ABSTRACT

GURRERA, MARLEE MOORE. An Evaluation of a Mental Health Court: Process, Procedure, and Outcome. (Under the direction of Virginia Aldige’ Hiday.)

The purpose of this research was to conduct an evaluation of a mental health court (MHC). A conceptual model was provided to theoretically explain the MHC’s functioning and the outcomes it hoped to achieve. Qualitative and quantitative data were used to examine the causal linkages specified in the conceptual model through which MHC participation in one MHC was believed to operate in reducing recidivism. Specifically, this study provides insight into how this MHC operated, who it served, what services it was able to marshal, how case decisions were made, how court monitoring influenced defendant participation and compliance, whether participation in MHC increased access to services, whether participation in MHC resulted in improved quality of life, and whether participation in MHC reduced reoffending and reoffending severity.

Qualitative data (observations, field notes, and semi-structured interviews) were used to examine court process and procedure, service utilization, defendant compliance, and defendant outcomes. These data were utilized as a link between defendants’ participation in MHC and their recidivism as indicated in the developed conceptual model. Specifically, qualitative data shed light on the mechanisms (team decision making processes, open court processes, and judicial power and control to ensure defendant compliance) within MHC operation that linked MHCs to improved defendant outcomes; and qualitative data provided insight into defendants’ treatment compliance and the impact of treatment services on defendants’ lives.
The quantitative portion of this evaluation used a nonequivalent comparison group design with two samples of defendants: MHC subjects and traditional court subjects (TCC). The first sample, MHC subjects, included defendants who chose to participate in the MHC from September 2001 - August 2002. The second sample, TCC subjects, included defendants who were in traditional court in the study county the year before the MHC was established (1998) who would have been eligible for MHC were it in existence, that is who were mentally ill.

Multivariate and pre-test/post-test analyses were used to examine recidivism and recidivism severity to determine the impact of the MHC on the rate of re-arrest and predict factors associated with the severity of re-arrests. Results indicated that MHC defendants had a re-arrest rate approximately half that of comparable defendants in TCC; and for those who were re-arrested, MHC defendants were re-arrested for less severe offenses than comparable TCC defendants. When recidivism of MHC defendants was separated into completers and non-completers, MHC completers’ re-arrest rate dropped to less than one-fourth that of TCC defendants; while the re-arrest rate of MHC non-completers increased making their difference with TCC subjects nonsignificant.

Analyses examining the severity of re-arrest of TCC and MHC defendants indicated that participating in the MHC had a significant impact on the severity of re-arrest. Of those MHC defendants who did re-offend, their offenses were significantly less serious than the offenses of similar TCC defendants. Last, pre-test/post-test analyses of matched samples indicated that TCC subjects were arrested more often and for more serious offenses during the post-test period as compared to the pre-test period.
For the matched comparisons, MHC defendants did not experience a decrease in arrests or arrest severity after entry into the court. However, when looking at MHC completers versus non-completers, MHC completers had reduced arrests and reduced severity of re-arrests when they occurred from one year pre-court to one year post court than did MHC non-completers and TCC defendants.
AN EVALUATION OF A MENTAL HEALTH COURT: PROCESS, PROCEDURE, AND OUTCOME

by
MARLEE MOORE GURRERA

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APPROVED BY:

Rodney Engen
Stacy DeCoster

Anne Schiller
Catherine Zimmer

Virginia Aldige Hiday
Chair of Advisory Committee
BIOGRAPHY

Marlee Moore Gurrera was born in Charlottesville, Virginia. She completed her undergraduate and graduate work in Sociology at North Carolina State University. She has accepted a position as a Policy and Research Associate with the North Carolina Sentencing Commission.
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CHAPTER 1

INTRODUCTION

Over the last twenty-five years, the United States has experienced enormous growth in its mentally ill jail and prison population. The Bureau of Justice Statistics indicates there were 831,600 individuals in the nation’s correctional system (jail, prison, and probation) in 1998 who were either identified as mentally ill, reported a mental or an emotional problem, or had been admitted to a mental hospital (Ditton 1999). That this number represents a proportion that is much higher than that of the general population is exemplified by Teplin’s findings of jail prevalence rates of severe mental illness that were two to three times higher than those of the general population (1990). Problems associated with the care of these persons are further exacerbated as 75% of mentally ill persons in jails and prisons also suffer from a substance abuse disorder (Abram, Teplin, and McClelland 2003, Lamb and Weinberger 1998, Abram and Teplin 1991).

Lack of mental health services and admission difficulties for substance abusing, seriously mentally ill (SMI) persons cause police to take them to jail rather than the hospital or some other psychiatric service (Teplin 1990). As a result, the correctional system has become the “de facto” caretaker to many of those who have SMI such that urban jails in some states house more persons with mental illness than do state mental hospitals (Torrey 1995). Lack of adequate treatment for these offenders in the community or in jails, and lack of community resources, has led to a revolving door syndrome of arrest, jail or probation, and release back in the community, where, with
little or no resources, re-offending starts the cycle again (Steadman, Cocozza, and Veysey 1999; Lamb et al. 1996; Teplin 1990).

Awareness of these problems has led criminal justice, mental health, and other professionals to advocate for diversion programs (Petrila, Poythress, McGaha, and Boothroyd 2000; Steadman et al. 1999, Steadman, Deane, Morrissey, Westcott, Salasin, and Shapiro 1999). These advocates argue that diversion could address the underlying problems by linking SMI offenders to appropriate treatment and services, and as a result, break the revolving door syndrome. One such diversion effort is specialty (drug and mental health) courts that provide community treatment and services as alternatives to incarceration or other punishments, and monitor offenders’ progress for periods up to the duration of their entire sentences.

Since the inception of the first mental health court (MHC) in Broward County, Florida, in 1997, there has been much enthusiasm for mental health courts by criminal justice personnel, mental health personnel, and community stakeholders. This enthusiasm was affirmed by the federal government in November 2000, when President Bill Clinton signed into law Senate bill S. 1865 authorizing the creation of up to 100 mental health courts and yearly funding for four years for their operation. This bill documented the government’s support for MHCs, a rapidly growing strategy to deal with the rapidly growing numbers of mentally ill offenders in jails and prisons (Steadman, Davidson, Brown 2001).

MHCs are based on the drug court model and are part of a larger movement, specialty courts, that were founded on the concept of therapeutic jurisprudence (Wexler
Therapeutic jurisprudence reflects the idea that the legal decision and process should promote the psychological and physical well-being of defendants. It is concerned not only with court disposition but also with the manner in which lawyers and judges produce therapeutic or anti-therapeutic consequences for defendants involved in the criminal justice system (Wexler 1996, Wexler and Winick 1991). Two rationales underlie the therapeutic approach: 1) by addressing the root of the problem, recidivism will be reduced which in turn protects the public from future criminal acts and 2) criminal sanctions are not appropriate for some offenders whose problems (e.g. anger control, conflict with spouse, lack of parenting skills, substance abuse, and/or mental illness) contributed to their criminal activity (Bazelon Center for Mental Health Law 2004). The primary goal of specialty courts is to break the cycle of criminal offending by providing effective treatment and needed services instead of incarceration for offenders with special problems (Bazelon Center for Mental Health Law 2004, Goldkamp and Irons-Guynn 2000).

**Mental Health Courts**

MHCs operate under a similar guiding philosophy and structure as drug courts do. They strive to address the root of the problem, mental illness, in an effort to reduce recidivism. MHC’s guiding philosophy is rehabilitative, although it recognizes the need to ensure public safety. The creators of MHCs thought the court could provide access to much needed services, and that judicial oversight of these services could increase the probability of treatment success leading to reduced offending (Watson, Hanrahan, Luchins, and Lurigio 2001; Goldkamp and Irons-Guynn 2000).
Of more than 100 MHCs that exist, all strive to reduce future re-offending of mentally ill defendants by mandating community treatment services coupled with MHC monitoring and supervision as an alternative to a criminal trial with the possibility of jail/prison. To implement the goal of reduced recidivism, each MHC developed its own operational model; however, there are many common features and processes across MHCs. All MHCs attempt to create a courtroom that has expertise and sensitivity to the special needs of persons with SMI; to create a team approach with both criminal justice and mental health professionals; to increase access to mental health services; expedite case processing; to reduce recidivism; and to ensure public safety (Watson et al. 2001; Petrila et al. 2000; Goldkamp and Irons-Guynn 2000). To ensure the court’s goals are met, MHCs limit the types of offenders and crimes allowed into their court. The majority of courts only hear cases involving misdemeanors, but some courts accept felony cases (Steadman et al. 2005; Goldkamp and Irons-Guynn 2000; Watson, Luchins, Hanrahan, Heyrman, and Lurigio 2000). Most exclude driving under the influence and domestic violence cases because there already exist specialty courts to hear these types of cases (Watson et al. 2000). Some courts accept violent cases; but in cases involving a victim, a court generally requires victim consent to the offender’s transfer to MHC (Hiday, Moore, Lamoureaux, and Demagistris 2005, Watson et al. 2001, Goldkamp and Irons-Guynn 2000).

Furthermore, each MHC has a docket, separate from criminal court, for defendants with mental illness with the purpose of diverting these defendants from jail and/or prison into the community with appropriate mental health treatment services.
Unlike traditional criminal court, MHCs are voluntary with defendants agreeing to follow a treatment regimen and to be monitored by the court for a set period of time in exchange for dismissal of charges or in lieu of jail/prison. Similar to other problem solving courts, MHCs strive to use a non-adversarial team approach where defense and prosecuting attorneys do not dispute guilt or innocence but rather work as a team with the judge, criminal justice personnel, mental health liaison, and other providers to find the best treatment and services while providing judicial oversight and monitoring. Judicial monitoring has as its goal to encourage defendants’ compliance by means of rewards for compliant behavior and sanctions for noncompliance; thereby, holding defendants accountable for their behavior.

The voluntary nature of the MHC means offenders must consent to have their cases transferred to MHC (Steadman et al. 2005; Watson et al. 2001; Goldkamp and Irons-Guynn 2000; Watson et al. 2000). MHCs vary in their plea requirements for offenders transferred to them. Some require a guilty plea as part of the plea/sentencing bargain and drop penalties upon successful completion of court supervised treatment, while others defer prosecution until all treatment options have been tried and either succeed or fail (Goldkamp and Irons-Guynn 2000). For those defendants who succeed, charges are dismissed. Those who fail are returned to Traditional Criminal Court (TCC) for prosecution of their original charges.

Each court differs in its mental illness eligibility requirements. Most courts specify that the offender must have a current Axis I diagnosis of serious mental illness, organic brain impairment, developmental disability, or a history of mental
hospitalizations to be eligible (Goldkamp and Irons-Guynn 2000). Some courts accept offenders with less serious mental illnesses, but place a priority on those with the more serious disorders (Watson et al. 2001, Watson et al. 2000).

Treatment options vary from one jurisdiction to another as each court is dependent on services available in its community (Boothroyd, Mercado, Poythress, Christy, and Petrila. 2005; Hiday, Moore, Lamoureaux, and DeMagistris 2005; Boothroyd, Poythress, McGaha, and Petrila 2003; Watson et al. 2001). These services may include psychotherapy, medication monitoring, supervised living, housing assistance, training in independent living, anger management, vocational education, and programs designed for those who have a dual diagnosis. Unfortunately, these services are limited in most communities, which is a challenge to the MHC (Boothroyd et al. 2005, Hiday et al. 2005, Watson et al. 2001).

Because early intervention is one of the goals, each MHC intervenes as soon as possible in the criminal processing of arrestees. However, the timing of the intervention is contingent upon each court’s next session, which varies by location. The defendant may be seen in MHC within 24 hours (Broward County, FL) or in a couple of weeks (San Bernardino, CA) (Goldkamp and Irons-Guynn 2000; Watson et al. 2000).

Many professionals are involved in the court process and form a team that consists of, at minimum, a judge, prosecutor, public defender or private counsel, and a mental health case manager. Some also include a court monitor, a MHC liaison, jail psychiatric liaison, and/or a probation officer (Hiday et al. 2005; Johnson, Formichella,
and Bowers 1998; Goldkamp and Irons-Guynn 2000). Such a team approach calls for judges, along with other MHC team members, to negotiate the best treatment disposition tailored to each individual defendant’s clinical and behavioral problems while protecting the public (Watson et al. 2001, Petrila et al. 2000, Goldkamp and Irons-Guynn 2000). In so doing, judges and defense attorneys must take on new roles. In MHCs judges play an active role in the treatment decision making process, that is, they, as other team members, outline treatment options and marshal services to ensure defendant compliance through a period of court monitoring lasting at least six months (Denckla 2002, Hanson 2002, Wexler 2001, Kaye 1998). Similarly, defense attorneys strive to craft interventions that meet clients’ mental health and social needs in cooperation with the court team rather than try to prove clients’ innocence (Thompson 2002, Clarke 2001, Kaye 1998).

The method used to monitor legal and treatment compliance and make case decisions varies across MHCs. In almost all, the mental health case coordinator or treatment provider monitors each defendant’s compliance and reports back to the court. In some cases clients seek treatment from private physicians and monitoring takes place in one of three ways: 1) attorneys monitor treatment attendance and progress through communications with these providers, 2) defendants bring to the court proof of treatment compliance in the form of letters from the treatment providers or attendance slips from treatment programs, or 3) case managers monitor treatment progress through communications with defendants’ private physicians. The reporting process varies across courts, but all case coordinators or attorneys report defendants’ treatment
compliance to the court team (Carns, Hotchkin, and Andrews 2002; Goldkamp and Irons-Guynn 2000). In Alaska’s MHC, defendants appear with their case coordinators, who give updates on treatment compliance at scheduled court hearings (Carns et al. 2002). Other MHCs hold meetings in which all team members share information about defendants in order to monitor compliance and negotiate treatment disposition prior to court sessions (Hiday et al 2005; Goldkamp and Irons-Guynn 2000). The King County MHC operates similarly, but only the prosecutor, the public defender, and the court monitor are involved in such meetings (Goldkamp and Irons-Guynn 2000).

Regardless of the monitoring method used, professionals involved in each MHC are willing to give second chances, understanding that defendants will have setbacks and failures as they attempt to change their behavior. If an offender fails to comply with the mandated treatment program, the judge may reprimand the noncompliant offender, alter the treatment plan, order jail time, and/or send the defendant back to TCC. Jail is usually used as a threat, and is only mandated in rare cases and for short periods of time. Each of the MHCs varies in its typical response to noncompliance (Steadman et al. 2005, Goldkamp and Irons-Guynn 2000).

A conceptual model of the MHC process is presented below as an “ideal type” of MHC and is provided to give the reader insight into how the observed MHC theoretically achieves its goals of reducing recidivism, improving defendant quality of life, and reducing court workload, jail/prison crowding, and criminal justice costs.
Figure 1.1 Conceptual Model of Operation of MHC
It is not the intent of this dissertation to test this conceptual model empirically; rather the conceptual model is provided to help the reader understand, theoretically, the purpose of the court and the outcomes it hopes to achieve. The intent of this research is to determine the effectiveness of one mental health court. Effectiveness is defined as this MHC’s ability to solve defendants’ underlying problem(s) through treatment, services, and court monitoring including encouraging and motivating defendant compliance so that the causes of criminal offending no longer exist. To assess effectiveness, I examine empirically MHC participants and MHC graduates and non-graduates and their recidivism indicated by number of arrests and arrest severity. I do not have quantitative data to test the links between MHC participation, treatment and services and recidivism. Therefore, I use qualitative data to examine the causal links as specified in the conceptual model through which MHC participation in one MHC is believed to operate in reducing recidivism. Specifically, the goals of the qualitative analyses are to explore:

- How a MHC operates;
- Who it serves;
- What services it is able to marshal;
- How case decisions are made;
- How court monitoring influences defendant participation and compliance;
- Whether participation in MHC increases access to services; and
- Whether participation in MHC results in improved quality of life.
Qualitative and quantitative data were used to achieve these objectives. Each type of data collection, qualitative and quantitative, used a micro substantive approach, but each was grounded in a different philosophical position. My qualitative data collection and analysis provided insight into structure and processes of the MHC on the micro-substantive level using a naturalistic approach where the MHC studied was observed in its natural setting allowing ideas, themes, and an understanding of the MHC to emerge as the study progressed (Hammersley and Atkinson 1995). Qualitative data on MHC team decision-making and judicial power and control in the courtroom provide information on two of the causal mechanisms by which the MHC is expected to reduce recidivism and improve quality of life for its defendants, thereby providing the necessary context for understanding how it is that the MHC is believed to positively impact MHC defendants as presented in quantitative data.

My quantitative data collection and analysis also offer insight into the effectiveness of the MHC at the micro substantive level where data were collected on quantifiable variables using a positivistic approach. This approach, based on the scientific method, called for the development of hypotheses specifying relationships between variables, systematic and uniform data collection on variables that could be quantitatively measured and manipulated, and creation of statistical models to test hypotheses.

This dissertation presents the six parts of my study. I begin by examining the historical development and rationale behind treatment for the mentally ill. My goal is to provide the necessary background to place the current study in social context for the
reader. Second, I review the literature on the development of specialty courts including the juvenile court, drug court, and MHC. This is followed by a discussion of evaluation research on drug and mental health courts. Fourth, I discuss the research setting and methodology which includes qualitative and quantitative methods. Fifth, I describe the MHC admission process and the types of defendants the court serves. Sixth, I analyze and discuss qualitative data using key themes such as new methods of decision making in the court, power and control in the courtroom, and treatment services. Seventh, I present quantitative data to aid in the determination of the court’s effectiveness assessed by defendants’ improved social functioning, improved quality of life, and reduced future offending. Finally, I discuss the overall implications and limitations of the study followed by suggestions for future research.
CHAPTER 2

HISTORICAL DEVELOPMENTS IN THE CARE OF PERSONS WITH MENTAL ILLNESS

Prior to the late 1700’s, mental illness was viewed as an individual problem, not a social problem, with the burden of care residing within the family. It was not until the late 1700’s that institutions were developed to house mentally ill persons. The construction of the first mental hospital in the United States occurred in Williamsburg, Virginia, in 1773, (Dowdall 1999, Gamwell and Tomes 1995, Rothman 1990). It marked the beginning of public mental hospitals created to be small curative institutions for the mentally ill, but which eventually became large, overcrowded institutions providing only long term custodial care (Dowdall 1999, Rothman 1990, Morrissey and Goldman 1984, Grob 1983, Horwitz 1982). Over time there were many reform efforts with varying success which attempted to provide treatment for the mentally ill, make asylums more humane, prevent the chronicity of mental illness, and relocate services from an institutional to a community setting. The following text describes these reform efforts in more detail.

Mental health policy in the United States has evolved through four major eras of reform: moral treatment (early 19th century), mental hygiene (early 20th century), community mental health (mid 20th century), and community support (late 20th century) (U.S. Department of Health and Human Services 1999, Morrissey and Goldman 1984). With each era, there was a shift in belief about the cause and curability of mental illness. However, each had in common the desire to control a social problem, a
problem that threatened public safety and social organization (Morrall and Hazelton 2000). In the following sections, the four major cycles of mental health reform are discussed.

**Colonial Times**

In Colonial times (pre 1776), persons with mental illness were tolerated and permitted to live in the larger community as long as their families provided for them (Gamwell and Tomes 1995, Grob 1994). Mental illness often led to unemployment and had dire economic consequences for the family. The community was not required to assist the mentally ill person or the afflicted family unless they were impoverished or unless the mentally ill person had no family or was not peaceful (Gamwell and Tomes 1995, Thompson 1994). In cases of impoverishment, the family received a subsidy to aid in the care of their mentally ill relative. In some other cases, dependent persons with mental illness were boarded in private houses or placed in poorhouses/almshouses (Grob 1994, Mechanic 1968). Communities were tolerant of persons with mental illness and provided for them as long as they did not exhibit violent behavior. If violent behavior was displayed in public, colonial legislation allowed local officials to “limit the freedom” of insane persons (Grob 1994: 16).

Society’s intolerance of violent mentally ill persons, coupled with population growth and an increase in sick and dependent persons, led to the creation of a general hospital, the Philadelphia hospital, in 1752. Civic leaders designated the hospital to care not only for the physically sick, but also the mentally ill. In their request for hospital funds, civic leaders argued a need for the hospital to house the mentally ill
because lunatics were increasing in number and provided a public safety threat to the community. The primary intent of hospital founders was to confine mentally ill persons with hopes that their reason would be restored (Gamwell and Tomes 1995).

Although the founders of early mental hospitals were optimistic that they would do more than house persons with mental illness, mentally ill persons were treated horrifically and did not receive treatment. Mentally ill patients were often restrained with cloth and chains, and were housed in barred cells in the basement of the hospital to seclude them from non-mentally ill patients. Only custodial care was provided and little was done to treat patient’s mental condition (Gamwell and Tomes 1995).

The first public hospital devoted entirely to persons with mental illness was built in Williamsburg, Virginia, to care for and cure the curable and to restrain the dangerous (Dowdall 1996, Grob 1994). The hospital’s interior included twenty-four rooms designed for security and isolation, not the cure, of its occupants. Each room had a barred window and was equipped with an iron ring to which unruly patients would have their wrists or legs tied. In the 1790’s a fence was erected around the perimeter of the building and two cells were constructed to house newly admitted patients if they were in a state of rage. Treatment in the hospital consisted of restraint, plunge baths, bleeding, blistering, and shock water therapy. Treatments did little toward curing mental illness (Dowdall 1996, Grob 1994).

**Moral Treatment**

The first wave of mental health reform, “Moral Treatment” (early 19th century), began in direct response to the abuses mental patients suffered under extant modes of
confinement (poorhouses and prisons) (Dixon and Goldman 2003, U.S. Department of Health and Human Services 1999, Gamwell and Tomes 1994, Grob 1994, Rothman 1990). Moral Treatment and the development of the asylum, rooted in Quaker tradition, were motivated by kindness, not the desire to punish the mentally ill (Thompson 1994). Quakers believed people experiencing mental troubles should be treated equal to other sick people, were deserving of care, and should be housed in tranquil, home-like environments away from the stresses of the city (Borthwick, Holman, Kennard, McFetridge, Messruther, and Wilkes 2001, Grob 1994).

Central elements incorporated in asylum care and construction were “comfort, nurture, beauty, purpose, and personal and social responsibility (Borthwick et al. 2001: 428)”. Mentally ill people were involved in structured work and leisure activities with increasing responsibilities as their mental state improved. Asylum employees were hired based on personal qualities such as tolerance, nurturance, and integrity. The overall goal was to provide structured, pleasing surroundings in which mentally ill persons could reside in a family-like environment (Borthwick et al. 2001). The expectation was the cure of mentally ill persons through a peaceful, serene, moral, properly structured environment (Grob 1994).

Horace Mann and Dorothea Dix, pioneers in the development of moral treatment and the asylum, believed that once separated from the daily stresses of everyday living, a mentally ill person exposed to a variety of treatments would return to sanity (U.S. Department of Health and Human Services 1999, Grob 1983). Mann, chair of the legislative committee in charge of enumerating the insane and developing a
recommendation for the state, was instrumental in securing funds within the legislature for the erection of a state lunatic hospital in Worcester in 1830. Dix’s crusade for the outcast mentally ill and their care began after witnessing cruel conditions and treatment of mentally ill persons in local jails, prisons, and poorhouses in the early 1840’s (Grob 1994, Morrissey and Goldman 1984). Dix advocated for the creation of asylums under the auspices of state government to provide humane treatment of mentally ill persons. She was in large part responsible for the creation of 32 state mental hospitals and for the expansion of several others (Grob 1994).

Over time, state mental hospitals (SMH), meant to be asylums, became overcrowded, understaffed, under-funded and inhumane places to reside. They became warehouses for the mentally ill where patients were neglected and where harsh discipline and brutal conditions prevailed (Rothman 2002, Gamwell and Tomes 1983). Although state mental hospitals no longer fulfilled their mission to be asylums, much less to cure the mentally ill, the public continued to endorse them.

**Mental Hygiene**

The second era of mental health reform, the “Mental Hygiene Movement” (early 20\textsuperscript{th} Century), was set into motion by criticisms of state mental hospitals by many different groups, from psychiatrists to former mental patients (Dixon and Goldman 2003, Rothman 2002, U.S. Department of Health and Human Services 1999, Goldman and Morrissey 1984). A major driving force initiating reform was a book by a former mental patient, Clifford Beers, *A Mind That Found Itself* (1908). This book detailed conditions in American state mental hospitals, discussed the etiology of mental
illness as then understood, and called for outpatient treatment of the mentally ill. The Mental Hygiene Movement advocated for creation of outpatient clinics, mental hospital improvement, and aftercare (Thompson 1994).

The Mental Hygiene Movement was part of an era in which great authority was placed in science, rather than in morality as in the previous era. Disease was believed to be the result of hereditary and environmental conditions, and its eradication depended upon scientific knowledge (Morrissey and Goldman 1984, Grob 1983). Dr. Adolf Meyer played a critical role in this movement through his scientific examination of the interconnections between the mind and body in the etiology of mental illness (Rothman 2002, Morrissey and Goldman 1984, Grob 1983). Meyer advocated for early detection and prevention of mental illness through outpatient clinics. Meyer’s ideas about psychoanalysis coupled with reports of inhumane conditions in SMHs, led to a dual system of care providing private treatment largely in outpatient settings for the affluent and inpatient treatment in SMHs for the poor (Thompson 1994, Grob 1983).

State mental hospital superintendents, who were concerned about the survival of the state mental hospital, were a major barrier to the success of the Mental Hygiene Movement. They were reluctant to contribute any of their state funding for the creation of publicly funded community clinics. In a time when hospital facilities were declining and overcrowding was a major problem, state mental hospital superintendents needed to preserve their funding for the survival of their institution (Rothman 2002).

The second arm of this reform effort, the release or parole of cured mental patients or patients deemed suitable for community treatment, was also blocked by state
mental hospital superintendents who were reluctant to release cured or curable patients because the institution was dependent on these patients’ labor for the daily maintenance of the hospital (Rothman 2002). As a result, the organization that was created to cure the mentally ill hindered reform efforts and continued to subject mentally ill persons to inhumane conditions and exploitation.

Reform efforts continued, but goals of asylum reform vanished and mentally ill patients in state mental hospitals were essentially forgotten. Strides were made in the private sector with the development of outpatient clinics for higher functional, less serious mentally ill persons. Thus, the Mental Hygiene Movement became one of early detection and prevention for less serious cases with little focus on the severely mentally ill (Rothman 2002, Thompson 1994).

**Deinstitutionalization and the Community Mental Health Centers Era**

From 1950 to 1970, the state mental hospital population decreased from 600,000 to 200,000 (Cutler, Bevilacqua, and McFarland 2003, Lamb and Weinberger 2001, Morrissey and Goldman 1984). Two events occurred that paved the way for this deinstitutionalization and the accompanying Community Mental Health Center Era which were fueled by exposes of journalists and scholarly studies about SMHs’ inhumane conditions and deleterious effects on the severely mentally ill patients they were supposed to help (Rothman 2002, Grob 1994, Rothman 1990 Goffman 1961). First, in the 1950’s, the discovery of major tranquilizers led to the ability to calm mentally ill patients and reduce their length of hospitalization (Cutler et al., U.S. Department of Health and Human Services 1999, Gamwell and Tomes 1995, Morrissey
Second, there was an increase in the number of outpatient mental health providers and facilities which increased the opportunity for mentally ill persons to receive treatment in the community (Cutler et al. 2003, Morrissey and Goldman 1984).

Deinstitutionalization and the Community Mental Health Movement gained momentum in 1963 with the passage of the Community Mental Health Centers Act (CMHCA). The intent of the CMHCA was to shift mental health care from state mental hospitals to community mental health centers, a major change in the locus of treatment. In this change, mental health services shifted from a centralized, inpatient process occurring at state hospitals to a decentralized, outpatient process occurring in the community involving thousands of public and private mental health providers (Cutler et al. 2003, Morrissey and Goldman 1984).

This new dispersed community mental health system made it difficult to obtain services especially for previously hospitalized mentally ill patients and persons with severe mental illness residing in the community (Morrissey 1999). While the provision of services in the community rather than the hospital made it more difficult for persons with serious mental illness (SMI) to obtain services, it brought services to persons with less serious disorders, a population not previously served. As a result, mental health centers treated those with less serious mental illness while those with severe mental illness went untreated and were often reinstitutionalized in jails or nursing homes, or became homeless (Jackson 2001).
Community Support

The fourth cycle of reform, Community Support Program, targeted persons with severe mental illness. Reacting to the inability of community mental health centers to provide treatment to the severely mentally ill, the National Institute of Mental Health launched the Community Support Program in the late 20th century (U.S. Department of Health and Human Services 1999, Morrissey and Goldman 1984), which would develop support systems in the community in order to expand social services and treatment to persons disabled by severe mental illness. Unlike earlier reforms targeted at serving those with acute mental illness or preventing mental illness, the Community Support Program aimed to provide appropriate medical and social services to persons with severe mental illness so that they could become functioning members of society (Goldman 1999, U.S. Department of Health and Human Services 1999).

A number of initiatives were begun to deal with the needs of persons with severe mental illness such as housing assistance, vocational training, social skills training, and other rehabilitative programs designed to improve behavioral functioning in, for example, activities of daily living, social functioning, family relationships, and leisure time (Drake et al. 2003, Goldman 1999, Thompson 1994). New policies were also implemented that addressed disability payments, housing, transportation, and social welfare (Goldman 1999). Programs were developed to address younger age groups early in their psychosis and the needs of increasingly obvious homeless mentally ill. Although gains were made, budget cuts which came almost as soon as the
programs began forced curtailment of these services and threatened the viability of all treatment services for the mentally ill (Thompson 1994).

The depopulation of state mental hospitals, budget cuts and lack of available community services for persons with severe mental illness (PSMI) led to the arrest and incarceration of PSMI who used to be hospitalized (Teplin 1990). This practice, often referred to as the criminalization of the mentally ill, has persisted to the point today that urban jails in some states house more persons with mental illness than do their state mental hospitals (Torrey 1995). Lack of adequate treatment for these offenders in jail and lack of services in the community for mentally ill offenders out of jail have led to a revolving door syndrome where mentally ill persons shift between jails, hospitals and homelessness (Steadman et al. 1999; Lamb et al. 1996; Teplin 1990).

According to a 1998 Department of Justice report, our jails and prisons housed 283,800 individuals with mental illness (Ditton 1999). This number represents 16.2% of the states’ prison inmates, 7.4% of federal inmates, and 16.3% of those housed in local jails (Ditton 1999). In addition to the mentally ill in jails and prisons, there were 547,800 mentally ill persons on probation and parole in 1998 (Ditton 1999).

Recognition of these problems led to creation of diversion programs (Petrila et al. 2000; Steadman et al. 1999, Steadman et al. 1995). One such diversion program, MHC, modeled after drug courts, was created by the judicial system in an attempt to address the growing numbers of persons with severe mental illness residing in local jails. MHCs aim to divert mentally ill offenders out of jail and into court mandated treatment services. In the next chapter, I describe the origin of specialty courts that
began with the juvenile court in 1899. I then discuss two modern specialty courts: drug courts and mental health courts.
CHAPTER 3
DIVERSIONARY SPECIALTY COURTS: HISTORICAL AND MODERN APPROACHES

This chapter examines several diversionary specialty courts, one older (juvenile court) and several new approaches (family, drug and mental health courts), used by the criminal justice system to “treat” rather than punish certain types of offenders. Before I describe these courts and their approach, I briefly discuss the Progressives’ philosophy of crime control, rehabilitation, which came to the forefront in the late 19th and early 20th centuries and was the impetus for the development of the first diversionary court, juvenile court. Next, I briefly talk about the development of the juvenile court because it was the first specialty court designed to hear cases of offenders meeting a specific criteria, in this instance children and youth. This is followed by a discussion of the early criticisms of the juvenile court because each criticism needs to be carefully considered today as we are seeing resurgence in the rehabilitative ideal exemplified in modern specialty courts (e.g. drug and mental health courts). Last, I discuss the more recent establishment of other specialty courts, examining their similarities with and differences from the juvenile court.

The Juvenile Court

Similar to changes in treatment philosophy of persons with mental illness, beliefs about the social control of criminal offenders underwent changes during the Progressive Era (Rothman 2002). Progressives had new ideas about crime control and delinquency; they aimed to modify the goal of criminal punishment from hopeless isolation to treatment of offenders (Rothman 2002). Their central tenant was that crime
was caused by social and psychological deficits of offenders which could be eradicated with appropriate treatment (Rothman 2002, Ryerson 1978). This approach called for individualized justice where defendants’ sentences were indeterminate and varied based on treatment needs. As such judges were afforded wide discretion in the length of time they sentenced offenders justified by the amount of time needed for rehabilitation, not the severity of the crime committed. Furthermore, prison wardens, parole boards, and probation officers had discretion in determining when offenders had completed treatment services and were successfully rehabilitated (Rothman 2002).

Progressives’ call for social policy reform included new methods aimed to control juvenile delinquents. Progressives believed the state had three choices in handling juvenile offenders: 1) prosecute juveniles as adults and incarcerate them with adults, thus ensuring they became adult criminals; 2) refrain from acting, letting juvenile delinquents continue their lives of crime in the community; or 3) provide a middle ground, offering treatment for juvenile offenders instead of punishment. In order to offer juvenile offenders treatment, Progressives called for the development of a special court to hear cases of juveniles on an individual basis using flexible procedures (Rothman 2002) allowing the court to address juveniles, their problems, and their treatment on an individual basis (Finckenauer 1984, Lemert 1971). The court was to act in loco parentis, take the place of the parent if the parent was unable to properly raise his/her child (Forst 1995, Finckenauer 1984, Lemert 1971). Acting as a parent, juvenile courts were to act benevolently, protectively, and in the best interest of
youthful offenders, not subject them to criminal trials or the harsh conditions of jail and/or prison (Forst 1995, Finckenauer 1984).

Indeterminate sentences used under this system were a logical extension of the belief that youthful offenders were sick and could be cured through rehabilitation. Thus, sentence length was based upon the length of time needed to “cure” the offender where judges relied on information provided to them about juveniles’ personal histories, families, home situations, personalities, and maladjustments to determine their likelihood of reform. Such sentencing practices gave judges wide discretion in sentencing minors ranging from community monitoring to incarceration until the age of majority (usually 18 years of age). As such, the focus was on the offender not on the crime s/he committed and punishment was imposed that had no bearing on the nature of the offense; rather the sentence was based on the rehabilitative needs of the child (Forst 1995).

Despite these good intentions, the juvenile justice system has a history of failures which have been widely criticized. Many in the field of juvenile justice would say that the rehabilitative model of the juvenile justice system has fallen short in many ways (Rothman 2002, Lundman 2001, Bortner 1982, Lemert 1971). First, although the system operated under the guise of benevolence and treatment, youthful offenders often spent more time in detention and/or treatment than they would if they were sentenced based on the severity of the offense committed (Rothman 2002, Lemert 1971). Furthermore, promised rehabilitation was often not offered or was inadequate and did not improve offenders’ circumstances (Rothman 2002, Bortner 1982, Lemert 1971).
Second, juveniles’ individual rights were often violated under the pretext of helping them because it was believed that the state was acting in their best interest (Forst 1995, Finckenauer 1984). Juveniles were not given due process protections (e.g. the right to counsel or the right to a trial by jury) because it was argued that juvenile court was not a criminal proceeding (Rothman 2002, Lemert 1971). As a result, some juveniles were held without proof of any offense being committed (Lemert 1971).

Third, the discretion afforded judges and other juvenile justice personnel assumed that all would act in the best interest of the child and would be experts not only in criminal law but also in moral law, psychology, and child welfare (Finckenauer 1984); but the discretion often resulted in discrimination based on race, gender, and social class (Rothman 2002, Lemert 1971, Lemert 1969). Fourth, there was a loss of dignity as family members’ personal lives were invaded and made part of official court records (Flicker 1977).

Fifth, juvenile courts may have allowed for an over-reach of the law, net widening, where police officers, magistrates, and prosecuting attorneys arrested and charged juvenile offenders who would have been otherwise let go were it not for the existence of a specialty court designed to hear their cases (Finckenauer 1984). If net widening occurred, then juvenile offenders who would normally have had their charges dismissed were referred to court, acquired a court record, and were stigmatized by the process which impacted their identities and their abilities to obtain employment, schooling, and participate in the military (Bortner 1982, Lemert 1971). Last, some critics argue that juvenile courts and their emphasis on community corrections are no
more successful than traditional methods of incarceration at reducing re-offending (Forst 1995, Finckenauer 1984). Research on the effectiveness of juvenile courts in reducing reoffending provides mixed results, neither clearly supporting the success nor condemning the juvenile justice system.

The criticisms of the juvenile courts are relevant to the establishment of modern specialty courts because they are based in part on the rehabilitative ideal and have similar operating principles as the juvenile court. The next section of this chapter reviews the development of more modern versions of specialty courts, their proliferation, and their similarities and differences as compared with juvenile court.

**Modern Specialty Courts**

Much like juvenile courts, the new specialty courts (e.g., family, drug, and mental health courts) were developed in response to a need to deal effectively with a population that needed help by addressing the underlying reason the person offended. In so doing, specialty courts were to reduce recidivism thereby ensuring public safety, reducing court caseloads, and reducing criminal justice system costs. To accomplish these goals, today’s specialty courts use a problem solving approach premised on therapeutic jurisprudence to offer a more humane process and meaningful solution of court cases for defendants who suffer from mental illness or substance abuse problems (Casey and Rottman 2000).

As previously discussed, therapeutic jurisprudence asserts that legal processes and decisions should promote the psychological and physical well-being of defendants (Wexler and Winick 1991). Two rationales underlie the therapeutic jurisprudence
model: 1) If the underlying problem is addressed, recidivism is reduced which in turn protects the community from future criminal acts by these same offenders; 2) therapeutic court processes can limit negative effects upon defendant well being, advancing the goal of offender rehabilitation; and 3) criminal punishments should not be suitable for some types of offenders whose illness/problem contributed to their offense (Wexler and Winick 1991, Wexler 1996).

Problem solving courts have proliferated during the last 16 years from the development of the first drug court in 1989, in Broward County, Florida, to the creation of speciality courts designed to deal with issues related to family conflict, addiction, domestic violence, driving under the influence, and mental illness (Petrila 2003, Berman and Feinblatt 2001, Kondo 2001, Goldkamp and Irons-Guynn 2000). Such expansion occurred for two reasons:

1) Court dockets are overcrowded because certain types of offenders cycle in and out of the criminal justice system, and

2) Criminal.justiced personnel realized that a “one size fits all” approach to criminal offending did not work in some situations, especially those involving human and social problems (National Judicial Institute 2005, Berman and Feinblatt 2001).

As a result, specialty courts were designed using a therapeutic jurisprudence approach which called for the courts to respond to cases holistically in partnership with community treatment agencies in an attempt to provide better outcomes for defendants suffering from special problems (Bernman and Feinblatt 2001). As such, therapeutic
jurisprudence is different from rehabilitative efforts in the criminal justice system widely seen prior to the 1980’s. Whereas rehabilitation focused on providing treatment for offenders after criminal processing (Albanese 2000), therapeutic jurisprudence focuses on a therapeutic court process where judges and court team members collaborate to decide upon the best course of action to bring about the most favorable outcome for defendants with “special” problems (Kondo 2001, Wexler 1996, Wexler and Winick 1991).

The implementation of specialty courts varies not only by target population but also in process and procedure. Nonetheless, there are several common elements in each:

1. Informal, non-adversarial court proceedings allow judicial attention to defendants’ needs;
2. Non-traditional roles of court personnel allow judges and attorneys to work together to craft the best treatment plan for defendants;
3. Informed decision making and collaboration between criminal justice personnel and community agencies permit the creation of individualized treatment plans to improve defendant functioning; and
4. Judicial monitoring permits the judge to use his authority to mete out rewards and sanctions for compliant and non-compliant behavior (Casey and Rottman 2003, Berman and Feinblatt 2001, Goldkamp and Irons-Guynn 2000).

The use of a non-adversarial approach to decision-making and case
processing, calls for attorneys to craft interventions that meet defendants’ personal, health, and social needs in cooperation with the court team rather than trying to have them found not guilty. To these ends, attorneys find themselves doing little traditional advocacy work. Rather than try to prove clients’ innocence, attorneys are expected to co-operate with other court team members and share all pertinent information, even if it is negative (Hiday et al. 2005, Steen 2002, Watson et al. 2001, Goldkamp and Irons-Guynn 2000).

Not only defense attorneys’ role but also their focus changes to one where they are concerned with the end result: their clients’ functioning in the community in the future, rather than focusing on due process and the facts of the case during trial (Thompson 2002, Clarke 2001, Kaye 1998). In this new role of working with a team of court professionals and social service providers, defense attorneys share a common goal: to determine the best treatment plan for the offender. This new role is different from defense lawyers’ tradition role of zealous advocate defending their clients, ensuring due process, focusing on the facts of the case, and striving to have their clients found not guilty. In specialty courts, the role of defense lawyers is somewhat passive and may cause discomfort for them.

The use of a non-adversarial, team approach has also created a new role for judges. Whereas in TCC, judges are impartial fact finders of evidence that emerges from counsel questioning (Poythress et al. 2002); in drug court they are part of a team process that involves discussing all information about a case and the underlying problems that may have led to the criminal act and to noncompliance with court
mandates. In this setting, judges play an active role in the treatment process, that is, they and other team members outline treatment options and marshal services to ensure defendant compliance through a period of court monitoring lasting at least six months (Burns and Peyrot 2003, Denckla 2002, Hanson 2002, Wexler 2001, Kaye 1998).

The last critical process of the specialty court model is judicial monitoring, supervision, and encouragement that are used to ensure defendant compliance (Hiday et al. 2005, Bean 2002, Watson et al. 2001, Goldkamp and Irons-Guynn 2000). In these courts the role of the judge is to build rapport with defendants and give priority to their protection, guidance, and treatment (Burns and Peyrot 2003). In carrying out this role during exchanges with defendants, judges build relationships, reinforce positive behavior, and motivate defendants to remain compliant. Control over defendant behavior is gained and maintained through incentives for positive behavior (e.g. verbal praise or a reduction in court monitoring sessions) and sanctions for non-compliance behavior (e.g. jail time or more frequent drug testing) (Hiday et al. 2005, Burns and Peyrot 2003, Bean 2002).

Proponents of specialty courts believe these courts are more successful gaining and maintaining compliance and rehabilitating defendants than simply placing them on probation with certain treatment requirements. Unlike probation, specialty courts provide defendants who have underlying problems (e.g., drug use or mental illness) monitoring, support and supervision by a more powerful authority, links to services often needed for them to remain engaged in treatment, and a positive resolution of criminal charges for those that successfully complete the program. Where services may
also be required as a part of probation, specialty courts require that defendants voluntarily opt into the court agreeing to mandated services as part of successful completion of the program (Hiday et al. 2005, Steen 2002, Bean 2002, Petrila 2001, Watson et al. 2001, Goldkamp and Irons-Guynn 2000). Furthermore, services may be mandated as a part of successful completion of both specialty courts and probation, but probation officers are not able to marshal services for defendants while specialty courts are (Hiday et al. 2005, Petrial 2001, Watson et al. 2001, Goldkamp and Irons-Guynn 2000, Lamb, Weinberger, and Gross 2001).

Advocates for specialty courts hope that these courts will provide better outcomes while protecting individual rights and providing public safety (Winick and Stefan 2005, Berman and Feinblatt 2001, Rottman 2000). However, specialty courts are so new that enough time has not passed to allow researchers to collect data using adequate follow up periods to determine their effectiveness. In addition, promising results do not insulate these specialty courts from scrutiny and criticism similar to that aimed at the juvenile courts. The following discussion examines each criticism of the juvenile court as it relates to modern specialty courts; however, little research to date has examined these issues.

First, critics charge that defendants in juvenile court serve more time in detention and/or treatment than they would if they were sentenced in the traditional criminal justice system (Rothman 2002, Forst 1995, Lemert 1971). To date, no research on modern specialty courts addressed this issue. However, because specialty courts are designed to serve nonviolent, chronic offenders, it is likely that defendants
will spend more time participating in mandated treatment plans, typically lasting one year, than if they were sentenced in TCC based upon the severity of their current offense and more time than if charges were dismissed or pleaded down (United States Sentencing Commission 2005, North Carolina Sentencing and Policy Advisory Commission 2004).¹

Another critique of the juvenile justice system that has not been fully addressed in research on modern specialty courts is whether rehabilitation is offered. Most modern specialty courts depend on community programs and resources for treatment of their participants so treatment services they are able to marshal for defendants will vary by county resources (Watson et al. 2001, Steadman et al. 2001, Petrila et al. 2000). A lack of existing programs or programs with long waiting lists could delay mandated treatment or make it impossible. However, research to date on drug courts does not indicate access to treatment services is a problem. Further, only one study to date on MHCs indicates that obtaining community treatment services was problematic for some defendants (Boothroyd et al. 2005).

A third question raised about specialty courts is their ability to maintain defendant’s individual rights. There is no evidence to date that indicates that specialty courts violate individual rights. Several procedures in specialty courts protect against this criticism: all defendants are appointed an attorney if they can not afford one, and

¹ U.S sentencing guidelines state the maximum time incarcerated for a misdemeanor is up to twelve months depending on the defendant’s criminal history. However, a sentence of one year is only imposed for class A1 misdemeanors and/or for defendants with more than 6 prior convictions. In the state of North Carolina punishment of misdemeanants ranges from 0 to 150 days in jail depending on an offender’s criminal history and is less than specialty court monitoring and treatment lasting one year.
all voluntarily opt into the court, and have the right to withdraw from the program and return to TCC at any time. Even though participants opt into the court, critics question the coercive nature of the court. A central question is the following: Are there procedures that ensure that offenders freely opt into the court and are informed of their possible outcomes in TCC and the specialty court before making such decisions? This question remains unanswered, but is beginning to be addressed in several specialty courts that allow defendants to “try out” the program while their case is pending as is done in Seattle and Portland. This trial period gives defendants a chance to decide whether or not they want to participate in the specialty court and also gives their attorneys time to investigate the strength of the case against them (Feinblatt and Denckla 2001, Goldkamp and Irons-Guynn 2000, Trupin and Richards 2001).

A fourth question for specialty courts to consider is whether the use of individualized treatment plans lead to discrimination. To date, there is no research on specialty courts that addresses this topic. Historically, it has been shown in the juvenile justice system that individualized justice can and often does lead to longer sentences and more negative effects for minority groups (Rothman 2002, Lemert 1971, Lemert 1969). Because specialty courts use individualized treatment plans and permit judicial/court team discretion in determining when successful completion of the program has occurred, it is imperative that research address whether discrimination occurs.

Another possible challenge for specialty courts, similar to the juvenile court, is that they may create a loss of dignity as defendants’ personal lives become part of court
records. Research on drug courts and MHCs indicates that open court hearings are often brief with little mention of defendants’ underlying problems (Hiday et al. 2005, Steen 2002, Goldkamp and Irons-Guynn 2000). During drug and MHC open court hearings, the judge and court team members only discuss topics necessary for adequate behavioral monitoring such as treatment services attended, compliance, and at times “dirty” drug tests. Exchanges about other troubles during the month are discussed at times, but are typically initiated by the defendant. Further, in some MHCs judges and court team members refrain from using psychiatric labels and never refer to defendants as persons with mental illness in open court (Hiday et al. 2005, Goldkamp and Irons-Guynn 2000).

Critics state that specialty courts may lead to net widening or the extension of government’s social control over persons who otherwise would not be brought into the court. Simply stated, does the implementation of specialty courts lead to arresting and charging of more offenders who meet their eligibility criteria who would have been otherwise “let go” if the courts were not in existence? Only one study to date points to net widening in drug courts; as noted in the increase in drug filings since the implementation of one drug court in Denver (Hoffman 2002). However, an increase in drug filings from 1991 to 1998 is not necessarily related to the inception of the drug court. Other factors could have contributed to the increase in filings such as the crack down on drug offenses that began in the 1980’s and continues today. In addition, there is no evidence to date that MHCs have led to the arrest of more mentally ill offenders who otherwise would not have been arrested (Winick and Stefan 2005).
Last, is the criticism that juvenile courts are no more effective than incarceration. Evidence to date on specialty courts indicates that drug courts, the first modern specialty court, are effective in keeping offenders in treatment, reducing drug use, and reducing recidivism (Gottfredson and Exum 2002; Berman and Feinblatt 2001; Spohn, Piper, Martin, and Frenzel 2001; Peters and Murrin 2000; Belenko 1998). Evidence that MHCs are effective is preliminary, but does show encouraging results (Christy, Poythress, Boothroyd, Petrila, Mehra 2005; Cosden, Ellens, Schnell, and Yamini-Diouf 2005; Herinckx, Swart, Ama, Dolezal, and King 2005; Hiday et al. 2005, Cosden, Ellens, Schnell, Yamini-Diouf, and Wolfe 2003; Trupin and Richards 2003; Boothroyd, Poythress, McGaha, and Petrila 2003; Poythress, Petrila, McGaha and Boothroyd 2002; Berman and Feinblatt 2001).

These issues as well as those related to the effectiveness of such courts require additional research before definitive answers can be given. In the following chapter, I provide recent qualitative and quantitative research on drug and MHC processes and effectiveness as a first step in this endeavor.
CHAPTER 4

LITERATURE REVIEW: DRUG COURTS AND MENTAL HEALTH COURTS

MHCs, a 1997 innovation, are so new that only four empirical studies have been published on their criminal recidivism effects. Drug courts, their precursors, have more outcome evaluations and offer a useful point of comparison as MHCs are modeled after them. However, little research exists on the causal links between drug court operation and defendant outcomes. This chapter first reviews the scant published qualitative research on drug and MHC processes that theoretically lead to positive outcomes for defendants, then empirical studies on drug and MHC effectiveness in reducing criminal recidivism are presented.

Qualitative Research

Drug Courts

Steen (2002) examined two county drug courts in the western United States for a period of six months during 1998. She conducted courtroom observations and interviews with court personnel including the public defender, prosecutor, and drug treatment coordinator to examine the power dynamics between court team members and defendants and their impact on defendant compliance during drug court participation, treatment and monitoring. Field notes and interviews were coded and analyzed using Atlas-ti, a software program for qualitative data analysis. Analyses indicated that drug court team members used a team approach to decision making which was facilitated through pre-court team meetings. In these meetings, court team
members worked together to formulate the best treatment plan for each defendant on the docket. Team members agreed on the best course of action that was fostered by the stability of court team members over time. Steen (2002) indicated that when drug court team members remained the same over extended periods, team member came to know and respect each other and developed working relationships with little conflict. The more familiar the drug court team was with one another, the more likely they were to reach a consensus (Steen 2002).

Steen’s research pointed out that team members, through the use of a non-adversarial team approach in court and by way of manipulating the court setting, were able to get defendants involved in the court process which also influenced their willingness to buy into the treatment process. The first step in this approach was to make defendants feel like they were involved in the decision making process which was done through the manipulation of the courtroom setting. In both courts observed as part of this study, the defendant stood in the middle of the two attorneys, a method which attempted to break the physical barriers between defense attorney/defendant and the prosecuting attorney; and they stood close to the judge, a technique used to bring the judge into the decision making process. She argued that by manipulating the “traditional” courtroom setting into a more informal venue with all members of the team working with the defendant to arrive at decisions, defendants came to feel they were part of the process which influenced their investment in the court program.

Another factor Steen concluded was important in getting defendants invested in the court process was their involvement in the decision to participate in drug court. In
making this decision, defendants in the two courts became involved in the decision making process and their status changed from defendant to client. Steen pointed out that this shift was critical to drug courts successful implementation because “clients” were individuals who were served by an organization thereby making the client a part of the team.

Another component of this study was the observation of methods used by judges in the courtroom to obtain defendant compliance. Judges use rewards, encouragement, and sometimes warnings and sanctions. Judges’ use of these methods was indicative of normative power, the allocation of symbolic rewards (e.g. acceptance and positive responses), to get defendants involved and invested in their treatment and to ensure their compliance. Critical to the success of this approach was recognizing small steps, emphasizing them, and showing defendants other participants’ successes. They served to keep defendants involved in the process leading to defendants becoming “morally involved” in treatment process and better defendant outcomes (Steen 2002). Judges also attempted to maintain a positive focus even in the face of non-compliance and sanctions. From her observations Steen (2002) concluded that when sanctions were necessary, judges often tried to focus on the overall goal of defendants’ treatment success not their relapse or misbehavior.

The last key finding from Steen’s study was that defendant motivation and “buy in” to the treatment program were critical to the drug court team’s ability to impact defendant behavior and render positive outcomes. Steen (2002) examined defendants’ motivation and dedication to drug courts’ goals and its impact on defendant outcomes.
Initially, defendants agreed to participate and complied with their treatment plan for calculated reasons. Defendants considered their relative gain (dismissal of charges) and the level of effort required to achieve it. Steen (2002) found that this calculated involvement evolved over time into an investment and a moral involvement in the drug court’s goals which led to more successful outcomes including reduced substance use and recidivism.

A second qualitative study on drug courts by Burns and Peyrot (2003) examined activities of participants in California drug courts and their differences from participants in traditional criminal courts. Observations of court hearings (N=75) were conducted in two southern California drug courts; one was in an affluent white community and the other was located in a low-income African American and Hispanic community. Most defendants observed were in their 20’s and 30’s, with a substantial number being female. Detailed notes were taken on the interactions in court hearings which were predominately between the judge and the defendant. Structured interviews were also conducted with four current or former drug court judges presiding in the observation sites. Additionally, informal interviews were conducted with prosecutors and defense attorneys in the two study sites on the days observations were conducted.

These researchers indicate that judges in both drug courts did not deem all defendants who met the admission criteria for drug treatment court as suitable participants for the drug treatment program. Through exchanges made in open court between judges and defendants, judges determined that while some defendants were motivated to change their drug using behavior, not all were inclined to do so.
Therefore, during court hearings, judges made every effort to speak with defendants about their motivation and incentive to change in an effort to weed out defendants whose motivation for being in the court was simply to avoid jail.

For noncompliant defendants, time was allowed where they could account for their behavior followed by an individualized sanction from the judge with the purpose of “teach[ing] them [defendants] a lesson or effect[ing] some change” (p. 423). Such sanctions were given on an individual basis determined by a defendant’s explanation of the infraction, willingness to accept responsibility for his actions, and expressions of remorse. Burns and Peyrot (2003) pointed out that the purpose of the dialogue and remedy for noncompliant defendants in drug courts differs from that of defendants in traditional criminal court. Sanctions in drug treatment court were designed to motivate defendants to remain in the program and engage in treatment while sanctions in traditional criminal court were designed to punish current misbehavior and deter future criminal behavior.

Further analysis of observation data revealed that drug court defendants pass through several stages during their participation in drug treatment court including a trial phase (initial assessments and evaluations by treatment providers and the judge about defendants’ potential for continuing in the program) followed by orientation (focusing in stabilizing and assessing defendants’ adaptation to treatment), intensive treatment (including group and individual treatment sessions), and transition/preparation for community living (emphasizing education, vocational rehabilitation, and daily living skills). However, advancing through these stages of the drug court treatment program
is not always linear; that is defendants may have set-backs and/or receive sanctions for noncompliance and be returned to a previous phase of the treatment process by the judge.

Burns and Peyrot’s (2003) findings showed that for the two drug courts studied the traditional approach to case processing as used in TCC was modified. Contrary to TCC, drug courts aim to treat offenders using an individualized approach rather than punishment. These two drug courts used a “tough love” approach expressing their desire to help defendants recover while holding them accountable for their actions hoping to aid defendants in becoming drug-free, law-abiding citizens (Burns and Peyrot 2003). Study results indicated that judges had discretion in formulating defendants’ treatment plans and in the methods used to hold defendants accountable for their behavior (Burns and Peyrot 2003). The authors conclude by raising an important issue: does the drug court process lead to an expansion of the state’s supervision, monitoring, and control over defendants’ lives, but they do not provide any evidence supporting or refuting this issue (Burns and Peyrot 2003).

**Mental Health Courts**

In an examination of the emergence of MHCs, Goldkamp and Irons-Guynn (2000) observed the first four MHCs in the United States. Observations in Broward County, Florida; King County, Washington; Anchorage, Alaska; and San Bernardino, California were used to provide insight into each MHC’s target population, procedures, treatment approaches, and successes and failures. Much of the descriptive information of court process and procedure including similarities and differences between the courts
is presented in Chapter One; therefore, it is not reviewed here. Rather, this discussion of Goldkamp and Irons-Guynn’s (2000) research focuses on issues that came to light during the implementation of the first four MHCs and how each concern is similar or different from drug court implementation.

Goldkamp and Irons-Guynn (2000) articulate five issues that arose with the emergence of MHCs as compared with drug courts including: early identification of MHC candidates, voluntary court participation, definitions of success, responses to participant behavior, and linkages with community services and resources. Court observations indicate the first four MHCs share a similar goal with other specialty courts (e.g. domestic violence and drug courts): to identify eligible defendants early in criminal processing to avoid the damaging experience of arrest and possible incarceration and replace this experience with appropriate treatment services (Goldkamp and Irons-Guynn 2000). This study indicates that MHCs may face a challenge meeting their goal of early identification while ensuring adequate and fair screening and mental health evaluations of potential defendants prior to their admission into MHC. Goldkamp and Irons-Guynn (2000) point out that it is difficult to rush mental health assessments especially when communication with some mentally ill defendants is difficult.

A second concern Goldkamp and Irons-Guynn’s (2000) observations bring to the forefront is that participation in the four MHCs was voluntary, but it was unclear whether defendants opting into the MHC were competent to make this decision. Voluntariness is an issue faced by other specialty courts; however, it is a more critical
challenge in MHCs because they must address competency issues. The authors of this study examined definitional issues of voluntary participation and determined it meant that a defendant was legally competent, understood the proceedings, and was able to make reasonable decisions (Goldkamp and Irons-Guynn 2000).

Comparing drug courts to mental health courts, Goldkamp and Irons-Guynn (2000) noted a third area of concern: defining success. Most drug court defendants have a similar starting point, drug addiction, which leads to clearly defined treatment requirements (e.g. drug testing with a specified frequency, completion of treatment programs, payment of fees, etc.) and easily definable successes (abstinence) (Goldkamp and Irons-Guynn 2000). But, MHC participants suffer from different illnesses with varying symptoms and unlike drug court participants they lack a common starting point which not only complicates the development of treatment requirements, but also makes the identification of success more difficult. Therefore, requirements for successful completion of MHC may vary considerably from one defendant to another.

Fourth, Goldkamp and Irons-Guynn (2000) point out that MHCs may need to modify the system of rewards and sanctions used by drug courts to reward progress and discourage misbehavior. The authors indicate that drug court defendants who are going through the treatment process typically respond well to a structured system of incentives and sanctions, but this same system of rewards and sanctions may not be appropriate for defendants with mental health disorders. Goldkamp and Irons-Guynn (2000) specify the necessity of MHC judges to expand their range of positive responses and incentives to motivate MHC defendants because they, depending on their disorder
and its severity, may require more encouragement and support to get them involved in treatment than drug court defendants.

Last, Goldkamp and Irons-Guynn (2000) discuss the linkage of the MHC with community services and resources and what impact a shortage of community resources could have on the effect of the MHC. The four MHCs observed in their study had linkages with community mental health services and relied upon their established services for the treatment of MHC defendants; but the established services tend not to be adequate to take on and address problems of defendants. MHCs that serve a large number of mentally ill defendants may encounter a lack of adequate or available treatment services in the community making it difficult to offer services to the defendants they seek to help. All of the MHCs observed by Goldkamp and Irons-Guynn (2000) had identified large numbers of defendants who were eligible for the MHC and who were in need of services, and all four courts indicated the resources in their community for persons with mentally illness were under-funded, insufficient, and/or inadequate to treat MHC defendants effectively.

In summary, qualitative research on drug and MHCs is sparse. I was only able to locate three qualitative studies, each of which observed different mechanisms by which these courts are theoretically linked to their intended outcomes. Research conducted by Steen (2002) examined how drug courts attempt to get defendants to buy into and become involved in treatment which in effect leads to successful outcomes. Burns and Peyrot (2003) studied two drug courts’ approaches to criminal processing. Their observations revealed that drug courts as compared to TCC used a different
approach, tough love, to criminal processing where the drug court mandates treatment services and holds defendants accountable for their actions. The last qualitative study reviewed by Goldkamp and Irons-Guynn (2000) on the first four MHCs in the United States provided an overview of the process and procedure used in these courts (as discussed in chapter one) and concluded with several issues that the implementation of these MHCs raise as compared to drug courts.

**Effectiveness of Drug Courts: Quantitative Data**

Now, I turn to a discussion of quantitative research that examines drug courts’ effectiveness in reducing recidivism. Most early drug court evaluations found drug courts to reduce recidivism\(^2\), but were criticized for not using comparison groups, having short follow-up periods, and failing to examine recidivism after program completion (United States GAO 1997). Without comparing drug court defendants to a similar group of defendants who did not participate in drug court and without adequate follow-up periods, it is difficult to determine whether drug courts produce their intended outcome of reduced recidivism. More recent drug court evaluations address these shortcomings by incorporating comparison groups, longer follow up periods, and/or multiple indicators of recidivism (Listwan, Sundt, Holsinger, and Latessa 2003; Wolfe, Guydish and Termondt 2002; Gottfredson and Exum 2002; Bavon 2001; Spohn, Piper, Martin, and Frenzel 2001; Peters and Murrin 2000).

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\(^2\) Two studies found no difference between drug court participants and control groups (Granfield, Eby, and Brewster 1998; Peters and Murrin 1998).
Wolfe et al. (2002) examined re-arrest among drug court participants/non-participants and graduates/non-graduates in San Mateo County, California, using a two-year follow-up period that began after completion of the drug court program or after disposition for the current charge for the comparison group (Wolfe et al. 2002). The drug court sample comprised all persons eligible for the drug court from November 1995 to October 1998 (n=618). The comparison group comprised defendants processed in superior court between January 1995 and April 1995, and included only persons who would have met eligibility for the drug court had it been in existence at that time (n=75). Controlling for possible confounding factors in multiple regression, there was not a significant difference between drug court participants and non-participants (39% and 37%); however, drug court graduates were found to have a significantly lower rate of re-arrest than non-graduates (19% and 53% respectively). Having a prior conviction, being male and younger were also associated with re-arrest. Criminal outcome differences between drug court graduates and non-graduates suggest that program completion is an important predictor of recidivism.

Gottfredson and Exum (2002) evaluated the Baltimore City Drug Court using random assignment of offenders eligible for drug treatment court into either drug court (n=139) or “treatment as usual” (n=96) (p. 343) from February 1997 to August 1998 using a one-year follow-up period beginning at entry into the program. The two groups were similar on race, gender, age, number of prior arrests, and number of prior convictions; thus, matching was not deemed necessary. Findings indicated drug court participants were more likely to participate in treatment and drug testing and were
arrested significantly less often than the control group. Examining all re-arrests, 48% of drug court participants and 64% of the control group were re-arrested; for only more serious offenses, 32% of drug court participants and 57% of the control group were re-arrested. Finally, after controlling for differences in opportunity to re-offend (incarceration time), control subjects were re-arrested at a rate almost three times that of drug court subjects (Gottfredson and Exum 2002).

Banks and Gottfredson (2004) extended this analysis using another indicator of recidivism: time to re-arrest. Findings indicated both drug court participants and the control group experienced similarly high rates of failure until about month four in the follow-up period. At that point, the drug court began to have an impact on participants’ likelihood of re-arrest, with proportionally fewer drug court participants being re-arrested for the duration of the follow-up. Further inspection of the similar decline during the first four months revealed that most drug court participants averaged four months from entry into the court until their first treatment experience. Those who entered treatment during the first two months of the court program were significantly less likely to be re-arrested during the first four months of the follow-up period (Banks and Gottfredson 2004). It was the connection to treatment provided by the drug court which was necessary to make an impact on recidivism.

Other drug court evaluations incorporating multiple indicators of recidivism also find drug courts to be more effective than traditional criminal court (TCC) on most measures (Listwan et al. 2003; Bavon 2001; Spohn et al. 2001). In one such study, Listwan et al. (2003) examined two indicators of recidivism, re-arrest and subsequent
jail time, among drug court participants (n=301) and drug using offenders eligible for
drug court but who either opted out or were refused admittance by the drug court team
(n=224) and found no significant differences between the groups. Although study
findings show no difference in re-arrest for any new offense or in incarceration, they do
indicate that drug court participants were arrested less often for drug offenses than
control subjects.

Bavon (2001) examined re-arrest rates, length of time until arrest, number of
bookings, and criminal sentences imposed on drug court participants (graduates and
drop-outs) and on other similar drug using defendants who were offered but did not
participate in drug court (opt-outs). Subjects were selected and categorized from a list
of closed cases spanning fiscal years 1995-1996 through 1997-1998. The total sample
size was 264: the participant group included 72 graduates and 85 dropouts and the
control group comprised 107 subjects deemed eligible but who opted out of drug court.

Compared to opt-outs, drug court participants did better on most indicators of
program success; however, the differences did not reach statistical significance. Re-
arrest rates were similar with participants being re-arrested at a rate of 12.7% while opt-
outs had a re-arrest rate of 16.8%. When examining the proportion of re-arrests that
occurred between participants who graduated versus those who dropped out; however,
it is the case that only 2.8% of drug court graduates had a new arrest while 21.2% of
drug court drop-outs were re-arrested. Similarly, drug court graduates represented a
small percent (17%) of new bookings for drug court participants. As with the Wolfe et
al. (2002) study, program retention and completion are important factors to be
considered when evaluating the success of drug courts. Successful outcomes were noted for those who graduated or remained in drug court long enough for the intervention to work; those who dropped out did so in the early phases of treatment and saw little benefit (Bavon 2001).

A third drug court evaluation utilized two comparison groups and multiple indicators of recidivism: occurrence of re-arrest and re-conviction, number of times re-arrested, number of times re-convicted, and the number of months to re-arrest during a twelve month follow-up period (Spohn et al. 2001). Drug court participants (n=285) in the Douglas County (Omaha, Nebraska) were compared to drug offenders assigned to a diversion program prior to the implementation of the drug court (n=232) and similar drug using defendants in TCC who were arrested for a felony drug offense after the implementation of the drug court between January 1997 and March 1998 (n=194). Drug court and diversion program defendants differed at the outset based on program eligibility requirements: the drug court served medium to high risk offenders while the diversion program targeted low risk offenders. Defendants in drug court and TCC had similar risk levels. To help ensure the comparability of the groups, offenders in each group were matched on most serious offense, race, gender, and age.

Findings consistently indicated that drug court participants fared better than TCC defendants on all outcome measures: that is, they were less likely to be re-arrested and re-convicted, and had a significantly longer time to re-arrest. Comparisons between drug court participants and diversion program defendants found no significant difference between re-arrest and length of time to re-arrest when controlling for level of
risk (Spohn et al. 2001). Overall, defendants processed in TCC were arrested sooner than both drug court and diversion subjects. Prior record, gender, and age also influenced time to re-arrest with being male, younger and having a longer criminal history being associated with being re-arrested more quickly.

Other drug court research examined drug court participants only to investigate why drug court graduates fare better than non-graduates. Peters and Murrin (2000) examined drug court participants who entered two drug court programs (n=168 in Escambia and n=58 in Okaloosa) in Florida from 1993 to 1996 using an 18-month follow-up period after release from the drug court program. Findings indicated that number of re-arrests was directly related to the length of time spent in the program. Varying lengths of program involvement (1 to 90 days, 91-180 days, 181-365 days, and more than 365 days in Escambia; and 1-90 days and greater than 90 days in Okaloosa due to the smaller sample size) were examined. It was determined that the length of time in the program was significantly related to number of re-arrests in the follow-up period with longer time in the program resulting in fewer arrests. Graduates and non-graduates who remained in the program for one year had significantly improved criminal justice outcomes (Peters and Murrin 2000).

Banks and Gottfredson (2003) examined two elements of the drug court treatment program: monitoring by the division of probation and parole, and a multi-phase treatment program. Drug court participants were assigned to either the diversion (n=52) or probation track (n=87). Both tracks received judicial monitoring, drug testing, and drug treatment while the probation track also received monitoring by the
division of probation and parole. Cox regression models were used to determine the risk of failure (re-arrest) based on whether they received probation supervision, treatment, or both. Probation supervision was defined as any monitoring that occurred through the division of probation (this is in addition to judicial monitoring) and treatment included any treatment lasting at least 10 consecutive days during the study period. Most individuals who spent less than 10 days in treatment only spent one day in treatment before dropping out of treatment. Of the two drug court components, receiving treatment only significantly decreased risk of failure (re-arrest) but receiving probation supervision only did not. Participants who received both treatment and probation supervision had the highest survival rate followed by those receiving treatment only and those receiving drug court monitoring only.

To determine if length of time in treatment and program completion impact drug court outcomes, Peters, Haas, and Hunt (2001) categorized drug court participants into four groups determined by length of participation in the program. The first three groups were created using ninety-day intervals (0-90, 91-180, 181-270) and included graduates and non-graduates, and the last group included only graduates in the program 271-365 days. Results indicate that arrest rates were lower for drug court graduates at both 12 and 30 months; however, arrest rates declined with length of time in the program regardless of completion. Drug court participants (regardless of completion status) who were in the program for more than nine months had lower arrest rates during the follow-up than did those in the program for 0-3 months, 3-6 months, and 6-9 months (Peters et al. 2001).
In summary, these more recent studies using more rigorous research designs to determine the effectiveness of drug courts have established that drug court participants have significantly lower re-arrest rates and longer time until re-arrest when it occurs than drug court non-graduates, drug court opt-outs, and other similar substance using defendants in TCC (Listwan et al. 2003; Wolfe et al. 2002; Gottfredson and Exum; Bavon 2001; Spohn et al. 2001; Peters and Murrin 2000; Johnson, Formichella, and Bowers 1998; Goldkamp and Weiland 1993). Two components of drug courts, active engagement in treatment and compliance with drug court programs, appear to be critical factors in participants’ success in the program (Banks and Gottfredson 2004).

**Mental Health Courts: Findings From Four Studies**

MHCs are so new that few outcome studies have been conducted on their effectiveness. Most of the knowledge about the workings of MHCs comes from four locations: Clark County, WA; Broward County, FL; Santa Barbara, CA; and Seattle, WA. Each study provides data on criminal outcomes while the Broward County study also provides detailed information about service utilization, procedural justice, and perceived coercion (Christy, Poythress, Boothroyd, Petrila, Mehra 2005; Cosden, Ellens, Schnell, and Yamin-Diouf 2005; Herinckx, Swart, Ama, Dolezal, and King 2005; Cosden, Ellens, Schnell, Yamin-Diouf, and Wolfe 2003; Trupin and Richards 2003; Boothroyd, Poythress, McGaha, and Petrila 2003; Poythress, Petrila, McGaha and Boothroyd 2002). As so few outcome studies are published on MHCs, the research conducted in these four locations will be discussed in detail.
Clark County, WA. Herinckx et al. (2005) examined re-arrest and treatment linkage of all MHC defendants entering the Clark County MHC between April 2000 and April 2003. MHC eligibility requirements included: being 18 or older and charged with a misdemeanor, having a diagnosable axis I mental illness, and volunteering to participate in the MHC. Defendants who had a developmental disability or a personality disorder were not eligible for the MHC. All defendants who met the MHC’s eligibility criteria were included in the study for a total sample size of 368 (69 graduates, 116 non-graduates who were terminated for non-compliance, 75 who opted out of the MHC, 24 who were transferred to another court, and 77 who were still enrolled). Arrest and mental health service use data were collected one year prior to and one-year post MHC entry for study subjects for whom at least 365 days had passed since entry into the MHC.

All of these defendants who were eligible and came before the court received more hours of case management, medication management, and more days of services, and they received fewer hours of crisis management and inpatient treatment post MHC entry than before MHC entry (Herinckx et al. 2005). They also had fewer arrests in the 12 months after entry into the MHC. In the year prior to entry into the MHC, defendants were arrested an average of 1.99 times as compared to .48 times post MHC entry with 54% of defendants having no new arrests.

Multivariate models predicting arrest of MHC graduates and non-graduates indicate that graduating from the MHC was the most significant factor in predicting re-arrest with graduates being 3.7 times less likely to be re-arrested when compared to
non-graduates (Herinckx et al. 2005). The authors do not indicate whether re-arrest of defendants in the non-graduate group is the cause of MHC termination and non-completion of the program. Defendants who were hospitalized in a psychiatric facility and/or booked for more than one crime in the year prior to MHC entry were more likely to be re-arrested in the follow-up (Herinckx et al. 2005). Herinckx et al. (2005) concluded that the Clark County MHC provided treatment services necessary to stabilize MHC defendants in the community which led to a reduction in arrests for new offenses and probation violations.

**Santa Barbara, CA.** Cosden and colleagues (2005) used a randomized control trial to examine two groups of defendants: 1) those assigned to the MHC who received assertive community treatment (ACT), skill building groups, and vocational training and 2) those assigned to traditional criminal court who received treatment as usual (TAU, typically less intensive case management). Eligibility criteria for the MHC and the study included having a diagnosable serious mental illness, a misdemeanor or felony charge, at least one prior booking, and being a current resident in the county. Each defendant who met these criteria was given the opportunity to participate in the study. A total of 235 defendants chose to participate: 137 were assigned to MHC and 98 to TAU. Each group of defendants was followed for two years to determine if defendants in MHC would have a reduction in criminal activity, psychological distress, and alcohol and drug problems and an increase in daily functioning and life satisfaction.
After one year, MHC defendants had fewer convictions for new crimes than the control group. The few MHC defendants who were convicted usually had charges related to probation violations rather than to the commission of new crimes; whereas the control group typically had charges related to new offenses (Cosden et al. 2003). Both groups made gains in life satisfaction and daily functioning, and experienced decreases in psychological distress and drug/alcohol problems; however, MHC defendants demonstrated greater advances in daily living skills and reductions in drug and alcohol problems (Cosden et al. 2003).

After two years (18 months treatment and 6 months post), the proportions of each group (12% in MHC, 10% in TAU) sent to prison for new crimes did not differ significantly. Analyses that excluded those in prison and MHC participants jailed for noncompliance found both MHC and TAU participants had increased bookings and no difference in convictions and jail days. Because there were a few defendants who were responsible for an excessive proportion of new bookings, convictions, and jail days, further analyses were conducted that excluded these defendants. Findings showed a significant decrease in jail days for both MHC and TAU participants from the two years pre participation to the two years after entry into the study with MHC defendants experiencing significantly fewer days in jail than TAU defendants; but no significant decline was found in bookings or convictions (Cosden et al. 2005).

When examining psychosocial functioning, only 157 sample members (67% of the original sample) were re-assessed: 96 in MHC who received intensive treatment services from ACT and 61 in TAU. Sample attrition was a result of the inability to
locate defendants and in a few cases the defendant declined the assessment or was too impaired to participate. Results echoed earlier findings that both MHC and TAU defendants improved in all areas of psychosocial functioning; however, MHC defendants exhibited significant gains over the TAU defendants. MHC subjects experienced an increase in global functioning and quality of life and a significant decrease in distress and drug and alcohol use relative to TAU defendants (Cosden et al. 2005).

Seattle, Washington

Trupin and Richards (2003) used a quasi-experimental approach to compare two groups of mentally ill offenders who were referred to one of Seattle’s two MHCs (Seattle and King County): those who opted in and those who opted out. All defendants were charged with a misdemeanor and had a diagnosable mental illness at entry into the study. Both MHCs were established in 1999; however, the Seattle MHC was organized at the municipal and county level and had a different pool of defendants than the King County MHC (urban vs. suburban). Due to variation in population density and volume of court cases, number of defendants entering each MHC monthly varied by location and time sampled. In Seattle, 158 defendants were referred to the court during a five-month period while in King County 246 defendants entered the court during a thirteen-month period. Seattle referrals yielded approximately 32 unduplicated referrals a month while King County had about 19 unique referrals each month. The resulting sample sizes were 65 “opt in” and 82 “opt out” defendants in Seattle and 31 “opt-in” and 46 “opt-out” defendants in King County.
Trupin and Richards (2003) examined treatment services and recidivism as well as detention days in the Seattle and King County MHCs for a period of nine months post referral. Pre-test/post-test analyses indicated those who opted into the MHC experienced a greater increase in treatment referrals, treatment hours, and social functioning, and a decrease in new bookings and re-incarceration after entry into the courts relative to their pre-entry as compared to “opt-outs.”

**Broward County, Florida**

The Broward County evaluation used a quasi-experimental design with a matched control group from a different county. The experimental group consisted of 121 participants in the Broward County MHC; and the control group had 101 defendants in Hillsborough County misdemeanor court who either currently had or previously had mental health problems as determined by trained screeners. The study period spanned one-year prior to entry and one-year post entry into the court.

The Broward County evaluation has been the most intensive of the four studies examining procedural justice, perceived coercion, service utilization, clinical outcomes, and criminal justice outcomes. Poythress et al. (2002) examining perceived coercion and procedural justice, found MHC participants did not perceive their experience in MHC as coercive. Scores on all dimensions of procedural justice (having a chance to inform the judge of one’s legal and personal situation, respectful treatment by authority, and fairness) were higher in the MHC group than the control group and had a greater impact on outcome satisfaction.
MHC participants had a significantly higher rate of service use than the control group. Similarly, pre-test/post-test analyses on service usage showed that MHC participants had a greater increase in service usage than did the control group, with control group members being less likely to be using services before entry into and after entry into the study (Boothroyd et al. 2003).

Changes in clinical symptoms were also examined in the Broward County evaluation among MHC participants and the control group at one, four, and eight months after initial court appearance (Boothroyd et al. 2005). Participants were only included if they participated in at least one follow-up resulting in a total of 97 MHC and 77 control group subjects. No significant change over time was noted in psychotic symptoms in either group of defendants.

Last, the Broward County evaluation included an assessment of the impact of the MHC on criminal justice outcomes (Christy et al. 2005). Results indicate that MHC subjects were not significantly different from the control group on mean number of re-arrests, felony arrests, proportion re-arrested, or survival time to re-arrest; but MHC subjects spent significantly less time in jail for their index offense than did the control group; thus, they were at risk of re-arrest longer than the control group (Christy et al. 2005).

The research conducted in these four sites presents evidence that mentally ill offenders are at no increased risk for re-offending when diverted from traditional criminal processing into the MHC than comparable defendants in TCC. Thus they show that MHCs are fulfilling their obligation of public safety in the community.
These studies are less clear on the impact of MHCs on criminal justice recidivism above that of traditional criminal courts, however, the Seattle study used self-selected groups, which introduces unknown bias and it only followed defendants for nine months after entry into the court. The Santa Barbara study improved upon the Seattle study design with its random assignment into either MHC or TAU and used a sufficient follow-up period (Cosden et al. 2003, 2005). Yet, it remains unclear whether it is the services provided by through participation in MHC or the receipt of more intensive services provided through ACT that make the difference in one-year convictions. Finally, the Broward County study does not provide sufficient evidence of the effectiveness of MHCs as almost half (45.2%) of the defendants had no mental health services during the follow-up period and only 36% of participants returned to the court for monitoring (Boothroyd et al. 2003). Since it is believed that the MHC makes an impact on defendants’ lives through court monitoring and participation in treatment services, this study can not adequately judge the impact of a MHC on recidivism.

Because just four MHC evaluations have been conducted, and each has its own shortcomings, there is a need for research in other judicial districts to discern whether such courts are effective in reducing recidivism and increasing access to treatment. This study evaluates the effectiveness of one MHC located in the Southeastern United States. It contributes to the current state of knowledge by presenting insights into one MHC’s operation, the population it serves, services it offers, and how decision making processes differ from TCC. It also addresses the court’s effectiveness in providing access to services and reducing re-arrest and re-arrest severity.
CHAPTER 5
THE RESEARCH SETTING

Selection of a Research Setting and Access

Selection of a research site was limited as there are not many MHCs in existence, especially in the eastern United States. Fortunately, a faculty member had already established contacts with a MHC, gained access, and obtained the court’s support for an evaluation. The faculty member introduced me to the court and informed them that we would be working together on the evaluation. My presence was welcomed, and I was invited to attend confidential pre-court meetings with the court team in both counties in which the court operated. Confidentiality was preserved in three ways: 1) I was required to sign a confidentiality agreement with the court stating that I would remove all identifiers from confidential information; 2) I only used first names in qualitative data collection, 3) and I removed all identifiers from quantitative data files.

Setting

The MHC operates in the eastern United States in a county that includes academic, research, small town and rural environments. The county is unique being basically rural except for a large major university in a college town with recent spin-off research and housing developments. There is no comparable county from which to draw a control sample. Two courthouses serve the county, one located in the town with a large university, the other located in a small rural town.
County Courthouse Near University Setting. Located in the downtown area across from a major university, this courthouse used to be a post office and a tiny post office still remains inside the building. From the exterior the courthouse retains its small town building appearance and appeal because of its small size in comparison to more modern courthouses and its plain, unremarkable architectural style.

Pre-court meetings take place in judge’s chambers. The inside of the judge’s chambers is very informal and plain; it is an average size room with a wooden desk and chair for the judge, two couches, and several chairs for others to sit. All of the furniture is old and worn. Team members appear unconcerned about the “old-timey” appeal of the court and judges’ chambers, rather their focus is on coming together, discussing defendants’ progress, and getting the job done.

Court monitoring sessions take place in the only courtroom in the courthouse. The courtroom is very unremarkable, has a small town appeal, and is used for multiple purposes. There is not a security check-point or a security officer present denoting the casual nature of the court; in fact, it is hard to tell that this is a courthouse until you enter the courtroom. In the courtroom, the authority and power afforded court officers are clearly demarcated by a bar separating the courtroom audience from court officers and the judge who is donned in a robe, seated in the front of the courtroom behind a large wooden structure that is elevated above the rest of the court. Other symbols of authority are the U.S. and state flags and the jury boxes.

County Courthouse in Rural Setting. This courthouse, located in the downtown historical district, is a beautiful, large, colonial brick building with many
white trimmed windows, topped by a tower that resembles a steeple. Above the front doors, “County Courthouse” is written in black letters. To enter the building, one goes up a set of stairs and through a large double wooden door. Unlike the courthouse described earlier, this rural courthouse has a security checkpoint where two security officers question arrivals concerning their purpose and oversee their passage through a metal detector before entering the courtroom. Although more formal than the university town courthouse, this courthouse retains a small town appeal where everyone seems to know everyone.

Pre-court meetings take place upstairs in the jury room behind the courtroom. The jury room, very informal and plain, is rectangular, painted white, and has a long rectangular table surrounded by twelve chairs, two corner chairs, and a long bookcase filled with legal books against one wall. All of the furniture is old and uncomfortable, but team members do not seem bothered as each is in attendance for a common goal: to discuss and decide upon the best plan of action for defendants on the court docket that day.

Similar to the court in the university town setting, court monitoring takes place in the same courtroom as TCC occurs, only on a different day and time. This courtroom is slightly more formal in appearance (e.g. chandeliers are used for lighting and the woodwork is more detailed) and has an old time colonial appeal. The judge, the authority figure, is seated at the front of the courtroom behind an elevated, large wooden desk. To both sides of the judge are seats where called witnesses sit when providing testimony in criminal trials; however, these are not used during MHC
because it employs a more informal process calling defendants and witnesses to the
front of the courtroom to stand between defense and prosecuting attorneys where each
answers the judge’s questions and give his/her statement. A jury box is located on each
side of the judge’s bench but is used in MHC only for mental health treatment
providers, probation officers, and jail officers to sit because juries to decide innocence
or guilt are not part of MHCs.

MHC Eligibility and Operation

Referral to and Eligibility for the MHC. To be eligible for the MHC a
defendant must have been arrested for a crime and have a 1) mental health diagnosis, 2)
developmental disability, or 3) mental health treatment history. Eligible defendants
may also have a substance abuse problem and each must be agreeable to any
recommended treatment services. Verifiable mental health information is often not
known or not initially available to criminal justice personnel who are largely
responsible for MHC referrals. As such, referral to and eligibility for the MHC occur
in two separate stages where referral does not guarantee eligibility (Figure 5.1 diagrams
the referral process).

Anyone can refer a case to MHC. Most defendants are referred by one of the
two MHC judges or the assistant district attorney (ADA), the latter of whom screens all
referrals to make sure defendants are appropriate3 for the MHC. Other referrals come
from magistrates, law enforcement, attorneys, public defenders, treatment providers,

3 Referrals are deemed appropriate if they have a possible mental illness, do not have a violent criminal
history, and if their current charges do not raise any public safety concerns.
family members, and/or friends. For a case to be referred to MHC, a referral source must report at least one of the following to the ADA: 1) a defendant’s behavior is indicative of possible mental illness (such as talking to oneself, uttering strange sounds, and/or gesturing incessantly for no apparent reason), 2) a defendant has engaged in repetitive nuisance acts (such as consistently trespassing, public drunkenness, and/or public urination), 3) a defendant has a past history of mental health treatment, and/or 4) a defendant has a mental health diagnosis. The ADA considers almost all referral reports valid, which results in the defendant’s case being “automatically” put on the MHC docket although occasionally referral sources such as friends and distant relatives have ulterior motives for referring a defendant to MHC and the ADA must consider the information given by these referral sources more carefully.

Determining if a defendant has a possible mental illness and/or deciding what behaviors indicate mental illness is highly discretionary regardless of the referral source. MHC team members noted the following types of behavior in interactions with defendants which raised “red flags” or were seen as indicative of a mental deficiency.

**MHC Judge:**
Those who exhibit an inability to understand and respond appropriately to simple questions, flat affect, manic affect, delusional references, and excessive emotion.

**Private Attorney:**
Those who do not understand their actions and the consequences of their actions, look at her with a blank stare, exhibit extremely anxious behaviors, and/or talk irrationally are often referred to MHC.

**ADA:**
Those who have a family member report they have a mental illness, behave erratically during arrest or during court proceedings, come to court drunk, are unresponsive to questioning in court, or do not seem to understand what is happening.
A few examples of such behaviors given by MHC team members include that a defendant who appeared in TCC and talked without interruption while waving her hands in the air gesturing the OK sign to the judge and ADA, a defendant who claimed his ex-wife was haunting him so he set the house on fire to burn her spirit, and a defendant who counted aloud continuously to ten in open court. Other examples include defendants who had blank stares, were not listening, and/or who did not understand court proceedings. The court team does not consider a report of any of the above mentioned behaviors as indicative of a diagnosable mental illness; rather these behaviors are only used as a warning to them that a MHC referral may be necessary. Team members are quick to acknowledge that a referral to MHC does not indicate an actual mental illness; they defer any determination of mental illness to mental health professionals working with the MHC.

When the ADA deems a referral appropriate, she places the defendant’s case on the MHC docket. At the defendant’s first hearing, the mental health liaison screens the defendant, asking a series of questions to determine his/her clinical characteristics, global functioning, and types of services needed (e.g. psychiatric care, substance abuse therapy/counseling)\(^4\). This screening is used as the preliminary basis for MHC eligibility\(^5\); however, defendants are also given an appointment for a more detailed

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\(^4\) Any questions of incompetence would have been answered earlier before referral to MHC. Questions of incompetence are raised in TCC and are sent from there for an evaluation.

\(^5\) To be eligible, a defendant must have a diagnosable mental illness or a history of mental health treatment.
assessment at the community mental health center.

Screened defendants who meet the MHC’s eligibility criteria are placed on the MHC docket for the next MHC session while defendants who do not have a diagnosed mental illness are discussed among members of the court team to determine appropriateness for the MHC. Team members discuss those defendants who do not meet the MHC’s eligibility criteria to determine if each should remain in MHC. Occasionally, MHC team members allow a defendant without a diagnosed mental illness but with unstable, troublesome, behavioral patterns to remain in the MHC if they consider the person in need of court monitoring and supervision. An ADA described the process as one in which “[team members] must consider not only mental illness but behavior in the community. If people are cycling in and out of the system, they are more likely to need court monitoring and be kept in the MHC.” MHC team members agreed eligibility determination is a collaborative effort between the community, the criminal justice system, and the mental health system.

The screening process may seem overly discretionary, but is designed to have an “open door policy” in which a wide net is cast to ensure no one in need of court monitoring and mental health/substance abuse treatment falls through the cracks in the criminal justice or mental health service systems. Casting a wide net could lead to too many cases in the MHC, too many cases for the MHC liaison to effectively manage, and/or an overreach of the law infringing on a defendant’s civil liberties. Overcrowding in this MHC was not a problem during this study; however, after the cessation of this study, the MHC occasionally had to restrict admission to the MHC for
those defendants with SMI only due to the MHC liaison’s case overload. MHC team members do not consider the breadth of the MHC’s reach as an infringement on a defendant’s civil liberties because each defendant has committed and been charged with a criminal offense, is appropriately screened by the ADA and MHC liaison for legal eligibility and any diagnosable mental illness, is going to have his/her case resolved in a court setting, and voluntarily opts to participate in the MHC.

All eligible defendants are given the opportunity to decide whether or not to participate in MHC. Before a defendant makes such a decision, the mental health liaison and the defendant’s attorney explain the court requirement of at least 6 months of consistent compliance including taking any prescribed medications, attending treatment sessions, and attending court once a month for monitoring for the MHC to review treatment, medication, and legal compliance. If a defendant chooses not to participate in the MHC, his/her case is transferred to TCC for hearing and disposition. Defendants who opt into MHC have their cases set for the next MHC session and are given an appointment for a mental health assessment. When there is a recent mental assessment, the defendant is asked to provide a copy of it.

The MHC at each location hears approximately 5 new cases and monitors about 40 on-going cases a month. Decision-making occurs behind closed doors, not in open court. Before court begins, the MHC Team, consisting of the judge, ADA, public defender (PD), two private attorneys on the indigent list who have experience with mentally ill persons, the mental health liaison, and at times a probation officer or mental health case manager, meets to discuss each case. Counsel and/or the mental
health liaison present new cases, describe offenses, offer relevant background
information, and recommend treatment and services. For cases that are so new that
defendants have not yet been interviewed, counsel and the mental health liaison agree
to talk with defendants during court recess taken after all other cases have been
processed. For review cases, team members discuss defendants’ well being, treatment
compliance, services received, needed modifications, and any new charges. In such
exchanges, team members indicate that they understand that relapses occur in this
population and that they are willing to give defendants second and sometimes third
chances depending on the situation. Discussion is free flowing, leading to team
members’ consensus on a course of action for each defendant. They recommend to the
judge issues to be addressed in open court to obtain a defendant’s compliance (such as
missed appointments, substance use during the previous month, and/or medication
compliance). They also recommend sanctions for non-compliance, words of
encouragement for the judge to relay, and at times effective ways to approach concerns
based on the defendant’s mental health status (Hiday et al. 2005).

Before the first court appearance, counsel and the mental health court liaison
explain the MHC’s goals and program to new defendants. For those defendants who
elect to participate in MHC, the mental health liaison conducts a mental health
screening and schedules a more detailed assessment. Defendants who agree to the
conditions of MHC participation and to their treatment plans are required to come to
court for monthly monitoring for at least six months. Treatment plans may include one
or more of an array of services including group and individual therapy, medication
management, housing and employment assistance, social services, and vocational training. In addition to these services, the treatment case manager and the court team provide structure, supervision, and encouragement for each defendant.

Although decision-making occurs behind closed doors, formal monitoring occurs once a month in open court where each defendant and members of the court team, primarily the judge, discuss progress, problems, and treatment compliance with each defendant. The ADA calls each case giving a brief summation of the defendant’s status. The judge talks with each defendant about how s/he is doing in treatment and any troubles s/he may be experiencing. In all cases, the judge gives reminders about subsequent treatment and court dates; and depending on compliance or noncompliance, the judge gives praise and encouragement, delivers a stern lecture, issues a warning or threat, or transfers the defendant back to TCC. The use of psychiatric labels and mental illness diagnoses are avoided, focusing instead on behavioral and treatment compliance during the past month.

At the end of continuous and consistent six-months of compliance with treatment and court appearances, and no new arrests, defendants graduate from the MHC. In cases of non-compliance, the MHC team understands that relapses may occur in the recovery process and continues to monitor the defendant until the MHC team deems the defendant has fulfilled all mandated requirements. Upon successful

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6 The MHC team reserves the right to transfer any defendant back to TCC if s/he exhibits a persistent pattern on non-compliance.
completion of all requirements, defendants are presented a graduation certificate by the
judge and encouraged to remain in contact with their treatment teams. All charges are
either dismissed or disposed in a positive fashion (such as a prayer for judgment).
Defendants who are consistently noncompliant and do not fulfill the MHC’s mandates
are terminated from the MHC, are returned to TCC for prosecution of their charges, and
do not graduate.
**Assistant District Attorney:**
Referral source reports any of the following to the ADA who screens the case to ensure legal criteria are met for MHC admission
- Behavior indicating possible mental illness
- Past history of mental illness/mental health treatment
- Mental health diagnosis
- Repetitive nuisance acts (e.g. Trespass, loitering)
- Person in need of court monitoring

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**Referral Source:**
- Friend
- Distant Relative
- Law Enforcement
- District Attorney
- Treatment Provider
- Close Family Member

**DA determines appropriateness of referral**

**ADA**
Case is scheduled for MHC

**1st Setting of MHC**
screening for mental illness by mental health liaison

**Discussion among the court team**
- No
- Mental illness criteria met

**Eligible for MHC**
- Yes
- Opt In
- Opt Out

**Appropriate Referral?**
- Yes
- Defendant participation decision

**Traditional Criminal Court**
- Case set for MHC

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**Figure 5.1 Referral Process to MHC**
CHAPTER 6
RESEARCH METHODS

This study utilizes qualitative and quantitative methods of data collection and analysis. Qualitative data are used to examine court process and procedure, service utilization, defendant compliance, and defendant outcomes. This qualitative data is used as a link between defendant’s participation in MHC and their recidivism as shown in the conceptual model in chapter one. Quantitative data are used to test one outcome in the model: recidivism. Each form of data collection, qualitative and quantitative, used a micro substantive approach, but each was grounded in a different philosophical position.

Qualitative methods are used increasingly in social science research as a means to gather more detailed information on some kinds of processes than quantitative methods can obtain. In addition, qualitative methods allow researchers to probe for subjective meanings of data and to obtain a deeper understanding of events in their “natural state” (Hammersely and Atkinson 1995, p. 6). Qualitative methods attempt to capture aspects of the social world that are not subject to precise measurement; therefore the focus of these methods is not to test causal relationships empirically (Neuman 1997). Rather, qualitative research methods allow researchers to observe social processes, describe how and what happens, elucidate how the people involved in the study act and react, probe their subject’s interpretations of events, and offer an analysis (Hammersley and Atkinson 1995). In turn, these explanations may lead to the
development of theories and/or hypotheses that can be tested empirically (Hammersley and Atkinson 1995).

Here I used qualitative data in a naturalistic approach to provide insight into structure and processes of the MHC. A naturalistic approach examines processes in their natural setting allowing ideas, themes, and understanding to emerge as the study progresses (Hammersley and Atkinson 1995). My qualitative data provide the necessary context for understanding and interpreting the quantitative data because they link MHC participation to one outcome, recidivism. Analysis of qualitative data on the non-adversarial process, team approach to decision making, service linkage, court monitoring, treatment service attendance, and medication compliance indicate the processes by which MHC participation is believed to impact defendants’ future criminal offending.

Qualitative methods are suited for this study as MHC involves a bureaucratic process and a personal journey that defendants make through court and treatment programs that cannot be captured solely with quantitative methods. Qualitative methods allowed me to observe the MHC’s functioning in its natural setting permitting ideas, themes, and hypotheses to emerge as the study progressed much unlike quantitative methods where one begins with hypotheses, chooses measures, and collects data designed to test those hypotheses. This was particularly useful in this research because I did not have any pre-existing expectations about the setting other than the use of a team approach and non-adversarial proceedings; however, how these would function to achieve the goals of MHC was unclear. Other themes that developed did so
through my observation of the MHC in its natural (unmanipulated) setting (Hammersley and Atkinson 1995).

Qualitative methods provide needed flexibility in research design, as data collection and new insights unfolded and occurred in my research during the pre-court and in-courtroom stages. For example during my initial observations, I realized that my observation form was inadequate and did not capture all of the interaction. Qualitative data collection using this refined observation form permitted flexibility in the information recorded during observations in pre-court meetings and courtroom hearings. Observing individual behavior, body language, and general disposition of the participants provided the context for understanding and deciding what information was significant for team members in arriving at decisions on how to approach defendants’ cases.

Further, the use of qualitative methods allowed me to observe defendants’ behavior and to explore potential motivators for defendants’ decisions to accept and comply with the treatment options offered by the MHC. Because I used qualitative methods I was able to be flexible when categorizing the factors that appeared to indicate defendants’ motivation level for treatment compliance and was able to develop a typology of four groups of defendants that was later reduced to three.

The use of qualitative methods also offered the means to gain a deeper understanding of the meaning and context of interactions that took place between court team members in pre-court staffings and between court team members and defendants in open court. In pre-court meetings, I was able to capture all discussions about
defendant treatment and behavioral compliance, problems encountered during the month, team members’ notions of how to address issues of non-compliance or misbehavior, and their recommendations to the judge to be used in courtroom monitoring sessions. In observing these discussions, I heard any disagreements between team members and the process by which court team members resolved them. In courtroom hearing observations, I saw how the judge used comments and recommendations made during the pre-court meetings to enact the script that was planned during pre-court meetings. Further, the use of qualitative methods allowed me to capture the MHC monitoring process where the judge attempted to encourage defendant treatment and behavioral compliance through the use of formal and informal social control mechanisms. In summary, the use of qualitative methods permitted a more informed explanation of the court and decision-making process and the journey that defendants make through mental health treatment and court monitoring which in turn aids in the explanation of the quantitative results on MHC effectiveness.

My quantitative data collection and analysis offer insight into the effectiveness of the MHC at the micro substantive level where data were collected on quantifiable variables using a positivistic approach. This approach, based on the scientific method, called for the development of hypotheses, systematic uniform data collection on quantifiable variables, and the use statistical models to test hypotheses.

**Methods of Data Collection**

I have been directly involved in an empirical examination of a MHC in the southeastern United States since 2001. During this time, I have become interested in
many facets of the MHC. These facets include its ability to exert social control over defendants by means of the judge’s verbal praise, encouragement, warnings and threats spoken to defendants in open court, its establishment of new roles for legal and mental health professionals involved in the MHC and new methods of case decision-making, and its overall effectiveness in reducing recidivism. My role as a researcher led me to the courthouse to observe pre-court meetings and MHC proceedings; to community mental health centers to review mental health records; and to the courthouse, community mental health centers, and law offices to interview MHC team members about their perceptions of the court, its functioning, and overall effectiveness. Largely, the analysis presented in the following chapters consists of an elaboration of the key issues earlier described using multiple sources of qualitative and quantitative data. First, I describe two forms of qualitative data, observations and semi-structured interviews. Within this section, I discuss the length of data collection, observation forms used, and the creation and coding of field notes. Next, I turn to quantitative data collection efforts and discuss the research design, sample selection and recruitment, and data collection procedures. Third, I present key qualitative themes and summarize quantitative variables. Last, I discuss methods of analysis for qualitative and quantitative data.

**Qualitative Data**

**Observations.** To assess this new legal intervention, I used the technique often referred to as non-participant observation. Non-participant observation is a process used by ethnographers whereby they immerse themselves into a social setting, get to
know the people involved in it, and observe their daily routine (Emerson et al. 1995).
In this study, I immersed myself into the MHC setting, got to know the court team, attended all MHC planning and quarterly meetings, and was present at pre-court meetings and courtroom proceedings for one year collecting information on approximately 480 individual events. During this year, I, along with two other researchers from NCSU, recorded interactions that occurred between court team members in pre-court meetings and between team members and defendants in court proceedings. After several months of observation, I developed two observation guides to assist us as we recorded the interactions between court team members in pre-court meetings and interactions between the judge, ADA, defendant’s attorney, and the defendant in court proceedings.

The development of the observation guides was guided by my review of the literature on drug courts and MHCs and occurred in stages beginning with a series of items to be checked (e.g. did someone speak, what their expressions were, the outcome of the review hearing, et cetera). My original goal was to check off what occurred during observations, and code the observations into a SAS dataset. After reading Emerson et al. (1995), I realized that my initial plan for “jottings” was incorrect, and I modified my approach. According to Emerson et al. (1995), ethnography should “produce some sort of written account of what [researchers] have seen, heard, and experienced in the field” (17). Thus to achieve good ethnography, I needed to modify the observation form to capture more of the interaction. My first draft of the observation form captured the topics that were discussed but missed the “thickness” of
the conversation. For example, I knew from the checklist that the team had discussed a defendant’s housing problems, but I missed specific details like when and why loss of housing occurred and if the case manager was able to provide assistance in obtaining housing. I revised my observations forms to enable me to capture most or all of the conversation which provided a fuller description of the process (Appendix A).

Another reading that had a profound influence on my qualitative data collection strategy was an essay entitled *The Zero* (Kutsche 1998). Kutsche (1998) suggests that qualitative research is not just about what one observes. In fact, what does not happen is often as important as what does. In pre-court meetings, there are “zeros” between team members when one member does not share his opinion about a course of action for a defendant. These “zeros” also convey important information. For instance, on one occasion I observed the public defender shake his head slightly and make a facial expression showing his disagreement with the ADA although he verbally said nothing. This non-communication was an indication of the differential power relationship between the public defender and the ADA, which was apparent in all MHC team meetings, and the public defender’s willingness concede to the ADA although he disagreed. My courtroom observations yielded similar moments. In many cases the judge asked the defendant a question about his/her compliance that month. The defendant heard the question, knew he/she was being addressed, but chose to avoid eye

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7 I observed the MHC for a period of time before the study began. The coding form in checklist format was used during preliminary observations and the revised coding from was used for the entire duration of this study.
contact with the judge and did not respond to his question. This non-communication was missed in my original observation checklist, and is very important because it suggests the defendant was not compliant with the MHC’s treatment mandate. Compliant defendants proudly respond to the judge.

**Field Notes.** After each observation period, jottings were expanded. At the cessation of court in an office located in the courthouse or in a restaurant across the street from the courthouse, I met and compared notes with one or two other researchers from my university who assisted me with data collection and accompanied me to MHC that day. If a discrepancy existed in our recordings, we would talk about what occurred in that particular case and reconcile our notes. In addition, I elaborated upon my jottings as soon as I got home from court that day. Jottings taken in the field often do not capture the richness of the social situation, rather they should be used to jog one’s memory about an event or conversation that took place when writing more elaborate field notes of the interaction (Emerson et al. 1995, Hammersely and Atkinson 1995). Elaborating field notes shortly after court enabled the capture of more of the conversation that occurred during pre-court and courtroom interaction. Such elaboration provides richer data to analyze. I typed the expanded notes the following day.

**Semi-structured Interviews.** Toward the end of observations, I conducted private semi-structured interviews with each member of the MHC team in a place convenient for him/her. The location of each interview varied from team members’ offices to restaurants. Before I began each interview, I obtained informed consent.
Each interview lasted about one and a half hours during which I took detailed notes. At the end of each interview, I went directly to my car and expanded upon my notes in more detail from memory, typing the interviews the following day.

**Mental Health Record Abstraction.** Mental health records were reviewed and data were abstracted (for abstraction form see Appendix B) for defendants in the subsample of those who consented to having their mental health records examined to determine defendants’ diagnoses, social functioning, quality of life, number and type of services MHC defendants were referred to and attended, and treatment and medication compliance. Although originally intended for quantitative analysis, the small sample size limited these data to qualitative descriptions and analyses. Therefore, the following summary of the data collected resembles a quantitative description because that was the original intent of the data. Each variable is described below:

**Diagnosis.** During each defendant’s initial treatment appointment at the CMHC, a trained case manager determined primary and secondary (if applicable) diagnoses.

**Social functioning** was assessed with two variables to examine each participant’s ability to function in the community. First, the Global Assessment of Functioning Scale (GAF, 1990) was administered by the mental health liaison at entry into the court and was used to determine each subject’s level of social and interpersonal competence. The second indicator of social functioning was the type of problems (health, family/friends, job/school, and alcohol/drug) recorded in mental health record each month.
Quality of life was assessed to determine whether MHC treatment and associated services brought about positive changes in defendants’ housing, employment, and benefits (Medicaid, SSI/SSDI, and VA). Information on each of these components was collected by the mental health liaison at entry into and exit from the MHC program to determine improvements in quality of life.

Mental health and substance abuse services were used to determine the number and type of services each defendant received while under the court’s supervision. Services such as medication management, individual/group therapy, case management, substance abuse treatment, residential treatment, and/or hospitalization were recorded in the year prior and following entry into the MHC.

Intensity and duration of treatment services were measured by treatment/service contact hours per week (treatment intensity) and length of time in treatment (treatment duration).

Social and rehabilitative services received while under court supervision was recorded from the community mental health center records (housing, employment, vocational rehabilitation, and financial assistance).

Treatment engagement was measured by the number of treatment sessions attended and the number of “no shows” without rescheduling.

Medication noncompliance was determined by any mention of noncompliance with prescribed psychiatric medication by the mental health liaison in pre-court team meetings or as documented in the mental health record.
Quantitative Data

Quantitative Research Design

Ideally, one would conduct a pretest-posttest control group design with random assignment into the treatment (MHC) and comparison groups (TCC); however, this was not possible as the MHC program was already in place. Given this constraint, a nonequivalent comparison group design is used for this evaluation. In this type of design, the experimental and control groups are not equivalent at the outset. They represent two assembled collections of people who are as similar as availability allows. Although the validity of the design is contingent on the ability to control for the differences between the two groups, this design has many advantages over the one group pre-test post-test design (Campbell and Stanley 1963). By using two groups (experimental and control), regardless of their equivalency, many threats to internal validity that exist in one group pre-test/post-test group designs are taken into account including: 1. history (events other than X that occurred during the study period), 2. maturation (biological and psychological processes that vary over time), 3. testing effects (the effect of the pre-test on the post-test), and 4. instrumentation (observers may be more lax in their observations the during the post-test as compared to the pre-test) (Campbell and Stanley 1963).

In my study, maturation is deemed problematic because psychological processes for mentally ill defendants do change over time with varying symptoms and different levels of functioning which can impact treatment and behavioral noncompliance. The TCC control group is used in an effort to take this into account; however, whether these
defendants have a diagnosable mental illness is not confirmed for their inclusion in the control group. Fluctuations in police officers’ decisions to arrest offenders over time may have occurred and could have impacted the likelihood of arrest for each sample. Testing is not thought to be an issue in this study because official records are used to measure prior criminal arrests and their severity (pre-test measures) and the main outcome, recidivism (post-test measure).

That this study attempts to account for these concerns by using a non-equivalent control group does not mean that all concerns about validity are solved. This design has two possible threats to validity. First, a possible threat to internal validity exists if significant improvements are found in the experimental group that can be explained away by a selection-maturation interaction; whereby, the two groups were different on some variable at the outset of the study and this difference was related to the gains found from pre-test to post-test (Campbell and Stanley 1963). Second, a threat to external validity exists when the effect of treatment is related to the specific selection of the individuals in the group (Campbell and Stanley 1963). I discuss each below specifically for my study.

These threats to validity are often serious concerns in research on criminal justice diversion programs designed to divert offenders out of the traditional criminal justice system and into treatment. One problem for researchers when evaluating such programs is the possibility that court personnel’s (e.g. judge, DA, magistrate, etc.) select offenders whom they deem to be good candidates for diversion where their selection may be based on who is likely to mature out of crime or be amenable to
treatment. In my study, the selection of the MHC sample may be problematic for two reasons. First, the DA must abide by the admission criteria set forth by the MHC, namely that the MHC typically does not admit defendants with violent criminal histories and/or current violent offenses. Second, the MHC sample in my study includes defendants who opted into the MHC which may be an indicator of motivation and willingness to comply with mandated mental health treatment. Unfortunately, only one of these selection concerns can be addressed in the selection of the control group, and then only partially: the judge did not select any defendants whose current offense was violent; but on the other hand, any information pertaining to the severity of their criminal history was not readily available during the selection process and would have only come from memory.

To address potential threats to validity, this study uses three measures to ensure the comparability of the treatment (MHC) and comparison groups (TCC). The first step involves the careful selection of the comparison group to ensure its comparability to the treatment group that is described in detail in the following section entitled sample selection and recruitment. Second, multivariate models include statistical controls for age, race, gender, prior criminal history, prior jail time, and severity of current charge. Last, pre-test/post-test analyses include a subset of subjects in each group (treatment and comparison) who were selected because they had the same race and criminal history severity scale score (variables that were significantly different between the two
samples at the outset of the study). SAS software was used to perform the matching procedure in which the larger sample (TCC sample) was used to match into the smaller sample (MHC sample). In cases where more than one TCC subject had the same race and score on criminal history severity scale, the first case selected was used in the subset. No individual records were used twice in the matching whether from the MHC or TCC; thus, both members of matched pairs are unique.

It is believed that these procedures do adequately control for differences between the two groups at the outset for most variables. However, there are two variables that remain a concern: past criminal offending severity and diagnosis. First, I have controlled for past criminal offending severity as best possible. The selection process for the treatment group limited defendants to those who had no violent criminal history and/or violent current charge. In contrast, for the comparison group a judge was selecting those who would have been eligible for the mental health court if it had existed. His decision, however, could not take past criminal history into account because it was not available unless he knew the defendants well. Second, I do not know for certain if comparison group members had a diagnosable mental illness or what the diagnosis was for those who were mentally ill. This prevents me from controlling for type and severity of mental illness in all analyses. Knowing the

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8 Age was also significantly different at the outset, but matching the two sub-samples on age resulted in a significant reduction of cases. Therefore, I decided to match only on race and criminal history. In addition, after matching on race and criminal history the significant difference between the two groups on age became nonsignificant.

9 The matched sample with a reduced sample size (N=142 vs. N=265) was not used in regression analyses because I was able to control for differences between the two groups in my statistical modeling.

10 Control group sample selection is described in the next section.
diagnoses of all sample members would have been ideal; however, not knowing this information is not thought to invalidate the research results. In a meta-analysis of published and unpublished sources from 1959 to 1995, Bonta et al. (1998) found predictors of recidivism to be the same for disordered and non-disordered offenders. In examining 35 predictors of general recidivism and 27 predictors of violent recidivism, Bonta et al. (1998) noted little effect of the ability of clinical variables to predict recidivism. But they noted that these variables are important when determining the appropriate intervention to properly manage this group of offenders.

**Sample Selection and Recruitment**

There are two samples of defendants. The first sample, MHC subjects, includes defendants who chose to participate in the MHC from September 2001 - August 2002. The second sample, TCC subjects, includes defendants who were in traditional court in the study county the year before the MHC was established (1998) who would have been eligible for MHC were it in existence, that is who were mentally ill. Informed consent was not necessary for either the MHC or TCC samples as the information collected (ie. prior criminal record and recidivism) is considered public record; however, from the MHC sample there is a subset of defendants who gave informed consent to the researcher to review their mental health records.

A total of 115 defendants appeared on the MHC docket during the data collection period. Of these, only 82 were used in analyses. Of the deleted cases, 14
were classified by the MHC team as inappropriate referrals\textsuperscript{11}, 11 opted out of the MHC, and 3 had their charges dismissed without becoming involved in the MHC. Five additional cases were not used in analyses as they classified themselves as some race other than white or African American (see description of race variable for a more complete description).

\textbf{The MHC Subsample} includes all defendants who were present in the MHC for their first court appearance during the second six months of the study. In this second six months, I recruited only those defendants in court for their first appearance, as one of the goals of this study is to follow defendants through the court from the beginning of their first experience to examine their access to treatment and treatment compliance during the court's supervision and their effects on recidivism. The court agreed to allow me to talk with each new defendant during court recess. At this time, I explained the study and obtained informed consent to follow their treatment and services in mental health center records. Forty-two MHC defendants were recruited for the subsample of which thirty-one agreed to participate.

\textbf{The comparison group, TCC defendants}, includes individuals similar to MHC subjects except each was in TCC rather than MHC. The selection of a sample to compare to MHC subjects was difficult for two reasons. First, the research county has a unique composition consisting of a highly educated and affluent population connected with local research institutions and universities, as well as a large rural population. A

\textsuperscript{11} Inappropriate referrals are defined by the court team as persons not having mental illness, having a violent criminal history, or deemed by the DA as a public safety risk on the current charge.
similar judicial district is desirable for the comparison group to control for socioeconomic differences between the two groups; however, there is no appropriate match in the state. Even if a comparable county were located, a second dilemma arises: necessity of knowing defendants in the control county who fit the eligibility criteria of the MHC in order to select a comparable group when the mental health status of defendants in another county is not available.

To resolve these issues, I used a comparison group consisting of a sample of mentally ill defendants who were in TCC during the year prior to the MHC’s inception (1998). From a list of all public criminal records for the county during 1998, the district court judge, who is familiar with and has expertise in dealing with this population, identified defendants who would have been referred to the MHC had it been in existence during this time period, that is defendants who meet the MHC criteria (having a diagnosis of mental illness, a dual diagnosis of mental illness and substance abuse or having a history of treatment for mental illness) and who had not been charged with a serious violent crime.

A list was obtained from the Administrative Office of the Courts of every public criminal record on the production criminal database for the county in 1998 (email per Patrick Tamer). From this list of 6,623 defendants (12,748 eligible offenses)\(^{12}\), 183 defendants were identified who would have been eligible for MHC had it been in existence. Sample selection bias was possible because the judge may have selected

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\(^{12}\) Multiple offenses often pertained to a single defendant, and defendants frequently appeared in the list more than one time.
defendants who frequented the court from this list or whose behavior was more bizarre, because he remembered them more than other defendants who offended less frequently or whose behavior was not as strange. Further, the judge may have selected defendants he knew and recognized from previous court appearances making it likely that he missed transients who had not lived in the county long, whose mental illness had not brought them to the court in this county before.

To examine the likelihood that selection bias occurred, the list of 6,623 defendants was divided into two groups: those who were selected for the control group (N=183) and those who were not selected (N=6,440). Next, the mean number of times defendants appeared on the list was examined. Defendants who were selected for the comparison group appeared on the list an average of 2.3 times while defendants who were not selected were listed an average of 1.9 times. The difference between the two groups of defendants was statistically significant (t-test, t=2.98, p=0.0029, df=6621) with control group defendants appearing on average more frequently on the list. Some may think that this confirms sample selection bias in control group, but it is argued here that the judge selected defendants who met the criteria of the population the MHC aimed to serve: defendants who were repeat offenders; thus, cycling in and out of the court system.

**Data Collection Procedures**

**Archival Record Abstraction:** Data were abstracted from official court records in a statewide-computerized database, Automated Criminal Infraction System (ACIS), for both the MHC and TCC subjects. ACIS is the computer database that tracks
criminal cases in the State (AOC 2005). In addition for subjects in the treatment group who consented (Subsample), data were abstracted from their mental health center records.

**Operationalization and Measurement of Key Variables**

**Qualitative Themes**

Each form of qualitative data is used to help tell the story of the operation of one MHC and defendants’ journeys through the court process. Observational, interview, and record abstraction data are used to describe how the court operates, who it serves, who court team members are, what services the court is able to marshal, and the impact of these services on defendants’ lives. Several key themes are addressed: new methods of decision-making, power and control in the courtroom, and the court’s overall impact on defendants’ lives. Quantitative data are used to augment these data.

**Quantitative Data: Measurement of Variables**

Quantitative analyses for MHC and TCC subjects include two main dependent variables, one independent variable, and six control variables. The dependent variables are two measures of recidivism: re-arrest and re-arrest severity. The independent variable is the type of court in which the defendant’s case is heard. The control variables are criminal history, jail time served prior to entry into the court, key charge, race, gender, and age.

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13 State Bureau of Investigation data was another possible source from which to get arrest information, however, it only includes fingerprinted arrests and does not include DWIs, driving while license revoked, no operator’s license, or other minor traffic infractions such as reckless driving, giving fictitious information to a police officer, and driving left of center which are relevant to this study.
Dependent Variables

Recidivism. This variable, used to determine the court’s impact on re-arrest of defendants with SMI, is operationalized in two ways. First recidivism is assessed as the number of new arrests occurring during the twelve months following entry into either the MHC or TCC. This operationalization is similar to other drug and mental health court studies that have used one or more of the following measurements for recidivism: the number of times a person was re-arrested or reconvicted (Christy et al. 2005, Cosden et al. 2005, Banks and Gottfredson 2004, Cosden et al. 2003, Listwan et al. 2003, Gottsfredson and Exum 2002, Spohn et al. 2001), the length of time until re-arrest (Banks and Gottfredson 2003, Bavon 2001, Spohn 2001), and the number of days spent in jail/detention (Cosden et al. 2005, Cosden et al. 2003, Trupin and Richards 2003).  

My second indicator of recidivism is different from those in earlier studies: MHC and TCC subjects’ score on a summation scale measuring recidivism severity. I coded this scale using rankings of offense seriousness from North Carolina’s “Structured Sentencing Guidelines” (N.C. Sentencing and Policy Advisory Commission 2004) plus infractions, traffic citations, and DWIs which are important in MHC team decisions. Each of sixteen states using structured sentencing guidelines ranks offenses according to its evaluation of offense seriousness for purposes of

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14 I had information on the number of defendants who spent time in jail during the follow up but so few defendants (8.5% for MHC and 9.8% for TCC defendants) spent time in jail coupled with the small sample size of MHC defendants that the data are not appropriate for regression analysis or a test of differences in proportions.
sentencing (Bureau of Justice Assistance 2004). Use of structured sentencing rankings of offense seriousness to create a scale for recidivism severity is a more precise measure of a state’s view of offense seriousness than other rankings. This approach is advocated by Steffensmeier and colleagues (1993) who used Pennsylvania’s structured sentencing offense rankings to measure offense severity in their research.

In North Carolina, misdemeanors have four levels of seriousness; felonies, nine levels; and infractions, traffic citations, and DWIs are not covered under structured sentencing guidelines (NC Sentencing and Policy Advisory Commission 2004). I coded offenses not covered by structured sentencing (infractions, traffic citations, and DWIs) as 1; misdemeanors, from 2 to 5 with 5 being the most serious; and felonies, from 6 to 14 with 14 being the most serious. In the case of more than one offense with an arrest, only the most serious offense was coded. For each defendant, a severity variable was computed that summed the values of the most serious offense for each new arrest (see Table 6.1 for examples of recidivism offense severity scores by number and type of arrest).

The use of a recidivism severity scale is somewhat unique in recidivism research. Most recidivism studies that examine severity either categorize re-arrest into misdemeanor, drug, felony arrests (Lanza-Kaduce, Parker, and Thomas 1999) or look only at the most serious offense committed using felony or violent re-arrest as an indicator of seriousness (Bonta et al. 1998; Teplin, Abram, and McClelland 1994; Harris, Rice, and Quinsey 1993; Villeneuve 1993). My severity scale better indicates re-arrest severity because the scale includes all re-arrests and their severity as
determined by structured sentencing. My creation of a recidivism severity scale is
similar to the Steffensmeier et al. (1993) approach. Like Steffensmeier et al. (1993), I
used the state’s structured sentencing guidelines offense classifications that are ranked
by severity to code the severity level of each re-arrest an offender incurred. However, I
took their approach one step further by creating a summation scale that included all
recidivist re-arrests and their severity for each offender in the sample during the follow-
up period. For my research, knowing the most severe re-arrest was not as meaningful
as knowing the severity of all re-arrests. Most re-offending among the study population
was not severe and many misdemeanants re-offended multiple times; thus, coding a
nonviolent misdemeanor as the most serious re-arrest would not provide a complete
picture in cases of defendants who committed several misdemeanors during the study
period.

**Independent Variables**

**Court type.** The independent variable of interest for this study is the type of
court which heard each defendant’s case: TCC (0) or MHC (1).

MHC participation is divided by completion status. To be considered a
completer, a defendant must consistently and continuously fulfill the court team’s
treatment recommendations and attend his/her court monitoring hearings for six
months. Conversely, non-completers are individuals who opt into the MHC, and never
begin a treatment plan or begin one but do not successfully complete it. Non-
completers also often fail to attend their court monitoring sessions.
Making a distinction between MHC completers and non-completers is substantively important when evaluating the effectiveness of the MHC because it is a full “dose” of MHC rather than a partial “dose” which is predicted to make the difference, that is, the treatment, services, structure, supervision, and encouragement under court monitoring for a sustained time constitute what is predicted to reduce recidivism. Making this distinction is critical because simply opting into a MHC does not guarantee any monitoring or reception of treatment and services, much less any beneficial impact; it only provides an open door to introduce services and structure within which a beneficial impact can occur.

A different but related measure, length of time under court supervision, has been associated with positive outcomes for offenders in drug treatment courts (Peters et al. 2001; Swartz, Lurigio, and Slomka 1996; Wexler, Falkin, and Lipton 1990). No such study exists examining the length of time in MHC programs. I propose that it is not simply number of days involved in the MHC that make a difference because defendants’ clinical and social conditions vary. Although more time in the program does allow more opportunity to receive services, some defendants beyond volunteering for MHC never fully engage in offered services despite spending longer times than others under the court’s jurisdiction.

At entry into the MHC most offenders deny any diagnosable illness and are unmotivated to change. Initially, treatment providers work to engage and motivate defendants, and develop a working relationship with them. The court team and treatment providers seek to demonstrate the benefits of active engagement through such
services as financial, housing, and employment assistance and removal of barriers that inhibit participation. These services coupled with court leverage serve to foster internal motivation for treatment compliance and acknowledgment of the need to make lifestyle changes (Peters and Osher 2004). Non-completers tend to leave the MHC early because they do not fully commit to the treatment process; they either never begin a “dose” because they drop out as soon as the structure impinges on their old behavior patterns or the MHC team ejects them because they never fully engage in treatment and services, and/or resist the structural requirements. In any case, they never taste the potential benefits of compliance with the “prescribed dose.”

**Control Variables.** This study uses six control variables, three criminal history controls and three demographic controls. These are 1) prior criminal record, 2) severity of key charge, 3) jail time served pre-court, 4) age, 5) race, and 6) gender.

**Prior criminal record** is measured as the number and severity of arrests in the twelve months prior to first entry in the MHC for the treatment group (not including the key arrest) and as the number and severity of arrests in the twelve months prior to the date of key arrest in 1998 for the comparison group. Severity was calculated using a summation scale that sums the state’s Structured Sentencing Guideline offense seriousness ranking for each prior offense committed (see recidivism above for a complete description). It was desirable to use the rubric that states use to calculate criminal history points under Structured Sentencing Guidelines as my indicator of severity of criminal history as done by Steffensmeier et al. (1993). This rubric includes the number of prior offenses and offense severity for calculating criminal history points.
used for sentencing purposes (NC Structured Sentencing Guidelines). Unfortunately, this research could not use the state’s rubric to calculate criminal history points for defendants as several offenses important to this research are not covered under structured sentencing guidelines (e.g. DWI) and would not be considered in defendant’s criminal history points. Therefore, I chose to extend this original offense severity classification into a scale for prior criminal history.

**Severity of key charge** is assessed for MHC subjects as the severity of the offense for which each was referred to the MHC. For TCC subjects, key charge is the first charge that was disposed of in court in 1998 that made each defendant eligible for sample selection. Severity of key charge is categorized using the Structured Sentencing Guidelines offense seriousness rankings as described earlier.

**Jail time served pre-court** is used as another indicator of seriousness of criminal history and controls for any jail time served in the year prior to entry into the court excluding time spent in jail, if any, for the key charge. It is coded as no previous time spent in jail (0) and some previous time spent in jail (1).

**Demographic Variables.** Age (actual years), race (white = 0, African American = 1), and gender (male = 0, female = 1) are the control variables. A measure of SES (income, education, occupation) is desirable, but is not available in court records.
Methods of Analysis

Qualitative Methods of Analysis

Qualitative data analysis consists of four stages: coding, sorting, local integration, and inclusive integration and occurs throughout the research study (Weiss 1994). Each stage of data analysis is discussed in the following sections.

Interview Data. During in-depth interviews, I took detailed notes. After each interview, I elaborated on my notes and typed them into a text file. I coded and sorted each interview into categories of interest including motivation for being involved in the court, role in the MHC and how it differs from TCC, the decision making process, importance of continual monitoring, purpose of courtroom interaction, necessity of the judge/defendant relationship, methods of social control exerted by the judge, and ability to influence defendant behavior. Each respondent’s answer on a particular topic was inserted into an excel file to be analyzed further by local and inclusive integration (discussed on pages 59-60).

Field Notes. I processed my field notes using two stages of coding as suggested by Emerson et al. (1995). They state that coding of qualitative field notes usually occurs in two phases: open coding and focused coding. Open coding refers to a process whereby researchers read their field notes line by line to identify themes and ideas to be used in focused coding. Focused coding involves reading the data line by line based on the themes formulated in open coding. The researcher develops and uses smaller categories of interest within those main themes (Emerson et al. 1995).
To code my data, I first read through a sample of field notes to identify and formulate the ideas and themes that were present. To aid in the development of themes, I modified questions developed by Emerson et al. (1995) that were important to this analysis. These questions included: What are MHC team members doing?; What are they trying to accomplish?; How do they accomplish this?; How do team members talk about the issues at hand?; What information is important?; and What did I learn from this process? With these questions in mind, I moved beyond the event itself and developed an overarching theme for pre-court meetings and courtroom hearings. The core theme developed for pre-court meetings is the decision-making process and for courtroom hearings was power and control in the courtroom.

Next, I proceeded to focused coding. I identified sub-themes relevant to both core themes. The sub-themes developed for pre-court meetings include: roles of court team members, topics of conversation (including treatment compliance, defendant’s motivation level, any setbacks incurred, and progress made), counsel advocacy, and case outcome. For courtroom hearings, the sub-themes identified include: treatment compliance; treatment modifications, problems during the month; verbal exchange tone of the judge (i.e. positive and complimentary, motivational, or warnings); and case outcome.

To analyze the data I used Atlas, a qualitative software package. All field notes were typed into Atlas and were coded using the methods discussed previously. I then produced reports by specific codes and reviewed these reports to understand what was happening during the court process relevant to each analytical category. These reports
enabled me to describe, classify, and interpret the data within categories and across
categories to provide a single, coherent explanation of the MHC workings.

To ensure the validity of the data, I used three methods. First, I spent a year in
the research site observing pre-court meetings to reduce outlying responses of taking
the exceptional for the norm. Second, I used team research throughout the study
period. At least two researchers were involved in each observational data collection
and notes were compared for consistency in note taking and perception of events.
Inconsistencies were rare, but when they did occur we discussed the observation in
question in detail and came to agreement. Third, I employed data triangulation of
observations and interviews to compare research findings ensuring consistency of data.
Data triangulation offers the opportunity to compare research findings from different
data collection techniques; thereby, reducing threats to validity from each different data
collection technique (Hammersley and Atkinson 1995). I verified many of my
observations with MHC team members during interviews by assessing their expressed
understanding of the court process. In addition, I compared results from observations
and interviews to assess the validity of the inferences made.

**Quantitative Methods of Analysis**

Analyses include a descriptive bivariate summation of variables by court type
and by court completion status. I use descriptive statistics to identify similarities and
differences between the MHC and TCC subjects as well as within the MHC alone.
Such a comparison sheds light on how comparable the treatment and comparison group
are at the outset of the evaluation.
Hypotheses 1 through 4 are tested with two types of analyses, multivariate modeling and pre-test post-test comparisons, both being used to test each hypothesis (see Table 6.2 for a list of hypotheses). Each analysis technique examines re-arrest and re-arrest severity of MHC and TCC subjects and MHC completers and non-completers. The following discussion elaborates on both types of analyses used and the information each provides to aid in the explanation of this MHC’s effectiveness in reducing recidivism.

First, I perform multivariate analyses using both measures of recidivism and employing different regression techniques as determined by the distribution of the dependant variables. However, each regression model uses the same independent and control variables. Results provide a first test of hypotheses 1 through 4 and indicate the impact of the MHC on the rate of re-arrest and predict factors associated with the severity of re-arrests.

Second, I conducted pre-test post-test analyses to examine differences in arrest and arrest severity over time between MHC and TCC subjects and between MHC completers and non-completers. Differences between the two sets of variables are calculated and paired t tests are performed. Results are used as a second test of hypotheses 1 through 4 and shed light on the impact of the MHC on defendants’ recidivism.

15 Hypothesis 5 is examined in Chapter 10 using qualitative data and descriptive quantitative data.
<table>
<thead>
<tr>
<th>Severity score</th>
<th>Number of Offenses Totaling Severity Score</th>
<th>Arrest 1</th>
<th>Arrest 2</th>
<th>Arrest 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2</td>
<td>reckless driving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 trespassing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1 shoplifting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>resisting arrest defrauding an innkeeper</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>possession of drug paraphernalia</td>
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<tr>
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<td>misdemeanor larceny</td>
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<tr>
<td></td>
<td>trespassing public urination</td>
<td></td>
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<tr>
<td>5</td>
<td>assault</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>breaking and entering</td>
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<td></td>
<td>carrying a concealed weapon</td>
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<tr>
<td></td>
<td>public urination</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>injury to real property disorderly conduct</td>
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</tr>
<tr>
<td></td>
<td>misdemeanor larceny</td>
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<tr>
<td></td>
<td>public urination</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>obtaining property by false pretenses</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>assault</td>
<td></td>
<td></td>
<td>trespassing</td>
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<tr>
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<td>trespassing</td>
<td></td>
<td>resistant arrest</td>
<td>open container</td>
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<td>beer on a public street</td>
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<tr>
<td>8</td>
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<td></td>
<td>possession of marijuana</td>
<td></td>
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<td></td>
<td>larceny</td>
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<td>intoxicated and disruptive</td>
<td>trespassing</td>
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<tr>
<td></td>
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<td>fictitious information to officer</td>
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<tr>
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<tr>
<td></td>
<td>assault on female</td>
<td></td>
<td>assault</td>
<td></td>
</tr>
</tbody>
</table>
Table 6.2 Hypotheses

1. MHC subjects will be re-arrested less often than TCC subjects.

2. MHC completers will be arrested less often than MHC non-completers.

3. MHC subjects will be re-arrested for less severe offenses than TCC subjects.

4. MHC completers will be re-arrested for less severe offenses than MHC non-completers.

5. MHC subjects will receive more treatment services when comparing pre-test services to post-test services.
CHAPTER 7
NEGOTIATION OF TREATMENT DISPOSITIONS

This chapter describes how a treatment-oriented disposition is negotiated among key MHC team members. To this end, it provides insight into the following processes: 1) How attorneys and judges view their new roles in this court; 2) How court team members enact their team roles; 3) What information is most important when deciding upon a course of action for defendants; 4) What information is pertinent when determining the success or failure of defendants; and 5) How these processes relate to the MHC’s effectiveness. Answers to these questions provide insight into one area of process and procedure in MHCs (as denoted in the conceptual model in Chapter 1): how MHC team members work collaboratively to reach a consensus on a course of action for defendants participating in the MHC. Without collaboration and consensus among team members conflict would prevail making the MHC team unable to have a united front bringing all legal and mental health forces together to reinforce each other in getting defendants to comply with treatment, refrain from negative behavior, and replace those behaviors with positive ones. Thus, qualitative data are presented in this chapter to examine how well the MHC team has implemented this part of the conceptual model provided in Chapter 1.

Pre-Court Staffing Procedure

Approximately 10-12 members of the MHC team are present for each pre-court meeting (staffing). Most MHC team members attend each staffing. Private attorneys may also be present if they have been retained to represent a defendant on the day’s
MHC docket. Everyone is dressed professionally, but the judge waits until formal court to don the black robe.

Before the meeting begins, the room is filled with hustle and bustle as team members converse with one another, discussing recent events in the court system and obtaining the latest treatment and compliance information on defendants’ who have been difficult to contact during the month. Attorneys may ask the case manager questions about certain clients’ treatment progress and/or give the case manager information about new defendants on the day’s MHC docket. The ADA may inform attorneys if any of their MHC clients have recently had a brush with the law, even if it did not result in an arrest.

The meeting proceeds in an orderly fashion with the judge presiding, calling each defendant’s name and asking for comments. The ADA, defendant’s attorney, or the case manager gives background information for new cases and a treatment/legal compliance update for review cases. For new cases this background information includes the key charge as well as medical and social functioning details relevant for decision-making purposes. For example, 16

**New Case 1:**
ADA: The defendant needs help dealing with a life crisis….She lost her husband and child through a divorce… Her husband left her for another woman and the defendant tried to run over her ex-husband’s girlfriend with her car. These are very serious charges. [The case manager] screened the defendant last month and recommends at least six months of therapy.

16 The following discussions were captured as close to verbatim as possible. Because dialogue proceeded quickly, it was impossible to record every word although the researcher took notes as a quickly as possible.
New Case 2:
Attorney: One month ago [she] sent an email to a co-worker with negative remarks about her [estranged] husband. Her husband saw the email and filed a domestic order violation. Her husband has withheld charges as long as she complies with the court. My client believes a relapse occurred during a time when her therapist was not available. There was about a three-week time period that she could not see her therapist.

New Case 3:
DSS case worker: [He] is making harassing phone calls to his estranged wife and threatening to take their son. He told us [DSS] he doesn’t have any mental problems except PTSD from being electrocuted. We have done some domestic violence assessments and are very concerned. His estranged wife is pregnant and due any day. Right now, neither parent is allowed unsupervised contact with their child.

For review cases, the discussion typically begins with the case manager giving a brief summary of treatment and behavioral compliance; however, at times the update is given by the ADA or the defendant’s probation officer or attorney. These updates vary in content depending on the complexity of the defendant’s case and treatment needs.

Some examples of information given are:

Review Case 1:
Case manager: She presented at the [mental health] screening as having no mental problems and not wanting treatment. So, we [CMHC] have nothing to offer her. She needs to face the consequences of her actions and not medicalize her behavior.

Review Case 2:
Attorney: I discussed the possibility of vocational rehabilitation with my client. She does not want to do vocational rehabilitation. If she does, it will knock her out of social security. She needs something to occupy about half of her day, but it cannot be taxing due to her condition.
**Review Case 3:**

Case Manager: He is compliant with treatment and is working hard to stay out of trouble. He wants to move to San Francisco. He likes [this town] and wants to leave with a clean slate so he can return if he wants to. He admits he is doing much better and wants to know when he will be released from the court. As a team we need to consider when he can go and how we can assist him in this move?

Background information or updates provide critical information for team members to make an informed decision about how to proceed with the case during court monitoring and treatment.

**Decision Making Processes**

After the background or update of about a defendant, team members may offer additional information about the defendant’s progress and an opinion on how to proceed. The number of speakers ranges from one to five with cases averaging three speakers. Normally, the case manager and ADA provide treatment and legal information respectively, while various other members of the MHC team may add additional information. Infrequently (occurring in 16% of the cases observed), attorneys advocate for their clients in an attempt to persuade the court team to allow them to remain in MHC when the team is considering their return to TCC. Examples of types of advocacy include:

**Attorney 1:**

My client is at a job conference today. That is why she is not here. I do not feel that the court has given her a chance yet. Let’s see how she deals with treatment.
Attorney 2:
I think the team needs to consider several things. He is depressed because he cannot see his children; he cannot afford visitation (the cost of transportation) at the visitation center; and he is unemployed. He has already done the Change program. I feel like this is really a child custody case.

Attorney 3:
Last month she did have some absences from school. Now, she has no absences and is doing well. She is very bright and has caught up on all of her school-work.

As illustrated in the examples above, attorney advocacy typically includes statements about giving second chances, extenuating circumstances, positive treatment information or client progress. Team members utilize this information as well as information presented by other team members in case decision making.

Case discussions typically include an array of topics including the type of the defendant’s main “problem” (either substance abuse or mental health), family issues (supportive family or troubled family), financial needs, employment situation, motivation level, treatment and medication compliance, and reasons for noncompliance if applicable. Discussions of cases in which the defendant is compliant are typically short, while those of more complex cases (defendants who have a host of problems, have multiple treatment needs, and/or are noncompliant) are longer. Length of discussion for a case ranged from 1 to 11 minutes with an average of 2.5 minutes spent on each case. Regardless of the type or length of discussion, facts proving guilt or innocence of the key charge are not considerations in the negotiation process.
Furthermore, the judge does not decide the course of action; rather the team makes this decision.

The following pre-court staffing dialogues illustrate both straightforward and complex cases before the court, the sharing of information that occurs, and how a team decision is made.

**Case 1: White female, age 51, length 1 minute**
Case manager: She is going to bring proof of compliance today. I hear she is doing a good job.
Judge: Good, we will see what she brings.

**Case 2: Black male, age 21, length 1.5 minutes**
Case manager: He is compliant this month. I called his case manager at TASC. He had one clean and 1 tampered with drug screen. He is up to speed and has been substance free for 90 days.
ADA: His family called me and wants him to live [stay] in MHC since he is doing so well.

**Case 3: Black male, age 29, length 2 minutes**
Case manager: He has been doing a lot of work on himself.
Attorney: He only has a few meetings left and he will have completed the program.
ADA: We will need to get certification that he completed all the sessions.
Judge: We should tell him we have a graduation coming up.

**Case 4: White male, age 20, length 5 minutes**
Case Manager: He had a neuropsychiatric evaluation. He was also screened for a head injury and a referral to cross disabilities is needed. He also needs a representative payee because he is using money for drugs.
Attorney: My client needs to be interviewed by [mental health liaison]...He needs to get out of his mom’s home. His family is very fractured and is not helping his condition...I agree that he needs a representative payee as [an acquaintance] comes by monthly, beats him up, and takes his disability check.
Judge: We will see what we can do. Can you work on this (addressing the mental health liaison)?
Case 5: White, female, age 28, 6 minutes
Case Manager: She has had a shaky month. She made one of four appointments but has done well attending AA. She needs an appointment reminder; Oct. 28 she goes for a med [medication] appointment and her doctor wants to change her medication. She needs to see her doctor and attend AA, not one or the other.
Judge: OK
ADA: How many visits should she have by next time?
Case Manager: Four.
Judge: Should I tell her that her therapist is disappointed with her about missed appointments?
Case Manager: No, don’t do that. Remember, she can’t regulate her emotions well and has a borderline personality disorder so be gentle with her.
Judge: OK, we will try the gentle approach today.

The previous dialogue illustrates the varying levels of complexity of cases that come before the court each session, the type of information exchanged, and how team members, including the judge, work together to determine the best approach for each defendant.

Determining Non-Compliance

Given the chronic problems mentally ill offenders face in their daily lives, the court team expects setbacks and is prepared to give second chances. In cases of noncompliance, team members in individual conversations and the judge in open court typically try to persuade the defendant to continue with treatment through the use of encouragement, warnings, and sometimes threats. Punitive sanctions are rarely used.

In general, team members agree that second chances should end after 2-3 months of persistent noncompliance, at which point a defendant should be considered a failure and terminated from MHC; yet they recognize that extenuating circumstances also exist and they are tolerant beyond three months. As stated by the ADA, “It
depends on what I hear, what the underlying diagnosis is, and the efforts being made.”

An attorney and judge echoed this sentiment in saying that level of effort and re-offending are key issues to consider when considering termination echoed this sentiment. The court team takes seriously the decision to send someone back to TCC and is cautious when making it. The following dialogues are from two cases that the team decided to send back to TCC. Each dialogue highlights the manner and amount of discussion that takes place before such a step is taken.

**Noncompliant Case 1:**
Case Manager: [The drug counselor] took him to [another county] for services and he was back in [this county] within twenty-four hours. [The defendant] told [his drug counselor] he would do [an inpatient program for drug users]. [The drug counselor] says if he doesn’t do [this program] then he should go to jail. He was supposed to be interviewed by [the program] by today.
Attorney: My client was interviewed by [the program] but [the program] needs information about pending charges. [The program] won’t take someone with pending charges.
Judge: What didn’t he like about services?
Attorney: He told me he is a country boy and didn’t like the big city and said he couldn’t find work there. He felt out of place.
ADA: If he couldn’t stay in services there, how will he do boot camp (referring to the new program)? He needs to be held accountable for his actions.
Judge: Can we put him in jail, rightfully so?
Case Manager: Well, he did go to [the program].
ADA: He needs at least 24 hours in lock-up for non-compliance. He needs some accountability. (The MHC team comes to this decision after looking at the court orders from his last court session. These orders stated he was to go to services in [other county] and have a full psychological work up by today. He has done neither. ADA continues reading order saying 150 days in jail if he does not comply with MHC.).
Judge: For today, we are suggesting at least a dip (jail time).

(After a dip in jail and continued noncompliance, this case ended back in TCC.)
Noncompliant Case 2:
Case Manager: He has not done well this last month. He has not attended sessions since October 8 [for six weeks].
ADA: This is his second time falling off the wagon. He needs to decide if he wants to do MHC or risk two years [in prison]. (ADA reports that she talked with his attorney and his attorney said his client had lied to him and was on his own.)
Judge: My reading of the record shows this is his third chance. What should we do today? [ADA], is he out of MHC today?
ADA: It must be a group decision.
Judge: Team confers and decides on sending him back to TCC.
Judge: I will give him a regular [criminal] court date.

These dialogues show the diligence with which team members discuss pertinent information before deciding to send a defendant back to TCC or to jail. Interviews with team members and observations of pre-court staffings indicate three key factors used to determine failures/successes: defendant motivation (the effort made to co-operate), treatment attendance and repeat re-offending. One attorney best summarizes the goal of the decision-making process, “We must try to consider if what we are doing here is working because the only thing prison means is punishment and segregation.”

Attorney’s Perception of New Roles

It is evident in the preceding case decisions that the methods used to decide cases are much different in MHC than in TCC. Where in TCC guilt or innocence based upon the evidence surrounding the charges is presented by defense and prosecuting attorneys, in MHC defense and prosecuting attorneys work as a team with the judge, criminal justice personnel, the MHC liaison, and other service providers to find the best services and treatment to address the underlying causes of the defendant’s behavior. These new methods involve new roles for attorneys where they are expected to share all
pertinent information about their clients even if it reflects negatively on their client and leads to sanctioning by the judge. Attorneys are challenged by their new roles and by the sharing of information that occurs in the MHC. They described how it is uncomfortable for them to reveal potentially negative information about their clients. However, this discomfort appears to be outweighed by the belief that their client will have a better chance to get much needed treatment in this court and subsequently have a better chance to avoid future offending and incarceration. Their perceptions are exemplified in the following quotes:

**Attorney 1:**
The biggest difference in my role in MHC is we are breaching client confidentiality left and right. We are telling the DA about falling off the wagon and she is making recommendations to the judge. [Revealing this information], makes me uncomfortable…there is a tradeoff….tradeoff is the outcome—the outcome is better for them. The overall process is good.

**Attorney 2:**
I have never given up anything by coming to MHC. The adversarial system is not always good at doing justice. The MHC provides another opportunity for justice. In the MHC revealing information is very uncomfortable—it is a tricky situation. We are treading a fine line with issues of confidentiality and rights of clients. We could probably be challenged on this.

Unlike attorneys, the judges and ADA are happy with their roles in the MHC. Both reported liking being able to help MHC defendants. The judges in particular liked the multitude of resources at their disposal, not being limited to either probation or jail, and having a wide variety of treatment programs to refer defendants. When asked to describe how the judge’s role in the MHC is different from TCC, one judge commented on two main differences:
The biggest difference is everything is decided ahead of time. There are a lot more resources at my disposal in the MHC. In regular court, there is either jail or probation. In addition, in regular court, I don’t see them [defendants] unless there is a problem and the probation officer brings them back to court. The MHC is part of a therapeutic remedy. By seeing the person every month we are building a personal relationship.

The ADA echoes this belief that the MHC offers a therapeutic relationship of which she is happy to be a part.

I love my new role. At heart, I am more of a social worker. This is a good fit for my personality. I like getting at the root of the problem, which is not an option in district court [TCC]. I can see long-term benefits in the MHC.

Overall, judges and the DA seem pleased with their roles in MHC and feel pre-court staffings are essential to their ability to determine the best course of action for each defendant.

These findings highlight the implementation by MHC team members of the non-adversarial decision making process. This new judicial process is a team process by nature of the pre-court meetings in which court team members discuss defendant’s treatment attendance, medication compliance, level of co-operation with treatment providers, motivation level for treatment, and conformity with proscribed behavior. The ultimate goal of these exchanges is for team members to come to agreement on the best course of action for each defendant in terms of treatment and behavior modification measures.

At times attorneys did feel at odds with their dual role of client advocate and team member. Observations and interviews indicate that attorneys balance the tension they feel in implementing this role by doing what is best for their client in the long run.
In addition, attorneys did not completely disregard their adversarial role as observed in pre-court meetings when attorneys advocated for their client; for example, when deemed necessary attorneys would argue for their client to be given a second or third chance or to graduate in a timely manner as specified in their treatment plan. That attorneys and other team members had worked together since the court’s inception appeared to work in everyone’s favor. As noted by Steen (2002) when team members work together for an extended period of time they come to know and respect each other and establish a working relationship with little conflict. This working relationship may have permitted team members to reach consensus more readily on the best plan of action for each defendant.

After reaching a consensus on a plan of action for a defendant, team members discussed how to best implement it, typically conferring about treatment services needed, requirements for treatment attendance and medication compliance, other behavioral requirements (e.g. curfews to keep or people to avoid) and recommendations for the judge as to how to address each defendant to ensure their compliance. Recommendation for the judge varied by case from praise and encouragement, to reminders to chastisement and warnings. After agreement was reached, the judge noted on his copy of the court docket the approach to be used in open court that day for each defendant then used these notes as his “script” in exchanges with defendants. In open court, the judge was the key authority figure who represented the authority of the state in ordering mental health treatment, but in pre-court meetings the judge was a member
of the team where the team pre-planned the points of discussion for use by the judge in review hearings.

In summary, MHC team members appear to have successfully implemented a non-adversarial team approach in this MHC. The team openly discussed defendants’ cases and made individualized decisions for each them based on the information exchanged. As postulated in the conceptual model, it is team decisions ensuring the “best” individualized treatment plans coupled with the MHC team’s monitoring and support which lead to defendant treatment adherence and compliance that theoretically result in a better quality of life and reduced re-offending for defendants.
CHAPTER 8
JUDICIAL POWER AND CONTROL
IN THE COURTROOM

This chapter describes the court procedure in one MHC and how the procedure enables the MHC to influence defendant behavior. To this end, it provides answers to the following questions: 1) How are MHC proceedings structured? 2) What is the purpose of the structure? 3) What is the purpose of the courtroom interaction? and 4) How important is the judge in MHC proceedings? Observation and interview data were used to address these questions. These data provide insight into how well the MHC team, by way of the judge, was able to implement another part of the conceptual model, judicial monitoring. Theoretically, if judicial monitoring is implemented successfully, judges are able to influence defendant behavior in a positive way to avoid future offending.

This chapter presents evidence on the implementation of judicial monitoring through the use of formal and informal social control with the goals of ensuring defendant treatment and behavioral compliance leading to a better quality of life and reduced criminal activity. Formal mechanisms of social control are the ordering of the docket, sanctions imposed, and the very nature of the proceedings in a court of law designed to enforce the rules of society. The judge, enforcer of the rules, uses sanctions as appropriate to ensure conformity to law-abiding behavior. Informal mechanisms of social control are the establishment of a positive connection with defendants and courtroom exchanges.
Formal social control is crucial to the functioning of the MHC. That MHC proceedings take place in a court of law with a presiding judge who represents the state in a position of power to enforce the laws of society is a major mechanism by which defendant behavior is controlled. Defendants are aware that their appearance in court and their subsequent behavioral compliance have legal ramifications that are enforceable by the judge either through transfer back to TCC where one faces a criminal trial and possible incarceration or through “dips” in jail for non-compliance. However, these measures are rarely discussed in open court and used only in cases of consistent non-compliance because the MHC’s focus is treatment rather than punishment.

**MHC Proceedings Structure**

The entire drama that unfolds in MHC hearings from the ordering of the docket to the content of the dialogue that ensues is preplanned in team staffings and seeks to reinforce positive treatment experiences and modify negative behavior both formally with traditional court procedures and informally with verbal exchanges between the judge and defendant. MHC hearings proceed in a manner that allows individual attention to each defendant and permits the judge to engage each defendant in a verbal exchange, unlike TCC where cases are handled in a hurried, formal, assembly-line fashion. Court begins with the ADA calling each case on the docket with the respective defendant and his/her attorney approaching the bench. The judge engages the defendant in verbal exchanges often by asking direct questions concerning treatment, behavior, and any criminal offenses during the past month. The content of the dialogue
includes relevant facts concerning receipt of services, treatment engagement, and problems encountered during the month. For compliant defendants, the judge responds with positive comments; while for noncompliant defendants, the message is one of disappointment and at times stern warnings, threatening jail or return to TCC.

Review hearings in the observed MHC last an average of two minutes, but range from less than a minute to 22 minutes. Typically compliant defendants’ review hearings last one minute or less each, with more time given to difficult or problematic cases. Each case is handled at the judge’s own pace allowing sufficient time to address compliance, encourage treatment attendance and involvement, and establish a relationship with the defendant by engaging him/her in discussions.

**Purpose of the Structure of MHC Proceedings**

The order in which cases are called and their review are discussed and settled in pre-court meetings by the MHC team as a method of social control with two goals: 1) to reward graduating and compliant defendants and 2) to act as a stimulus for behavior change for noncompliant defendants. As such, graduates’ cases are called first followed by compliant defendants’ cases with noncompliant defendants’ cases being called last.

Calling graduating defendants’ cases first serves to celebrate and acknowledge achievements. Graduation ceremonies are intended to provide encouragement, hope, motivation, and models to other MHC defendants seated in the courtroom awaiting call of their own cases. When each graduating defendant’s case is called, the judge summarizes, compliments, and praises accomplishments and encourages continued
contact with treatment case managers. Not infrequently, graduates talk about progress and/or life changes the MHC brought. The following quotes from graduating defendants in open court demonstrate both the inspiration the MHC team hopes will positively influence other defendants and the impact the MHC had on their lives.

**Defendant 1:**
I am so grateful for this court. If I had not come here and done what you asked me to do, I would be in jail. I was going through one of the worst times in my life [pause] emotionally and mentally; and this court saved me. I am so thankful for this court and the second chance it gave me.

**Defendant 2:**
This court has done so much for me. When I first started [this court], I was self medicating to feel better...to get through the day. Now, I am working to take my medicine like I should. I still have some work to do, but I am on my way.

**Defendant 3:**
This court gave me a chance. It saved my life. Before this court, I was drinking myself to death. I was on the path to being six feet under. [The judge] saved my life. He got my attention like no one else before. I did all the hard work, but the court supported me. It [MHC] was better than throwing me in jail and throwing away the key.

**Defendant 4:**
I am a recovering alcoholic. I have been in recovery for 17 years. I had a relapse 11 months ago. I was evicted and arrested for trespassing in my own home. I ended up here [MHC]. This court saved me. I knew what I needed to do, but I just couldn’t do it on my own. With the court’s help and support, I am clean today. I am living in [supervised housing for substance abusers] and am working to get my own place.

After giving each defendant a chance to speak, the ADA informs each graduate how his/her charges will be disposed and presents each with a certificate of completion, at which time the judge asks the graduate to approach the bench and shakes his/her
hand. At this point, the MHC team begins applauding and is joined by other defendants and their families and/or friends in the courtroom audience. The presentation of a certificate of completion and the judge’s and ADA’s comments during defendants’ last court appearance (graduation) gives defendants a sense of pride and personal achievement as evidenced by defendants standing proud, smiling, and at times clapping for themselves.

Compliant cases are called next as a reward for good behavior because defendants are excused from the day’s court session after their cases are heard. The judge and ADA respond with compliments and praise as a reward for good behavior and to encourage continued compliance (see examples on page 80). Noncompliant defendants are called last giving them the opportunity to hear about others’ progress and to witness the judge’s responses to commendable treatment experiences as well as to set-backs and failures with the hope that these exchanges will encourage them to become compliant. Whether this praise motivates non-compliant defendants to change their behavior is not readily discernable in this research. Certainly, it does not work for all defendants as witnessed in cases of non-compliant defendants that get transferred back to TCC, get remanded to jail, or only comply to get their charges dropped. For example, a pregnant female MHC defendant who regularly attended her court monitoring sessions continued to abuse substances was sentenced to jail time until the birth of her child to protect it from further harm caused by the mother’s substance abuse. Second in an overheard conversation, I learned that a mentally ill, male defendant became treatment compliant only to have his charges dismissed instead of
being motivated to change his behavior on a more permanent basis. Therefore, it can
not be said that the praise offered to MHC defendants in open court effects change in
all MHC defendants in the courtroom audience.

**Purpose of the Courtroom Interaction and the Significance of the Judge in
MHC Proceedings**

Not only is the MHC team able to influence defendant behavior through the
order of cases called during open court, the judge is able to influence defendant
behavior in three ways: 1) through attendance and participation in MHC proceedings,
2) through the establishment of a relationship with defendants, and 3) through verbal
exchanges with defendants made in open court.

**The Judge’s Presence Indicates Authority.** The judge is able to influence
defendant behavior through the defendant’s presence in the courtroom where the judge
is symbol of authority. Attendance at MHC review hearings indicates the seriousness
of the charges and the level of accountability the court team expects. One judge best
illustrated his belief in this process by saying,

> The judge is seen as a symbol in his black robe. That is why I will never
appear [in MHC] without my robe. [The judge] is the authority and it is
his duty to uphold the law. It shows the defendant that the court takes his
treatment performance seriously. Only the judge has the authority to
mete out sanctions and rewards to offenders.

A private attorney echoed this sentiment by saying,

> The judge brings seriousness and accountability to the [MHC]
process. His presence makes it more meaningful and real to
defendants in the courtroom.
As the authority figure in MHC, the judge is a powerful force who is able to influence defendant behavior and treatment compliance through his presence in MHC and through the establishment of a caring relationship and verbal exchanges with defendants.

**Establishment of a Personal Relationship.** When asked about the relationship between the judge and MHC defendants, one judge commented that many people overlook the importance of this relationship and the impact judges may have on MHC defendants’ behavior. He stated,

*The authority figure who cares about the life outcomes of a challenged person in crisis with potentially low self esteem and encourages and rewards with individualized praise and acknowledgement is probably underestimated by those of us who don’t ‘need’ that kind of attention. We show them we care by talking to [defendants] by name, citing their accomplishments, letting them know that one in the highest authority deems them a worthy, valuable person, cares about their life in our community, helps reconnect them [helps them] to want to be a part of the community and, hopefully, observe their therapeutic regime which also regulates their behavior so the community finds it acceptable.*

A connection is formed between the judge and a defendant whereby the judge talks with each defendant, shows compassion, and treats each as a valuable citizen. Judges may be able to influence defendant behavior whereby defendants want to behave in a manner to please the judge. One way to achieve this one judge said, is by “making sure each defendant feels cared about. If defendants know we [the MHC team] are concerned about their welfare and are confident they can succeed, they don’t want to let us down.”
The following review hearings show the consideration given to MHC defendants by the judge during court hearings.17

**Case 1:**
Judge: Welcome to MHC. We would like for you to meet with [the mental health liaison] today.
Attorney: He wants to participate in this court your honor, but he is very concerned over housing today.
Judge: When you meet with [the mental health liaison] today, talk with him about your housing and medication. He can help you with these.
Defendant: [Crying and visibly upset] OK.

**Case 2:**
Judge: How are you feeling?
Defendant: I am feeling good.
Judge: When was the last time you had a drink?
Defendant: [Looks up and thinks for a moment] It has been six months today.
Judge: I can tell when someone is telling me the truth if they know to the day when their last drink was. Get your calendar and mark out 18 months and 24 months. From what I hear from others this is the toughest time. Be extra vigilant. Temptation is easy. You have met your legal requirements. We have to do a judgment in your case, but you will not need to be there.

**Case 3:**
Judge: Tell me it is true, you are going?
Defendant: Yes, I will go [to residential treatment program].
Judge: I am so proud of you. This may save your life. If you go with [your case manager] and complete the program, you don’t have to come back here.

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17 The following discussions were captured as close to verbatim as possible. Dialogue proceeded quickly and the researcher took notes as quickly as possible but was unable to record every word.
Case 4:
Judge: [Reads progress report from defendant’s school] Your teacher says great things about you. This is wonderful. I am very pleased. Every teacher says you have wonderful behavior with exclamation points. This is wonderful. Is this a special form you made [referring to progress report form].
Defendant: Yes.
Judge: You are pretty smart. What are your plans after graduation?
Defendant: I may go to college. [My attorney] and I have talked about it.
Judge: I am so happy your teachers are pleased about your participation in class. Please don’t disappoint your teachers. Have a good Thanksgiving. I would say you have a few things to be thankful for.
Defendant: Thank you.

Case 5:
Judge: I know I am not your usual judge. First, I am pleased because you are doing a good job, but I have concerns about the piling on of services. I don’t want you to be overwhelmed. [Judge addresses case manager] Can you modify [this defendant’s] treatment plan as needed?

Each of these cases demonstrates the same underlying message: the judge cares about defendants, thinks they are worth the time and effort expended, and has faith that they can succeed in treatment if they try.

Verbal Exchanges. Verbal exchanges in MHC are primarily between the judge and the defendant. To initiate an exchange with a defendant, the judge typically inquires about the defendant’s general well being asking: “How are you today?” “Are you doing all right?” “How are things going?” followed by questions regarding treatment attendance, motivation, and compliance. For example, the judge asked the following questions of different defendants to engage them in dialogues about treatment and medication compliance: “Did you do exactly what we asked?” “Did you attend all of your treatment sessions?” “How many treatment sessions did you attend

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this month?” “What did you think of the treatment sessions?” “Are you still using substances?” “Are you taking your medication?” “Are you having any problems with your medication?” Compliant defendants, in response to these questions, openly talk to the judge about their treatment stating the number of sessions they have attended, specific classes in which they have participated, and what they learned in these classes. Conversely, noncompliant defendants attempt to account for their behavior and lack of treatment attendance, offering explanations which the judge may or may not consider valid excuses.

Judicial feedback includes positive and negative statements (rewards and punishments) to encourage defendant treatment compliance and accountability for behavior. In open court, defendants are either praised for compliance; or in cases of noncompliance they are asked to explain publicly why they have not cooperated with their treatment regimen followed by the judge warning or threatening to return them to jail or TCC if improvements are not made.

Rewards come in the form of praise and encouragement for treatment compliance. Positive feedback varies depending on the defendant and his/her achievements as exemplified in the following statements from the bench.

*I got a wonderful report on you. You are making good use of therapy. This is very encouraging.*

*I get good reports on you. Keep up the good work. We are proud of you.*

*It is straightforward today. I get good reports. Keep all of your appointments. We will see you next month.*

*I am pleased with your progress. You look great. How do you feel?*
Although the preceding statements are similar to those spoken at graduation from MHC, their use during court monitoring serves to reinforce and reward treatment compliance for the particular defendant being addressed and to serve as a motivational tool for defendants observing in the courtroom.

At times, defendants discussed the impact of the judge’s comments, praises, and compliments on their behavior and motivation to change. As best stated by two defendants,\(^{18}\)

**Defendant 1:**
*For the first three months of court I did what I was supposed to, but I was just riding it out. That’s when the judge put his hand on my back, shook my hand, and told me he was proud of me. This was a turning point for me. For the first time in my life someone thought I was doing a good job. This made me want to work harder. I had finally gotten someone to realize that I was really trying.*

**Defendant 2:**
*All my life people have put me down. My dad and step mom always called me a screw-up. I turned to drugs and alcohol because they made me feel good. Coming to this court has been a blessing. I really dig this place. It is the first place I have been that makes me feel good about myself. I come and get compliments as long as I am doing what I am supposed to do. I hear good stuff and it makes me want to work harder to keep hearing it.*

Negative statements, warning or threats, are also used by the judge in an attempt to modify noncompliant behavior. One attorney described this process,

*[The judge’s response] to noncompliance puts the client on the line...The judge has a menu of options available [to deal with noncompliance] and is flexible in how they are used.*

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\(^{18}\) These quotes were obtained in a quarterly MHC team meeting in which compliant defendants near graduation or those who had recently graduated were invited to talk with team members about the impact of the MHC on their lives.
In pre-court meetings, the court team makes recommendations to the judge on the intensity of the warning and the sanction imposed based on the level of noncompliance and individual mental health needs. Warnings statements delivered at varied intensity levels are exemplified in the following:

*This may be your last time in this court. We are concerned that you are not participating. I hear you have spotty attendance. Is there a reason you haven’t been attending treatment sessions?*

*How will you make the 2:00 pm appointment on Friday and keep the kids? You can tell me this is too much or you can come back next month having gone to all appointments. Do you want regular court? Is this a waste of your time?*

*I want to be clear with you. Your attorney is the only reason you are not in jail today.*

*I hear you missed your appointment with Jim. I am going to give you a day in jail for each missed appointment. Do you understand?*

Public accountability and admonishment show defendants the seriousness of their noncompliance, advise them about the consequences of their actions, and give them a push to become compliant.

The interaction between the judge and the defendant plays a significant role in the treatment process of MHC defendants in four ways: 1) defendants coming before the judge monthly serves as a reminder to them that they are accountable for their actions; 2) judicial response to defendants’ behavior in the previous month clarifies and reinforces the court team’s treatment expectations; 3) the judge’s attention to their compliance with treatment and behavioral mandates shows defendants the seriousness
with which the court takes their compliance; and 4) this interaction serves positively to affect their behavior. One attorney best explained this process,

*Court is a way of reaffirming...reminding them [defendants] that they are answerable to someone...The interaction also has a secondary agenda. When the judge gives positive feedback, admonishes, reviews what they need to do, and gives them reminders, he is making clear what is expected. Natural consequences don’t make sense if you don’t know what you should have done.*

Three cases are described below to demonstrate how review hearings are used to remind defendants of the court team’s expectations for treatment engagement and attendance and the consequences of noncompliance.

**Case 1:**
Judge: We are only going to let you stay [in this court] right now because we know you and your family. I know you can do it.
Defendant: I know I can do it; too.
Attorney: He began classes yesterday.
Judge: I expect to see your shining face; and you need to do well. We care a lot about you and we are going to stay fully engaged with you.
Defendant: OK.

**Case 2:**
Judge: It is judgment day. Your case manager thinks you can make it. He says you are ready to have a better life. I want you to show me. I was ready to bump you, but the team convinced me to let you stay. Don’t make me look like a fool. I had better get a good report next time. You will do it right? If you don’t want to, let’s go to jail.
Defendant: I want to do it.
Attorney: You will have to do everything your case manager says.
Judge: Does she [defendant] know what these things are?
Defendant: No.
Case manager: The treatment team will put it in writing for you. Come at 1:30 this Friday. That is the first step. [Addresses judge] We will need you to set a curfew for her.
Judge: Your curfew is 7:00 pm. If you are out past 7:00 pm and anyone sees you, you will be arrested. Understand?
Defendant: Yes, your honor.
Case 3:
Judge: By next court date you need to make all appointments or you are going to jail. This court is a compliance court so you must do what we say. I think you can do it. That is why I am spending the time and effort on you. We will see you next month.
Attorney: [Gives his client an appointment card for the next court date]

In summary, this chapter illustrates that this MHC effectively implemented another link in the conceptual model, judicial monitoring, that theoretically leads to defendant treatment and behavioral compliance and better defendant outcomes. By way of informal and formal social control mechanisms, the judge strives to obtain and maintain defendant compliance. The court attempts to influence defendant behavior informally through the ordering of the docket where compliant defendants are rewarded and their good behavior is reinforced by having their cases called first and noncompliant defendants are called last giving them the chance to hear about and be encouraged by others’ successes and to witness the judge’s responses to positive treatment experiences as well as to set-backs and failures. The judge also strives to influence defendant behavior by establishing a connection with defendants through court interactions whereby s/he expresses concern, compassion, and/or disappointment as well as expectations for appropriate behavior. Through the use of a team approach to decide upon rewards and punishments delivered to defendants in court monitoring sessions by a judge, the MHC team attempts to reinforce positive behavior and modify noncompliant behavior with the goal of improving defendants’ quality of life and reducing recidivism.
Although the judge is a member of the court team in reviewing cases in pre-court meetings, in court the judge is clearly the one with power representing the authority of the state in ordering arrest, time in jail, or return to TCC when defendants do not co-operate with court mandates. Findings point to the necessity of the judge presiding over MHC to enforce the rules and ensure defendant compliance. The role of the judge is thought to be critical to MHC and their ability to influence defendant behavior. It is believed to be the judge’s monitoring, encouraging, and supervising defendants’ behavior in MHC that make a MHC different and presumably better in influencing positive defendant outcomes than probation with mandated services or outpatient commitment (Stefan and Winick 2005; Lamb, Weinberger, and Gross 2001; Lamb, Weinberger, and Reston-Parham 2001; Watson et al. 2001).

Because judicial monitoring and supervising are a critical component in the MHC model, the character of the judge is crucial to the successful implementation of the MHC conceptual model. This MHC seems to work well because the judge is sympathetic to persons with mental illness, treats them with respect, and functions as a member of a court team in case decision-making. If a judge did not have these qualities, it is questionable whether the mechanisms by which MHCs are thought to work would be implemented with efforts made to ensure individual rights are maintained, defendants are treated fairly and respectfully, and social control is not overbearing.
CHAPTER 9

MHC DEFENDANTS

This chapter describes the MHC sample including demographics, criminal history, key arrest, length of time in the MHC, diagnosis, and global functioning using data from the full MHC sample supplemented with information on the MHC subsample. The full MHC sample uses data contained in public records: demographics, criminal history, key arrest, and length of time in the MHC. Data on diagnosis and global functioning from mental health records, supplemented with observational data, are available for the MHC subsample only. Unless otherwise stated, data presented in this chapter are from the full MHC sample.

The original intent of this chapter was to provide a description of MHC defendants followed by quantitative analyses of mental health treatment data; however, limitations in the size of the sub-sample for which outcome data were collected (see Chapter 5 for a description of sub-sample selection) restrict this and the next chapter to qualitative descriptions and analyses interspersed with quantitative data. During the six months defendants were recruited to participate in mental health record review portion of this study, 42 defendants were asked to participate and only 31 consented. Of the two MHC locations, the rural location had fewer new referrals (18) as compared to the university setting (24), but had a higher consent rate (77%) as compared to (70%).

Although enumeration of refusal reasons was not made, a few defendants mentioned either needing to talk with parents about signing the consent whose parents
then said no (for younger defendants) or being very distrustful about the accuracy and one-sided point of view of data in the mental health record (ie. data in the record only reflect the treatment provider’s perception of events, symptoms, etc.). A few others, not giving a specific reason, appeared to be wary of the researcher. In two cases the MHC liaison requested that I wait until a later date to ask these defendants for informed consent, because both were angry and cautious of the MHC. The MHC liaison was concerned that my talking with them could influence them to opt out of the MHC.

The consenting group of 31 was reduced to an effective sub-sample size of 19 because four never engaged in treatment; one obtained treatment in another county; and seven obtained treatment by a provider other than the CMHC. Those who obtained treatment outside of CMHC were not included in the sample, because the language in the consent form only permitted record review at CMHC. Although an oversight, adding eight to the sub-sample size would not change the analytic technique permitted.

DESCRIPTION OF MHC SUBJECTS

Demographics

The MHC sample is predominately male (68.29%) and white (60.98%). Age for MHC subjects ranges from 17-62 years with an average age of 35. The MHC subsample is predominantly single with most having less than a high school education. Of the 19 sub-sample members, almost all (18) were not married (single, divorced, or widowed). Highest grade completed was two years of college; however, the majority of sub-sample members (N=17) had less than a high school education with a sub-sample mean of 11 ½ years of school. Socioeconomic information was not available, but most
sample members are presumed to be of low socioeconomic status (SES) because most received services through the local CMH center. Only a small proportion (17%) of sample members had private insurance and/or received services through a private clinician.

The MHC sub-sample is representative of the whole MHC sample for two reasons: 1) The sub-sample and MHC sample are similar demographically on age, race, and gender; however, statistical tests of significant differences can not be made due to small size of the sub-sample and 2) Eligibility into the MHC and MHC court process and procedure were the same during the six months of sub-sample recruitment and the twelve month period of data collection for the larger MHC sample.

Criminal History

Almost half (42.7%) of the MHC sample was arrested in the year prior to their key arrest which led to entry into the MHC. A breakdown of number of prior offenses by MHC sample members is seen in Figure 9.1, which indicates that 57.3% had none, 13.4% had one, 12.2% had two, and 17.1% had three or more arrests in the year prior to their key arrest. That almost half the sample had at least one prior arrest is not surprising because this MHC was established to deal with mentally ill offenders whom the court saw frequently. As noted by the Chief District Court Judge,

Mentally ill offenders were getting lost in regular court [TCC] and they kept coming back over and over which increased the number of cases to be heard in regular court. The operational motivation behind the development of the [MHC] was to give them [mentally ill offenders] special attention in a special court to address their needs.
An examination of the type of crimes for which defendants had prior arrests indicates almost all were infractions and non-violent misdemeanors. Inspection of the most serious charge for the first arrest during the year prior to this study shows that all arrests were infractions and misdemeanors with the exception of one non-violent felony: traffic (9%), drug/alcohol (31%), misdemeanors (40% nonviolent and 17% violent) (see Figure 9.2).\textsuperscript{19} Most offenses committed by mentally ill persons are nonviolent in nature and often are nuisance (trespassing, open container in a public place, indecent exposure) or survival (petty theft, shoplifting) crimes committed as a result of their illness and the disadvantages it produces in ability to function and cope with difficult situations, as found by earlier researchers (Draine 2002, Engel and Silver 2001, Hiday 1999, Bonta 1998, Lamb and Weinberger 1998, Teplin 1984). If provided adequate and appropriate treatment and services, these mentally disordered offenders may not have committed their offenses and been arrested (Lamb and Weinberger 1998).

Only 12% of the MHC sample spent some time in jail prior to their key arrest that led to entry into the MHC with a range of 1 to 26 days. That so few spent time in jail prior to their key arrest is not surprising for two reasons: 1) The judge in this county strives to keep offenders who have committed nonviolent misdemeanors out of jail prior to their court hearing. To this end, all jail detainees’ cases are reviewed and those with such minor charges are released. 2) With the implementation of structured

\textsuperscript{19} Types of charges were examined for defendants who were arrested more than one time during the year prior to the study and a similar pattern was noted. Therefore, a discussion of offense type is not included for second, third, fourth, etc. charges.
sentencing guidelines, most defendants who are found guilty of infractions and/or misdemeanor offenses are not given jail time but are often sentenced to probation coupled with community service.

**Key Charge**

Type of offenses that led to entry into the MHC can be seen in Figure 9.3. Most offenses were misdemeanors (40% nonviolent and 23% violent) followed by drug and alcohol offenses (23%), felonies (9%), and traffic violations (5%). Of the misdemeanors, nonviolent offenses (e.g. trespassing, breaking and entering, larceny, carrying a concealed weapon, and indecent exposure) comprise the largest category followed by violent misdemeanors (simple assault and assault with a deadly weapon). Drug and alcohol offenses (e.g. possession of alcohol on a public street, driving under the influence, possession of marijuana, possession of a controlled substance, etc.) are the next largest category with the majority of offenses being alcohol related. Felonies represent a small percent of cases admitted to the MHC: 7% nonviolent (felony larceny, possession of stolen goods, obtaining property by false pretenses, and breaking and entering a motor vehicle) and 2% violent (assault with a deadly weapon with intent to kill or inflict serious injury).

That this MHC allows defendants with felony charges to participate is not deemed a public safety risk by the court team, because the ADA carefully screens all defendants entering the court (see chapter 4) especially those with felony charges and/or violent offenses. The ADA pointed out that balancing the community’s safety...
while allowing defendants to reside in the community is “always a struggle but for the most part the MHC is doing a good job.” She continued by pointing out that,

“Most victims are okay with their perpetrators’ participation in the MHC. Only a few [victims] have been hesitant, and it is usually because something else is happening. For example, [one defendant’s] husband wanted her in regular court, but there were other things going on--a divorce and custody suit.”

It is the MHC’s policy that, if a victim is involved, the ADA must get the victim’s consent for the defendant to participate in the MHC. In all cases involving victims in the study, all victims knew their perpetrator and all agreed to allow the offender into the MHC. Only a few victims were reluctant initially; however, most wanted the offender to obtain treatment rather than punishment and were glad the offender had the chance to obtain the services and monitoring of the MHC.

The majority of the nonviolent misdemeanors were nuisance and/or survival crimes. Of the violent misdemeanors committed, most were assaults committed against friends or family. This is consistent with the literature on violence and the mentally ill indicating that most violent acts committed by mentally ill offenders are not violent. Defendants who committed the violent felonies tended to have dual diagnoses with primary diagnoses of substance abuse/dependency. The literature on mental illness, drug use, and violence indicates that most persons with SMI are not violent, but when their mental illness is coupled with substance abuse there is an increased risk of violence (Hiday forthcoming; Lamb and Weinberger 1998; Steadman et al. 1998, Swartz, Swanson, Hiday, Borum, Wagner, Burns 1998; Swanson, Borum, Swartz, Monahan 1996; Swanson 1994).
**Length of Time in the MHC**

Length of time in the MHC was calculated as the number of days from the date of entry into until the date of exit (either through graduation or transfer to TCC) from the MHC. The mean number of days involved in the MHC was 230 with a range of 29 to 365 days for all MHC defendants in the sample. Figure 9.4 displays the distribution of days in the MHC using four categories. A separate category is used for 180 days (six months) as this is the established minimum time to be spent in the MHC before graduation.

As noted in Figure 9.4, 14.6% of MHC defendants leave the program in the first 3 months, 7.3% leave the program in 3-6 months, and 78.1% remain in the program for six months or more. Those who leave in the first few months after entry into the MHC never begin a “dose” of treatment, dropping out before treatment, as soon as the structure impinges on their old behavior patterns. Other defendants who leave the program before successful completion begin a “dose” of treatment but never fully engage in treatment and services and/or resist the structural requirements. After numerous failed attempts to develop a working relationship, the MHC Team ejects them back to TCC. Others, who typically persist until graduation (78.1%), remain in the program for six months or more and have the opportunity to taste the potential benefits of compliance with the “prescribed dose.”

**Diagnosis**

Diagnosis was not available for the entire MHC sample. It was obtained for the MHC subsample (N=19) and was supplemented with observational data obtained in
pre-court meetings where diagnosis was mentioned for an additional 55 MHC defendants;\textsuperscript{20} therefore, diagnosis is available for 74 MHC defendants.\textsuperscript{21} The distribution of primary diagnoses is presented in Figure 9.5. It is presumed that many MHC defendants suffered from mental illness and substance abuse disorders; however, secondary diagnoses were rarely discussed by court team members and the proportion of MHC subjects in the full sample suffering from dual diagnosis is not known.

Primary diagnoses for defendants indicate the court serves its target population: persons with a mental illness diagnosis, developmental disability, or a mental health treatment history including the presence of a substance abuse or alcohol dependence disorder. The court intentionally set broad diagnostic admission criteria giving admission priority to individuals with severe mental illness (MHC documents included in Appendix B). Psychiatric diagnoses include depression, schizophrenia, bipolar, and personality disorder while substance abuse disorders include alcohol and drug abuse or dependency. Persons with severe mental illness comprised 50\% of the MHC sample while 15\% had depression, severity not specified,\textsuperscript{22} 9\% had borderline personality disorder, 26\% had an alcohol or substance abuse disorder, and 9\% were developmentally disabled.

That the MHC sample included a large percentage (50\%) of defendants who did not have a severe and persistent mental illness is not deemed unique or problematic for

\textsuperscript{20} Diagnoses were discussed in pre-court meetings for some members in the subsample, but these diagnoses are not included in the additional 55 to prevent any duplication in reporting.

\textsuperscript{21} Reported diagnoses are only primary diagnoses as secondary diagnoses were typically not discussed in pre-court team meetings.

\textsuperscript{22} The severity of depression is unknown as data were obtained during the case manager’s presentation of the defendant’s background and mental health history to the court team.
the generalization of study results because many other MHCs do not limit eligibility to
only the severely and persistently mentally ill (Boothroyd et al. 2005; Cosden et al
The chart below presents sample percentages by primary diagnosis for the study site
and other MHCs.23

Chart 9.1 Primary Diagnosis of MHC Defendants

<table>
<thead>
<tr>
<th>Study Site</th>
<th>Serious Mental Illness (psychosis, schizophrenia, bipolar disorder, delusional disorders, chronic psychotic)</th>
<th>Mental illness (depression, post traumatic stress disorder, mood disorder, and anxiety disorder)</th>
<th>Developmentally Disability</th>
<th>Substance Abuse/Alcohol Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>King County</td>
<td>50%</td>
<td>15%24</td>
<td>9%</td>
<td>26%</td>
</tr>
<tr>
<td>Seattle</td>
<td>45%</td>
<td>55%+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broward County</td>
<td>66%</td>
<td>34%+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Santa Barbara</td>
<td>88%25</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clark County</td>
<td>94%26</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ indicates that type and severity of the mental illness were not specified.

Courts vary in the percent of defendants served with severe and less serious
mental illnesses; but an accurate comparison is difficult to make because it is not
possible determine the seriousness of some diagnostic categories. The study site is
clearly different in being the only court that explicitly included persons with

23 The research studies presented in this table categorized mental illness differently; therefore, the
categories used herein are summarized as precisely as possible but are limited by previous research.
24 Each of these sample members was diagnosed with depression although the level of severity is unclear
as mental health diagnosis was mentioned during pre-court meetings and was only referred to as
depression.
25 37% of these were diagnosed with mood disorders which could include less serious depression
diagnoses.
26 72% were diagnosed with mood disorders which could include less serious depression diagnoses.
substance/alcohol abuse disorders and developmentally disability as primary diagnoses in its target population (37% of the sample). That twenty six percent of the subjects in this MHC had substance abuse as their primary diagnosis may negatively impact MHC outcomes because substance abuse has strong direct and indirect effects on criminal offending and because MHCs do not monitor defendants as closely or as strictly as drug courts (Goldkamp and Irons-Guynn 2000, Bonta, Law, and Hanson 1998, Hiday et al. 1995, Swanson 1994). Specific mental illness diagnoses should not impact the study outcome, re-arrest, because according to a 1998 meta-analysis of published and unpublished sources from 1959 to 1995 Bonta et al. (1998) found predictors of recidivism to be the same for disordered and non-disordered offenders. In examining 35 predictors of general recidivism and 27 predictors of violent recidivism, Bonta et al. (1998) concluded that criminal history variables were the best predictors of recidivism for disordered and non-disordered offenders. They noted little effect of the ability of clinical variables to predict recidivism. But they also noted that these variables are important when determining the appropriate intervention to properly manage this group of offenders.

Although this meta-analysis led me to conclude that there would not be a difference in recidivism among mentally disordered and non-disordered offenders, it does provide some evidence that my sample could fair worse in terms of recidivism. The above discussed meta-analysis indicated that drug use was a predictor of recidivism regardless of the mental health of offenders and twenty six percent of my sample were known substance abusers. Furthermore, my qualitative analyses of the
MHC sample indicated that more substance abusers than persons with mental illness were treatment non-compliant and less likely to complete the MHC program (discussed in Chapter 10).

**Diagnosis and Global Functioning: The Subsample**

Examination of primary diagnosis of the sub-sample indicates that ten defendants had a psychiatric diagnosis: major depression (n=5), schizophrenia (N=2), bipolar (n=1), and personality disorder (n=2); while the remaining nine had an alcohol or drug dependency disorder (7 and 2 respectively). Most defendants (n=13) also had a secondary diagnosis: major depression (n=1), psychosis NOS (n=1), alcohol abuse (n=5), drug abuse (n=4), or personality disorder (n=2). Categorizing MHC defendants by diagnosis type: 3 had mental illness only, 8 had alcohol or drug dependence only, and 8 had a dual disorder.

Global functioning scores (GAF), a measure of overall psychological, social and occupational functioning, are examined for the sub-sample as a whole and by type of diagnosis: mental illness, alcohol/substance use disorder, or dual disorder. GAF scores can range from 1 to 100 with each ten-point increment indicating a higher level of functioning. For example, a score of 1-10 indicates a person is in danger of hurting self or others, is unable to care for personal hygiene, or is suicidal while 91-100 indicates superior functioning with no symptoms. MHC sub-sample GAF scores at intake into MHC ranged from 30 to 85 with a mean of 59.\(^{27}\) The lowest score, 30, indicates that

\(^{27}\) GAF scores were not indicated in the mental health record of two subjects.
one’s behavior is affected by delusions or hallucinations or has an impairment of communication and/or judgment. The mean score, 59, is an indication of moderate symptoms or modest difficulty in functioning while the highest score, 85, indicates minimal symptoms. A comparison of GAF scores by diagnosis (see chart below) indicates that persons with dual disorders have the lowest level of functioning followed by those with mental illness only; while those with alcohol/substance abuse disorders had the best overall functioning.

**Chart 9.2 Global Functioning Scores by Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>GAF Range</th>
<th>GAF Mean</th>
<th>GAF Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sub-sample</td>
<td>30-85</td>
<td>59</td>
<td>51</td>
</tr>
<tr>
<td>Mental illness</td>
<td>44-85</td>
<td>58</td>
<td>45</td>
</tr>
<tr>
<td>Alcohol/substance abuse disorder</td>
<td>30-68</td>
<td>64</td>
<td>65</td>
</tr>
<tr>
<td>Dual disorder</td>
<td>30-70</td>
<td>53</td>
<td>50</td>
</tr>
</tbody>
</table>

In summary, this chapter has provided a snapshot view of MHC participants; specifically, demographics, criminal history, key charge, length of time in the MHC, diagnosis, and global functioning, all of which are important to consider when examining the effectiveness of the MHC. The next chapter focuses on the qualitative impact of the MHC on defendants’ lives with the subsequent chapter containing quantitative analyses of recidivism.
CHAPTER 9: FIGURES

Figure 9.1 Number of Prior Arrests for MHC Defendants in the Year Prior to Entry into the MHC (N=82)

Figure 9.2 Most Serious Offense of First Arrest in Year Prior to Entry into the MHC (N=82)
Figure 9.3 Most Serious Offense of Key Arrest for MHC Defendants (N=82)

Figure 9.3  Most Serious Offense of Key Arrest for MHC Defendants (N=82)

Figure 9.4  Length of Time Defendants Were in MHC (N=82)

Figure 9.4  Length of Time Defendants Were in MHC (N=82)
Figure 9.5 Mental Health Court Participants' Primary Diagnosis (N=74)

- Developmental disability: 9%
- Drug abuse: 8%
- Alcohol abuse: 18%
- Depression (severity unknown): 15%
- Major depression: 7%
- Schizophrenia: 16%
- Bipolar: 18%
- Borderline personality disorder: 9%
CHAPTER 10:
IMPACT OF THE MHC

This chapter presents qualitative and quantitative data to determine how effective the MHC is in producing its intended outcomes: improved quality of life and reduced recidivism. To fully understand the impact of the MHC, it is important to understand the individual needs of defendants, the context in which their cases are monitored, and the types of services the court is able to marshal for defendants to assist them in the recovery process. Qualitative and quantitative methods are used to examine services marshaled, treatment engagement, motivation and recovery, treatment compliance, and recidivism. Data for this chapter originate from different samples: 1) the full MHC sample, 2) the MHC subsample (including information obtained from mental health treatment records), 3) pre-court and court observations and 4) in-person interviews with the MHC team, depending on availability. These data provide the context for understanding defendants’ situations and are critical in characterizing defendants’ successes.

Mentally ill offenders have a multiplicity of needs: mental health/substance abuse treatment; social and vocational rehabilitation; and financial, housing, and employment assistance. Locating providers to supply these services is challenging because most service agencies serve only a single problem or issue as in most communities in the United States (Mechanic 2003, Morrissey 1999), are in short supply (U.S. Department of Health and Human Services 2000), and/or have strict regulations about admitting persons with substance abuse problems and/or with pending criminal
charges (Rock 2001, Teplin 1984). Marshaling services (rehabilitative and treatment) are crucial to the success of the MHC and are often the first step in helping defendants regain control over their lives.

**Services Marshaled**

Though gains have been made in access to mental health treatment in the United States, SMI persons who are poor and disenfranchised remain underserved and neglected (Mechanic 2003). Persons with SMI have difficulty obtaining services for three reasons: 1) the service system is fragmented and hard to navigate even for persons without mental illness, 2) many persons with SMI have cognitive and functional impairments which decrease their motivation and ability to locate and comply with mental health treatment services, and 3) disadvantaged persons with SMI are unemployed, poor, and lack health insurance coverage and/or the money to pay for treatment services (Mechanic 2003, Morrissey 1999). Given these difficulties, it is not surprising that most have never had or have become disengaged from mental health treatment. Recognizing this, the MHC facilitates receipt of services through a court liaison, a certified social worker, who works to establish individualized treatment plans and link defendants to appropriate services tailored to their diagnoses and needs.

The job of the mental health liaison is best described by the court liaison,

> I have many duties. I link and refer clients for services. I also provide support for clients and try to help them function better in the community… I have developed my own personal style…It involves getting to know what [defendants’] worlds are really like and figuring out how to make myself useful to them. I try to figure out what their deficits are and help them that way. This includes treatment services but often includes skills training, income assistance, housing, and substance abuse treatment.
To fulfill this role, the court liaison must have knowledge of and ability to connect defendants to an array of community services including but not limited to mental health and substance abuse treatment.

The MHC liaison is able to carry out his role in large part because at inception of the MHC, team members obtained support from local treatment agencies making them collaborative partners in the MHC treatment process. These agencies include the CMHC, Department of Social Services, Assertive Community Treatment, Club Nova, Freedom House, Interfaith Council, University of North Carolina Clinics, TASC, Vocational Rehabilitation, and the Schizophrenia Treatment and Evaluation Program. Most services are provided by the CMHC; but when the CMHC does not offer the appropriate level of service (e.g. supervised housing), defendants are referred to other local treatment agencies by the MHC liaison. Services provided by the CMHC include individual and group mental health and substance abuse therapies, psychiatric services, medication administration and management, case management, life skills training, anger management groups, case support, and crisis intervention. Examples of other types of available community programs are vocational training (e.g. Orange Enterprises), supervised housing (e.g. Freedom House, a residential halfway house), and alcohol/substance abuse treatment (e.g. Alcoholics Anonymous and Narcotics Anonymous).

Observations from pre-court staffings and court hearings revealed the MHC liaison found services and scheduled initial mental health treatment appointments for
every defendant in the MHC unlike in the Broward County MHC where 45.2% of
defendants did not receive any treatment services after their hearings and 11% of
defendants were only offered a name and phone number to call without any treatment
linkage (Boothroyd et al. 2003). Similar to outpatient commitment, locating the
appropriate treatment service and scheduling an appointment does not guarantee a
defendant will attend and engage in services (Hiday, Swanson, Swartz, Borum, and
Wagner 2002). To effectively deal with this difficult to treat population, mental health
services must be not only available but also accompanied by monitoring and outreach
(Hiday 2003), both of which are provided in this MHC. The probability of treatment
participation and engagement by defendants is enhanced through court monitoring.
Treatment progress and compliance are reviewed monthly in open court where each
defendant is held publicly accountable for his or her actions. Defendants who engage
in and comply with treatment are praised and complimented by the judge; while those
who do not are encouraged to engage in treatment and are sometimes warned or
threatened with jail or a return to TCC by the judge (see chapter 7).

**Treatment Engagement**

Treatment engagement: attendance, motivation, and participation in services, is
essential to the success of defendants in MHC and is the focus of discussion of ongoing
cases in pre-court meetings. Discussion of each defendant includes a briefing by the
court liaison on each defendant’s treatment and behavioral compliance encompassing:
number of treatment sessions attended and missed, motivational level, and additional
services needed. If treatment attendance is sporadic and/or motivation is low, team
members briefly discuss ways to increase a defendant’s level of participation in the program.

Whether or not defendants “buy into” and take part in services varies. But, defendant “moral involvement” (Steen 2002, p. 64) is crucial to the success of the MHC in that defendants must internalize the goals of the MHC for its effects to be lasting (Steen 2002). Given the importance of defendant “buy in”, I categorized defendants into four groups to distinguish them by motivation level from information related to motivation and compliance discussed in pre-court meetings and court monitoring sessions, and written in mental health treatment records: motivateds, slow motivateds, resisters, and refusers. Motivateds are inspired to make good use of the opportunity provided by the MHC at the outset and engage in all recommended treatment programs without fail, that is they buy into the goals of the MHC and attempt to comply with its mandates. Slow motivateds need a push to begin and remain involved in treatment. Resisters, “tough nuts to crack” as described by the MHC liaison, are difficult to engage and typically only comply minimally at first. Last, refusers are defendants who the MHC liaison said “see this as a court thing,” that is they opt into the MHC only to have their charges dismissed; they deny their illness and refuse to accept treatment.

Motivateds and refusers were the easiest of the MHC sample to pick out and code: Motivateds consist of 12% and refusers comprise 6% of the MHC sample. Percentages of slow motivateds and resisters were much harder to determine. After trying to distinguish slow motivateds and resisters, I realized that the difference
between the two groups was subtle. Only through establishment of clearly defined sorting rules could these two groups be distinguished; but the distinction would have been arbitrary and substantively meaningless. What was important was that upon entry into and during participation in the MHC, defendants’ motivation levels varied: some were willing to engage in services at the outset, others needed a push or the court’s leverage to induce participation, and a few never accepted mental health treatment.

Initially, most defendants are wary of the court liaison because of his dual role: treatment case manager and member of the MHC team. As described by the court liaison, “at the outset [defendants] don’t think I am going to help them because of my association with the court. I must establish myself as a useful ally. I set this up by coordinating services for them in whatever area they need help.” With defendants who are willing to engage in treatment initially or with enticement, the court liaison is able to develop a trusting relationship thereby influencing their participation. However, for slow motivators, resisters and refusers, it takes the leverage of the court with its warnings of jail or return to TCC to obtain participation; but even then, engagement is not guaranteed. Examples of warnings and leverage used by the court are highlighted in the following comments by the judge in court hearings:

*Do you want to be here or not? Listen to me. Do you want special court or regular court? If you want special court you need to attend all of your treatment appointments. Do not miss any. Are we clear?*

*I was ready to bump you back to regular court today, but the team convinced me to let you stay. Don’t make me look like a fool. If you don’t want to be here, let’s do jail. I better get a good report next time.*
We have a bed lined up for you [in residential treatment]. If you don’t complete this program, you will go to jail. I will hold you in contempt of court if you do not go on Friday.

Each category of defendants raises important questions to be considered. For the motivated offenders regardless of time to engagement, it is perplexing that they did not get services on their own. Research studies indicate that the structure of the service system and the impairments associated with many mental illnesses make it difficult for many to obtain services without help (Morrissey 1999). Unfortunately, the court cannot restructure the service system to facilitate its outreach to these difficult to engage persons. However, the MHC assists mentally ill defendants to overcome these barriers by way of its collaborative relationship with local treatment agencies and in the person of the MHC liaison who marshals services and offers case management to defendants.

Slow motivateds, resisters and refusers raise important questions for the MHC to consider: Why do these defendants agree to participate in the MHC if they are unwilling to cooperate with mental health and substance abuse treatment? Are they simply trying to beat a wrap, and if so, how does the court determine this? And even if they are, can they be enticed and threatened into cooperating such that they get help and see the benefits of that help and engagement? These are complex questions; but must be considered by the court to maintain its integrity.

In a specially called MHC team meeting to discuss accountability, team members talked about whether or not certain defendants were “playing the court” and whether or not their was “enough teeth in the [MHC] program.” MHC team members
reviewed cases for noncompliant, unmotivated defendants. MHC team members decided to send two defendants back to TCC, because each was “too far gone” and needed long-term substance abuse care. Several other noncompliant defendants were given another chance because each had an acceptable excuse for his/her noncompliance. However, MHC team members agreed they must be ready and willing to hold defendants accountable for their behavior. A procedure was established to hold noncompliant defendants responsible for their legal and treatment behavior. Defendants who are consistently noncompliant without satisfactory justification will be asked to sign a behavioral contract specifying their legal and treatment requirements set forth by the MHC. Defendants will be given a date by which they must be in compliance or they will be held in contempt of court and given a “dip in jail” or returned to TCC. MHC team members agreed the sanction chosen, jail time or a return to TCC, should be “decided on a case-by-case basis because a little jail time may make some defendants come around while others will not (private attorney).”

It is difficult for the court team to assess defendants’ willingness to change at entry into the court program. Often defendants state their willingness to engage in treatment when they consent to participate in the MHC, but actual motivation can only be determined by treatment attendance, medication compliance, and behavior compliance. The court team strives to allow ample time for defendants to become involved in a therapeutic relationship. In cases of slow motivateds, resisters and refusers, the court team is willing to give second and third chances allowing sufficient time for defendants to come to compliance with the court’s mandates. But, if
improvements are not seen in compliance and/or motivation after several months, the court team transfers defendants back to TCC.

**Motivation and Coercion**

The court team is aware that for mental health and substance abuse treatment to be successful, the affected person must be willing and motivated to engage in treatment. Even though participation in the MHC is voluntary, most defendants stay in the early stages recovery for some time, have varying levels of motivation, and may deny any mental health and/or substance abuse problems (Peters and Osher 2004). In the treatment of dual disorders, intervention typically occurs in stages and begins with engagement or establishment of a trusting relationship between the case manager and the defendant (Peters and Osher 2004). But, for most MHC defendants’ treatment attendance is initially persuaded by means of a “carrot-stick” approach and by use of the court’s leverage. MHC defendants are enticed to participate because upon successful completion of the MHC, their charges are either dismissed or otherwise disposed of in a positive manner. When the “carrot” does not work, case managers and MHC team members use the “stick,” threats of return to TCC or jail time, to push defendants’ compliance with treatment services. During this period of persuaded treatment engagement, case managers are able to establish a trusting relationship with most defendants. The MHC liaison noted,

"Initially defendants comply to get their charges dismissed [pause] and some comply out of fear, but over time they begin to trust me and develop a positive relationship with the MHC team. When this happens, they comply because they want to and because they are encouraged and praised by the MHC team for their compliance."
After a relationship is established between a MHC defendant, his/her case manager, and the MHC team; the stages in treatment and recovery are similar between MHC defendants and those who voluntarily seek treatment without the involvement of the court. The next step in recovery, persuasion, is when the case manager helps the client develop motivation for participation in treatment programs. The third stage, active treatment, teaches defendants strategies for becoming and maintaining a substance free, medication compliant lifestyle. Last, relapse prevention teaches defendants a series of approaches to maintaining recovery (Peters and Osher 2004).

The MHC encourages and helps defendants in their recovery process in several ways: 1) The court liaison establishes a trusting relationship with defendants whereby he marshals and links them to services while also providing case management and case support; 2) The MHC is able to influence defendant participation by dismissing charges or offering prayer for judgments in cases of successful program completion; and 3) The MHC also encourages and at times coerces with threats treatment involvement by holding defendants publicly accountable in open court for their treatment attendance and medication and behavioral compliance.

Coerced treatment and its fairness and effectiveness have been and remain a controversial topic in the treatment of psychiatric patients (Hiday 2003, Hiday et al. 2002, Swartz and Monahan 2001). A key issue surrounding coerced treatment is does it work or does treatment participation need to be voluntary to be effective? Early studies on coercion focused on a patient’s legal status, whether or not one was
involuntarily committed, as an indicator of coercion; while more recent studies use patient perception of the treatment process to assess coercion. A seminal study, The McArthur Coercion Study (Monohan, Lidz, Hoge, Mulvey, Eisenberg, Roth, Gardner, and Bennett 1999), found that it was not legal status that reflected coercion but rather patient perceived coercion, which may or may not coincide with being voluntarily or involuntarily committed.

Coercion is important to consider in MHCs because defendants may feel that they are forced into mental health treatment even though their participation is voluntary. Unfortunately, this can not be addressed with the available data, but findings from the Broward County MHC indicate that defendants do not feel coerced into treatment (Poythress et al. 2002). Using the MacArthur perceived coercion scale (Gardner, Hoge, Bennett, Roth, Lidz, Monahan and Mulvey 1993) to assess perceived coercion in participation in the MHC, Poythress et al. (2002) determined that defendants in the MHC perceived relatively little coercion in the decision to participate in the court which is assumed to be synonymous with agreeing to treatment and to have that treatment monitored by the court. That study further determined that giving defendants clear reminders that their participation in the court is voluntary further reduces any perception of coercion (Poythress et al. 2002).

My courtroom observations revealed that defendants are told about and reminded of the voluntary nature of the court by MHC team members. At first court appearance, defendants meet with their attorney and the MHC liaison where they are informed about the voluntary nature of the MHC and are given the opportunity to opt
into or out of the MHC. After this meeting, either that day or at the next court appearance, the judge reiterates the voluntary nature of the court and asks defendants if they want to participate in the MHC or not. Other reminders of the voluntary nature of the court and defendants right to terminate their participation in it are given at various times (typically for those who are noncompliant and at risk of transfer back to TCC) throughout MHC monitoring.

Judge: This is a voluntary court. You do not have to stay in this court. Do you want to talk to your attorney first?

Judge: You are not being forced into treatment. We just have rules that must be followed if you want to remain in this court. It is not easy. Just do your best. We care about you and want you to do well. Good luck.

SERVICES RECEIVED

Rehabilitation Services

Rehabilitative interventions and psychiatric/substance abuse services are critical in helping defendants function more effectively in the community. Rehabilitative interventions focus on improving defendants’ quality of life rather than alleviating their mental health symptoms and target areas such as daily living, housing, employment, and education (Drake et al. 2003). Such services are one focus of pre-court meetings where court team members discuss specific needs of and decide upon courses of action for defendants. The following section highlights examples of rehabilitation services defendants received and the MHC team’s role in service linkage. The services I discuss provide evidence of a larger pattern, the court team’s awareness and willingness to provide assistance in all areas of need, not only mental illness and/or substance
abuse/dependency. Defendants varied in their needs and everyone did not require assistance in each of the rehabilitation services discussed.

**Daily Structure.** Many persons with SMI need external controls and a structure or schedule to help them deal with the challenges in daily life. Therapists often recommend clients’ days be structured through therapy sessions and a combination of work, volunteer activities, and/or social activities (Lamb and Weinberger 2001, Heilbrum and Griffin 1993). The importance of structure is recognized by the MHC team. It was discussed in several pre-court planning meetings as highlighted in the following excerpts:

**Case 1:**
Case Manager: He is panhandling again. He was standing too close to the teller machine. He needs something else to do with his day. I took [my client] by Club Nova and he hated it. He was paranoid there.
Judge: Is there anywhere else he can go during the day? If we can get him busy, he will love it.
Attorney: He needs a day program he can go to. Can we work on finding one?
Case Manager: I will look into [day treatment facility].

**Case 2:**
Case Manager: She is open to treatment, but needs some type of activity to occupy her day…. Her current charges stem from her going off on her own and walking into someone’s house. It sounds like she goes off on her own and walks with the wrong people.
Probation: She has been doing this for years.
Judge: So, what should we do?
Case Manager: We should put a structure into place to occupy her day. If she is busy, she won’t be able to roam with the wrong people. I will look into [organization that assists with supported employment].

Although structuring a defendant’s day is not the main focus of the MHC, the preceding dialogues highlight the court team’s awareness that some defendants
need a structure imposed on them to keep them busy and out of trouble with the law.

**Housing.** Surprisingly, not many defendants in the MHC were homeless; however, housing services were at the center of pre-court discussions for those who needed them. From subsample data and pre-court observations, it is estimated that about 10% of the MHC sample needed some form of housing assistance while the remaining 90% either lived alone, with a partner/roommate, or with family. As a part of services, the court liaison was able to locate housing in independent living apartments, group homes, residential treatment programs, and at times local shelters for defendants that needed housing.

One example that represents the lengths the court liaison went to assisting a MHC defendant in his quest for housing and a better quality of life is shown in the following description. Although anecdotal, it shows the court liaison’s willingness to help with a variety of defendant needs, not just mental health treatment.

**Case Description:**

Nearing the end of his court program, a MHC defendant [herein called Bill] who was residing in the local shelter expressed a desire to relocate to another state by means of hitchhiking. This was discouraged by the court liaison but he worked to obtain a bus ticket from the Department of Social Services for this defendant. Before issuing the bus ticket, Social Services required Bill have proof of housing at his destination. Through many phone calls to shelters and homeless advocacy organizations, the court liaison was able to find Bill a place to stay. In addition, he got Bill bags of donated food for the trip, drove him to the bus station, and made sure he made it on the bus. Bill emailed the court liaison and thanked him for his help once he was in his new location.
Employment. It was difficult to determine who needed employment unless it was explicitly discussed in pre-court meetings or court review hearings; thus, only subsample data were used to determine employment patterns. Prior to MHC entry, 11 of 19 defendants were employed, but after entry only eight were employed. Record review indicated that five defendants lost their jobs and two obtained employment during MHC. Of the five that became unemployed, four terminations were related to the legal charges that placed them in MHC. The other termination was noted in the file, but a reason for such termination was not. The two defendants who gained employment in the open market did so as a result of their active participation in MHC whereby the MHC liaison helped them complete job applications and provided transportation to job interviews when needed.

Although two defendants becoming employed as a result of treatment seems small, it is noteworthy given the multiple disadvantages and associated stigma offenders with SMI must overcome when competing for jobs against non-disordered, law-abiding persons. As noted by the case manager, “Most folks I serve don’t have stable job histories and may not be capable or willing to work regular jobs. Add pending criminal charges to that scenario and you have eminently unmarketable clients.” He continued by describing three strategies used to help clients find employment:
For Club Nova (a Fountain House type club) clients, the transitional employment program provides intermittent supported employment for clients that can handle working part time...I refer [defendants] to vocational rehabilitation for possible job placement at local sheltered workshops... I also help my clients look in the want ads; polish up resumes and present their spotty work history in the best possible light; complete job applications, attend interviews, and follow up with prospective employers.

**Economic Assistance.** Similar to employment, it was difficult to ascertain which defendants were in need of and which would qualify for financial assistance. Mental health records provide indirect data of need as indicated by method of payment: supplemental security income (SSI), Medicaid, Medicare, private insurance, or no insurance. Method of payment was examined prior to entry into the court and after entry into the court program. Of the 19, 15 did not have insurance at entry into the program; and of the remaining four, one had SSI, two had Medicaid, and one had Medicare. None of the defendants had private insurance. This is not surprising given the nature of the population and that only files were reviewed for individuals seeking services through the community mental health center.

During the MHC program, two of the four (50%) defendants who were unemployed and whom the court liaison believed to be disabled enough to qualify for financial assistance obtained SSI. Successfully getting financial assistance (either SSI or SSDI) is no small task as seen in the court liaison’s description of the process of helping one client in her quest for disability:28

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28 It was noted by the court liaison that this defendant had just recently been denied Medicaid, but he felt she qualified for financial assistance.
I researched [the defendant’s] medical needs related to her asthma and multiple back surgeries and consulted with her medical staff at [treatment agency] regarding [her] possible need for disability; I consulted with her psychiatrist about her mental health needs; and I obtained and reviewed her records to verify that while of borderline cognitive ability she was definitely not mentally retarded. Then, I researched the status of her pending disability/Medicaid claim, advocated and testified for her at a Medicaid appeal hearing, fired her disability attorney, assisted in searching for a new disability attorney and attended the initial session with him to explain her case, wrote a detailed letter on behalf of [the CMHC] signed by our psychiatrist outlining the multiple factors contributing to her need for disability.

As seen in the passage above, applying for and getting financial assistance is a complicated, bureaucratic process that takes time and commitment. Given the defendant’s level of functioning and mental disability, she probably would not have pursued the application after the first denial without the court liaison’s assistance.

**Barriers to MHC Program Participation.** An important function of the court team is removing barriers to effective MHC participation. Occasionally, family members or members in the courtroom audience either discouraged treatment attendance or interfered in the courtroom discussion making it counterproductive for the defendant. In such cases, the ADA and judge did not hesitate to take action to prevent their interference. Two examples are seen in the following exchanges:
Case 1:
Case Manager: [The defendant] wants to do MHC but his mom says he can not do it. His mom is in denial about the offense and wants [his attorney] to get him off.
Attorney: I need help with [my client’s] mom this week. She is getting in the way. I talked with my client and encouraged him to do what his treatment counselor said.
ADA: We may need to remove his mom from the courtroom when we do his case.
Judge: I will meet in my chambers with his mom. If she interferes, I will hold her in contempt because he is under court order to get treatment. I will give her the riot act.

Case 2:
Background: This case involves a husband [herein called Dad] and his expectant wife [herein called Mom] who have one child and are currently separated and have a social services case worker helping them figure out issues of domestic violence, separation, visitation, and mental health treatment. Both spouses are in MHC for domestic violence each presenting his or her own mental health problems. The wife’s parents (herein called grandparents) come to each court session to provide social support to their daughter while no family is present for the husband.

Over the course of several review hearings in open court, the grandparents sporadically interrupted the dialogue between the judge and each husband and wife. Some examples of their interjections are:

Grandad: … but…Both [Grandmom] and I work during the day. How can we supervise [Mom] with the baby? [This issue has arisen because Mom and Dad are not allowed to have unsupervised time with their child.]

Grandad: Who is going to supervise [Dad’s] visitation?

Grandmom: How do we get her things from the house? [There is concern here because a no contact order has been put into place.] What about child support?

Grandmom: What about Christmas? How will we know [Dad] is on his medication and is safe to visit the children?

Prior to the fourth review hearing in the pre-court meeting, the court team discussed the grandparents and what to do about their interference.
DSS: Dad’s visits are going well. He and his children interact well and are affectionate, but the [grandparents] continue to interfere.

Attorney: I suggest [the grandparents] stay out of the courtroom. They are horrible to [Dad].

Judge: For now, one defendant should come to [one county location] and one should go to [the other county location].

The court team is attentive to individuals in the courtroom audience and the impact of their presence on defendants. If the court team believes a person’s court observance is distracting or counterproductive to the defendant, it does not hesitate to have him/her removed from the court and/or held in contempt of court.

**Psychiatric and Substance Abuse Treatment Services**

**Receipt of Services.** Data for this section are only available from record review; therefore, they are only presented for the sub-sample. All defendants in the MHC subsample participated in at least one type of treatment service including: individual therapy, group therapy, case management, service planning, case support, medication therapy, crisis intervention, Alcoholics Anonymous (AA) or residential treatment programs. AA and residential treatment programs are reflected in the records because they are not provided by the CMHC.

The type of services received at the CMHC while in MHC varied by defendant, but all received treatment services appropriate for their diagnosis and current level of functioning. All sub-sample members received an intake session and all either received treatment services through CMHC (17) or attended AA meetings (2). Number of services sub-sample members received ranged from one to five with an average of two
to three different kinds of services. The table below shows the kinds of services and number of sub-sample members receiving such services.29

**Table 10.1 Types of Treatment Services Received**

<table>
<thead>
<tr>
<th>Type of Treatment Service</th>
<th>Number of Sub-sample members who received service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>12</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>6</td>
</tr>
<tr>
<td>Case Management</td>
<td>4</td>
</tr>
<tr>
<td>Service Planning</td>
<td>4</td>
</tr>
<tr>
<td>Case Support</td>
<td>7</td>
</tr>
<tr>
<td>Medication Checks</td>
<td>8</td>
</tr>
</tbody>
</table>

The total number of treatment sessions received at the CMHC varied considerably by sub-sample members with a range of 1 to 43 sessions.30 On average, sub-sample members attended 14-15 sessions at CMHC while participating in the MHC.

Inspection of the number of mental health or substance abuse treatment services received prior to and during MHC participation indicates that service usage increased after entry into the MHC supporting hypothesis 5. Of the 19 subsample members, ten defendants had no prior services, six had been engaged in services at one time but had become disengaged, and three were active in treatment at CMHC at the time of their key arrest; thus, 84% of defendants in the MHC were not involved in treatment services in the year prior to involvement in the MHC but through participation in the MHC.

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29 Most sub-sample members received more than one type of service so the sum of sub-sample members receiving each service is not equal to the sample size.

30 Services not received at the CMHC are not included in these numbers. Several sub-sample members attended AA in conjunction with mental health treatment services with one attending AA only so it appears these defendants received one to a few sessions when in actuality they attended many AA sessions.
gained access to and participated in treatment services. I can conclude that the MHC is achieving its goal of increased access and utilization of mental health services for defendants during court participation.

Although the MHC is able to increase access and use of mental health and substance use treatment services for defendants during court participation, a key question in this line of research, as with outpatient commitment, is will defendants continue in treatment voluntarily after cessation of the court program? No research on outpatient commitment has followed persons committed to outpatient treatment long enough to answer this question (Hiday 2003). Unfortunately, the present study is unable to address this question due to the small sample size, the difficulty in tracking this population, and the relatively short follow-up period.

What can be examined are treatment outcomes at the end of MHC (for the MHC sub-sample). Table 10.2 indicates whether or not defendants completed all recommended treatment services, continued in treatment, discontinued treatment, or if their status is unknown. As noted in Table 10.2, five defendants completed all recommended treatment services, seven continued in treatment, three discontinued treatment services, and treatment outcome is not known for four subsample members as they moved or the information was not available in their mental health records.
Table 10.2 Mental Health Treatment Service Outcome at MHC Completion

<table>
<thead>
<tr>
<th>Treatment Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed All Services</td>
<td>5</td>
</tr>
<tr>
<td>Continued in Treatment</td>
<td></td>
</tr>
<tr>
<td>Committed to a psychiatric facility</td>
<td>1</td>
</tr>
<tr>
<td>Transferred services to another county</td>
<td>1</td>
</tr>
<tr>
<td>Moved and continued in services in new location</td>
<td>2</td>
</tr>
<tr>
<td>Continued in Services with the CMHC</td>
<td>3</td>
</tr>
<tr>
<td>Discontinued Services</td>
<td>3</td>
</tr>
<tr>
<td>Treatment Status Unknown</td>
<td></td>
</tr>
<tr>
<td>Moved</td>
<td>2</td>
</tr>
<tr>
<td>Not Stated in Mental Health Record</td>
<td>2</td>
</tr>
</tbody>
</table>

Notable is the number of defendants (n=12) who either completed all recommended services or continued in mental health treatment at the CMHC or some other facility after MHC completion. Further inspection of those continuing services revealed they had lower GAF scores at entry into the MHC than those who completed all recommended treatment. Those with lower GAF scores needed to continue in services to maintain and/or improve their level of functioning while those with higher GAF scores were able to stabilize and/or improve their functioning through counseling and medication while participating in the MHC, with a few continuing in treatment and others not needing further treatment as determined by the CMHC.\(^{31}\)

\(^{31}\) I was unable to determine who continued going to Alcoholics Anonymous and Narcotics Anonymous because these services are not offered by CMHC.
Interestingly, all who discontinued services had drug or alcohol abuse as their primary diagnosis. Furthermore two of the three did not successfully complete the MHC. This suggests that substance-abusing defendants may differ from mentally ill defendants in their treatment and court monitoring needs, motivation, and willingness to change. It is possible that these defendants would have been better served by drug court; however, one was not in existence in this county at the time.\(^{32}\) Had these substance-abusing defendants been in drug court, they would have been held more accountable for their behavior through a system of graduated sanctions for a period of at least one year. There would have been more incentives to participate in treatment, more intense monitoring with random drug testing, and possibly harsher sanctions for noncompliance.

**Treatment Attendance and Length of Time in MHC.** Data for treatment attendance come from CMHC mental health record review and are only available for the sub-sample. Average length of time in MHC for the subsample was 264 days with a range of 119 to 365 days. During this time, almost half (8) of the sub-sample members did not miss any appointments (treatment or medication checks). Of the eleven who missed an appointment without an excuse (no shows), these unexcused missed appointments ranged from one to 13 with most falling between one and five. Reasons stated for missing appointments (when given) varied from having transportation problems, needing to work, having to care for sick family members, forgetting, or not wanting to go because the prescribed medications had side effects.

\(^{32}\) This county has since established a drug treatment court.
Notable is the number of missed appointments permitted by court team members, highlighting the fact that they are willing to give second chances. As long as efforts were being made, the court team was willing to let defendants stay in the program. More importantly, it does not appear to be the number of missed appointments that determines when one was transferred back to criminal court, but motivation and willingness to engage in services. The two defendants who were transferred back to TCC missed minimal appointments (1 and 5), but according to their clinician expressed behaviorally an unwillingness to engage in services and a lack of motivation to change.

**Medication Compliance**

Medication compliance is a major issue in community mental health treatment because failure to take anti-psychotic medications is associated with a resurgence of symptoms and relapse which may result in hospitalization, violence, or arrests (Swartz, Swanson, Hiday, Wagner, and Burns 1998, Trauer and Sacks 1998, Swanson et al. 1996, Swanson 1994, Hogarty 1993). For defendants who were prescribed psychiatric medication, MHC team members discussed medication compliance in pre-court meetings as a part of treatment compliance. The MHC liaison reported to team members about defendants’ medication compliance or noncompliance, side effects reported as problematic by defendants, and changes or adjustments in dosage deemed necessary by the CMHC. Most defendants who were reportedly medication noncompliant had problems with medication side effects. As a solution, some defendants tried to cut the dosage in half while others either stopped taking the
medication or self medicated with alcohol to relieve symptoms. In cases of medication noncompliance, the MHC liaison requested the judge give defendants reminders about the importance of taking medications as prescribed. When medication side effects caused noncompliance, the MHC liaison asked the judge to encourage defendants to talk with their doctors about adjusting the dosage or changing their medication. Regardless of medication compliance, MHC team members, especially the judge in open court, always reminded and encouraged defendants to take their medications.

Specific data on medication compliance are only available for the MHC subsample. Of the 19 defendants in the subsample, mental health records indicated eight were prescribed some form of psychiatric medication, and three (37.5%) were medication noncompliant as indicated by psychiatrists’ notes in their mental health records. Furthermore, four sub-sample members missed one and one sub-sample member missed two medication check appointments at the CMHC during participation in the MHC.

Research indicates that psychiatric patients have low rates of medication compliance (Cramer and Rosenheck 1998). Estimates of the extent of medication noncompliance among persons with SMI vary widely. In a review of studies from 1975 to 1996, Cramer and Rosenheck (1998) found medication compliance rates to vary from 24 to 90%. Research indicates several reasons psychiatric patients do not take or discontinue taking their prescribed medication: 1) Taking medication reminds them they are mentally ill and have been labeled as such by community members; 2) With medication, they may become symptom free and they may feel they can succeed

Pre-court and court observations indicate that team members are cognizant of the need to encourage defendants to take medications as prescribed as well as to remind them of the need to take prescribed medication in general. The following provides some examples of the judge giving medication reminders:

**Case 1:**
Judge: You are doing very well. You need to keep all of your appointments this month and remember to keep taking your medication.

**Case 2:**
Judge: You are doing well. Just take it one step at a time. Remember you need to keep all of your appointments this month. This includes therapy and medication.

**Case 3:**
Judge: Are you taking your medication?
Defendant: Sometimes.
Judge: Why not all the time?
Defendant: They make me sleepy so sometimes I only take half a pill.
Judge: It is important that you take the medication as prescribed. If the side effects bother you, you should talk to your doctor about the dosage.

**Case 4:**
Judge: Are you supposed to be taking any medications?
Defendant: Yes. I am taking them, but they aren’t making me feel any different.
Judge: Tell [court liaison] about your medication not making you feel any different. He will work with you. It is important that you keep taking them. You need to work with your doctor until you get the dosage right.
Re-Arrest

Criminal justice outcomes are important to examine in determining program success, because the primary goal of the MHC is to reduce recidivism through treatment services. Over half of the sample (57.3%) was not re-arrested during the follow-up while 18.3% was re-arrested once, 7.3% was re-arrested twice, and 17.1% was re-arrested three or more times (see Figure 10.1). The pattern of re-arrest noted in Figure 10.1 is similar to the pattern of arrests prior to entry into the MHC (refer to Figure 9.1) indicating the MHC may not reduce re-offending but rather may stabilize it. This finding is explored in more detail in quantitative analyses presented in Chapter 11.

It is also important to examine the types of offenses for which defendants were re-arrested. Inspection of the types of re-arrests for all new arrests revealed similar types of offenses for first and subsequent arrests after entry into MHC; therefore, only first re-arrest is examined in detail (Figure 10.2). The majority of re-arrests were nonviolent: traffic 17%, drug/alcohol 14%, non-violent misdemeanors 57%, non-violent felonies 3% while only 9% of re-arrests were violent misdemeanors. This reiterates the previous finding that most mentally ill offenders commit nonviolent survival and/or nuisance crimes.

Days Spent in Jail During the Follow-Up

Very few defendants in the MHC sample spent any time in jail during the follow-up. Of these defendants, one was a completer and six were non-completers. Average days in jail for those who did receive jail time were 30 for the completer and 85 for non-completers. That few spent time in jail is not unexpected for two reasons:
1) The MHC strives to keep defendants with mental illness out of jail and in treatment, rarely using jail as a sanction for noncompliance; and 2) Most MHC defendants’ arrests are for minor offenses that would typically not be deserving of jail time.

Testimonials

Throughout this chapter, evidence has been presented pointing to the effectiveness of the MHC in marshaling and linking defendants to services they may have otherwise not received without such participation. It has been established that the court team, especially the court liaison, has a variety of ways to encourage defendants to engage in services ranging from offering rehabilitative services to using leverage of the court. An increase in service usage was shown with 63% of defendants completing all recommended services (n=5) or continuing in services after completion of the court program (n=7). Only 16% of defendants (n=3) discontinued treatment; and service continuation is unknown for four defendants (two moved and two had incomplete information in the mental health record). It is presumed that the services defendants engaged in during MHC participation coupled with monitoring by the court contributed to a reduction in re-arrest.

One disadvantage of this study is the inability to provide defendants’ perspectives on the effect of the MHC; most importantly, whether and how MHC defendants perceive court participation, and whether and how MHC made changes in their lives. However, improvements in defendants’ functioning can be gauged through judges’ comments during court hearings and through testimonials provided by defendants at MHC graduation. Some examples of comments made by the judge are:
Case 1:
I see some settling in you. I am pleased about this. You look better and calmer.

Case 2:
You are a perfect example of someone that applied himself and did a great job. You have turned your life around. I can tell by the way you look.

Case 3:
This is great. You look good. Would it be true to say you are in better shape this Thanksgiving than last?

Case 4:
You look great. You look much happier than you were when you entered the court. If you continue in treatment you will be fine. If you need help, don’t hesitate to call.

Defendants typically responded to these compliments by smiling, standing tall and proud, and saying thank you to the judge. Additionally, defendants’ perspectives on the effectiveness of the court can be gauged by comments made by them to the judge at their graduation from MHC.

Case 1:
I am a different man now. It has been a long road. Thank you very much.

Case 2:
I know what I need to do now. I need to stay on the right path. I think I can make the right choices now. I could not have done this without you.

Case 3:
I have been trying so hard. I have been taking my medication and praying a lot. I have finally gotten a job. Things are looking up for me. [The court liaison] has been a blessing.

Case 4:
I feel great. This is the best I have felt in years. Thank you for allowing me to participate in the court.
Other defendants did not show their happiness and gratitude with words but often smiled and clapped for themselves and a few even bowed and danced.
CHAPTER 10: FIGURES

Figure 10.1 Number of Re-Arrests for MHC Defendants During the Follow-Up (N=82)

Figure 10.2 Most Serious Offense of 1st Re-Arrest During Follow-Up (N=82)
CHAPTER 11

MHC’S IMPACT ON RECIDIVISM AND RECIDIVISM SEVERITY: A COMPARISON OF MHC AND TCC DEFENDANTS

This chapter is presented in four sections with tables for all analyses included at the end of the chapter. In the first section, I present descriptive statistics for the entire sample for each variable used in regression analyses. Second, an overview of sample characteristics is given for all variables for MHC (MHC) and traditional criminal court (TCC) subjects. The third section presents results from regression analyses as a first test of hypotheses one through four. Last, pre-test/post-test analyses are presented as a second test of hypotheses one through four.

Descriptive Statistics of Dependant and Independent Variables Used in Regression Analyses

Dependant Variables. The two dependant variables used in all regression analyses are re-arrest (used as a count variable and a dichotomous variable) and re-arrest severity. The average number of times re-arrested is 1.97 for the entire sample with a range of 0 to 15. Almost half of the sample (44.5%) was not re-arrested during the year following the key arrest leaving a highly skewed (2.02), kurtotic (4.91) distribution for which logging did not help. Therefore, analyses using this dependent variable include methods designed for dealing with dependent variables having large numbers of zero values (this is explained in more detail in the analysis section).

The second measure of recidivism, score on the recidivism severity scale, has an average of 7.75 (skewness of 2.62, kurtosis of 8.43) and presents the same problems as
number of times re-arrested in that it has the same percentage of zero values because the scale is based on the number of times a defendant was re-arrested. To remedy this problem, a two stage approach is taken (discussed in more detail in the analysis section) where only those re-arrested are used in the analysis when severity of re-arrest is the dependant variable. Once persons who were not re-arrested during the follow-up are removed from the sample, average score on the recidivism severity scale is 13.97 with a range of 1-72 where skewness is reduced to 2.13 and kurtosis is reduced to 5.31.

**Independent Variable.** Type of court each defendant was in is the main independent variable used in regression analyses. Of the 265 sample members, 69.1% were in TCC and 30.9% were in MHC. MHC is further divided into completers (19.6% of the entire sample; 63.4% of the MHC sample) and non-completers (11.3% of the entire sample; 36.6% of the MHC sample).

**Control Variables.** Each regression analysis incorporates six independent variables as controls: 3 criminal history variables and 3 demographic variables. Criminal history control variables include: criminal history severity, severity of key charge, and prior time spent in jail. Demographic control variables include age, race, and gender.

Criminal history severity is used as a continuous variable with a mean of 5.85 and a range of 0 to 44. The distribution is skewed (1.852) and kurtotic (3.33); no continuous transformation corrected this. A categorical transformation was also tried where 3 dummy variables were created representing 0 (49.1% of the sample), 1-10 (30.1%), and 11-44 (20.8%) on the prior offense severity scale. Analyses were
examined using criminal history severity as a continuous and categorical variable and the same pattern was noted in all models; therefore, for parsimony I have used criminal history severity as a continuous variable in all models.

Severity of key charge is also used as a continuous variable. It has a mean of 4.29 and a range of 1-13. The distribution has minor skewness (.834) and kurtosis (2.19) is not helped by logging. Another method used in an attempt to correct for kurtosis was to cap the maximum value at 8 because outliers fell between 9 and 13. When capping the maximum value at 8 and running regression analyses predicting re-arrest and severity of re-arrest, no difference was found in the pattern or significance of any variable; therefore, severity of key charge is used in analyses in its original form with values ranging from 1-13.

Prior jail time in the year prior to entry into either TCC or MHC ranges from 0 to 180 days with a mean of 3.81; however, the distribution is highly skewed (6.59) and kurtotic (50.6). Most sample members did not spend any time in jail; therefore, prior jail time is used as a categorical variable: no time spent in jail (90.6%) or some time spent in jail (9.4%).

Age of the sample members ranges from 16 to 78 years with an average age of 31.94 years. Age is not skewed (.71) and is not kurtotic (.40). Race is used as a demographic control variable and is almost equally distributed among the sample: 50.2% of the sample is white and 49.8% are African American. Last, the majority of the sample is male (71.3%).
Comparability of the Groups

Table 11.1 presents an overview of the samples with demographic, criminal history, and recidivism comparisons between TCC subjects and MHC subjects as well as between MHC completers and non-completers. One can observe significant differences between TCC subjects and MHC subjects on age and race. Age for TCC subjects ranges from 16-78 and from 17-62 for MHC subjects. Overall, TCC subjects are significantly younger than MHC subjects with a mean age of 30 versus 35 (t-test, t = –4.13, df = 263, p<.0001). The TCC sample is more heavily African-American (54.60%) compared to the MHC sample (chi-square test, value = 5.52, p< .05). There is no significant difference in any demographic variable between MHC completers and non-completers.

Of the criminal history control variables only average score on the prior offense severity scale differs significantly between defendants in the two courts. TCC subjects have a higher average score (6.62 vs. 4.13, t-test, t = 2.14, df = 263 p< .05) indicating more serious offenses in the year prior to key arrest. There are not any significant differences between MHC completers and non-completers.

Results

Both measures of recidivism, the two dependant variables, are significantly different between defendants of the two courts. TCC subjects are re-arrested significantly more often than MHC subjects during the 12 months follow-up, with an average of 2.36 new arrests versus 1.10 new arrests (t-test, t = 4.21, df = 248, p< .0001). The same pattern appears in the recidivism severity scale: TCC subjects score
significantly higher than MHC subjects on the recidivism offense severity scale (9.46 vs. 3.90, t-test, t = 4.38, df = 262, p< .0001)\textsuperscript{33}.

MHC completers and non-completers differ significantly on both measures of recidivism with non-completers being arrested more often and for more serious offenses. Non-completers average 2-3 arrests while completers average less than one-third that amount (.58 arrests (t-test, t = 3.47, df = 41.3, p< .001) and non-completers average 7.13 on the recidivism severity scale versus 2.06 for completers (t-test, t = 3.16, df = 42.8, p< .001).

Overall Table 11.1 shows that the two populations of TCC and MHC are not similar on all control variables. Sample differences in age, race, and criminal history severity noted above could lead critics to question significant findings in forthcoming analyses. Two measures are used to ward against this criticism. In regression analyses, all six control variables are used in the equations. As control variables in regression modeling, all of them are held constant simultaneously which allows the model to make predictions as if individuals are alike on all variables in the model even if in fact they are not (Allison 1999). Second, in pre-test post-test analyses the two populations are matched on two of the three variables on which they differ. This process is explained in more detail in the section entitled “Pre-Test Post-test Analyses.” Each of these measures should increase confidence in the results obtained.

\textsuperscript{33} This comparison is between the total sample of MHC and TCC defendants, not just those who re-offended.
Regression Analyses

Regression analyses are presented separately for each dependent variable. First, I examine the rate of re-arrest among MHC subjects and TCC subjects followed by an inspection of the severity of re-arrest. Different regression techniques (negative binomial, logistic, and OLS) are used for the dependent variables as determined by their distributions, although the same independent and control variables are used in every model.

Multivariate Analysis: Rate of Re-arrest

Given the nature and distribution of the dependent variable re-arrest, a count variable with many zeros and, therefore, not normally distributed, negative binomial regression models are used to determine efficient, unbiased estimates of the relationship between court type and re-arrest\(^{34}\) (StataCorp 2003). Each analysis includes a full model and two nested models. Because court type is the main focus in these analyses, Model 1 shows the results for differences in the rate of re-arrest by court type. Model 2 introduces criminal history control variables. Last, Model 3 adds demographic control variables race, gender, and age.

Table 11.2 presents these negative binomial regression models predicting the effect of court type on the rate of re-arrest, sequentially adding groups of control variables. Model 1, showing the basic bivariate relationship, indicates that MHC subjects’ rate of re-arrest is less than half (47%) that of those in TCC (p< .001). In

\(^{34}\) Poisson and negative binomial models were compared to determine the better model for predicting re-arrest. The LR statistic was significant which provides evidence of over dispersion; thus, the negative binomial model is the better model for predicting re-arrest.
Model 2, the addition of criminal history variables slightly decreases the effect of court
type but it remains significant. In addition, the number and severity of prior offenses
are significantly related to the rate of re-arrest. As the criminal history offense severity
scale increases by one, the rate of re-arrest increases by 2.9% (p < .01). Demographic
variables added in Model 3 are nonsignificant and do not change the effect of other
independent variables on rate of re-arrest. Model comparisons indicate that the
addition of criminal history variables in Model 2 significantly improve the explanatory
power of the model; however, the addition of demographic controls in Model 3 do not.

In Table 11.3, MHC completers and non-completers are compared to TCC
subjects on the rate of re-arrest. Model 1 indicates that MHC completers are re-arrested
at a rate that is about one-fourth (24%) that of TCC defendants (p< .001); but MHC
non-completers are not significantly different from TCC defendants. Comparing MHC
completers with non-completers\textsuperscript{35}, one sees that completers are re-arrested at a rate that
is less than non-completers (28%, p<.001).

Model 2 adds criminal history control variables to the regression equation.
Completion status in MHC remains significant; those who completed the MHC are re-arrested
at a rate less than that of TCC subjects (28%, p< .001). Of the criminal history
control variables, only severity of criminal history is significantly related to the rate of
re-arrest. As the criminal offense severity increases by one unit, the rate of re-arrest
increases by 2.7% (p< .01). Again, this finding reiterates earlier research that criminal

\textsuperscript{35} The difference between MHC completers and non-completers was determined by re-estimating the
model with MHC non-completers as the reference category instead of TCC defendants.
history is one of the best predictors of future criminal behavior among mentally ill offenders (Bonta et al. 1998, Ulmer 2001). Demographic variables added in Model 3 are nonsignificant and do not change the effect of the main independent variable on re-arrest. Again, model comparisons indicate that adding criminal history control variables increases the explanatory power of the model, but demographic controls do not.

In general, results support hypothesis 1 because MHC defendants have a lower rate of re-arrest than TCC subjects even when controlling for criminal history and demographics. This relationship is further specified with the addition of participation status to the model. These findings also support hypothesis 2 as there is a significant difference between MHC completers and non-completers with completers having a significantly lower rate of re-arrest than non-completers\textsuperscript{36}. However, there is not a significant difference between MHC non-completers and TCC subjects; thus, emphasizing the need to account for participation status to predict accurately the effectiveness of the MHC.

**Re-arrest Offense Severity**

To examine the MHC’s impact on re-arrest severity, a two-stage approach was necessary to account for selection bias. Selection bias occurs when observing a value on a certain variable (score on recidivism severity scale in this study) depends on the value of another variable (re-arrest in this study) (Breen 1996). This dependency

\textsuperscript{36} The difference between MHC completers and non-completers was determined by re-estimating the model with MHC non-completers as the reference category instead of TCC defendants.
creates selection bias because a non-random subset of my total sample (N=147) were re-arrested, thus having a score on the recidivism severity scale. It was impossible for the remaining 118 subjects to have a score on this scale because they did not re-offend. Selection bias in the dependant variable is problematic because it can cause bias in regression coefficient estimates. To remedy this problem, Heckman (1979) and Berk (1983) recommend a two-stage approach where the first step models the probability of re-arrest (the variable that determines the value of the dependant variable of interest) for the entire sample; the second stage models the expected value of the score on the recidivism severity scale conditional on re-arrest. This approach is often used in research on criminal sentencing (Demuth and Steffensmeier 2004, Leiber and Mack 2003, Peterson and Hagan 1984).

In the first step of my analysis, I used logistic regression to model the probability of re-arrest. The coefficients from this equation were used to form a new variable, the predicted probability of re-arrest. Using STATA, each individual in the sample was assigned a probability based on the coefficient estimated by the selection equation. In the second step of my analysis, OLS was used to model score on the recidivism severity scale only for those who were re-arrested. This model included all of the explanatory variables and the predicted probability of re-arrest that was calculated in the first stage. Use of the predicted probability of re-arrest in the second

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37 Tobit analysis is another possible remedy for analysis of limited dependent variables and is used when the dependent variable is either censored or truncated. In my sample the dependent variable, recidivism severity, was not truncated or censored; rather it is limited through sample selection. Therefore, the approach recommended by Heckman (1979) and Berk (1983) was the most appropriate.
step of modeling captured the observed variables that affected selection (Sales, Plomondon, Magid, Spertus, and Rumsfeld 2004)\(^{38}\). Such an analysis helped determine what factors were related to the severity of re-arrest above and beyond the probability of re-arrest for those who did have an arrest during the follow-up.

Table 11.4 presents results of models predicting the odds of re-arrest and the severity of re-arrests by court type. In predicting the odds of being re-arrested (or having some score on the recidivism offense severity scale), only criminal history offense severity scale has a significant, though small effect. Specifically, as the criminal history offense severity scale increases by one, the odds of being re-arrested increase by 7% (p< .001). The lack of significance of MHC as compared to TCC differs from the negative binomial model. The noted difference is explained by the coding of the dependent variable, re-arrest, as dichotomous in this series of analyses and results in the loss of re-arrest information as compared to its previous coding as a count variable. When used as a count variable, re-arrest more extensively tells the story of the MHC’s effectiveness.

The second stage of modeling, including all variables and the predicted probability of re-arrest, uses OLS regression to predict the severity of recidivism only for those who were re-arrested during the follow up period (N=147)\(^{39}\). In this model, MHC and severity of key charge are significant when taking the probability of arrest

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\(^{38}\) Multicollinearity may be a potential problem that arises from inclusion of the predicted probability and the explanatory variables in the OLS model. Multicollinearity is examined in the results section of analyses using the two-stage approach.

\(^{39}\) A potential problem may arise when putting the predicted probability of re-arrest in a subsequent equation when the selection equation had the same independent variables. There is the potential for
into account. MHC defendants score 7.80 points lower on the recidivism offense severity scale than those in TCC controlling for other variables in the model (p< .05). As severity of key charge increases by one unit, score on the recidivism offense severity scale goes up by 1.55, all else held constant (p< .05). Above and beyond the probability of being re-arrested, defendants in MHC score significantly lower on the recidivism severity scale than do TCC subjects.

Table 11.5 presents the same analysis for MHC completers and non-completers. When looking at the odds of re-arrest, being a MHC completer and score on the criminal history severity scale are significant. Those who completed MHC have lower odds of re-arrest: one-third the odds of re-arrest of those in TCC, all else held constant (p< .01); and 81% the odds of re-arrest of non-completers (p< .001). Prior offense severity scale is significant: as score on the severity scale increases by one, the odds of re-arrest increases 7% (p< .001).

Stage two of the analyses indicates that being a MHC completer is not significant. That is, MHC completers are not significantly different from TCC subjects (parameter estimate noted in Table 11.5) or MHC non-completers (t-test, t =.50, df = 9, p = .6168). That completion status is not significant indicates that the positive effect of being a MHC completer is seen in the reduced probability of arrest and not in the multicollinearity between the predicted probability and the other variables in the model. The calculated variance inflation factors (VIF) ranged from 1 to 17. The calculated VIFs show the predicted probability of re-arrest is highly collinear with MHC defendants, score on the criminal history severity scale, and spending time in jail prior to entering the court as one would expect. When the predicted probability of re-arrest is removed from the model, the results remained the same in significance and magnitude.

40 The difference between MHC completers and non-completers was determined by re-estimating the model with MHC non-completers as the reference category instead of TCC defendants.
severity of re-arrest when re-arrest is taken into account. Only severity of key charge is significant: with each additional one-unit increase in the severity of key charge, score on the recidivism offense severity increases, on average, by 1.44 (p< .01)41.

In summary, the pattern noted between court type and completion status and recidivism shows that it is completing the MHC that significantly reduces the likelihood of being re-arrested. Further, when examining only those who have been re-arrested, participation in the MHC, as opposed to TCC, significantly reduces the severity of re-offending. Thus, hypothesis 3 is supported because MHC defendants are re-arrested for less severe offenses than TCC subjects when re-arrested. However, support is not found for hypothesis 4 because there is not a difference between MHC completers and non-completers and TCC subjects in recidivism severity.

**Pre Test Post-test Analyses Using Paired T-Tests**

Analyses presented above tell us about changes in the sample of MHC defendants as a whole, but not criminal activity patterns of each individual over time. To gain a better understanding of how MHC and TCC subjects differ on criminal involvement, it is useful to examine pre-test and post-test scores of each individual subject on the same two variables, number of times arrested and severity of those arrests. To this end paired t tests, an appropriate statistical technique for individual changes, are conducted. A paired t test is used to compare the means of two variables.

41As in the previous model, calculated VIF’s ranged from 1 to 17 and indicate the predicted probability of re-arrest is highly collinear with MHC completer, score of the criminal history severity scale and spending time in jail prior to entry into the court as expected. When the model was run without the predicted probability of re-arrest, the results remained the same for severity of key charge in significance and magnitude. All other variables remained nonsignificant.
Specifically, it computes the difference between the pre-test and post-test score of each individual for number of arrests and severity of those arrests and tests to determine whether the average differences of these scores are significantly different from zero (Levin 1999).

Initially, paired t tests were run for the two samples. These analyses indicated that TCC subjects were re-arrested more often and for more serious offenses during the post-test period than the pre-test period. No differences between pre and post-test scores were detected for MHC subjects. One could argue that significant results were found because the two groups differed significantly at the outset on age, race, and average score on the criminal history severity scale.

**Matched Pairs**

To increase confidence in the results, TCC and MHC subjects were matched on race and criminal history severity. Sample size was reduced from 265 to 142 after matching on these two variables. Age was not matched, as it would have resulted in a substantial loss of cases, but after matching the two groups, the age difference was reduced such that it was no longer significant.

Sample characteristics for the matched sample are presented in Table 11.6. MHC and TCC samples both consist of 58.33% African Americans and 41.67% whites. In addition, each sample has an average score of 3.47 on the prior offense severity scale. A significant difference no longer remains for age although on average, MHC subjects are 35 and TCC subjects are 32 years of age. After matching, differences still remain between the two court types on the two outcome variables, re-arrest and severity.
of re-arrests. MHC subjects are re-arrested significantly less often than TCC subjects during the 12 months follow-up with an average of 1.08 new arrests versus 2.08 new arrests for TCC subjects (t-test, t-value 2.61, df 118, p< .01). The same pattern appears in the recidivism severity scale: MHC subjects score significantly lower than TCC subjects on the recidivism offense severity scale (3.62 vs. 8.40, t-test, t-value 2.68, df 101, p< .01).

Differences in re-arrest and re-arrest severity also remain between MHC completers and non-completers in the matched sample (Table 11.6). MHC completers are re-arrested significantly less than non-completers (.59 vs. 2.00, t-test, t-value 3.06, df 34.4, p< .01). Similarly, MHC completers score significantly lower on the recidivism severity scale (2.08) than non-completers (6.52) (t-test, t-value 2.62, df 37.2, p<.01).

Table 11.7 examines pre-test and post-test scores for the number of arrests for MHC and TCC subjects. The difference in arrests, arrests at time 2 (post-test) minus arrests at time 1 (pre test), is inspected to determine if members in each group experienced reduced arrests over time. Overall, Table 11.6 and 11.7 support hypothesis 1 because MHC subjects have significantly fewer re-arrests in the post-test period than TCC subjects (1.08 MHC, 2.08 TCC, t-test, t-value 2.61, df 118, p< .01). Further inspection of the pre-test post-test results in Table 11.7 indicates the difference in average arrests between MHC and TCC subjects is not because MHC had a reduction in arrests, rather TCC subjects had an increase in arrests from pre-test to post-test. It is this increase in arrests from one year pre-court to one-year post court for matched TCC
defendants which is responsible for the lower arrest rates of MHC subjects in previous regression models.

Turning to the severity of arrests, Table 11.6 and 11.7 support hypothesis 3 that MHC subjects are arrested for less serious offenses than TCC subjects in the follow-up period (3.62 vs. 8.40, t-test, t-value 2.68, df 101, p< .01). Closer inspection of pre-test/post-test results in Table 11.7 indicates that MHC defendants’ re-arrest severity did not change significantly over time while TCC defendants experienced a significant increase in re-arrest severity. Thus, it is the increase from one-year pre-court to one-year after court entry in severity of offenses among matched TCC subjects which is responsible for the lesser severity of arrests of MHC subjects in the previous regression models.

As done in previous analyses, matched MHC subjects are divided into completers and non-completers to determine whether there is a significant difference in arrests and severity of arrests by completion status. Table 11.6 indicates that there is a significant difference between MHC completers and non-completers in mean number of arrests (.59 vs. 2.00, t-test, t = 3.06, df = 34.4, p< .01) and in the mean severity of arrests (t-test, t = 2.62, df = 37.2, p<.01) in the post-test period lending support to hypothesis 2 and 4. However, the pre-test post-test differences for both groups (seen in Table 11.8) are not significant meaning that no differences occurred from pre-test to post-test in the number of times arrested or in the severity of arrests for MHC completers and non-completers. The pre-test/post-test differences of MHC completers and non-completers are both not significantly different from zero, and therefore not
different from each other. Thus, the significant differences noted in Table 11.6 between MHC completers and non-completers in post-test arrest and in arrest severity could be unrelated to participation in the MHC because there is not a significant decrease in arrest or arrest severity from pre-test to post-test. The contradiction between this finding and the significant difference between MHC completers and non-completers in rearrest in the negative binomial regression may be explained by the lack of matching done on these two groups (completers and non-completers) prior to the pre-test/post-test comparison.42

Figures 11.1 and 11.2 display the data from tables 11.7 and 11.8 graphically for all subjects by court type and completion status: TCC, MHC (total sample), MHC completers and MHC non-completers. As noted in Figure 11.1, all four groups have similar values for arrests in the year prior to entry into TCC or MHC; however, post-test scores show a different pattern. Post-test scores indicate that TCC and MHC non-completers are re-arrested more often than MHC completers and the total MHC sample with MHC completers experiencing a decrease in arrests after entry into the MHC.

Figure 11.2 presents severity of arrests pre-test and post-test for TCC, MHC (regardless of completion status), MHC-completers, and MHC non-completers using data from Tables 11.7 and 11.8. The pattern noted for severity of arrests is similar to that seen above in the number of times arrested such that all four groups have similar scores on severity of arrests prior to entry into the court. Post-test scores for each

42 Matching was performed for the MHC and TCC samples for the pre-test/post-test comparisons. Matching was not performed on the MHC completers and non-completers due the small sample size of non-completers and the risk of losing cases when performing the match.
group are different with TCC defendants having the highest score on the recidivism offense severity scale followed by MHC non-completers. MHC completers have the lowest score on the recidivism severity scale and have a decrease in the severity of all offenses committed after entry into the MHC.

Although contrary to my initial thinking, these findings are substantively important. Paired t tests indicate that MHC subjects (whether completers or non-completers) are arrested about the same number of times in the year prior to and after entry into the MHC. In addition, severity of arrests prior to entry into the MHC and in the follow-up period remains about the same. Thus, rather than reducing criminal involvement and the severity of such involvement for MHC defendants, MHC appears to provide a stabilizing effect. However, when MHC completion status is taken into account, MHC completers fair significantly better in terms of arrest and severity of arrest than MHC non-completers. Conversely, for TCC subjects, arrests and the severity of arrests increase during the follow-up period.
### Table 11.1  Sample Characteristics by Type of Court and Completion Status

<table>
<thead>
<tr>
<th></th>
<th>Traditional Court (N=183)</th>
<th>MHC Total Completer (N=52)</th>
<th>Mental Health Court Completer (N=52)</th>
<th>Non-Completer (N=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of times re-arrested*</td>
<td>2.36</td>
<td>1.10</td>
<td>0.58</td>
<td>2.03</td>
</tr>
<tr>
<td>Average score on recidivism offense severity scale*#</td>
<td>9.46</td>
<td>3.90</td>
<td>2.06</td>
<td>7.13</td>
</tr>
<tr>
<td><strong>Criminal History Controls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average score on prior offense severity scale*</td>
<td>6.62</td>
<td>4.13</td>
<td>3.04</td>
<td>6.03</td>
</tr>
<tr>
<td>Average severity of key charge</td>
<td>4.39</td>
<td>4.06</td>
<td>3.96</td>
<td>4.23</td>
</tr>
<tr>
<td>Percent spending some time in jail pre-court</td>
<td>11.48%</td>
<td>4.88%</td>
<td>2.00%</td>
<td>10.00%</td>
</tr>
<tr>
<td><strong>Demographic Controls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age*</td>
<td>30.08</td>
<td>35.65</td>
<td>36.23</td>
<td>34.66</td>
</tr>
<tr>
<td>Race*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>54.60%</td>
<td>39.02%</td>
<td>32.69%</td>
<td>50.00%</td>
</tr>
<tr>
<td>White</td>
<td>45.40%</td>
<td>60.98%</td>
<td>67.31%</td>
<td>50.00%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>72.68%</td>
<td>68.29%</td>
<td>69.23%</td>
<td>66.67%</td>
</tr>
<tr>
<td>Women</td>
<td>27.32%</td>
<td>31.71%</td>
<td>30.77%</td>
<td>33.33%</td>
</tr>
</tbody>
</table>

* indicates a significant difference between court type and variable of interest
# indicates a significant difference between completers and non-completers and variable of interest
Table 11.2 Negative Binomial Regression Model Predicting the Rate of Re-Arrest (N=265)

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IRR Coefficient</td>
<td>IRR Coefficient</td>
<td>IRR Coefficient</td>
</tr>
<tr>
<td></td>
<td>(se)</td>
<td>(se)</td>
<td>(se)</td>
</tr>
<tr>
<td>Mental Health Court</td>
<td>0.47*** (.21)</td>
<td>0.53** (.20)</td>
<td>0.55** (.21)</td>
</tr>
<tr>
<td>Score on Prior Offense Severity Scale</td>
<td>1.02** (.01)</td>
<td>1.02** (.01)</td>
<td></td>
</tr>
<tr>
<td>Severity of Key Charge</td>
<td>1.05 (.04)</td>
<td>1.05 (.05)</td>
<td></td>
</tr>
<tr>
<td>Jailed Pre-Court</td>
<td>1.27 (.30)</td>
<td>1.29 (.30)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.99 (.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>0.99 (.18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>0.96 (.20)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Model chi-square: 12.53*** 25.10*** 25.39***

Degrees of freedom: 1 4 7

***p<.001  **p<.01  *p<.05

Standard errors (se) are in parentheses
Table 11.3  Negative Binomial Regression Model Predicting the Rate of Re-Arrest  (N=265)

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IRR</td>
<td>Coefficient</td>
<td>IRR</td>
</tr>
<tr>
<td></td>
<td>(se)</td>
<td>(se)</td>
<td>(se)</td>
</tr>
<tr>
<td>MHC-Completer</td>
<td>0.24***</td>
<td>-.141</td>
<td>0.28***</td>
</tr>
<tr>
<td></td>
<td>(.27)</td>
<td>(.26)</td>
<td>(.27)</td>
</tr>
<tr>
<td>MHC-Non Completer</td>
<td>0.86</td>
<td>-.15</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>(.27)</td>
<td>(.27)</td>
<td>(.28)</td>
</tr>
<tr>
<td>Score on Prior Offense Severity Scale</td>
<td>1.02**</td>
<td>0.02</td>
<td>1.02**</td>
</tr>
<tr>
<td></td>
<td>(.01)</td>
<td>(.01)</td>
<td>(.01)</td>
</tr>
<tr>
<td>Severity of Key Charge</td>
<td>1.05</td>
<td>0.06</td>
<td>1.05</td>
</tr>
<tr>
<td></td>
<td>(.04)</td>
<td>(.04)</td>
<td>(.04)</td>
</tr>
<tr>
<td>Jailed Pre-Court</td>
<td>1.23</td>
<td>0.21</td>
<td>1.24</td>
</tr>
<tr>
<td></td>
<td>(.29)</td>
<td>(.29)</td>
<td>(.29)</td>
</tr>
<tr>
<td>Age</td>
<td>0.99</td>
<td>-.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.00)</td>
<td>(.00)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>1.00</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.18)</td>
<td>(.18)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>0.96</td>
<td>-.03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.20)</td>
<td>(.20)</td>
<td></td>
</tr>
<tr>
<td>Model Chi-Square</td>
<td>25.09***</td>
<td></td>
<td>37.13***</td>
</tr>
<tr>
<td>Degrees of Freedom</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

***p<.001  **p<.01  *p<.05
Standard errors (se) are in parentheses
Table 11.4 Logistic Regression Model Predicting the Odds of Re-Arrest and OLS Regression Models Predicting Recidivism Severity by Court Type

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Logistic Regression (N=265)</th>
<th>OLS Regression (N=147)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds of Re-Arrest</td>
<td>Coefficient Predicting Recidivism Severity</td>
</tr>
<tr>
<td></td>
<td>Odds</td>
<td>Coefficient (se)</td>
</tr>
<tr>
<td>Mental Health Court</td>
<td>0.63</td>
<td>-.45 (.29)</td>
</tr>
<tr>
<td>Score on Prior Offense Severity Scale</td>
<td>1.07*** (.02)</td>
<td>.07 (.02)</td>
</tr>
<tr>
<td>Severity of Key Charge</td>
<td>1.02 (.07)</td>
<td>.02 (.07)</td>
</tr>
<tr>
<td>Jailed Pre-Court</td>
<td>3.33 (.66)</td>
<td>1.20 (.66)</td>
</tr>
<tr>
<td>Age</td>
<td>0.98 (.01)</td>
<td>-.01 (.01)</td>
</tr>
<tr>
<td>Race</td>
<td>1.40 (.27)</td>
<td>.33 (.27)</td>
</tr>
<tr>
<td>Gender</td>
<td>0.95 (.29)</td>
<td>-.04 (.29)</td>
</tr>
<tr>
<td>Probability of Re-arrest</td>
<td>-19.98 (26.9)</td>
<td></td>
</tr>
<tr>
<td>Model chi-square</td>
<td>38.82***</td>
<td></td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>R square</td>
<td>0.10</td>
<td>0.10</td>
</tr>
</tbody>
</table>

***p<.001  **p<.01  *p<.05
Standard errors (se) are in parentheses
Table 11.5 Logistic Regression Model Predicting the Odds of Re-Arrest and OLS Regression Models Predicting Recidivism Severity by Court Status

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Logistic Regression (N=265)</th>
<th>OLS Regression (N=147)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds of Re-Arrest</td>
<td>Coefficient Predicting Recidivism Severity</td>
</tr>
<tr>
<td></td>
<td>Odds</td>
<td>Coefficient (se)</td>
</tr>
<tr>
<td>MHC-Completer</td>
<td>0.33**</td>
<td>-1.10 (.37)</td>
</tr>
<tr>
<td>MHC-Non Completer</td>
<td>1.78</td>
<td>0.58 (.45)</td>
</tr>
<tr>
<td>Score on Prior Offense Severity Scale</td>
<td>1.07***</td>
<td>0.07 (.02)</td>
</tr>
<tr>
<td>Severity of Key Charge</td>
<td>1.02</td>
<td>0.02 (.07)</td>
</tr>
<tr>
<td>Jailed Pre-Court</td>
<td>3.07</td>
<td>1.12 (.66)</td>
</tr>
<tr>
<td>Age</td>
<td>0.98</td>
<td>-.01 (.01)</td>
</tr>
<tr>
<td>Race</td>
<td>1.32</td>
<td>0.28 (.28)</td>
</tr>
<tr>
<td>Gender</td>
<td>0.39</td>
<td>-.06 (.30)</td>
</tr>
<tr>
<td>Probability of Re-arrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model chi-square</td>
<td>49.79***</td>
<td></td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>R square</td>
<td>0.13</td>
<td>0.09</td>
</tr>
</tbody>
</table>

***p<.001  **p<.01  *p<.05
Standard errors (se) are in parentheses
Table 11.6 Sample Characteristics for Matched Sample by Type of Court and Completion Status

<table>
<thead>
<tr>
<th></th>
<th>Traditional Court (N=72)</th>
<th>MHC Total (N=72)</th>
<th>Mental Health Court Completer (N=47)</th>
<th>Mental Health Court Non Completer (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of times re-arrested*#</td>
<td>2.08</td>
<td>1.08</td>
<td>0.59</td>
<td>2.00</td>
</tr>
<tr>
<td>Average score on recidivism offense severity scale*#</td>
<td>8.40</td>
<td>3.62</td>
<td>2.08</td>
<td>6.52</td>
</tr>
<tr>
<td><strong>Criminal History Controls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average score on prior offense severity scale</td>
<td>3.47</td>
<td>3.47</td>
<td>3.12</td>
<td>4.12</td>
</tr>
<tr>
<td>Average severity of key charge</td>
<td>4.81</td>
<td>4.19</td>
<td>4.00</td>
<td>4.56</td>
</tr>
<tr>
<td>Percent jailed pre-court</td>
<td>8.22%</td>
<td>4.11%</td>
<td>2.08%</td>
<td>8.00%</td>
</tr>
<tr>
<td><strong>Demographic Controls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age</td>
<td>32.25</td>
<td>35.12</td>
<td>36.17</td>
<td>33.16</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>58.33%</td>
<td>58.33%</td>
<td>36.17%</td>
<td>52.00%</td>
</tr>
<tr>
<td>White</td>
<td>41.67%</td>
<td>41.67%</td>
<td>63.83%</td>
<td>48.00%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>75.00%</td>
<td>66.67%</td>
<td>70.21%</td>
<td>60.00%</td>
</tr>
<tr>
<td>Women</td>
<td>25.00%</td>
<td>33.33%</td>
<td>29.79%</td>
<td>40.00%</td>
</tr>
</tbody>
</table>

* indicates a significant difference between court status and variable of interest
#indicates a significant difference between completers and non-completers
Table 11.7 Pre-test Post Test Comparisons of Matched Sample by Court Type

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Court (N=72)</th>
<th>Traditional Court (N=72)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post Test</td>
</tr>
<tr>
<td><strong>Number of times arrested</strong> (1 year prior to entry into the court and 1 year after entry into the court)</td>
<td>1.04</td>
<td>1.08</td>
</tr>
<tr>
<td><strong>Severity of all arrests</strong> (1 year prior to entry into the court and 1 year after entry into the court)</td>
<td>3.47</td>
<td>3.62</td>
</tr>
</tbody>
</table>

***p<.001  **p<.01  *p<.05
Table 11.8 Pre-test Post-test Comparisons of Matched Sample by Completion Status

<table>
<thead>
<tr>
<th></th>
<th>Completers (n=47)</th>
<th>Mental Health Court</th>
<th>Non-Completers (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of times arrested</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1 year prior to entry and 1 year post entry into court)</td>
<td>0.93 0.59 -0.34</td>
<td>1.24 2.00 0.76</td>
<td></td>
</tr>
<tr>
<td><strong>Severity of all arrests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1 year prior to entry and 1 year post entry into court)</td>
<td>3.12 2.08 -1.04</td>
<td>4.12 6.52 2.40</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 11: Figures

Figure 11.1. Pre-Test/Post Test Comparisons of Number of Arrests by Court Type and Completion Status for the Matched Sample (N=144)

Figure 11.2. Pre-Test/Post Test Comparisons of Severity of Arrests by Court Type and Completion Status for the Matched Sample

Figure 11.1  Pre-Test/Post Test Comparisons of Number of Arrests by Court Type and Completion Status for the Matched Sample (N=144)

Figure 11.2  Pre-Test/Post Test Comparisons of Severity of Arrests by Court Type and Completion Status for the Matched Sample
CHAPTER 12

DISCUSSION AND CONCLUSIONS

This study examined MHC processes and procedures, and criminal outcome data for MHC defendants as compared to TCC subjects using qualitative and quantitative data. It contributes to the literature on MHCs in several ways:

1. A conceptual model of MHC operation is provided indicating the mechanisms by which MHCs lead to improved defendant outcomes and provide relief for the criminal justice system;

2. Qualitative data shed light on the mechanisms (team decision making processes, open court processes, and judicial power and control to ensure defendant compliance) within MHC operation that link MHCs to improved defendant outcomes;

3. Qualitative data provide insight into defendants’ treatment compliance and the impact of treatment services on defendants’ lives;

4. Quantitative data and statistical analyses empirically tested one outcome of the MHC, recidivism, controlling for relevant causal variables; and

5. Negative binomial methods allow for improved statistical modeling of re-arrest.

The following discussion of contributions is organized around the points above.

Qualitative Contributions (Numbers 1-3)

Major contributions of this research are a conceptual model that indicates how MHCs theoretically operate and how one MHC attempted to reduce reoffending among mentally ill defendants. Central to this conceptual causal model of MHCs is the use of a non-adversarial approach that focuses on rehabilitation, not adjudication and punishment
of defendants. In this study’s MHC, MHC team members worked together to marshal services and to monitor and sanction MHC defendants in the hope of getting to the root of the problem, mental illness, thereby, reducing further criminal involvement. The model indicates that critical to this approach and the success of MHCs are the working relationships established among MHC team members where defense attorneys, prosecutors, and judges take on new roles. This study could not test this but lends support to the importance of the non-adversarial, team approach.

To successfully implement the non-adversarial team approach, defense attorneys, prosecutors, and judges become members of a court team, whereby all pertinent information about defendants is shared and discussed in pre-court team meetings to foster the development of individualized treatment plans appropriate to the psychological, physical, and social needs of defendants. Pre-court team negotiations are designed to allow timely and relevant discussions of defendants’ behavior, treatment compliance, and needed service modifications or additions. Such deliberations conclude when team members concur on the best course of action. The current study indicates that this MHC has effectively implemented the team approach for decision-making the model deems essential to success because it leads to informed decisions with the opportunity for individualized treatment plans for defendants and one voice giving directions and sanctions.

The new role of counsel and new method of trying criminal cases is quite different from traditional roles and methods and causes some tension for defense attorneys. Defense attorneys occasionally feel at odds with the role and relieve this strain by indicating that they are doing what is ultimately best for defendants in terms of life
outcomes. However, the fact that defense attorneys may not get their clients the best deal in terms of time under the court’s supervision raises important issues that date back to the establishment of the juvenile justice system. Is defense counsel adequately representing defendants and getting the best “deal” for them in terms of freeing them from immediate court control and punishment? Would defendants have gotten a shorter sentence or possibly had their charges dismissed in traditional court? Are defendants’ due process rights being upheld? These are all important questions that speak to the ability of MHCs to maintain defendants’ due process and individual rights that have not been investigated empirically.

Only study to date comes close to providing insight into the above questions. The Broward County study examined procedural justice and coercion of defendants in MHCs (Poythress et al. 2002). On a procedural justice scale with items measuring a defendant having a chance to inform the judge of his legal and personal situation, respectful treatment by authority, and perception of fairness, findings indicated that MHC defendants felt they had higher levels of procedural justice than did TCC defendants. Further, MHC participants indicated they did not perceive their MHC experience as coercive. The results provide some insight into the questions raised above from the perspective of the defendant and indicate that they seemed satisfied in terms of procedural justice and did not feel coerced into treatment. However, two important questions remain unanswered: 1. Do MHC defendants receive adequate attorney representation in MHCs and 2. Are MHC defendants’ due process rights maintained in MHCs?
I now turn to a discussion of research findings on how well this MHC has implemented another link in the conceptual model, MHC monitoring. Observation data on pre-court and court hearings indicate that the MHC monitored MHC defendants’ behavior during pre-court team meetings and open court sessions. The MHC team discussed defendant treatment attendance, motivation, and behavioral compliance during pre-court meetings. Positive and negative information about treatment and behavioral compliance revealed in pre-court meetings was often discussed during open court monitoring sessions to let defendants know they were being monitored and to either reward or encourage compliant behavior.

The judge, the key figure in the courtroom, made every effort to build relationships with defendants through exchanges in open court with the goal of reinforcing treatment compliance or rectifying treatment noncompliance. The judge effectively employed the use of informal social controls such as public praise, compliments, and acknowledgment of achievements to reinforce positive behavior and promote motivation to remain engaged in treatment not only for the defendant whose case was being heard but also for other defendants in the courtroom awaiting call of their cases. The judge applied formal sanctions enforceable by the court in cases of misconduct and noncompliance with treatment but only in cases of consistent misconduct and non-compliance and had as their purpose showing defendants the seriousness with which the court took their actions and pushing defendants to become treatment and behavior compliant.

My study findings on the use of judicial power and methods of social control are similar to Steen’s (2002) in her study on judicial power in drug courts and moral
involvement of defendants in their treatment. Steen (2002) reported that judges employed normative power, the allocation of symbolic rewards (e.g. acceptance and positive responses), to get defendants involved and invested in their treatment and to ensure their compliance. She described recognizing small steps, emphasizing them, and showing defendants other participants’ successes to keep them involved in the process as critical to this approach. All of them lead defendants to become “morally involved” in treatment and to the goals of the court, changing behavior and changing lives, which result in better defendant outcomes (Steen 2002). Judges attempted to maintain a positive focus even in the face of non-compliance and sanctions. Steen (2002) indicated that when sanctions were necessary judges often tried to focus on the overall goal of defendants’ treatment success not their relapse or misbehavior.

The threat and imposition of sanctions to get defendants morally involved in their treatment process could lead critics to question the coercive nature of the MHC. MHC team members do not view the court as coercive because participation is voluntary, that is, the court process is explained to defendants and they have the continuing option to remain in MHC for treatment and monitoring or return to TCC for case prosecution. Once defendants opt into MHC, they are empowered and have control over their outcomes: if compliant, their cases are resolved in a positive manner or if persistently non-compliant, their cases are referred back to TCC. Regardless, the worst thing that can happen from participating in MHC is getting kicked back into TCC or in rare cases receiving a ‘dip’ in jail for repeated noncompliance.

In this study’s MHC, counsel, and the mental health liaison discussed the voluntary nature of the court with each defendant before s/he made a decision to
participate in the MHC. However, this is not the case in all MHCs as indicated by research on the Broward County MHC (Poythress et al. 2002). Findings from court transcripts indicate that the voluntary nature of the court was only discussed in 15.7% of transcripts, but in interviews with defendants 53.7% indicated they were aware that participation in the court was voluntary (Boothroyd et al. 2003). Boothroyd et al. (2003) concluded that defendants may have discussed this information with their attorney in private conversations. That only about half of the defendants in the Broward County court knew MHC was voluntary is startling since defendants have given up their right to due process to participate with the possibility of getting longer sentences. MHC team members should be informed of the criticism of the juvenile court for failing to provide juveniles due process and the ramifications this had for the juvenile justice system because similar accusations could be made of MHCs.

Now, I turn to a third component of the conceptual model, the MHC’s ability to marshal services for defendants. This study found the MHC effective in marshaling services for MHC defendants, indicating the benefit of the collaborative effort between community stakeholders in the criminal justice and mental health service systems. Such a relationship enables defendants to obtain an array of comprehensive services based on their individual needs. Qualitative data indicate all defendants were linked with and obtained treatment services because a majority of them either completed all recommended treatment and services or continued in treatment after the end of their court monitoring.

Findings from this study indicate this MHC is more successful than the Broward County MHC in marshalling services and providing treatment linkages for defendants. In
Broward County, court transcripts showed that 35.3% of defendants were referred to the agency where they had a recently established treatment plan, 35.3% were referred to an agency deemed appropriate to serve their needs, 11% were only offered a name and phone number to call without any treatment linkage, and 18% had no mention of specific service linkage (Boothroyd et al. 2003). Further, 45.2% of defendants in the Broward County MHC did not receive any treatment services during court monitoring.

Last, I discuss the impact the implementation of these components of the conceptual model had on outcomes for MHC defendants in this study. If successful outcomes are achieved for those receiving services, it is an indication that the model has been implemented effectively and yields its intended results. Qualitative data indicate that MHC defendants made gains in a number of areas: housing, financial assistance, vocational skills, and daily structure either through activities or employment. Such treatment and rehabilitative services act to stabilize MHC participants helping them achieve better outcomes in the community such as a better quality of life and a reduction in criminal offending (Jinnett, Alexander, and Ullman 2001; Ziguras and Stuart 2000; Mueser, Bond, Drake, and Resnick 1998; Solomon 1992).

**Quantitative Contributions (Bullet 4)**

This section discusses the impact of one mental health court on criminal re-offending that serves as an indication of how well this MHC implemented the “ideal type” of MHC as illustrated in Chapter One in the conceptual model. If all of the components outlined in the conceptual model were implemented adequately, one would expect to see a reduction in re-arrests among MHC defendants as compared to TCC
defendants. Before turning to these empirical results, it is useful to discuss two contributions of this research in the operationalization of recidivism.

**Improved Measure of Re-arrest.** Research on drug courts and MHCs typically measures re-arrest using a dichotomous variable (yes/no); yes meaning a person was re-arrested and no meaning a person was not re-arrested (Christy et al. 2005, Herinchx et al. 2005, Listwan et al. 2003, Wolfe et al. 2002, Spohn et al. 2001). Operationalizing re-arrest in this way does not take advantage of all the variation in the data in that it assumes a defendant with one re-arrest is the same as a defendant with 7 re-arrests because any value that exceeds zero is coded as a one. Others operationalize re-arrest continuously but only compare the means of two groups in statistical analyses leaving many factors that contribute to recidivism uncontrolled (Cosden et al. 2005, Trupin and Richards 2003, Gottfredson and Exum 2002, Bavon 2001).

I not only measure re-arrest as dichotomous but also as a count variable using negative binomial regression models to solve the problem of a large number of zero values which allowed me to keep re-arrest at its “real” value and examine defendants’ full range of re-offending. Using a measure of recidivism that takes all offenses into account while controlling for other variables is especially important for this population because they tend to be chronic offenders who have come to the attention of the criminal justice system for their cycling in and out of the court system (Hiday et al. 2005, Goldkamp and Irons-Guynn 2000). Thus, predicting their rate of re-arrest provides a more complete picture of their criminal involvement.

**Measured Severity of Re-arrest.** Most drug court and MHC research does not consider the severity of re-arrest in empirical analysis. The one study that does
incorporate recidivism severity only use a felony re-arrest as a dichotomous dependent variable to indicate severity (Spohn et al. 2001). In research on this population, knowing that a felony arrest occurred is not as meaningful as knowing the severity of all additional offenses. Most re-offending among this population is not severe; thus, counting only felony offenses does not provide a complete picture of a defendant’s re-arrest severity. The current study improves upon this approach by including a recidivism severity scale as a dependant variable. To create this scale, I summed the severity of each re-arrest as scored by the state’s structured sentencing guidelines; thus, this measure included both number of re-arrests and their severity (for further discussion of this measure see Chapter 6). Further, I added a value to the scale to include minor infractions that this state, like most states that use structured sentencing guidelines, does not cover in its guidelines. The severity scale employed in this research provides a better representation of defendants’ criminal recidivism severity because it includes all arrests and their severity.

Empirically Tested One Outcome: Recidivism. Outcome data on re-arrest are used to test empirically one outcome of the conceptual model. If the defendants in MHC have reduced arrests, it is an indication that the ideal type of MHC has been implemented effectively in the study site and the MHC is meeting one of its goals: reduced recidivism. Results indicate this MHC is successful in reducing the number of new arrests and the severity of such re-arrests among the population it serves. MHC defendants have a re-arrest rate approximately half that of comparable defendants in TCC; and for those who are re-arrested, MHC defendants are re-arrested for less severe offenses than comparable TCC defendants. Through reduced arrests, this MHC is achieving its goal of decreasing the amount of time and resources the court, police, jail, probation, and parole expend on
this population. Furthermore, reduced arrests and a decrease in the severity of re-arrest when arrest occurs provide evidence that the MHC team is effective in screening referrals to the court and identifying offenders who can be safely diverted into treatment from jail, thereby enabling the MHC to meet its goal of ensuring public safety.

When recidivism of MHC defendants is separated into completers and non-completers, MHC completers’ re-arrest rate drops to less than one-fourth that of TCC defendants; while the re-arrest rate of MHC non-completers increases making their difference with TCC subjects nonsignificant. Analytically this finding is important as it highlights the need to distinguish between those who complete a MHC program of treatment and monitoring and those who do not when evaluating the success of a MHC. This finding has programmatic and political significance in that it points to the necessity of completing the prescribed mental health treatment program and court monitoring in order for the MHC to reduce re-arrest.

Critics may argue that re-arrest caused non-completion of the MHC, but three study findings challenge this line of thought: 1) Re-arrest alone did not lead to MHC termination as defendants in both groups of completers and non-completers were arrested at least once during MHC participation (12% and 47% respectively); 2) arrested non-completers date of MHC termination did not follow shortly the date of arrest (obtained from inspecting the data on date of subsequent arrest and date of MHC termination); and 3) non-completers had a consistent pattern of failure to engage in and remain treatment compliant which the MHC team interpreted as an unwillingness to work with the court to change their lives and resulted in their termination (as observed in pre-court team meetings and in open court hearings).
Analyses examining the severity of re-arrest of TCC and MHC defendants also yielded findings pointing to improvements for MHC defendants as compared to TCC defendants in the severity of re-arrests regardless of completion status. Participating in the MHC alone (regardless of completion status) has a significant impact on the severity of re-arrest. Of those MHC defendants who did re-offend, their offenses were significantly less serious than the offenses of similar TCC defendants. These findings suggest that it is MHC participation rather than completion status that impacts severity of re-arrest for those defendants who are re-arrested.

Last, pre-test/post-test analyses of matched samples comparing arrest and arrest severity prior to entry into either TCC or MHC and one year after entry into the court (TCC or MHC) indicate that TCC subjects are arrested more often and for more serious offenses during the post-test period as compared to the pre-test period. For the matched comparisons, MHC defendants did not experience a decrease in arrests or arrest severity after entry into the court. However, when looking at MHC completers versus non-completers, MHC completers had reduced arrests and reduced severity of re-arrests when they occurred from one year pre-court to one year post court than did MHC non-completers and TCC defendants.

Findings for TCC subjects are consistent with the criminological literature on criminal involvement and the effects of criminal labeling on future criminal activity (Sherman, Smith, Schmidt, and Rogan 1992). Labeling theorists postulate that legal sanctions increase rather than reduce crime by the application of a criminal label (Lemert 1951). Legal sanctions and the imposed criminal label increase criminal behavior through lowered societal expectations and a change in the offender’s self-image
Research on labeling indicates that individuals with social resources are better equipped to use their resources to overcome the criminal label while individuals who lack social resources are not as likely to overcome the label (Rosenfield 1997). MHC gives resources to SMI defendants it monitors, thus, reducing the criminological effects of labeling. Conversely, TCC subjects (with presumed mental illness) lack the necessary resources to overcome the criminal label so they become more involved in criminal activity.

In addition to lacking social resources, mentally ill offenders often face barriers in obtaining and receiving treatment on their own. Research points out that once released into the community, mentally ill offenders often find it difficult to navigate the complex, fragmented mental health service system (Morrissey 1999). If services are located, it is often difficult to find community programs willing to serve them as mental health professionals are not immune to the fear and stigma associated with mentally ill offenders (Roskes, Feldman, Arrington, and Leisher 1999). Without services and successful treatment, it is very likely that disordered offenders will be re-arrested and end up back in court, and possibly in jail.

Conversely, while MHC subjects have been labeled, the label is one of sickness, not criminality. Although MHC defendants may lack social resources at the outset, access to treatment may increase their social resources. Through the MHC, defendants are offered mental health treatment, which includes access to social resources such as social services, vocational training, housing, and employment assistance. Access to such resources and to a case manager who is available to help navigate the mental health system may have a positive impact on mental health status and quality of life as well as
reduce future criminal activity (Herinchx et al. 2005; Jinnett, Alexander, and Ullman 2001; Ziguras and Stuart 2000; Mueser, Bond, Drake, and Resnick 1998; Solomon 1992). Qualitative data showed that for MHC defendants who got treatment and services, such services made a positive difference in their outcomes; conversely, those MHC defendants who were offered services and refused or were consistently non-compliant did not see such a positive benefit.

**Two Unanswered Questions and a Caution.** When considering MHCs in relation to the concerns raised about another specialty court, juvenile courts, two questions remain: 1) Does individualized justice lead to discrimination? and 2) Do MHCs allow for an overreach of the law resulting in net widening? The use of a team approach to decision making with its focus on individual situations and behavior brings issues of individualized justice to the forefront. Individualized justice as applied in the juvenile court received criticism for leading to discrimination (Rothman 2002, Bortner 1982, Lemert 1970). Today many states have enacted sentencing guidelines, including the state in which this MHC is located, to reduce discretion, prevent discrimination, and ensure consistency in sentencing across the board in traditional criminal court. MHCs need to be conscious about fairness in devising treatment plans ensuring equal treatment of defendants with similar circumstances but different social backgrounds.

My research does not address discretion and discrimination; however two suggestions are included for MHCs to consider. First, MHC team members should be aware of the tendency for judicial discretion to lead to discrimination which may result in discussions of discretion and discrimination when considering courses of action for defendants in pre-court meetings. Second, MHCs should keep data on defendant
outcomes that include race, gender, and age to allow MHC team members or outside researchers to examine issues of discrimination.

Second, MHCs must consider the issue of net widening. Previous research criticizes diversionary efforts for widening the net of the state’s control where more people are placed under the supervision of the criminal justice system even though the intent of the diversion program was to deflect people out of it (Decker 1985, Bortner 1982, Austin and Krisberg 1981, Lemert 1970). Research on diversion in the juvenile justice system indicates that net widening occurs: when diversion programs exist, police are more likely to arrest and refer juveniles who would have been otherwise released. The end result being more juveniles are subjected to the control of the criminal justice system (Decker 1985). No study of MHCs has addressed net widening; thus, the question remains: are more persons with mental illness who otherwise would not have been arrested charged with offenses than would be if MHCs did not exist?

Unfortunately, this study only indirectly addresses net widening through anecdotal evidence observed in pre-court meetings. Many times during pre-court meetings, the judge or DA would state that they knew particular defendants from prior arrests, court involvement, and/or their being detained in jail. Although this is not conclusive evidence regarding net widening, it does indicate that many MHC defendants are known to the judge and/or DA because they have been arrested prior to the establishment of the MHC indicating that the police did not take them to the hospital and their charges were not dismissed.

Last, caution should be taken in the implementation of defense attorneys’ new role. Interview data reveal that defense attorneys feel a tension between their new role as
a team member versus their traditional role of zealous advocate ensuring their clients’
due process rights are maintained and their clients receive the least restrictive sentence.
This is a classic tension, benevolence versus social control, described in the sociological
has been shown in the juvenile court system and in the evolution of mental health
commitment laws that operating under the guise of kindness and treatment can lead to
abuse and harm of those the legal system seeks to help (Rothman 2002, Rothman 1990,
Lemert 1970). So as to not repeat the mistakes of the past, MHCs must ensure individual
rights are maintained. This is critical to the validity of MHCs and their ability to provide
equality in justice to all participants.

The current study does not provide empirical evidence about defendant’s due
process rights being maintained or violated. But, pre-court observations indicate that
defense attorneys are aware of the tension between benevolence and social control. At
times in pre-court meetings, defense attorneys would object when the judge or DA
suggested adding treatment services or delaying graduation. Although defense attorneys
bought into the MHC and its goals as indicated by their participation in the MHC,
observations indicated they did not forget their “traditional” advocacy role or their
clients’ due process rights when they felt their client was not being treated according to
the conditions of treatment set forth by the MHC team.

Limitations

Conclusive findings from the subsample are not possible in this study for three
reasons: the subsample is not representative of the entire MHC population, the sample
size is small, and follow-up treatment data were unavailable for most subsample
members. Because the consent form language was flawed, the subsample does not include any individuals who sought mental health treatment outside the local community mental health center, and therefore, is not representative of the entire MHC population.

The small size of the subsample severely limited quantitative analyses and prevented analysis of the intervening variables linking MHC participation to reduced recidivism. Last, the inability to follow treatment attendance among MHC subsample members after release from MHC limited the pre-test/post-test comparisons that could be made. If treatment was not continued at the community mental health center, then treatment records were not accessible.

Turning to the selection of the two main samples, rigorous efforts were taken to ensure the adequacy of the study design; however, there are some methodological limitations. First, the adequacy of sample selection for TCC defendants was contingent on the chief district court judge’s ability to assess accurately which TCC defendants would have been slated for the MHC had it been in existence at the time. This is not deemed a serious problem as the court is located in two small towns and the Judge is familiar with defendants coming through criminal court. Despite this fact, sample selection bias may have been a factor because the judge may have selected defendants who appeared more frequently in the court for the comparison group. If this did occur, comparison group defendants may have more serious criminal histories than MHC defendants. As substantiated by past research, a predictor of future criminal activity is past criminal activity. Thus, this could account for the differences in recidivism outcomes found.
Second, it is possible that defendants selected by the judge suffered from more severe mental illness with more notable symptoms leading to the judge remembering them. However, this is not deemed a serious problem as Bonta et al. (1998) in a meta-analysis of recidivism studies from 1959-1995 determined that clinical variables have little effect on recidivism. Furthermore, they found recidivism predictors to be the same for disordered and non-disordered offenders. Thus this form of selection bias, if it occurred, is not believed to pose serious problems or to have impacted the study results in a significant way.

Also related to sampling, the treatment and control groups were not similar on all variables at the outset. Having significant differences in age, race, and prior offense severity could have impacted the findings. The more severe criminal histories of control group defendants could have led to their increased re-arrest rate. To control for these differences, regression modeling was employed in all analyses of the full sample. In addition, a smaller sample was used in pre-test/post-test analyses that was matched on race and criminal history severity to control for differences in these variables in the full sample.

One last precaution should be taken when interpreting study results. It is possible that a self-selection process is at work where defendants who enter the MHC are different in ways that I can not control in statistical analyses; for example, amenability to treatment and motivation to change. Defendants who are amenable and motivated to obtain treatment may also be those who are less likely to re-offend for each group of defendants (MHC and TCC) resulting in both samples containing a mixed bag of defendants (amenable vs. not amenable to treatment). In the MHC sample, MHC completers are
different from non-completers, and it may be these differences that make them more amenable to treatment and less likely to re-offend rather than participation in the MHC. Likewise, the TCC sample probably has defendants who are inherently different; but I do not know which defendants in TCC are amenable to treatment. Therefore, caution should be taken when examining the results of the analyses that compare MHC completers, MHC non-completers, and TCC defendants because it is not known whether self-selection occurred with some defendants being more amenable to treatment and more motivated to change.

What this study can tell us about the effect of the MHC is seen in regression models that do not separate MHC completers and non-completers. Negative binomial models examining MHC and TCC defendants’ rate of re-arrest indicate that MHC defendants have a lower rate of re-arrest than do TCC defendants. In addition when examining only those who were re-arrested during the follow-up, MHC defendants were re-arrested for less severe offenses than TCC defendants. Both of these analyses include the “mixed bag” of defendants and provide evidence that the MHC does have an impact of future criminal offending.

Future research can ward against these threats to the validity of study findings by using a random assignment into MHC and TCC. Variables should be included that indicate defendants’ amenability for treatment, motivation to change, treatment services received, diagnosis and arrest(s) pre-test and post-test. Such a design would allow researchers to say more definitively whether MHCs are successfully meeting their goals of reduced recidivism and improved quality of life for defendants that participate in the MHC.
Last, caution should be taken as official measures of criminal offending were used; thus, any criminal activity that went undetected by police is not included in the analyses. Other mental health court research has also used official measures of arrest as their indicators of recidivism (Cosden et al. 2005, Christy et al. 2005, Herinchx et al. 2005, Trupin and Richards 2001).

**Future Research**

As with the inception of any new program, much research remains to be done on MHCs. First and foremost, more evaluation research is needed to determine whether these new specialty courts are successful in their implementation of the conceptual model provided, assuring reception of needed services, improving functioning levels among defendants, and/or reducing re-offending. Suggestions for research stemming from this study are qualitative and quantitative. Qualitative efforts should include interviews with MHC defendants. Data from interviews could be used qualitatively and quantitatively to address criticisms of specialty courts. Several interesting interview themes to explore are:

- Do defendants feel their individual rights are being violated in MHC?
- Do defendants feel the informal procedure is fair and procedurally just?
- Do defendants feel their attorney has adequately represented them?

In addition, interviews with defendants could shed light on several topics that this research was unable to definitively address:
• What were defendants’ initial reasons for participating in the court?
• Do defendants “buy into” the goal of the MHC?
• At what point during their participation did they come to accept the goals of the court?
• What impact did the judge/defendant relationship have on their willingness to remain or become treatment compliant?
• Did comments made during court proceedings impact their behavior? If so, how?
• What was the impact of the MHC on defendants’ lives beyond re-offending (e.g., improvements in mental health status, quality of life, employment, social support, coping strategies, and reduced distress)?

Quantitative research should include examining treatment outcomes for all defendants consisting of a follow-up after release from the court to determine whether defendants remain engaged in treatment and with services post-release. Second, MHC non-completers should be followed to examine any treatment services received outside of MHC participation and re-offending patterns. Third, future research should use five-year follow-up periods to determine if the impact of the MHC is temporary, and if so, how long the impact lasts. Fourth upcoming research should address the potential criticisms of specialty courts that this study leaves unanswered related to discrimination and net widening. Last, the scope of subsequent evaluations should be expanded to include other professionals involved in the criminal justice process that deal with mentally ill offenders such as police officers and jailers.

During the course of my observations and interviews, it became evident that there are two levels of decision-making in the MHC the decision to refer an offender to MHC
and the decision of what to do with those who are referred. This research captured the
decision-making process after referral to the MHC, but does not capture the decision
making process used in making court referrals. Although this research included
interviews with the DA and defense attorneys, front line criminal justice personnel such
as police, jailors, and magistrates should be interviews to provide valuable insight into
the process for determining who is routed into the court.
REFERENCES


Drug Court Clearinghouse and Technical Assistance Project. 1999. *Looking at a Decade of Drug Courts*.


APPENDIX A

ABSTRACTION FORMS
Pre-Court Staffing Meeting Checklist

Court Docket: ______________
Time: 1 2 3 4 5 6
Date: _______________
Time begin: _______
Time End: _______

<table>
<thead>
<tr>
<th>Who Speaks?</th>
<th>Type of stmt</th>
<th>What Said</th>
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<tbody>
<tr>
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<td>info</td>
<td>+ -</td>
</tr>
<tr>
<td>Atty</td>
<td>info</td>
<td>+ -</td>
</tr>
<tr>
<td>Other Atty</td>
<td>info</td>
<td>+ -</td>
</tr>
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<td>DA</td>
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<td>+ -</td>
</tr>
<tr>
<td>Judge</td>
<td>info</td>
<td>+ -</td>
</tr>
<tr>
<td>Probation</td>
<td>info</td>
<td>+ -</td>
</tr>
</tbody>
</table>

Compliance not compliant /compliant
- Doing well
- Relapsed
- Rehospitalized
- Re-arrested
- Violated probation
- Missed appts ( # _____)
- Unmotivated

Medication/Substance compliance
- Drinking during month
- Drug/alcohol use during month
- Med. noncompliant

Problems During Mth Add Help
- Financial
- Family/Personal
- Job difficulties
- lost/need job
- Need/lost housing
- Transportation
- Medication side effects
- Other

Recommendations for Judge
- Congratulate/pleased/compliment
- Needs positive reinforcement/encouragement
- Needs reminder (medication or appointment)
- Needs a push to remain compliant
- Warning/threat transfer back
Judge’s Remarks (no=0; yes=1)
- Congratulate/pleased/compliments defendant
- Welcome to the court/meet with DC
- Are you doing alright
- Encourages do what doing
- Asks defendant if s/he has questions/wants to speak
- Gives reminder (medication/appointment/court date)
- Push to remain compliant/encourage good behavior
- Warning/threat
- Transfer back
- Other:

Counsel make arguments?
- 0-none
- 1-basic info
- 2-Other positive explanatory statements
- 3-dismissal

Outcome
- 1-See next month
- 2-Release
- 3-Transfer back
- 4-No show
  - OFA
- Continued
  - 5-graduate

Any family/Friends in court
- 0-No
- 1-Yes

Defendant’s Comportment:
- quiet/withdrawn
- agitated
- pleased

Judge’s Remarks (no=0; yes=1)
- Congratulate/pleased/compliments defendant
- Welcome to the court/meet with DC
- Are you doing alright
- Encourages do what doing
- Asks defendant if s/he has questions/wants to speak
- Gives reminder (medication/appointment/court date)
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  - OFA
- Continued
  - 5-graduate

Any family/Friends in court
- 0-No
- 1-Yes

Defendant’s Comportment:
- quiet/withdrawn
- agitated
- pleased

Court Checklist

Court Docket Number: _______________

Total Time (minutes): _______________

Judge opening remarks: ______________________________

Judge positives: ______________________________________

Judge negatives: ______________________________________

Judge remiders: _______________________________________

Judge Warnings: _______________________________________

Judge Other: _________________________________________

Did defendant speak?

☐ 0-No
☐ 1-Yes

Problems mentioned:

Other remarks by defendant:

Judge’s Remarks (no=0; yes=1)
- Congratulate/pleased/compliments defendant
- Welcome to the court/meet with DC
- Are you doing alright
- Encourages do what doing
- Asks defendant if s/he has questions/wants to speak
- Gives reminder (medication/appointment/court date)
- Push to remain compliant/encourage good behavior
- Warning/threat
- Transfer back
- Other:

Counsel make arguments?
- 0-none
- 1-basic info
- 2-Other positive explanatory statements
- 3-dismissal

Outcome
- 1-See next month
- 2-Release
- 3-Transfer back
- 4-No show
  - OFA
- Continued
  - 5-graduate

Any family/Friends in court
- 0-No
- 1-Yes

Defendant’s Comportment:
- quiet/withdrawn
- agitated
- pleased
Mental Health Record Abstraction Form

Name: _________________________

Education: ________  # yrs.
GAF: _____________

Diagnosis:
Y N Schizophrenia
Y N Depression
Y N Bipolar
Y N Psychosis NOS
Y N Delusional disorder
Y N Alcohol abuse/dependence
Y N Drug abuse/dependence
Y N Personality disorder-ASPD
Y N Personality disorder-borderline
Y N Personality disorder-other

Financial Situation:
Prior to court After entry
Private ins Y N Y N
SSDI/SSI Y N Y N
Medicaid Y N Y N
Medicare Y N Y N

Marital Status: 0 Single
1 Married

Employment:
Prior to court After entry
Employed Y N Y N
In school Y N Y N

Support:
Y N Supportive family
Y N conflicting family
Y N Supportive spouse/partner
Y N conflicting partner
Y N No family
Y N Supportive friends

Living Situation:
Prior to court After entry
Homeless Y N Y N
Shelter Y N Y N
alone/with partner Y N Y N
with parents/family Y N Y N
group home Y N Y N
residential trmt-MH Y N Y N
residential trmt-SA Y N Y N
Recent Abuse:
Physical  Y  N
Sexual    Y  N
Date Data Collected: __________________
By Whom: __________________________
Date entered MHC: ___________
Date exit MHC: ___________

Childhood Abuse:
Y  N  Physical
Y  N  Sexual
Y  N  Neglect

Date of 1st service under MHC: __________
Date of last service under MHC: __________
Date of last service post MHC: __________
Date of 1st service pre MHC: ___________
Date of last service pre MHC: ___________

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<tr>
<td>Group</td>
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Total # hospitalizations: __________

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<tr>
<td># comments doing better/meds</td>
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