

Process Evaluation of Harford County Mental Health Diversion Program



Maryland Judiciary Research Consortium

**Maryland Judiciary,
Administrative Office of the Courts**

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A COLLABORATION BETWEEN:

THE MARYLAND JUDICIARY, ADMINISTRATIVE OFFICE OF THE COURTS

Robert M. Bell, Chief Judge, Court of Appeals of Maryland
Frank Broccolina, State Court Administrator
Faye D Gaskin, Deputy Court Administrator

COURT RESEARCH AND DEVELOPMENT DEPARTMENT

Diane S. Pawlowicz, Executive Director
C. David Crumpton, Ph.D., Deputy Executive Director
Jamie L. Walter, Ph.D., Senior Researcher

OFFICE OF PROBLEM SOLVING COURTS

Gray Barton, Executive Director
Jennifer Moore, Deputy Executive Director
Robert Pointer, Program Manager

and

**UNIVERSITY OF MARYLAND
INSTITUTE FOR GOVERNMENTAL SERVICE AND RESEARCH**

Jayne Delano, M.S.W., Senior Faculty Researcher
Jeanne Bilanin, Ph.D., Associate Director
Tara Rice, M.D., M.P.P., Faculty Researcher

and

MORGAN STATE UNIVERSITY

Anita Hawkins, Ph.D., Assistant Professor
Kim Sydnor, Ph.D., Associate Professor

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- Community Behavioral Services (CBS) Inc.
- Alliance, Inc.
- Partners in Recovery: Addiction Treatment Center-GBMC/Sheppard Pratt
- Open Doors Career Center, Inc.
- Harford County Housing Agency
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THE MARYLAND JUDICIARY RESEARCH CONSORTIUM

This report is a product of the Maryland Judiciary Research Consortium (MJRC). The Consortium comprises units of Maryland's public universities, which collaborate under memoranda of understanding with the Maryland Judiciary, Administrative Office of the Courts. The unit responsible for the production of the current report, University of Maryland, Institute for Governmental Service and Research, is a member of MJRC. The contact representative for the Consortium is C. David Crumpton, Administrative Office of the Courts, Court Research and Development Department. He can be reached at 410-260-1274 and david.crumpton@mdcourts.gov.

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Executive Summary

The Maryland Judiciary, Administrative Office of the Courts (AOC), under a grant awarded by Governor's Office of Crime Control and Prevention (GOCCP) partnered with the University of Maryland, Institute for Governmental Service and Research (IGSR), and Morgan State University, School of Community Health and Policy, to conduct a process evaluation of the Harford County Mental Health Diversion Program (MHDP) located in District Court in Bel Air, Maryland.

To assist in providing context for this report, Appendix A includes a summary of the literature concerning court-based mental health interventions. The report includes findings regarding how the Harford County MHDP was originally designed to operate and how the program has been implemented. Information on the MHDP was gathered through: face-to-face individual interviews with the MHDP team comprising 10 members, including six from the criminal justice system and four treatment providers; data on program participants compiled by the Harford County State's Attorney's Office; and a review of program documents, which include written policies and procedures, minutes from planning meetings, and grant proposals.

Court-based mental health interventions are among the many problem-solving court initiatives introduced across the U.S. during the past decade. According to the Council of State Governments Justice Center (2008), 150 mental health courts are in operation nationwide. The design of mental health courts has not been research-driven, and only recently have courts begun collecting and analyzing outcome data that can provide empirical verification of their positive impact (BJA, 2005).

Development of the MHDP began in 2002 through collaboration among the Harford County District Court, State's Attorney's Office, and Office of Mental Health Core Service Agency (CSA). This was a response to their perception of inadequate coordination among and between the criminal justice and treatment provider systems and an incomplete understanding of the extent of mental illness among offenders in Harford County. To formalize the MHDP effort, these agencies convened an advisory committee that included representatives of the Harford County State's Attorney's Office, Public Defenders' Office, Maryland Division of Parole and Probation, and Harford County treatment provider agencies. The advisory committee's goals were to develop a program that would 1) decrease recidivism among offenders with mental illness; 2) provide access to community-based services for offenders with mental illness; 3) adjudicate cases in less time than in a traditional court setting; 4) allow the court to monitor more closely the compliance and progress of the court mandated treatment service plans of offenders with mental illness; 5) identify practices to ensure proper management and flow of criminal cases; 6) develop a strong and experienced team proficient in dealing with problems specific to offenders with mental illness; 7) enable the court staff, and collaborating organization representatives to work as a team and avoid traditional adversarial roles that usually define courtroom procedures; 8) provide a "seamless connection" between community mental health and the criminal justice system; and, 9) identify offenders who could be better served in dealing with their mental illness in the community rather than in jail.

The Advisory Committee invited existing Harford County community-based treatment organizations and working groups to join together to provide coordinated services to a maximum of 20 offenders with mental illness who met eligibility criteria established by the committee. Inter-agency memoranda of understanding (MOUs) were established to formalize the

relationships among MHDP team members and address issues of participant confidentiality. In 2004, MHDP became fully operational and accepted its first participants.

Candidates eligible for MHDP include individuals who 1) are charged with crimes that appear to be related to mental illness; 2) have medical histories that include past and present diagnosis of major mental illnesses; 3) meet the medical necessity criteria for Intensive Case Management or Psychiatric Rehabilitation Services; 4) are competent to stand trial; 5) are approved by the State's Attorney's Office; 6) are approved by the judge upon review of the evaluation results; 7) are current or expected residents of Harford County; and 8) have given informed consent for MHDP team members to share confidential information. In practice, MHDP does not accept defendants who are not eligible for services through the public health system or defendants who have felony drug convictions, a history of violence or an instant offense that is a crime of violence, sex offense, or Driving Under the Influence (DUI). Veterans have been excluded from MHDP because the Veterans Administration has not agreed to the MHDP process for sharing confidential information. Defendants with mental illness who are not eligible for MHDP are processed through the traditional District Court system but are assigned to a separate collateral court docket, referred to treatment, and monitored informally by the judge.

MHDP is a pre-adjudication program. Generally, candidates are drawn from among misdemeanor arrestees who have been detained or released on their own recognizance pending their first court appearance. A defendant can be offered the opportunity to participate in the program only if the Harford County State's Attorney's Office agrees to move for a *stet* processus (or in short, *stet*), which means that adjudication of the charges is postponed while he/she participates in the program.

MHDP participants are considered to have completed the program when they have been consistently compliant with their treatment service plan for one year after they have received stents. Other than consistent compliance with the plan, there are no set program completion criteria. Participants can be terminated from the program if at any point during participation they are non-compliant with their treatment service plans. After review of compliance and progress information, decisions regarding participants' completion and non-completion status are made by the entire team.

Of the 60 defendants that had entered the MHDP as of December 2008, 19 had graduated, 35 had been terminated, and six were still active participants. Of the 35 terminated, seven were not Harford County residents, six had died, five refused to comply with program rules, four were indicted on new charges in other counties, three received Veterans Administration benefits, three had other mental health disorders that were not eligible for treatment services, two had private insurance, two received new charges that were not within the criteria of the program, one did not qualify for the public mental health system benefits, and one fled the jurisdiction.

Findings and Recommendations

Judge Mimi Cooper has stated that, in establishing the Harford County Mental Health Diversion Program, the court and collaborating criminal justice and treatment system agencies purposefully took on the challenge of working with some of the toughest cases in the local criminal justice system. Despite the potential adverse impact on MHDP's statistics, the planners of the program determined that its participants could be more effectively engaged with treatment within the context of the program than in business as usual adjudication. The evidence gathered during the

study indicates that MHDP is generally operating as intended by its planners to this end.

Substantial collaboration among the jurisdictions and agencies that support the program was observed by the researchers. The very limited data obtained from the State's Attorney's Office for the study indicates that MHDP is serving its target population, but not as many participants as had been envisioned. Over a period of approximately four years, 60 defendants, or roughly 15 per year, have entered the MHDP. This enrollment level is 25% less than the ceiling of 20 per year established by the program's founders.

Although the researchers found substantial general alignment at the policy level among MHDP and its source organizations regarding the objectives of MHDP, on the operating level less clear alignment was found. For example, MHDP team members were found to be collectively unclear regarding program eligibility and admission criteria and the assessment process. The MHDP team understands the importance of inter-agency coordination and collaboration to provide services for the population of offenders with mental illness. Not all team members, however, are experienced in working with individuals with mental illness. Current training provided to team members is limited to MHDP policies and procedures. Team members were also found to have varying levels of understanding of the constraints on sharing of participant information.

Consistent with its original design, MHDP excludes individuals not eligible to be treated by the public health system. As a result, they are prevented from receiving stets and the monitoring and support structures available through participation in MHDP.

An area of concern expressed by MHDP team members is the exclusion of veterans from the program because a collaborative agreement is not in place with the Veterans Administration to participate in the MHDP confidentiality and data-sharing processes.

With respect to the MHDP's program completion criteria, there is an understanding by some team members that within a year of participants' acceptance into MHDP they successfully complete the program if requirements of the treatment plan are adequately met. No completion criteria, however, are documented in the program procedural manual.

There is currently no formal structure or process for compiling data on MHDP participants. The program does not currently maintain a database for tracking participants' progress and aggregating data to measure program performance.

Based on these findings, the researchers identified the following items that may contribute to improving MHDP performance:

1. Training regarding the needs of offenders with mental illness will assist MHDP team members in effectively responding to their needs.
2. Cross-training and team building activities among MHDP team members will help them understand the roles of all collaborating organizations and the role of each team member.

Team building will also enhance team work by helping team members to understand and use the strengths of each member to achieve shared objectives. It will help to further engage the team members who do not view themselves as integral parts of the team.

3. Exploration of ways to expand access to MHDP to individuals not eligible to be treated by the public health system may result in increasing the number of offenders assisted through the program to desired levels.
4. Examination of how other courts have resolved issues of confidential information sharing with the U.S. Veterans Administration may assist MHDP in overcoming this barrier to serving the program's target population.
5. Updating the policy and procedures documents to reflect changes that have occurred over the four years of MHDP operations and ensuring that all team members are familiar with the updated material will contribute to inter-organizational cohesion and program effectiveness.
6. To address confusion among team members concerning what information can be shared with whom, training regarding the type of information that can be shared under the federal regulations that govern confidentiality should prove useful. A review of MHDP data-sharing policies and procedures among team members periodically to ensure that members share critical information about participant compliance and progress to the full extent needed and permitted should also prove to be helpful.
7. Development of an explicit set of completion criteria and documentation of such in the policy procedures manual will contribute to improved program performance and participant monitoring. Documented completion criteria will also help ensure that each participant is given similar opportunities to meet goals for program completion.
8. Use of a central database that facilitates tracking participant progress and aggregating data to measure program performance will support program management and evaluation. The data should include all quantifiable measures needed to track the following: 1) number of cases referred to the program and by whom; 2) whether participants have histories of mental illness prior to proximate qualifying arrests; 3) whether or not participants had encounters with the

mental health system prior to proximate qualifying arrests; 4) date of intake into the MHDP; 5) ineligible cases and reasons for non-acceptance; 6) number of cases accepted; 7) number of active participants; 8) number of participants discharged and the reasons for discharge; 9) number of cases referred to treatment; 10) date of acceptance into the treatment program; 11) type of assessment administered; and 12) type of treatment modality recommended and implemented.

The Harford County Mental Health Diversion Program has thus far proven to be successful in establishing levels of inter-organizational collaboration and bringing together criminal justice system and treatment system resources needed to address the needs of a challenging offender population. By attending to the operational issues indicated in the preceding discussion the program should be able to more effectively respond to its goals and objectives.

I. Background

A. Literature Review

The researchers have prepared a literature review that examines current national information regarding court-based mental health interventions. The historical perspective offered in the literature review supports an understanding of the precipitating factors for the formation of the Harford County MHDP. The literature review appears in Appendix A.

In general terms, the literature review confirms that little applied research has been conducted regarding the contextual factors and dynamic ingredients that characterize court-based mental health interventions. As a result, methodologies most appropriate for evaluation of these interventions and evaluations that follow such methodologies have not heretofore appeared in the mental health court discourse. In response to this deficiency, the Institute for Governmental Service and Research and Morgan State's School of Community Health and Policy, through the GOCCP grant that funded the current study, developed a methodology for process and outcome evaluations of court-based mental health interventions. The process evaluation of MHDP considered in this report and a process evaluation of the Baltimore City Mental Health Court (BCMHC) represent the first applications of this new methodology.

B. Historical Perspective on the Mental Health Diversion Program (MHDP) and the Offenders with Mental Illness

In 2002, Honorable Mimi Cooper of the Harford County District Court along with the Office of State's Attorney, and the Office of Mental Health Core Service Agency (CSA) spearheaded a two year planning initiative for the development and implementation of the Mental Health Diversion Program (MHDP). This effort was motivated by inadequate coordination between the

criminal justice and the treatment provider systems to treat this population. Of particular concern to Judge Cooper and her associates was that no one in these systems possessed a complete understanding of how many offenders with mental illness were in custody at any given time in the County. To formalize the MHDP development effort, Judge Cooper worked with the Office of the Public Defender, Maryland Division of Parole and Probation and Harford County treatment provider agencies to endorse the initiative and provide representatives to serve on an advisory committee.

The MHDP advisory committee sought to develop a program that 1) provides access to community-based services for offenders with mental illness; 2) has an impact on recidivism among offenders with mental illness; 3) adjudicates cases in less time than in a traditional court setting; 4) allows the court to more closely monitor the compliance and progress of the court mandated treatment service plans of offenders with mental illness; 5) identifies practices to ensure proper management and flow of criminal cases; 6) employs a strong and experienced team proficient in dealing with the problems of the offenders with mental illness; 7) enables court staff and source organization representatives to work as a team and avoid traditional adversarial roles that usually define courtroom procedures; and 8) provides a “seamless connection” between the community mental health and the criminal justice systems. The Advisory Committee recommended that existing Harford County community-based treatment organizations and working groups join together to provide coordinated services to a maximum of 20 offenders with mental illness eligible for participation in the MHDP.

II. Contextual Analysis

The operating context of a court-based mental health intervention is important to how it functions. This section describes the community and organizations that support the operation of MHDP. It also considers the interactions, relationships and level of communication among and between source organizations and MHDP, the program's operating components, the external resources required to operate the program and the impact of the program on the criminal justice and local community treatment systems.

A. Harford County Demographics

Harford County covers 440 square miles and, as of 2008, had an estimated population of 249,753 living in 92,446 households (Office of Mental Health, 2008). The county's growth rate between 2000 and 2007 was nearly 10% as compared to the statewide population increase about 6% (Maryland Department of Planning, 2008). The Harford County Planning and Zoning Department reports that the County can expect its population to increase by 58,000 over the next five years as people move into the area because the Base Realignment and Closure (BRAC) process (Office of Mental Health, 2008).

Harford County's population is approximately 87% Non-Hispanic White, 11% African-American, 2% Hispanic, 2% Asian, and less than 1% listed as other. (Office of Mental Health 2008). The median household income for Harford County is slightly above the average for the state. Roughly 15,000 individuals meet low to moderate income criteria (Office of Mental Health 2008).

In recent years, the number of children living in single parent homes has increased steadily along with the number of families in need of public assistance (Office of Mental Health, 2008). Five percent of the population or about 12,000 County residents receive County Medical Assistance through either Medicare or Medicaid (Office of Mental Health, 2008).

Services for County Residents with Mental Illness

The Office of Mental Health Core Service Agency (CSA) of Harford County, a non-profit organization funded by the Maryland Department of Health and Mental Hygiene (DHMH), is responsible for the development, planning and management of the local mental health system in Harford County. CSA handles calls for help, including crisis calls, and refers callers in need of services to private providers and to the Harford County public mental health system, which includes 21 agencies and 75 individual practitioners under contract to CSA. A contract with Alliance, Inc. provides for mental health services to special populations, including incarcerated and homeless individuals and individuals in need of case management support (Office of Mental Health, 2008).

In Fiscal Year 2008, CSA handled 2,458 help/crisis calls (Office of Mental Health, 2008). The Harford County public mental health system provided services to 1,921 adults aged 18 and older, of which 189 people were new to the system (Office of Mental Health, 2008). Among people receiving services, 486 were uninsured and 1,209 received Medical Assistance, an increase of 6% from Fiscal Year 2007 (Office of Mental Health 2008).

Under the CSA's contract with Alliance, a total of 651 adults received services during Fiscal

Year 2008. This number included 176 homeless individuals, 136 people in diversion and re-entry programs, 22 in the Shelter Plus Care program, 304 in need of general case management, and 13 in MHDP (Office of Mental Health, 2008).

The Mental Hygiene Administration (MHA) of the Maryland Department of Health and Mental Hygiene (DHMH) also provides services to 141 homeless individuals (Office of Mental Health, 2008), and Alliance serves 653 individuals with case management through the use of specialized CSA grant funds.

In addition, the Harford County Office of Mental Health and Harford County Office of Drug Control Policy, through a Jail and General Case Management Program Diversion Grant, provides partial funding to support a part-time forensic case manager employed by Alliance who facilitates discharge planning to treatment services and community resources for individuals with mental illness who are released from the County Detention Facility. During Fiscal Year 2008, the part-time forensic case manager established and developed collaboration with Maryland Division of Pre-Trial Services for early identification of individuals who would be eligible for MHDP.

The case manager refers these defendants to MHDP, and if they are accepted for MHDP participation, the case manager then monitors their treatment compliance and progress. Of the 339 individuals served by the forensic case manager during the year, 136 were referred to MHDP (Office of Mental Health, 2008).

B. Relationship of MHDP to the Court System

As noted earlier, the Honorable Mimi Cooper of the Harford County District Court, the Office of the State's Attorney, and CSA spearheaded a two-year planning initiative for the development and implementation of the MHDP. This was accomplished with the cooperation of the Office of the Public Defender, Division of Parole and Probation, and local treatment agencies. The goals identified by the MHDP advisory committee suggest that members of the committee had the following specific concerns regarding offenders with mental illness: access to community-based services, recidivism, lack of speed in adjudicating cases, the court's ability to monitor compliance and progress of mandated treatment service plans, case management practices, proficiency of treatment providers in dealing with the problems of offenders with mental illness, impact of the traditional adversarial roles that characterize the judicial process, and a need for more effective coordination between the community mental health and criminal justice systems.

The MHDP advisory committee sought to address these concerns by developing a team approach to working with offenders with mental illness. The MHDP team members include the District Court judge, assistant state's attorney, assistant public defender or private attorney, probation agent, and health and mental health professionals. The advisory committee made a conscious decision to name the initiative a "diversion program" instead of a "mental health court" in light of Harford County initiatives to divert offenders with mental illness from jail into treatment. A description of these initiatives is discussed later in the report.

The MHDP is located in the Harford County District Court in Bel Air, Maryland. It operates within the organizational structure of the District Court of Maryland. The District Court adjudicates misdemeanor offenses, such as traffic violations, violations of county and municipal ordinances and other misdemeanors. As discussed in more detail later in this report, the MHDP is a pre-adjudication program. Eligible offenders who agree to enter the program receive a *stet* processus (or in short, *stet*), which means that adjudication of the charges is postponed while offenders participate in the program.

MHDP effectively functions as an administratively distinct entity within the District Court. Among the key resources directly provided by the Judiciary to MHDP are the services of the judge who presides over MHDP cases; court support staff that includes a court clerk, bailiff, and legal secretary; a courtroom; and the expenses associated with the daily operations of the courtroom. The indirect resources include all of the administrative support and oversight needed to operate MHDP effectively. The program recently received an operating grant from the Judiciary's Office of Problem-Solving Courts.

C. Source Organizations

As with other forms of court-based problem-solving interventions, MHDP operates in an organizationally complex setting. A variety of state and local public jurisdictions and agencies, and private organizations serve as its "source organizations." Source organizations are organizational entities that have direct impacts on planning, implementation, and operations of the MHDP. Each source organization's goals, organizational structure, and operating resources impact MHDP operations. Collaboration among multiple organizations as seen in MHDP differs from the more narrowly focused approaches typically used in the delivery of services to the

population of offenders with mental illness. For a collaborative approach to work, the dynamics of the relationships between and among the source organizations and the MHDP need to be highly sensitive to each entity's individual mission. For MHDP to be effective the objectives of the source organizations regarding its operation should be closely aligned. To achieve this, the MHDP has formally documented the methods of interactions with each source organization through formal memoranda of understanding (MOUs). The interests of the following source organizations are represented by individuals who serve as MHDP team members:

Harford County District Court adjudicates misdemeanor offenses. The court assigns a dedicated judge to oversee and monitor the compliance and progress of the offenders participating in this specialized court. To be effective the goals of MHDP align with the court's historic interest in acting appropriately, effectively and efficiently in providing access to justice for all suspected offenders.

Harford County State's Attorney Office is primarily responsible for the investigation and prosecution of criminal cases at the trial level. Assistant state's attorneys work with law enforcement agencies in the development of cases, presentations to the Grand Jury and trial of cases in the Circuit, District and Juvenile Courts. The office dedicates an assistant state's attorney to MHDP to prosecute its specialized cases. The State's Attorney's Office has an interest in MHDP aligning with its objectives of reducing recidivism and enhancing public safety.

The Office of the Public Defender (OPD) provides legal representation to indigent defendants in the State of Maryland. The office assigns a dedicated assistant public defender to MHDP offenders who qualify for free representation. OPD is concerned that the policies and practices of

MHDP align with its interests in protecting the rights and welfare of suspected offenders who participate in the program.

Maryland Division of Parole and Probation is an agency of the Maryland Department of Public Safety and Correctional Services. The division is responsible for supervising offenders who are serving sentences in the community (Maryland Department of Public Safety and Correctional Services, 2006). The Division assigns a dedicated probation agent to the MHDP team to supervise individuals released from the Harford County Detention Center who are under pre-trial supervision by the Division. The Division has an interest in assuring that MHDP aligns with its objective of providing effective and efficient public safety services.

Harford County Office of Drug Control Policy (ODCP) promotes and provides prevention services through strategies utilizing the resources of public and private agencies (Harford County Government, 1997). In September 2008, the ODCP entered into an MOU with the Harford County District Court that gives the drug court program coordinator, employed by the ODCP, the role of monitoring the funds awarded to the MHDP by the Maryland Office of Problem Solving Court. In this role, the drug court coordinator provides administrative support to the MHDP to ensure client services such as housing, medications, transportation, case management and job training are paid for out of the grant. In addition, the program coordinator lends support to MHDP by attending team member meetings and court sessions regularly. Thus, ODCP is interested in MHDP aligning with the Harford County Executive's interest in reducing crime associated with offenders with mental illness and more effectively and efficiently producing and delivering public safety and community health services.

Office of Mental Health Core Service Agency (CSA) of Harford County is responsible for the development, planning and management of the local mental health system in Harford County. The purpose of the CSA of Harford County is to ensure culturally competent, efficient, coordinated and effective mental health services to the Harford County community. Services include information and referral, advocacy, emergency assistance for prescriptions, housing (e.g., eviction prevention), laboratory assistance, child and adolescent respite referral, adult residential referral, and complaint resolution. CSA assigns a dedicated representative to the MHDP team to insure offenders with mental illness receive appropriate and timely treatment services. CSA also allocates \$5,000 per year for MHDP emergency needs such as medication and housing security deposits. Similar to ODCP, CSA has an interest in MHDP aligning with its mission of producing and delivering community services as effectively and efficiently as possible.

Harford County Department of Health is the local agency representing the policies and programs of the Maryland DHMH. It is responsible for delivery of a wide range of preventive health care, clinical and environmental health services to citizens living in Harford County. The Health Department has eight major divisions: Addiction Services, Administration, Environmental Health, Health Education, Health Services, Health Promotion and Disease Control, Care Coordination, and Women, Infants, and Children. Under a special DHMH initiative, *Integrating Services for Patients with Co-occurring Mental Illness and Substance Abuse*, in June 2008, the Maryland Community Health Resources Commission awarded the Division of Addiction Services a grant to identify and link dually diagnosed inmates at the Harford County Detention Center with comprehensive substance abuse, mental health, and medical services in the community immediately upon release. The Health Department partnered with the Harford County Sheriff's Office and Detention Center, the Harford County Office of Mental Health Core

Service Agency, Alliance, and Upper Chesapeake Health to obtain the grant. The Health Department provides a Substance Abuse Specialist to the MHDP team to ensure that health and mental health services are coordinated for those participants with co-occurring issues. The Health Department's interest as a source organization for MHDP involves its mission of promoting public health in the community and its objective of responding to the mental health needs of the County's offender and suspected offender populations.

Alliance, Inc. is a private, residential psychiatric rehabilitation program that serves individuals with chronic mental illness learn social and economic skills to allow for long-term independent living. It operates under contract with CSA. Alliance assigns a dedicated case manager to the MHDP team to monitor participant progress and compliance with a court ordered treatment service plan and provide regular updates to the MHDP team. Alliance's interest in alignment with MHDP policies and practices relates to its contractual obligations to Harford County to provide community services.

In addition to the organizations represented on the MHDP team, the following source organizations also provide services to offenders in MHDP. As with Alliance, their interests in aligning with the policies and practices of MHDP relate to their contractual obligations to Harford County:

Community Behavioral Services (CBS) Inc. is a nonprofit agency offering several types of mental health programs, including Psychiatric Rehabilitation Programs for adults and children in Harford, Cecil, and Baltimore counties. CBS offers on-site and off-site services to assist clients with community support and achieving and maintaining independent living. CBS also offers a

supported employment program. CBS assigns a dedicated clinician and a case manager to the MHDP team to conduct mental health evaluations, monitor clients' progress and compliance with court ordered treatment service plans, and provide regular updates to the MHDP team.

Key Point Health Services, Inc. provides mental health services that include an outpatient clinic, a day psychiatric program, residential services, outreach services, mental health service coordination, and forensic services.

Open Doors Career Center, Inc. is a nonprofit agency that addresses the employment needs of at-risk adults and teens by offering job skills training, career counseling, support groups, and job placement assistance. Programs include: the Women's Employment Program (for women who have lost their primary means of financial support due to separation, divorce, death of a spouse, or unemployment of a spouse), Project Tomorrow (for pregnant and parent teens), and court services programs for drug offenders.

Partners in Recovery: Addiction Treatment Center-GBMC/Sheppard Pratt provides a continuum of addiction treatment and care to meet individual needs. Services provided include ambulatory detoxification, partial hospitalization, dual diagnosis, intensive outpatient, continuing care, outpatient group therapy, outpatient education, relapse prevention, multifamily group, family and individual therapy, intervention services, adolescent intensive outpatient, and driving while under the influence (DUI) programs.

Upper Bay Counseling and Support Services administers: *SHARE* (Self Help Awareness Reaching Everyone), an adult psychiatric rehabilitation program that provides assistance to adults with chronic mental illness: *SunRise*, a residential rehabilitation program that provides housing with up to 24-hour supervision to adults with severe and persistent mental illness; and *SEP* (*Support Employment Program*).

Villa Maria Behavioral Health Clinic is an organization administered by Catholic Charities, Inc., that provides individual, children and family services to people with mental health illness.

There are additional public agencies that produce and deliver services that impact MHDP participants:

Crisis Intervention Team (CIT) was launched in June, 2008 as multi-jurisdictional police-based intervention. The CIT Program is a partnership among the Harford County Affiliate of the National Alliance on Mental Illness, CSA, Harford County Sheriff's Office, Aberdeen Police Department, Bel Air Police Department, Havre de Grace Police Department, Maryland State Police, Sheppard Pratt Health Systems- Mobile Crisis Program, Upper Chesapeake Health System, and community mental health providers. Thirty-two law enforcement officers received specialized training to recognize and respond more safely and compassionately to people experiencing a mental health crisis, while enhancing public safety, reducing officer injuries, and reducing stigma. The intent of CIT is to divert unnecessary hospital emergency department visits and arrests while improving overall mental health responses and resource linkages.

Harford County Housing Agency provides a rental assistance program for income qualified citizens and housing rehabilitation programs that provide rent and mortgage delinquency counseling, and home ownership and reverse mortgage counseling.

State Psychiatric Facilities: DHMH Mental Hygiene Administration (MHA) operates six hospitals that provide acute, intermediate and long-term care for adults. MHA operates one psychiatric forensic facility.

The Maryland Advisory Council on Mental Hygiene was created in 1976 to advise the Mental Hygiene Administration (MHA) on the provision of services to citizens with mental illness and to “be a strong advocate of a comprehensive, broad-based approach to the social, economic, and medical problems of mental hygiene.” The Council was expanded in 1989 to comply with the composition requirements of Public Law (PL) 99-660 and subsequently PL 102-321. The Council is now designated as the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council and is often referred to as the Joint Council. The Joint Council participates in the planning and operation of the public mental health system, meeting monthly with the MHA Director and key agency staff. Members serve on various workgroups and task forces, and participate in plan/policy development meetings as requested.

An underlying assumption of the current study is that alignment of the objectives, policies and procedures of MHDP with those of its source organizations will most likely have a positive influence on its operational success and sustainability.

D. Relationship of Mental Health Diversion Program to Source Organizations

As noted earlier, the judge cannot provide treatment to defendants who appear in MHDP. The MHDP judge does not have direct or hierarchical control over the resources of source organizations such as grant funds, personnel, and treatment opportunities made available to the defendants participating in MHDP. By applying the legal theory of therapeutic jurisprudence, however, the judge has been able to coordinate and delegate the provision of treatment to offenders with mental illness in MHDP through its source organizations.

III. Design of the Mental Health Diversion Program

Assessing the performance of MHDP in comparison to its intended purpose and goals form the basis of the evaluation. This section describes the goals and objectives articulated for the court, including those related to participant progress and those associated with systems change. It also identifies the positions that constitute the core MHDP team as well as other organization representatives who routinely interact with MHDP, the intended role of each and how the interactions among these organization representatives were intended to work. This section also considers the overall program design, including types of services offered within the various components of the program (e.g., assessment and evaluation, treatment and psychosocial activities, housing, case management, family involvement, drug testing for clients with co-occurring disorders) and mechanisms and procedures by which program participant compliance and progress are tracked. A description is also included that outlines the plan for assessing participant performance, criteria to be used to judge successful completion and non-completion, and what happens when a participant does not succeed in completing the program.

A. Development and Description of Goals and Objectives

MHDP goals were established by the Advisory Committee, are documented in the *MHDP Policy and Procedural Manual*, and are part of official court documents that describe the operations of MHDP. Team members interviewed for the current study acknowledged receiving copies of the program manual. The goals of the MHDP focus on public safety, timely case processing and accessing treatment for the population. MHDP goals are in general alignment with the goals of MHDP source organizations:

- To reduce the number of times offenders with mental illness come into contact with the criminal justice system in the future
- To reduce the inappropriate institutionalization of people with mental illness
- To develop greater linkages between the criminal justice system and the mental health system
- To expedite case processing
- To promote public safety
- To establish linkages with other County agencies and programs that target offenders with mental illness in order to maximize the delivery of services

MHDP goals do not address competency. Unlike other court-based mental health interventions in Maryland, competency cases are not handled by this specialized court. Competency is dealt with under the provisions of the Maryland Procedure Annotated Code of Maryland section 3-104 through 3-106 that set forth requirements for defendants when there is a question of whether or not they are competent to stand trial. In Harford County District Court and Circuit Court these defendants are referred directly to the County funded psychologist for an evaluation by the

Court. In Harford County, the psychologist conducts approximately 70 competency evaluations a year. Defendants found to be incompetent are referred to either Spring Grove Hospital Center or Clifton T. Perkins Hospital Center for treatment. MHDP will consider a defendant for participation if, after an evaluation, he or she is found competent.

B. Roles of MHDP Team Members and Others Associated with MHDP

MHDP was designed to promote effective inter-functional and inter-organizational collaboration among the judge, prosecutor, public defender or private attorney, probation officer, mental health professionals, case manager, and treatment providers to encourage defendant success in the program. Inter-agency MOUs were established to formalize the relationships among team members and the information flow regarding participant compliance and progress, including issues of confidentiality. The following describes the role of each team member and his or her individual responsibilities on the team:

The judge leads the MHDP team. In this role, the judge seeks to establish a rehabilitative and recovery relationship with the suspected offender by supervising and reinforcing a service treatment plan. The judge reviews progress and compliance reports from the treatment providers and case managers. The judge discusses barriers, issues and concerns with the MHDP participant. The judge rewards successes and, when necessary, imposes sanctions when the offender deviates from the treatment plan. Throughout the MHDP process, the judge balances the therapeutic interests of participants with statutory and judicial rule requirements of Maryland judicial process.

The assistant state's attorney (ASA), in representing the organizational interests of the State's Attorney Office approves suspected offender participation in MHDP, monitors and reinforces treatment, support, and necessary sanctions. Throughout the MHDP process, the ASA represents the public safety interests of the State of Maryland and Harford County.

The assistant public defender (ADP), in representing the organizational interests of the Office of Public Defender, counsels clients and potential MHDP participants on the benefits of program participation, as well as their responsibilities as program participants. The ADP advocates for and supports participants in the completion of their treatment service plan. He/she keeps the MHDP team informed from the perspective of the defendant. Throughout the MHDP process, the ADP works to assure that the rights and welfare of the participant are protected.

The parole and probation agent (PPA), in representing the organizational interests of the Maryland Department of Public Safety and Correctional Services, Division of Parole and Probation, supervises suspected offenders who are released from the County Detention Center to participate in MHDP and are under pre-trial supervision. The probation officer reports offender progress and compliance to the team. Throughout the MHDP process, the PPA works to assure that the State's public safety and probationary services interests are represented.

The case manager from Alliance assesses the participant's strengths and needs to link him/her to services in the community. The dedicated case manager also reports to the MHDP team regarding participant progress and compliance and any barriers, issues, or concerns that may arise. The case manager also ensures that treatment providers use the MHDP monitoring form

when documenting participant progress. The case manager adheres to policies and uses methods of practice that are consistent with those used in the community mental health system outside of MHDP.

The substance abuse specialist works for the Harford County Health Department. This position is responsible for assessing the need for substance abuse services, makes recommendations to the team regarding substance abuse issues and treatment, provides outpatient treatment services, and reports to the team on participant progress including urine analysis tests results. As with the case manager, this position adheres to policies and uses methods of practice that are consistent with those used in the community mental health system outside of MHDP.

The mental health professional from CSA completes the evaluation ordered by the judge, makes recommendations regarding treatment and linkages with community resources, completes the initial treatment service plan, and has the release of information signed by the participant. Information from the prospective participant evaluation is used by the team to determine if the individual is eligible and can be best served by involvement in the MHDP program. The mental health professional assists with resource procurement for both the individual and MHDP, and helps the team resolve larger community service system issues. The mental health professional adheres to policies and practices consistent with the community health system outside of MHDP.

C. Case Eligibility, Participant Case Flow, and Admission

Establishment of Eligibility Criteria

In establishing MHDP eligibility criteria, public safety considerations and individual mental health treatment needs were examined by the judge, legal and clinical MHDP team members as well as source organizations involved in program planning.

Case Eligibility

Candidates eligible for MHDP include suspected offenders who 1) are charged with crimes that appear to be related to their mental illnesses; 2) have medical histories that include past and present diagnoses of major mental illnesses; 3) do not have histories of drug felonies and crimes of violence; 4) meet the medical necessity criteria for Intensive Case Management or Psychiatric Rehabilitation Services; 5) are competent to stand trial; 6) are approved by State's Attorney Office; 7) are approved by the judge upon review of the evaluation results; 8) are current or expected residents of Harford County; and 9) give informed consent for MHDP team members to share confidential information (Harford County MHDP Policy and Procedural Manual, 2004).

Defendants can be offered opportunities to participate in the MHDP only if the prosecutor is willing to move for a stet.¹ The State's Attorney's Office does not permit offenders to participate in MHDP if they are charged with violent assault, assaults on police, crimes involving weapons or injury to victims, sex offenses, DUIs, distribution of controlled dangerous substances or possession with intent to distribute (PWID), and most domestic violence offenses (Harford

¹ In Maryland, the State Attorney's office can make a motion to transfer a case to stet docket; the court has to approve the move. Being moved to the stet docket constitutes an indefinite postponement. The case may be brought back to trial within one year if either party requests. After a year, the case can still be brought back to trial for "good cause".

County MHDP Policy and Procedural Manual, 2004). With respect to domestic violence cases, the State's Attorney may make exceptions, such as for young adults with mental illnesses who exhibit relatively minor unlawful touching of parents and/or siblings.

To ensure all defendants with mental illnesses receive services, even if they are not eligible for MHDP, the MHDP judge has established a separate docket called the "*collateral court.*" The collateral court is not a specialized docket and does not have standard operating procedures. The defendants in this court are treated like other defendants processed through the traditional district court system. One difference is that they are referred to treatment and informally monitored by the judge. Unlike MHDP participants, defendants in this program do not receive a stet. Rather, they receive suspended sentences as incentives for participation in treatment.

Participant Case Flow

The MHDP process usually begins with identification of possible candidates at the probable cause/bail hearing stage. At any point in defendants' involvement in the criminal justice system, they also may be referred to MHDP by court commissioners, Pre-Trial Services, Detention Center screeners, Detention Center medical staff, State's Attorney Office, Office of the Public Defender, judges, parole and probation agents, defendants, family members, and community mental health providers.

Candidates for the MHDP are generally drawn from among misdemeanor arrestees who have been detained at the Harford County Detention Center pending their bail status hearing or first court appearance (Harford County MHDP Policy and Procedural Manual, 2004). Upon

admission to the Harford County Detention Center, defendants with suspected mental illnesses are first identified through the jail's normal intake screening procedure. When the mental health screening conducted by the jail staff indicates that detainees have serious mental health problems and might be candidates for MHDP, they are referred to the Alliance case manager, informed about the program and their consent is requested by the case manager for jail staff to share assessment information with the State's Attorney Office (Harford County MHDP Policy and Procedural Manual, 2004). The State's Attorney Office reviews the charges and prior criminal records of defendants. If the State's Attorney Office agrees to divert defendants into the MHDP, it forwards prospective MHDP participant information to the Office of the Public Defender or the defendant's private attorney (Harford County MHDP Policy and Procedural Manual, 2004). An Assistant Public Defender or private attorney meets with prospective participants, explains the MHDP, reviews all rights defendants would waive, and asks whether they want to participate in MHDP. If the defendant agrees to participate, the judge signs an order for a mental health evaluation (Harford County MHDP Policy and Procedural Manual, 2004).

The mental health professional conducts evaluations and has candidates sign releases of confidential information if they have had prior mental health treatment (Harford County MHDP Policy and Procedural Manual, 2004). The mental health professional sends signed release forms to the prospective participants' former treatment providers to request releases of information regarding their diagnoses, prescription medication, attendance records and other pertinent information needed to prepare treatment service plans (Harford County MHDP Policy and Procedural Manual, 2004). Once this information is gathered, the mental health professional prepares two documents for each defendant. The first document is an initial report for the MHDP

team and the second document is the discharge treatment plan that takes effect upon candidates' admission into the MHDP (Harford County MHDP Policy and Procedural Manual, 2004).

Discharge plans include information pertaining to their living arrangements and provisions for supervision and treatment (Harford County MHDP Policy and Procedural Manual, 2004).

Admission

Prior to bail review hearings, the assistant state's attorney, the public defender and the mental health professional review the results of evaluation conducted for eligible candidates. If all parties agree that candidates meet MHDP admission criteria, they are scheduled for a mental health diversion bail reviews (Harford County MHDP Policy and Procedural Manual, 2004).

At bail reviews, the MHDP judge reviews charges, assessment, and recommendations for diversion. The judge has total discretion and may reject candidates from participating in the MHDP. If the judge concurs with recommendations to allow defendants to participate in the MHDP, the defendant will be released under the supervision of a Psychiatric Rehabilitation Program or to the Alliance, Inc. case manager who monitors and supports the MHDP participants. Individuals who are released from the Detention Center under the diversion program are placed on pre-trial supervision by the Maryland Division of Parole and Probation (Harford County MHDP Policy and Procedural Manual, 2004).

Most MHDP candidates who wish to enter the program are released pending adjudication under the terms of service plans for provisional participation periods. During these periods, defendants are given opportunities to become familiar with the aspects of their proposed treatment regimen under the supervision of the court monitor before they are returned to court to decide as to

whether they wish to continue. After a four to six week adjustment period in the program, defendants sign agreements to follow the requirements of their participation in MHDP. If defendants agree to the terms of their release, then stets will be set for the defendants' charges at their trial dates. If defendants decide to opt out of the program, the criminal cases are returned to the usual adjudication process. Defendants occasionally decide to go to business as usual adjudication because they do not agree that they have a serious mental health problem or because they believe that they will realize more favorable outcomes at trial. Should they be found guilty at trial, defendants will be eligible to continue in treatment diversion programs. Documentation is not available regarding how many defendants choose to continue with their original treatment plans after they go to trial. (Harford County MHDP Policy and Procedural Manual, 2004).

D. Program Services

There were no new treatment programs and/or services added to the Harford County treatment system for MHDP participants; they utilize existing services. Mental health treatment is provided to MHDP participants by the local public mental health system, which comprises CSA under contract to Harford County, treatment agencies under subcontract to CSA, and DHMH psychiatric facilities. Services provided by treatment agencies include mobile crisis services, case management, outpatient therapy, psychiatry, psychiatric rehabilitation, residential rehabilitation, and supported employment. Substance abuse treatment services are provided by the Harford County Health Department and include individual therapy, group therapy, and peer support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Urinalysis is conducted by probation and parole officers, substance abuse and mental health

treatment providers, and case management staff (Harford County MHDP Policy and Procedural Manual, 2004).

Confidentiality

Mental health and substance abuse assessment and treatment information is confidential and protected by both federal and state regulations. Such client information is covered by the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rule (45 CFR Parts 160 and 164) and federal substance abuse confidentiality laws and regulations (42 CFR Part 2). Information is not disclosed until *consent to release information* forms are completed and signed by participants during their assessments. Signed releases allow the MHDP team to discuss evaluation findings and information regarding compliance and progress with treatment plan requirements.

E. Program Completion and Non-completion

MHDP participants complete the program when they have been consistently compliant with their treatment service plan for one year after they have received a stet. Other than consistent compliance with the plan, there are no set program completion criteria. Participants can be terminated from the program if at any point during participation they are non-compliant with the treatment service plan. After reviews of compliance and progress information, decisions regarding participants' completion and non-completion status are collectively made by the MHDP team.

IV. Operational Characteristics of MHDP

This section addresses: 1) the correspondence between program operations and stated goals, as well as the program's progress in achieving program goals and objectives; 2) the extent to which roles and responsibilities of team members and other individuals involved in MHDP are consistent with what was envisioned when the program was planned; 3) understanding whether MHDP team members are performing as intended and the reasons for any deviations; 4) who is participating in the court-based mental health intervention; 5) whether the program is operating as it was designed; 6) how MHDP participants receive assessments and evaluations, treatment, and other services in comparison to what was planned prior to program implementation; 7) mechanisms by which program participant compliance and progress is tracked and shared; 8) how participants' performance in the program is assessed in practice and how this compares to the original program design; and 9) data on participant retention and completion.

Information regarding operation of MHDP was gathered through in-person individual interviews with each of the 10 members of the MHDP team, including six members from the criminal justice system and four treatment providers. (Refer to the Appendix for Criminal Justice Team Member Questionnaire and Treatment Provider Team Member Questionnaire). Other sources of information are data compiled by the State's Attorney's Office and program documents, including written policies and procedures, minutes from planning meetings, and grant proposals.

A. Program Goals

MHDP's program goals are described in a policy and procedure document. All respondents interviewed indicated that they were knowledgeable of the program goals. Of the four treatment providers and six criminal justice team members interviewed, all indicated that either they or

representatives from their agencies were part of the Advisory Committee involved in developing MHDP goals. All respondents agreed that MHDP was designed within the context of the existing County mental health system with an expectation that the court and mental health systems would develop a coordinated method to provide services to the population of offenders with mental illness. Each team member interviewed agreed that his/her agency's priorities align with MHDP goals. These aggregated agency priorities include 1) reduce arrests and incarceration of offenders with mental illness; 2) design a method through which offenders with mental illness can access treatment on a coordinated and timely basis; and 3) develop standard procedures by which offenders with mental illness are referred to treatment. Team members agreed that MHDP is progressing toward achieving the program goals because: 1) individuals participating in the program have fewer contacts with the criminal justice system; 2) linkages between the criminal justice system and the mental health system have been improved; and 3) MHDP cases are processed more quickly than normal case processing. Respondents also indicated that currently this information is not officially tracked. As a result, there is no empirical basis for assessing whether agency priorities have been met and MHDP goals achieved.

B. Roles and Relationships among MHDP Team Members and Others Associated with the Program

Staffing

The MHDP team composition conforms to the program's original design. The team includes the judge, assistant state's attorney, assistant public defender or private attorney, probation agent, a case manager from Alliance, a CSA mental health professional, and a County Health Department substance abuse specialist.

Training

The criminal justice system and treatment system interview respondents generally agreed that MHDP training regarding program processes is adequate. Half of the respondents were involved in the development of the program's policies and procedures. The respondents generally agreed that training covered all essential information and that it was relevant to the needs of the program and program participants. One respondent indicated that training provided by MHDP was at a level too basic for the program. Responses from the interviewees indicate that on-the-job training is not emphasized in MHDP. There is not a formalized process for training new team members on MHDP policies and procedures.

Extent of Team Member Collaboration and Common Understanding

The criminal justice and the treatment provider team members indicated that communication among MHDP team members is good, resulting in a high level of trust. They reported that they primarily use e-mail to share client information. There was disagreement among the interviewees regarding the extent to which team members can share information with one another. Several interviewees indicated that there are members of the MHDP team with whom they cannot share confidential information. Representatives of treatment providers, however, stated that the consent process allows them to share information with the judge and the other members of the MHDP team.

The interviewees were asked if they inform other team members of client compliance and progress, and how often they inform the other team members. Of the six criminal justice respondents, two indicated that they do not inform other team members, and the other four

indicated that they provide weekly updates to other team members. Three of the four treatment provider respondents indicated that they have bi-weekly contact with the team, whereas one respondent indicated that he/she has daily contact with other team members.

Team members were also asked which events trigger immediate notification of other team members. Two of the criminal justice respondents stated that they are informed of re-arrest, non-compliance, failure to appear/inability to locate the client, and drug use. One respondent indicated that he/she rarely receives any information. Two respondents indicated that they are informed of all of MHDP participant issues, whereas another respondent stated information is not shared with him/her because of attorney-client confidentiality protections. Of the four treatment providers, three respondents indicated that they notify other team members immediately of re-arrest, positive urinalysis test result, client not showing up for a scheduled treatment appointment and if there has been loss of contact with the client.

Although the MHDP team has documented the roles of team members and has entered into MOUs for information sharing among and between team member agencies, standards for the type of information shared, when that information should be shared, who should receive which type of information, how often team members meet to share the information and the avenue by which information is shared is not well documented. Furthermore, there appears to be a lack of clarity in understanding among the team members regarding these issues.

Although team members know that consent is required to share participant information among team members, it appears that the team is collectively unclear of the MHDP consent process. For

instance, team members indicated that they can only share information with certain members of the team even though the MHDP consent process was designed to allow all members of the team to share client information. Some of this confusion may be a product of lack of clarity among team members as to the type of information that can be shared among the team members and not with whom they can share it under the consent guidelines. This may stem from lack of familiarity among team members regarding the client confidentiality rules governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR, the Code of Federal Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records.

Team members were asked about the interrelatedness of their roles on the team. Four of the six criminal justice respondents indicated that they consider their roles highly interrelated, whereas the other two respondents indicated their roles are somewhat interrelated. Two of the four treatment provider respondents indicated that their roles are highly interrelated. One respondent indicated that his/her role is somewhat interrelated, whereas the other respondent did not know if there was any interrelatedness in his/her role.

Two of the 10 respondents indicated that the role of the judge and the assistant state's attorney on the team is to consider public interest and protection of the community before making a decision about cases. All 10 respondents indicated that the essential role of the judge is to monitor participant progress and compliance. Two of the six criminal justice respondents indicated that they believe the state's attorney has the most influence over team decision making, whereas the other four criminal justice respondents indicated that the treatment providers have more influence over decision making.

All 10 respondents were asked how team member conflicts were handled. Four respondents indicated that when conflict occurs discussion takes place. Four respondents did not provide answers, and two respondents indicated that conflict does not exist within the team.

Even though all team members agreed that the judge's role was an integral part of the team as it related to monitoring client progress and compliance, the team members' responses regarding their own roles ranged from *highly interrelated to no interrelatedness*. This may indicate that some team members do not view themselves as important parts of the team, particularly with respect to having influence over decision making. Non-response from some team members regarding team member conflict may be a reflection of the diverse interests and professional/organizational backgrounds reflected in the composition of the MHDP team.

C. Case Eligibility, Participant Case Flow, and Admission

Case Eligibility

Treatment provider and criminal justice respondents to the interview agreed that the target population for the MHDP is offenders with mental illness who are eligible for services through the public health system, have no history of violence or driving under the influence (DUI), and have chronic or severely persistent mental illness (SPMI)². All respondents indicated that the primary reason for limiting the number of participants admitted is fiscal constraints. Resources are not available to allow broader participation. One of the 10 respondents indicated that the target population was identified for participation in MHDP because the DHMH Mental Hygiene

² The term "serious and persistent mental illness," or SPMI, is the currently accepted term for a variety of mental health problems that lead to tremendous disability.

Administration provides public funding to those individuals diagnosed as SPIMI. There is no written policy that excludes suspected offenders from MHDP who are not eligible for treatment through the public health system or suspected offenders who are not diagnosed with a SPIMI. Nonetheless, all respondents reported awareness of these exclusions. Veterans are also excluded from MHDP because the Veterans Administration has not agreed to the MHDP confidentiality/consent process.

Although the MHDP's maximum caseload is 20 at any given time, the State's Attorney's Office reports from its record tracking system that as of December 2008, 267 offenders with mental illness had been referred to MHDP since inception. Of this number, the State's Attorney's Office accepted 136 (50% of those referred) of which 60 (45.5% of those accepted) entered the program. The remaining 76 (54.5% of those accepted) declined to participate. Given only 60 defendants had been accepted for MHDP participation as of the date of this study, it is unlikely that a maximum caseload of 20 participants has been sustained at any point in time over the four years of program operations.

Criminal justice and treatment provider survey respondents agreed that essentially all defendants referred to MHDP have histories of mental illness prior to their proximate qualifying arrests. Estimates of the portion of program participants who had encounters with the mental health system prior to proximate qualifying arrests ranged from 40 to 90 percent among these respondents

Two of the six criminal justice organization interview respondents indicated that defendants are primarily influenced to participate in MHDP to avoid incarceration. Two respondents disagreed with this assessment and indicated that incarceration was the least motivating factor for participation. One criminal justice organization respondent stated that defendants are primarily influenced by access to treatment for their mental illnesses. Of the four interviewees from treatment providers, two respondents indicated that avoiding incarceration was the most influential factor for offenders choosing participation in the MHDP, whereas one respondent indicated that it varied from case to case.

The State's Attorney's Office informally tracks the numbers of defendants who are referred, are accepted for participation, and choose to participate in the MHDP. However, there is no method to track the following systematically: 1) source of referral; 2) number of individuals participating in the program at any given time; 3) whether program participants have histories of mental illness prior to their proximate qualifying arrests; 4) whether or not participants had encounters with the mental health system prior to their proximate qualifying arrests; and 5) reasons for offender participation or non-participation in MHDP.

Participant Case Flow

Interview questions regarding the flow of cases through MHDP revealed some incoherence among the perceptions of team members. Approximately half of defendants accepted into MHDP by the State's Attorney's Office opt to participate and half opt not to participate. The perceptions among MHDP team members are, however, that defendants are much more likely to participate. The interview respondents estimated that from less than 5% to 15% of offenders eligible for MHDP choose to proceed with usual adjudication rather than participation in MHDP.

All six criminal justice organization respondents stated that offenders have the option to withdraw from the MHDP after they have started the program. Two respondents stated that the program is voluntary. Three respondents stated that offenders could return to traditional court after choosing to participate in MHDP. One team member responded that there are no procedures to deal with people who opt out of the MHDP. Criminal justice organization team members were also asked, “What happens to clients who initially opt into the MHDP, but change their minds and have their cases transferred to conventional court?” Three of the six criminal justice respondents did not know; two respondents stated that the participants could enter a guilty plea, have a trial with the MHDP judge, or transfer to another part of the District Court. One respondent indicated that participants could opt out of MHDP but continue in treatment.

When all respondents were asked to state the specific goals and objectives for MHDP compliance and progress status review hearings, three answered that monitoring compliance was part of the hearings, three indicated that giving praise was a component, one noted that identifying potential problems was an objective, one stated that giving negative feedback was a component, whereas two respondents were unsure of the hearing goals and objectives.

Admissions

Sixty defendants entered the MHDP from its inception in 2004 through December 2008. Data obtained from the State’s Attorney’s Office do not reveal whether the selection criteria and screening process has been suspended or inconsistently applied such that offenders who may not be eligible for the program according to MHDP guidelines have been admitted to the program. MHDP has not collected information that supports comparison of the characteristics of

defendants that enter the program and defendants that are eligible for but not offered participation in the program. MHDP has not tracked the length of time it takes clients to enter the mental health court after arrest.

D. Program Services

Assessments

MHDP's policy and procedures do not include information regarding whether or not a standardized assessment instrument is used to guide treatment and transitional planning for program participants. To determine if such standardized assessment instruments were used and the extent to which the team has knowledge of the use of the instruments, interview respondents were asked a series of questions regarding this topic area. When asked, "Is a standardized mental health assessment used for treatment planning?", four out of six criminal justice organization respondents indicated that standardized mental health assessments were used to determine eligibility and treatment planning for MHDP participants. When asked what type of assessment was used, one respondent indicated that the Structured Clinical Interview for Diagnostic Statistical Manual Disorders (also known as SCID) modified version was used. Another respondent stated that Alliance conducted the assessment and he/she did not know what type of assessment instrument was used. Two respondents indicated that the County Health Department conducts assessments for co-occurring disorders (i.e., mental illness with substance abuse disorder), but did not know the type of instrument used. Of the four treatment provider organization respondents, three indicated that a standard assessment was used, and one respondent stated that he/she was unaware of a standard assessment being used. Of the three who indicated that a standard assessment was used, one respondent indicated that a licensed clinical

social worker conducted the assessment; one respondent stated that a psychiatrist conducted the evaluation and a third respondent did not know who conducted the assessment.

Policies/Guidelines for Service Provision

MHDP policies and procedures describe service coordination for participants. Interview respondents were asked a series of questions to determine if such services were in fact coordinated and provided to the MHDP participants. All four treatment organization respondents indicated that their agencies coordinate access to housing, transportation, vocational and educational services, job placement, food banks, and Medicaid or other healthcare, and psychosocial clubs for MHDP participants. Two respondents, however, indicated that Assertive Community Treatment (ACT) teams are provided to MHDP participants, whereas two respondents indicated this type of service was not provided. Three of the six criminal justice organization respondents indicated that there are designated treatment slots in the community for MHDP participants. All four treatment organization respondents indicated that their agencies coordinate and/or provide day treatment services, individual therapy, intensive psychiatric rehabilitation, community-based case management, addiction counseling, family counseling, and residential treatment. All four treatment organization respondents reported that their agencies coordinated services for participants with co-occurring disorders; three indicated services are provided through referral to appropriate resources, and one respondent did not know where the clients received services. Of the four treatment provider organization respondents, one indicated that his/her agency coordinates inpatient treatment beds, two reported that their agencies provide treatment only for individuals with a mental health diagnosis and refer program participants with substance disorders to programs that specialize in treating those particular disorders. Two

respondents stated their agencies were not completely integrated, but coordinated with a psychiatric rehabilitation program that treats individuals with co-occurring disorders.

Interactions between MHDP and Ancillary Organizations

Based on MHDP planning information provided, a central program goal is for MHDP to collaborate with other community-based organizations to ensure all program participant ancillary service needs are met. To determine if this goal has been achieved, the 10 team members were asked how interactions with ancillary services/organizations were developed, managed, and maintained. Five respondents noted that a case manager is involved in the process and has a close working relationship with the agencies. One respondent noted that meetings and contacts with other agencies occurred regularly. One respondent indicated that an all-provider quarterly meeting is held, whereas three other respondents stated that they did not know and that organizations other than theirs maintain the interactions.

Confidentiality and Consent

To determine if the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rule (45 CFR Parts 160 and 164) and federal substance abuse confidentiality laws and regulations (42 CFR Part 2) are being followed by the team as indicated in the MHDP policies and procedures, all 10 team members were asked, “What kinds of confidentiality protections are appropriate?” Of the six criminal justice respondents, two respondents did not know; two respondents indicated that the entire team should have all the information and it should be confidential among the team members; one respondent indicated that as much confidential protection as possible is appropriate and felt that some information is not pertinent to the court. One respondent stated that program participant identity should be protected as much as possible

and noted that email used by team members is password protected to maintain confidentiality. All four treatment provider respondents referenced HIPAA and individual informed consent as appropriate protection.

All 10 respondents were asked, “How would you compare the right to privacy and privilege of [MHDP] participants with persons in treatment who are not in mental health [MHDP]?” Of the six criminal justice organization team members interviewed, two did not know and two indicated that the information is shared with more people. One respondent noted that confidentiality is still protected. One respondent stated that the confidentiality is about the same in MHDP as in traditional mental health treatment settings. One respondent stated that confidentiality in MHDP is better than in traditional court because team members are aware of the rules that govern confidentiality. Of the four treatment provider organization respondents, the majority of interviewees reported that MHDP participants and offenders not being supervised by MHDP have the same rights. One respondent indicated that there is less privacy in MHDP because more information is shared.

Use of Sanctions and Incentives

All 10 respondents concurred in an assessment that sanctions are effective among MHDP participants. When asked about the type of sanctions used in MHDP when participants exhibit behaviors not allowed according to MHDP policies and procedures, interview respondents offered the following examples: 1) incarceration; 2) increased treatment, group therapy, or clinical action; 3) community service; 4) essays or journaling; 5) verbal reprimands; 6) terminated from the program; and 7) stet revoked.

All 10 respondents indicated that MHDP uses incentives when participants exhibit positive behavior, and that these incentives are effective.

E. Program Completion and Non-Completion

According to the State's Attorney's Office, of the 60 defendants that had entered MHDP as of December 2008, 19 had graduated, 35 had been terminated, and six were still active participants. Of the 35 terminated, seven were not Harford County residents, six died, five refused to comply with program rules, four were indicted on new charges in other counties, three received Veterans Administration benefits, three had other mental health disorders that were not eligible for treatment services, two had private insurance, two received new charges that were not within the criteria of the program, one did not qualify for the public mental health benefits, and one fled the jurisdiction.

V. Process Evaluation Findings

Process evaluation findings serve two primary purposes: to support understanding of the adequacy of program processes and to assist policy leaders and program managers in improving them. The following findings have emerged from the researchers' examination of the organization and processes of MHDP.

A. Goals and Objectives of MHDP

A review of MHDP goals and objectives was conducted by the researchers to determine how well they align with the Advisory Committee's vision of developing an intervention to improve access to treatment that results in reduced contact with the criminal justice system. Specific MHDP activities intended to achieve the program's goals and objectives were documented.

Finally, how well the goals and objectives were communicated to and understood by MHDP team members, and if there is a common understanding of the goals and objectives, was also determined.

Interviews with MHDP team members revealed that MHDP goals and objectives are consistent with those of its criminal justice system and treatment system source organizations. MHDP effectively provides opportunities to link resources of these organizations to potentially enhance realization of their individual goals. The MHDP team meets regularly to ensure that goals and objectives for treatment service delivery are achieved and sustained. Program goals and objectives have been formalized in the written MHDP policies and procedures. The impact of MHDP's efforts in pursuing the intent of its designers is somewhat diminished by the lack of a formal tracking system that can assist in the monitoring the extent to which the program is fulfilling its goals and objectives.

B. Team Member Collaboration

The researchers' review of MHDP documents and interviews with program team members revealed extensive and effective collaboration among representatives of the program's source organizations. This has resulted in a productive blending of inter-organizational perspectives and resources to support the objectives of MHDP. Interview findings indicate that MHDP is effective in achieving linkages between the criminal justice system and mental health system; processing cases more quickly than under business as usual conditions; and in reducing the number of times offenders come into contact with the criminal justice system. In these areas of concern the collaborative approach of MHDP appears to be more effective than the fragmented situation in

existence before MHDP was established. Although all interview respondents reported that overall communication is good and there is trust among MHDP team members, they also indicated that there is ambiguity regarding program standards for information sharing and the consent protocol. The interviews conducted for this study confirm that the MHDP team understands the importance of inter-agency coordination and collaboration to provide services for the offender population with mental illness. The interviews also reveal that not all team members have experience working with individuals with mental illness and that MHDP training has not fully compensated for this deficiency.

C. Case Eligibility, Participant Case Flow and Admission

Case Eligibility

Interview findings indicate that MHDP team members are knowledgeable of the target population eligibility criteria. Although there is no written documentation of exclusionary criteria, team members share a common understanding of which defendants are not eligible for participation. They expressed concern regarding fiscal constraints that limit participation of some in need of mental health services and the exclusion of veterans resulting from lack of a collaborative agreement with the U.S. Veterans Administration. Excluding offenders with mental illness in need of the MHDP's services based on their health insurance status raises the issue of access to justice and may result in offenders with mental illness continuously cycling through the criminal system untreated.

There is limited information regarding the MHDP caseload. Since there is no MHDP database, determinations cannot be made as to whether a satisfactory number of participants were served during the study period or the length of time participants were involved in MHDP.

Team member interview responses could not be confirmed for accuracy because of the lack of MHDP information tracking. Interview responses that could not be validated include: mental illness histories of referred offenders; the rate at which defendants encountered the mental health system prior to the proximate qualifying arrest; and defendant motivation for participation in MHDP.

Participant Case Flow

MHDP documents reveal that the program team has systematically planned and developed the steps by which defendants are identified as suitable for MHDP. Nonetheless, it is difficult to assess whether or not this process is working as effectively as intended because there is no mechanism in place that monitors and tracks the case flow process. Without a systematic data-supported monitoring structure there will continue to be a gap between the perception and evidence of MHDP operational effectiveness.

Admission

As detailed in MHDP documents, there is a systematic approach for admitting participants. There is no formal tracking mechanism in place to provide evidence as to whether MHDP is admitting the target population.

D. Program Services

No new mental health treatment slots were created for MHDP participants. Rather, MHDP participants receive treatment from pre-existing resources through community-based treatment

providers. MHDP does not formally track types of services provided and dates of admission, attendance and discharge. Therefore, a determination of whether and to what extent participant access to services is timely and coordinated cannot be made.

Interviews with MHDP team members revealed that they are not familiar with the types of treatment services provided to MHDP participants. There are no guidelines or other evidence concerning the range of available treatment services, their intensity or length of treatment. A majority of MHDP team members agreed that collaboration with community-based organizations providing ancillary services has been realized. Again, this assertion could not be confirmed because records concerning provision of these services are not kept.

With respect to HIPAA privacy rule (45 CFR Parts 160 and 164) and federal substance abuse confidentiality laws and regulations (42 CFR Part 2), MHDP team members are not in agreement regarding their understandings of the extent to which confidential information can be shared among team members. They agree, however, that protections are needed to protect participant information and should be strictly adhered to by the MHDP team.

MHDP team members agreed that the use of sanctions and incentives is effective in shaping participants' behavior. The team is familiar with the types of sanctions and incentives used. The team members are not in agreement regarding who was responsible for applying sanctions and incentives. Information concerning the application of sanctions and incentives is not being tracked.

E. Completion and Non-Completion

Completion of MHDP is based on participant treatment plan progress. Members of the MHDP team provide input as to whether participants are ready to graduate from the program. There are no documented compliance and completion criteria. Rates of compliance and completion cannot be assessed because they are not currently tracked.

VI. Discussion

MHDP is a specialized court-based intervention involving collaboration with the State's Attorney's Office, Office of Public Defender, Division of Parole and Probation and community-based treatment providers. MHDP diverts a specific group of misdemeanor offenders with mental illness from incarceration into treatment and monitors their compliance with treatment plans. According to MHDP stakeholders, in the absence of this specialized intervention, the target group would be left untreated and frequently rearrested. The scope of this evaluation is to determine whether the MHDP was implemented and operates as intended. A subsequent outcome evaluation will seek to answer whether the MHDP has effectively diverted the population into treatment, has had an impact on recidivism among the population and is cost effective.

The process evaluation has confirmed the following regarding the implementation and operation of MHDP:

1. The collaborative effort sought by the MHDP Advisory Committee with the program's source organizations has been formalized by memoranda of understanding.

2. MHDP has begun to address the overarching concern regarding lack of coordination among and between the criminal justice and treatment system organizations to treat the offender population with mental illness. To what extent, however, this has been achieved cannot be fully determined because of a lack of a systematic data tracking system.
3. Only defendants eligible for public mental health treatment services who meet eligibility criteria are accepted for MHDP participation. Although the collateral court serves defendants with mental illness who are not eligible for public mental health treatment services, these defendants do not have the same opportunity to receive status and experience formal monitoring of treatment by the court provided to MHDP participants.
4. New community treatment resources were not introduced to serve MHDP participants. Direct and indirect financial support for MHDP comes from the program's source organizations. The goals and objectives of MHDP align with those of its source organizations. This alignment of inter-organizational purposes provides policy support for continuation of financial support for MHDP from its source organizations.

VII. Recommendations

Based on the findings of this study, policy makers and program leaders might consider the following to enhance the effectiveness of MHDP:

1. Team members might be encouraged to attend training that is specifically geared toward understanding the needs of the population of offenders with mental illness.

2. Cross-training and team building activities among team members could be encouraged. Cross training will help individual team members understand the roles of MHDP's collaborating organizations and the role of each team member. Team building will enhance team work by helping team members understand the strengths of each member to achieve shared objectives. It will help to further engage team members that have not viewed themselves as an integral part of the team.
3. MHDP could explore ways to expand access to MHDP to individuals not eligible to be treated by the public health system.
4. MHDP could explore how other courts that focus on veterans have resolved issues of confidential information sharing with the U.S. Veterans Administration.
5. MHDP might update its policy and procedures to reflect changes that have occurred over the four years of program operation and ensure that all team members are familiar with updated material.
6. MHDP could address apparent confusion among team members concerning what information can be shared with whom. Training regarding the type of information that can be shared under the federal regulations that govern confidentiality could be provided. MHDP data-sharing policies and procedures could be reviewed with team members periodically to ensure that members share critical information about individual participant compliance and progress to the full extent needed and permitted.
7. MHDP might develop an explicit set of completion criteria and document such in the policies and procedures manual. Documented completion criteria will help ensure that each participant is given similar opportunities to meet goals for program completion.

8. MHDP will find it of value to maintain a central database that facilitates tracking participants' progress and aggregating data to measure program performance. Useful data will include all quantifiable measures needed to track the following: 1) number of cases referred to the program and by whom; 2) whether participants have histories of mental illness prior to program eligibility; 3) whether or not participants have had encounters with the mental health system prior to the proximate qualifying arrest; 4) date of intake into MHDP; 5) number of cases deemed ineligible and the reasons for non-acceptance; 6) number of cases accepted; 7) number of active participants; 8) number of participants discharged and the reasons for discharge; 9) number of cases referred to treatment; 10) date of acceptance into the treatment program; 11) type of assessment administered; and 12) type of treatment modality recommended and implemented.

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Appendix A

Literature Review

According to a 1999 U.S. Department of Justice study, the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population (BJA, 2005). Traditional jurisprudential methods often ignore the myriad of issues of offenders with mental illness and as a result, offenders go untreated and are at a higher risk to recidivate (Hora & Schma, 1998). As part of the judicial branch of government, judges cannot provide treatment to defendants that appear before them. However, by incorporating the legal theory of therapeutic jurisprudence³ into practice, judges are able to coordinate and delegate the intent of the Court to provide treatment to offenders with mental illness through the other organizations (Hora & Schma, 1998).

In 2000, federal funding became available under the America's Law Enforcement and Mental Health Project for the implementation of mental health courts throughout the country to address the problems of offenders with mental illness. Subsequently, in 2000, the Conference of Chief Justices and Conference of State Court Administrators adopted a resolution titling these initiatives "problem-solving courts," encouraging their careful study, and, perhaps most importantly, promoting the integration of their core concepts into the general administration of justice. In 2004 this group broadened the resolution to include curriculum development, additional educational opportunities, identification of best practices, and expansion of resources available to problem-solving courts (BJA, 2005). As of 2004, BJA's *Mental Health Courts*

³ Therapeutic jurisprudence is defined as the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects. By examining the effects of the law in this fashion, therapeutic jurisprudence can illuminate how laws and legal processes may in fact support or undermine the public policy reasons for instituting those laws and legal processes (Hora and Schema, 1998).

Program provided support to 37 mental health courts in 24 states (BJA, 2005). According to the Council of State Governments Justice Center (2008), more than 150 mental health courts are in operation.

Despite the fact that there are supporters of the proliferation of mental health courts in the U.S., there are also outspoken critics who believe that problem-solving courts mask a defective treatment delivery system and hide the problems and inadequacies of the system from decision makers. One such critic, Seltzer (2005, p. 570) argues:

Although the goals of problem-solving courts are laudable, they have flourished because of systemic failures in public mental health and the criminal justice system. In addition to raising various civil rights and public policy concerns these specialty courts are inherently flawed, unintentionally signaling an acceptance of the rates at which people with serious mental illnesses are entering the criminal justice system. Their very presence makes it more difficult to generate political will to address the root of the problem. Alternative, evidence-based programs address the same concerns without raising the same civil rights and policy questions. No amount of tinkering with policies and procedures of mental health courts can correct the fatal flaws that are inherent in mental health treatment systems.

Mental health courts are socially, structurally, and procedurally complex interventions; what they do, who is involved, how they work, and what resources are available are subject to external pressures and internal dynamics (Wolff & Pogorzelski, 2005). Steadman and Redlich (2001, p. 2) hypothesize that "...the emergence of mental health courts reflects the frustration of the criminal justice system in processing more persons with serious mental illness and seeing some of the same persons with mental illness continually reappearing before the criminal courts." Furthermore, mental health courts have grown with little empirical evidence that they have a positive impact (Steadman, Davidson & Brown, 2001).

Research Methodology and Evaluations

Although drug courts have been operating for nearly 20 years and have been the subject of more than 100 evaluations, only recently have the research designs and methods approached scientific standards for reliability and validity (Wolff & Pogorzelski, 2005). Since mental health courts are new to the problem-solving court arena, they can benefit from the evolution of the drug court evaluation methodology. The assessment of mental health courts can, from the beginning, be designed to avoid or at least minimize the methodological problems that have chronically plagued research regarding the effectiveness of other socially complex interventions such as drug courts (Wolff & Pogorzelski, 2005). Wolff and Pogorzelski (2005) suggest a research approach to document and monitor program effectiveness that includes a) static and dynamic factors within and surrounding the mental health court; b) court's internal functioning and performance; and c) outcomes of the court that reach beyond treatment compliance and recidivism. The evaluation should be based on a conceptual model that captures the internal and external processes acting on and within the intervention.

Decisions related to diagnoses, will perhaps have the greatest impact on the success rate of mental health court participants. The key intervention provided by mental health courts is connecting defendants to treatment. Accordingly, whichever diagnoses the court decides to include, it must consider whether the corresponding treatment is available in the community and how that treatment will be accessed and monitored (BJA, 2005). For example, O'Keefe (2006) concluded from her evaluation of the Brooklyn Mental Health Court that significant barriers to achieving program goals included limited local mental health treatment and housing capacity;

reliance on an informal referral process; and communications dependent on interpersonal relationships rather than institutionalized meetings. The Bazelon Center for Mental Health Law, in a review of 20 mental health courts, concluded that no diversion or alternative disposition program, whether prosecutor-driven, court-based, within law enforcement, or jail-based, can be effective unless the services and supports that individuals with serious mental illnesses need to live in the community are available (Seltzer, 2005).

The design of mental health courts has not been research-driven. Only recently have courts begun collecting and analyzing outcome data that can provide empirical verification of the positive impact of the mental health court. Some studies are underway, and more are being planned, to better understand the operation and impact of mental health courts (BJA, 2005). The Maryland Judiciary's current commitment to evaluate the impact of court-based mental health interventions stands as one the most substantial state level investments in research in this area of concern.

An evaluation of the Broward County mental health court measured success in terms of involvement in treatment. All research subjects faced misdemeanor charges. The study found that the portion of participants engaged in treatment increased from 36 percent in the eight months prior to the first mental health court appearance to 53 percent during the eight months following that appearance; whereas a comparison group undergoing regular case processing did not show any change between equivalent periods (29 percent to 28 percent). (Boothroyd, Poythress, McGaha, & Petrila, 2003; O'Keefe, 2006).

Wolff and Pogorzelski (2005) argue that treatment compliance and recidivism are narrow measures of mental health court success. The court may have other socially beneficial effects, such as improving the individual's integration in the community and increasing the individual's productive contributions to society. Evaluation of the court's performance should consider a broader set of outcomes including changes in quality of life for the individual and related family members, family burden, stable housing, involvement in education and vocational training, stable employment, and participation in civic activities.

An evaluation of the mental health court in Santa Barbara, California incorporated an experimental design and broader measures of success. The study randomly assigned 235 defendants to either the mental health court or to standard case processing and tracked outcomes over a two-year follow-up period (Cosden, Ellens, Schneell, & Yamini-Diouf, 2005). The authors found that a majority of the defendants in both study groups spent less time in jail and showed improved psychosocial functioning when comparing post to pre-enrollment periods of times. The mental health court participants also showed reductions in substance abuse and new criminal activity (Cosden, Ellens, Schneell, & Yamini-Diouf, 2005; Frisman & Sturges, 2006). The study leaves open the question of whether mental health courts are a more cost-effective intervention relative to the more traditional approaches.

A 2005 study examined the extent to which jail diversion programs serve repeat clients. Data were obtained from 18 months of consecutive entries into the Hillsborough County (FL) jail diversion program (n = 336) and the Broward County Mental Health Court (n = 800). Overall, similar re-diversion patterns were observed for the two diversion programs. About one fifth of

those who were diverted during the 18-month study period were re-diverted at least once. Nearly half of those who experienced re-diversion did so within 90 days of their initial diversion.

Although fewer than six percent were re-diverted two or more times, these individuals accounted for a disproportionately large number of overall diversions and were re-diverted more quickly than those with only one re-diversion. As such, these diversion programs appear to be experiencing a level of repeating clients similar to that observed in other pathways for accessing mental health treatment. The authors suggest that future research should examine characteristics such as diagnosis, substance use, and index offense, which may provide more useful information about who is at risk for re-diversion (Boccaccini, Poythress, & Kershaw, 2005).

Herinckx and Ama (2005) examined re-arrest and linkage to mental health services among 368 misdemeanants with severe and persistent mental illness who received services from the Clark County Mental Health Court established in 2000. Secondary data on the use of mental health services and jail data for the MHC clients enrolled from April 2000 through April 2003 were obtained. A 12-month pre-post comparison design was used to determine whether MHC participants experienced reduced re-arrest rates for new offenses, reduced probation violations, and increased mental health services 12 months post-enrollment in the MHC compared with 12 months pre-enrollment. The Clark County MHC findings indicate successful reduction of arrest rates for new criminal offenses and probation violations, and provided the mental health support services to stabilize mental health consumers in the community. At one year post-enrollment, 54% of participants had no arrest, and probation violations were reduced by 62%. The most significant factor in determining the success of MHC participants was graduation status from the MHC, with graduates 3.7 times less likely to re-offend compared with non-graduates.

Wolff and Pogorzelski (2005) recommend the use of some form of random assignment to treatment and control, which is conditioned on the client's willingness to participate in supervised treatment. They recommend further that the mental health court model be compared to innovative approaches for engaging defendants with mental illness in treatment, rather than usual processing. Additionally, they recommend that researchers have an understanding of the court process for the development and application of fidelity measures.

Available evaluations focus on courts treating misdemeanor offenders, whereas the current "second generation" of mental health court focuses more on offenders facing more serious felony charges (O'Keefe, 2006; Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). The Bazelon Center (Bernstein & Seltzer, 2003) acknowledged that mental health courts were becoming increasingly likely to accept felony defendants and argued that misdemeanants are ill-suited for mental health courts because they should be diverted from the criminal justice system entirely (e.g., pre-arrest diversion programs). Bernstein and Seltzer (2003, Types of Offenses section, para. 2) recommend "To avoid becoming the entry point for people abandoned by the mental health system, mental health courts should close their doors to people charged with misdemeanors. If the trends we have noted from the first to second-generation courts continue, third- or fourth- generation courts may indeed be exclusive to felony defendants." Finally, with an increase in the number of pre-trial/pre-arrest diversion and Crisis Intervention Training (CIT) programs for persons with mental illness, there may be a diminished need for mental health courts to accept misdemeanants in localities with alternative forms of diversion (Naples &

Steadman, 2003; Steadman & Redlich, 2006). Some local jails will not accept misdemeanants, primarily because of overcrowding, regardless of mental health issues.

Program Environment, Characteristics and Selection Impact Findings

If observers of mental health courts agree on anything, it is that there is not a standard definition of a mental health court. Indeed, the only existing nationwide survey of mental health courts offers no descriptive model, relying instead on jurisdictions to identify themselves as having mental health courts (BJA, 2005). Therefore, it is critical that, when providing a description of their court, mental health court professionals offer a clear picture of the participants, court system, and services available in the community and offered by the court, and explain why it works in their community and reasons why it may not work for other people with mental illness, court systems, and communities (Wolff & Pogorzelski, 2005).

Research has shown that the scope and duration of the mental health courts' supervision varied from court to court (Bernstein & Seltzer, 2003). In at least 40 percent of the courts reporting in the Bazelon Center (2003) study, the limits of court supervision significantly exceed the possible length of incarceration or probation for the offense. Such policies likely discourage many individuals with mental illnesses from transferring their cases to the mental health courts. Most courts lack any written procedures, so uncertainty is great and the outcome depends on the judge's decision. In several courts the length of supervision is not specified, but is decided on a case-by-case basis. Given these factors, Wolff and Pogorzelski (2005) recommended that there be a delay in evaluation of individual mental health courts until the court has been fully implemented and procedures have been standardized. Also, the collection of information on the

percentage and characteristics of defendants eligible for mental health courts who are not willing to participate in supervised treatment is essential to conducting comprehensive evaluations of the model (Wolff & Pogorzelski, 2005).

On the basis of their assessment of drug court and other mental health innovations, Wolff and Pogorzelski (2005) identified five challenges particularly salient for the assessment of mental health courts: the nature of the intervention, the control condition, the subject sample, the dosing or exposure protocol and the observation period. They suggested that to conduct an effective evaluation of these courts, the emphasis needs to be on how variation in the environmental conditions, program characteristics, and the selection process might interact with the mental health court intervention in ways that limit the validity of the findings. They observed:

Given the discretion afforded to mental health court judges in terms of adjudication, monitoring, and motivation, inconsistencies in process and outcomes should be expected to the extent that personal preferences and notions of justice have been enshrined. Analogously, the treatment orientation and style of the mental health worker are also likely to be enshrined in the treatment plans of clients and in the way compliance is defined and measured. Inter-court variation may arise because personalized decision rules and processes guide the actions of the court staff but also may result in intra-court variation over time after personnel changes on the court team, especially the replacement of the judge. (Wolff & Pogorzelski, 2005, p. 558)

Furthermore, mental health courts should be judicious in determining the segment of the population to be best served by establishing diagnosis-related eligibility criteria in consultation with mental health treatment providers, giving careful consideration to the community's capacity for treatment and the most effective use of existing resources (BJA, 2005).

Steadman and Redlich (2005) found in their two-step process evaluation of seven mental health courts located in Santa Clara County, CA; Orange County, NC; Allegheny County, PA; Washoe County, NV; Brooklyn, NY; Bonneville County, ID; and Orange County, CA, that there was no clear pattern of participants' mental health characteristics. The three most common diagnoses were schizophrenia/schizoaffective disorder, bipolar disorder, and depressive/mood disorders.

Another recommendation by Wolff and Pogorzelski (2005) was that a collective effort among the practitioners take place to develop a) a definitional taxonomy for mental health courts (and their environments) that identifies their key active ingredients and acknowledges their natural variation; b) fidelity of measures for these courts; and c) standardized outcomes for measuring their performance. For instance, the terms "reward" and "sanction/clinical response" were purposely never defined in court documents for the Brooklyn Mental Health Court since the team believed that the same court response may be viewed as a "sanction" for one participant and a "clinical response" for another. As such, there was a loose understanding that a reward would be used to acknowledge a participant's compliance; a sanction would be implemented as a punishment or consequence for non-compliance; and a clinical response would be a modification in treatment services or a treatment plan but not with punishment as a goal (O'Keefe, 2006).

In order to develop a meaningful sampling strategy for an outcome study, it is essential to provide basic descriptive work on the characteristics of such courts (Steadman & Redlich, 2006). Indeed, Steadman and Redlich advocate for the field to begin conducting both single- and multi-site studies that follow mental health court participants into the community, measure the services and supervision they receive, and collect outcome data on clinical, satisfaction, quality of life,

and social policy indicators including recidivism, violence, and hospitalization, as well as cost data that can be used to assess the effectiveness and the cost effectiveness of mental health courts. More specifically, what types of detainees are most likely to profit from which of the various types of mental health courts that are proliferating across the U.S., and at what price? Ultimately, the question is a broader one of whether mental health courts are the preferred public policy option for jail diversion.

Cost Effectiveness

John B. Engberg, PhD, a study author and senior economist at RAND, reported that Allegheny County, Pennsylvania saved an estimated \$18,000 per person on average during the two years after the offenders entered the mental health court system. With about 200 individuals served by the mental health court each year, this translates to about \$3.6 million savings for the County (Kuehn, 2007). Jail inmates with mental illnesses require significant staff resources to manage, protect from harm, and treat, and the cost of providing psychotropic medications can be staggering. For these reasons, preventing the return to jail of only a few mental health court participants could be very significant to the jail administrator (BJA, 2005).

Summary

Since the late 1990's, courts around the country have adopted the mental health court model to respond to the increase of offenders with mental illness incarcerated in jails and prisons. More than 150 mental health courts are currently operating in the U.S. Many experts in the field believe that, before additional mental health courts are implemented, a rigorous methodology for evaluation needs to be developed. The methodology should capture the myriad issues, and

unique characteristics offenders with mental illness bring to the court and the treatment systems. Wolff and Pogorzelski (2005) recommend a research approach that addresses 1) static and dynamic factors within and surrounding the mental health court; 2) court's internal functioning and performance; and 3) outcomes of the court that reach beyond treatment compliance and recidivism. More specifically, researchers should examine characteristics such as diagnosis, substance use, and index offense, and a broader set of outcomes that include changes in quality of life for the individual and related family members, family burden, stable housing, involvement in education and vocational training, stable employment, and participation in civic activities. Other factors to be considered when designing an evaluation are recidivism, violence, and hospitalization, and cost. Many experts also encourage mental health courts to use the so-called research "gold standard" of randomizing subjects to determine true intervention effectiveness.

Appendix B

**Mental Health Court Evaluation
Criminal Justice Questionnaire**

Date of Interview: _____

Background Information

Interviewer Suggested Script: *This first series of questions helps to build a relevant professional profile of the mental health court criminal justice team with whom interviews are being conducted.*

1. Age: _____
2. Sex : Male
 Female
3. Race/Ethnicity: Black (non-Hispanic) White (non-Hispanic) Hispanic
 Asian American Indian
 Other _____
4. How many months have you worked for MHC/MHDP _____ (months)
5. What is your current position at the MHC/MHDP :
 Judge State’s Attorney Supervisor
 Case Manager Public Defender Private Defense Attorney
 Pre-Release Officer Parole/Probation Officer
 Intake Coordinator Other: _____
6. How long have you worked with mentally ill offenders? _____
7. Do you have any type of professional certification?
 No
 Yes Type: _____

8. Do you have any type of specialized degrees?
 No
 Yes Type:: _____

Reasons for the MHC/MHDP

Interviewer Suggested Script: *With the next set of questions, we would like to know what you know about how the mental health court came into being in **Harford County**. If you do not know the answer to any of these questions you are always welcome to state that they do not know the answer to any of the questions.*

9. How would you rank the performance of the court in dealing with the mentally ill offender before the planning of the mental health court?

- Excellent
- Good
- Fair
- Poor
- Terrible
- Don't know

10. In your opinion, what precipitated the change in the court system to adopt a mental health court?

11. Describe how the court dealt with mentally ill offenders prior to the MHC/MHDP. Note if there have been changes with the offenders' ability to access treatment since the implementation of the mental health court.

Planning of the MHC/MHDP

Interviewer Suggested Script: *This next series of questions seeks information on the planning efforts to establish the mental health court in **Harford County**. If you do not know the answer to any of these questions you are always welcome to state that you do not know the answer to any of the questions.*

12. Was anyone from your agency involved in the development of the MHC/MHDP?

- No a. Why do you believe that no one from your organization was involved? (skip to question 27 after an explanation is provided)

- Yes Provide the position of the person involved in the planning process: _____

- Don't Know (skip to question 27)

13. Were you involved in the development of the MHC/MHDP?

- No (skip to question 27)
- Yes

14. How many planning meetings took place? _____

15. How many did you attend? _____

16. In developing the MHC/MHDP what were your agencies goals and objectives?

17. Were the goals of the MHC/MHDP designed around the existing mental health system or was the goal to change the mental health system?

- No
- Yes
- Don't know

18. What population was the MHC/MHDP designed to serve?

19. How was the target population identified?

20. Why was that population selected?

21. Was the availability of resources taken into account before selecting a target population?

- No
- Yes
- Don't know

22. Were population selection criteria driven by any of the following (check all that apply):

- Resource availability
- Fiscal conditions
- Political environment
- Other – List: _____

23. Were designated treatment slots in the community identified as part of the planning process?

- No
- Yes
- Don't know

24. Were designated treatment slots in the community acquired as part of the planning process?

- No
- Yes
- Don't know

25. How was the issue of balancing the individual's treatment needs and public safety addressed?

26. What was the process for developing MHC/MHDP goals and objectives?

Explain: _____

Operations of the MHC/MHDP

Interviewer Suggested Script: *While the previous questions focused on what you knew about the development of the mental health court in **Harford County**, for this part of the interview, I will now be asking questions on the current day to day operations of the mental health court in **Harford County**.*

27. Did you receive written policies and procedures explaining the MHC/MHDP upon your hire?

- No
- Yes

28. Were you trained on the policy and procedures upon your hire?

- No
- Yes
 - a. Was the training voluntary or mandatory?
 - Voluntary
 - Mandatory
 - b. How helpful did you find the training?
 - Very helpful
 - Helpful
 - Partially helpful
 - Not helpful

Explain: _____

c. Do you think that the training covered all of the necessary information needed to perform your job within the rules of the MHC/MHDP?

- No Explain: _____

Yes

29. Have you received training in any of the following (check all that apply):

- Communication strategies (e.g. motivational enhancement techniques)
- Procedural justice techniques
- Social work and psychology techniques
- Clinical risk assessment instruments and procedures
- Working with the developmentally disabled
- Working with people with traumatic brain injury
- Working with people with psychiatric disabilities
- Offender population
- Other – Describe:

30. What are the criteria used to:

a. Include participants in MHC/MHDP:

Describe: _____

b. Exclude participants from MHC/MHDP:

Describe: _____

31. Is a **STANDARDIZED** mental health assessment used to determine eligibility and treatment planning?

No

Yes Describe: _____

Don't know

32. Are assessments for co-occurring disorders conducted?

No

Yes Describe: _____

Don't know

33. Are there any policies or guidelines of the type of services to be provided?

No

Yes Describe: _____

Don't know

34. Are there any policies or guidelines for the following:

	Yes	No	Don't Know
Intensity of treatment			
Length of Time			

35. State the specific goals and objectives for the MHC/MHDP's review hearings. Describe:

36. Do any of the following legal factors impact the treatment plan?

	Yes	No	Don't Know
Criminal History			
Probation/Parole status			
Type of charge			

37. Does victim input impact the treatment plan?

No

Yes

Don't know

Services and Resources

Interviewer Suggested Script:

We are about half way through the interview. The aim of the next few questions is to learn more about the services and resources available to mental health court clients.

38. Are there designated treatment slots in the community for program participants?

- No
- Yes
- Don't know

39. Which of the following is provided to the MHC/MHDP offenders?

- Day treatment Individual therapy Intensive psychiatric rehabilitation
- Psychosocial clubs Assertive community treatment (ACT) teams
- Community-based case management services Addition counseling
- Other: _____

40. Does your agency coordinate access for MHC/MHDP participants to ancillary services:

- No
- Yes a. If yes, which of the following do you coordinate? (Check all that apply)
 - Housing
 - Transportation
 - Vocational and Educational Services
 - Job Placement
 - Food banks
 - Medicaid/Other Healthcare
 - Other – List: _____

b. How are the interactions with these systems and/or organizations developed, managed, and maintained?

41. Does your agency provide services for participants with co-occurring disorders?

- No a. Does your agency coordinate access to substance abuse treatment?
 - No
 - Yes – Describe: _____
 - Don't know
- Yes Describe: _____
- Don't know

Consent and Confidentiality

Interviewer Suggested Script:

It is important for the evaluation to understand how matters of consent and confidentiality are handled.

42. Does the consent process allow you to share confidential information?

No

Yes a. Which of the following can you share treatment information with?

Judge

Prosecutor

Defense Attorney

Case Manager

Clinical Staff

Probation Officer

Coordinator

Other: _____

Don't know

43. In your opinion, what kinds of confidentiality protections are appropriate for the information that defendants reveal? (Types of information such as mental health diagnosis, details of the crime, length of treatment diagnosis, and history of illness)

44. How would you compare the right to privacy and privilege of mental health court participants compared with persons in treatment who are not in mental health court?

45. Did the MHC/MHDP plan to develop, manage, and maintain interactions with other systems?

No a. Were there any specific obstacles that prevented this from happening?

No

Yes – Describe: _____

Don't know

Yes b. What were those other systems? (list): _____

Don't know

Offenders

Interviewer Suggested Script:

Without looking at individual case records, we would like to know more about the offenders you serve in the MHC.

46. Does the offender have the option to withdraw from the MHC/MHDP after they have started the program?

No

Yes Explain: _____

Don't know

47. Which appear to be the most influential in an offender's decision to participate in the MHC/MHDP? Rank the following in order of their importance (1 as the lowest and 4 as the highest).

___ Avoid incarceration

___ Receive treatment for mental illness

___ Receive treatment for drug problem ___ Other: _____

48. From your estimation, approximately what percentage of the offenders in the MHC/MHDP have a history of mental illness prior to this arrest? (indicate percentage)_____

49. In your estimation, approximately what percentage of the offenders in the MHC/MHDP have a history of encounters with the mental health system prior to this arrest? (indicate percentage)_____

50. What happens to defendants who opt into the MHC/MHDP but have their case transferred to a conventional court?

51. Have there been any exceptions to allow ineligible defendants to participate?

No

Yes Explain: _____

Don't know

52. On average, how many contacts do you have with your MHC/MHDP offenders? (give number)_____

53. Are offenders involved in their treatment mandate?

No Explain: _____

Yes Explain: _____

Don't know

Sanctions & Incentives

Interviewer Suggested Script:

The next set of questions involve finding out information about how the court deals with non-compliant and compliant offenders.

54. Do offenders sign behavior contracts?

No

Yes How is compliance with behavior contracts tracked and monitored?

Don't know

55. Do you use sanctions when an offender exhibits negative behavior?

No What type of action do you take? _____

Yes a. What kind of sanctions do you use? _____

_b. Do you think the use of sanctions is effective with this population?

No

- Yes
- Don't know

c. How are the sanctions given? _____

56. Do you use incentives when an offender exhibits positive behavior?

No

Yes a. What types of incentives are used? _____

b. Do you think the use of incentives is effective with this population? _____

c. How are the incentives given? _____

Court Process

Interviewer Suggested Script:

We would like to know more about the MHC court process.

57. Does the judge monitor all participants in the MHC/MHDP?

No

Yes Explain: _____

Don't know

58. How would you rate the judge's role in monitoring progress and compliance?

Essential

Somewhat helpful

The judge does not have a role in this area.

59. How would you rate the judge's effectiveness at managing public safety?

Highly effective

Highly ineffective

Moderately effective

Moderately Ineffective

Effective

Ineffective

60. How does the court distinguish the offenders that are eligible from the offenders that participate?

61. From your estimation, what percentage of eligible offenders opt to go through traditional court? (list percentage) _____

a. In your opinion, why would some offenders choose tradition court over the MHC/MHDP? _____

62. Are offenders with co-occurring issues (e.g. substance abusers with mental illness) accepted into the MHC/MHDP?

Teamwork

Interviewer Suggested Script:

The mental health court team consists of service providers and officers of the court (e.g., the judge, defendant's attorney, parole officer, State's attorney). In your role as one of the members of the MHC team, we would like to know your perspective on how the team operates.

63. In your opinion, do some team members have more influence over final decisions regarding treatment mandate?
- No
 Yes a. Which team members? _____
64. Are there any team member conflicts?
- No
 Yes a. How are these conflicts dealt with? _____
 Don't know
65. How often is offender progress and compliance shared?
- Daily
 Weekly
 Monthly
 Only at court
 Never
66. How interrelated is your role to the roles of the other MHC/MHDP team members?
- Highly Interrelated
 Somewhat Interrelated
 Not Interrelated (Independent of one another)
67. Do you immediately notify the other MHC/MHDP team members of changes in compliance such as failure to appear for treatment session, drug use, non-compliance with medication?
- No a. Why not?
 Yes b. Which events do you notify other team members about immediately?

 Don't know

Other Issues/Team Member Opinions

Interviewer Suggested Script:

We are near the end of the interview. This is the last set of questions.

68. How would you rate the coordination of the services among treatment providers and the court when there is a problem?
- Excellent
 Good
 Fair
 Poor
 Terrible

I do not communicate with other team members and/or the court.

69. In your opinion, is mental health court implemented without racial, ethnic, gender, or socioeconomic status bias?

No Explain: _____

Yes

Don't know

70. How can you describe the way participants are being treated in the program? Is it:

Fairly Unfairly

Justly Unjustly

Respectfully Disrespectfully

With dignity Without dignity

71. Do you trust the treatment staff to balance the public safety concerns when creating a treatment plan for program participants?

No Explain: _____

Yes Explain: _____

Don't know

72. Do you think that all needed services are available?

No Explain: _____

Yes Explain: _____

Don't know

73. Do you think that offenders are actually receiving all of the services that they need?

No Explain: _____

Yes Explain: _____

Don't know

74. Do you think that everyone has the same goals for balancing treatment and public safety?

No Explain: _____

Yes Explain: _____

Don't know

75. Do you think that the MHC/MHDP is successful at reducing recidivism?

No Explain: _____

Yes Explain: _____

Don't know

76. Do you think that the MHC/MHDP is a successful program that should be retained?

No Explain: _____

Yes Explain: _____

Don't know

77. Please rate your agreement with this statement. The MHC/MHDP helps to break down the stigma and misconceptions that keep many people with mental illness isolated and marginalized.

- Completely agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Completely disagree

Explain: _____

78. What do you see as the limitations of what the MHC/MHDP can achieve?

**Mental Health Court Evaluation
Treatment Provider Questionnaire**

Date of Interview: _____ **Name of Interviewer:** _____

Background Information

Interviewer Suggested Script: *This first series of questions helps to build a relevant professional profile of the mental health court service providers with whom interviews are being conducted.*

1. What is your current position at the treatment program:
 Director Clinical Director Supervisor
 Case Manager Counselor/Therapist Assessor
 Intake Coordinator
 Other: _____

2. How many months have you worked with the Harford County Mental Health Diversion Program (MHDP)? _____ (months)

3. How long have you worked in the Mental Health field? _____ (years)

4. Do you have any type of specialized degrees?
 No
 Yes – Type: _____

5. Do you have any type of professional certification?
 No
 Yes -- Type: _____

Reasons for the MHDP

Interviewer Suggested Script: *With the next set of questions, we would like to know what you know about how the mental health court came into being in **Harford County**. If you do not know the answer to any of these questions you are always welcome to state that they do not know the answer to any of the questions.*

6. In your opinion, what precipitated the change in the court system to adopt a mental health court?

7. If you know, describe how the court dealt with mentally ill offenders prior to the MHDP. Note if there have been changes with the offenders' ability to access treatment since the implementation of the mental health court.

8. How would you rank the performance of the court in dealing with the mentally ill offender before the planning of the mental health court?

- Excellent
 Good
 Fair
 Poor
 Terrible
 Don't know

Planning of the MHDP

Interviewer Suggested Script: *This next series of questions seeks information on the planning efforts to establish the mental health court in **Harford County**. If you do not know the answer to any of these questions you are always welcome to state that they do not know the answer to any of the questions.*

9. Was anyone from your agency involved in the development of the MHDP?

- No – a. Why do you believe that no one from your organization was involved? (skip to question 26 after an explanation is provided)

- Yes Provide the position of the person involved in the planning process: _____

- Don't Know (SKIP TO QUESTION 26)

10. Were you involved in the creation of the Mental Health Court?

- No (SKIP TO QUESTION 26)
 Yes

11. How many planning meetings took place? _____

12. How many did you attend? _____

13. In developing the MHDP what were your agencies goals and objectives?

14. Were the goals of the MHDP designed around the existing mental health system or was the goal to change the mental health system?

- No
- Yes
- Don't know

15. What population was the MHDP designed to serve?

16. How was the target population identified? _____

17. Why was that population selected? _____

18. Were population selection criteria driven by any of the following (check all that apply):

- Resource availability
- Fiscal conditions
- Political environment
- Other – List:

19. Were designated treatment slots in the community identified as part of the planning process?

- No
- Yes
- Don't know

20. Were designated treatment slots in the community acquired as part of the planning process?

- No
- Yes
- Don't know

21. How was the issue of balancing the individual's treatment needs and public safety addressed?

22. What was the process for developing MHDP goals and objectives?

Explain:

Operations of the MHDP

Interviewer Suggested Script: *While the previous questions focused on what you knew about the development of the mental health court in **Harford County**, for this part of the interview, I will now be asking questions on the current day to day operations of the mental health court in **Harford County***

23. Have you received written policies and procedures explaining the Mental Health Court?

- No
 Yes

24. Were you trained on the policy and procedures?

- No
 Yes -- a. Was the training voluntary or mandatory?
 Voluntary
 Mandatory
b. How helpful did you find the training?
 Very helpful
 Helpful
 Partially helpful
 Not helpful

Explain: _____

c. Do you think that the training covered all of the necessary information needed to perform your job within the rules of the MHDP?

- No – Explain:

- Yes

25. Have you received training in any of the following (check all that apply):

- Social work and psychology techniques
 Clinical risk assessment instruments and procedures
 Working with the developmentally disabled
 Working with people with traumatic brain injury
 Working with people with psychiatric disabilities
 Offender Population
 Communication strategies (e.g., motivational enhancement techniques)
 Procedural justice techniques
 Other – Describe: _____

26. What are the criteria used to:

a. Include participants in MHDP: (Describe)

b. Exclude participants from MHDP: (Describe)

27. Is a **STANDARDIZED** mental health assessment used to determine eligibility and treatment planning?

- No
- Yes -- Describe: _____
- Don't know

28. Are assessments for co-occurring disorders conducted?

- No
- Yes
- Don't know

29. Are there any policies or guidelines for the type of services to be provided to mental health court participants?

- No
- Yes – Describe: _____
- Don't know

30. Are there any policies or guidelines for the following:

	Yes	No	Don't Know
Intensity of treatment			
Length of Time			

31. Can you tell me the specific goals and objectives for the MHDP's review hearings in the court. Describe:

32. Do legal factors such as (see below) impact the treatment plan?

	Yes	No	Don't Know
Criminal History			
Probation/Parole status			
Type of charge			

33. Does victim input impact the treatment plan?

- No
 Yes
 Don't know

Services and Resources

Interviewer Suggested Script:

We are about half way through the interview. The aim of the next few questions is to learn more about the services and resources available to mental health court clients.

34. Are there designated treatment slots in the community for program participants?

- No
 Yes
 Don't know

35. Which of the following do you provide to your MHDP clients?

- Day treatment
 Individual therapy
 Intensive psychiatric rehabilitation
 Psychosocial clubs (e.g., self help groups)
 Assertive community treatment (ACT) teams
 Community-based case management services
 Addiction counseling
 Family counseling
 Other: _____

36. Does your agency coordinate access for MHDP participants to the following resources:

- No
- Yes -- a. Which of the following do you use?
 - Housing
 - Transportation
 - Vocational and Educational Services
 - Job Placement
 - Food banks
 - Medicaid/Other Healthcare
 - Other – List: _____
 - I am not aware of any.

a. How are the interactions with these systems and/or organizations developed and managed?

37. Does your agency provide services for participants with co-occurring disorders?

- No
- Yes - Describe: _____
- Don't know

37a If no, does your agency coordinate access to substance abuse treatment?

- Yes
- No

Consent and Confidentiality

Interviewer Suggested Script:

It is important for the evaluation to understand how matters of consent and confidentiality are handled.

38. Does the consent process allow you to share confidential information?

- No
- Yes-- a. Which of the following can you share treatment information with?
 - Judge
 - Prosecutor
 - Defense Attorney
 - Case Manager
 - Clinical Staff
 - Probation Officer
 - Coordinator
 - Other: _____
 - Don't know

39. In your opinion, what kinds of confidentiality protections are appropriate for the information that defendants reveal. (Types of information such as mental health diagnosis, details of the crime, length of treatment diagnosis, and history of illness)

40. How would you compare the right to privacy and privilege of mental health court participants compared with persons in treatment who are not in mental health court?

Clients

Interviewer Suggested Script:

Without looking at individual case records, we would like to know more about the clients you serve in the MHDP.

41. Which of the following reasons appear to be influential in a defendant's decision to participate in the MHDP?

- Avoid incarceration Receive treatment for mental illness
 Receive treatment for drug problem Other: _____

a. Of these, which is the most important:

- Avoid incarceration Receive treatment for mental illness
 Receive treatment for drug problem Other: _____

42. In your estimation, approximately what percentage of the offenders in the MHDP have a history of mental illness prior to this arrest? (indicate percentage)_____

43. In your estimation, approximately what percentage of the offenders in the MHDP have a history of encounters with the mental health system prior to this arrest? (indicate percentage)

44. Have there been any exceptions to allow ineligible defendants to participate?
 No
 Yes --Explain: _____
 Don't know
45. On average, how many contacts per month do you have with your MHDP clients? (give number)
46. Are clients involved in the creation of their treatment plan?
 No – Explain: _____
 Yes -- Explain: _____
 Don't know

Sanctions & Incentives

47. Do your clients sign behavior contracts?
 No
 Yes -- How is compliance with behavior contracts tracked and monitored?

 Don't know
48. Do you use sanctions when a client exhibits negative behavior?
 No – What type of action do you take? _____

 Yes a. What kind of sanctions do you use? _____
 b. Do you think the use of sanctions is effective with this population? _____
 c. How are the sanctions given? _____
49. Do you use incentives when a client exhibits positive behavior?
 No
 Yes – a. What types of incentives are used? _____
 b. Do you think the use of incentives is effective with this population?

 c. How are the incentives given? _____

Teamwork

Interviewer Suggested Script:
The mental health court team consists of service providers and officers of the court (e.g., the judge, defendant's attorney, parole officer, State's attorney. In your role as one of the members of the MHDP team, we would like to know you perspective on how the team operates.

50. In your opinion, do some team members have more influence over final decisions regarding treatment planning?
 No
 Yes -- a. Which team members? _____
51. Are there any team member conflicts?
 No
 Yes -- a. How are these conflicts dealt with? _____
 Don't know

52. How often is client progress and compliance shared?

- Daily
- Weekly
- Biweekly
- Monthly
- Only at court.
- Never

53. How interrelated is your role to the roles of the other MHDP team members?

- Highly interrelated
- Somewhat interrelated
- Not interrelated (Independent of one another)

54. Do you immediately notify the other MHDP team members of changes in compliance such as failure to appear for treatment session, drug use, non-compliance with medication?

- No – a. Why not?
 - Yes –b. Which events do you notify other team members about immediately?
-
- Don't know

Other Issues/Team Member Opinions

Interviewer Suggested Script:

We are near the end of the interview. This is the last set of questions.

55. How would you rate the coordination of the services among treatment providers and the court when there is a problem?

- Excellent
- Good
- Fair
- Poor
- Terrible
- I do not communicate with other team members and/or the court.

56. In your opinion, is mental health court implemented without racial, ethnic, gender, or socioeconomic status bias?

- No – Explain:

-
- Yes
 - Don't know

57. How would you describe the way participants are being treated in the program? Is it:

- Fairly Unfairly
- Justly Unjustly
- Respectfully Disrespectfully
- With dignity Without dignity
- Other: _____ ?

58. Do you trust the legal staff to balance the clinical needs with public safety concerns when creating a treatment plan for program participants?

No – Explain:

Yes -- Explain:

Don't know

59. Do you think that all needed services are available?

No – Explain:

Yes -- Explain:

Don't know

60. Do you think that clients are actually receiving all of the services that they need?

No – Explain:

Yes -- Explain:

Don't know

61. Do you think that everyone has the same goals for balancing treatment and public safety?

No – Explain:

Yes-- Explain:

Don't know

62. Do you think that the MHDP is successful at reducing recidivism?

No – Explain:

Yes-- Explain:

Don't know

63. Do you think that the MHDP is a successful program that should be retained?

No – Explain:

Yes

Don't know

64. Please rate your agreement with this statement. The MHDP helps to break down the stigma and misconceptions that keep many people with mental illness isolated and marginalized

- Completely agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Completely disagree

Explain: _____

65. What do you see as the limitations of what the MHDP can achieve?

Suggested Script:

We are at the end of the interview but before closing I would like some personal information from you which you may or may not wish to provide.

66. What is your age? _____

67. Sex : Male
 Female

68. Race/Ethnicity: Black (non-Hispanic) White (non-Hispanic) Hispanic
 Asian American Indian
 Other _____

Suggested Script for Closing Statement:

Thank you very much, Mr./Ms/Dr _____ for your willingness to participate in this survey and for the important information you have provided us about the role of your organization in the mental health court/diversion program. The information collected from all providers will be summarized and shared with you and your organization. If you have any question for me I will be glad to answer, and if you need to follow up on the project please contact the PI at Morgan with the contact information provided earlier. Thank you for your time.