is the easiest and, generally, the most cost efficient. The more "random" a drug testing schedule is, the more likely the tested client who is using drugs and alcohol can be discovered and have their treatment plan altered. Clients who are discovered to be compliant to sobriety mandates can also have their treatment plan altered accordingly. Drug testing is a difficult process. Treatment teams must collectively determine what

days each client are to be tested. Drug testing options or facilities must be available on weekend and holidays in order to facilitate the "random" drug testing option. Collected samples must be collected under witness supervision and under proper custody and control in order to better preserve the integrity of the specimen. MHC clients may attempt to adulterate, replace, or dilute their sample to hide drug use. Proper specimen collection, handling, and analysis allows for less questioning of results. Accurate results and confirmation tests allow for fewer "false positives". With accurate results and test cut-off levels, clients with positive drug tests are less likely to attempt to "explain away" the positive, due to passive inhalation or past drug use. Additionally, drug test results must be available relatively soon after the test in order to adapt program treatment options to the needs of clients.

Alcohol monitors

Alcohol use is commonly against MHC program requirements. Frequent alcohol use violations are often met with added sanction/ supervision measures, alcohol testing, or alcohol monitors. To complicate matters, alcohol is one of the most difficult drugs to test for due to rapid elimination from the body. Alcohol tests that indicate testing for alcohol ingestion up to 80 hours after consumption are not always as valid, reliable, or sensitive as they claim to be. Tests for biological markers of alcohol like ethyl glucuronide and ethyl sulfate are costly, rare in testing laboratories, and results can often provide a false positive due to clients interacting with alcohol-based products like hand sanitizers, medications, mouthwashes, and body sprays (Arndt, Schrofel and Stemmerich 2012) . Some MHCs utilize alcohol monitors that attach to the clients' car or body. "Sobrietors" are essentially alcohol monitors that use breathalyzer technology to deactivate car engines based on blood-alcohol content (BAC). Ankle alcohol monitors constantly send reports of sweat-derived BAC. However, both methods of alcohol detection are quite expensive to install and upkeep. In addition, staff, like a probation officer or home visit staff, must be on-call all the time to ensure rapid response to positive alcohol reports. Like other methods of

alcohol detection, false positives occur and clients attempt to circumvent compliance to this method of mandated sobriety. The price of installation and upkeep of drug tests is either partially or fully paid by the client, the MHC, or governmental funding. Some MHC programs have made deals with the jurisdiction in where the client can pay off the costs of alcohol monitors by engaging in community service hours.

Community supervision

In addition to drug tests and sobrietors, MHC teams employ other supervision methods to allow MHC clients to remain in the community while receiving treatment. Supervision methods vary from court to court based on funding, resources, and preference. Some courts implement global positioning system (GPS) and other electronic monitors for high-risk offenders. GPS devices allow court team members to track clients. Court teams discuss which clients deserve house arrest or are subject to "exclusion zones" like bars or neighborhoods where negatively influencing affiliates reside. GPS trackers help court teams know if the client is at work when scheduled and at home by mandated curfews, and even help discover the location of clients who try to avoid contact with the court team. Commission probation officers typically work with the court, local police, and alcohol monitor services to ensure mandated compliance. Research on the effects of electronic monitoring of individuals with psychological issues is limited (Tully, Hearn and Fahy 2014). However, research splits over the costs and benefits regarding use of electronic monitors and its long-term effects on offenders. While advocates of electronic monitors indicate they are far less restrictive compared to jail, others indicate that electronic monitors may hurt offenders by stigmatization and embarrassment. Future research must validate the therapeutic benefit of electronic monitoring of mentally ill offenders, if any (Renzema 2010, Yeh 2010)DeMichele 2014).

Probation officers or other court team members also conduct random home visits to ensure compliance to curfews, house arrest, or to check on the living arrangements of clients.

Home visits can be conducted with or without the assistance of electronic monitors. Home visit conductors may also conduct drug tests while visiting clients at their homes. Additionally, some courts mandate clients to visit with court team members for general "check-up" meetings on a scheduled basis. These, among other various methods of supervision, create a "network of supervision" in which clients are continually monitored for compliance to program mandates. The more methods of supervision, the more likely court teams will not miss clients' improvement or lack thereof. Court team members adapt the clients' current treatment plan to implement more or less supervision methods as needed during staffing meetings and status reviews.

Mental Health Court Research

MHC research struggles to keep pace with the rapid expansion of drug courts and the amount of evaluation research on the topic. Official evaluations of MHCs are still few in number, but growing (See VanGeem 2015 for a review of conducted MHC program evaluations). Most MHC program evaluations are either process evaluations (Redlich et al. 2005, Winstone and Pakes 2010) or quantitative outcome evaluations (Boothroyd et al. 2003, Boothroyd et al. 2005, Christy et al. 2005, Steadman et al. 2011). Mixed-method and purely qualitative research are two additional areas ripe for MHC research (McGaha et al. 2002, Trupin and Richards 2003, Wales, Hiday and Ray 2010). Drug courts and DUI courts more frequently utilize qualitative research in attempt to understand perceptions of clients and court teams of the program and their understandings of program success (Liang, Long and Knottnerus 2016, Marlowe et al. 2006, McPherson and Sauder 2013, Wolfer 2006). To date, most MHC evaluations and research only evaluate one court a time and are predominately focused on MHCs in large urban cities. Therefore, information regarding the level of successful outcomes may not be generalizable to MHCs who vary widely in the type of operating jurisdiction, program size, and structure.

Additional large-scale evaluation of multiple MHCs and participant-level outcome research must discover "how they work, for whom, and under what circumstances" (Almquist

and Dodd 2009). To date, MHCs are typically evaluated in terms of outcomes like recidivism rates (Dirks-Linhorst and Linhorst 2012, Hiday and Ray 2010; Hiday, Wales, and Ray 2013; McNiel and Binder 2007, Steadman, Redlich, Callahan, Robbins, and Vesselinov 2011, connection to behavioral health services (Boothroyd et al. 2003; Steadman and Naples 2005) public safety (Keator, Callahan, Steadman and Vesselinov 2013;), and ability to reduce psychiatric symptoms (Cosden, Ellens, Schnell, and Yamini-Diouf 2005; Trupin and Richards 2003; Sarteschi, Vaughn and Kim 2011). One study has also looked at quality of life as an outcome (Cosden et al. 2005). While outcomes in these regards are generally favorable (but see Boothroyd et al. 2005; Steadman and Naples 2005 for negative psychiatric outcomes and Cosden et al 2005 for negative results on recidivism), all of these studies examine MHC success at the individual level. Qualitative research shows that MHCs tend to better involve defendants in their cases, allow for better evidence gathering, and treat clients with fairness and respect (Wales Hiday and Ray 2010).

MHCs portray one area where empirical studies are desperately needed. To date, currently published empirical evidence is limited by errors in methodology, inconsistent results across studies, and incompatible samples for comparisons. Many of these evaluation problems are based on the fact that many MHCs are run in a variety of different ways, serve a variety of populations, and use various forms of resources based on what is available in the community (Erickson, Campbell, Lamberti 2006). Unlike drug courts, MHCs more often need to individualize program aspects such as services, sanctions, incentives and others to suit each client's needs. This individualization of programs makes evaluation research exceedingly difficult to undertake, especially when seeking to control on the many variables within program and between multiple programs. MHCs are adaptable to serve interrelated populations like individuals with co-occurring mental health and SUD, juveniles, and veterans. Research is also limited due to the privacy laws enacted by the court and through medical disclosure laws. Both mentally ill and

incarcerated populations are protected subjects for research. Attempting to research the population served by MHC requires quite a bit of clearance. However, stronger experimental meta-analyses, which could help to prove small-scale studies on a larger scale definitely, are still underdeveloped.

MHC empirical research still struggles to match the vast collection of meta-analytic supportive research available in support of drug courts (Marlowe 2011, 2014). While new studies have overcome some of the methodological errors of early assessment of MHCs, current results are inconsistent as to the outcomes of MHCs. Marlow (2011:83) says MHCs and other newer programs that focus on conditions other than addiction are "likely to substantially alter core ingredients of the drug court model". While MHC studies are growing, the existent studies are still fairly limited to individuals in court programs and examinations of singular MHC programs.

Essential Elements of a Mental Health Court

Scholars and advocates frequently mention how MHCs experienced rapid expansion before their use was empirically proven or best practices considered (Honegger 2015). In 2008, the existing 150 MHCs varied widely in practices, structure, and resources. A working definition of a MHC was yet to be operationalized. In light of this, Thompson, Osher, and Tomasini-Joshi collaborated with Justice Center professionals and MHCs to develop a best practices guide, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (2008) (Table 2). The document was created by a team of stakeholders who served within the MHC courts and aimed to provide a definition for MHCs, and outline a theoretical foundation for what policies and practices were required to help ensure success for the program and the clients they serve. However, it is important to note, while the professionals who developed the *Essential Elements* were informed members of court teams and legal professionals who used existing social and behavioral research for the selection process, the *Essential Elements* were not

empirically validated prior to inclusion. These *Essential Elements* are still assumed to form the theory of MHCs, but have also still yet to be understood in terms of their individual levels of importance or need. The *Essential Element* document indicates that not every MHC will use each *Essential Element*, the elements will manifest differently in different MHCs, and some may argue that one or more elements should be eliminated, modified or added. This debate over the *Essential Elements*, the authors argued, will facilitate better practices and outcomes. Empirical research is still required to determine which elements are important, uncover potentially missing Essential Elements, and discover to what extent and in which contexts *Essential Elements* should be implemented to ensure success of MHCs.

SUMMARY

MHCs could serve as the next attempt at solving the fundamental contradiction between fear of mental illness and desire to reintegrate individuals with mental illness into society. I believe the current stage of empirical knowledge about mental illness causes, symptoms, and most effective treatments will allow society to make rational, informed decisions about the care of mentally ill individuals. By understanding the historical context and failings of prior community mental health treatment attempts, we can avoid yet another moral panic at the unethical and unproductive treatment of mentally ill individuals within the confines of total institutions. However, doing this takes work. For MHCs to be successful, their key elements must be tested, the best treatment options must be used, the right population of offenders must use them, and vital resources must be made available. Program evaluation of MHCs must be continued and expanded to see that this fundamental contradiction in society is dismantled once and for all.

CHAPTER III

THEORY

This theory section is broken into two parts, Part I discusses the theories that guide MHC implementation and practice. Part II describes the theories used to argue that MHCs can be judged by their community-level impacts.

PART I- GUIDING THEORIES FOR MENTAL HEALTH COURTS

The legal theories of therapeutic jurisprudence and restorative justice, are two core "vectors" that help comprise the comprehensive law movement theoretically guiding MHC implementation and practice (Scheff 1998). The comprehensive law movement began in the 1990s out of frustration with the criminal justice system's growing reliance on tough-on-crime policies and anti-therapeutic views on corrections (Daicoff 2006). Since their fairly recent introductions, these comprehensive law movement vectors have merged into one another in hopes of creating effective, empirically validated alternatives to regular judicial processes and punishments blamed, in part, for mass incarceration and the criminalization of mental illness. These two legal theories found their way into problem-solving courts and specialized courts like MHCs, and guide the courts' theoretical understanding of how interactions with the court can be made more effective with understanding of social psychological responses of people interacting with that system. Therapeutic jurisprudence and restorative justice represent two theories of law

that serve as the core theoretical mechanisms underlying how a MHC reduces recidivism and promotes mental health.

Therapeutic Jurisprudence

Mental health law gained footing in America in the 1970s. Quickly thereafter, unprecedented issues began developing in regards to courts' decisions about people with mental illnesses (Wexler and Winick 1991). Therapeutic jurisprudence, as a scholarly concept, originated in the early 1990s as a scholarly approach to mental health law and soon became the core theoretical rationale behind problem-solving courts. Originally created as an approach to dealing with mentally ill defendants, the concept illuminated the therapeutic and anti-therapeutic effects of dealing with the legal system (Winick 1997). Proponents argued that anti-therapeutic consequences of the court and criminal justice system should be recognized and removed wherever possible. Doing so would promote increased adherence to judicial rulings and ensure that people were no less psychologically well-off for having to deal with the court system (Winick and Wren 2002).

Creators David Wexler and Bruce Winick see therapeutic jurisprudence as a method to study individuals' interactions with law through legal rules, procedures, and roles of legal actors (Wexler and Winick 1996).The aims of therapeutic jurisprudence are not to undermine the constitution or destroy established laws, but, unlike the study and application of law, therapeutic jurisprudence does not claim to be value-neutral. Winick and Wexler believed by using social sciences to study laws in terms of their therapeutic and anti-therapeutic consequences on individuals, therapeutic jurisprudence could adapt established legal rules, procedures, and actors to negate their anti-therapeutic effects and promote positive therapeutic effects. Therapeutic jurisprudence is conceived as a lens, or an orienting framework, through which other legal theories like restorative justice can explain positive legal outcomes.

Restorative Justice

Reintegrative shaming is an integrated theory of justice taking elements from labeling theory (Becker 1963), social control theories (Gottfredson and Hirschi 1990), and the symbolic interactionist tradition (Mead 1934) to understand how societal reactions to crime and feelings of shame affect subsequent criminal behaviors. Restorative justice is practiced by way of victim/offender mediation (Peters and Aertsen 1995). It acts as a "way to restore the criminal offender to the community, as the offender may have become alienated and have lost connection with any kind of healthy or supportive community" (Hafemeister, Garner, and Bath 2012 p.192). Restorative justice outlines how formal responses to crime can be structured in a constructive manner (Walgave and Aestersen 1996).

The foundational principles of restorative justice are: 1. "Crime causes harm and justice should focus on repairing that harm". 2. "The people most affected by the crime should be able to participate in its resolution" and 3. "The responsibility of the government is to maintain order of the community to build peace" (Center for Justice and Reconciliation 2018: paragraph 4). Restorative justice programs have run into some growing pains. Scholars note that despite restorative justice's desire to reintegrate offenders into the community, the concept of "community" is vague. Mere geographic region is not a proper conceptualization of a goal for reintegration and the concept should be altered or broadened (Ashworth 2002).

Integration of Justice Theories

The vectors of the comprehensive criminal justice movement began separately in academia (Nolan 2003). However, these vectors soon merged and collectively found their way into legal practice within creative-problem solving courts and specialty courts like drug courts and MHCs (Daicoff 2015; Nolan 2003; Schopp 1998; Scheff 1998).

Theories of justice share two common traits. First, "they seek to optimize human wellbeing in legal matters, whether that wellbeing is defined as psychological functioning, harmony, health, reconciliation, or moral growth"; Second, "they focus on more than legal rights, to additionally include the individual's values, beliefs, morals, ethics, needs, resources, goals, relationships, communities, psychological state of mind, and other concerns in the analysis of how to approach the legal matter at hand" (Daicoff 2010: 99). Additionally, therapeutic jurisprudence and restorative justice are both collaborative; therapeutic, committed to evidence-based practices, aim to alter thinking, impact legal outcomes, focus upon problem-solving adjudication, and are frequently interdisciplinary (Daicoff 2010; Braithwaite 2002). These theories have the capacity to solve crime, reduce inequalities, and serve as alternatives to War-on-Crime policies (Schopp 1998).

Restorative justice and therapeutic jurisprudence, while very similar in many regards, have some differences in scope and focus. Some argue restorative justice's focus on "reintegrative shaming" is incompatible with the therapeutic goals of therapeutic jurisprudence and the theory should include more focus on rehabilitation than shame (Winick 2000). Others offered that therapeutic jurisprudence was narrowly focused upon promotion of pro-therapeutic interactions within the justice system and was less concerned with the preservation of "traditional justice values" than restorative justice (Nolan 2003). Braithwaite (2002) posited that therapeutic jurisprudence and restorative justice are the same, but both with radical wings that individually promote radical transformation of the justice system and conservation of traditional legal values. Below, I summarize the empirical and theoretical work on these two theories of justice within problem-solving courts and MHCs.

Use of Therapeutic Jurisprudence in Problem Solving Courts

Therapeutic jurisprudence acts as the orienting conceptual framework for theories of justice assumed to motivate problem solving courts. Therapeutic jurisprudence is the underlying

premise of problem-solving courts and especially MHCs. Therapeutic jurisprudence can be seen through problem-solving court judges' interactions with clients, at the organizational level when a court creates linkages to therapeutic social support systems through their court procedures, systems, and punishments, and in positive therapeutic changes to court rules or laws (Rottman and Casey 1999).

Best Practices literature lauds judges' ability to practice therapeutic jurisprudences in drug courts. Judge demonstrate therapeutic jurisprudence to defendants through their respect, fairness, attention, and knowledge about the defendant's case and situation. These abilities are assumed to play a major role in reducing drug use and criminal behavior (Zweig 2012; Boldt and Singer 2006). Only two studies directly connect therapeutic jurisprudence to specialized court program outcomes (Senjo and Leip 2001a; Senjo and Leip 2001b). The twin studies found reductions in positive drug test screenings (Senjo and Leip 2001a), increase in program completion (Senjo and Leip 2001b), and program success correlated with supportive judicial comments in drug court programs (Kaiser and Holtfreter 2016).

Most MHCs identify therapeutic jurisprudence as the guiding philosophy for their program and its successes in reducing recidivism and increasing compliance (Goldkamp and Irons-Guynn 2000; Kondo 2000; Lurigio and Snowden 2009; Wiener, Winick, Georges, and Castro 2010; Winick 2002; Winick and Wexler 2003). Thus, most research has been conducted in regards to this principle of justice within MHCs. Specific components of therapeutic jurisprudence have been studied among MHC clients. Studied components of therapeutic jurisprudence include: perceived voluntariness (O'Keefe, 2006; Poythress, Petrila, McGaha and Boothroyd 2002), knowledge about the program, and understanding of one's responsibilities in the program (Redlich, Hoover, et al., 2010). One recent study operationalized therapeutic jurisprudence as voluntariness to enroll in program, knowledge about program, and perceptions of procedural justice. Using a theoretical model, they find an indirect path between these aspects of

therapeutic jurisprudence and MHC success and a direct path between recidivism likelihood and compliance with the court (Redlich and Han 2014).

Johnston (2011) critiques the use of therapeutic jurisprudence as the justification of MHCs. He argues that MHC values of therapeutic jurisprudence conflict with traditional courtroom values. He also critiques the underlying assumption for MHCs, namely, that untreated mental illnesses are responsible for crime and recidivism (Johnston 2011). Thus, he argues, therapeutic jurisprudence should not be the guiding framework for MHCs. He states that crimes are, by and large, not directly produced by mental illness, and recidivism is more predicted by risk factors like substance abuse, poverty, peer influence, family problems, and antisocial tendencies than a mental illness diagnosis (Morse 1999; Johnson 2011; Skeem and Cooke 2010). If therapeutic jurisprudence enacted through mental health treatment interventions is not predictive of reductions in criminal behavior, he argues, why is therapeutic jurisprudence the number one used guiding framework? I argue his focus is too limited in conceptualizing mental health treatment interventions as the only use of therapeutic jurisprudence in MHCs. MHCs frequently intend every interaction with the court, from judicial interactions to psychosocial interventions, to have a positive psychological impact on defendants. Despite Johnston's argument , evidence supports that factors related to mental health such as the severity of mental illness symptomology (Andrews and Bonta 2010) are related to likelihood of recidivism and re-arrest within MHC client populations (Herinckx, Swart, Ama, Dolezal, and King 2005; Steadman et al. 2011).

Wexler also argues that therapeutic jurisprudence was never meant to be a "full blown theory", but a field of inquiry, a lens to use to identify and understand anti-therapeutic practices within the court system (Wexler 2010). The lack of concrete definition of "therapeutic" for therapeutic jurisprudence also enables flexibility in practice, but difficulty in theory as "whether a legal rule, procedure, or approach is deemed therapeutic will likely vary according to the identity,

ideology, interests, experience, values, and perspective of the evaluator" (Wexler, 1995: 224). Johnston ends by saying other theories may better justify the nearly 400 MHCs currently in existence (Johnston 2011).

Use of Restorative Justice in Problem-Solving Courts

Treatment courts are based on principles of therapeutic justice and restorative justice (Petrila 2013) and both theories are conceptually supported for use within problem-solving courts (Nolan 2003; Braitwaite 2002). However, while problem-solving courts theoretically follow the principles of restorative justice, relatively little research has been done to analyzing how and to what extent this theoretical model for reducing recidivism in problem-solving courts has been played out.

While domestic abuse courts, unified family courts, and batterer intervention courts are specialty courts that adhere strongly to the principles of restorative justice in healing the victim (Braithwaite 2002; Dignan 2004; Boldt and Singer 2006), it appears that therapeutic jurisprudence is not often a key feature of the courts. In these courts, therapeutic jurisprudence is not so much used for behavioral change, but as a compliance tool focusing on the batterer (Labriola et al. 2009; Turgeon 2008). These programs vary widely from court to court, but none appear to have found a balance between the implementation of therapeutic, restorative, and punishment measures (Wolff 2013). Nevertheless, the outcome evidence of the success of these types of courts are not often supportive of these courts as they are theoretically practiced (Gondolf 2011; Saunders 2008; Stover et al. 2009).

Restorative justice occurs within MHCs in similar manners as other problem-solving courts (Fritzler 2003; Dollar and Ray 2015). Methods of restorative justice have been found to relate to strengthened support networks. Supportive networks are theorized to help in MHCs by increasing opportunities for rehabilitation outside of MHCs (Robinson and Shapland 2008).

MHCs that use restorative justice aspects in their program may promote community awareness, reduce stigma, promote reintegration of, and facilitate more services and funding for community mental health services and facilities (Corrigan and Matthews 2003; Hafemeister Garner and Bath 2012).

In practice, MHCs appear to use the theory of restorative justice by use of the medical model of deviance. The offenders are not shamed for committing crimes due to mental illness, but the behaviors are shamed in a way that promotes reintegration into the group and adherence to norms. It appears that MHs are recently starting to distance themselves from the medical model of deviance to focus more upon a recovery model based on four dimensions of recovery: health, home, purpose, and community (SAMHSA 2012; Fisler 2012). The recovery model aims to help people live full lives and reintegrate back into society despite coming from marginalized and stigmatized populations. This model is fully in line with the concept of restorative justice. Additionally, MHC clients rely on a court team as well as co-participants in the program for actual and perceived support. Another method of restorative justice seen in MHCs are the use of graduation ceremonies, rewards, and sanctions, to support a compliant client's success in the program.

Some worry that MHCs run the risk of behaving too paternalistically, specifically the judge's ability to behave in a condescending manner "in the best interest for their client", which negates the principles of restorative justice and runs counter to the principles of therapeutic jurisprudence (Casey 2004). Boothroyd et al (2003) found MHC clients spoke less than 33% of the time at MHC proceeding and victims often did not play a role in MHCs. Another concern about use of restorative justice conferences within MHCs is the need to disclose mental illness diagnosis to victims or community members and the capacity of some mentally ill offenders to take responsibility over their actions (Garner and Hafemeister 2003). Despite studies that find

restorative justice operating within MHC programs, there are no studies, to my knowledge, that explicitly link the use of restorative justice theory in MHCs to outcomes.

Integrated Justice Theories Use in Problem-Solving Courts

Despite the lack of combined theoretical research, there appears to be very little impeding studies of how MHCs, or other problem-solving courts, collectively use therapeutic jurisprudence and restorative justice to affect participant behaviors and outcomes.

The claims of therapeutic jurisprudence and restorative justice frequently intersect in MHCs (Wexler 1993). MHCs, while varied in focus and practice, generally apply pro-therapeutic practices in their courts with the intersecting principles of restorative justice. MHCs practice therapeutic jurisprudence in their small caseloads and individualized forms of justice and treatment planning (Steadman et al., 2005). MHCs practice restorative justice in their aims to make clients accountable for their misdeeds and restore them to their communities through utilization of community-based recovery options, social service providers, and connections to positive social groups that encourage pro-social behaviors. Empirical analysis of the ways these theories are implemented in MHCs and relate to client outcomes are still required.

PART II-THEORY TO ARGUE FOR COMMUNITY LEVEL OUTCOMES

Community-level outcomes may serve as a potentially overlooked source of data upon which to judge MHC success. MHCs aim to divert mentally ill offenders away from jail and into community-based treatment. The programs typically mandate pro-social activities, offer social services, and aim to reconnect clients into positive social networks. On a broader level, mental health courts aim to facilitate collaboration between mental health, social service, and criminal justice systems to create a system of support for individuals with mental health issues within communities. I argue, that it is possible that the impacts of these types of program-level success could be visible, not only in terms of client outcomes, but within the context of the broader

community. Next, I provide theoretical information to support the use of community-level impacts as a source of outcome evaluation in future research.

Social Disorganization Theory

Social disorganization theory supports the idea that a successful MHC can be determined by examining community-level outcomes. First developed by Shaw and McKay in 1942, social disorganization theory links neighborhood-level crime to the ecology of a community. Neighborhoods that experience high levels of crime are communities that experience low levels of neighborhood cohesion-"size, density, and breadth of network ties and levels of organization among residents" (Markowitz, Bellar, Liska & Liu 2001:293: Bursik 2000; Sampson and Groves 1989) and low levels of "collective efficacy-the ability to effectively intervene in neighborhood problems and to supervise residents to maintain public order" (Markowitz, Bellar, Liska & Liu 2001:294; Sampson et al. 1997, 1999).

Studies of social disorganization theory resurged in popularity beginning in the 1980s. While most early social disorganization theorists focused on major crimes, later, Skogan (1990) found that when low-level nuisance violations like panhandling, public drug use, and graffiti go undealt with, it creates a social environment with weak social ties that signal "acceptance" of increasingly more serious crimes in which police and community members will not intervene. Very few studies have examined the relationship between community disorder, neighborhood cohesion, and crime. The conducted studies are limited and the results are mixed (Conklin 1975; Hartnagel 1979; Liska and Warner 1991; Skogan 1990; Skogan and Maxfield 1981; Taub, Taylor and Dunham 1984; Taylor 1995). Results show relationships between fear of crime and neighborhood incivility, i.e. abandoned buildings, vandalism, drug use, and loiters (Lewis and Maxfield 1980), and fear of crime and level of neighborhood cohesion (Liska and Warner 1991; Liu et al. 1993, Sampson and Raudenbush 1999). One key example, Markowitz et al (2001)

found that community-level disorder indirectly effects crime through fear and neighborhood cohesion and that disorder reduces community cohesion, effectively creating an escalating feedback loop of disorder, fear, lack of neighborhood cohesion, and serious crime.

Social disorganization of neighborhoods contributes to crime due to a variety of factors such as a community's inability to support social institutions like schools, churches, business and organizations. Lack of racial integration combined with socioeconomic disadvantage promotes lack of social integration, structural dilapidation, and amenity scarcity (Massey and Denton, 1989, 1993; Sampson et al., 1997, Alexander 2010; Hill and Maimon 2013).

Community context and mental illness

Social disorganization theory has also been applied to the study of mental health. Sociologists of mental health have found that the neighborhood context and social disorganization is a predictor for levels of mental disorder within a community. Faris and Dunham's (1939) research explains the relationship between neighborhood social disorganizations and the prevalence of mental disorders in communities marked by high rates of social isolation and deviance exposure.

Studies consistently link neighborhood context and mental illness symptomology. Consistently, findings portray the most socio-economically disadvantaged neighborhoods with higher levels of depression (Ross 2000; Turner, Shattuck, Hmaby, and Finkelhor 2013), anxiety (Ross and Mirowsky 2009), and psychological distress (Cutrona, Russell, Hessling, Brown, and Murry 2000; Hill, Burdette, and Hale 2009; Stockdale et al. 2007), and poorer cognitive functioning (Wight, Botticello and Aneshensel 2006). Anashensel and Sucoff (1996) found a relationship between socioeconomic status and mental health among 877 youth in Los Angeles neighborhoods. Youth perceptions of their own neighborhood as dangerous through exposure to neighborhood crime violence, drug use, and graffiti were related to mental health symptoms,

some of which were related to criminal activity like conduct disorders and oppositional defiant disorder. They concluded that social stability, and, to some extent, social cohesion contributed to mental health disorders. Ross (2000) finds that the relationship between neighborhood disadvantage and depression is entirely explained by perceptions of neighborhood disorder. Cutrona, Russell, Hessling, Brown, and Murry (2000) found a relationship between symptoms of psychological distress and neighborhood disorder. Hill, Burdette, and Hale (2009) and Stockdale et al., (2007) found relationships between psychological distress and negative perceptions of the neighborhood. However, social resources, social ties, and social support can partially mediate relationships between neighborhood disorder and depression (Kim and Ross 2009; Stafford, Chandola and Marmot 2007; Cutrona et al. 2006).

Stress Process and Mental Health

Social support is found to moderate the relationship between mental health and stress. Social support is well documented in research literature in relation to its positive effects on psychological well-being (see Turner and Turner 2013b for a review). Perceived support is studied as a coping resource against stressful situations (Thoits 1995) and also as a resource in healthy social and personality development (Cohen 1992; Uchino 2004; Umberson and Montez 2010). Social supports are individuals, groups, or organizations seen as resources one uses to dealing with life's problems. These social support resources are found in all types of social institutions including religion, occupation, family, neighborhood, voluntary associations, and others (Turner 1983; Pearlin 1989).

Social integration and fear

In a society increasingly shaped by fear of crime and fear of mental illness, the lack of social support resources and community integration may be contributing to both crime and mental illness, thus creating a vicious cycle of fear of crime and mental illness, community disorder, lack of neighborhood cohesion, and serious crime (Markowitz et al 2001).

Americans' perceptions of crime rates often conflict with actual crime rates and perceptions of crime have generally increased over the last few decades, though a moderate decrease in crime perceptions occurred in the 90's but resurged after 9/11 (BJS 2013; (Warr 2000). Americans' perception of risk and fear of crime are more strongly linked to neighborhood incivilities like disorderly conduct "abandoned storefronts, unkept lots, litter, noise, bench sleepers, and public drunks" than crime rates themselves (LaGrange, Ferraro and Supancic 1992; Lewis 2017). Although criticized (Farrero 1995), Gallup poll data helps see trends in neighborhood fear of crime and social cohesion. One question asks, "Is there any area near where you live—that is within one mile-where you would be afraid to walk alone at night?" In 1965, the first year the question was asked, 34% of Americans responded "yes". The highest percentage of respondents stated yes in 1982 (48%). Levels reached 30% in October of 2001, but began to slightly increase until 2017, where levels have returned to 30%. Another Gallup poll question that gets at fear of crime at a community level is "Is there more crime in your area than there was a year ago, or less?" In Oct 2017 40% responded there was more crime, but the highest peaks in response to more crime were in 1981 and 1992, both at 54%.

People react to fear of crime most commonly by avoidance of unsafe areas (Warr and Ellison 2000; DuBow, McCabe, and Kaplan 1979; Warr 2000). Fear of crime negates social cohesion, pushing individuals more into their homes and away from their neighborhoods out of fear of victimization (Warr 2000).

The fear of the mentally ill, while less researched than general fears of crime, shows evidence of increasing since the 1950s (Star 1952; Phelan and Link 2004; Phelan, Link, Stueve, Pescosolido 2000). For example, Martin, Pescolsolido, and Tuch (2000) found that 38% of Americans are unwilling to have a mentally ill person move next door, 56% are unwilling to spend an evening socializing with a person with mental illness, 33% of are unwilling to make friends with a mentally ill person, 58% are unwilling to work closely with a mentally ill person,

and 68% are unwilling to let a person with mental illness move into the family. Despite decades of anti-stigma advertisements, the news and media still has a fascination with scary, criminal, and violent depictions of mental illness (Wahl 1997). As people become increasingly disengaged from taking part of their communities due to fear of crime and associations between mental illness and crime, they have fewer interactions with the mentally ill. These fear-based media depictions become individuals' understandings of the mentally ill. Fear of crime and fear of mental illness combine with lack of social integration and cohesion to ensure that the mentally ill are not supported by their communities and social networks are unable to connect people to needed resources for treatment. I argue that crime occurs amongst the mentally ill, at least in part, because they are increasingly unintegrated into society due to stigma and public fear.

Fear relates to mistrust, and mistrust is found to relate to psychological distress (Mirowsky and Ross 2003). "Mistrust represents a profound form of alienation that has gone beyond a perceived separation from others to a suspicion of them… The suspicion of others indicates a heightened sense of threat" Mirowsky and Ross (2003). In terms of neighborhoods, Ross and Mirowsky (2009) found that perceived neighborhood disorder is partially explained by mistrust. "If perceptions of disorder contribute to negative dispositions toward humanity it is reasonable to expect that residents of disadvantaged neighborhoods might go out of their way to avoid social interaction" (Hill and Maimon 2013). We return once again to the relationship between fear, lack of social cohesion, and neighborhood disorder. The mentally ill are feared to the point of social exclusion and have low levels of social support within these fearful communities which associate mental illness with violence and crime (Kim et al. 2010; Ross and Mirowsky 2009).

The mentally ill are frequently socially excluded from community integration. I argue that the lack of social integration on a community level, disorganized communities lack of social supports severely experienced by mentally ill individuals is what pulls mentally ill individuals

into criminal activity. Mentally ill individuals are more likely to get arrested than those without mental illness for similar behaviors (Teplin 1984) and the mentally ill comprise a large proportion of offenders who wind up in jails and prisons (Feder 1991; Ditton 1999). Today, jails and prisons have become the new mental institutions for those with mental illness and approximately 40% of offenders fail to receive any mental health treatment (Steadman et. al 2009).

SUMMARY

Interestingly, the "criminalization of mental illness" hypothesis has come under fire (Abramson 1972). Critics have make some interesting claims as to the empirical validity of the notion that crime is directly related to mental illness (Johnston 2011; Fisher et al 2006). They call out the idea of a low-level offender who commits "survival crimes" (Hiday 1999) as more a social construction than a reality. Studies also critique the idea that mental illness causes crime. These studies show that recidivism is better predicted by criminogenic and contextual factors like prior arrest, days in jail before treatment, co-occurring substance use, homelessness, unemployment, poverty, education, and younger age (Rossman 2012; Steadman et al 2011; Keator et al 2013; Peterson, Skeem, Kennealy, Bray and Zvonkovic 2014; Silver 2006; Silver 2000; Fisher, Roy Bujnowski Grudzinkas 2006; Croker Mueser, Drake et al. 2005; Bonta, Law, Hnason 1999; Peterson, Skeem, Kennealy, etal 2014). Johnston (2011) argues that social science research only predicts a causal relationship between mental illness and crime in 10% of cases.

This criticism has, in part, spurred researchers to search for other answers on how MHCs solve the issue of crime and mental illness. While MHC research frequently finds that MHCs "work" to reduce recidivism and jail days compared to regular incarceration processes, some findings appear to contradict the theoretical justifications and core assumptions upon which MHCs rest:

> (1) untreated, or inadequately treated, mental illness contributes to criminal behavior; (2) criminal justice involvement can serve as an opportunity to connect people to appropriate treatment;(3)appropriate treatment can improve the symptoms of mental illnesses and reduce problematic behavior, especially

when(4) judicial supervision, including the use of graduated incentives and sanctions, helps keep people in treatment; and, thus, (5) the combination of treatment and judicial supervision will reduce recidivism and improve public safety" (Fisler 2015: 8-9).

The next line of inquiry should evaluate whether or not MHCs truly do rely upon these theories of crime reduction, in what ways, and to what extent they effect crime. Unanswered hypotheses seek research that will help to uncover under what assumptions and through which mechanisms MHCs work. While limited in implementation, the newest research looks for answers within the impact of various court processes and the program's ability to implicitly or explicitly address criminogenic needs. So far, no studies look at the role MHCs play in encouraging participant engagement within the community and none address system-level goals originally formulated by stakeholder planning teams (Fisler 2015).

The complicated nature of the offenders served and variation in MHC program implementation makes their evaluation a complicated process. The use of program-theory evaluation may serve as a potential method of determining success in spite of the complications that arise due to variations in program implementation, community context, and population served, among others. Potential discovery of new outcome evaluation questions and methods could prove to be essential in creating and maintaining a cost-effective and outcome positive MHC programs and serving the most benefitting population. Results of this study could be potentially useful for policy makers, law enforcement, and MHC team members and the community at large. Increased positive outcomes for clients of these courts can assist in reducing the burden the incarcerated population places on America. Effective MHCs assist clients in becoming productive, healthy members of society.

President Kennedy's community mental health program failed to effectively treat mentally ill individuals in the community due to implementation failure and lack of understanding of community context. The program's failure became most evident by the 1980s

due to economic downturns, rise in homelessness, and fear/criminalization of the mentally ill. MHCs now serve as another chance to effectively treat mentally ill offenders in the community. Effective community treatment will promote reintegration and acceptance into society and decrease societal fears and stigma. Inclusion into the community will promote increased social control and reduced criminality. Effective mental health treatment options in the community facilitated through MHCs could serve as a solution to the seemingly endless cycle of institutionalization, moral panic, deinstitutionalization, and failed community treatment.

CHAPTER IV

METHODOLOGY

The current gaps in MHC research and evaluation are best addressed through a mixed-methods program-theory evaluation (Chen 2006). Program-theory evaluation addresses the system-level assumptions and goals articulated by stakeholders (e.g. the *10 Essential Elements*), evaluates how various program elements are thought to impact outcomes, and examines the role of the community both in court practices and outcomes.

PURPOSE

The purpose of this research is to evaluate MHC programs' practices, organization, and environments to uncover the variations in assumptions guiding current MHCs and determine to what extent MHCs adhere to the *10 Essential Elements of Mental Health Courts* and in what ways (Thompson, Osher and Tomasini-Joshi 2008). Through the process, this research identifies program issues and offers solutions using evidence from social science and successful programs.

HYPOTHESES

I first hypothesize MHCs vary in their assumptions, goals, and interpretations of the *Essential Elements*. MHCs have existed for almost three decades. Over time, new research, best practices, and understanding of the criminogenic needs of offenders with mental illness evolved.

Evidence of that evolution will be visible in particular programs' deviation from the established model set forth by the *Essential Elements of a Mental Health Courts* (Thompson, Osher and Tomasini-Joshi 2008). I hypothesize that there will be limited variation in different courts' key stakeholders' assumptions about how and why the program should work. Their responses will not deviate much from the previously mentioned theories of justice and the *Essential Elements*. However, I do expect much variation in which particular elements and theories they feel are *most* important to success and how they specifically implement those elements and theories within their own programs.

Second, I hypothesize that transportation serves as a necessary MHC resource for program success. Network connectivity, in terms of how well the MHC client population is able to access services via public transportation or other methods offered by the city or the MHC program (i.e. public transportation, vehicle mandates for program entry, or pick-up services), may serve as an untapped ecological context requiring evaluation. MHCs are intended to work with existing community resources and partners, but if limited transportation services are available in the area to facilitate access, then treatment options will be limited and client success will encounter major hurdles.

Third, I hypothesize that MHC can be evaluated through analysis of community level-impacts. Determination of MHC program successes are most typically expressed in terms of individual client outcomes. However, proper reintegration of clients into the community via jail diversion, community-based treatment, and pro-social activities in combination with increased inter-system collaboration between criminal justice, mental health treatment, and social service providers serves to fundamentally change not only the lives of the clients served by MHCs, but the communities in which clients reside.

RESEARCH METHODS

Program-theory is an appropriate method to study MHCs because the evaluation method addresses the identified gaps in the research literature and addresses the current politically-motivated need for additional justifications for MHC programs' existence. I believe my chosen hypotheses related to community-level program assumptions take into consideration a currently implicit and largely overlooked resource for conducting MHC evaluations and determining outcomes.

Since their inception little over two decades ago, MHC programs have been evaluated through a narrow collection of outcomes based primarily upon the assumption that proper mental health treatment impacts recidivism rates. MHCs now seek validation of their program successes that rests upon other components of their program aside from mental health treatment. Program-theory evaluation's strengths lie in the method's ability to elicit a detailed description of a program, who it serves, the political context in which it operates, the rational for its existence, and explain why and through what mechanisms the program works best. Unlike objectives-oriented approaches, the theory-driven evaluation does not place singular focus on previously established program objectives and their measurement, but allows evaluators the opportunity to find overlooked and untapped sources for outcomes. Since the newest research indicates that the general assumption of MHCs reduced recidivism through access to mental health treatment components does not inadequately explain success, a program-theory's focus on uncovering "why" a program works is crucial.

MHC research has largely failed to research or validate the 10 *Essential Elements* that are presumed to guide successful program implementation. This guide currently exists as little more than mere suggestions on how to run a MHC program that may or may not be related to program success. Again, a program-theory evaluation's strength lies in its ability to uncover overlooked assumptions related to program success by laying out detailed program descriptions and testing

causal linkages between those assumptions, inputs, activities, and outcomes. I believe program-theory evaluation serves as the needed conceptual framework for identifying what *Essential Elements* are used in MHCs and in what ways they are enacted. Though only a first step, by identifying the elements actually in use within MHCs, it is possible to, in the future, test and potentially empirically validate their inclusion as a *truly* essential element for MHC success.

Embedded in nearly every element of the *Essential Elements* guide are statements about how MHCs impact the community through improved criminal justice/mental health treatment service collaboration, client-community reintegration, and improved community safety (Thompson, Osher, Tomasini-Joshi 2008). While implicitly embedded in assumptions about program success, these community-level assumptions also need to be elucidated by individual MHC programs in order to be identified and evaluated. Community-level assumptions and related positive outcomes may further support the need for MHCs. Program evaluators are aware of the need for these kinds of program justifications in a political world that must justify program success for their continued funding or expansion. Additionally, identification of the specific inputs, activities, ecological contexts, and causal mechanisms that relate to positive community-level impacts could serve to create new, empirically validated Best Practices to further positive outcomes for MHC clients. Social science data on criminal behaviors, mental illness, and community integration serves to only further validate the use of my hypotheses related to community-level outcome evaluation measures and methods.

POPULATION AND SAMPLE

Population

Over 350 adult MHCs operate today, although many have opened since the last major census account of programs was taken in 2016. Some programs have also since shut down due to lack of funds or staff. Both MHCs and co-occurring MHCs serving adult individuals with felony and/or misdemeanor offenses across the U.S. were included for study participation. Programs

must have been in operation since 2016. The states of Nebraska, New Jersey, North Dakota, Rhode Island, South Dakota, West Virginia, and Connecticut do not currently operate MHCs. The states of Arkansas, South Dakota, Mississippi, and Wyoming currently operate MHCs, but all are less than two years old. Currently, many types of diversionary efforts exist in courts for those with mental illness. Eligible MHCs could also either be structured as dockets or their own program. Mental health dockets were excluded if their program structure only consisted of a pre-booking diversion effort that targeted mentally incompetent to stand trial individuals. Programs that did not include program elements like use of supervision, sanctions, incentives, treatment plans, and a specialized docket for adults with mental illness were not considered for the purpose of this research.

Recruitment Procedures

All procedures and materials were approved by Oklahoma State University Institutional Review Board. The initial solicitation process lasted from March 21st through Sept 45th 2018 and included in-person solicitations, email, and phone calls to generate interest from the approximately 350 MHC programs. The process began at the 2018 Forensic Mental Health Association of California conference in Monterrey, California on March 21st. Calling cards were distributed that provided the survey web link, QR code, and personal contact information.

Beginning June 10th, 2018, every state-level MHC director or coordinator in the United States was emailed a letter to encourage their state's MHC judges and coordinators to participate in the survey. Some state-level coordinators offered to distribute the survey. Some gave permission to contact the courts, but requested that I distribute the survey myself. Many of the state-level coordinators were unable to be contacted. Five states rejected the offer on behalf of their state's courts. Washington DC and Oklahoma mandated additional governmental research IRBs to be completed prior to individual court solicitation.

I also solicited participants in person as a presenter at the 2018 bi-annual Mental Health Court Summit in Park City, Utah on June 19-21st. After presenting my program evaluation proposal, I distributed approximately 40 calling cards to interested court team members from various states.

I then used the SAMHSA MHC database and the National Drug Court Institute (NDCI) resource center to solicit individual MHC coordinators and judges via email and phone from June 28th to September 4th 2018. The SAMHSA database has not been updated since 2015 and the NDCI website was last updated in 2016. It was necessary to search for individual courts online to find updated contact information. Even through search of government webpages, over half of the emails were unable to be delivered due to outdated email addresses or privacy blockers. Courts that were able to be contacted by email received a follow up email two and four weeks after initial contact if responses did not receive a reply.

The email solicitation provided the purpose and type of research, the link to the online survey instrument, and IRB approval documents. Courts were offered a logic model of their court and chance to win one of three $25 gift cards for full participation. (Refer to Appendix D for email recruitment letter and Appendix E for informed consent form). When I was unable to contact the courts via email, I then called the courts to solicit participants. Most phone call solicitations were left via voicemail wherein the same offer was provided as via email. Less than 20% of courts called back. In all, I attempted to email approximately 300 courts and called nearly 100 courts. Courts who declined participation frequently mentioned lack of time to complete the survey, a recent completion of another evaluation, too many requests for evaluations, or sole use of an on-staff or state-level program evaluator. Interested MHCs frequently requested due date extensions and some requested that the court team evaluator take the survey rather than the judge or coordinator. Extensions were offered through August 21st, upon request, and permissions were given for court program evaluators to take the survey

Response Rate

Online survey responses were received between June 12th and October 3rd. Responses received after this date as well as surveys that were less than 25% complete were excluded from analysis. Courts called and emailed with questions, requests for extensions, and supplemental documentation though October 5th. In total, 32 courts submitted a survey, but only 27 were included in analysis resulting in an approximately 8.5% response rate of the entire population of U.S. adult MHCs thus not exemplifying a representative sample of MHCs.

Sample

The resultant sample represented 12 MHCs and 15 co-occurring courts from 18 states: Alaska, Arizona, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Michigan, Missouri, North Carolina, Oklahoma, Pennsylvania, Texas, Utah, Virginia, Washington, and Wisconsin (Figure 1). The MHC sample operated on three jurisdictions: 14 county courts, 6 circuit courts, and 7 district courts. 21 courts accept both misdemeanors and minor felonies, 5 accepts felonies, and 1 accepts misdemeanors violations (Table 3).

INSTRUMENT

An online survey instrument was designed to assess the underlying assumptions, goals, policies, and procedures of MHCs to determine how these elements varied from the BJA guidelines outlined in the *Essential Elements of a Mental Health Court* (Thompson, Osher and Tomasini-Joshi 2008). The survey is located in Appendix C. The online survey was developed using Qualtrics online survey software. The questions are formatted in Likert scale, multiple-choice, and open-ended write-in response formats. The survey also provided options for MHCs to upload unobtrusive data sources including: mental health court participant handbooks, employee handbooks, sanction/incentive matrixes, evaluation and research studies conducted on their court, demographic outcome data, summarized performance outcome measures, and online links to further information about the court (National Center for State Courts 2010).

The questions aimed to uncover:

1. The explicit and implicit assumptions of how the MHCs are supposed to work
2. The explicit and implicit assumptions of the goals set forth by the MHCs
3. To which *Essential Elements* and/or judicial theories the MHCs ascribes
4. To what extent each *Essential Element* and/or judicial theory is assumed to be important to court success
5. How the *Essential Elements* and/or judicial theories relate to program inputs and activities
6. How the MHCs are organized and who comprises the full court team
7. The types and frequency of services (e.g. treatment, supervision, social services, and self-help)
8. The perceptions of ecological context of the area in terms of community involvement, community funding, and political support
9. The problem MHCs aim to address
10. The perceptions of MHC community impacts

Dissertation committee members reviewed the survey for face validity and checked for issues in question construction and subject matter coverage. The survey was pilot tested by a convenience sample consisting of younger and older age demographics to evaluate survey length and readability, and to account for potential technological issues accessing the survey. Then, members of the problem-solving court community pilot tested the survey. Issues with survey length and page breaks were identified and corrected before ultimate distribution.

RESEARCH DESIGN

I used a convergent mixed-methods design within the framework of program-theory evaluation research. This design was used to simultaneously collect information from both qualitative and quantitative data sources for the purpose of comparing and combining the results (Creswell and Clarke 2018). The combined qualitative and quantitative results were used to inform the program-theory logic model creation and suggest evaluation questions and methods

(Chen 2006; Greene and Caracelli 1997). See Figure 2 for a graphical summary of research design procedures.

Supplemental Data Collection

After each online survey was completed, additional online information was collected about each participating MHC. The information was gathered from courthouse websites, district attorney web pages, mental health advocacy websites, state Department of Mental Health pages, previously published research and program evaluations, and news media outlets who reported on the programs. Supplemental data was also collected about the community or jurisdiction where each MHC was located using Census data, GIS and Google map data, and Mental Health America (2018) reports.

Data Analysis

The resultant body of information was analyzed to generate descriptive statistics of survey data, grounded thematic codes of qualitative survey data and program documents, and descriptive maps of the areas served by the MHCs. I used a convergent sequential design wherein I analyzed the qualitative and quantitative data simultaneously.

Supplements for Missing Data and Data Triangulation.

On occasion, surveys included missing responses, but the requested survey response data was available within provided court documents (e.g. MHC participant handbooks). In these cases, the corresponding qualitative data that referred to the missing survey data was converted into quantifiable data points to include in summative descriptive statistics. For example, some MHCs did not answer fill-in-the-blank responses about who comprised their court team. Instead, they referred to the participant handbook uploaded within the survey. This type of missing data was presumed to occur and was considered during survey development. MHC document upload requirements were placed in the beginning of the survey to ensure sufficient data collection in the

case of respondent survey fatigue. The provided documents acted as a supplement to missing data as well as a source of triangulation with provided survey responses. This form of document supplementation for missing survey responses was used for missing data in the policies, practices, and stated goals of MHC when missing survey data occurred, but not for development of implicit assumptions of MHCs.

Qualitative Coding.

Next, I thematically coded the qualitative survey responses and documentation. Data was analyzed to uncover patterns in procedures, activities, and structures among the MHCs. Fortunately, most MHC programs use the same *in-vivo* terms for program components. Therefore, a key word search was utilized to find particular bits of data about practices, services, and individuals. For example, in a coding effort designed to understand the interpretations of Essential Element, "Confidentiality", a key word search for terms like "confidentiality, gossip, secret, private, HIPAA, and disclosure" was conducted. Key terms were used to target policies and procedures within the participant handbook and policy and procedures guides. Then those phrases and paragraphs were collected along with the included write-in survey responses about Confidentiality and organized using Microsoft Excel computing program. I then axially compared the types of processes to each other using the data related to confidentiality. Phrases and practices that mirrored one another were coded together and discrepant information was coded separately. The resultant axial codes that represented common practices among MHCs were converted into frequency counts. The discrepant codes were used to highlight a particularly novel or well-exemplified practice of Confidentiality within a particular court. This process was undertaken for all 10 *Essential Elements* as well as the hypothesized topics of community and transportation.

Map Generation.

MHCs supplied the address of their program along with locations of treatment options, social service providers, and peer-support groups. Courts also provided information regarding whether

public transportation was made available in their community and the program's use of jail. I used these pieces of information along with Google maps and city transportation route data to create a GIS map of key locations utilized by MHCs and the relative locations of available public transportation routes. While merely descriptive in purpose, the generated maps were used to make conclusions regarding the relative location of MHCs to identified community resources, treatment providers, and public transportation routes. Additionally, generated maps help draw conclusions about the overall distribution of court services providers within a MHCs legal jurisdiction and inform issues of accessibility and transportation.

Program-Theory Evaluation Framework.

Merging the qualitative and quantitative data resulted in a thick, rich description of each MHC that lent itself to use in a program-theory evaluation (Geertz 1974). Program-theory evaluations, or theory-driven evaluations, seek not to know just *if* a program works, but *how* and *why* a program works by developing theories that identify the relationships between the problems a program aims to solve, the conditions program components and processes are thought to operate within, and what the program is doing to solve those problems (Chen 2012; Bickman 1987; Donaldson 2007). The previously discussed survey construction and data collection strategies were selected as a reflection of the components of a theory-driven logic model, thus allowing for direct transfer of analyzed data into a program-theory logic model format once primary data analysis was complete. The next section outline the three steps generally undertaken in a program-theory evaluation.

I utilized Chen's (2006) conceptual framework for theory-driven logic models that incorporates an action model and a change model. A change model aims to get at the implicit and explicit assumptions for how a program should work in theory. A change model contains three elements: (1) Interventions: activities that imply change between determinants and outcomes; (2) Determinants: mechanisms that mediate interventions and outcomes; and (3) Outcomes: the

anticipated program effects. The action model consists of six components that illustrate how the program is structured through program inputs, resources, and organization. Components of the action model include: (1) implementing organizations, (2) program implementers, (3) associate organizations and community partners, (4) ecological context, (5) intervention and service delivery protocols, and (6) target population" (Chen 2006:77). See Figure 3 for the theory-driven conceptual framework layout. Logic models form a visualization of the conceptual framework of a program's resources, activities, outputs, and intended outcomes and impacts so that causal linkages between the elements and desired outcomes can be identified (W.K Kellog Foundation 2004; Fitzpatrick, Sanders and Worthen 2014).

I first developed a normative program-theory model based on the various assumptions listed in the *Essential Elements of a Mental Health Court* document (2008). This program-theory model is based entirely on the assumptions of what a MHC *should be* including, the assumptions for the problem it is meant to address, the way the program should be structured, and the goals of the program (Figure 10). After creating a normative program-theory logic model for MHCs, I then used the data from the survey and document analysis to create "actual" logic models for the 19 MHCs that provided enough data to complete this portion of analysis (Appendix A).

By comparing the normative model to the 19 actual models, I determined if key elements of the MHCs are delivered as originally intended or if the programs experienced drift or alteration in their assumptions, practices, and goals. In a program-theory evaluation, programs that do not adhere to their own theoretical assumptions are experiencing "implementation failure".

Next, I used the collection of program-theory logic models and ethnographic court data to suggest new outcome evaluation questions and potential methods for empirically testing outcomes and impacts. While the program-theory logic models are complex and contain information for the generation of numerous theories that explain linkages to inputs and activities,

not every theoretical assumption required testing. Social science and established evaluation practices were used to support my decisions to identify a particular outcome evaluation question and also helped to select methodological manners by which to test the identified linkages (Weiss 1995: 78).

The limited sample of MHCs in this study varied widely in program size, structure, and contextual factors like environment and program start year. Due to these issues, as well as a limited time frame and budget, it was illogical to test any of the identified outcome measures. While outcome measures and variations from the normative program-theory were identified, this research stops short of being a full program-theory evaluation. Due to the lack of outcome measure testing, this dissertation constitutes mixed-methods research conducted within the framework of a program-theory evaluation.

Future research will require testing of identified outcome measures from this research. If programs adhere to the normative model and identified outcomes are positive, the program-theory of MHCs will be validated and the program will be considered a success. However, if programs are found to not adhere to the model, but outcomes are positive, it should be recommended that the program-theory be changed to better match the program implementation and use the program implementation as a new normative theoretical model (Fitzpatrick, Sanders and Worthen 2012:164). However, bear in mind that particular community context may be the reason behind the normal model's success despite adaption from the ideal model. If the program adheres to the model theory, but existing outcome measures are negative, MHCs of this nature are an example of "theory failure", but also bear in mind that failure may be due to the program working with an inappropriate served population or inappropriate community context (Suchman 1968). Programs experiencing program-theory failure should consider changes to the target population, program context, program implementation, or consider adapting to an entirely new program-theory (Fitzpatrick, Sanders and Worthen 2012: 161-2).

SUMMARY

MHCs serve a unique population and there is a critical need for innovative evaluation research to determine the effectiveness of MHC programming and to identify areas for improvement. While outcomes appear positive in terms of recidivism rates and days in jail, it appears that the core assumptions under which MHCs originally rested are now under fire. The primary MHC assumption is that criminal activity is reduced by connecting clients to needed mental health treatment, but it appears that other mechanisms might be more responsible for positive outcomes. The current study will assess whether MHCs still operate under the assumptions and related to the *Essential Elements*. This study will also uncover other assumptions that may help to explain program success. In the process of uncovering assumptions, I will evaluate linkages between these assumptions, community/ecological context, court inputs/resources, court activities/process, outcomes, and goals. These findings will be used to identify outcome measures to later test these linkages and determine how they relate to court success. I argue that ecological context may be an important link to positive court outcomes. Thus, community-level impacts may be an overlooked and untested measure of court success.

CHAPTER IV

FINDINGS

The *Essential Elements of a Mental Health Court* is a touchstone document for MHCs created through collaboration of individuals from the Bureau of Justice Assistance (2008), the National Drug Court Institute, the Council of State Governments Justice Center, and key representatives from 150 MHCs across the U.S. The document was formed out of a need to consolidate a definition of MHCs and their common practices. The early 21st century saw rapid expansion of this type of problem-solving court without a real framework to guide implementation. MHCs encompassed a variety of program types, structures, mandates, and resources based largely on the needs of the community and available community resources. The document outlines then existing commonalities within the 150 MHC programs and goals they strived to achieve.

While the *Essential Elements* was created through collaboration of extraordinarily informed stakeholders, the authors recognized that MHCs will not operate with all ten elements present. Additionally, court teams will interpret the elements in different ways, disagree with the selection or feasibility of elements, and potentially identify missing elements. The authors argued that dissent with the assumptions in the document will motivate improvements to the *Essential Elements* and drive research to empirically validate their, admittedly, empirically invalidated assumptions about what makes a successful MHC. In the following pages, the assumptions, goals,

and each of the *10 Essential Elements* are summarized in terms of their perceived relative importance to success and interpretations within 27 operating MHC programs.

This section begins with findings regarding the assumptions and goals of the sample of MHCs. These assumptions and goals are then used to develop program-theory-of-change models. After discussion of each MHC's interpretation of the 10 *Essential Elements* and a look at the contextual environments in which these courts exist, the findings will be used to develop program-theory action models. The resultant program-theory models, comprised of both change and action model components, will then be compared to the normative program-theory models, general findings, and existing social science to highlight areas of theory deviation, identify issues, and suggest future methods and avenues of evaluation.

ASSUMPTIONS OF MENTAL HEALTH COURTS

MHCs are based on a variety of assumptions. They are assumed to operate off the principle of therapeutic jurisprudence, to adhere to the 10 *Essential Elements*, to utilize common determinants, and to pursue common goals. I start by outlining the way courts adhere to the commonly stated normative assumptions of their programs. Which are

> (1) untreated, or inadequately treated, mental illness contributes to criminal behavior; (2) criminal justice involvement can serve as an opportunity to connect people to appropriate treatment; (3)appropriate treatment can improve the symptoms of mental illnesses, (4) appropriate treatment can reduce problematic behavior, (5) judicial supervision helps keep people in treatment (6) the use of graduated incentives and sanctions helps keep people in treatment (7) The combination of treatment and judicial supervision reduces recidivism and (8) The combination of treatment and judicial supervision improves public safety (Fisler 2015: 8-9).

To address potential variation in MHC actual and normative assumptions, the sample of courts responded to what extent they agree with the above stated collection of statements addressing the assumptions of program interventions and determinants (Table 4). The respondents were asked to what extent each of the eight assumption statements were important to their MHC on a five-item scale ranging from "extremely important" to "not at all important" (N=26). All of the respondents indicated that seven of the eight statements were at least moderately important to

their MHC. In each of those seven categories, the majority of respondents indicated that each of the seven assumptions was “extremely important” to their MHC. The only variant from this pattern was the assumption that stated, “The use of graduated incentives and sanctions helps keep people in treatment”. With this assumption, the majority of respondents indicated that was only “very important” to their mental health court rather than “extremely important”. Additionally, this particular assumption merited three responses of “slightly important”.

GOALS OF MENTAL HEALTH COURTS

The *Essential Elements* indicate four goals for MHCs are: 1. Increase public safety; 2. Facilitate participation in effective mental health and substance abuse treatment; 3. Improve quality of life for people with mental illness charged with crimes; and 4. More effective use of limited criminal justice and mental health resources. Court goals should be realizable, mirror the court’s purpose, and “provide a foundation for measuring the court’s impact” (2006). In addition to the normative goals derived from (?) the *Essential Elements*, three common theoretical goals exist within MHC research: therapeutic jurisprudence, restorative justice, and procedural fairness. Three measures addressed the goals MHC assumed for their courts: a 5-item scale inquiring into the level of importance courts held on various common normative goal assumptions, a write-in survey response asking for the stated goals of the court, and content analysis of goals stated in available court documents.

Survey Goals

To quantitatively address goals and potential goal variations within MHCs, respondents responded to the perceived importance of twelve commonly identified MHC goals to the success of their MHC. The twelve goals are: 1: Increased public safety for communities, 2: Increased treatment engagement by participants, 3: Improved quality of life for participants, 4: More effective use of resources for sponsoring jurisdictions, 5: Keeping those with mental illnesses out of jail, 6: Reintegrating the clients back into the community, 7: Ensuring clients are treated fairly,

8: Ensuring clients feel their opinions are heard, 9: Ensuring clients are not stigmatized by mental illness diagnoses, 10: Ensuring clients are not stigmatized by prior criminal involvement, 11: Ensuring clients feel forgiven for their past misdeeds, and 12: Ensuring all aspects of mental health court are therapeutic. Respondents were asked how important each of the goals were to the success of their MHC on a 5-item scale ranging from "extremely important" to "not at all important".

Twenty-six courts responded to the survey question. Overall, the majority of respondents felt that all but two of the twelve goals were "extremely important" to the success of their MHC (Table 5). The largest majority of responding courts felt that two goals were only "very important" to their MHC success: Goal 4: More effective use of resources for sponsoring jurisdictions 50% (13) of responding courts and Goal 11: Ensuring clients feel forgiven for their past misdeeds with 34.64% (9) of responding courts. Additionally, a few goals merited responses that were perceived as only "slightly important" to court success: Goal 4: More effective use of resources for sponsoring jurisdictions and Goal 10: Ensuring clients are not stigmatized by prior criminal involvement both merited a "slightly important" response in 3.85% (1) of responding courts. Goal 11: Ensuring clients feel forgiven for their past misdeeds, was the only goal of the twelve that merited a response of "not at all important" from 2 of the 26 courts (7.69%).

Write-in Goals

In addition to quantitatively addressed goals, each MHC was offered the opportunity to provide their MHC program's goals through a write-in response in the survey and, when provided, as listed within participant handbooks and policy and procedure guides. Provided participant handbooks and policy and procedure guides frequently included goals, vision, impact, and mission statements. The data resultant from the write-in responses and provided court documents were merged, quantitatively coded, and compiled for common ideas and themes. The

goals broke down into three umbrella themes: client-level goals, program-level goals and community impacts.

Client-level goals.

Most frequently, MHCs listed the following kinds of goals for their clients: decreased recidivism (18) and decreased incarceration (18). Other common goals include improving clients' mental health and stability (13), improved quality of life (11), facilitating long term sustainability (9), community integration (9), collaboration between clients and their access to resources (14). Few courts also mentioned housing (3), education (3), and vocational (4) goals as part of the program goals (N=27; not shown).

Program-level goals.

Some goals referred not to goals for clients, but for the program itself. These goals involved facilitating collaboration between the criminal justice system and community services (8), treating clients with the principles of therapeutic jurisprudence (3), and providing trauma-informed services (1). Coordinated Resources Project-Palmer and 13th Judicial Circuit Treatment Court provided detailed program goals that aligned with the 10 *Essential Elements*. Their explicit reliance on these goals allowed for elaboration of one program-level goal: evaluation of practices/program improvement (N=2) (N=27; not shown).

Community-level impacts.

Goals set forth by MHCs were not all merely statements regarding clients or program, but also community-level impacts. The most common community-level impacts are improving public safety (19), reducing the burden of mentally ill overpopulation within their criminal justice system (6), decreasing hospitalizations (3) reducing criminalization of mental illness (3), and reducing mental illness stigma (2) (N=27). Marion County MHC's impact-level goal stands out. Marion County MHC aims to create "a community that supports overall wellness and

understanding of mental health issues". Another interesting set of broad goals are Fayette County MHCs aim to save lives and preserve families.

Therapeutic Jurisprudence.

While therapeutic jurisprudence constitutes a normative assumption for MHCs, the application of therapeutic jurisprudence also constitutes a goal for MHCs. MHCs rely on the broad assertion that regular criminal justice practices and incarceration are anti-therapeutic and result in negative outcomes for mentally ill offenders. MHCs aim to divert mentally ill offenders from these regular, non-therapeutic practices and into diversion programs that promote positive, therapeutic interactions with the criminal justice system. The majority of courts feel that ensuring all aspects of the court are therapeutic is an "extremely important" (53.85%; n=14) or "very important" goal (38.46%; n=10) for their MHC (Table 5).

To further address therapeutic jurisprudence, MHCs judged how well they feel interactions with the Judge, Court team, Supervision staff, Courtroom, Community service providers, Substance abuse service providers, Mental health service providers, Local police, Local community, Jails, and Jail staff are currently conducted in a therapeutic manner. MHCs responded on a 7-item scale ranging from "extremely well" to "not well at all", with a "not applicable" and "don't know" option available (Table 6). Twenty-four courts responded to this survey question. The majority of courts feel they therapeutically handle client interactions with the judge 54.17% (13), supervision staff 62.50% (15), and interactions within the court room 45.83% (11) "extremely well". Client interactions with community service providers 41.67% (10) substance abuse service providers 37.50% (9), and mental health service providers 45.83% (11) are reportedly handled therapeutically "very well" in the majority of courts. Courts report handling clients interactions with the local police 50.0% (12), the local community 41.67% (10), within jails 41.67% (10), and with jail staff 41.67% (10) only "moderately well". 4.17% (1) court

feels that clients' interactions with the jail and jail staff are not conducted in a therapeutic manner at all. Also interestingly, 8.33% (2) courts felt that handling interactions with local police in a therapeutic manner does not apply to their MHC.

CHANGE MODELS

A change model, or theory-of-change model, outlines the causal process of a program and contains three core elements- *Interventions: "*a set of program activities that focus on changing the determinants and outcomes", *Determinants/Outputs: "*leverages or mechanisms that mediate between the intervention and outcomes;" and *Goals/Outcomes:* "anticipated effects of the program" (Chen 2006). Essentially, change models provide a depiction of what MHCs believe are the problematic issues they should address and what needs to occur to successfully address those issues. A well-implemented program change theory depicts logical connections between interventions, determinants, goals, and impacts assumed in play in each MHC.

The *Essential Elements* and established social science literature provides information used to create a normative change model for MHCs which is outlined in Figure 4. Information gathered from the courts regarding their assumptions and goals was then used to create "actual" change models for MHCs. These figures were created using the collection of survey write-in goal statements of courts and from available court documents, more specifically, the courts listed goals, visions, and mission statements. Figure 5 includes a summary collection of each type of MHC mentioned intervention, determinant, outcome, and impact, a count of how many MHCs adhere to the various normative features, and identified variations from the normative statements. 19 MHCs supplied enough information to create these models.

Interventions

While the actual explicitly used terms varied, most courts mention the use of appropriate treatment (19) and judicial supervision (13), and identification of individuals in the criminal

justice system, aka criminal justice involvement (12) as interventions necessary for court success. Additionally, while related to appropriate treatment, one commonly listed intervention was the use of "social support services" (10). Other courts mention use of evidence-based services and evaluations (2), problem-solving approach and a (2), team-based approach (2), and use of therapeutic jurisprudence in their interventions. Interestingly, "the use of graduated sanctions and incentives", is only explicitly mentioned in one court's goals. Two other singly noted instances of interventions include "treating clients with dignity and respect" and "respecting needs".

Determinants

The determinants, collected from MHC's statements of goals, most commonly included mention of how their interventions "improved symptoms of mental illness" (11), "served as an opportunity to connect people to appropriate treatment" (8), and "keeps people in treatment" (5). Additionally mentioned determinants included promotion of "accountability and self-reliance (6), promotion of healthy lifestyle changes (6), effective time management (1), relationship management (1), and individual strengths promotion (1).

Goals

Most commonly, MHCs explicitly mention goals of reducing recidivism (16), improving quality or life/self-sufficiency of clients (13), and reducing criminal justice involvement (14). Other goals included reducing psychiatric hospitalizations (4), meeting guidelines outlined by the *Essential Elements* (1), and program completion (1).

Impacts

The most commonly stated impacts are improving public safety (15), more effective use of limited criminal justice and mental health resources (9), and reducing jail strain (7). While related to more effective use of limited resources, courts also explicitly mention cost savings (3) as a desired court impact. Additionally, courts mention improving family quality of life (1),

decreasing mental illness stigma (1), saving lives (1), preserving families (1) , promoting community (1), providing justice for the community (1), a community that supports overall wellness and understands mental health issues (1) and assisting law enforcement in their contact with mentally ill individuals (1).

INTERPRETATION OF THE 10 ESSENTIAL ELEMENTS

The following section includes findings in relation to interpretation and application of each of the 10 *Essential Elements.* After each element is described, the information will be used to develop "action models" as part of the program-theory logic models for MHCs.

ESSENTIAL ELEMENT 1: PLANNING AND ADMINISTRATION

The first *Essential Element* of a Mental Health Court is Planning and Administration, which the BJA summarizes as "A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court" (Thompson, Osher and Tomasini-Joshi 2008). During program establishment, MHCs require planning, organization, and guidance from a broad variety of stakeholders who work together to ensure that program goals are clearly defined and help ensure policy-maker support. The stakeholders also make sure that the program provides activities aimed at achieving stated goals and ways to evaluate the level goal obtainment. When identified, the stakeholders should implement policy and/or procedure changes within program's structure. The stakeholders should ensure support and training opportunities for the court team.

To address how various MHCs interpret and implement this *Essential Element*, each MHC responded to what level of importance they placed the element, Planning and Administration, to the success of their MHC on a scale from 1 (most important) to 10 (least important) compared to the other *Essential Elements*. Twenty-five of the 27 responding courts addressed this question (Table 15). Reponses ranged from 1st to 10th most important. The largest

percentage of courts, 20% (5), perceived Planning and Administration as the 8th most important element to their success. (M=5.52, SD=3.32, N=25).

Courts also responded to a write-in survey response aimed at understanding how they implemented program Planning and Administration in their programs. Court documents such as the programs' participant handbooks, policy and procedure guides, where used whenever provided to triangulate survey statements with published statements. To further address Planning and Administration, an online search was implemented to determine the existence of any state-level established statewide standards or certification processes governing MHCs (NCSC 2016) whether the court attended training conferences, and whether the court was mandated to procure a policy and procedures manual.

State-level Standards

State-level standards, overall, are fairly new, most states published a form of standards, certification process, or checklist for their MHCs within the past seven years. Eighteen of 27 MHCs exist in states that use coordinated certification processes and best practice standards for their MHC programs. From this sample, MHCs in Missouri, Virginia, Pennsylvania, North Carolina, Louisiana, Alaska, and Washington do not have published state-level standards. Florida also does not have MHC standards, but rather, a set of general standards for mental health and criminal justice systems. Michigan, Utah, and Texas published their standards this year, but those state-level standards do not go into effect until 2019.

State-level Training

Next, I looked at whether each state had access to state-level training for problem-solving courts. While many of the courts indicated that they attended national-level training through the NADCP or NDCI. Some states, like Oklahoma, Arizona, Utah, Idaho, Illinois, Michigan, Louisiana, Georgia, Missouri, introduced their own state-level conferences. Idaho has gone even

further moving from state level to regional training and creating online webinars for training specialty courts. However, the state-level meetings ranged widely on how much they are specifically tailored for MHC training. Some are intended specifically for MHCs while others are generally problem-solving court conferences.

Policy and Procedure Manual

Another important component to the Planning and Administration of MHC is the creation and use of a policy and procedure manual. A document required by some states for MHC certification. Of the 27 responding courts, thirteen provided policy and procedure manuals upon request. Three courts' policy and procedure manuals, Boone County Treatment Court II, Marion County MHC, and the Coordinated Resources Program-Palmer, listed the *Essential Elements*.

Environment

The environment in which MHCs reside acts as a factor in planning and administration. Community environments determine if there is a need to start a MHC, determines whether there will be community or court support, and impacts the availability of treatment resources. To address the types of environments the 27 MHCs exist within, I looked at the population and area served, the general voter demographics and the issues identified in the community that led to MHC creation. I also examined the state's mental health ranking as operationalized by Mental Health America, Ranking the States (2018).

The state mental health ranking is a 15-item measure of level of population need for mental health and addiction treatment, access to services, and mental health workforce availability (MHA 2018). Two-thirds (18) of the sampled courts operate in areas below the 50th percentile in mental health ranking (Table 7). Only three MHCs operate in predominately rural communities and two operates in a mix of urban and rural counties. 51.8% (14) operate within a Democratic swinging political community and 48.2% operate in a predominantly Republican

community. When MHCs were asked what about their communities made starting a MHC a necessity, common responses revolved around a large severely mentally ill (SMI) population, lack of access to treatment services, overpopulated jails and court dockets, issues with various drugs being trafficked and abused, and judicial or community desire. Urban community serving MHCs were more likely to mention issues of homelessness and judicial desire while rural courts or courts that served mixed rural and urban demographics were more likely to mention poverty. Two rural operating MHCs and two urban MHCs also explicitly mentioned the urban or rural dynamic of their community and how it contributed to the need for MHCs.

ESSENTIAL ELEMENT 2: TARGET POPULATION

The second *Essential Element* 2 Target Population states,

> Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered (Thompson, Osher and Tomasini-Joshi 2008).

Court respondents indicated how the perceived the value of "Target Population" to the success of their MHC on a scale from 1 to 10. Responses ranged from 1st to 9th with bi-modal responses at #1 and #2 in importance (M=3.84, SD=2.48) (Table 15). The *Essential Elements* description of a MHC indicates that, in terms of target population, successful MHCs are part of a collaborative system of interconnected diversion elements at various points in the criminal justice system. MHC should work with local police and other diversionary programs. The programs population should not extend beyond the community resource capacity and inclusion criterion should be well defined. These highlights were addressed utilizing survey data, court documents, online information and correspondence with programs and collaborative law enforcement agencies.

Police Collaboration

MHC should work with local law enforcement to created specialized police-based responses. 21 of 24 MHCs are known to operate in jurisdictions where police receive Crisis Intervention Training (CIT) or some similar mental health intervention training. 19 MHCs indicated that information about the MHC program is delivered as part of the CIT training or the coordinator acted as the CIT trainer. Three MHCs indicated that while police received CIT training, they were not informed about the MHC program as part of that training. Two courts indicated there was no training available to local law enforcement about the program (N=24).

Comprehensive Strategy

MHCs should operate as part of a comprehensive strategy of diversion. To address this question, courts were asked about other diversionary program available in the jurisdiction served. Of the 27 areas served, 92.59% (25) also offer a drug court, 66.67% (18) veterans court, 51.85% (14) juvenile court, 37.04% (10) family drug court, 5.38% (5) child support court, 18.51% (5) DWI/DUI courts, 18.52% (5) domestic violence court, 14.81% (4) truancy court, 11.11% (3) prostitution/human trafficking court. 11.11% (3) responding courts also mentioned a corresponding felony or misdemeanor version of MHC, veterans, and drug court in their jurisdiction. Individual instances (3.7%) of a co-occurring court, child protection court, re-entry court, Zero to Three Court and a probation court were also found in individual jurisdictions. (N=27). Stands outs in terms of making the MHC part of a comprehensive strategy include 11th Judicial District Criminal Mental Health Project, Consolidated Resources Project-Palmer, and Whatcom County MHC. These three courts are publicly conceptualized as a piece of a larger continuum of mental health diversion efforts in their respective jurisdictions. For example, 11th Judicial District Criminal Mental Health Project incorporated CIT police training and MHC orientation, post-booking and pre-booking diversion, a forensic alternative center, the SOAR entitlement benefits program, a jail In-Reach program that targets high utilizers of mental health

services, peer recovery specialists, and a first-of-its-kind mental health diversion facility. These efforts aim to divert people from the criminal justice system at all intercept points along the continuum of justice system involvement.

Program Size

To address target population of the court, each court was asked about the maximum program population. Twenty-three courts responded and answers ranged from 12 to 100 participants (M=41.24 SD=24.83). See Figure 6 for a court-by-court maximum participant population. The size of the population served was not related to the size of the jurisdiction, but the operating capacity and funding of the MHC.

Eligibility Criterion

Eligibility criteria was collected from survey data, participant handbooks, and policy/procedure manuals, and legal statutes. The responses were then coded into various response categories as they arose in the data. Codes are grouped into categories of age, criminogenic risk, felony v. misdemeanor, co-occurring, SMI/severe and persistent mental illness, AXIS diagnoses, linkage between crime and illness, violent offenses and sexual offenses.

Of the 27 responding programs, each indicated that potential clients must have a mental illness, be willing to participate in the program, and be emendable to treatment. Three adult MHCs accept clients younger than 18 years of age into their adult court, upon legal approval.

While only one court was a purely misdemeanor MHC, 26 courts accept felony charges with various stipulations and on a case-by-case basis. More often, those with violent, sexual offenses, weapons involved, and felony drug trafficking charges are excluded from MHC participation. Seven courts reject offenders with sex offenses explicitly in the eligibility criteria and twenty courts rejected violent offenders with recent or multiple violent charges. Some courts allow the prosecutor to reduce felony charges to misdemeanors to allow for participation when

the nature of the crime appears reasonable to accommodations. Four of the courts excluded DUI charges, but Coordinated Resources Project-Palmer mentioned a reduction of drunk driving charges from "DUI" to "negligent driving" upon program completion with a minimum program commitment of 18 months.

While all programs deem a mental health diagnosis necessary for program inclusion, MHCs varied on what kinds of mental disorders could result in acceptance into the program and how specific the kinds of accepted diagnoses were. Eleven courts utilized the SMI or severe and persistent criterion for mental health diagnoses accepted. Fourteen courts used the Axis I criterion and three of those courts identified allowing individuals with an Axis II diagnosis as long as they had a dual and primary Axis I diagnosis. Two courts made no mention of the severity or types of mental illness acceptable for program inclusion. PTSD, borderline personality disorder, Traumatic Brain Injury, dementia, organic brain disorders, autism, and mental retardation were the most commonly excluded mental illness criterion, although some accepted mild forms on a case-by-case basis or when the disorder was secondary to an accepted condition. Nineteen courts explicitly mention the assumption that many of their accepted clients experience a co-occurring substance abuse disorder, even so, the mental health disorder must be the primary issue for resolution.

Seven MHCs clearly articulate a moderate-to-high criminogenic risk requirement as a criterion for acceptance into the MHC. Whatcom County and 38th Judicial Circuit MHCs target individuals with extensive case histories, while Fayette County MHC rejects clients with extensive case history. Twelve courts explicitly mention that the clients' criminal behavior and mental illness must be linked. One of the courts indicate that the most current offense did not have to be the offense linked to mental illness for program inclusion.

ESSENTIAL ELEMENT 3, TIMELY PARTICIPANT IDENTIFICATION AND LINKAGES TO SERVICES

Essential Element 3, Timely Participant identification and linkages to services is summarized as "Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible" (Thompson, Osher and Tomasini-Joshi 2008). To address this element, MHCs were asked the relative importance of this element as compared to the other nine *Essential Elements* to program success. Then courts were asked to explain how their court implemented this element. Statements were triangulated with online websites, participant documents, policy and procedure manuals, program brochures, and contact with national problem-solving court organizations.

MHCs ranked Timely Participant Identification and Linkage to Services as the 1st to 9th most important element to court success (M=3.84, SD=1.94, N=25) (Table 15). MHCs also interpreted this element within their courts. The responses predominately revolved around referral sources, mandated time constraints for program acceptance, assessment of psychiatric and non-criminogenic needs, specialized collaboration programs and technologies used, and issues experienced in upholding this element to acceptable standards. Timely Participant Identification and Linkages to Services were triangulated with statements regarding referral sources and processes within the provided participant handbooks, policy and procedure guides, and prior court evaluations.

Referral Sources

MHCs should welcome referrals from a wide array of sources. Of the 24 courts who provided feedback, 15 mentioned who acted as their primary sources of referrals in their response. Most commonly, defense attorneys and prosecutors were listed as primary referral sources. Other fairly common sources included community sources like treatment and social services providers, judges, law enforcement, and jail staff. A select few courts individually

mentioned “anyone”, family members, pretrial services, probation, and the individual potential clients themselves. One standout, the 11th Judicial Criminal Mental Health Project, mentioned their new In-Reach program which is a specialized program intended to facilitate cross system collaboration. The program began May 2017 and is grant funded for $1.2 million dollars for the next three years. The community collaborative program assesses and targets high risk, high needs SMI adults who are eligible for services and helps link them to services and community-based monitoring.

Advertising

While none of the courts explicitly mentioned the details of how they advertise of their courts to potential referral services, the element description suggests that MHCs should be able to advertise eligibility criteria and actively inform referral sources (Thompson, Osher and Tomasini-Joshi 2008). Provided documents and online materials revealed whether each program provided a pamphlet or brief program summary capable of advertising the program to the public and/or potential referral sources like defense attorneys. Through examination of provided documents and a general web search for each court name, only Coordinated Resources Project-Palmer and 30th Circuit MHC uploaded available program brochures upon request. Northampton MHC stated that district judges have copies of program brochures. General online information was more readily available. Most programs were explained briefly on courthouse websites and, in fewer cases, on attorney websites. Applications, referrals or screening forms were found online for eight courts and eligibility criteria was published online for six of the 27 courts.

In some cases, the only online mention of the court was merely a statement that it existed. For example, on the Georgia Accountability courts website, Muscogee County MHC was excluded in the comprehensive list of problem solving courts or MHCs in the area. The court and point of contact can only be found on the website by downloading the directory of problem solving courts found elsewhere on the website. However, in a single instance dated in 2015,

information about an event where an in-person information session was found on the NAMI website for the Muscogee County MHC (NAMI 2015). Additionally core websites used for locating MHCs and other problem-solving courts, e.g. SAMHSA and NDCRC, provided outdated contact information. A phone call with a representative from the NADCP stated that a comprehensive list of problem-solving courts and contact information was created in 2016, but has not since been updated.

Timely Screening and Intake Mandates

Five courts included a discussion of policy mandates on the period between referral and intake in survey responses. Muskogee County MHC has a policy of 30 days, Washtenaw County Mental Health Treatment Court mandates 21 days or less. Bexar County MHC receives notifications of mentally ill within the jail and reviews them within 48 to 72 hours. Within 24 hours after receiving attorney permission, the court works with the Sheriff's office to conduct video conference screenings of clients in jail. Fayette County MHC receives preliminary arraignment sheets after booking. The arraignment sheets included whether the incarcerated is diagnosed with a mental health diagnoses. Then the court meets with them within 3 days at the jail or in the community to coordinate services and their participation in mental health court. McHenry County MHC aims for 60 days between arrests and program acceptance, their evaluations from the past three years track an average arrest to intake process of 7 days.

Timely Forensic and Non-criminogenic Needs Assessments/Screening

Another common piece brought up in the description of courts adherence to Timely Participant Identification and Linkages to Services was the timely assessment of clinical and treatment needs as well as non-criminogenic needs like housing and primary care. Variation existed in who was responsible for conducting the forensic or clinical assessments of potential clients. Some courts contracted with local outside agencies such as criminal diversion agencies, community mental health agencies and the mental health department to conduct evaluations. In

other cases, the court program manager or the alternative court staffing team conduct the screenings of participants within the jail.

Tracking Attendance

While most courts interpret Timely Participant Identification and Linkages to Services through a discussion of their referral sources, referral-intake procedure, and related time mandates, the 14th JDC MHC of Louisiana varies in their interpretation. They interpret this element within their court as their ability to track participant appointments and meeting attendance. They track appointments and attendance through a computerized calendar through Memorandum of Understanding (MOU) waivers with service providers. MOU waivers are documents that outline the roles of agencies who interact with the programs. Kitsap County MHC also outlines how their program manager acts as a quasi-compliance officer providing information on any required proof of treatment or other mandates needed for the court file and procession with phase requirements.

Appointment Reminders

Related to appointment attendance monitoring, mental health court participants are required to attend frequent court dockets, group meetings, counseling sessions, drug testing, and service appointments. Due to the multitude of appointments and clients' potential to experience health conditions that negatively influence memory and organizational skills, each court indicated how their program helps clients remember their various appointment times and dates. Twenty-three courts provided a response to the query. Responses covered the use of appointment calendars, phone, verbal, and written reminders, use of participant handbooks, consistency in scheduling, and the use of a bus to transport clients to court.

Twelve courts indicated that they provided calendars or planners for their participants. One detailed entry from Marion County MHC discussed the use of "barrier busting funds" used

to purchase calendars for clients when needed. Additionally, Marion County MHC assigns clients recovery coaches from their local behavioral health court who helps with appointments and developing scheduling skills. Bexar County MHC follows a similar framework where treatment providers promote time management skill building and communication with team members. They encourage clients to use their phones' calendars and set reminders for appointments.

Nine courts mentioned the use of phone call reminders from case managers and treatment providers. Some courts mandate weekly call-ins for all clients to discuss upcoming appointments while in some courts clients receive phone calls reminders only when deemed necessary to encourage meeting attendance. Two courts also mentioned texting reminders to clients in addition to phone calls. Whatcom County MHC discussed how they ensured clients were able to ensure their ability to call and text clients by providing clients resources to obtain a phone when needed. Whatcom MHC also utilizes "helpers" which are family members and residential program staff who are tasked with reminding clients of appointments The 5th Judicial District MHC does something similar wherein they task phone calls reminders to clients from members of a participant advisory committee and assigned mentors. Seven courts discussed verbal communication and when court team members give verbal reminders of upcoming appointments and dockets.

Most typically, clients receive verbal reminders during open court and during check-in appointments. Six courts mentioned using written reminders or appointment cards to encourage clients to remember their appointments which they receive from either the judge or court coordinator. Clients also receive appointment cards from treatment specialists. Four courts mentioned how the participant handbook acts as a reminder for program requirements. The handbooks of respondents who mentioned the handbooks as a way to remind clients mentioned dates and times for clients to attend docket based on their phase of program and the frequency with which call-ins and check-ins should occur. However, they did not mention specific times for

treatment or counseling appointments other than times for AA and NA community peer support meetings available within the community.

Less commonly mentioned, three courts discussed their aim for consistency with weekly appointment times to encourage client's ability to remember when they were supposed to attend meetings. One court, the Creek/Okfuskee County Anna McBride Court, discussed how they ensured clients remember their court program attendance mandates through a bus provided by the services provider.

ESSENTIAL ELEMENT 4: TERMS OF PARTICIPATION

The fourth listed *Essential Element* is Terms of Participation which states "Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program" (Thompson, Osher and Tomasini-Joshi 2008). To evaluate how this element was valued and interpreted within MHCs, each court was asked to rank how important they felt Terms of Participation acted on the success of their MHC (Table 15). The 25 responding courts placed Terms of Participation from first most important to least most important to the success of their program (M=6.08, SD=2.04). The mode ranking was 6th with 28% (7) courts.

Then courts were asked to discuss the terms of participation for their MHC. Twenty-two courts responded. All but four courts only responded to the query by referring to the terms of participation listed within their own handbooks. The handbooks and various survey answers were then used to mark commonalities in general terms of participation in plea agreement, program duration, impact of program completion, and consequences of non-compliance.

General Terms of Participation

In all courts, MHC clients sign performance contracts to participate in the program. Some clients also sign their individualized treatment plan and some sign contracts with probation and parole as well as the with the court program managers. Clients are most commonly informed of program expectations through meetings with the court team and review of the participant handbooks. Generally, these contracts and handbooks outline what they can expect from the program and what is expected of them. Handbooks discuss how clients can expect to attend court dockets, treatment, meetings, and undergo substance testing and supervision. Expectations for clients include general respectful behaviors towards court team and peers, abstinence from drugs and alcohol, avoidance of negative influences or triggering locations, curfews, mandates to attend court docket on time and dressed appropriately, communication with court team members, contribution in group meetings, engagement with treatment, medication compliance, and abstention from crime. In some cases, MHCs also list a mandate to attend peer recovery meetings like NA and AA, as well as engagement in various life skills, housing, education, and vocation improvement efforts.

Plea Agreements

A pre-adjudication model allows for significant reductions or complete dismissal of original charges for clients upon program graduation. Post-adjudication models allow for successful clients not to have sentences lifted, but to receive benefits like early termination of supervision, vacated please, and removal of fines and fees (Thompson, Osher and Tomasini-Joshi 2008). The pre-adjudication model was used by 25% (6) of surveyed courts while another 25% (6) courts indicated they used a post-adjudication model. The remaining 50% (12) courts indicated that their program utilized a combination of pre and post-adjudications (N=24).

Length of Program

The *Essential Elements* (2008) also warns against programs for participants that last longer than their original traditional court incarceration length or probation period. While the length of the program varies based on individual client progress and level of success, the base program structure allows for estimates minimum estimates of program length. Often, program length depends on whether the defendant is charged with a misdemeanor or a felony. Each program that provided a handbook or listed minimum program length online was included (N=25, Figure 7). Court programs that solely addressed misdemeanors tend to be shorter in minimum duration than felony court programs. Courts that accept felony and misdemeanor offenders frequently had two separate tracks with two separate minimum time requirements. Among misdemeanor programs and tracks, the minimum amount of time in program required was nine months set by Marion County MHC and 14th JDC MHC. Some programs accepted felony and misdemeanors, but set both minimum program length expectations within the same timeframe. Forsyth County MHC, who predominately accepts misdemeanor offenses, but some low-level felonies with approval, set their minimum program length at 8 months. Coordinated Resources-Palmer, Coconino County, 5th Judicial District, City of Norfolk and 11th Judicial District MHCs did not provide program length estimates within their participant handbooks, policy and procedure guides, or online materials, preferring to rely on client goal obtainment over set time standards. Coordinated Resources-Palmer states that that any case involving an offense related to driving under the influence must be in the program for a minimum of 18 months. On average, felony tracks or courts who handled exclusively felony cases last for an average minimum of 14.17 months (SD= 3.55, N=17). In courts that handled exclusively misdemeanor cases or had separate program tracks for misdemeanor cases, the average minimum length of program lasts 12.4 months (SD= 3.44 , N=10).

Impact of Program Completion

Courts mentioned what legal consequences participants would incur upon successful graduation of the program. Typically, the plea structure of the program impacts specific graduation impacts. Clients who enter the court on a deferred adjudication or pre-plea model frequently see charges completely removed upon program graduation. Misdemeanor offenders more typically see total revocation of charges from their criminal record. Felony offenders in post-adjudication model programs may also see a total removal of charges from their record upon graduation. Many courts mandate clients plead "guilty" or "no contest" to enter the program, but actual sentencing is postponed until the end of the clients stay in the program. These successful clients receive a reduction in the charges on their records, reduced fees, and/or early probation termination. Some post-adjudication programs allow clients to enter the program as a condition of probation or agree to participation in lieu of revocation.

Consequences of Non-compliance

Original sentences are frequently re-imposed for those who drop out of the program or are dismissed for program violations in the post-adjudication model. Some courts indicated that any additional criminal violations resulted in revocation of program participation became eligible for convictions once dismissed from the program. For clients who participate in the MHC as a condition of probation, it was up to the discretion of the sentencing judge to determine if the client could return to regular probation or was sent back to jail. For clients who leave willingly or opt-out of the program, participation does not affect their original sentence. Court handbooks and policy and procedure guides point out the necessity for judges to inform clients who are dismissed from the program the potential consequences of their actions.

ESSENTIAL ELEMENT 5: INFORMED CHOICE

Essential Element Informed Choice is (2008) summarized, "Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are

provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise". Court teams felt informed choice ranged from 1st to 10th most important element to the success of their MHC. Most courts, 24% (6), listed it as the 9th most important element (M=6.40, SD=2.65, N=25) (Table 15). To further address informed choice, each court was asked to explain how they interpreted the element within their court. Twenty-one MHCs provided feedback. Responses were then triangulated through review of participant handbooks and provided agreement forms/waivers. Predominately, these elements were interpreted through the lens of practices that helped to ensure clients knew program and participation was voluntary. Courts explained how they made sure court team members and legal counsel explained the issue of voluntary participation and the various program expectations before and throughout the length of the program. Courts also addressed issues of forensic competency and the use of waivers and agreement forms frequently found within participant handbooks. Finally, two courts interpreted informed choice through discussion of treatment options.

Voluntary Participation

Most courts interpreted Informed Choice as ensuring clients knew the program was completely voluntary even when clients were referred to the program by an attorney. They frequently mention telling participants to seek advice from their attorneys or legal counsel about participation in the program and ongoing program decisions. To participate in the program, clients must sign documents confirming their decision. Other programs discuss how their judge, court coordinator, or dedicated defense counsel took time to explain the voluntary nature of the program to clients on multiple occasions before program entry and throughout the program. Some interesting standouts, three programs (Marion County, 14th Judicial Circuit MHC, and Pierce

County MHC) offer potential participants an opt-in or observation period where they can watch the court proceedings for themselves a few times before fully committing to the program.

Agreement Forms

All MHC participant handbooks include program expectations, rules, and behavior guidelines. Of the 23 courts that provided participant handbooks, only five (Norfolk, 1st District Brigham City, 5th Judicial, Western Judicial Circuit Treatment and Accountability Court, Pierce County MHC) did not include or mention program agreement documents or participation forms for clients to sign as part of the participant handbook. With handbooks, nine courts included handbook receipt acknowledgement forms and nine courts included participant agreement forms or performance contracts. Unique to the sample, Fayette County MHC included a handbook section where the client and the case manager both sign each of the program phase pages as an acknowledgment of the various phase requirements. Norfolk MHC mentioned that participants must sign a treatment plan once created, but included no other types of signature documents or mentions. Most creative, Boone County Treatment Court II constructs their informed consent form as a survey and their participant agreements and acknowledgement in quiz formats. While many courts included the assessment and program acceptance procedure within their policy and procedure manuals for court team members, only one court, 30th Circuit MHC, included a section explicitly titled "Informed Choice" within their participant handbook.

Four courts included forms that waived and/or informed participant of their legal rights as a program participant. Unusual waivers included Rome Circuit MHC's consent to publications and photography form, which, along with other release forms and rights waivers, is stated as a *required* document for program participation. Also unusual, Okaloosa County MHC included a form that participants sign upon graduation. The form lists the services clients received while in the program and a suggestion to continue receiving those services outside the program. Boone County Treatment Court II and Okaloosa County MHC included an exit questionnaire in their

participant handbook to assess customer satisfaction and inform the program of future desired changes.

Competency Issues

Nearly all courts mandate that their clients be deemed competent, determined via forensic assessments, prior to signing any waivers, program acceptance forms, or plea agreements. Three courts (Kitsap, Northampton, and 30th Circuit MHC) mentioned competency issues being dealt with as they arose throughout the duration of the program. Thanks to Florida's involuntary commitment laws, 11th Judicial Criminal Mental Health Project can accept clients involuntarily into their program before deemed competent on a case-by-case basis, but they need to consent to continue treatment once stabilized. In the 30th Circuit MHC, client incompetency invalidates any previously signed waiver of consent. Once the client is re-stabilized, they must sign new waivers to continue program participation.

Treatment Interpretations

Forsyth and Fayette County MHC each included participation agreement forms in their participant handbook, however, within the survey, they both interpreted the *Essential Element* of Informed Choice for their court in reference to treatment providers. Forsyth MHC interpreted Informed Choice upon the issue of payer source for treatment providers. The court aims to not disturb existing therapeutic relationships and allow participants to use treatment providers whose services were covered by the client's insurance. Funding for clients without insurance is limited in this court. This court ensures clients have a choice in their treatment providers and do not mandate a single service provider for their clients. Alternatively, Fayette County MHC interpreted informed choice in their court by allowing clients and the judges to discuss likes and dislikes about treatment so as to address providers about acknowledged issues.

ESSENTIAL ELEMENT 6: TREATMENT SUPPORTS AND SERVICES

Essential Element Treatment Supports and Services indicates, "Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of— treatment and services that are evidence-based" (Thompson, Osher and Tomasini-Joshi 2008). Treatment Supports and Services ranks 1st through 9th in terms of the court's assumptions on the element's relative importance to program success (M=3.52, SD=2.37, N=25). Most commonly, 28% (7) courts listed it as first in ranking of importance (Table 15). Treatment Supports and Services was also addressed by an examination of listed service providers who offer treatment, counseling, and substance use treatment options. The specific service provider and types of counseling varied from court-to-court and state-to-state based on availability of services in the area, program funding sources, and individual client needs.

Treatment Supports and Services Offered

Despite lack of variety of options in some states, many types of psychological and clinical interventions are offered by the courts. For example, Coconino County MHC offers individual counseling, vocational counseling, dialectical behavior therapy, co-occurring mental health and substance abuse and other group treatment sessions, medication management and peer support. The *Essential Elements* suggest offering evidence-based services to clients and services that address the commonality of co-occurring substance use and mental health issues. Psychological research finds that addressing criminogenic needs (e.g. antisocial peers and cognitions, poor coping skills, and family stressors) in specially-tailored programs, using positive reinforcement, a cognitive behavioral approach, and treatment dosage administered according to risk of re-offense level produces more effective results in reducing recidivism rates (King 2013) In 2010, Eau Claire County was awarded a three-phase grant to implement such evidence-based decision-making (EBDM) processes within their entire court system and MHC program.

Courts provided lists of service providers that ranged from a single agency to very comprehensive lists. One standout, Whatcom County MHC, provided a comprehensive list of clinicians, therapists, and counselors in the area. The comprehensive list included their contact information, associated firm, sex, languages spoken, types of issues addressed, populations of specialty, treatment modalities utilized, notes about contact response times, and what insurance they took. All in all, the list included over 250 individuals. Whatcom County MHC also provided a far shorter "Alpha List" of primarily utilized therapists, counselors, and resource providers. Other courts utilized a very short list of organizations whom they contracted with for their mental health and substance use treatment. Interestingly, some courts' handbooks mandated specific treatment agencies for clients use. Others, like Rogers County Anna McBride Court, indicate that clients become automatically eligible for services with the court's contracted provider, but if a client wants to receive treatment at another location, the court requires a written request. The court evaluates the requested program based on philosophy, services offered, treatment intensity, and needs of client to make a final approval for the client.

Treatment and Support Service Eligibility

Various courts mention how client eligibility and/or its court maximum population is circumscribed by available funding for treatment services. Courts navigate the issue of treatment costs in a variety of ways. Some courts are contracted with service providers who are funded through grants, donations, or taxes. Some courts only accept clients who already have insurance. The courts expect them to pay for the insurance-subsidized costs of services and medications, but frequently offer a sliding payment scale based on income. Seventeen of 24 offer services to help ensure clients obtain health insurance once accepted to the program. Other courts only accept indigent clients who are eligible for Medicaid or similar low-income insurance provision and then only work with service providers who accept said insurance. One example, The Coordinated Resources Project-Palmer, mandates that all clients must be beneficiaries of the Alaska Mental

Health Trust Authority. The Alaska Mental Health Trust Authority does not provide services, but funds services for people with mental illnesses, developmental disabilities, chronic alcoholism, memory diseases, and traumatic brain injuries (Trust Land Office 2018).

Social and Specialty-Tailored Services Offered

The *Essential Elements* (2008) suggests for MHCs to offer gender-specific and ethnically-sensitive services to clients. Courts were asked about the availability of twenty-two varieties of social and specialty- tailored services available as part of their program and whether all clients received them or if services were targeted for certain clients (Table 8). 15 of the 25 responding courts (60%) utilize culturally sensitive services and 19 (76%) utilize gender-sensitive services for all or targeted clients. Most commonly, 92% (23) of courts offer life skill services and educational/vocational services to all or targeted clients. Other most commonly offered services included psycho-social clubs, community service facilities, housing services, food assistance, employment services, and financial services/money management, and health care/medical service referrals. Most commonly excluded, 56% (14) of the courts do not offer spiritual/religiously tailored-services or childcare services to all or some clients (N=25). However, upon review of MHCs who provided lists of utilized social service providers who offered food pantries, clothing donations, and housing services, many of the providing organizations operate out of church facilities or religious organizations.

ESSENTIAL ELEMENT 8: COURT TEAM

The 8th *Essential Element* is the Court Team, which the *Essential Elements* describes as "a team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process"(Thompson, Osher and Tomasini-Joshi 2008). While the actual composition of the court team may vary from jurisdiction to jurisdiction, the pivotal team member is the judge who facilitates collaboration

among other team members to promote program cohesiveness. Team was addressed in terms of its perceived level of importance to the success of individual mental health courts and composition of court team.

Of the 24 responding courts, Court Team ranged from the first to the 9th most essential to the success of their MHC (M=4.80, SD=2.21) (Table 15). All courts included a judge as a court team member, 87.5% (21) utilized a court coordinator, 87.5% (21) included treatment providers, 70.8% (17) included case managers, 75% (18) included probation officers, 91.67% (22) included defense attorneys, 87.5% (21) included prosecuting attorneys, 25%(6) clinical liaisons, 16.67% (4) sheriffs or police representatives, 20.83% (5) social workers, 33.33% (8) jail staff, 4.17% (1) representation from the Department of Human Services, 16.67% (4) community Liaisons, and 20.83% (5) other. Others listed: County Developmental Programs, Court Clerks, corporation counsel, peer support, and domestic abuse workers. Figure 8 displays the court team members utilized by each of the sampled MHCs.

Staffing Frequency

To further address court teams, each MHC was asked how often they held staffing meetings. Staffing meetings are on opportunity for court team members from various agencies and organizations to come together and collaborate. Topics of discussion in staffing usually center on client progress, adherence to mandates, use of sanctions and incentives, and identifying needed modifications for treatments or services. Courts were asked how often they held staffing meetings. Of 24 courts, 54.17% (13) indicated they met weekly, 12.5% (3) courts met bi-weekly, 12.5% met monthly, 16.67% met bi-monthly. The remaining 4.17% (1), Whatcom County MHC, indicated that their program was held at both the district and municipal court levels. The district court met weekly while the municipal court met bi-weekly.

ESSENTIAL ELEMENT 9: MONITORING ADHERENCE TO COURT REQUIREMENTS

Within this element, the *Essential Elements* outlines the importance of having up-to-date information on client progress and adherence to court mandated behaviors like medication compliance, treatment engagement, curfew adherence, and other related behaviors. The element states, "Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery" (Thompson, Osher and Tomasini-Joshi 2008). Courts employ a variety of support staff and mechanisms to facilitate information collection and often require interagency collaboration to ensure the court team is informed accurately and quickly about client behaviors and level of adherence to program mandates. To address Monitoring Adherence to Court Requirements, courts ranked the element in terms of its level of importance to the success of their MHC, described types of monitoring personal and mechanisms utilized and described the types and use of sanctions and incentives. .

First, courts ranked Monitoring Adherence to Court Requirements in terms of how important they felt it acted on the success of their MHC compared to the other 9 *Essential Elements*. The element ranked from 2nd to 9th most important element to the success of courts (M=5.24, SD=2.01, N=25). Most frequently, 24% (6) of courts ranked the element as 6th most important to court success (Table 15).

Supervision Methods and Personnel Employed

MHCs vary in the types of monitoring mechanisms employed. Variation is often due to level of funding, level of collaboration with probation, and staffing power of the court. While some provide some monitoring methods for all clients regardless of individual assessments or needs, some apply monitoring methods for only targeted clients. Typically, as clients prove capable of adhering to program mandates and advance through the program, the level and frequency of monitoring methods is reduced. The *Essential Elements* suggests using the least

restrictive monitoring methods possible for low-risk clients to reduce potential net-widening or iatrogenic effects.

Drug tests via testing urine sample and in-person check-ins are the most frequently utilized monitoring methods (Table 9). Twenty-one MHCs state use urine testing and in-person check-ins for all clients and 3 use those methods for only targeted clients. Other commonly used monitoring methods for all or target clients include medication checks (23), phone call check-ins (23), meeting requirements (20), alcohol monitors (12), GPS monitors (11), hair follicle drug tests (4), and blood drug analysis (2), and moral recognition therapy (2). Moral recognition therapy (MRT) is used as a monitoring method in both Bexar County and the McHenry County MHC. "MRT is a cognitive-behavioral counseling program that combines education, group, and individual counseling, and structured exercises designed for foster moral development in treatment-resistant clients" (Austin 2016) Additionally, courts make use of various individuals and departments to monitor client adherence including: probation staff (23), case managers (21), treatment providers (20), counselors (18), client's family members (7), and court liaisons (2), police (2), and surveillance officers (1) (N=25).

Sanctions

When MHCs become aware of violations and non-adherence to program mandates, the use of graduated sanctions helps to redirect clients back into compliance. The types and frequency of sanctions used by the courts are displayed in Figure 9. Sanctions included program dismissal, (21) community service (21), jail time (21), specially tailored punishments for offenders (20), prolonged phase retention or repetition (19), additional call-ins (15) or check-ins (20), curfews (15), in-patient treatment center stays (14), do not contact orders (13), alcohol monitors (10), GPS monitors (10), geographic restrictions (9), essays (5), driving restrictions (1), residential work programs (2), regular work programs (2), court fees (2), and drug test fees (2) (N=24). Certain sanctions double as intensive treatments, like in--patient therapy and some

sanctions double as increased supervision methods, like alcohol and GPS monitors. While some MHCs provide monitors as sanctions to clients at no charge, others mandate clients to both wear the monitors and fund their use. Some courts use community service hour options or mandates in lieu of paying related monitors expenses.

Types of Incentives Used

Incentives reward clients for desired behaviors and reinforce future pro-social behaviors. To address the use of incentives, courts were asked what kinds of incentives they used, presented in Table 10, and when the courts distributed incentives, presented in Table 11. Of the 24 courts, the most common incentives offered were praise from court team 87.50% (21), praise from the judge 87.50% (21), and graduation ceremonies 87.50% (21). Other common incentives include: Personalized certificates 70.83% (17), program phase-ups 70.83% (17), gift cards 58.33% (14), reduced mandated attendance at court dockets 50.00% (12), reduced or dismissed charges or sanctions 45.83% (11), and candy or toys 45.83% (11). Less common incentives include: praise from peers 37.50% (9), reduced docket time / "rocket docket" status 37.50% (9), reduced program mandates 33.33% (8), reduced supervision methods 33.33% (8), parties or events 33.33% (8), reduced fees or fines 25.00% (6), movie passes 25.00% (6), reduced community service hours 20.83% (5), and small trinkets 20.83% (5). The sample of courts rarely gave personalized plaques 12.50% (3) and no court reported giving t-shirts or other apparel items. Other incentives mentioned by courts include: birthday and special occasions cards, key chains for new/renewed license, approval of out of state travel requests, bus passes, UA vouchers, and "All Star" Status at docket. Whatcom County MHC uses All Star status to headline compliant clients during docket, the court does not dismiss early to foster program relationships and sense of communities community. A unique incentive, the 5th Judicial District MHC uses lunch with the court coordinator and judge as an incentive.

When Incentives are Used

Next, MHCs discussed when they gave out incentives to clients (Table 10). The majority of the 24 courts distribute incentives or rewards at program graduation (83.33%; n=20), when clients promote to the next program phase (79.17%; n=19), and when clients meet general compliance mandates (79.17%; n=19). Two-thirds (16) of courts incentivize clients when they achieve particular set goals, e.g. earning a driver's license or passing a GED test. About half of the MHCs (14) distribute incentives to clients for attending required meetings and appointments (58.33%; n=14) or for noticed good behaviors (50%; n=12). Only 33.33% (8) courts consistently reward clients when they attend dockets. Docket attendance incentives are typically something small, like a trinket or candy. Some courts conduct "fish bowl drawings". During docket, compliant clients with no active sanctions may enter their name in a drawing to win tangible or court-related prizes like a gift certificate for coffee or a coupon for a free UA drug test.

Use of a Matrix

Sanctions and incentives matrices are thought to help reduce discretion in decision making on when and how to promote compliant behaviors and punish undesirable behaviors. While these matrices are frequently used in Drug Courts, due to assumptions about the variation in MHC client legal culpability, mental stability, and cognitive abilities, the strict use and adherence to concrete matrices in MHC meets some criticism. Some suggest MHCs should use matrices as guidelines, but welcome variation based on individual clients and their needs. Only six courts (the 30th Judicial Circuit MHC, Bexar County MHC, Kitsap County Behavioral Health Court, Marion County MHC, Rome Circuit MHC, Western Judicial Circuit Treatment and Accountability Court) supplied sanctions and incentives for the research. Kistap County indicates that while they did provide a matrix, it has just been developed and is not yet utilized. More often, and within this sample as well, MHCs will provide a list of gradually intensifying sanctions and

incentives, but not a matrix structure for what behaviors at what level of the program merit particular rewards or punishments.

ESSENTIAL ELEMENT 10: SUSTAINABILITY

Sustainability, the final listed *Essential Element*, is a rather comprehensive element. Summarized, "Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded" (Thompson, Osher and Tomasini-Joshi 2008). The *Essential Elements* suggest data should include demographic and statistical data on clients and the courts as well as qualitative data to understand participant and court team perceptions. Both methods help to highlight needed program changes and validate various program successes. While data collection and evaluation is important to court sustainability, MHCs must also promote buy-in from the court, policy makers, and the community to ensure MHCs funding and continued survival.

To address this final element, MHCs ranked Sustainability's level of importance to the success of their MHC. Sustainability ranged from 2nd to 10th most important element to MHC success. Most frequently, 24% (6) of courts listed Sustainability as the 5th most important element to the success of their court. (M=8.96, SD=1.78, N=25) (Table 15). MHCs also disclosed their funding source types and provided demographic information, outputs, and evaluations or research conducted on their MHC. The body of output, outcome, research, and evaluation data was coded for common trends and data types. An internet search was also conducted to review any other types of research conducted on the 27 programs included in the sample. Finally, to address support for the court, courts were asked about resistance from the community and court system, media presence, and community outreach efforts.

Funding

Courts further addressed Sustainability through their ability to access program funding. Twenty-one courts provided responses on the type(s) of funding that supported their court operations. Information on funding sources from the remaining six courts were located through examination of provided documents, organizational and federal grant application approvals, court records, local tax information, press releases, and online news media reports regarding program funding sources.

At least 50% (12) of the MHCs utilized more than one type of funding source since the programs' inception. Half of the sample had used at least one or more of the following methods: local funds (typically tax provisions), grant funds, and state funds, two use funds from organizations, two use trusts, two fund the program through client fees, and one court is funded through a private philanthropic organization. Commonly, grants came from the Bureau of Justice Assistance, Therapeutic Justice Foundations, CSG Justice Center, Problem-Solving Court Enhancement Project, National Association of Counties, Council of State Governments, National Center for State Courts or Stepping-Up Initiatives. Courts frequently obtained funds through their state Department of Human Services or federally through SAMHSA.

The following is an example of state-funding. The Michigan MHC Grant provides state-level grant funding for court operations, supervision, and treatment. Courts who receive this grant must follow the *Essential Elements of a Mental Health Court* in structuring their court. In 2019, the state will begin certifying their MHC based on their own best practice guides. Currently, MHCs in the state of Michigan are required to document minimum data standards for clients and the program pursuant to *MCL 600.1099.*

Data Collection and Research

The *Essential Elements* (2008) marks data collection and evaluation as important to the sustainability of MHCs. As these courts are still novel, courts must record data to make informed program decisions and demonstrate program effectiveness. While only eight courts supplied demographic, output, outcome or evaluation data upon request, it was mentioned in all but one MHC that demographic court data was collected in some fashion in either the participant handbook or the policy and procedure manual (N=27; not shown). Most courts did not mention who holds primary responsibility for the collection of demographic program data. In cases where a court team member was identified, it was most typically the program liaison/coordinator or case manager. Marion County employs an on-staff evaluator. Two courts contracted with local universities to conduct program evaluation with the help of graduate students and researchers. Five courts mentioned the use of MIS data entry systems that collected data on clients and outcomes for the problem-solving court initiatives within their state. Oklahoma Department of Mental Health and Substance Abuse holds an annual specialty court training conference with session discussions center on evaluation and using their MIS system (Wilson et al. 2014). The bi-annual Mental Health Court Summit in Utah this year also held sessions on types of evaluations and their importance to court success (National Mental Health Court Summit 2018)

While most courts collect demographic, quantitative data, Okaloosa County MHC, Marion County MHC, and Boone County Treatment Court II collect qualitative data from participants to inform the program. A few courts have had outside researchers or state-level court evaluators conduct research on their court (VanGeem 2015). Typically, this research is mixed-methods, collecting demographic and statistical outcome data as well as client and/or court team perspectives.

The states of Washington, Georgia, and Oklahoma regularly conduct site reviews for their MHCs. Oklahoma conducts site reviews through the Oklahoma Department of Mental

Health and Substance Abuse Services. Georgia MHCs conduct peer reviews through other MHCs in the state. Part of the evaluation addresses which Georgia Best Practices standards they currently adhere to and which practices they should change. Courts with statewide coordination efforts more often utilize collaborative online demographic data collection and frequent program evaluations. However, the publicly available evaluation data are not often framed as single court reports, but summative reports of all available MHC programs in the state.

Community Outreach

MHCs are more successful when supported by the community. MHCs must work to ensure policy-makers and community members are aware of the program and its successes. To address the community outreach component of Sustainability, courts were asked what about their community made starting a MHC a necessity, the level of community resistance in starting the program, the level of court resistance to the program, how they improve clients' interactions with the community, and whether they felt the community was aware of the program's existence.

Reason for MHC implementation.

Despite variations in population size, rural vs. urban setting, drugs of choice, and year of program initiation, each provided depiction of MHCs' justification for its inception largely mirrors one another and the larger national epidemics. MHCs began due to lack of mental health services and limited housing and transportation resources. Communities deal with a high prevalence of untreated seriously mentally ill individuals, drug use, and homelessness in the communities. Judges noticed a need for diversion programs due to criminal court dockets, jails, and emergency rooms overfilled with people who were impoverished, drug-addicted, and experiencing untreated mental illness. MHC dockets typically began in communities where drug court diversion programs were operational and seeing successes. In only one case did the drug court begin after the MHC. Communities that started co-occurring courts recognized that many of

the individuals they targeted for drug court needed additional attention paid to their underlying mental health issues.

Initial courthouse resistance.

Courts discussed how resistant they felt their court was in starting a MHC program on a 5-item scale scaled response ranging from "not resistant" at all to "extremely resistant" (Table 16). The majority of courts felt no (18) or only slight resistance (6) from their courthouse in starting their MHC (N=25). A related example from a study of rural MHCs in Pennsylvania, 7% of rural MHC judges indicated that court personnel had negative perceptions of MHC being "soft on crime" which acted as a barrier to establishing a MHC (Troxell and Frenzel 2011).

Initial community resistance.

MHC also discussed how much resistance their communities offered in starting a MHC on the five-item scale ranging from "not resistant" at all to "extremely resistant" (Table 17). Of the 23 responses, most MHCs stated that their community posed absolutely no (15), or only slight resistance (6) to starting the program. Additionally, despite the sample of MHCs operating for a range of two to eighteen years, the majority (17) of MHC indicate that they felt the community was, to some extent, largely unaware of the MHC program's existence. (N=26) (Table 14).

Media Presence

Courts promote awareness of the court through media and community outreach. An analysis of court documents revealed court coordinators and program liaisons largely take on the role of program promotion. Most frequently coordinators mention awareness efforts and outreach with police programs and among attorneys who could target and refer clients to the program. Rome Circuit MHC informs participants in their handbook about the possibility of media promotion of the program. Rome Circuit MHC ensures clients sign a media release to participate

in the program. MHCs whose policy and procedure manual contains the *Essential Elements*, or similar state-level interpretation, include a description of the need for outreach.

In a review of news media on the various MHCs from the sample, media reports were more sparse for the newer MHCs. Typically, older courts experienced a push in published stories about starting a program and documentation of when the program first opened. News stories about the ongoing operations of MHCs are typically framed about the life and experiences of a particularly successful graduated client. The client stories also include information describing the operations, funding sources, and basic client outcome data (e.g. number of clients accepted, graduated, and recidivism rates). These stories are published by mental health organizations, county newspapers, and local TV news segments. Less positively framed news stories frame the need for MHCs through a discussion of people with untreated mental illness who went on to kill others, themselves, or engaged in violent altercations with law enforcement. This frame is more commonly seen in local papers and TV rather than in mental health organization promotions. Rare to the sample, Kitsap County MHC promotes their own online media presence by hosting a website comprised of client success stories, photos and artwork.

The 11th Judicial District Jail Diversion Project, the oldest MHC in the sample, contains the largest collection of news stories and promotions from local, state, and federal mental health organizations. From years prior, published stories document the ongoing mental health crisis, efforts of the court, outcomes and cost savings of interventions, and new developments in different aspects of their sequential intercept mapping project. Most stories from the past few years document progress and are in support of various efforts of the Criminal Mental Health Project like police CIT training, the new Mental Health Diversion Facility, and the Miami-Dade Forensic Alternative Center, (Bordas 2017, National Association of State Mental Health Program Directors 2016) .

Supporting Client's Interactions with the Community

Finally, courts discussed efforts to improved clients' interactions with the community. Discussions centered on community service, media and organizational outreach, treatment and skill building, program goals, and social interaction opportunities.

Community service program goals.

Most courts mentioned how they improved clients' interactions with the community through community projects or volunteer hours. Some MHCs mandated community service as part of the program or particular phase goals. Twenty-two MHCs collaborate with community service facilities. Twenty-one MHCs use community services as a sanction, and some also mentioned use of community service hours in lieu of paying court fees. Kitsap County argued that while clients have suggested community service hours as part of the program mandates, the varying degrees of client ability makes it difficult to define an appropriate baseline number of hours.

Peer support groups and social events.

A few courts mentioned how clients are encouraged, or mandated, to find sober peer support networks. Most frequently, these groups take the form of Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or Drug Replacement Therapy (DRT) groups, or, less frequently, moral reconation (MRT) groups. Other MHCs suggest "community inclusion time" or finding pro-social community and leisure groups geared for community reintegration. One court offers clients an opportunity to collectively participate in physical fitness goals like running in the local 5k. Courts considered graduations and holiday celebrations as social opportunities for clients. Two courts discussed program alumni groups. One active alumni group mentioned attending cohort graduations and holding reunion events to keep a pro-social peer network. 17 of 24 surveyed courts offer post-graduation services, but not all offer an alumni group.

Outreach.

Three courts framed improving client interactions with the community in terms of media and organizational outreach. Court coordinators or managers visit local engagements, community groups and task forces to teach them about the program and mental illness in an effort to reduce stigma. Other courts invite the media or local mental health organizations like NAMI to come to docket and graduations. NAMI local organizations publish program updates and hold information seminars for interested parties. Local media attend graduations and report client success stories.

Effective treatment.

Effective treatment improves clients' community reintegration. Treatment and medication stabilizes clients and reduces interactions with jails and in-patient treatment within institutions. Life skills training teaches clients pro-social life skills like communication, stress and anger management, and self-advocacy. Family members become more willing to associate with stabilized loved-ones, clients obtain stable housing, and are more attractive for employment.

Employment.

Courts referred to mandates for and services to assist with employment as a method of community integration for clients. Rogers County Anna McBride Court took an impressive step in maintaining positive relationships with businesses who hire participants. In prior ethnographic study of 12 Oklahoma MHCs, employment and court requirements often conflicted. Courts schedule dockets during regular business hours. Clients, who typically worked those hours in low skill, hourly positions would have to schedule time off for attendance at dockets or treatment meetings and lose income or scheduling priority as a result. Some companies were not supportive of navigating client schedules so clients struggled to keep their jobs. Clients felt stigmatized when parole would conduct check-ins or UAs at the clients' place of employment to the knowledge of coworkers. Employment was also impacted by missed shifts due to jail sanctions. Clients

struggled when the program mandated employment, but operated in ways that made continued employment difficult (Bullard 2014).

POTENTIAL NEW ESSENTIAL ELEMENTS

The creators of the *Essential Elements* acknowledged that MHCs vary in their interpretations and implementation of the 10 *Essential Elements*. They recognized some courts would feel like certain elements were missing. Stakeholders argued that the document was not a complete list, but a general framework for what MHCs should be. As time passed, data and experience would allow for refinement of existing elements and inclusion of potentially missed elements. Here, various courts offered their own MHC's *Essential Elements* and their brief justifications for it. It is hoped that other MHC professionals may see these suggested elements and enter into a conversation regarding their level of applicability within their own program.

Fifteen of the 27 MHCs provided a name and description for what they perceive as their own *Essential Elements* for their MHC. To avoid researcher misinterpretation, the fifteen elements and brief descriptions are provided in their entirety in Table 12. The fifteen created Essential Elements are named: 1) Culture-friendly environment, 2) Incentives, 3) Re-entry, 4) Participants stabilized on appropriate medication while in custody, 5) Transitional planning and Identifying appropriate need, 6) Support from all parties, 7) Relationships with provider agencies, 8) Evidence-based practices, 9) Targeting and oversight of undiagnosed/untreated severely mentally Ill, 10) Advocacy and legal literacy, 11) Accurate and comprehensive assessments, 12) Proper assessment, 13) Making amends with the victim, 14) Low compliance officer-to-participant ratio, and 15) Individualized case plans and services.

IDENTIFIED ISSUES

An overarching principle of MHCs is collaboration between criminal justice, mental health and substance abuse treatment, and social service providers. Writers of the *Essential*

Elements knew that programs would vary based on what services were available to collaborate with the MHC. To delve deeper into the capability of a community to sustain a MHC. It was hypothesized that MHCs may also be negatively impacted by structural and ecological barriers experienced by clients. Namely: transportation and cost. MHCs cannot successfully serve their intended population if ecological and individual barriers preclude potential and current participants from participating in the program and accessing needed services. The following section includes a discussion of common issues revealed over the course of the research including issues related to transportation, court cost, court funding, use of jail time, timely-participant identification, therapeutic jurisprudence, court team turnover, and use of policy and procedure manuals.

Client Transportation

Transportation was a commonly mentioned barrier and complaint for clients, identified within write-in responses, participant handbooks, and prior evaluations of courts (not shown). To examine accessibility of transportation, MHCs detailed their transportation services and policies. Of the 24 responding MHCs, 70.83% (19) provided some form of transportation assistance through the use of pickup service or assistance in providing tokens or vouchers for use of public transportation services. Some communities offered free pick-up services for individuals with disabilities and the mental health court staff assisted clients in accessing these services. In two of those MHCs, contracted service providers provided rides to treatment, but not to court docket or other program services. One-quarter (6) of the courts did not offer any form of transportation assistance, but 4 of those courts were located in areas where transportation services are offered. Western Circuit Treatment and Accountability Court posted a suggestion on their MHC webpage: Families can help clients succeed by providing transport. The McHenry County MHC states in their participant handbook, using all capital letters and bold font, that it is client's responsibility to acquire transportation to and from program requirements.

To further drill down into the level of accessibility of court services to clients, courts provided information regarding the area(s) served and the addresses of the court program, courthouse, primary treatment providers, and collaborating social service providers. The lists were then cross referenced with available online information regarding existing transportation services, route information, and location of the local jail. Using GIS mapping software, maps of the area served by the MHCs were generated along with pinpoints primary locations (see Appendix B). Maps were not generated for courts who did not provide enough necessary data. Maps were analyzed to understand the general proximity of services to one another, whether fixed public transport routes existed in proximity to program and service locations, and the location of primary locations within the entire area of court jurisdiction. While merely descriptive in purpose, the maps revealed a predominately centralized and aggregated collection of treatment services, social services, peer support locations, and courthouse/program locations within the most heavily populated city centers in the served jurisdiction. Services in the rural areas and less populated towns were more dispersed or non-existent. Overall, most jurisdictions that had a local public transportation route had at least some services along, or within close proximity to the transportation route.

Even in communities with public transportation systems, courts suggested that clients frequently missed appointments and court dates due to busses that did not arrive on time or confusing bus routes. Courts that did not as frequently mention issues with transport tended to utilize a door-to-door pick up service or the court coordinator helped to pick up clients for court meetings and requirements. Courts that had a consistent funding source for transportation passes were also less likely to mention transportation being a hurdle for client success.

Housing

Housing is also a current area of concern for MHCs. Policy and procedure handbooks and survey responses frequently point to the prevalence of homeless, mentally ill individuals in

communities as a primary reason for why many of the sampled MHCs initially began. Coconino County MHC is emblematic of this issue. They state that denial of disability benefits and limited local housing options pose challenges to client success. In the summer, local Coconino County shelters shut down leaving clients to camp in local parks. Local parks have rules that frequently interfere with court schedules. MHCs attempt to address this pervasive issue by collaborating with housing authorities, homeless shelters, and advocating for new or expanded residential treatment and diversion facilities for current and future clients.

Court Cost

Cost of program may also be an inhibiting factor for eligible, potential clients. Prior program evaluations frequently mentioned issues of funding and court costs in promoting the success of clients. Courts varied widely on funding sources, what services were funded, and the overall cost of client participation. Participant handbooks include costs of program, restitution mandates, and associated fees for drug tests and treatment services rendered. Courts listed the price of various aspects of court participation and what clients should expect to pay for in their handbooks and policy and procedure manuals. Frequently, courts listed program fees which ranged from $150-$500 total or $5-$40 a month. Five courts indicated that there was no program fee thanks to program funding through taxes or mandatory entitlement benefits of program participants. Another common fee was for drug tests, yet only two courts mentioned the specific costs for drug tests: ranging from $5 to $15 per test. In these two programs, as clients progress through the phases of the program, drug tests become less frequent, but more expensive. Six courts indicated that costs of contested drug tests, where drug test initial results are sent to labs for further verification, were the responsibility of the client. Costs for drug test re-verification ranged from $32 to $55 each. Rome Circuit MHC indicated that if a drug test was contested and reverification labs showed an initial false positive result, the client did not have to pay the contested drug test fee. Treatment and medication costs were also commonly the responsibility of

clients, however, most clients are on entitlement benefits to help subsidize those costs. Only two MHCs mentioned that clients would have to pay for their initial psychological evaluations. One court mentioned a cost of the psychological evaluation: $175. Finally, most courts mentioned having to pay court fines and restitution. However, two courts proudly indicate that there were no court fees associated with their court program.

Program Funding

The participant handbooks and policy and procedure guides frequently mention funding issues in preventing what types of incentives could be offered and what populations they could serve. In some cases, courts indicate that they can only serve clients who had a particular type of beneficiary coverage, e.g. Medicaid. Some courts indicate that while there was a variety of mentally ill people that needed help accessing services, they are only funded to help the severely mentally ill population. MHC desire more funding to help those who needed services, but are not clinically defined as worthy of court participation.

Some courts address the funding issues by accepting public donations for client incentives. Some courts are funded by an allotted portion of the Department of Mental Health and Substance Abuse Services funding. Other courts have consistent funding through sales tax measures. While getting tax funding is surely a lengthy and complicated process, a consistent funding source is likely to promote program sustainability and is more stable than applying for grants that run out after a few years and must be re-granted.

Another way to help in program funding source acquisition is the use of an on-staff program evaluator. In most courts, evaluation, or more often, data collection, is conducted by the program coordinator. Program coordinators hold numerous responsibilities, and data collection may not top-priority, or regularly conducted, other than for ensuring adherence to meeting state-level mandates. A program evaluator on staff could devote their job to collecting quantitative and

qualitative data to determine program outcomes, and make recommendations for policy changes or therapeutic adjustments. Additionally, evaluators' responsibilities could include grant application and renewal. Only two courts in this sample mentioned having on-staff evaluators, but this practice appears to be efficient for those who use it.

Timely-Participant Identification

Courts that mentioned issues adhering to Timely Participant Identification and Linkages to Services discussed their inability to provide the desired level of swiftness for intake of clients due to the slow process of acquiring forensic evaluations of potential clients. Funding for the forensic evaluation was also identified as an issue inhibiting desired evaluation swiftness and program accessibility for potential clients. Courts suggest allowing treatment while in jail prior to program admission could help speed along issues of competency and compliance with program mandates.

Use of Jail Time

Twenty-one MHCs use jail time as a sanction and three state that they do not (Figure 9). The courts that did not mention jail time as a sanction are Northampton County MHC, 11th Judicial Criminal Mental Health Project-Jail Diversion Project and Okaloosa County Florida. One interesting note, the 11th Judicial Criminal Mental Health Project stated their program goal is "make jail the last resort".

Jail time was identified an issue in numerous program evaluations, policy and procedure manuals, and survey responses. Communication between court team members and jail staff are notoriously slow and inefficient compared to other community partners. Client's treatments and medications schedules are not delivered as originally scheduled or not received at all. Clients also miss scheduled appointments and are released early without proper supervision. Yet another found MHC issue is the incompatibility of employment mandates and jail sanctions. Clients may

lose jobs due to missed work during jail sanctions, being unable to adhere to program work mandates, or being unable to fund treatment services and program costs without a steady source of income.

Jail is an inappropriate place for clients because jails tend to exacerbate underlying symptoms of mental illness. Evidence from studies on probation and problem-solving courts also show that over-surveillance and overuse of jail stay sanctions jail times actually increases the likelihood of recidivism, especially among low-level misdemeanor offenders through the "iatrogenic effect" (Hiday, Wales, Ray 2013; Andrews & Bonta 2003). This evidence supports not using jail as a sanction for misdemeanor offenders and limiting jail use at all costs. However, MHCs must balance the benefits of jail against risks related to disruption in medications and missed therapeutic appointments. Most MHCs in the sample mention only using jail as a sanction when clients engage in extremely high-risk behaviors and represent a threat to public safety.

If jail is to be used, collaboration between jail staff and MHC court staff must be improved. If at all costs, MHC clients should not miss vital medications or therapeutic appointments while incarcerated. One program facilitates continued medication and treatment adherence even from jail by actively working with jail staff. Two other programs have made efforts to remove even incompetent individuals from jail and into the program. One MHC helps to divert clients from jail before admission into a diversion program by helping increase inpatient bed space for psychiatric patients in existing mental health centers. Other communities in the sample recently show similar pushes for bed space, funding, and legislative support. Thanks to full community support and tax funding, another MHC created an entire mental health diversion facility where targeted "heavy users" can receive treatment at a much lower cost and with less wait time than in alternative state forensic centers.

Therapeutic Jurisprudence

Overall, with the exception of court team interactions with clients, it appears that the data trends away from being handled well in a therapeutic manner as interactions move away from the primary program locations and key staff members. Essentially, interactions become less pro-therapeutic in dealing with contracted organizations, the larger community, and jails. While it is a general assumption that MHCs operate under the principal of therapeutic jurisprudence, courts should make evaluation efforts to monitor the interactions with contracted agencies to ensure anti-therapeutic interactions are reduced wherever possible. Client and service provider interviews could help to determine which program aspects and which service providers require "therapeutic adjustments" to improve the implementation of therapeutic jurisprudence and encourage positive outcomes for clients.

Court Team Turnover

Another identified issue was the rate of turnover among court personnel including treatment providers, case managers, and even judges. Some courts addressed judicial turnover by mandating judges to a number of years presiding over the program. Potential for a lack of proper communication of assumptions, goals, and program procedures between old and new court team members relates to staff turnover issues. While many courts share similar goals or aim to address the same problems, variation exists in the goals and assumptions from court to court. Some may argue that the goals of their MHC are similar to others, but just were not written down or made explicit. Addressing all goals and aims and program logic in an explicit form will address potential goal drift as staff turnover inevitably occurs. Additionally, orientation of new staff members will help them to internalize the goals so they can better mention such goals in theory-driven evaluations. One identified solution to program drift is explicit statements of assumptions, goals, and mechanisms in a policy and procedure manual.

Policy and Procedure Manual

While twenty-one courts offered a participant handbook, only 11 courts offered a policy and procedure manual upon survey request (N=27). Policy and Procedure manuals help to keep new and current court team members updated not only with their responsibilities and the structure of the program, but also the history of the program, who started the program, and the specific issue the program aimed to address in its inception Additionally, inconsistencies were found between the participant handbook, the policy and procedure guides, and available online information. Typically, inconsistencies were related to the number of phases in the program, minimum age of target population, program costs, and the average minimum length of program. Programs with state-level oversight are frequently mandated to have a policy and procedures manual, an easy adjustment to court mandates is to include mandates to continually update the manual to reflect current practices.

ACTION MODELS

An action models is the portion of the theory-logic model that visualizes a program's plan for "arranging staff, resources, setting, and support organizations in order to reach target populations and provide intervention services" (Chen 2006). It includes six components (Target Population, Implementing Organization, Program Implementers, Peer Organizations and Community Partners, Intervention/Service delivery Protocols, and Ecological Context) and two outside factors (environment and resources). The *Essential Elements of Mental Health Courts* (2008) document serves as an outline for a normative plan of action for MHCs to follow and references the majority of the previously mentioned components of the action model. The following section outlines how the *Essential Elements* and various other MHC-related variables were defined and conceptualized within the framework of a normative action model for inclusion in the program-theory logic model. See Figure 10 for a detailed normative program-theory logic model contextualized by the *Essential Elements.*

Environment

MHC environment is conceptualized by whether the community served was an urban or rural population, the major voting demographic of the community, the Mental Health in the States (2018) ranking of mental health/substance abuse needs vs. available services, and what survey respondents said about the community that led them to start their program, e.g. large homeless population, abundance of a particular trafficked drug, or lack of treatment facilities for mentally ill, etc.

Resources

MHCs are funded by donations, local funding like taxes, state-level funding like funds from the Department of Mental Health and Substance Abuse, federal funds from governmental mental health diversion initiatives or grant funds from a variety of advocacy sources. Level of police training is also a resource. Police could be trained to deal with the mentally ill generally through Crisis Intervention Training programs or taught about the MHC program specifically.

Target Population

Information from surveys and participant handbooks regarding the similarly named *Essential Element* Target Population was used to garner information about each of the program's target population and exclusion criteria.

Implementing Organizations

Implementing organizations organize staff, allocate resources, and coordinate program activities (Chen 2006). The *Essential Element* Planning and Administration was used to derive the stakeholders on the original planning committee and/or current advisory committee.

Program Implementers

Program implementers deliver program services (Chen 2006).Those who comprise the *Essential Element* Court Team are the program implementers. The *Essential Elements* list pivotal

court team members as the judicial officer; a treatment provider or case managers, prosecutors, defense attorneys, and suggests for optional probation officer and court coordinator.

Peer Organizations and Community Partners

Programs do not often operate in a vacuum, but frequently require collaboration between implementing organizations, associate organizations, and community partners (Chen 2006). This component is comprised of two *Essential Elements*: 1. Treatment Supports and Services and 2. Monitoring Adherence to Court Requirements. Treatment Supports and Services, includes all mental, physical dental health providers, substance abuse programs, and social service providers used by the program. Monitoring Adherence to Court Requirements includes the use of probation services or jail staff.

Ecological Context

Ecological context refers to environments that directly affect the program (Chen 2006). This component relied on aspects from the *Element* Sustainability. Ecological Context was focused upon macro and micro contextual factors like whether the court received support from the community, whether the courthouse supported the program, the year the program began, what other diversion programs existed within the community, and how the clients interacted with the community through program mandates or incentives.

Intervention and Service Delivery Protocols

Intervention protocols outlining the entirety of the content, structure, and activities in the program. Service delivery protocols are "the particular steps to be taken to deliver the intervention in the field" (Chen 2006). These items constitute the most complex component of the MHC action model. Invention/ Service Delivery Protocols includes all the rules and mandates for how a program should be run and what services are offered. Therefore this component pulls from

all the *Essential Elements* including, but not limited to, descriptions of sanctions, incentives, services offered, client program mandates, and program structure.

Thanks to the thick, rich description of the sample of MHCs provided in the survey and accompanying documents, action logic models were developed for 19 MHCs and then compiled with the previously created program-theory models. Due to the complicated nature of MHC programs intervention and service delivery protocols, the entirety of the program could not be visualized in the logic model illustrations (See Appendix A). Instead, a choice was made to focus upon visually depicting overall program structure, program length, and activities related to the use of incentives, sanctions, supervision, and sanctions and incentives. The nineteen "actual" logic models were used to help identify deviations and evolutions of programs from the "normative model" generated from the *Essential Element*s document.

IDENTIFIED VARIATIONS AND DEVIATIONS FROM PROGRAM-THEORY

In a typical program-theory program evaluation, programs that deviate from the normative model are experiencing "program implementation failure". However, the *Essential Elements* accounts for a lot of potential MHC program variations thanks to awareness of contextual and environmental changes from program to program. However, while the *Essential Elements* assumes for a lot of variation in the actual implementation of the normative theory, the sample of MHCs' actual implementation of the program-theory is fairly well aligned with the normative model. Predominately, the courts align in programs goals, impacts, types of associate organizations and community partners. The following sections highlight various program assumptions and activities that aligned and deviated from the normative program-theory model.

Action Model: Ecological Context

Variation exists in the ecological context of MHCs in terms of what training is provided for police and what other court diversion programs are available. However, no court was found to

stand on its own without at least some support from the community or courthouse in its implementation. More so, variation was found in how the court attempts to reintegrate their clients back into the community through program mandates as well as how well the court promotes itself within the community.

Action Model: Target Population

The *Essential Elements* explicitly state that MHCs are meant to apply to adult populations. The document indicates that addressing both juvenile and adult mental health court populations is too difficult within the confines of one document. Additionally, at the time of document construction, juvenile mental health courts were few and far between. Interestingly, three courts are listed as adult MHC, but accept clients under the age of 18. A variance from the indicated target population for adult MHC programs.

Action Model: Program Implementers

The *Essential Elements* indicates that the court team composition is expected to vary, but assumes certain roles will be included for program success. The *Essential Elements* mandates a judge, defense attorney, prosecutor, and treatment providers/case managers. It includes optional suggestions for probation staff and a court coordinator. Most MHC listed these four core members as their court team. Many included the optional court coordinator, probation staff, and a variety of other program roles on the court team. However, two courts did not include defense attorneys as members of their court team. Additionally, one of those courts did not include the judge as a member of their court team, but upon revision of their program documentation, the judge is listed as a court team member. Variation was also found to exist in whether the judge attended court staffing or if the court excluded the judge from staff due to a preference for a judge who served impartially and enforced the opinions of the court team devised during court staffing.

Action Model: Intervention and Service Delivery Protocols

As expected, courts varied widely in their overall structure and delivery of services. Programs varied in their overall length, structure, and mandated interventions for clients. While all programs utilize sanctions and incentives, MHCs varied widely on which sanctions and incentives are utilized and when incentives are distributed. Extreme variety also existed amongst the types of social supports and specialty-tailored services offered. A minority of MHC deviate from the *Essential Elements* suggestions by failing to provide gender and culturally-sensitive services and/or housing assistance. While not specifically investigated, the lack of these types of services could be due to a lack of funding or lack of service availability within the community.

Program-theory: Interventions and Goals

It is interesting to note the variation in the explicit interventions listed in the program goals and mission statements. All programs primarily focused their statements about intervention in terms of meeting needs and linkage to services, but five failed to explicitly mention anything regarding judicial supervision as an intervention. Additionally, while most of the goals adhered to the goal assumptions in the normative logic model (community safety, reduction of mentally ill from prison populations, improved well-being), some MHCs stated goals went even broader. Their goals also include a desire to reduce mental illness stigma and create communities that supported mental wellness and understood mental illness.

Program-theory: Outputs and Outcomes

Programs cannot determine if they achieve the goals they assume for their target population if accounting measures are not undertaken. The *Essential Element* Sustainability recommends courts create measurable goals and outcomes for their courts and report qualitative and quantitative data to use to validate the program's success. These reports can be used for acquisition of grant funds or to promote public awareness and approval of the program. Interestingly, although demographic reports, evaluations, and research on the programs was

requested, fourteen courts provided no such data nor was data available online. While this may be due to the youth of some programs, many of the programs were also under state mandated guidelines for data collection as stated in their handbooks. Predominately, courts that provided data or were mandated under state guidelines to collect data report on output measures like social demographic variables, referral rates, acceptance rates, and discharge rates. Courts that have been established for a few more years also collect data and use benchmarks for performance in terms of time spent between arrest and referral, referral and program acceptance.

While promoted by the *Essential Elements*, relatively few courts mentioned regularly collecting qualitative data on perceptions of the court from clients or court team members. Outputs and Outcomes help to determine if the change model assumptions and goals are being realized in actuality. Interestingly, while nearly all courts mentioned that data was collected for the sustainability of their court in their handbooks and manuals, most of the courts did not provide actual data about what they were doing to ensure the sustainability of their court in terms of evaluations and data recording. Refer to the logic models in Appendix B for detailed information regarding the output and outcome measures known to be collected by each of the MHCs.

IDENTIFIED AVENUES FOR EVALUATION QUESTIONS

While program outcomes were not tested, two survey questions aimed to examine avenues to pursue future outcome evaluation questions. Courts were asked to what extent they felt their MHC was having an impact on the clients they serve and to what extent they felt their MHC was having on the community at large.

Client Impact Assessment

Courts were first asked to respond to, "Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court has on the

clients it serves?" on a five-item scale of "strongly agree" to "strongly disagree" (Table 13). Of the 26 responding courts, all or almost all agreed or strongly agreed that their courts impacted the clients they served through improved self-confidence (26), improved mental health (25), improved quality of life (25), and improved interactions with the community (25). Twenty-three courts agreed or strongly agreed that their courts reduced crime participation, drug use, and recidivism rates, and their courts improved relationships with criminal justice system. Majorities of courts agreed/strongly agreed that their courts improved physical health (20), home life (20), and employment stability (19) for their participants. A single court disagreed that their court reduced crime participation, reduced recidivism, improved job skills, and improved relationships with criminal justice system and "strongly disagreed" that the court reduced drug use.

Community-level Impacts Assessment

Courts then were asked to respond to, "Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court have on the community at large?" on a five-item scale of "strongly agree" to "somewhat disagree" (Table 14). A majority of the 26 courts agreed or strongly agreed that their courts improved awareness of mental health issues (20), improved family acceptance of MHC clients (24), improved local police and criminal justice system understanding of mental health issues (22), reduced recidivism rates (23), improved community mental health (22), improved acceptance of mental health court clients (20), and created or improved policies/procedures for working with the mentally ill (20). Only a small number of courts disagreed with the idea that their MHC positively impacted any of the following community-level impacts including: Reduced crime rates (1), reduced drug use (1), reduced recidivism rates (1), improved awareness of mental health issues (1), improved awareness of drug use issues (1), improved acceptance of individuals with drug use issues (1), created or improved criminal justice policies and/or procedures for working with the mentally ill

(1), the MHC improved community access to existing helpful services and treatment providers (2), and the MHC created jobs for community members (3).

While most of the questions directed at client impact appeared to mirror current common methods of evaluation, the results of the survey question direct at community-level impacts appear to suggest that evaluation of courts in terms of their community-level impacts are viable avenues to pursue for outcome variable operationalization in future research. Recommendations for future avenues of evaluation are suggested in the following chapter.

CHAPTER V

DISCUSSION

This research uses a mixed-methods design within a program-theory framework for the purpose of understanding MHC assumptions, structure, activities, and operational environments. Use of quantitative and qualitative survey responses and court documents uncovered variations in MHC program assumptions and interpretations of the *10 Essential Elements of Mental Health Courts* which largely guide MHC program-theory and activities (Thompson, Osher and Tomasini-Joshi 2008). The study finds theoretical support for the principles of therapeutic jurisprudence and also, to a lesser extent, principles of restorative justice that guide MHCS.

This section outlines six key findings: 1. MHCs are largely experiencing expansion from predominate emphasis on meeting clinical treatment needs to inclusion of a variety of services/activities aimed to meet identified dynamic criminogenic needs. 2. MHCs do not place as much emphasis on sanctions and incentives as an intervention required for program success as originally assumed. 3. Despite identified evolution in program assumptions and expanded variety of program activities, MHC goals are largely the same as originally outlined in the *Essential Element*s. 4. Client transportation acts as major barrier to program success. 5. The *10 Essential*

Elements continue to largely encompass what court teams assume makes a successful MHC, restorative justice, however, may merit future consideration for inclusion. 6. MHCs largely feel their programs impact the level of social organization in their communities, thus, community-level impacts are a viable source for methodological pursuit in future program evaluation. This section details these six key findings and their associated implications, identifies avenues for future MHC evaluation, and concludes with study limitations and future research directions.

Overall, it appears MHC still primarily adhere to the logic originally formulated for MHCs. MHCs largely assume that,

> (1) untreated, or inadequately treated, mental illness contributes to criminal behavior; (2) criminal justice involvement can serve as an opportunity to connect people to appropriate treatment; (3) appropriate treatment can improve the symptoms of mental illnesses and reduce problematic behavior, especially when (4) judicial supervision, including the use of graduated incentives and sanctions, helps keep people in treatment; and, thus, (5) the combination of treatment and judicial supervision will reduce recidivism and improve public safety (Fisler 2015).

According the survey results, the sample of MHCs largely assume that untreated, or inadequately treated, mental illness contributes to criminal behavior, and providing clients access to mental health treatment reduces problematic behavior and improves mental illness symptoms. These assumptions form the basis of the *Essential Elements*. Contrary to the original hypothesis, these MHC assumptions do not appear to have deviated as the basis for the theory of change model underlying MHCs within the past decade. Despite this lack of change in most assumptions, there does appear to be a major expansion in the theory of change model for MHCs. The collection of information gathered from participant handbooks, policy and procedure manuals, and identified program goals indicate growing explicit emphasis on providing social services that address dynamic criminogenic needs.

The *Essential Elements* (2008) explicitly mentions addressing two criminogenic needs: housing and co-occurring substance abuse. In this sample of MHCs, it appears that addressing these as well as additional dynamic criminogenic needs like criminal thinking, anti-social

personalities, family/social dynamics, as well as education levels, vocational skills, leisure activities, and employment is growing in assumed importance to court success. This apparent social inclusion focus is also exemplified in the variety of program activities related to employment, housing, education, community engagement, and other social services tailored to meet individualized needs of clients.

This expansion in meeting criminogenic needs appears reflective of the very recent policy shift in support of the "needs-responsivity model" (Bonta and Andrews 2007). The model makes three assertions regarding risk, need, and responsivity.

> Risk principle: Match the level of service to the offender's risk to re-offend
> Need principle: Assess criminogenic needs and target them in treatment.
> Responsivity principle: Maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender (Bonta and Andrews 2007)

The needs-responsivity model is supportive of inclusion of a high-risk, high-needs target population. This shift in focus explains why some programs explicitly mention "high-risk, high-needs" as part of their target population and why many of the older sampled program began as misdemeanor courts, but now accept felony offenders. Empirical data on its use in MHCs is limited due to novelty, but initially promising (Bonfine, Ritter and Munetz 2016, Skeem, Steadman and Manchak 2015). If research continues to support this policy in regards to target population, programs who do not currently adhere to this model for their target population may see reduced chances of grant funding and/or less positive outcomes for their clients (Marlowe 2013).

While addressing housing, education, and employment are mentioned goals for a variety of MHCs in the sample, less than a third of courts provided information regarding established relationships with these types of social service providers within the community. More commonly, exemplified relationships only demonstrated collaboration between the program, mental health treatment, and substance abuse providers. Establishing on-going collaborative relationships with

additional social service providers is surely helpful to meeting the individualized needs and addressing speed of services. Ability to identify relationships between community partners will help to evaluate program effectiveness and identify additional needed social services.

As future research and practice validates the importance of addressing dynamic criminogenic needs, outcome evaluation questions should address to what extent programs adhere to the Needs-Responsivity Model and verify how meeting these needs are associated with achievement of overall program goals (Campbell et al. 2015). Although already utilized by a good portion of courts in the sample, employment and education levels should be included as part of demographic measures collected on potential and accepted clients as well as part of any quality of life outcome assessments immediately after program graduation and years after. Measuring these types of quality of life variables can help assess immediate MHC goals of meeting criminogenic needs and the determine whether addressing those needs impacts long term goals of discontinued criminal activity. Additionally, making these measures and outcomes more readily available to the public will help promote program sustainability through social support and awareness of community impacts.

While not deviating too far from the assumptions outlined in the normative program-theory model, the increased emphasis on meeting dynamic criminogenic needs marks an area of expansion of the program-theory logic and supports the original hypothesis that MHCs vary in their program assumptions, goals, and interpretations of the *Essential Elements*. Research is still required to validate the relationships of changing assumptions and activities to program success. If validated as an activity related to better client outcomes, future guiding documents should be structured to emphasize the importance of meeting dynamic criminogenic needs.

The second important finding is that MHCs show slight deviation from the assumption that graduated sanctions and incentives helps keep clients in treatment. While still “extremely

important" to 38.46% of courts in the sample, the survey showed use of graduated sanctions and incentives to keep clients in treatment is not as important to court success as originally assumed. The majority of courts found this element to be only a "very important" MHC assumption with some responses indicating that it was only "moderately important" assumption. Additionally, while all twenty-seven courts demonstrated that they use a variety of sanctions and incentives, only one court explicitly mentioned the use of sanctions and incentives at all in any of their write-in responses or document-provided goals, mission, or vision statements.

In the survey responses, the 22nd Judicial Circuit MHC, 30th Circuit MHC, and the Northampton County MHC all said the sanctions and incentives assumption was only slightly important to their MHC. These three courts only have two contextual factors in common, they all reside within states above the 50th percentile in mental health ranking, listed at 11th, 15th, and 14th respectively, and they are all states within the Northeastern region of the United States (MHA 2018). Additionally, within provided goals and mission statements/documents, five courts did not mention how achieving goals were related to activities like monitoring compliance, sanctions or incentives, or judicial supervision. All five of these courts were located within the northern region of the U.S. Perhaps the reduced emphasis on sanctions and incentives in these courts relates to the increased availability of services within each of those states or maybe these findings are related cultural de-emphasis of disciplinary measures among MHCs residing in courts in Northern states vs. historically more punitively cultured, Southern-states (Cohen 1996, Johnson 2009). However, these findings do point to evidence in support of regional variation in program assumptions and regional drifts from the normative theory model. More data is required to validate either of these suggestions.

Early social science on sanctions and incentives in MHCs is hard to come by as early problem-solving courts did not keep accurate accounts of their use and frequency of sanctions (Griffin, Steadman and Petrila 2002). Currently, MHCs most typical rely on the rule of thumb 4:1

ratio of incentives to sanctions created from clinical, not empirical, observations of drug courts (Gendreau, 1996; Wodahl et al., 2011; Marlow 2012). Newer MHC sanctions and incentives research predominately focuses on the frequency of incentives and the use of jail as a sanction, but actual experimental research validating the policy is non-existent (Callahan, Steadman, Tillman & Vesselinov 2013). As MHCs aim to adhere to science-backed practices, it is important to empirically validate the use, types, and frequency of sanctions and incentives. While a number of sampled courts already record sanctions and incentives information, it should become a standard practice in all MHCs. The hypothesis that MHCs vary from one another in their assumptions has minimal support in the data, but is evidenced by the variation in indicated assumed importance of sanction and incentives.

Despite identified variation from the normative model in court assumptions regarding sanctions and incentives and expansion in the use of inventions aimed to address dynamic criminogenic needs, the goals of MHCs as described in write in survey responses and court documents, largely remained in accordance with the originally outlined goals in the *Essential Elements.* Marking the third major finding from this research, this sample of MHCs shares largely the same goals: increasing public safety, increasing treatment utilization for clients, improving quality of life, reintegrating clients back into the community, and reducing stigma. Thus not providing support for the hypothesis that MHCs vary in their goals.

The fourth major finding relates to network connectivity, specifically how well the MHC client population is able to access services via public transportation or other methods offered by the city or the MHC program (i.e. public transportation, vehicle mandates for program entry, or pick-up services), and its relationship to achieving MHC goals. Although not specifically requested in the survey, the collection of survey responses related to transportation availability and collected documents frequently positioned the issue of transportation as one of the biggest hurdles for the program and clients.

Generated maps of the MHCs that provided addresses of their affiliated service providers commonly revealed a concentration of service locations primarily within the major downtown city center of the jurisdiction served with limited services elsewhere. Generally, the location of services appear in close proximity to the local transportation routes, when available. However, one survey indicated that even though the community had a public transportation system available to clients, it was too confusing and frequently arrived late. Participants frequently missed court dates and appointments due to inability to arrive on time using public transport options.

Courts in rural areas mentioned how lengthy distances to treatment facilities and absence of transportation services/systems available to their most rural and impoverished citizens not only impede current client success, but are also partly to blame for the overall communities' lack of mental health treatment and level of criminal justice involvement. Communities with high levels of mental health need, but limited access, cope by using illegal drugs available in the area, e.g. meth and opioids. Courts in both rural and urban areas attempted to avoid transportation issues by collaborating with transportation service providers for the disabled, ensuring curb-side pickup of clients through treatment agencies, or picking clients up for court and meetings themselves. Without transportation, numbers of clients cannot attend treatment, adhere to program mandates, avoid sanctions, make progress, or achieve goals. Thus, a plan for transportation appears to be an important facilitator for program success.

Future and current MHC programs should work to have a transportation plan in place if their target population is one that is primarily without access to personal transportation or located in an area without available public transportation services. Court teams should consider the overall area of court jurisdiction, client residence, and the relative costs-benefits of collaborating with service providers located within a single concentrated area. In determination of potential new clients, residence proximity to services and available transportation services should be

influential factors. Additionally, participant handbooks should include addresses of established treatment/social service providers, maps of locations frequently visited by clients, and available transportation options. Only one court in the sample provided a map identifying the program location and community partners. Providing this information can promote the informed choice of potential clients and encourage accountability among current clients.

The fifth major finding relates to the use and interpretation of the *Essential Elements*. When the survey asked to explain how their court interpreted and implemented each of the 10 *Essential Element*s, MHCs interpreted and implemented each of the elements with only slight variations in terms of their program activities, target population, community partners, or implementers. The *Essential Elements* make no rigid mandates in these areas, thus, even found variations do not necessarily exemplify a deviation from the normative action model or indicate program implementation failure.

While all of the existing *10 Essential Elements* were considered important to court success, it is curious that each of the 27 MHCs ranked the 10 *Essential Elements* in order of importance to the success of their court in an overall different order. While the 10 *Essential Elements* make no claims to be listed in any particular order of importance, it is also interesting to note that none the courts ranked the *Essential Elements* in the same order as they are published in the well-known document (2008). As empirical evidence validating the necessity or overall importance of each element to the success MHCs is virtually non-existent, the extreme variation in level of assumed importance is understandable. Additionally, since all the *Essential Elements* were identified as important, the actual ranking of them may prove insignificant as a valid measure (Table l5).

Despite variation in perceived level of importance, the *10 Essential Elements* document continue to largely encompass what court teams assume makes a successful MHC. None of the

Elements appear to not be perceived as important to court success. While the sampled MHCs vary widely on what they identified as their own *Essential Element*, many of the suggested *Essential Elements* refer to existing topics located within descriptions of the original *10 Essential Elements,* namely: Monitoring Adherence to Program Requirements, Treatment Supports and Services, Informed Choice, Court Team, and Target Population. Regardless of similarities, the offered suggestions offer contextual insight as to what courts find important to their own success. For example, two courts focus their element upon re-entry and the lack of access to medications/treatment while incarcerated before program admission. Two other courts suggest the importance of proper assessment by noting the difficulty of assessing clients who experience both mental health and substance use issues.

One identified notable variation from the original *Essential Elements* is "making amends with the victim" found in the write-in survey response about whether or not a court could identify their own *Essential Element*. While Planning and Administration suggests that crime victims should provide insights into the development plan for a MHC, the *Essential Elements* do not go into detail about incorporating victims of clients into the day-to-day structure or mandates of the program. Making amends to the victim appeals to a line of problem-solving court research that looks into courts' ability to provide "restorative justice" which seeks to repair relations between offenders and victims. In future studies, the relative importance of achieving restorative justice should be addressed. If deemed important to a far larger collection of operating MHCs, it could be argued that the suggested new elements merit their own individual place on the list or that the existing *Essential Elements* document should undergo modifications.

The sixth and final major finding of this research is that MHCs largely feel their programs impact the level of social organization in their communities. This finding is exemplified in program goals and survey responses related to perceptions of community-level impacts. MHCs' stated goals frequently expand beyond individual client improvements and social re-

integration. They also aim to combat social disorganization and its negative impacts on mental health. For example, they aim to create safer communities, facilitate collaboration between law enforcement, legal, treatment and social service providers, and create communities that are informed and supportive of individuals with mental health issues.

A robust collection of survey data supports using community-level impacts as an evaluation measure in future research. For example, the majority of courts agreed that their MHC impacted their clients by improving interactions with the community. Additionally, 17 MHCs felt their court impacted the community one way or another even though most courts felt the larger public was, to varying extents, largely unaware of the program's existence. Thus, community-level impacts are a viable source for methodological pursuit in future program evaluation.

Despite these identified goals and perceptions of community-level impact, this sample largely does not yet collect data or evaluate these types of impacts. Most courts indicated that they collect demographic data output/outcome information on clients including: referral source, clinical diagnoses, criminal history, retention/dismissal data, graduation rates, and recidivism rates. Only programs that serve large client populations and over ten years-old commonly evaluate their impacts in terms of reducing the overall number of people incarcerated in the local prisons. For example, one of the largest programs, the 11th Judicial Circuit boasts their efforts impacting the closure of one of the local jails. This program released a "heavy utilizers" study that compared costs of the program over time to the costs related to this particular population's frequent incarcerations, ER hospitalizations, and use of in-patient forensic treatment centers. Additionally, older programs were more capable of measuring costs effectiveness and longer term impacts like recidivism multiple years post client graduation. However, two younger programs also followed this pattern for evaluating long-term recidivism rates. Despite program youth, these programs included quality of life measures and drug free babies. Variation in evaluation measures could be blamed on differences in the overall number of clients served, years of program

operation, or logical oversight. However, it appears that the biggest influence over the kind of output and outcome data collected is not program size or year of implementation, but state-level oversight and stipulated data collection mandates for program certification or funding.

Regardless of program variations or state-level oversight, if MHCs theoretically assume that their interventions can affect not only their clients, but the larger community, then these potential impacts must be clearly identified, operationalized, and evaluated. The next section outlines identified potential future avenues for evaluation methods and questions. The identified avenues for future research are related to community-level impacts and other identified avenues grounded in the findings from this study.

Courts in the sample predominantly evaluate themselves in terms of statistical demographic output and outcome data. *Essential Elements* mandate recording of qualitative and quantitative data for evaluation and support of the program. While most courts appear focused on the statistical and demographic data collection, very few of the sampled courts mentioned collecting qualitative information as part of regular self-evaluation. When qualitative data collection occurred, it was typically collected as a client entry/exit survey or as a mandated client writing assignment. Court team and community partner interviews were collected only in a few cases for the purpose of a formal evaluation conducted by an outside evaluator. A major suggestion, courts should more frequently utilize qualitative data collection. Qualitative data in the form of interviews or essays can be used to glean perceptions of potential, past, and current clients as well as court team members and community partners to evaluate ongoing practices and facilitate collaboration. Qualitative data is great for use in press releases, community outreach, and program awareness efforts.

In addition to the previously stated methodological suggestion, the results also help to suggest the following five evaluation questions related to community impact, therapeutic jurisprudence, and restorative justice.

1. Does the MHC improve family acceptance of MHC clients?

Family reunifications are an important aspect of mental health recovery. MHCs encourage clients to build a support network of law-abiding family and friends. MHC are also known to offer family therapy, counseling, and treatment efforts not only to clients, but to clients' family members. Mental health stabilization, successful program completion, and reduction/elimination of criminal charges helps family members reconnect. Within the sample, only one program currently measures family reunifications and two provided counts of drug free babies born to clients and graduates. Family members' impact could be evaluated through qualitative interviews and Likert-scale structured surveys to measure improvements with clients and family members at various points in the program.

2. Does the MHC improve local police and criminal justice system understanding of mental health issues?

Contact with law enforcement revealed issues with the level of awareness local law enforcement had regarding the existence or training for the MHC programs in the sample. While the majority of law enforcement received CIT training, not all officers within an agency were CIT trained. Additionally, while some law enforcement agencies were provided MHC orientation, not all officers were oriented to the MHC program or even aware of the program's existence. Ensuring officers are sufficiently trained to deal with mentally ill population and also aware of the possibility of diversion efforts for mentally ill justice-involved individuals will help increase the efficiency of law-enforcement interactions in this early intercept point. Additionally, MHCs

who don't currently work with police could offer certification courses and training programs for current and new law enforcement officials.

Some MHCs collaborate with local jails to inform jail employees about the program, identify individuals who are in the program, and ensure reductions in early, unsupervised releases. They also work with jails to ensure timely client identification, rapid forensic assessment treatment of potential clients and create systems so medications/ treatment are not interrupted even during client jail sanctions. Law enforcement and criminal justice system understanding of mental health issues or program awareness could be evaluated through a survey or qualitative interview with law enforcement and jail personnel.

3. Does the community feel safer?

MHCs aim to reintegrate law-abiding, mentally stable individuals back into the community. Stabilized clients graduate, gain stable housing, reconnect with family, work and volunteer in the community, and participate in continuing education. These kinds of community integration should serve to reduce stigma and fear of successfully stabilized clients living within the community. Additionally, outreach on behalf of clients and about the program should also help to reduce stigma and promote understanding of mental illness within the community. While numerous programs indicated they wanted to reduce stigma and create an informed, positive community for their clients, these particular program goals have limited evidence of current measurement within this sample of programs aside from one comprehensive program evaluation. Therefore, MHCs should make efforts to evaluate their ability to promote acceptance, reduce stigma, and community reintegration.

Americans' perception of risk and fear of crime are more strongly linked to neighborhood incivilities like "disorderly conduct, abandoned storefronts, unkempt lots, litter, noise, bench sleepers, and public drunks" than crime rate themselves (LaGrange, Ferraro and Supancic 1992;

Lewis 2017). The criminalization of homelessness and mental illness over the years helps to promote public fear associated with individuals living on the street. Identified as a major hurdle for MHCs, but still a fairly common goal is addressing housing needs and homelessness of clients. It could be assumed that successfully addressing housing needs of clients helps to get them off the street where they are more likely to increase community member's perception of risk and crime. If people are less afraid, they are likely to support such programs and perceive them as valuable. Programs that address housing needs of a large number of clients may be able to evaluate their program not only through connecting clients to housing, but also in terms of public perceptions, program support, and reduced fear of MHC clients over time.

The type of evaluation could be conducted through interviews with family, friends, neighbors, and employers of graduates. However, due to the private nature of mental illness and HIPAA concerns, the evaluations would have to be centered upon the program in general, not upon specific clients. Perhaps a community-wide survey could be distributed to judge the impact of the program or discern whether the general community is even aware of the program. Results could serve to validate current outreach efforts or justify the need for additional outreach efforts or community integration mandates for clients.

4. Is each program component implemented in a therapeutic manner?

Data from this study showed that program implements tended to become viewed as less therapeutic as the services moved away from services offered by the court itself. Interactions with jails and jail staff appeared to be the consistently least therapeutically implemented program components. A functional evaluation measure for courts could be a survey for clients and various service providers designed to determine how the therapeutic nature of each service offered or collaborating agency. These surveys could be used internally to identify issues with particular

treatment/ service providers or pinpoint agencies requiring a therapeutic adjustment or program orientation.

5. Does the court implement restorative justice?

Courts varied upon how important the goal of making participants feel forgiven for past misdeeds applied to their court. According to the survey responses about goals, some felt it was very important to their court while others didn't feel it was important at all. While results indicate that restorative justice priorities are not uniform among MHCs, its application and prevalence in court goals merits further research and potential inclusion as part of program evaluation for courts who make restorative justice a goal for their courts. Courts who feel restorative justice is a goal for their courts could work to implement community conferencing as part of their program activities. As appropriate, victims and court clients could work together to create and achieve collaborative goals aimed at rectifying harms done to particular individuals and the community at-large. Achievement of the individualized goals could be recorded as a measure of program success and additionally could serve to improve public appreciation and awareness for the MHC program.

The collection of findings and support for community-level impacts as future lines of inquiry speaks volumes to the potential societal impact of MHCs. MHCs potentially impact the communities in which they serve by successfully reintegrating clients into the community, promoting community acceptance of the mentally ill, decreasing stigma and fear, and making community-based treatments more viable as options over incarceration. If true, then MHCs may serve as a major force in halting the historical cyclical pattern of societal fear, institutionalization, moral panic, and deinstitutionalization.

Limitations

While this research identified variations in program assumptions, structure, activities, and goals, and supported new lines of outcome evaluation, a final step remains in a full program-theory evaluation: testing identified outcome measures. Thus, this research is not a full program-theory evaluation, but a theory-driven research project within the framework of a program-theory evaluation. Tests of measures for success will be saved for future research. Primarily, future research must evaluate courts in terms of their assumed community-level impacts.

Due to the small sample's variation in years of initial program implementation, legal structure, funding availability, and overall number of clients served, it was impossible and illogical to make comparisons between programs or test outcomes across the sample. For example, it would not be fair to compare the community-level impacts of a program that has been in operation for almost twenty years to a program that only began in 2016. Future research that evaluates developed outcome measures must be implemented in a scientifically rigorous fashion to determine the success of MHCs and their various policies and practices. If not implemented a true experimental design complete with pre and post-tests and control vs. test groups, future research must at least compare MHC implements through matching of program structure, client population, and years of program operation. This research revealed that even comparing programs within a single state proves difficult due to program variation.

This research was also limited by low response rate. In future studies involving survey research, survey length will be substantially shortened to encourage programs to take and complete the survey. In addition, sources of court contact information must be continually updated and readily available to allow for efficient and effective program solicitation. Another related limitation is this studies inability to determine if the court teams took the survey as a collective group or utilized a single court team member. A single court team member may have

different program assumptions than other court team members which may be exemplified in the survey responses.

Another related limitation of this study was the lack of provided or available data on program demographics, output, or outcomes. Knowingly, many of the sampled programs are new, have relatively little data collection to distribute, or have not yet developed benchmark standards to which they aim to adhere and judge themselves upon. Additionally, only a handful of programs previously implemented a full formal evaluation. However, the majority of the sample's program handbooks and manuals indicate that various forms of data *are* collected, but that data was not largely provided for this research upon request. Either this data collection statement is merely lip service to the *Essential Element* Sustainability, in that data is not *actually* collected, or the collected data is not made easily available for public distribution. Regardless of reason, the absence of outcome data made discerning the logic between particular activities and goals extremely difficult. The research encountered fewer problems following the logic of MHCs that clearly outlined the types of data collected or actually provided the data and reports on program adherence to developed benchmark standards. Updates to policy and procedure manuals' statements regarding data collection and sustainability will help facilitate future research and evaluation efforts.

Future Research

This research is not a representative sample of MHCs. Ideally, future research will include a larger sample of MHCs to determine if the identified variations in program-theory are consistently identified or if other unexamined variations in program-theory exist. As MHCs develop over time, it is expected to see continual changes in the program assumptions and activities. Continual program-theory evaluations can document the program evolution and ensure the program logic remains sound. With a more representative sample, outcome evaluation questions may be tested resulting in a full program-theory evaluation. Ideally, MHC outcome

questions will empirically address the five previously identified evaluation questions regarding community-level impacts, therapeutic jurisprudence and restorative justice.

Any future theory-driven evaluations will involve in-person observations and interviews with court team members to ensure that all implicit and explicit assumptions by the entire court team are shared, heard, and given the possibility for research inclusion. Not only will this allow for equal participation of court team members in the research, reduce the possibility of survey-taker bias, but it will also allow for court teams to collaboratively discuss their different assumptions about the problems their program solves and how implemented activities addresses those problems. Active court communication regarding program assumptions and activities will help better address logical inconsistencies between court team members and facilitate collaboration for improved program success.

A final identified avenue for future research is the evaluation of juvenile MHC programs. During this research solicitation process, MHC court coordinators frequently asked to include their juvenile programs in this study, but due to the limited scope of this project and the assumed variations in program legal structure, were excluded. Evaluation research is even more sparsely conducted on these programs, but desperately required. Examination of juvenile MHC assumptions and their variance from the adult MHC model constitutes an area ripe for research.

Conclusion

While this study is not without limitations, it does establish a precedent for program-theory evaluation as a new type of evaluation for MHCs. The *Essential Elements of Mental Health Courts* (2008) was designed to guide program-theory and implementation. Primarily, this study asserts that the core assumptions set forth by problem-solving courts, while relatively stable, evolved somewhat since the *Essential Elements* were published in 2008. These evolutions were thanks, in part, to a more than doubling of overall MHCs in operation and a decade's worth

of program practice and research. This study also demonstrates that while MHCs generally ascribe to the same assumptions and goals outlined in the *Essential Elements*, some variations exist in regard to how important courts feel those assumptions are to the success of their court and the way in which courts implement various *Essential Elements*. Courts also vary in some of the client-level goals, target populations, and the assumptions about meeting various criminogenic needs.

In the future, MHCs can use program-theory evaluations to look in-depth at the assumptions and problems they aim to address to see if they logically align with the activities, goals, and the manners in which outcomes are collected. Clear program logic delineation is of pivotal importance during this current period of MHC expansion and evolution. As new data become available, scientists and policy makers will continue to push for changes in program activities, services, and target populations in a well-intentioned effort to best address "what works" and "for whom". However, without proper reflection, the original assumptions upon which MHCs rest may stagnate, distort, and ultimately contribute to an illogically implemented program. Programs that rapidly change to adhere to a collection of newest best-practices may result in a Frankenstein-like collection of components that do not make sense in relation to addressing previously identified issues within a particular community context, achieving original program goals, or evaluating success. Illogically constructed programs contribute to negative outcomes. MHCs are still relatively new. Negative outcomes resulting from illogical programs may reduce public and political support for existing MHC programs or result in a lack of support for new mental health diversion efforts along every point along the criminal justice-intercept continuum.

This study is additionally important because it asserts that MHCs feel their programs not only impact the clients they serve, but the wider community. Currently, courts typically evaluate their success through graduation rates, recidivism rates, and cost savings. The logical next step in

evaluating the success of these MHCs require assessment of any broader community impacts such as improved understanding of mental health issues in the criminal justice system, family impacts, implementation of therapeutic jurisprudence/restorative justice principles, and the reduction of community-wide held fears and mental illness stigmas. Evaluation of community-level impacts has the capacity to help promote access to care and reduce the burdens felt due to the criminalization of the mentally ill. If community-level program impacts are validated, MHCs existence can be strengthened with the knowledge that the program promotes community integration and social well-being of a group of historically mistreated and isolated individuals.

Most importantly, MHCs can reduce society's current reliance on jails and prisons as the total institution of choice for the mentally ill. Removal of the mentally ill from criminal justice institutions helps to address concerns of prison overpopulation and inadequate treatment therein. MHCs can provide the mentally ill individuals they serve access to needed treatment and social services to successfully reintegrate into communities. Successful criminal justice and mental health system collaboration further promote this success by addressing community-level structural impediments to successful integration. Healthy, productive clients and program outreach help reduce negative stigmas and public fear. With all these elements working together, MHCs can help to halt the seemingly endless cycle of societal fear, institutionalization, moral panic, and deinstitutionalization once and for all.

TABLES

Table 1: Key Components of Drug Court

#	Key Component
1	Drug courts integrate alcohol and other drug treatment services with justice system case processing
2	Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights
3	Eligible participants are identified early and promptly placed in the drug court program
4	Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
5	Abstinence is monitored by frequent alcohol and other drug testing
6	A coordinated strategy governs drug court responses to participants' compliance
7	Ongoing judicial interaction with each drug court participant is essential
8	Monitoring and evaluation measure the achievement of program goals and gauge effectiveness
9	Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations
10	Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness

National Association of Drug Court Professionals. Drug Court Standards and United States. Drug Courts Program Office. 1997. *Defining Drug Courts: The Key Components*: US Dept. of Justice, Office of Justice Programs, Bureau of Justice Assistance.

Table 2: ***10 Essential Elements of a Mental Health Court***

#	Element Name	Element Description
1	Planning and Administration	A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.
2	Target Population	Eligibility criteria address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered
3	Timely Participant Identification and Linkage to Services	Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.
4	Terms of Participation	Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.
5	Informed Choice	Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.
6	Treatment Supports and Services	Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of— treatment and services that are evidence-based.
7	Confidentiality	Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.
8	Court Team	A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.
9	Monitoring Adherence to Court Requirements	Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.
10	Sustainability	Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.

Thompson, Michael, Fred C Osher and Denise Tomasini-Joshi. 2008. Improving Responses to People with Mental Illnesses:

The Essential Elements of a Mental Health Court: Justice Center, the Council of State Governments.

Table 3. Mental Health Court Sample Overview

Court	Area Served	Misdemeanor	Felony	Start Year
Coordinated Resources Project- Palmer	Mat-Su Borough, AK	X	X	2005
Coconino County mental Health Court	Coconino County, AZ	X	X	2012
Okaloosa County Mental Health Court	Okaloosa County, FL	X	X	2003
11th Judicial Criminal Mental Health Project- Jail Diversion Programs	Miami-Dade County, FL	X	X	2000
Western Judicial Circuit Treatment and Accountability Court	Oconee County, GA Clarke County, GA	X	X	2008
Muskogee County Mental Health Court	Chattahoochee County, GA	X	X	2008
Rome Circuit Mental Health Court	Floyd County, GA	X	X	2016
5th Judicial District MHC	Twin Falls, ID		X	2005
22nd Judicial Circuit MHC	McHenry County, IL	X	X	2007
Marion County Mental Health Alternative Court	Marion County, IN	X	X	2016
14th Judicial District Mental Health Court	Calcasieu Parish, LA	X	X	2011
30th Circuit MHC	Ingham County, MI	X	X	2015
Washtenaw County Mental Health Treatment Court	Washtenaw County, MI	X	X	2015
Boone County TC II (Treatment Court II)	Boone County, MO	X	X	2003
The Forsyth County MHC	Forsythe County, NC	X	X	2012
Creek and Okfuskee County Anna McBride Court	Creek County, OK Okfuskee County, OK	X	X	2010
Rogers County Anna McBride Court	Rogers County, OK	X	X	2008
Northampton County MHC	Northampton County, PA		X	2015
Fayette County MHC	Fayette County, PA	X	X	2003
Bexar County MHC	Bexar County, TX	X		2008
38th Judicial District Specialty Court	Uvalde County, TX Medina County, TX Real County, TX		X	2014
1 District Brigham City MHC	Box Elder County, UT	X	X	2015
Norfolk Mental Health Docket	Norfolk County, VA	X	X	2004
Kitsap Behavioral Health Court	Kitsap County, WA	X	X	2016
Pierce County Felony MHC	Pierce County, WA		X	2015
Whatcom County MHC	Whatcom County, WA		X	2016
Eau Claire County MHC	Eau Claire County, WI	X	X	2008

Table 4. To what extent are these assumptions important to your mental health court?

	Extremely important	Very important	Moderately important	Slightly important	Not at all important
Untreated, or inadequately treated, mental illness contributes to criminal behavior	73.08% (19)	26.92% (7)	0.00% (0)	0.00% (0)	0.00% (0)
Criminal justice involvement can serve as an opportunity to connect people to appropriate treatment	61.54% (16)	23.08% (6)	15.38% (4)	0.00% (0)	0.00% (0)
Appropriate treatment can improve the symptoms of mental illness	88.46% (23)	11.54% (3)	0.00% (0)	0.00% (0)	0.00% (0)
Appropriate treatment can reduce problematic behavior	84.62% (22)	11.54% (3)	3.85% (1)	0.00% (0)	0.00% (0)
Judicial supervision helps keep people in treatment	61.54% (16)	38.46% (10)	0.00% (0)	0.00% (0)	0.00% (0)
The use of graduated incentives and sanctions helps keep people in treatment	38.46% (10)	42.31% (11)	7.69% (2)	11.54% (3)	0.00% (0)
The combination of treatment and judicial supervision reduces recidivism	65.38% (17)	30.77% (8)	3.85% (1)	0.00% (0)	0.00% (0)
The combination of treatment and judicial supervision improves public safety	61.54% (16)	34.62% (9)	3.85% (1)	0.00% (0)	0.00% (0)

N=26

Table 5: How important are these goals to the success of your mental health court?

	Extremely important	Very important	Moderately important	Slightly important	Not at all important
Increased public safety for communities	73.08% (19)	15.38% (4)	11.54% (3)	0.00% (0)	0.00% (0)
Increased treatment engagement by participants	80.77% (21)	15.38% (4)	3.85% (1)	0.00% (0)	0.00% (0)
Improved quality of life for participants	73.08% (19)	26.92% (7)	0.00% (0)	0.00% (0)	0.00% (0)
More effective use of resources for sponsoring jurisdictions	38.46% (10)	50.00% (13)	0.00% (0)	3.85% (1)	7.69% (2)
Keeping those with mental illnesses out of jail	61.54% (16)	30.77% (8)	7.69% (2)	0.00% (0)	0.00% (0)
Reintegrating the clients back into the community	73.08% (19)	15.38% (4)	11.54% (3)	0.00% (0)	0.00% (0)
Ensuring clients are treated fairly	73.08% (19)	23.08% (6)	3.85% (1)	0.00% (0)	0.00% (0)
Ensuring clients feel their opinions are heard	65.38% (17)	34.62% (9)	0.00% (0)	0.00% (0)	0.00% (0)
Ensuring clients are not stigmatized by mental illness diagnoses	69.23% (18)	30.77% (8)	0.00% (0)	0.00% (0)	0.00% (0)
Ensuring clients are not stigmatized by prior criminal involvement	65.38% (17)	15.38% (4)	15.38% (4)	3.85% (1)	0.00% (0)
Ensuring clients feel forgiven for their past misdeeds	30.77% (8)	34.62% (9)	15.38% (4)	11.54% (3)	7.69% (2)
Ensuring all aspects of mental health court are therapeutic	53.85% (14)	38.46% (10)	7.69% (2)	0.00% (0)	0.00% (0)

N=26

Table 6. Judging your mental health court in its current state, how well do you feel these components of your mental health court are conducted in a therapeutic manner?

Client Interactions with…	Extremely well	Very well	Moderately well	Slightly well	Not well at all	Does not apply to my MHC	Don't know/ prefer not to answer
Judge	54.17% (13)	33.33% (8)	8.33% (2)	4.17% (1)	0.00% (0)	0.00% (0)	0.00% (0)
Court team	37.50% (9)	50.00% (12)	12.50% (3)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)
Supervision staff	62.50% (15)	25.00% (6)	8.33% (2)	0.00% (0)	0.00% (0)	4.17% (1)	0.00% (0)
In courtroom	45.83% (11)	33.33% (8)	20.83% (5)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)
Community service providers	37.50% (9)	41.67% (10)	16.67% (4)	0.00% (0)	0.00% (0)	0.00% (0)	4.17% (1)
Substance abuse service providers	33.33% (8)	37.50% (9)	25.00% (6)	0.00% (0)	0.00% (0)	0.00% (0)	4.17% (1)
Mental health service providers	33.33% (8)	45.83% (11)	16.67% (4)	4.17% (1)	0.00% (0)	0.00% (0)	0.00% (0)
Local police	4.17% (1)	20.83% (5)	50.00% (12)	8.33% (2)	0.00% (0)	8.33% (2)	8.33% (2)
Local community	4.17% (1)	37.50% (9)	41.67% (10)	0.00% (0)	0.00% (0)	0.00% (0)	16.67% (4)
Jails	0.00% (0)	33.33% (8)	41.67% (10)	12.50% (3)	4.17% (1)	0.00% (0)	8.33% (2)
Jail staff	4.17% (1)	29.17% (7)	41.67% (10)	8.33% (2)	4.17% (1)	0.00% (0)	12.50% (3)

N=24

Table 7. Environmental Information for Areas Served by Mental Health Courts

Court	Counties Served	Rural or Urban (% rural)	2010 Census Population	Voter Demographic (2016)	State Mental Health Ranking 2018	Community Issues Identified
Coordinated Resources Project-Palmer	Mat-Su Borough, AK	Rural (50.3%)	88,995	R	47th	Homelessness Service Access Jail strain ER strain
Coconino County mental Health Court	Coconino County, AZ	Urban (31.5%)	134,421	D	39th	Housing options Homelessness SMI Addictions
Western Judicial Circuit Treatment and Accountability Court	Oconee County, GA Clarke County, GA	Rural (50.3%) Urban (5.9%)	32,808 116,714	D	21st	
Muskogee County Mental Health Court	Chattahoochee County , GA	Urban (29.5%)	11,267	R	21st	Jail strain Homelessness Judicial recognition
Rome Circuit Mental Health Court	Floyd County, GA	Urban (36.8%)	96,317	R	21st	
Okaloosa County Mental Health Court	Okaloosa County, FL	Urban (12.1%)	180,822	R	32nd	SMI Addiction Homelessness Judicial desire Existing program influence
11h Judicial Criminal Mental Health Project	Miami-Dade County, FL	Urban (0.4%)	2,496,457	D	32nd	SMI
McHenry County MHC	McHenry County, IL	Urban (9.9%)	308,760	R	11th	
5th Judicial District MHC	Twin Falls, ID	Urban (0.0%)	44,528	R	50th	SMI
Marion County Mental Health Alternative Court	Marion County, IN	Urban (0.6%)	903,393	D	42nd	Homelessness Judicial desire Community desire Jail strain Addiction SMI
14th JDC Mental Health Court	Calcasieu Parish, LA	Urban (20.5%)	192,768	R	38th	Jail strain Drugs
30th Circuit MHC	Ingham County, MI	Urban (13.2%)	280,895	D	15th	Judicial desire MI Service access
Washtenaw County Mental Health Treatment Court	Washtenaw County, MI	Urban (16.4%)	344,791	D	15th	

Boone County Treatment Court II	Boone County, MO	Urban (18.8%)	162,642	D	30th	
The Forsyth County MHC	Forsythe County, NC	Urban (7.3%)	350,670	D	28th	Jail strain SMI Homeless Judicial desire Community desire
Creek and Okfuskee County Anna McBride Court	Creek County, OK	Rural (53.9%)	69,967	R	27th	Rural Poverty
	Okfuskee County, OK	Rural (74.1%)	12,191	R		Service Access Transportation
Rogers County Anna McBride Court	Rogers County, OK	Rural (50.3%)	86,905	R	27th	Services Access Transportation Rural Addiction
Northampton County MHC	Northampton, PA	Urban (12.8%)	297,735	R	14th	Resource Access Docket strain Judicial recognition
Fayette County MHC	Fayette County, PA	Urban (47.9%)	136,606	R	14th	Homelessness SMI
Bexar County MHC	Bexar County, TX	Urban (4.5%)	1,714,773	D	43rd	Jail Strain
38th Judicial District Specialty Court	Uvalde County, TX	Urban (31.4%)	26,405	R	43rd	Poverty
	Medina County TX		46,006	R		Services access
	Real County, TX	Rural (61.6%) Rural (100.0%)	3,309	R		Family support Drug trafficking.
1st District Brigham City MHC	Box Elder County, UT	Urban (31.1%)	49,975	R	44th	Addiction Jail Strain
Norfolk Mental Health Docket	Norfolk County, VA	Urban (0.0%)	242,803	D	33rd	Urban homeless SMI
Kitsap Behavioral Health Court	Kitsap County, WA	Urban (16.7%)	251,133	D	34th	Judge budget Victim advocacy Homeless Jail strain judicial desire addiction
Pierce County Felony MHC	Pierce County, WA	Urban (6.6%)	795,225	D	34th	Urban area Homelessness Felony activity
Whatcom County MHC	Whatcom County, WA	Urban (25.9%)	201,140	D	34th	Jail strain Homelessness Housing Addiction Service access SMI
Eau Claire County MHC	Eau Claire County, WI	Urban (23.0%)	98,736	D	20th	Addiction MI

Table 8. Availability of Social and Specially-Tailored Services Offered to MHC clients

Service	Yes, all clients receive these services Percent (Count)	Yes, targeted clients receive these services Percent (Count)	No Percent (Count)	Don't know/ Prefer not to answer Percent (Count)
Culturally-specific services	25.00% (6)	37.50% (9)	29.17% (7)	8.33% (2)
Gender-specific services	20.83% (5)	58.33% (14)	12.50% (3)	8.33% (2)
Age-specific services	20.83% (5)	33.33% (8)	37.50% (9)	8.33% (2)
Spiritual/ religious services	8.33% (2)	25.00% (6)	58.33% (14)	8.33% (2)
Psycho-social clubs (e.g., self-help groups AA/NA meetings)	29.17% (7)	62.50% (15)	8.33% (2)	0.00% (0)
Financial services/ money management	25.00% (6)	58.33% (14)	8.33% (2)	8.33% (2)
Disability or welfare services	33.33% (8)	41.67% (10)	16.67% (4)	8.33% (2)
Homelessness/ Housing Services	29.17% (7)	62.50% (15)	8.33% (2)	0.00% (0)
Food assistance	20.83% (5)	66.67% (16)	8.33% (2)	4.17% (1)
Family/ spousal/parenting services	8.33% (2)	66.67% (16)	20.83% (5)	4.17% (1)
Childcare services	4.17% (1)	33.33% (8)	58.33% (14)	4.17% (1)
Life skills services	37.50% (9)	58.33% (14)	4.17% (1)	0.00% (0)
Educational/Vocational program services	12.50% (3)	83.33% (20)	0.00% (0)	4.17% (1)
Employment services	8.33% (2)	79.17% (19)	8.33% (2)	4.17% (1)
Community Service Facilities	16.67% (4)	75.00% (18)	8.33% (2)	0.00% (0)
Health insurance services	25.00% (6)	45.83% (11)	29.17% (7)	0.00% (0)
Dental services or referrals	16.67% (4)	54.17% (13)	25.00% (6)	4.17% (1)
Health care/medical services or referrals	25.00% (6)	62.50% (15)	12.50% (3)	0.00% (0)
Post-graduation services	37.50% (9)	33.33% (8)	29.17% (7)	0.00% (0)

N=25

Table 9. Supervision Methods Employed MHCs

Type of Supervision Method or Personnel	Used for all clients Percent (Count)	Used, but only used for some clients Percent (Count)	Not used Percent (Count)	Don't know/ prefer not to answer Percent (Count)	Item N
Probation supervision	66.67% (16)	25% (6)	8.33% (2)	0.00% (0)	24
Other: Describe	100% (3)	0.00% (0)	0.00% (0)	0.00% (0)	3
Case manager supervision	66.67% (16)	20.83% (5)	12.50% (3)	0.00% (0)	24
Drug tests (urine)	87.50% (21)	12.50% (3)	0.00% (0)	0.00% (0)	24
Counselor supervision	45.45% (10)	36.36% (8)	18.18% (4)	0.00% (0)	22
Drug tests (blood)	0.00% (0)	10.53% (2)	89.47% (17)	0.00% (0)	19
Check-ins (in-person)	87.50% (21)	20.83% (3)	0.00% (0)	0.00% (0)	24
MHC related meeting attendance requirements	52.17% (12)	34.78% (8)	8.70% (2)	4.35% (1)	23
Family supervision	9.09% (2)	22.73% (5)	63.64% (14)	4.55% (1)	22
Police supervision	5.00% (1)	5.00% (1)	85.00% (17)	5.00% (1)	20
Treatment provider supervision	62.50% (15)	20.83% (5)	16.67% (4)	0.00% (0)	24
Check-ins (on phone)	75.00% (18)	20.83% (5)	4.17% (1)	0.00% (0)	24
Medication Compliance Checks	50.00% (12)	45.83% (11)	4.17% (1)	0.00% (0)	24
Drug tests (follicle)	0.00% (0)	21.05% (4)	78.95% (15)	0.00% (0)	19
Alcohol monitors	11.11% (2)	55.56% (10)	33.33% (6)	0.00% (0)	18
GPS monitors	0.00% (0)	57.89% (11)	42.11% (8)	0.00% (0)	19

N=24

Table 10. Types of MHC Incentives

Type of Incentives Used	Percentage (Count)	Type of Incentives Used	Percentage (Count)
Candy or toys	45.83% (11)	Program phase-ups	70.83% (17)
Small trinkets	20.83% (5)	Reduced docket time / "rocket docket" status	37.50% (9)
T-shirts or other apparel items	0.00% (0)	Reduced mandated attendance at court dockets	50.00% (12)
Movie passes	25.00% (6)	Reduced community service hours	20.83% (5)
Gift cards	58.33% (14)	Reduced program mandates	33.33% (8)
Personalized certificates	70.83% (17)	Reduced supervision methods	33.33% (8)
Personalized plaques	12.50% (3)	Reduced fees or fines	25.00% (6)
Parties or events	33.33% (8)	Reduced or Dismissed charges or sanctions	45.83% (11)
Praise from court team	87.50% (21)	Graduation ceremonies	87.50% (21)
Praise from judge	87.50% (21)	Others-please list	16.67% (4)
Praise from peers	37.50% (9)		

N=24

Table 11. Timing of MHC incentives Distribution

	Percent (Count)
Rewards for attending dockets	33.33% (8)
Rewards for attending required meetings or appointments	58.33% (14)
Rewards for program phase promotion	79.17% (19)
Rewards for general program mandate compliance	79.17% (19)
Rewards for good behaviors	50.00% (12)
Rewards for achieving particular program goals	66.67% (16)
Rewards for program graduation	83.33% (20)

N=24

Table 12. Mental Health Court's Own Essential Element

#	Element Title	Element Description
1	Culture-friendly environment	We do not have a good track record with black males, who are disproportionately represented in the criminal justice system.
2	Incentives	Rewarding participants' success often drives their internal motivation, and when our participants are successful, the court is successful.
3	Re-entry	The transition from incarceration to community is critical. Having treatment, services, and medication at time of discharge is key to participant engagement and their chance for success.
4	Participants stabilized on appropriate medication while in custody	Ability to get participants stabilized on appropriate medication while in custody
5	Transitional planning and Identifying appropriate need	Many of our clients experience a delay in beginning the program due inadequate/safe housing. The client sometimes falls through the cracks due to not clear definition of whose role it is to figure out housing, as they are not officially in our program and attorneys often do not know whom to contact for these issues.
6	Support from all parties	Support from all parties, including family. Each team member is willing to go the extra mile to help participants achieve success.
7	Relationships with provider agencies	Not only due to the essential role of timely and appropriate services, but because they have often seen these individuals before. Many of our members have "blown out" of housing and other resources due to behavior related to symptoms of their mental illness and substance use disorder. Providers have to trust us in order to try again.
8	Evidence-based practices	The use of evidence-based treatment practices is important to reduce recidivism and improve outcomes for our participants.
9	Targeting and oversight of undiagnosed/untreated severely mentally Ill	Chronically mentally ill have a revolving door to the jail. Oversight reminds them of service appointments and interactions with treatment providers. Unfortunately the more severe, the faster the revolving door swings. A great first chance for those who have undiagnosed/untreated MI. This population, of course, has the best outcome.
10	Advocacy and legal literacy	Helping participants to understand their legal rights as well as the criminal code to develop self-determination.
11	Accurate and comprehensive assessments	Inaccurate assessments are common and lead to very inappropriate treatment planning.
12	Proper assessment	Many assessed as mentally ill have substance induced bipolar symptoms also with serious Personality Disorders. It is of greatest importance to recognize and identify the true causation of their criminality before the correct planning can be put in place.
13	Making amends with the victim	Making amends to those that were affected by the actions of the client in mental health court. This gives the victim some "peace" knowing that the client knows he/she did wrong and acknowledges this and thus moving on to get treatment.
14	Low compliance officer-to-participant ratio	Allows the court team to know more about the overall situation of each participant and intervene quickly when there are problems which could result in safety concerns.
15	Individualized case plans and services	Individualized case plans and services to really meet each person's needs.

Table 13. Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court has on the clients it serves?

	Strongly agree Percent (Count)	Agree Percent (Count)	Neither agree nor disagree Percent (Count)	Disagree Percent (Count)	Strongly Disagree Percent (Count)
Reduced crime participation	42.31% (11)	46.15% (12)	7.69% (2)	3.85% (1)	0.00% (0)
Reduced drug use	26.92% (7)	61.54% (16)	7.69% (2)	0.00% (0)	3.85% (1)
Reduced recidivism rates	42.31% (11)	46.15% (12)	7.69% (2)	3.85% (1)	0.00% (0)
Improved mental health	61.54% (16)	34.62% (9)	3.85% (1)	0.00% (0)	0.00% (0)
Improved physical health	26.92% (7)	50.00% (13)	23.08% (6)	0.00% (0)	0.00% (0)
Improved self-confidence	38.46% (10)	61.54% (16)	0.00% (0)	0.00% (0)	0.00% (0)
Improved quality of life	38.46% (10)	57.69% (15)	3.85% (1)	0.00% (0)	0.00% (0)
Improved home life	30.77% (8)	46.15% (12)	23.08% (6)	0.00% (0)	0.00% (0)
Improved education	7.69% (2)	53.85% (14)	38.46% (10)	0.00% (0)	0.00% (0)
Improved job skills	15.38% (4)	53.85% (14)	26.92% (7)	3.85% (1)	0.00% (0)
Improved employment stability	19.23% (5)	53.85% (14)	26.92% (7)	0.00% (0)	0.00% (0)
Improved life skills	34.62% (9)	61.54% (16)	3.85% (1)	0.00% (0)	0.00% (0)
Improved relationships with criminal justice system	53.85% (14)	34.62% (9)	7.69% (2)	3.85% (1)	0.00% (0)
Improved interactions with the community	34.62% (9)	61.54% (16)	3.85% (1)	0.00% (0)	0.00% (0)

N=26

Table 14. Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court have on the community at large?

	Strongly agree Percent (Count))	Agree Percent (Count)	Somewhat agree Percent (Count)	Neither agree nor disagree Percent (Count)	Somewhat disagree Percent (Count)
Reduced crime rates	19.23% (5)	42.31% (11)	30.76% (8)	3.85% (1)	3.85% (1)
Reduced drug use	23.08% (6)	38.46% (10)	34.62% (9)	0.00% (0)	3.85% (1)
Reduced prison/jail population	19.23% (5)	53.85% (14)	23.08% (6)	3.85% (1)	0.00% (0)
Reduced recidivism rates	26.92% (7)	61.54% (16)	7.69% (2)	0.00% (0)	3.85% (1)
Improved community mental health	23.08% (6)	61.54% (16)	11.54% (3)	3.85% (1)	0.00% (0)
Improved awareness of mental health issues	42.31% (11)	34.62% (9)	19.23% (5)	0.00% (0)	3.85% (1)
Improved awareness of drug use issues	19.23% (5)	53.85% (14)	23.08% (6)	0.00% (0)	3.85% (1)
Improved acceptance of mental health court clients	26.92% (7)	50.00% (13)	15.38% (4)	7.69% (2)	0.00% (0)
Improved acceptance of individuals with mental illness	26.92% (7)	46.15% (12)	23.08% (6)	3.85% (1)	0.00% (0)
Improved acceptance of individuals with drug use issues	15.38% (4)	50.00% (13)	23.08% (6)	7.69% (2)	3.85% (1)
Improved family acceptance of mental health court clients	46.15% (12)	46.15% (12)	7.69% (2)	0.00% (0)	0.00% (0)
Improved local police and criminal justice system understanding of mental health issues	42.31% (11)	42.31% (11)	11.54% (3)	3.85% (1)	0.00% (0)
Created or improved criminal justice policies and/or procedures for working with the mentally ill	34.62% (9)	42.31% (11)	15.38% (4)	3.85% (1)	3.85% (1)
The community feels safer	11.54% (3)	26.92% (7)	42.31% (11)	19.23% (5)	0.00% (0)
The mental health court brought new helpful services and treatment providers to the community	23.07% (6)	26.92% (7)	15.38% (4)	26.92% (7)	7.69% (2)

The mental health court improved community access to existing helpful services and treatment providers	30.77% (8)	38.46% (10)	19.23% (5)	3.85% (1)	7.69% (2)
The mental health court created jobs for community members	11.54% (3)	26.92% (7)	26.92% (7)	23.08% (6)	11.54% (3)
The community is largely unaware of the mental health courts existence	7.69% (2)	23.08% (6)	34.62% (9)	7.69% (2)	26.92% (7)
No community-level improvements are due to mental health court	3.85% (1)	0.00% (0)	3.85% (1)	26.92% (7)	65.38% (17)

N=26

Table 15. These are the *Essential Elements* of a MHC. Please re-order these elements from most important to least important in terms of the success of your MHC.

	Minimum	Maximum	Mean	Standard Deviation	Variance
Sustainability	2.00	10.00	8.96	1.78	3.16
Monitoring Adherence to Court Requirements	2.00	9.00	5.24	2.01	4.02
Court Team	1.00	9.00	4.80	2.21	4.88
Treatment Supports and Services	1.00	9.00	3.52	2.37	5.61
Confidentiality	1.00	10.00	6.80	2.83	8.00
Informed Choice	1.00	10.00	6.40	2.65	7.04
Terms of Participation	1.00	10.00	6.08	2.04	4.15
Timely Participant Identification and Linkage to Services	1.00	9.00	3.84	1.91	3.65
Target Population	1.00	9.00	3.84	2.48	6.13
Planning and Administration	1.00	10.00	5.52	3.32	11.05

N=25

Table 16: How resistant was your court in starting a mental health court program?

Answer	%	Count
Extremely resistant	0.00%	0
Very resistant	0.00%	0
Moderately resistant	4.00%	1
Slightly resistant	24.00%	6
Not resistant at all	72.00%	18
Total	100%	25

Table 17: How resistant was your community in starting your mental health court?

Answer	%	Count
Extremely resistant	0.00%	0
Very resistant	0.00%	0
Moderately resistant	8.70%	2
Slightly resistant	26.09%	6
Not resistant at all	65.22%	15
Total	100%	23

FIGURES

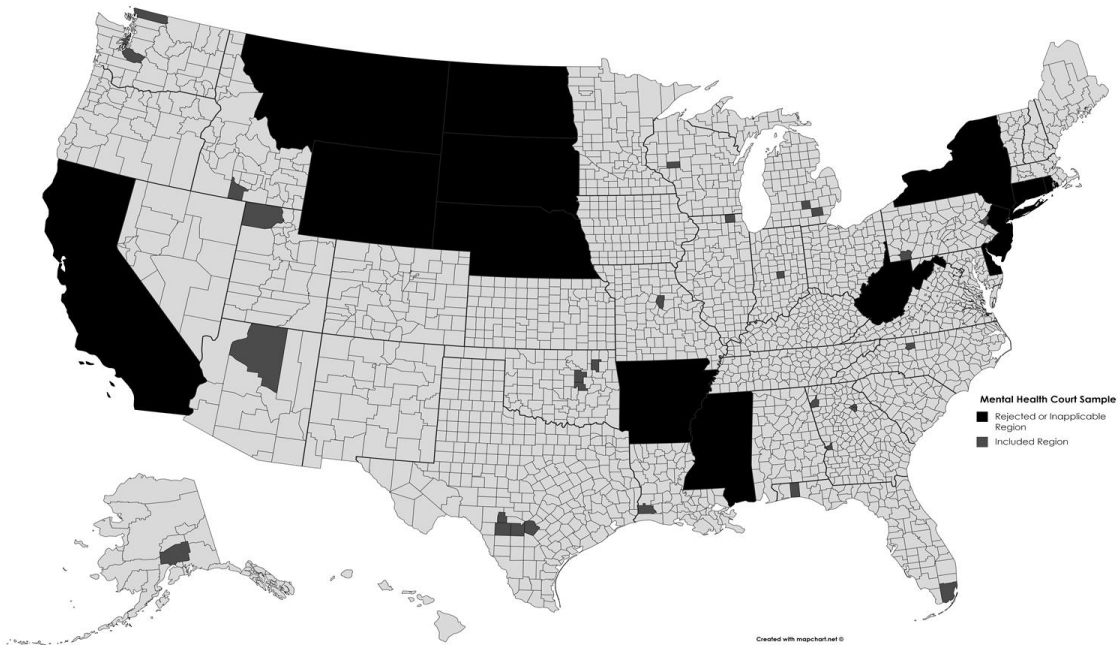

Figure1: Mental Health Court Sample and Excluded States

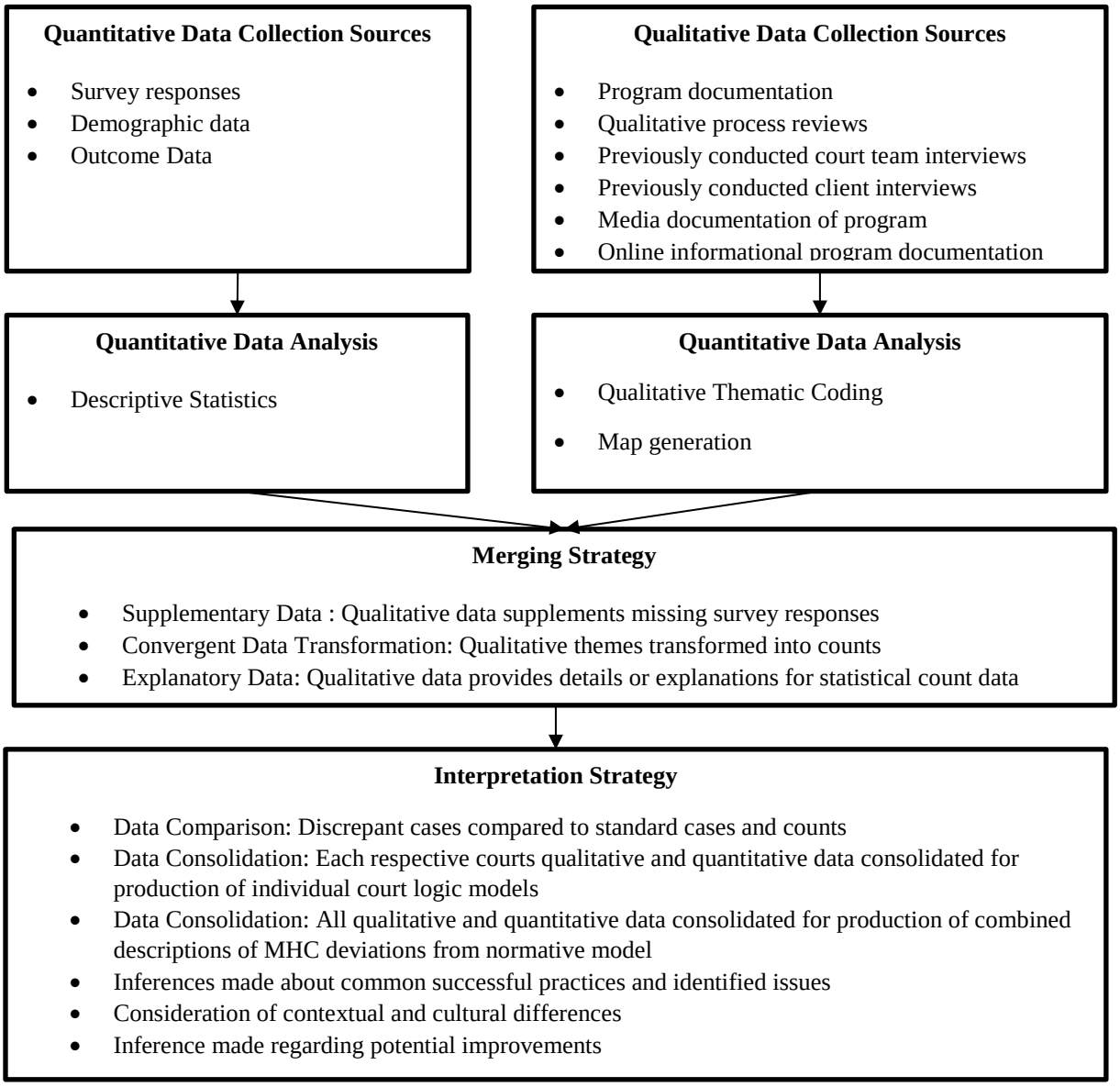

Figure 2. Research Design Procedure

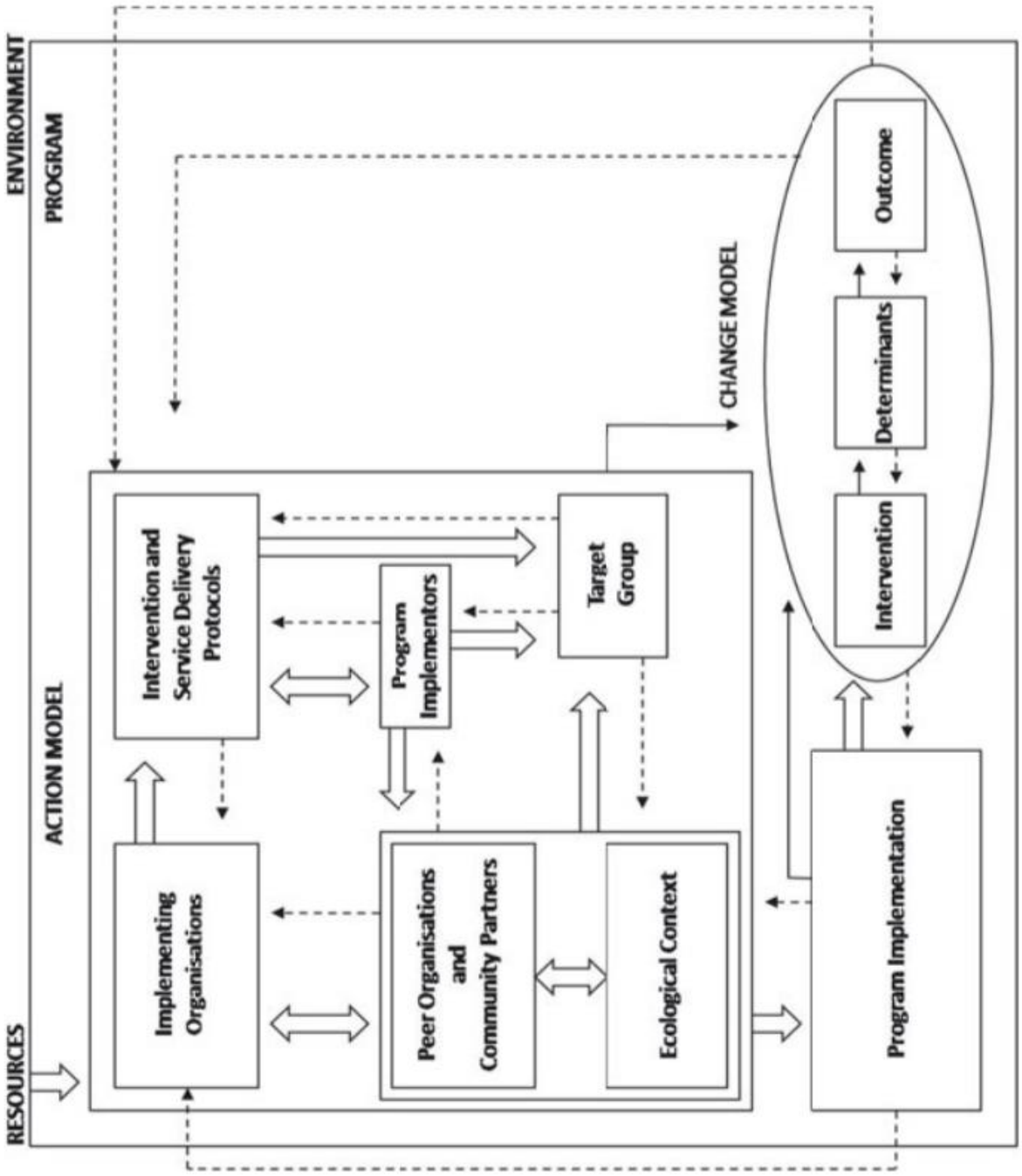

Figure 3. Chen, H. T. (2012). Theory-driven evaluation: Conceptual framework, application and advancement. In Evaluation von Programmen und Projekten für eine demokratische Kultur (pp. 17-40). Springer VS, Wiesbaden.

Figure 4. Normative Change Model for Mental Health Courts

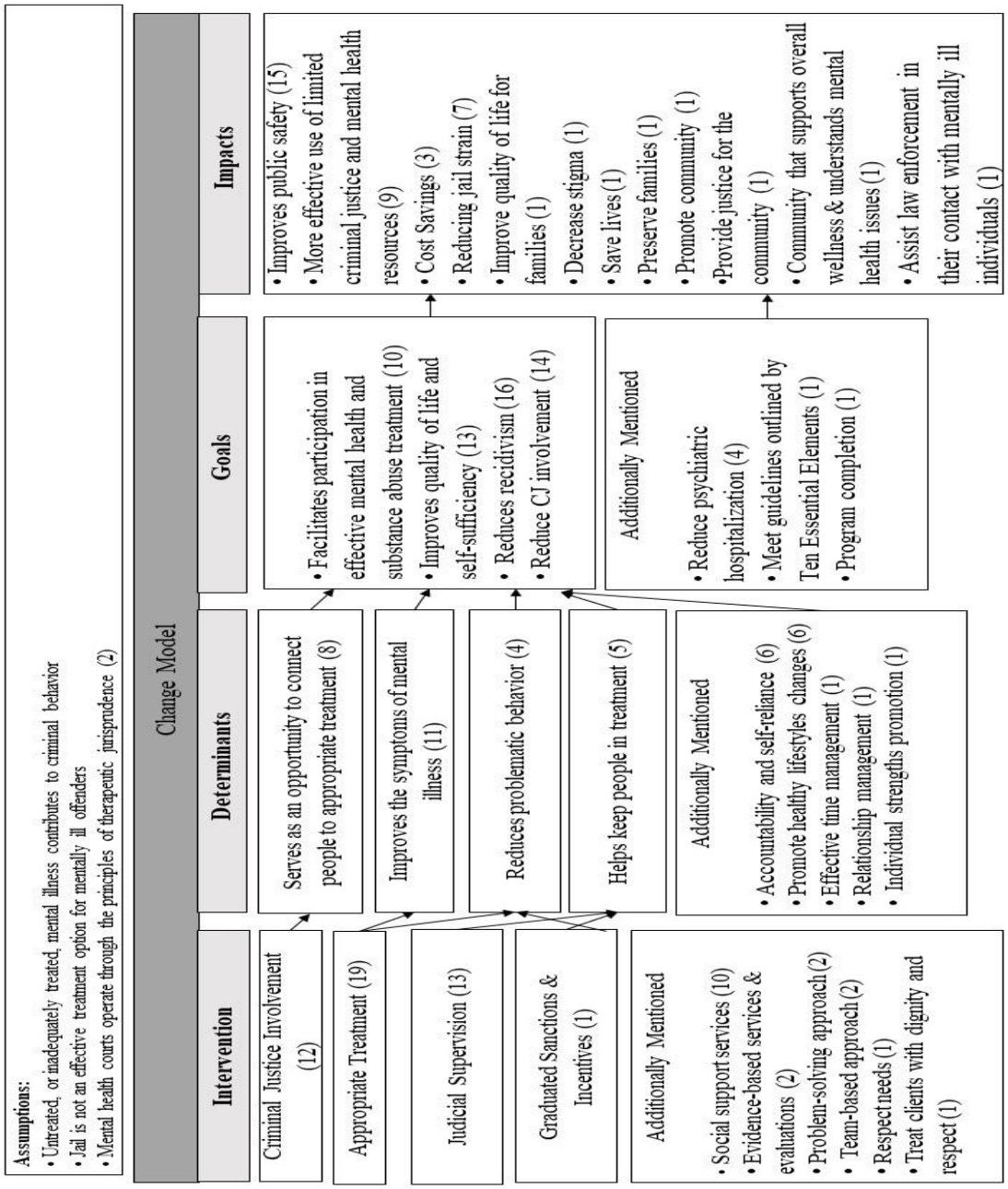

Figure 5. Summative Actual Change Models for Mental Health Courts

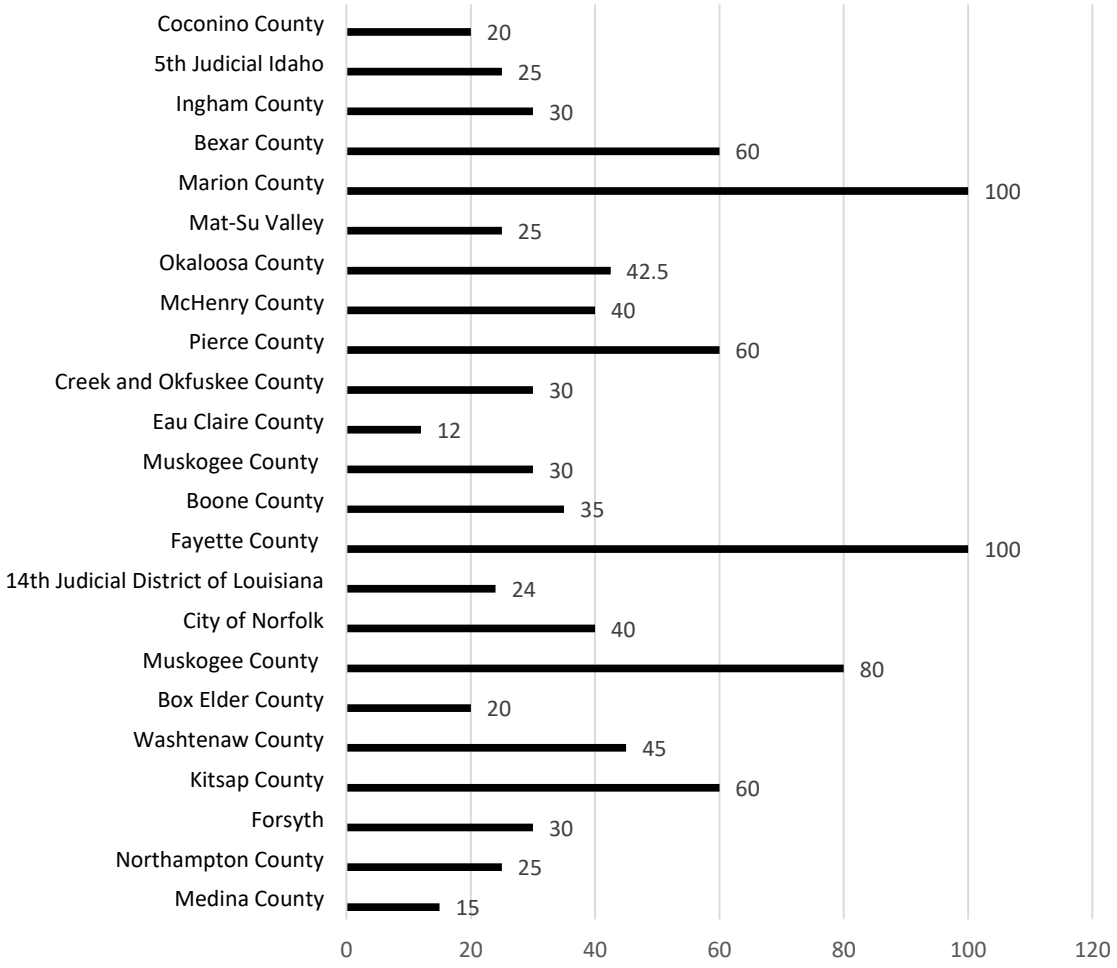

Figure 6. Maximum MHC Participant Population

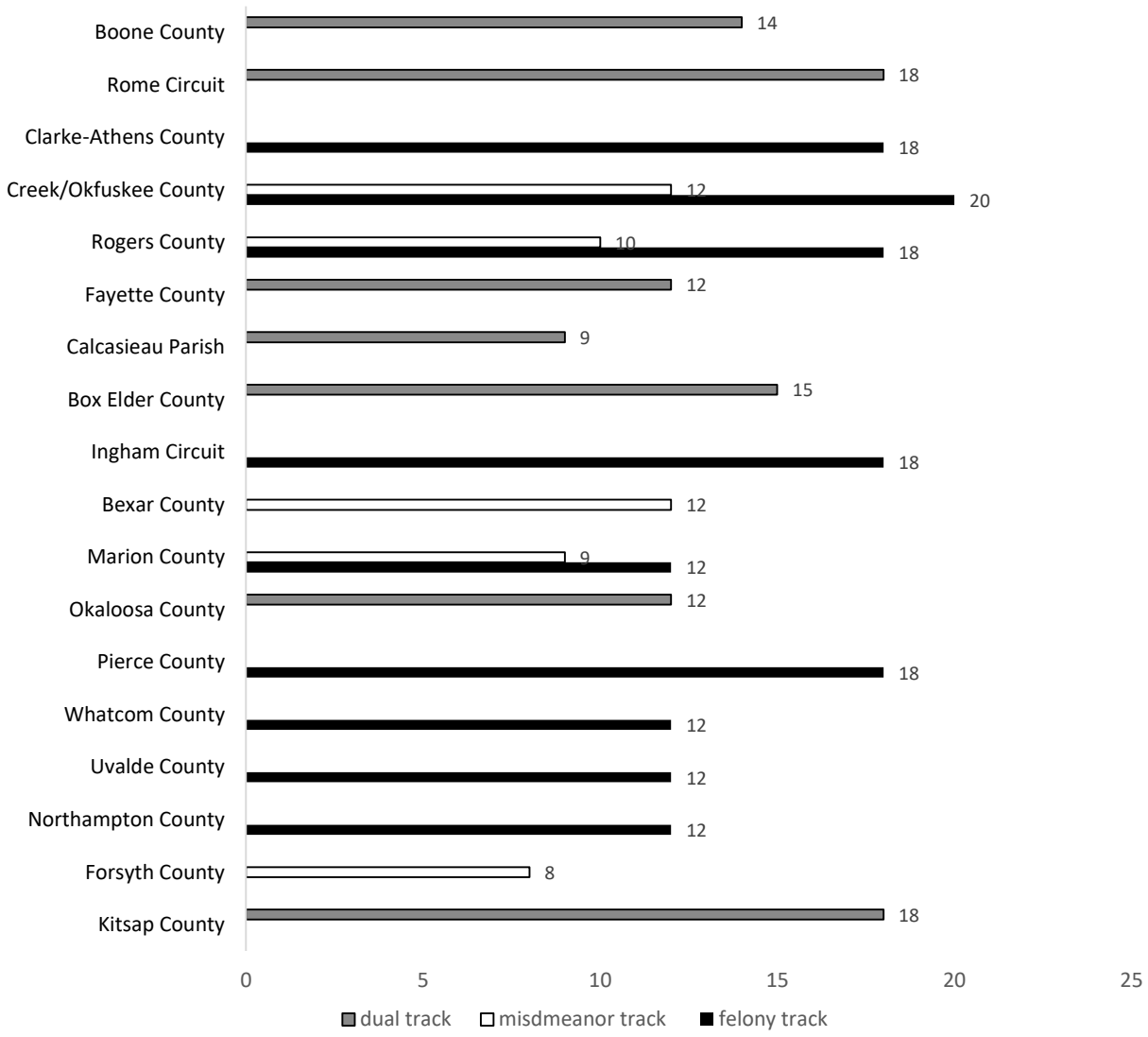

Figure 7. Minimum Length of Program by Track

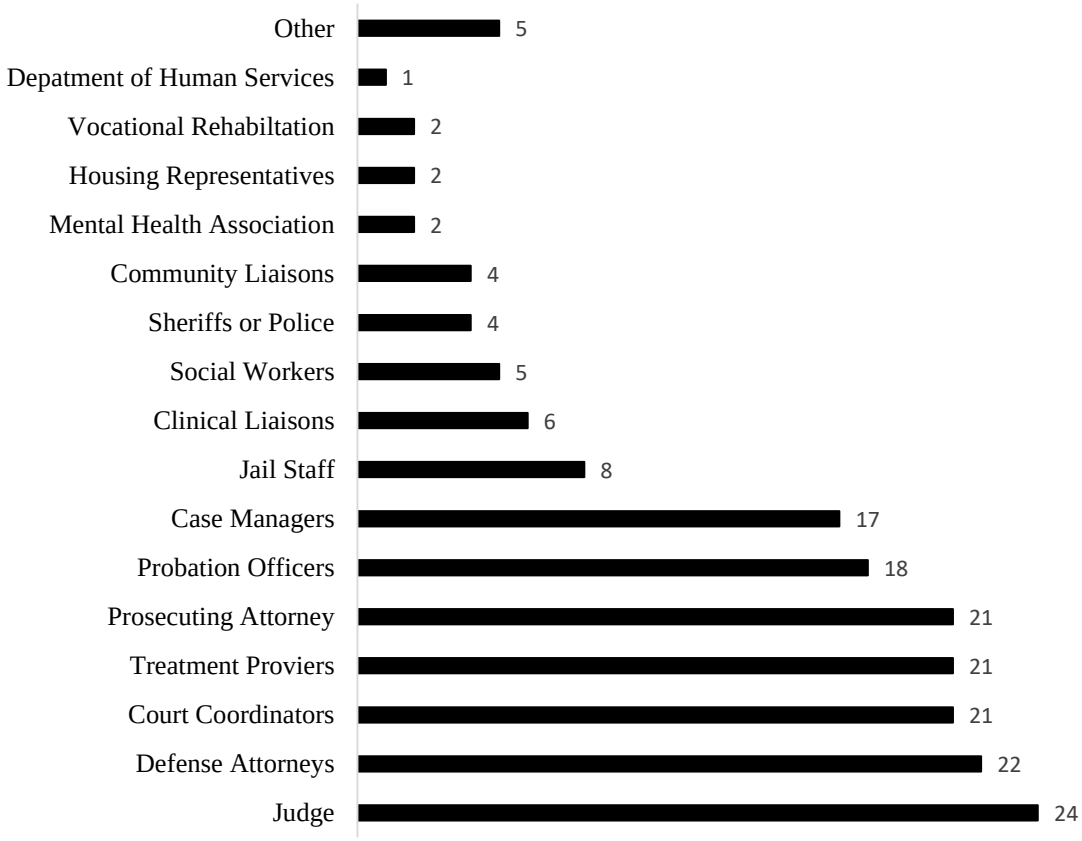

Figure 8. Court Team Members (N=24)

Figure 9. Types of Sanctions for MHC Non-Compliance

Figure 10. Normative Program-theory Logic Model for Mental Health Courts

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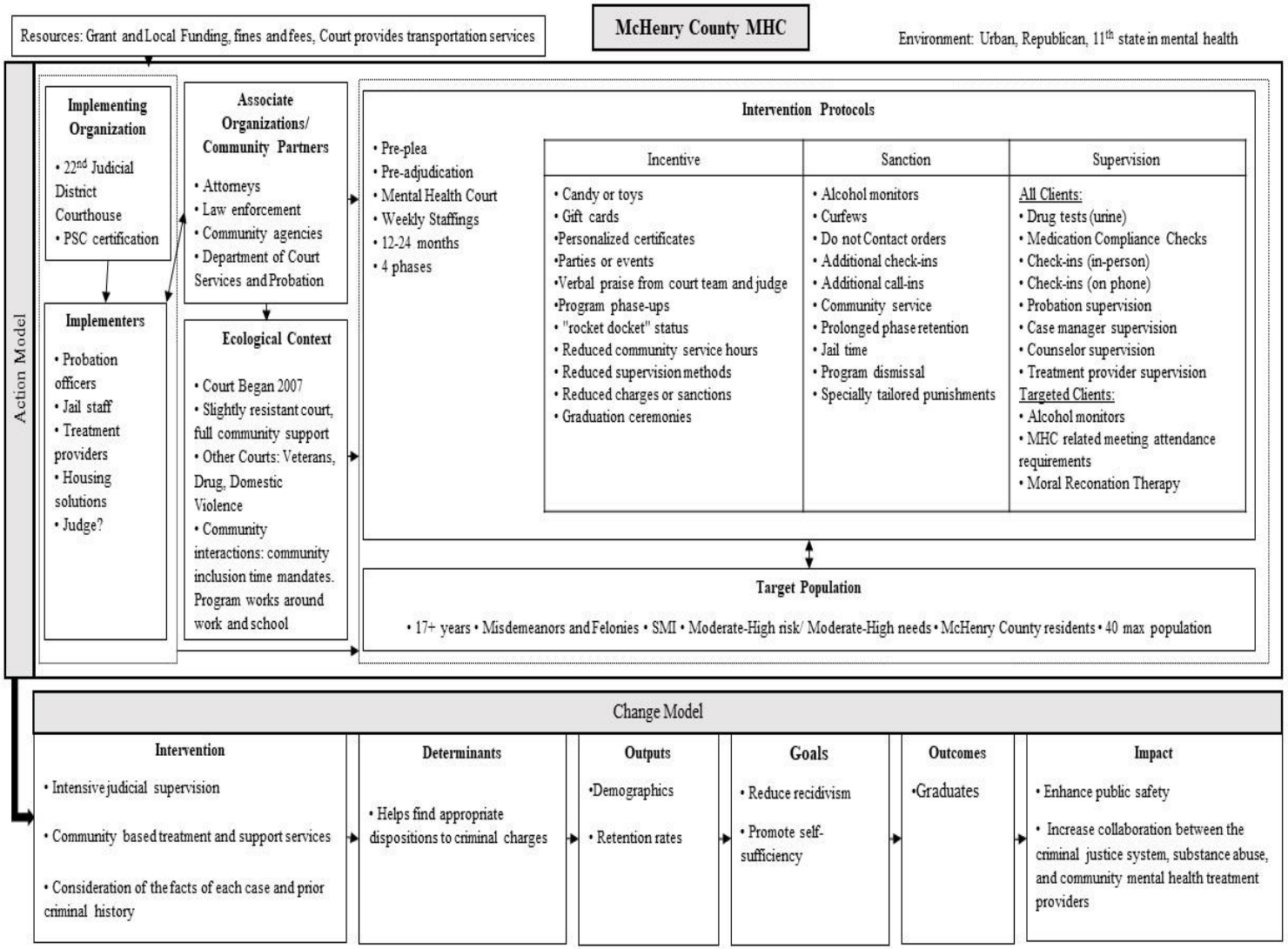
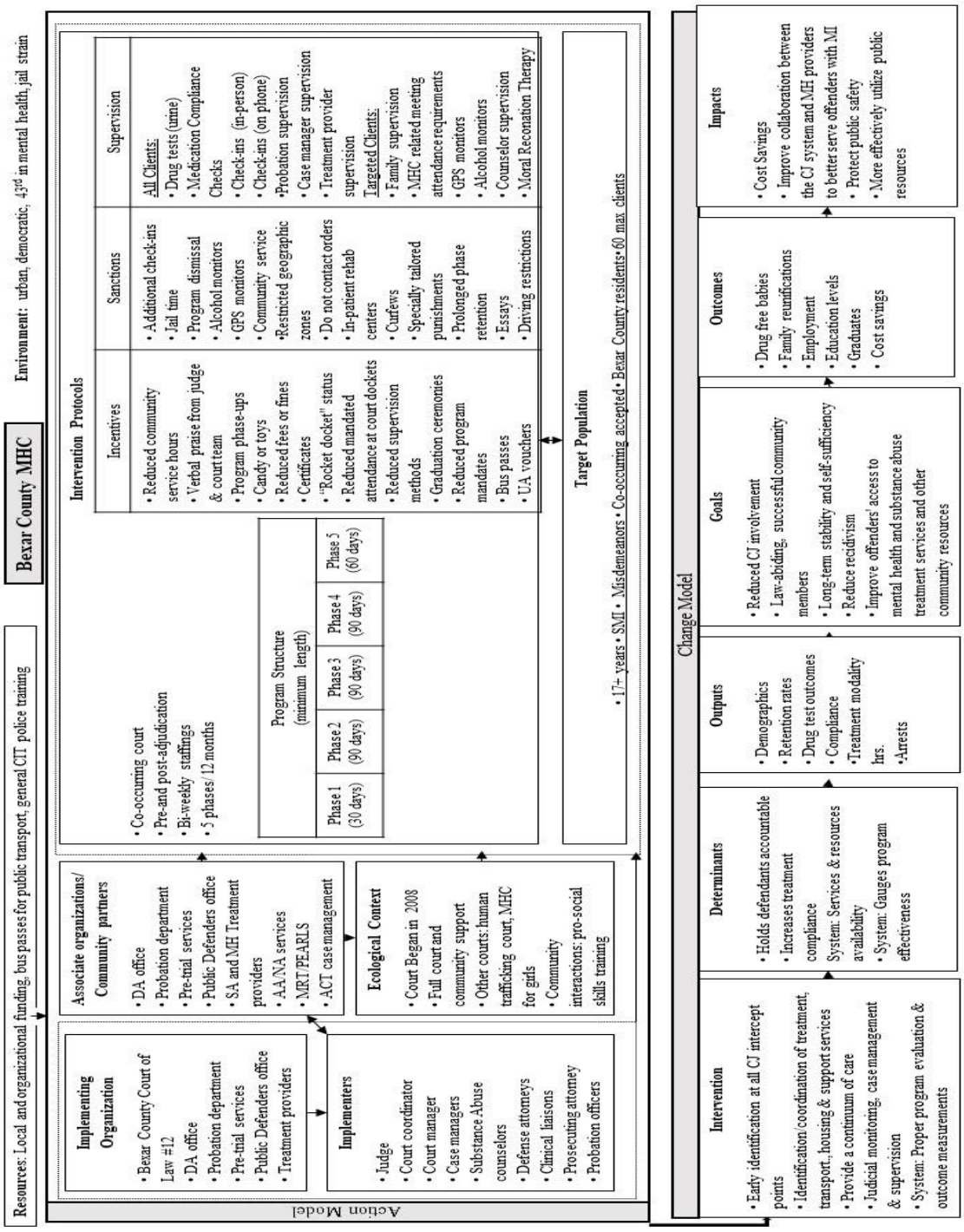
APPENDIX A

Full Program Theory Logic Models

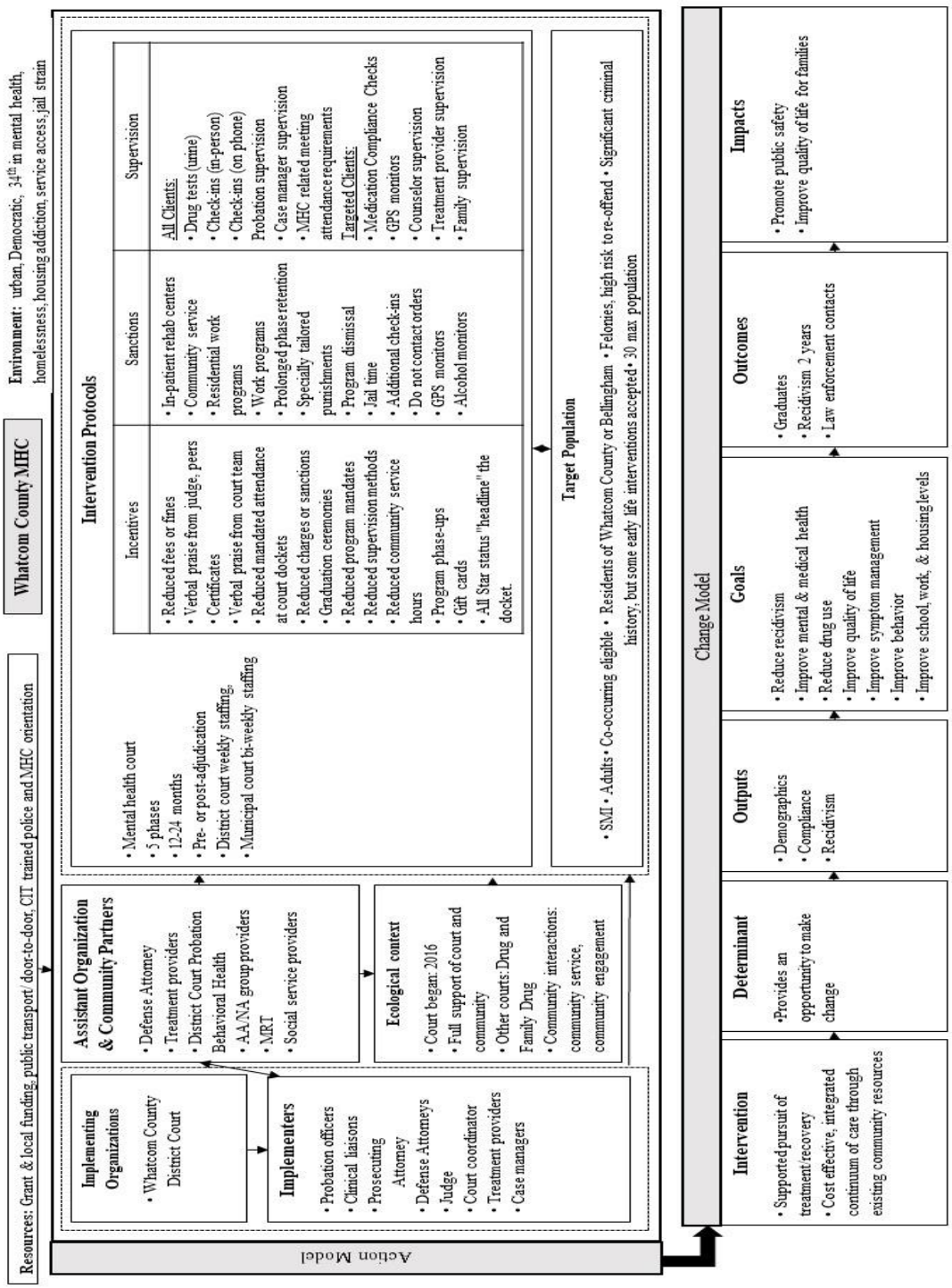
30th Circuit MHC Full Program Theory Logic Model


McHenry County MHC
Resources: Grant and Local Funding, fines and fees, Court provides transportation services
Environment: Urban, Republican, 11th state in mental health
Action Model
Implementing Organization
• 22nd Judicial District Courthouse
• PSC certification
Implementers
• Probation officers
• Jail staff
• Treatment providers
• Housing solutions
• Judge?
Associate Organizations/ Community Partners
• Attorneys
• Law enforcement
• Community agencies
• Department of Court Services and Probation
Ecological Context
• Court Began 2007
• Slightly resistant court, full community support
• Other Courts: Veterans, Drug, Domestic Violence
• Community interactions: community inclusion time mandates. Program works around work and school
Intervention Protocols
• Pre-plea
• Pre-adjudication
• Mental Health Court
• Weekly Staffings
• 12-24 months
• 4 phases
Incentive
• Candy or toys
• Gift cards
•Personalized certificates
•Parties or events
•Verbal praise from court team and judge
•Program phase-ups
• "rocket docket" status
• Reduced community service hours
• Reduced supervision methods
• Reduced charges or sanctions
• Graduation ceremonies
Sanction
• Alcohol monitors
• Curfews
• Do not Contact orders
• Additional check-ins
• Additional call-ins
• Community service
• Prolonged phase retention
• Jail time
• Program dismissal
• Specially tailored punishments
Supervision
All Clients:
• Drug tests (urine)
• Medication Compliance Checks
• Check-ins (in-person)
• Check-ins (on phone)
• Probation supervision
• Case manager supervision
• Counselor supervision
• Treatment provider supervision
Targeted Clients:
• Alcohol monitors
• MHC related meeting attendance requirements
• Moral Reconation Therapy
Target Population
• 17+ years • Misdemeanors and Felonies • SMI • Moderate-High risk/ Moderate-High needs • McHenry County residents • 40 max population
Change Model
Intervention
• Intensive judicial supervision
• Community based treatment and support services
• Consideration of the facts of each case and prior criminal history
Determinants
• Helps find appropriate dispositions to criminal charges
Outputs
•Demographics
• Retention rates
Goals
• Reduce recidivism
• Promote self-sufficiency
Outcomes
•Graduates
Impact
• Enhance public safety
• Increase collaboration between the criminal justice system, substance abuse, and community mental health treatment providers

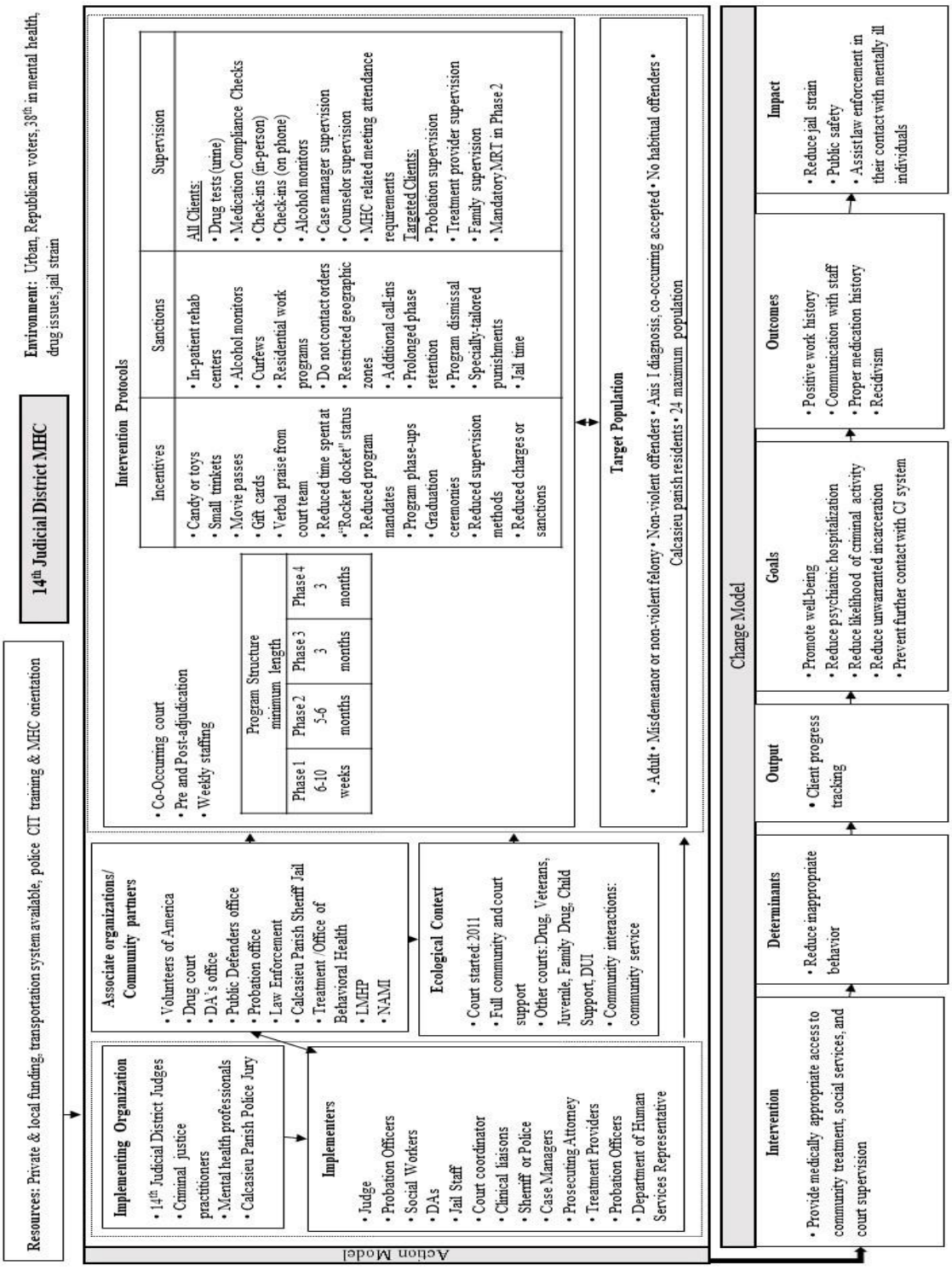
McHenry County MHC Full Program Theory Logic Model



Bexar County MHC Full Program Theory Logic Model



Whatcom County MHC Full Program Theory Logic Model



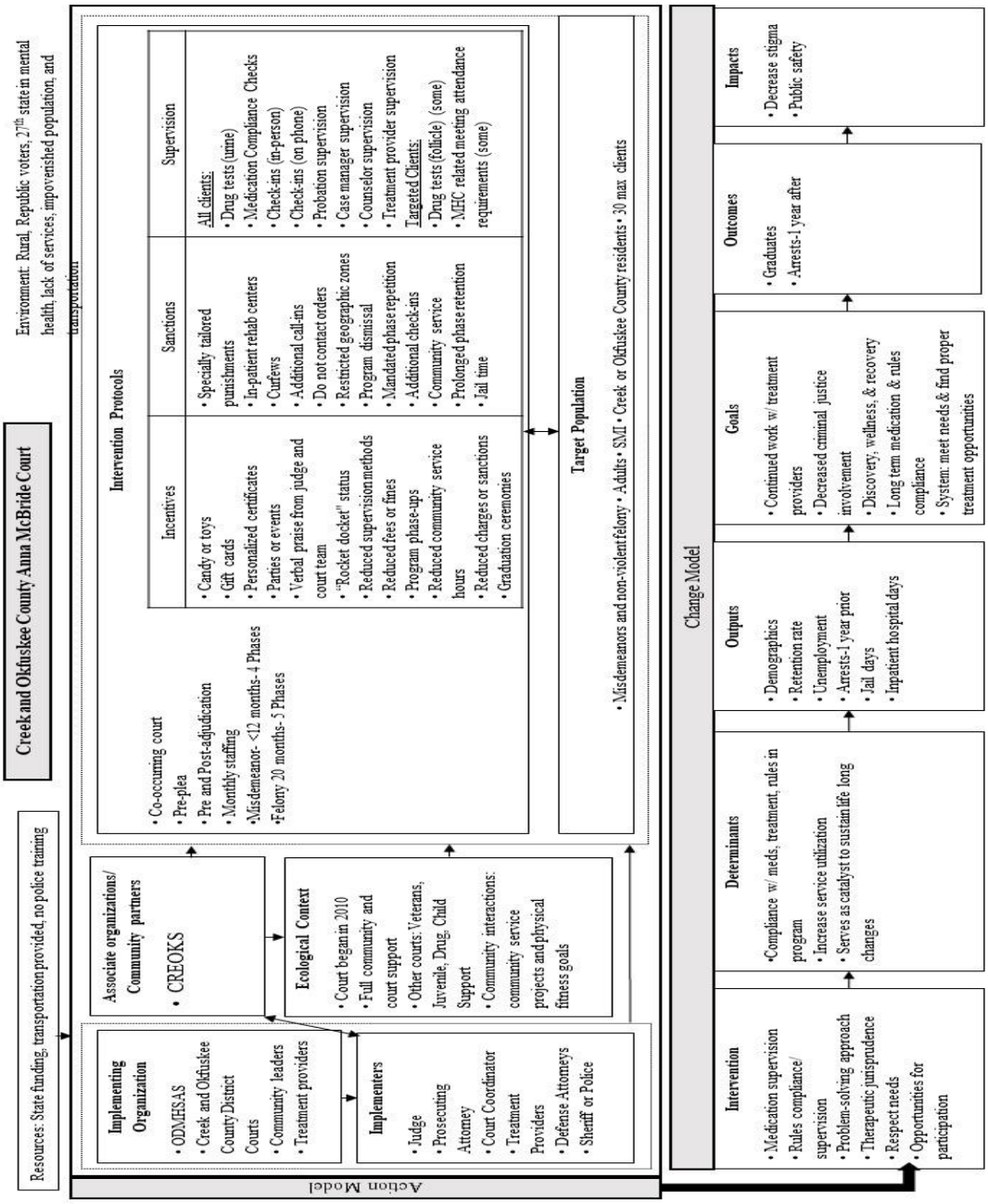
14th Judicial Circuit MHC Full Program Theory Logic Model

Boone County Treatment Court II Full Program Theory Logic Model

1st District Brigham City MHC Full Program Theory Logic Model

Coconino County MHC Full Program Theory Logic Model

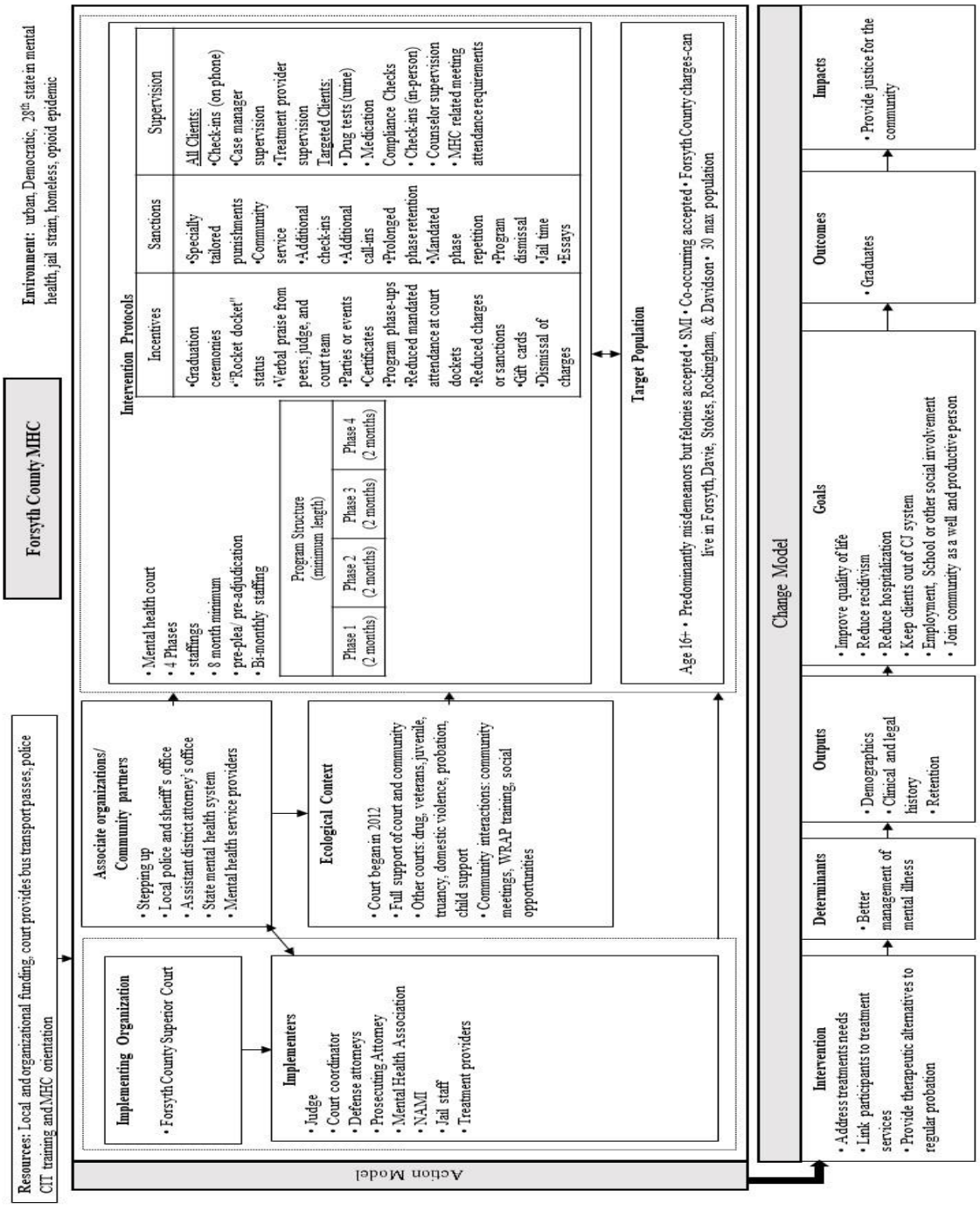
Eau Claire County MHC Full Program Theory Logic Model



Creek and Okfuskee Anna McBride Court Full Program Theory Logic Model

Fayette County MHC Full Program Theory Logic Model

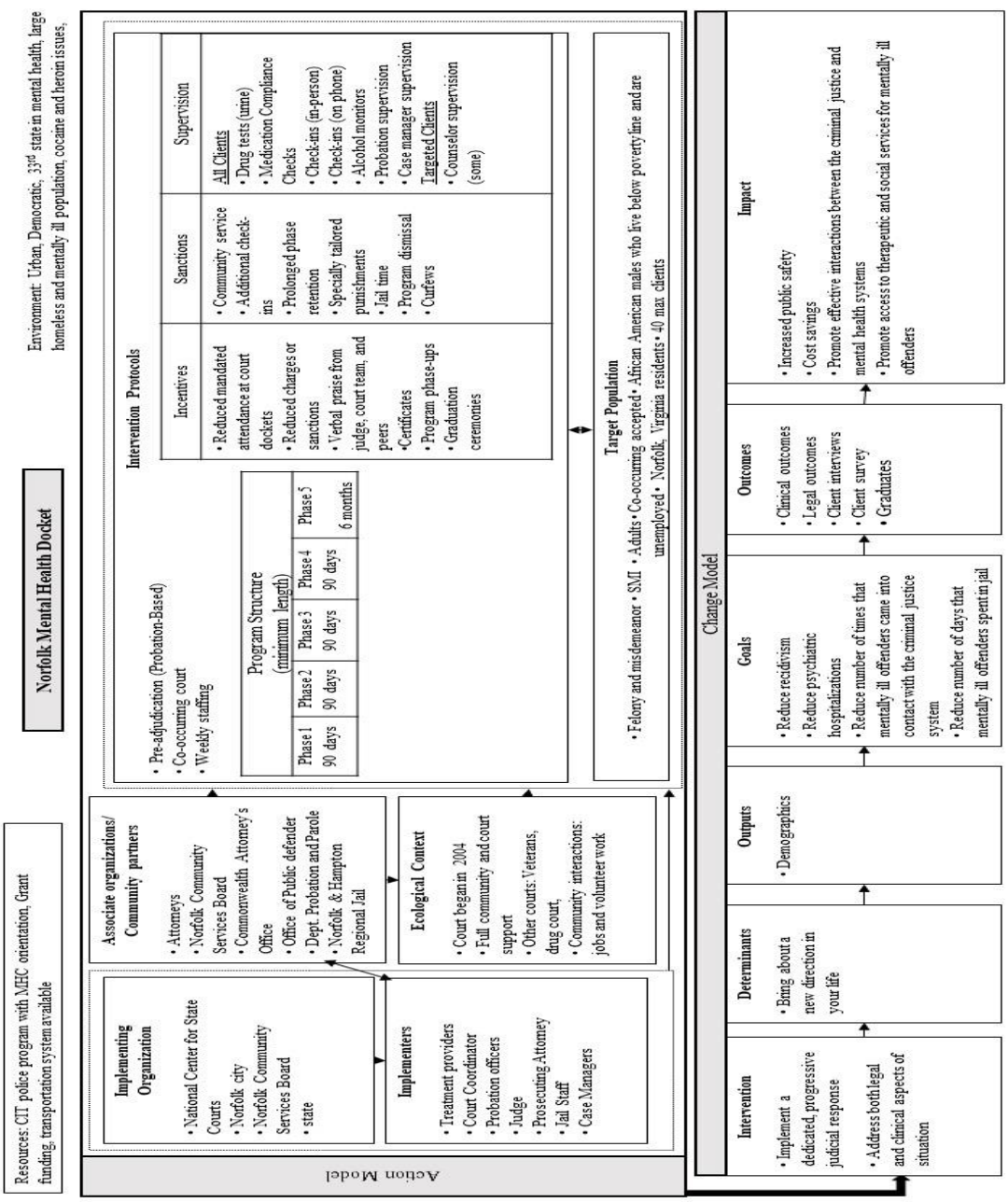
Kitsap Behavioral Health Court Full Program Theory Logic Model



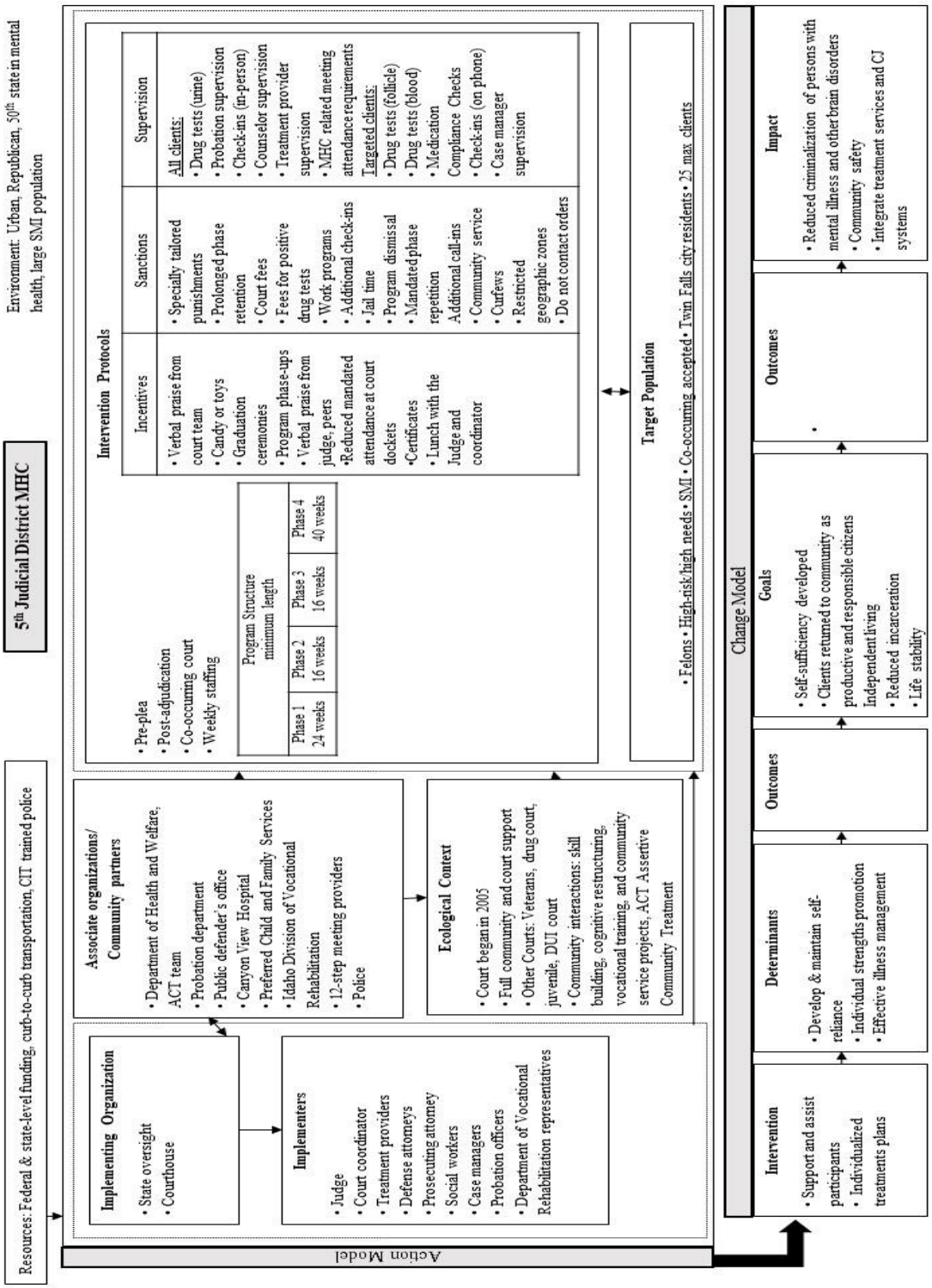
Forsyth County MHC Full Program Theory Logic Model

Marion County MHC Full Program Theory Logic Model

Coordinated Resources Project-Palmer Full Program Theory Logic Model



Norfolk Mental Health Docket Full Program Theory Logic Model



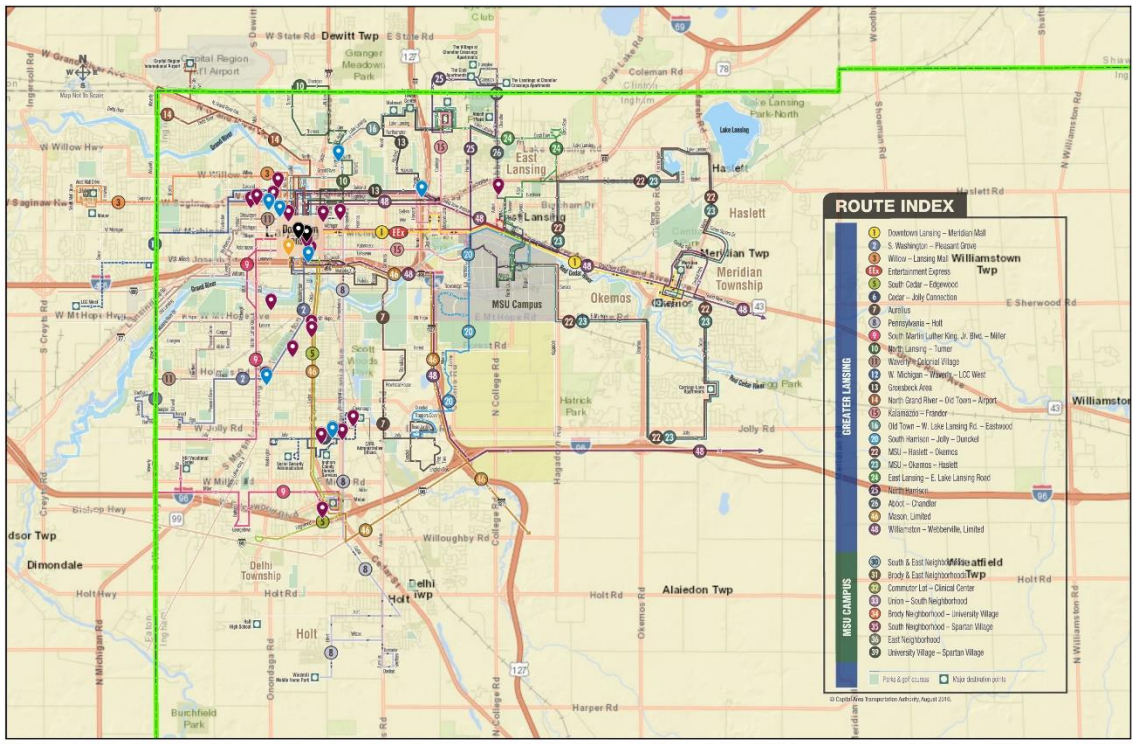
5th Judicial District MHC Full Program Theory Logic Model

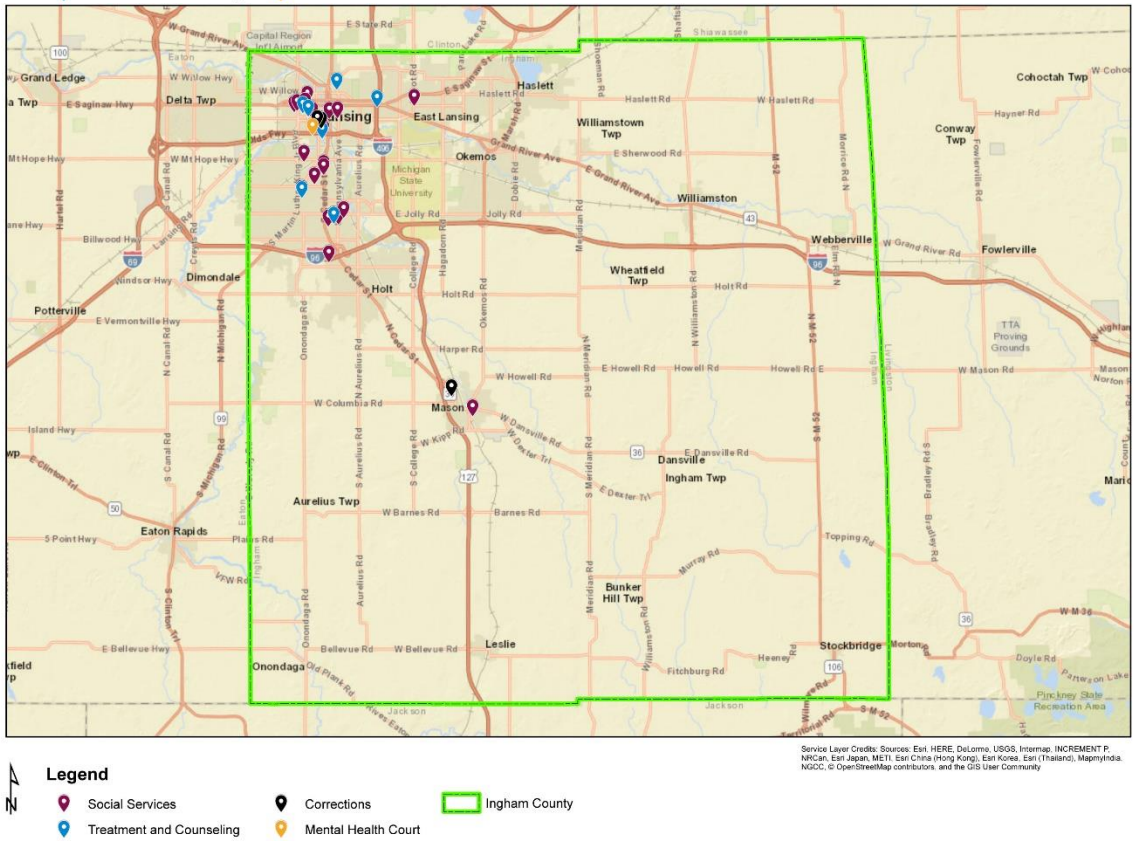
Pierce County Felony MHC Full Program Theory Logic Model

38th Judicial District Specialty Court Full Program Theory Logic Model

APPENDIX B

Maps of Programs and Community Partners


ROUTE INDEX
GREATER LANSING
MSU CAMPUS
Dewitt Twp
East Lansing
Haslett
Meridian Township
Okemos
MSU Campus
Williamston
Delhi Township
Holt
Alaiedon Twp
Wheatfield Twp
Dimondale
Bunchfield Park
Harper Rd
Holt Rd
Jolly Rd
Willoughby Rd
Legend
Social Services
Treatment and Counseling
Corrections
Mental Health Court
Ingham County
Service Layer Credits: Sources: Esri, HERE, DeLorme, USGS, Intermap, INCREMENT P, NRCan, Esri Japan, METI, Esri China (Hong Kong), Esri Korea, Esri (Thailand), Mapmyindia, NGCC, © OpenStreetMap contributors, and the GIS User Community


Lansing
East Lansing
Haslett
Okemos
Williamston
Webberville
Fowlerville
Cohoctah Twp
Conway Twp
Williamstown Twp
Wheatfield Twp
Delta Twp
Grand Ledge
Dimondale
Holt
Potterville
Mason
Aurelius Twp
Ingham Twp
Dansville
Eaton Rapids
Bunker Hill Twp
Leslie
Onondaga
Stockbridge
Michigan State University
TTA Proving Grounds
Pinckney State Recreation Area
Legend
Social Services
Treatment and Counseling
Corrections
Mental Health Court
Ingham County
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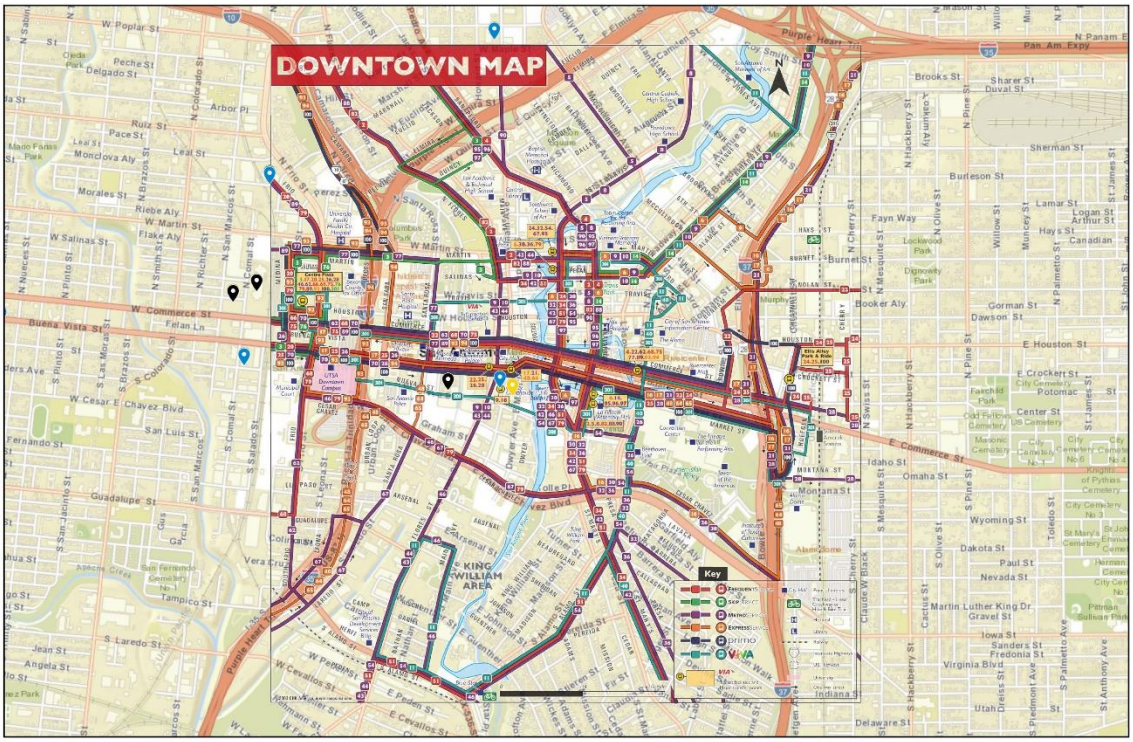

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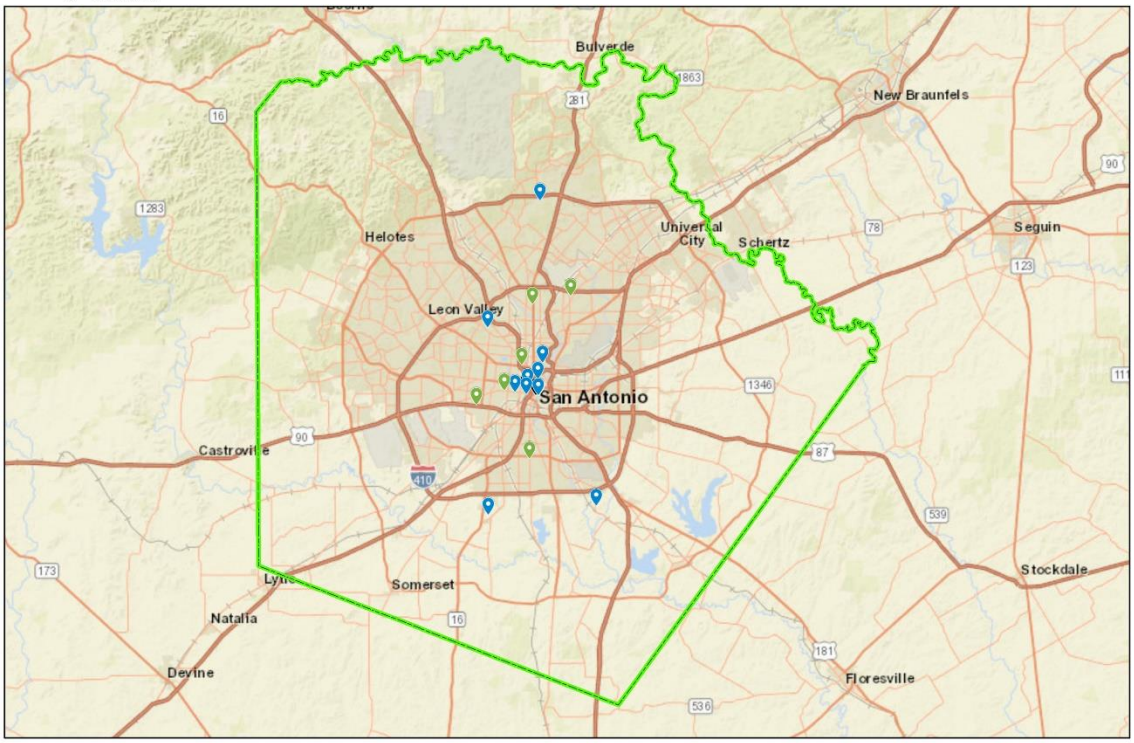
Legend

- Mental Health Courts
- Treatment and Counseling
- Bexar County
- Corrections



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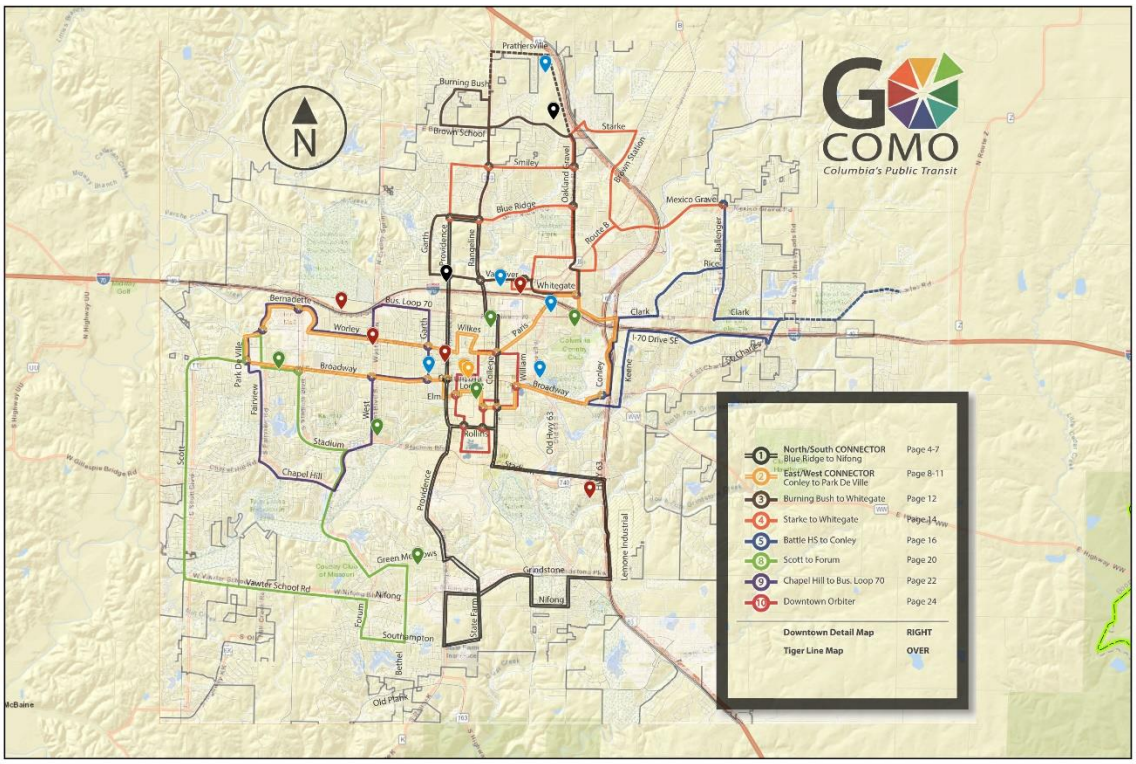
Legend

- Mental Health Courts
- Treatment and Counseling
- Bexar County
- Corrections
- Peer Support



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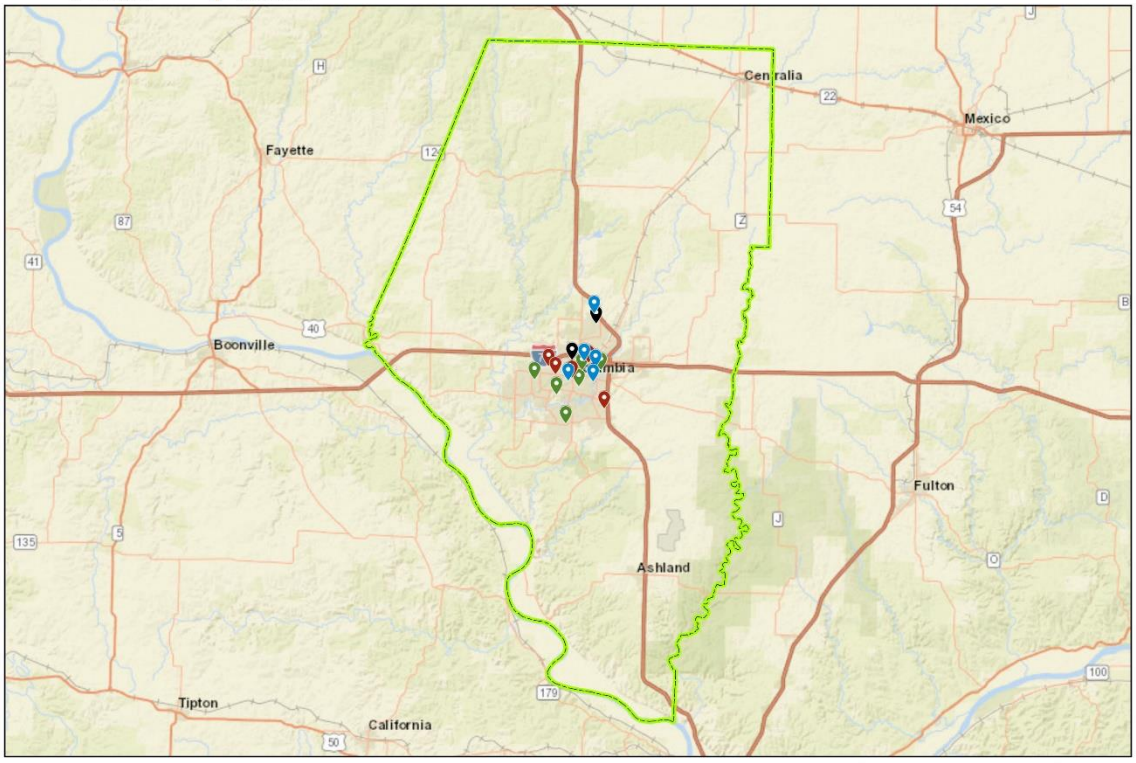
Legend

Mental Health Courts · Peer Support · Treatment and Counseling · Boone County
Corrections · Social Services



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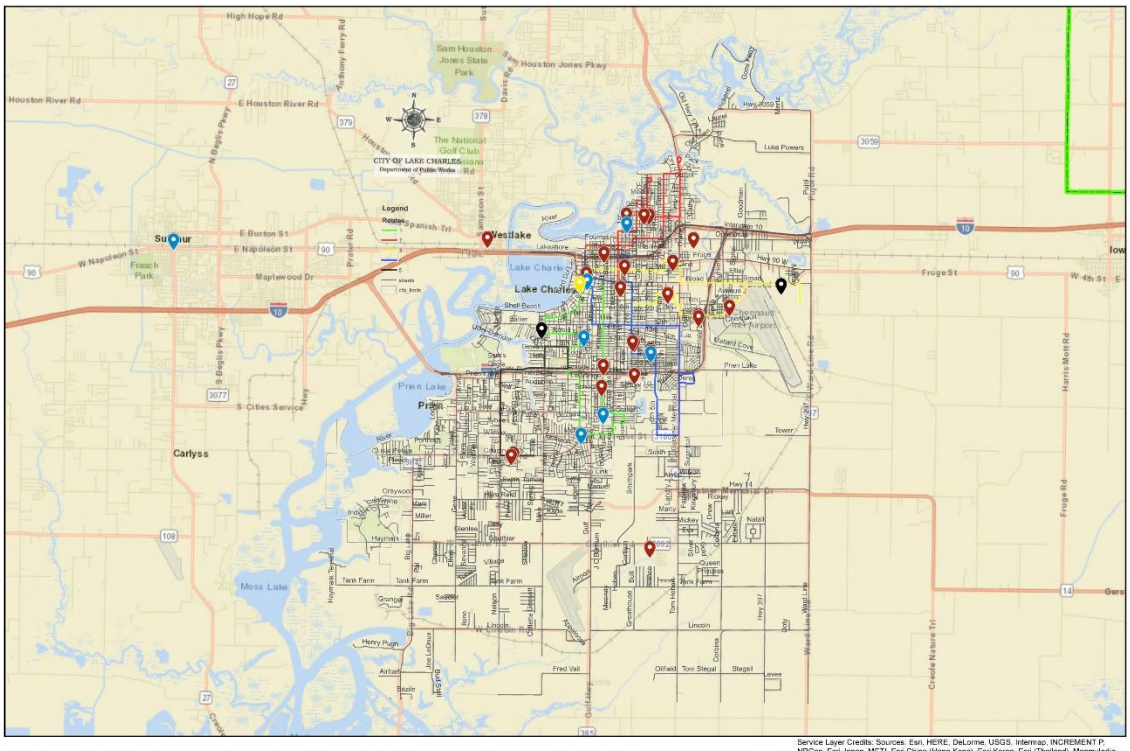
Legend

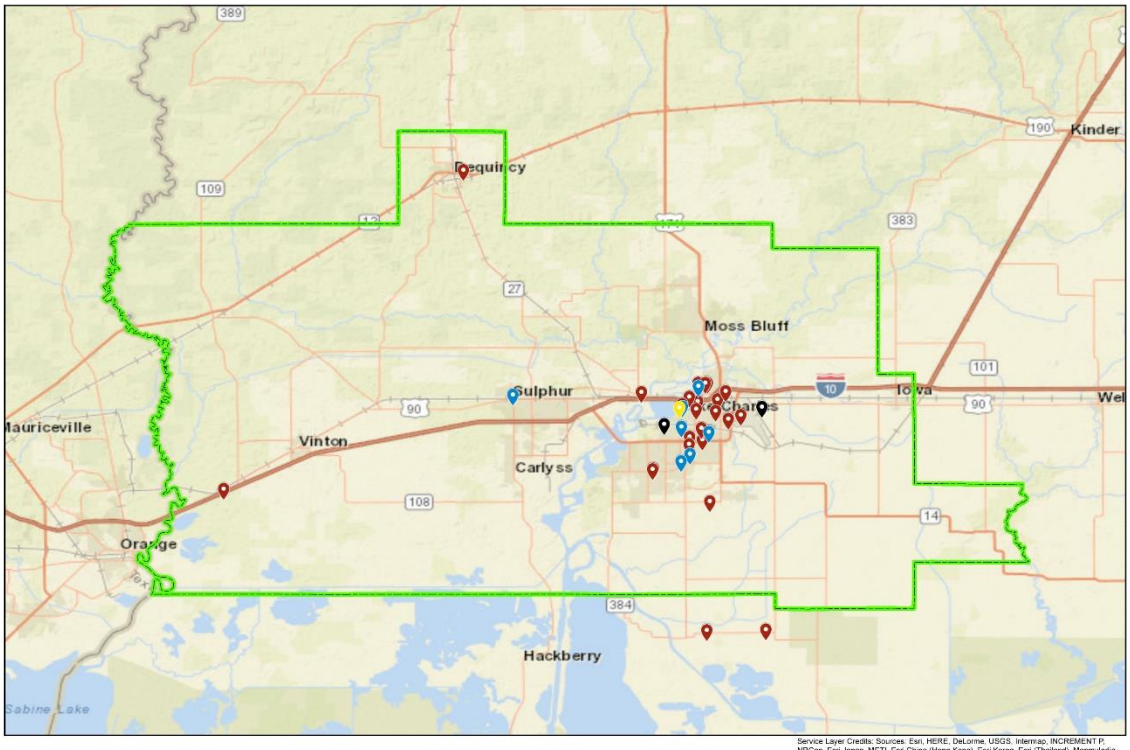
Mental Health Courts · Peer Support · Treatment and Counseling · Boone County
Corrections · Social Services



Legend

Corrections | Treatment and Counseling | Calcasieu Parish

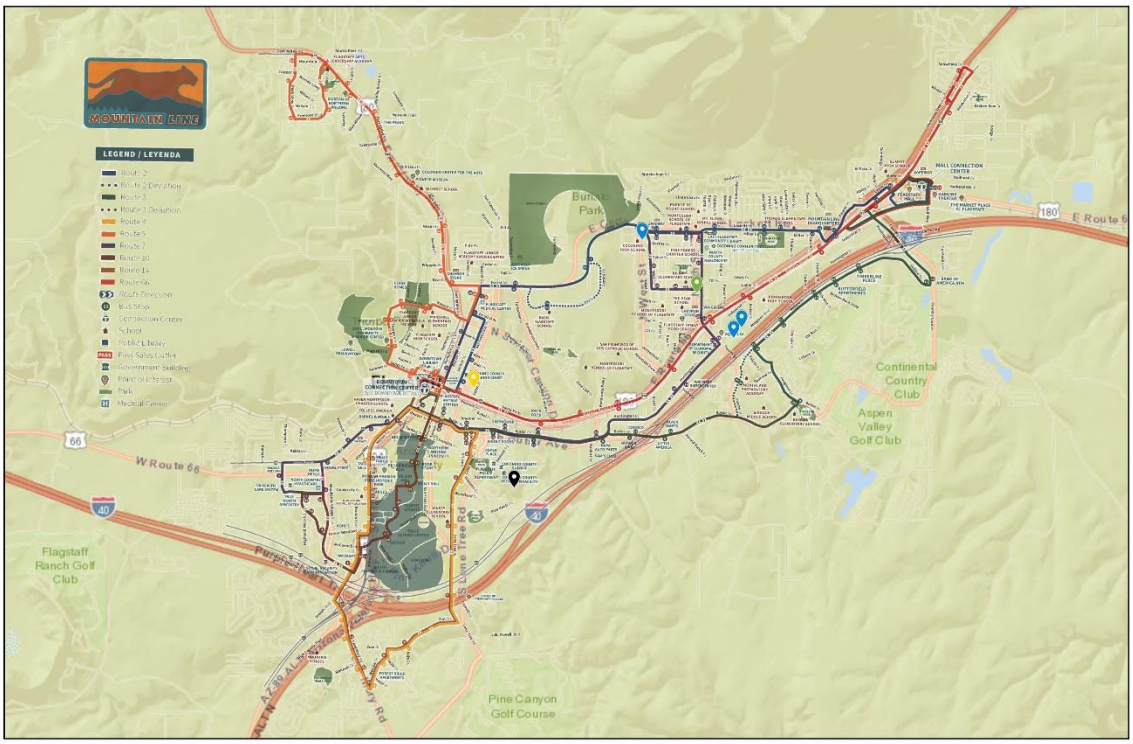
Social Services | Mental Health Courts



Legend

Corrections | Treatment and Counseling | Calcasieu Parish

Social Services | Mental Health Courts



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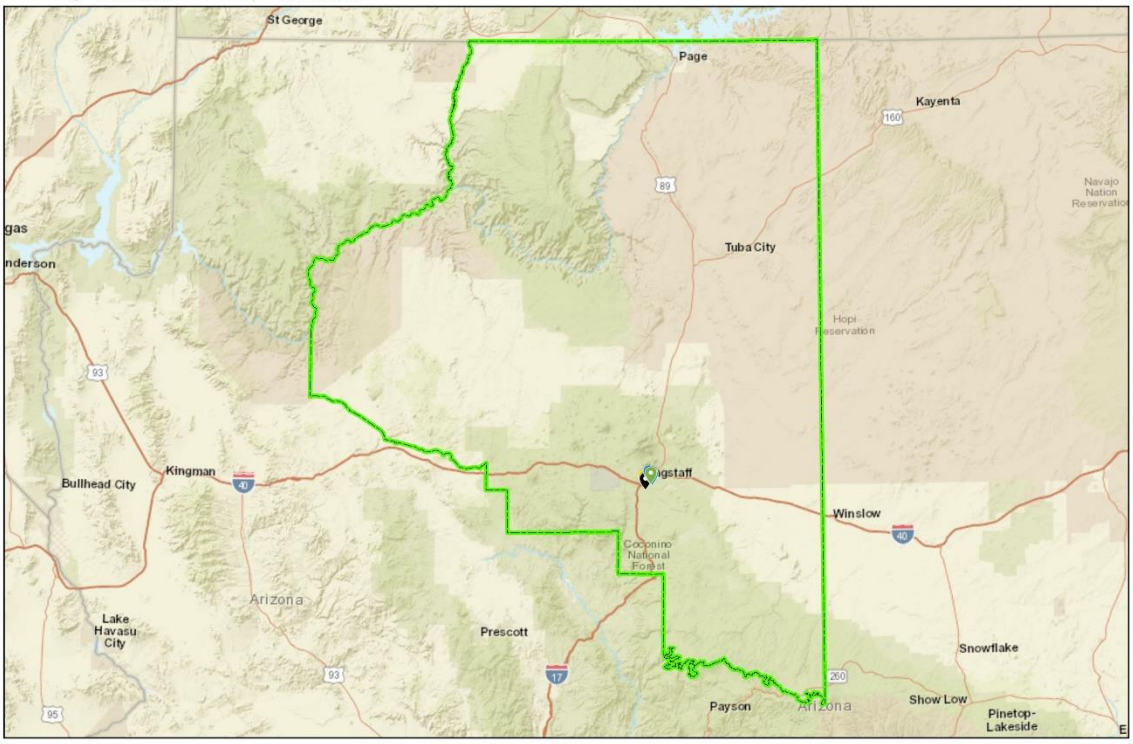
Legend

- Mental Health Courts
- Corrections
- Treatment and Counseling
- Peer Support
- Coconino County



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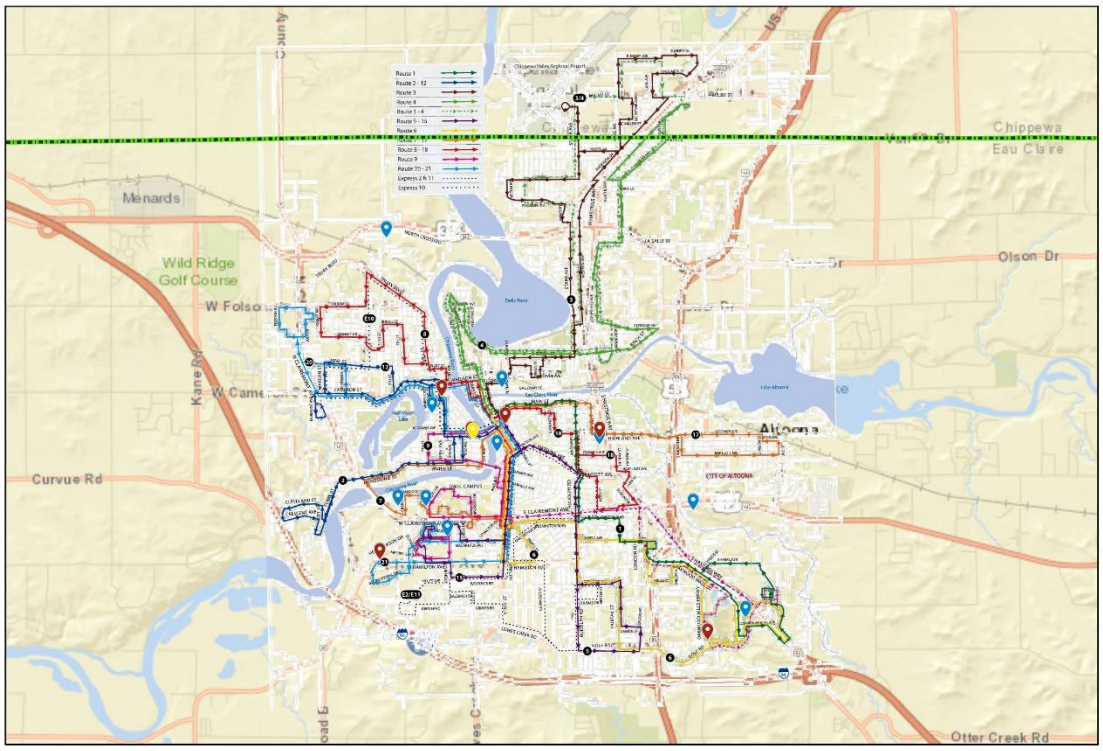
Legend

- Mental Health Courts
- Corrections
- Treatment and Counseling
- Peer Support
- Coconino County



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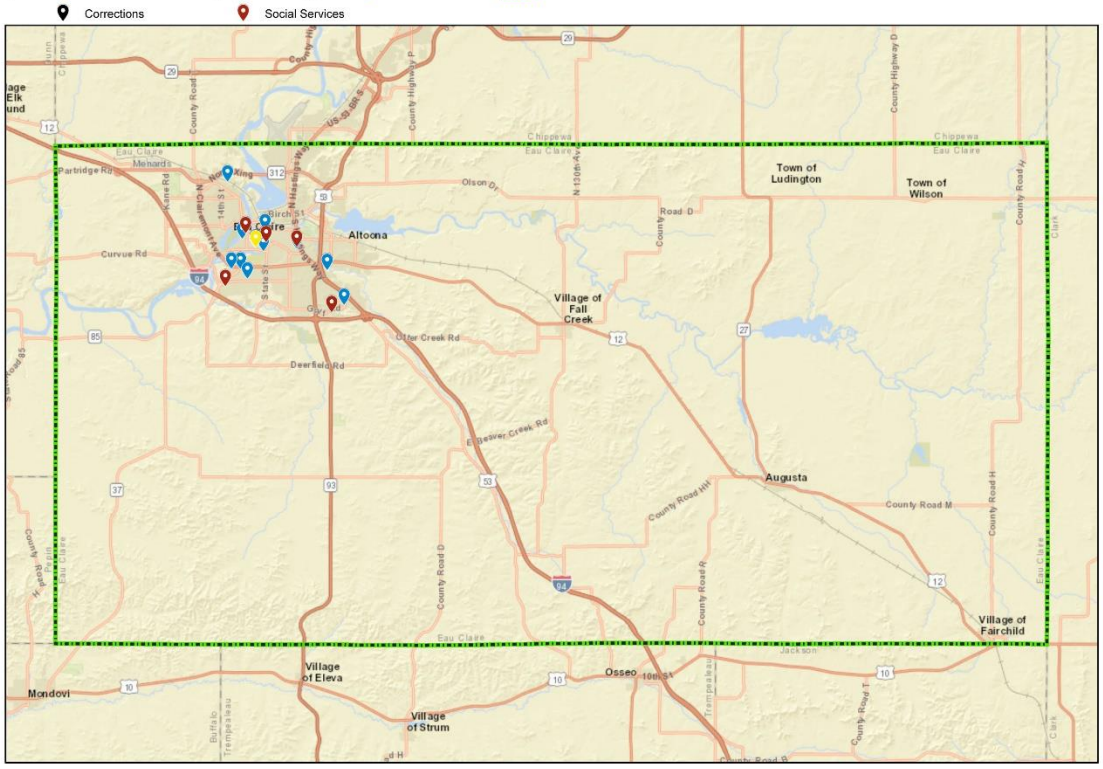
Treatment and Counseling | Peer Support | Mental Health Courts | Eau Claire County

Corrections | Social Services



Legend

Treatment and Counseling | Peer Support | Mental Health Courts | Eau Claire County

Corrections | Social Services

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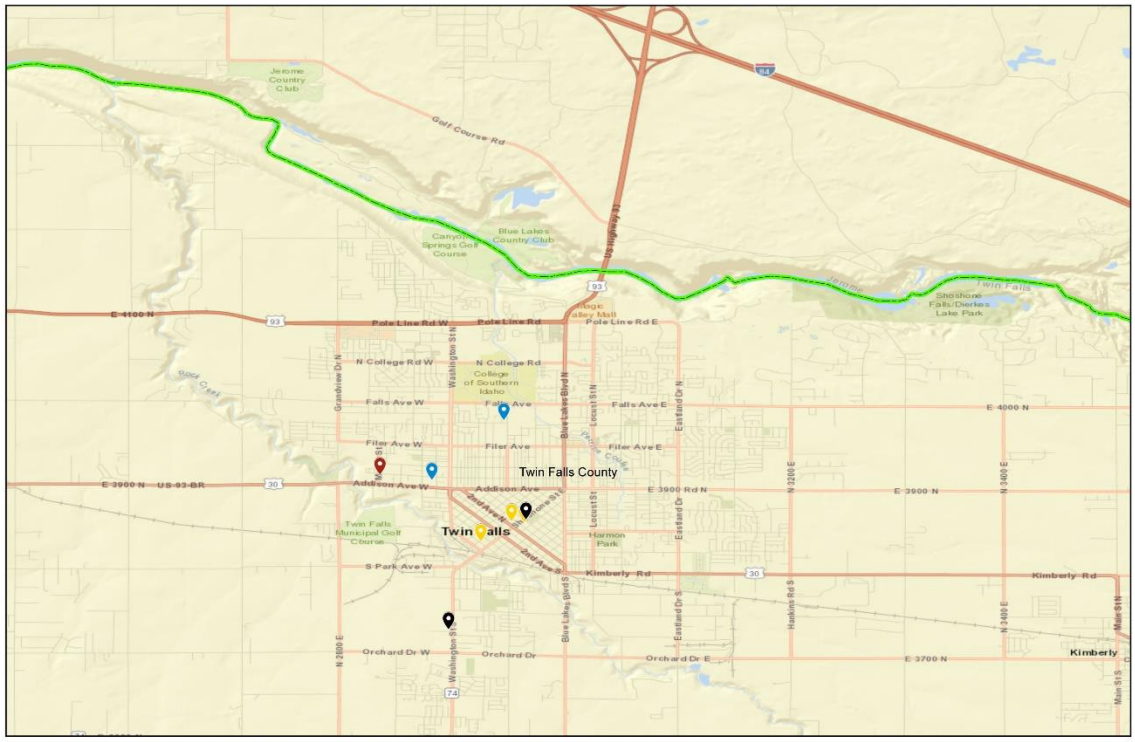
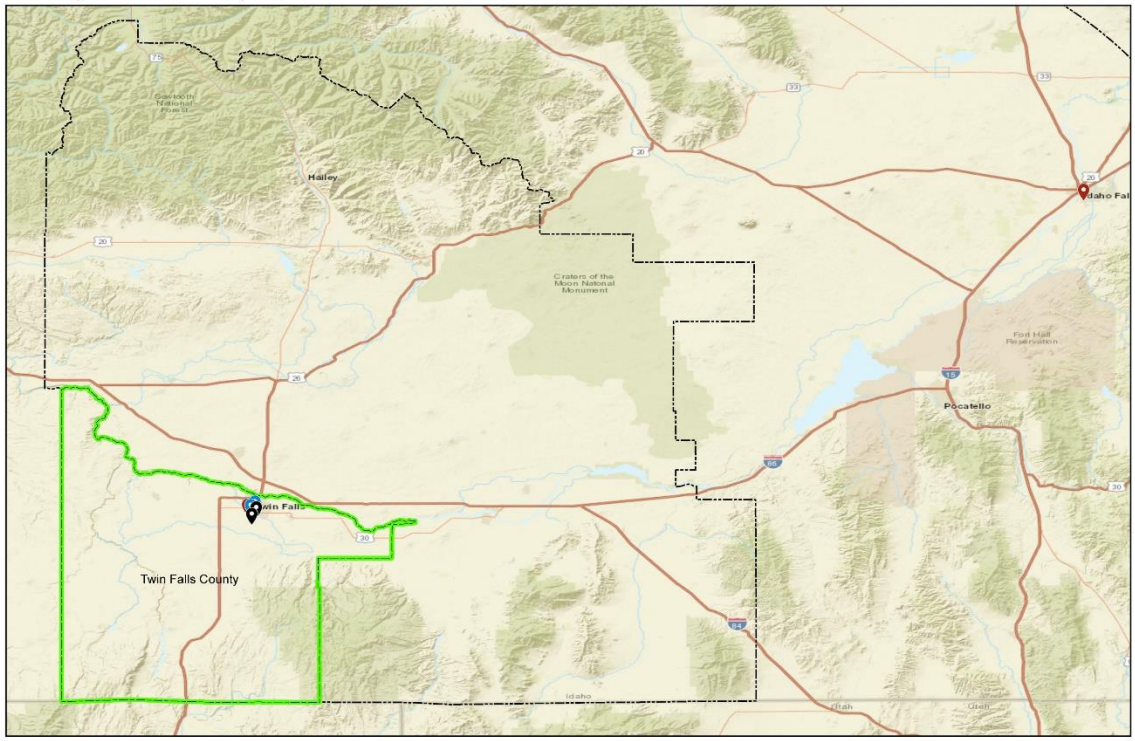


Legend

Mental Health Courts | Treament and Couseling | Twin Falls County

Social Services | Corrections



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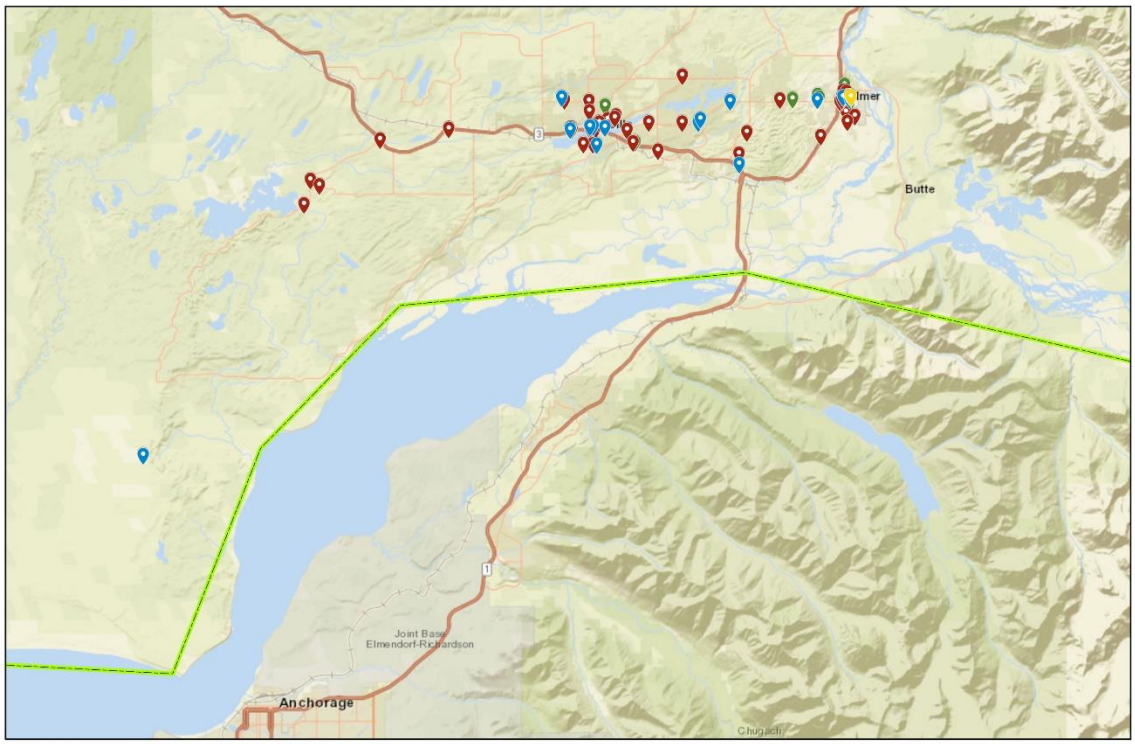
Mental Health Courts | Treament and Couseling | Twin Falls County | 5th District Area

Social Services | Corrections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Joint Base Elmendorf-Richardson
Anchorage
Chugach
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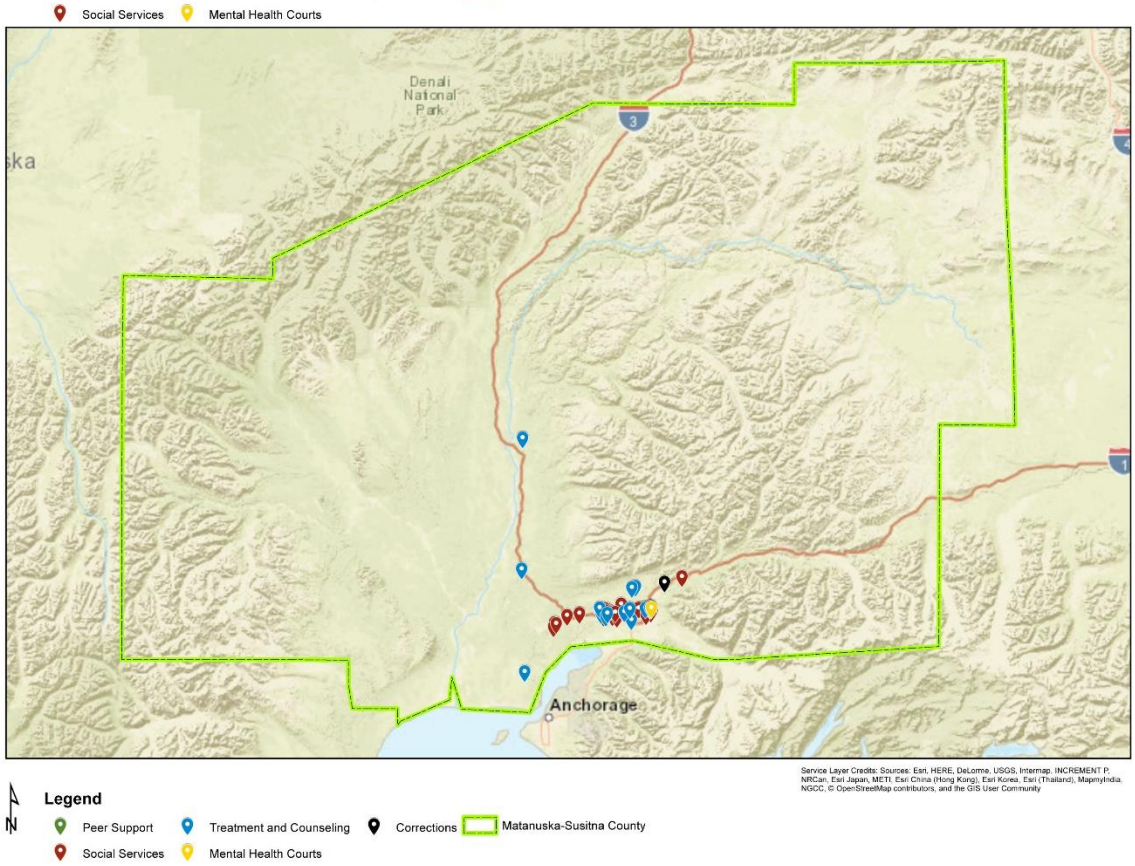
Peer Support
Treatment and Counseling
Corrections
Matanuska-Susitna County
Social Services
Mental Health Courts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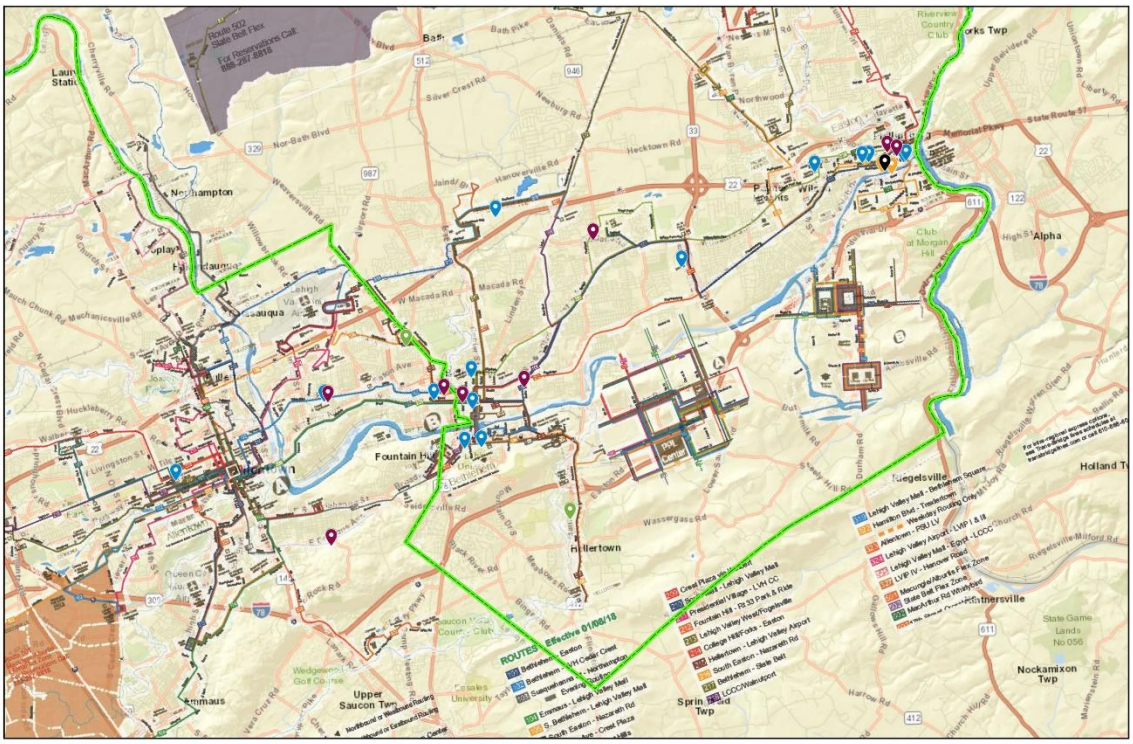
Legend
Peer Support
Treatment and Counseling
Corrections
Matanuska-Susitna County
Social Services
Mental Health Courts



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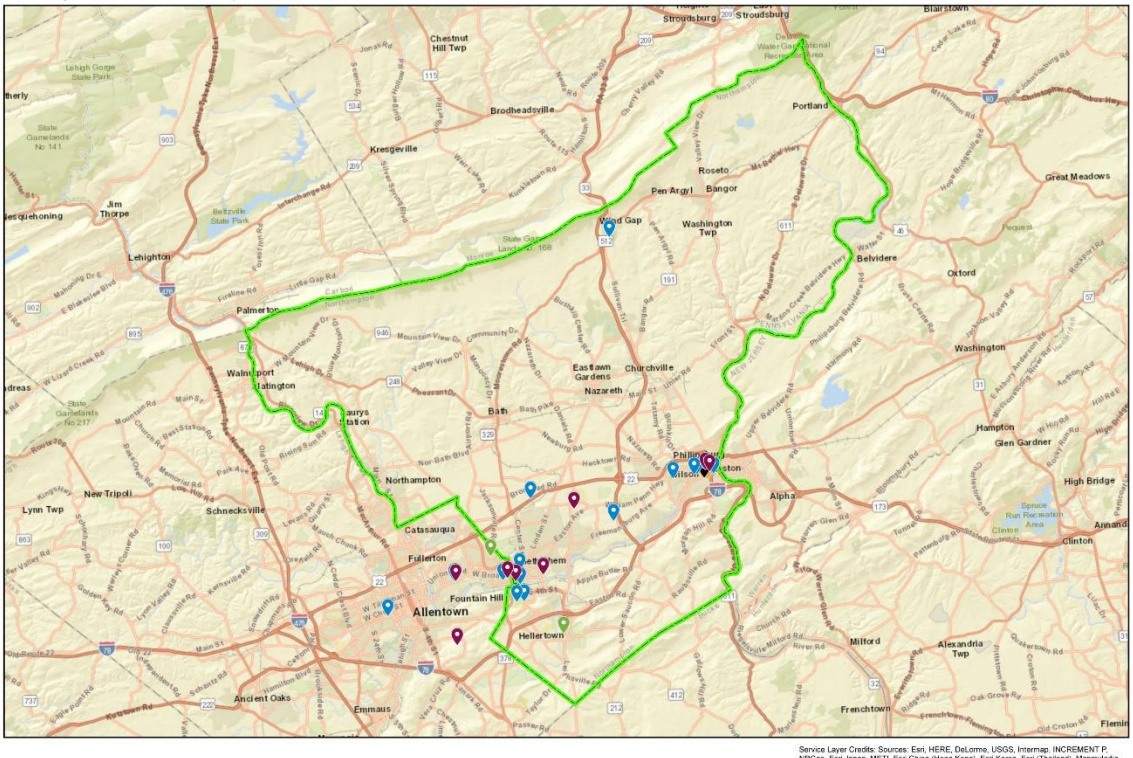
Mental Health Courts | Treatment and Counseling | Social Services | Northampton County

Corrections | Peer Support



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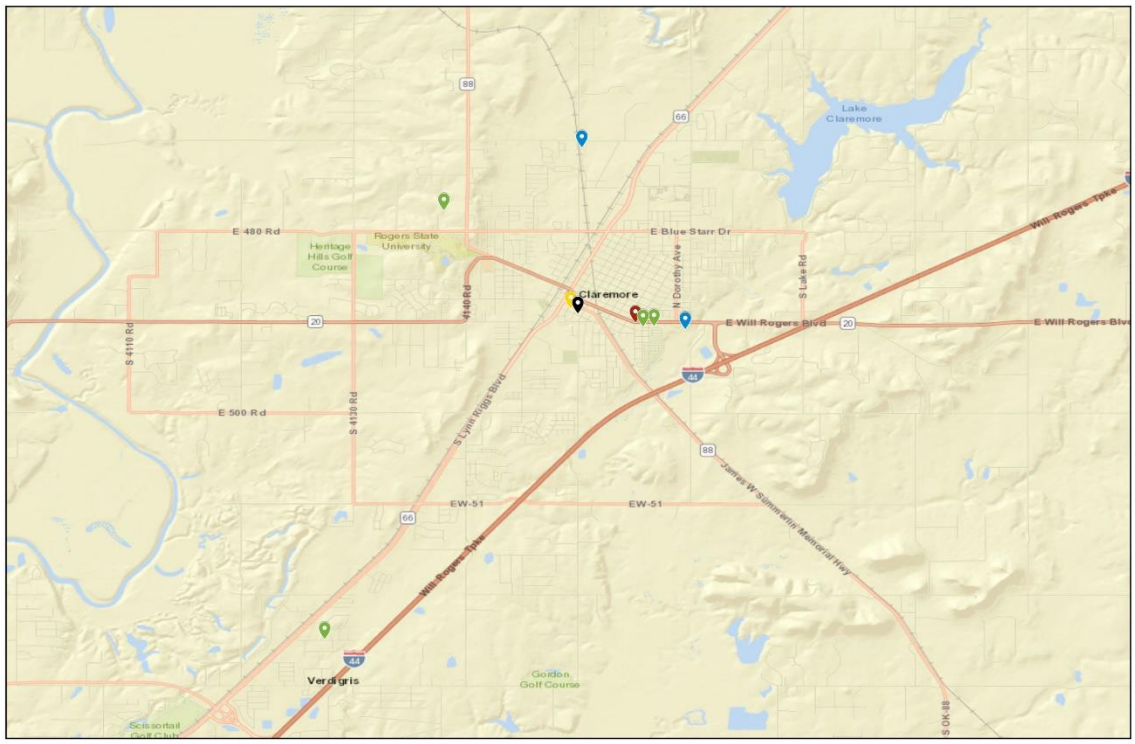
Mental Health Courts | Treatment and Counseling | Social Services | Northampton County

Corrections | Peer Support



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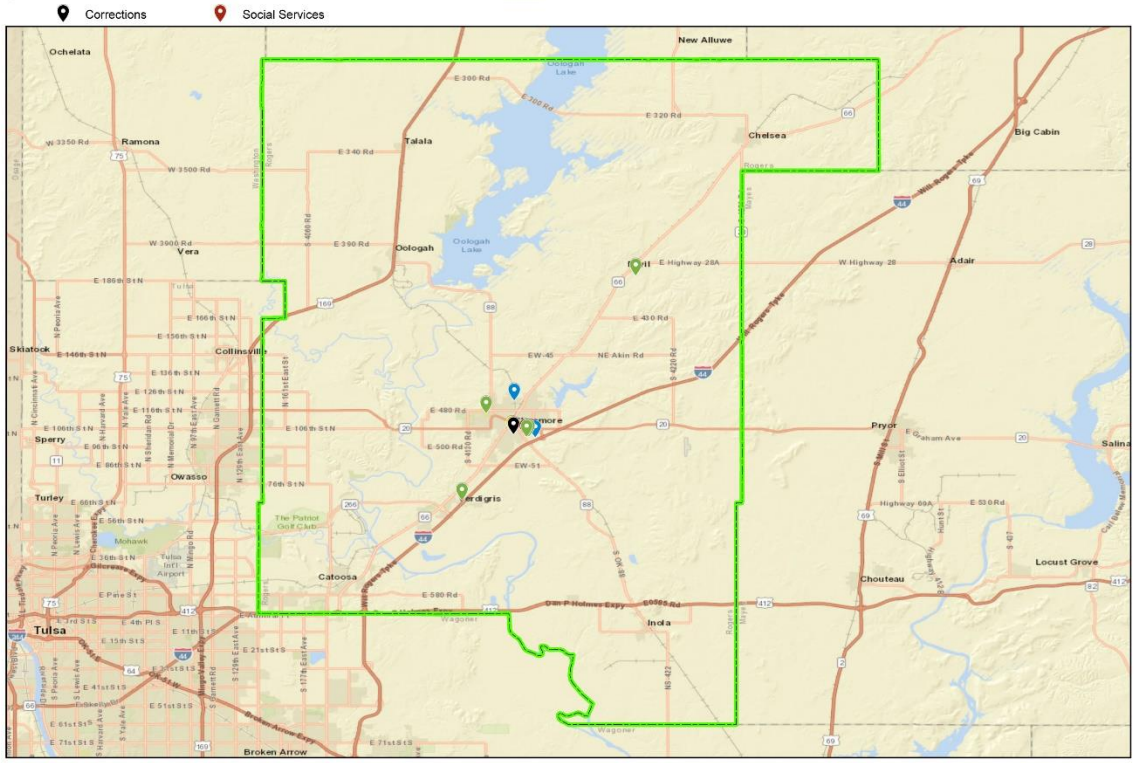
Legend

Mental Health Courts | Treatment and Counseling | Peer Support | Rogers County

Corrections | Social Services



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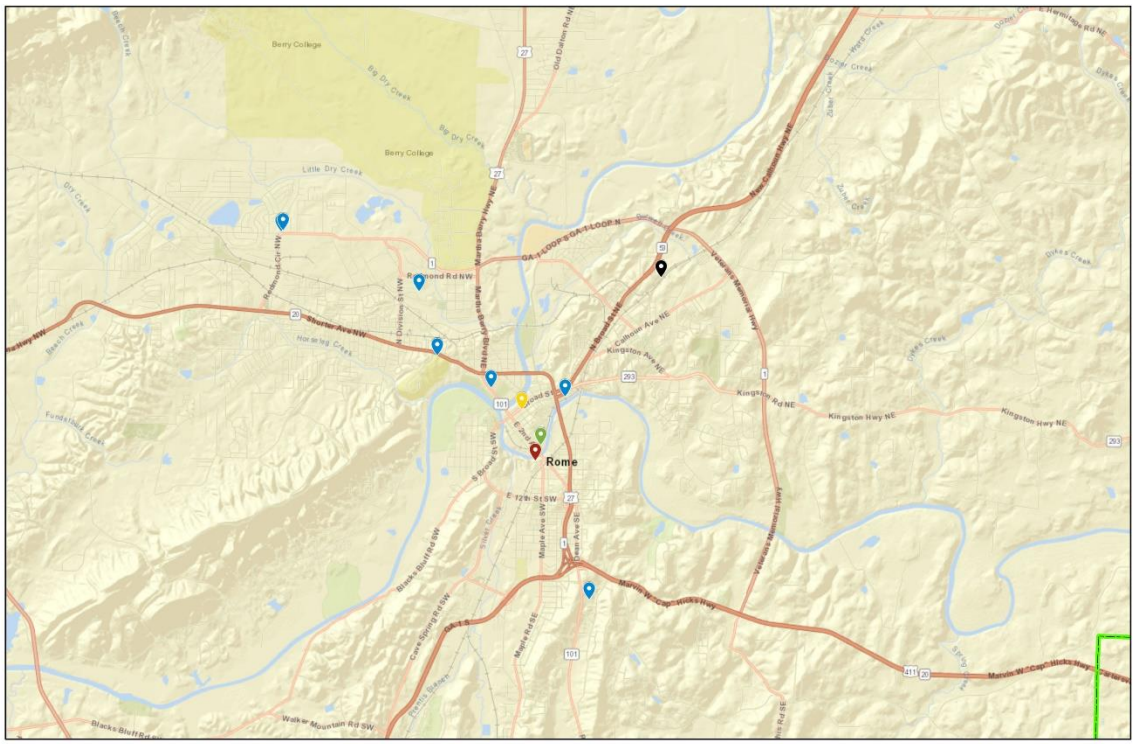
Legend

Mental Health Courts | Treatment and Counseling | Peer Support | Rogers County

Corrections | Social Services


Rome
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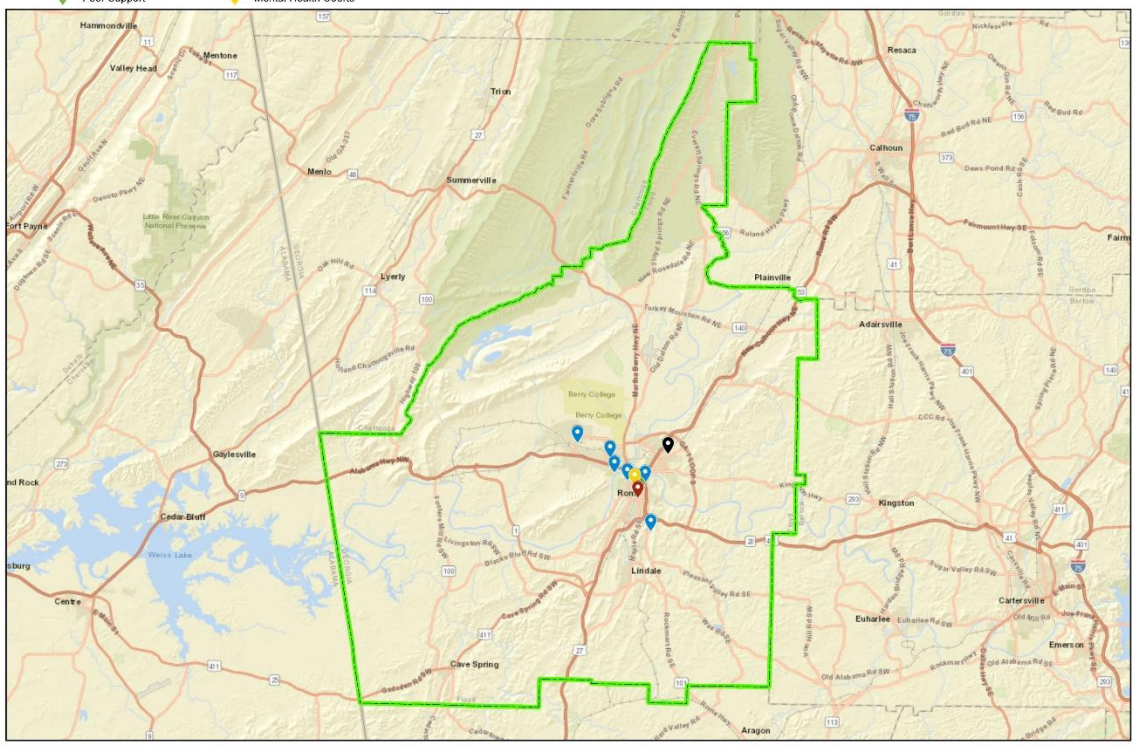
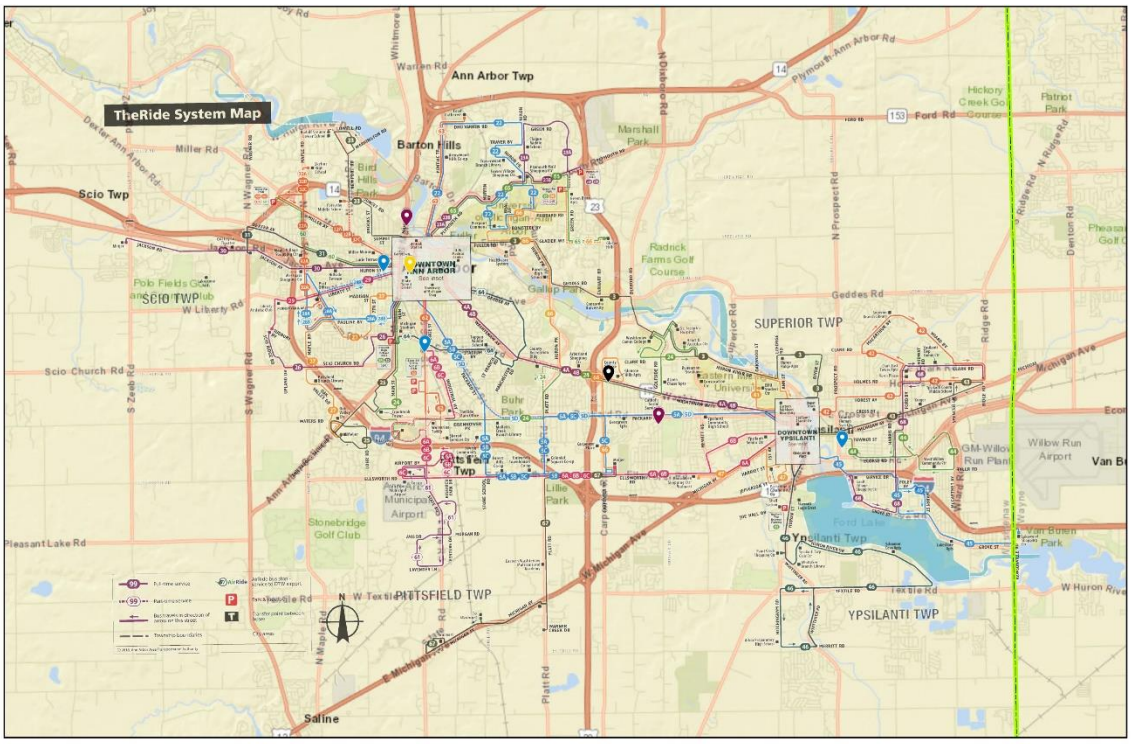
Legend
Treatment and Counseling
Corrections
Support Services
Floyd County
Peer Support
Mental Health Courts


Hammondville
Valley Head
Mentone
Trion
Resaca
Calhoun
Menlo
Summerville
Lyerly
Plainville
Adairsville
Gaylesville
Cedar Bluff
Rome
Kingston
Lindale
Cartersville
Euharlee
Emerson
Cave Spring
Aragon
Service Layer Credits: Sources: Esri, HERE, DeLorme, USGS, Intermap, INCREMENT P, NRCan, Esri Japan, METI, Esri China (Hong Kong), Esri Korea, Esri (Thailand), MapmyIndia, NGCC, © OpenStreetMap contributors, and the GIS User Community
Legend
Treatment and Counseling
Corrections
Support Services
Floyd County
Peer Support
Mental Health Courts


TheRide System Map
Ann Arbor Twp
Scio Twp
Barton Hills
SUPERIOR TWP
YPSILANTI TWP
PITTSFIELD TWP
Saline
Ypsilanti Twp
Stonebridge Golf Club
Radrick Farms Golf Course
Willow Run Airport
Pleasant Lake Rd
Scio Church Rd
W Liberty Rd
Geddes Rd
Ford Rd
Plymouth-Ann Arbor Rd
W Michigan Ave
E Michigan Ave
W Textile Rd
Tex Ble Rd
Ann Arbor Municipal Airport
Lillie Park
Buhr Park
Gallup Park
Bird Hills Park
Marshall Park
Hickory Creek Golf Course
Patriot Park
Van Buren Park
Ford Lake
GM-Willow Run Plant
Miller Rd
Dexter-Ann Arbor Rd
N Wagner Rd
S Wagner Rd
S Zeeb Rd
N Prospect Rd
N Ridge Rd
S Ridge Rd
Ann Arbor-Saline Rd
Platt Rd
N Maple Rd
Carpenter Rd
Ridge Rd
Wiard Rd
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Legend
Treatment and Counseling
Social Services
Mental Health Courts
Corrections
Washtenaw County
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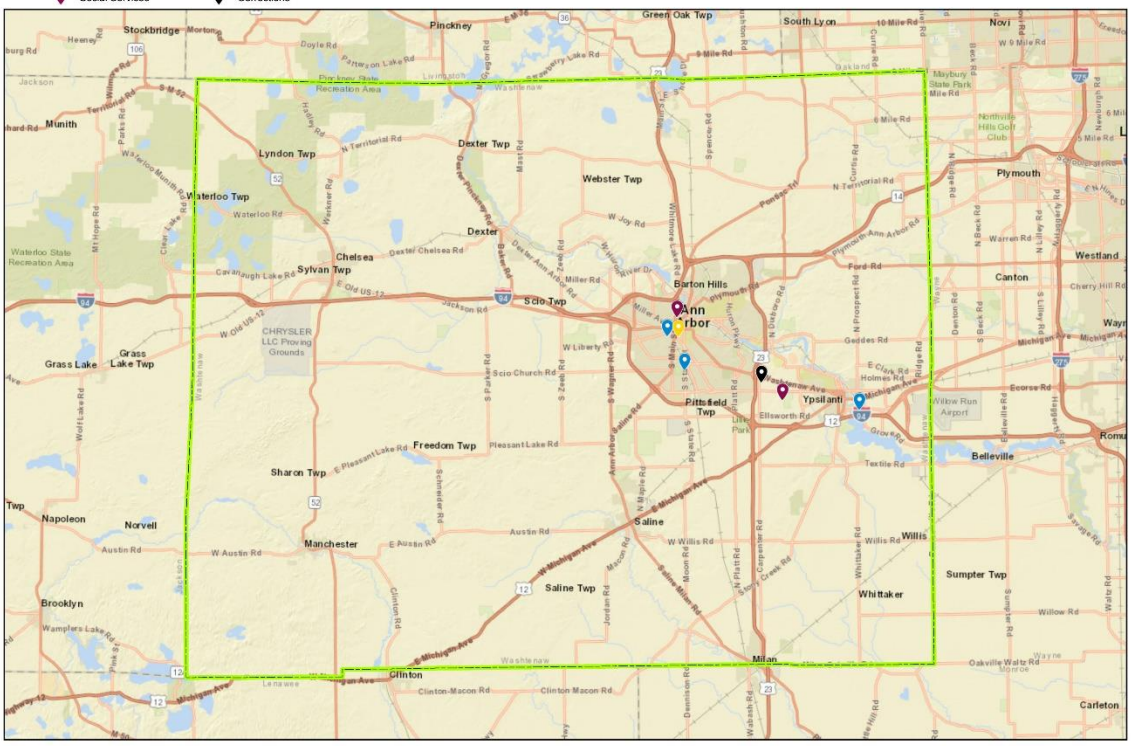
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Pinckney
Green Oak Twp
South Lyon
Novi
Munith
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Webster Twp
Plymouth
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Chelsea
Sylvan Twp
Scio Twp
Barton Hills
Ann Arbor
Westland
Canton
Grass Lake
Grass Lake Twp
Pittsfield Twp
Ypsilanti
Freedom Twp
Sharon Twp
Napoleon
Norvell
Manchester
Saline
Saline Twp
Willis
Sumpter Twp
Whittaker
Brooklyn
Clinton
Milan
Belleville
Carleton
Waterloo State Recreation Area
Pickney State Recreation Area
CHRYSLER LLC Proving Grounds
Willow Run Airport
Legend
Treatment and Counseling
Social Services
Mental Health Courts
Corrections
Washtenaw County
Service Layer Credits: Sources: Esri, HERE, DeLorme, USGS, Intermap, INCREMENT P, NRCan, Esri Japan, METI, Esri China (Hong Kong), Esri Korea, Esri (Thailand), Mapmyindia, NGCC, © OpenStreetMap contributors, and the GIS User Community

APPENDIX C

Mental Health Court Survey
Mental Health Court Theory-Driven Evaluation

D1 Name of your Mental Health Court program or docket

GD2 Physical Address of Mental Health Court program. Include city and state

GD3 Please identify the jurisdiction(s), district(s), or area(s) served by your mental health court

GD4 To the best of your knowledge, what month and year did your mental health court program or docket begin? Please respond with month then year: e.g February 2001

U1 Please upload your participant handbook here. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U2 Please upload your employee handbook or training guides here. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U3 If not already provided within the uploaded participant/employee handbooks, please upload a list of mental health/ substance abuse service centers/ facilities that your court works with and their addresses, if available. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U4 If not already provided within the uploaded participant/employee handbooks,please upload a list of any social service providers that your court works with and their addresses, if available. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U5 If not already provided within the uploaded participant/employee handbooks, please upload your sanctions/incentives matrices here. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U6 Please upload any demographic performance measures your mental health court collects.

Ensure that no sensitive client information is uploaded. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U7 Please upload any previously conducted evaluations of your mental health court, if available. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U8 If you have any other helpful documents that will help to understand your mental health court, please upload them here. If unable to upload, please email it to chelsea.e.bullard@okstate.edu

U9 Are there any internet links (URLS) to useful information about your mental health court? Please add them here.

C1 To what extent are these assumptions important to your mental health court? Extremely important /Very important/Moderately important /Slightly important/Not at all important

- Untreated, or inadequately treated, mental illness contributes to criminal behavior
- Criminal justice involvement can serve as an opportunity to connect people to appropriate treatment
- Appropriate treatment can improve the symptoms of mental illness
- Appropriate treatment can reduce problematic behavior
- Judicial supervision helps keep people in treatment
- The use of graduated incentives and sanctions helps keep people in treatment
- The combination of treatment and judicial supervision reduces recidivism
- The combination of treatment and judicial supervision improves public safety

EE1 These are the essential elements of a mental health court. Please re-order these elements from most important to least important in terms of the success of your mental health court.

_____ Planning and Administration

_____ Target Population

_____ Timely Participant Identification and Linkage to Services

_____ Terms of Participation

_____ Informed Choice

_____ Confidentiality

_____ Treatment Supports and Services

_____ Court Team

_____ Monitoring Adherence to Court Requirements

_____ Sustainability

EE2 If you were to create your own "essential element" of your mental health court, what would it be? Please provide a brief description of why you think your created element is vital to your mental health court's success.

G2 How important are these goals to the success of your mental health court?
Extremely important /Very important/Moderately important /Slightly important/Not at all important

- Increased public safety for communities
- Increased treatment engagement by participants
- Improved quality of life for participants
- More effective use of resources for sponsoring jurisdictions
- Keeping those with mental illnesses out of jail
- Reintegrating the clients back into the community
- Ensuring clients are treated fairly

- Ensuring clients feel their opinions are heard
- Ensuring clients are not stigmatized by mental illness diagnoses
- Ensuring clients are not stigmatized by prior criminal involvement
- Ensuring clients feel forgiven for their past misdeeds
- Ensuring all aspects of mental health court are therapeutic

O1 Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court has on the clients it serves?

Strongly agree /Agree /Neither agree nor disagree /Disagree /Strongly disagree

- Reduced crime participation
- Reduced drug use
- Reduced recidivism rates
- Improved mental health
- Improved physical health
- Improved self-evaluation/ self-confidence
- Improved quality of life
- Improved home life
- Improved education
- Improved job skills
- Improved employment stability
- Improved life skills
- Improved relationships with criminal justice system
- Improved interactions with the community
- Other: Describe.

O2 Judging your mental health court in its current state, to what extent do you agree with these impacts that your mental health court has on the community at large?

Strongly agree /Agree /Somewhat agree /Neither agree nor disagree /Somewhat disagree

- Reduced crime rates
- Reduced drug use
- Reduced prison/jail population
- Reduced recidivism rates
- Improved community mental health
- Improved awareness of mental health issues
- Improved awareness of drug use issues
- Improved acceptance of mental health court clients
- Improved acceptance of individuals with mental illness
- Improved acceptance of individuals with drug use issues
- Improved family acceptance of mental health court clients
- Improved local police and criminal justice system understanding of mental health issues
- Created or improved criminal justice policies and/or procedures for working with the mentally ill
- The community feels safer
- The mental health court brought new helpful services and treatment providers to the community
- The mental health court improved community access to existing helpful services and treatment providers
- The mental health court created jobs for community members
- The community is largely unaware of the mental health courts existence

- No community-level improvements are due to mental health court
- Other: Describe.

C2 How resistant was your court in starting a mental health court program?

- Extremely resistant
- Very resistant
- Moderately resistant
- Slightly resistant
- Not resistant at all

C3 How resistant was your community in starting your mental health court?

- Extremely resistant
- Very resistant
- Moderately resistant
- Slightly resistant
- Not resistant at all

EE3 In what way(s) does your mental health court adhere to planning and administration?

EE4 What is your mental health court programs target population?

EE5 What is your mental health court program's maximum population size? Please respond with a number.

EE6 How does your mental health court ensure timely participant identification and linkage to services?

EE7 What are your mental health court's terms of participation?

EE8 How does your mental health court ensure clients have an informed choice in program participation?

EE9 How does your mental health court ensure that clients remember their court program mandates, appointments, and court dates?

EE10 How does your mental health court program ensure clients' confidentiality?

G1 What are the established overall goals/aims of your mental health court?

C1 What is it about your specific community/area served that makes having a mental health court a necessity? (e.g. large homeless population, overburdened jail/prison system, large volume of a particular drug trafficked in community, judicial desire, etc.)

C4 What does your mental health court do to improve clients interactions with the community? Describe.

C5 What training or information do the local police receive about your mental health court program and/or your clients?

C6 Does your mental health court program provide any transportation services for clients? Select the answer that best describes your mental health court's policy on transportation.

- No
- No, but clients must have access to reliable transportation to be in the program
- No, but clients generally live within walking distance of the court program
- No, but the community offers public transportation services
- Yes, the court provides transportation assistance through bus tokens or other similar services
- Yes, the court provides transportation assistance through a shuttle or other similar pickup service
- Other _____

C7 What kind of funding does your mental health court use? Drag and drop all applicable funding sources into the "yes" box.

_____ Organizational funding e.g. NAMI

_____ Private funding

_____ Local funding

_____ State funding

_____ Federal funding

_____ Grant funding

_____ Other funding, please add

_____ Prefer not to answer/ don't know

TJ1 Judging your mental health court in its current state, how well do you feel these components of your mental health court are conducted in a therapeutic manner?

Extremely well /Very well /Moderately well/ Slightly well/Not well at all /Does not apply to my MHC / Don't know/ prefer not to answer

- Client interactions with judge
- Client interactions with court team
- Client interactions with supervision staff
- Client interactions in courtroom
- Client interactions with community service providers
- Client interactions with substance abuse service providers
- Client interactions with mental health service providers
- Client interactions with local police
- Client interactions with local community
- Client interactions with jails
- Client interactions with jail staff
- Other (please list)

CT1 Who comprises your court team? Drag members of your mental health court team into the "yes" box.

_____ Judge

_____ Court coordinator

_____ Treatment providers

_____ Case managers

_____ Probation officers

_____ Defense attorneys

_____ Prosecuting attorney

_____ Clinical liaisons

_____ Sheriff or police

_____ Social workers

_____ Jail staff

_____ Department of Human Services Representatives

_____ community liaisons/ coordinators

_____ Other, please add

_____ Other, please add

- GD5 Does your mental health court offer these services?

  Yes, ALL clients receive these services /Yes, targeted clients receive these services /No /Don't know/ prefer not to answer
- Culturally-specific services
- Gender-specific services
- Age-specific services
- Spiritual/ religious services
- Psycho-social clubs (e.g., self-help groups AA/NA meetings)

- Financial services/ money management
- Disability or welfare services
- Homelessness/ Housing Services
- Food assistance
- Family/ spousal/parenting services
- Childcare services
- Life skills services
- Educational/Vocational program services
- Employment services
- Community Service Facilities
- Health insurance services
- Dental services or referrals
- Health care/medical services or referrals
- Post-graduation services

GD6 Aside from your mental court, which of these court programs are offered in your court's jurisdiction? Drag and drop the specialty/ problem-solving courts offered by your court's jurisdiction into the "yes" box.

_____ Veterans court

_____ Juvenile court

_____ Drug court

_____ Co-occurring court

_____ Family drug court

_____ Truancy court

_____ Domestic violence court

_____ Child support court

_____ Community court

_____ Federal reentry court

_____ Reentry court

_____ Prostitution court

_____ Homelessness court

_____ Sex offender court

_____ Parole violation court

_____ Gun court

_____ General problem solving court

_____ Other court(s) (please list)

GD7 When does your mental health court offer incentives? Drag and drop all the occasions your mental health court uses incentives into the "yes" box.

_____ Rewards for attending dockets

_____ Rewards for attending required meetings or appointments

_____ Rewards for program phase promotion

_____ Rewards for general program mandate compliance

_____ Rewards for good behaviors

_____ Rewards for achieving particular program goals

_____ Rewards for program graduation

_____ Other, please describe

GD8 What incentives does your mental health court program offer? Drag and drop the incentives your court uses into the "yes" box.

_____ Candy or toys

_____ Small trinkets

_____ T-shirts or other apparel items

_____ Movie passes

_____ Gift cards

_____ Personalized certificates

_____ Personalized plaques

_____ Parties or events

_____ Verbal praise from court team

_____ Verbal praise from judge

_____ Verbal praise from peers

_____ Program phase-ups

_____ Reduced time spent at docket or "rocket docket" status

_____ Reduced mandated attendance at court dockets

_____ Reduced community service hours

_____ Reduced program mandates

_____ Reduced supervision methods

_____ Reduced fees or fines

_____ Reduced charges or sanctions

_____ Graduation ceremonies

_____ Others-please list

GD9 Which of the following sanctions does your mental health court use? Drag and drop the sanctions your court uses into the "yes" box.

_____ GPS monitors

_____ Alcohol monitors

_____ In-patient rehabilitation centers

_____ Curfews

_____ Do not contact orders

_____ Restricted geographic zones

_____ Additional check-ins

_____ Additional call-ins

_____ Community service

_____ Work programs

_____ Residential work programs

_____ Fees for positive drug tests

_____ Court fees

_____ Prolonged phase retention

_____ Mandated phase repetition

_____ Jail time

_____ Program dismissal

_____ Specially tailored punishments to individual clients/circumstances

_____ Others (please list)

GD10 In what ways does your mental health court monitor adherence to court requirements?

Used for all clients / Used, but only used for some clients / Not used / Don't know/ prefer not to answer

- Drug tests (urine)
- Drug tests (follicle)
- Drug tests (blood)
- Medication Compliance Checks
- Check-ins (in-person)
- Check-ins (on phone)

- GPS monitors
- Alcohol monitors
- Probation supervision
- Case manager supervision
- Counselor supervision
- Treatment provider supervision
- Police supervision
- Family supervision
- MHC related meeting attendance requirements
- other: Describe

GD11 Is your court strictly a mental health court or a co-occurring court?

- Mental health court
- Co-occurring court

GD12 Does your mental program work as a pre-adjudication or post-adjudication court?

- Pre-adjudication
- Post-adjudication
- Combination of pre and post adjudications
- Neither, please describe

GD13 How often does your mental health court hold staffing meetings?

- Weekly
- Bi-weekly
- Monthly
- Bi-monthly
- As needed

- Other, please describe

GD14 Is your MHC program divided into phases?

- Yes
- No

GD16 Does your MHC have different program tracks for different sub-populations of clients?

- Yes
- No
- If other tracks available: please name additional program track(s)

Q87 Please provide email address if you would like to be added into the drawing to win one of three $25 Amazon gift cards. Your email will only be used for the purpose of this particular survey research drawing. If you win, your gift card will be emailed electronically to the email address you provide. Good luck!

APPENDIX D

Mental Health Court Informed Consent Form

Department of Sociology

CONSENT FORM

Mental Health Courts: A Theory-Driven Program Evaluation

Background Information

I invite your mental health court or co-occurring court program to take part in a program-evaluation study that aims to determine best practices by uncovering common resources and procedures among mental health courts. This project is being conducted as a dissertation research project by Chelsea Bullard, M.S., OSU Department of Sociology, under the direction of Dr. Kelley Sittner, OSU Department of Sociology. Your participation in this research is voluntary. There is no penalty for refusal to participate, and you are free to withdraw your consent and participation in this project at any time. You can skip any questions, pause and return to the survey at any time, or stop the survey after beginning.

Procedures

If you agree to be in this study, here is what is expected:

To agree to participate, click the link to the survey at the bottom of this letter or scan the QR code. The online survey asks questions regarding your mental health court's practices, jurisdiction, and utilized community resources. Answer questions to the best of your knowledge. You are not required to identify yourself as the survey respondent. The survey should take no more than an hour to complete.

Within the survey, you will find sections that allow you to upload documents such as training manuals, procedure guides, participant handbooks, demographic data, summary reports, sanctions/rewards lists, and any other materials you deem useful to understanding how your mental health court operates. Please ensure that no sensitive or identifiable client information is uploaded. If you wish to upload materials that includes sensitive information about clients, please be sure to redact or remove all client names and information that could be linked back to participants in your program. These materials may also be delivered via mail, email, or arranged for in-person pickup.

Compensation

Participation in the survey will enter you, as the survey respondent, in a drawing for 1 of 3 $25 Amazon gift cards. Based on total amount of mental health court participation, your odds of winning are near 1/100. Drawings will take place once the study concludes. Additionally, the researcher

will create a logic model of your court for your use in future planning and administration. You will also be sent all outcome results and publications that result from this study. If desired, the researcher will also solicit your court program for inclusion in post graduate research in future years.

Confidentiality

The information you provide will be used in connection with your specific mental health court's name, state, and country. Due to your position as a public and/or political figure connected to a mental health court, please recognize that the nature of your responses about your mental health court program could potentially be linked back to you by those who are aware of your position of employment at your particular mental health court.

While the researcher may be able to identify who participated, they will not request your name within the survey or collect names of other mental health court employees. Most survey data will be published in aggregate with no direct linkages to you or your court. However, some write-in responses and interview comments may be selected for verbatim use and mentioned in relation to your particular court in publications. Use of direct quotes in publication will only be used with your explicit permission.

The researcher works to ensure confidentiality to the degree permitted by technology. It is possible, although unlikely, that unauthorized individuals could gain access to your survey responses because you are responding online. However, your participation in this online survey involves risks similar to a person's everyday use of the internet. If you have concerns, you should consult the survey provider privacy policy at https://www.qualtrics.com/privacy-statement/ .

At no time will the investigator request for you to identify any of your past or current clients. Any non-aggregated client information inadvertently collected will not be recorded or used in any way. All physical and written materials (e.g. training manuals, progress reports, client handbooks etc.) about your mental health court will be kept in a secure file in a locked office. Any materials containing identifiable client will be de-identified upon receipt if not already redacted prior to submission.

Contacts and Questions

The Institutional Review Board (IRB) for the protection of human research participants at Oklahoma State University has reviewed and approved this study. If you have questions about the research study itself, please contact the Principal Investigator at 405-476-2319, chelsea.e.bullard@okstate.edu. If you have questions about your rights as a research volunteer or would simply like to speak with someone other than the research team about concerns regarding this study, please contact the IRB at (405) 744-3377 or irb@okstate.edu. All reports or correspondence will be kept confidential.

Statement of Consent

I have read the above information. I have had the opportunity to ask questions and have my questions answered. I consent to participate in the study.

If you agree to participate in this research, please to continue to the survey online via https://okstatecoe.az1.qualtrics.com/jfe/form/SV_1Lf2lZvz94O1We1 or scan the QR code using your smart mobile device.

APPENDIX E

Mental Health Court Recruitment Email

Mental Health Court Coordinator,

I am conducting a multi-site, theory-driven program evaluation of mental health and co-occurring court programs for my doctoral dissertation. I'd like to extend my offer to evaluate your court program, free of charge. I hope you will take this survey-based evaluation. I am looking for a mental health court from each state that runs a mental health court program to take this survey.

This evaluation involves an online survey. In the survey you can upload various court documents and community partner lists. I am not soliciting any personal client information or information about you as the survey-taker. The survey is long, but I request you answer as much as your busy schedule allows. You can also pause and come back to it later. Here is the link to the survey. https://okstatecoe.az1.qualtrics.com/jfe/form/SV_1Lf2lZvz94O1We1

As a thank you, I will produce a logic model for your court to use in court planning and administration. There is also a chance to win a $25 Amazon gift card located at the end of the survey. You may pass this link along to any other informed court team member from your court program to take in your stead. I've attached the official research documentation. I hope to begin analyzing your results in the next two weeks, but extensions can be arranged if necessary. Let me know if you have further questions.

Much appreciated,
Chelsea Bullard, M.S. Forensic Science
PhD Candidate
Department of Sociology
Oklahoma State University

APPENDIX F

IRB FORM

Oklahoma State University Institutional Review Board

Date:	04/12/2018
Application Number:	AS-18-31
Proposal Title:	Mental Health Courts: A Theory-Driven Program Evaluation
Principal Investigator:	Chelsea Bullard
Co-Investigator(s):	
Faculty Adviser:	Kelley Sittner
Project Coordinator:	
Research Assistant(s):	
Processed as:	Expedited
Status Recommended by Reviewer(s): Approved	
Approval Date:	**04/12/2018**
Expiration Date:	**04/11/2019**

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

The final versions of any recruitment, consent and assent documents bearing the IRB approval stamp are available for download from IRBManager. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be approved by the IRB. Protocol modifications requiring approval may include changes to the title, PI, adviser, other research personnel, funding status or sponsor, subject population composition or size, recruitment, inclusion/exclusion criteria, research site, research procedures and consent/assent process or forms.

2. Submit a request for continuation if the study extends beyond the approval period. This continuation must receive IRB review and approval before the research can continue.
3. Report any unanticipated and/or adverse events to the IRB Office promptly.
4. Notify the IRB office when your research project is complete or when you are no longer affiliated with Oklahoma State University.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact the IRB Office at 223 Scott Hall (phone: 405-744-3377, irb@okstate.edu).

Sincerely,

Hugh Crethar, Chair Institutional Review Board

VITA

CHELSEA BULLARD

Candidate for the Degree of

Doctor of Philosophy

Thesis: MENTAL HEALTH COURTS: A THEORY-DRIVEN PROGRAM EVALUATION

Major Field: Sociology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Sociology at Oklahoma State University, Stillwater, Oklahoma in December, 2018.

Completed the requirements for the Master of Science in Forensic Sciences at Oklahoma State University Center for Health Sciences, Tulsa, Oklahoma U.S.A in 2014.

Completed the requirements for the Bachelor of Arts in Applied Sociology at Oklahoma State University, Stillwater, Oklahoma U.S.A in 2012.

Experience:

Bullard, C. E. 2014. Evaluating dimensions of mental health courts by their effect on jurisdictional crime rates. Oklahoma State University.

Bullard, Chelsea. E., & Ronald Thrasher. 2016. Evaluating mental health court by impact on jurisdictional crime rates. *Criminal Justice Policy Review*, *27*(3), 227-246.