MENTALLY ILL OFFENDER INITIATIVE

PROGRESS REPORT

BACKGROUND

Growing Numbers

Criminal and juvenile justice systems in the United States and Utah are being overwhelmed by the growing numbers of mentally ill offenders. At every point throughout the system, law enforcement, courts, jails, and Corrections agencies must deal with individuals who are seriously mentally ill, at great cost to the public. Our jails and prisons are becoming the "de facto" providers of mental health services across the country.

Study on "Time to Return to Prison for Serious Mentally Ill Offenders Released from Utah State Prison 1998-2002

A study conducted by Dr. Kristin Cloyes of the University of Utah has shown that recidivism rates are higher for mentally ill releasees.

This study was conducted because of "…the perception of prison administrators and clinical staff that…more offenders with serious forms of mental illness were being incarcerated in state prison. Additionally, there was an increasing sense that more offenders with mental illness were returning to prison and at higher and faster rates than offenders without mental illness."

Findings include:

- 23% of offenders released from prison between 1998 and 2002 qualified as seriously mentally ill (SMI).
- Time to return to prison was shorter by almost 200 days for SMI parolees than non-SMI parolees.
- 77% of SMI releasees returned to prison within 36 months compared to 62% for the non-SMI group.
- This difference was especially noticeable for women with 72% of SMI women returning to prison within 36 months compared to 49% of non-SMI women.

The study concluded that SMI is a major risk factor for incarceration and re-incarceration. The authors estimated that if the SMI recidivism rate could be reduced to the same rate as the non-SMI population, the Corrections system would save $5 million a year in incarceration costs.

Impacts on the System

The growing number of mentally ill individuals intersecting with our criminal and juvenile justice systems has significant implications for:

- Law enforcement which is often confronted with the question of what to do with out-of-control individuals who may pose a risk to themselves or others.
- The judicial system which faces congested dockets with few options for dealing with mentally ill individuals.
- Jails and prisons which must provide costly mental health treatment and safe and secure housing for difficult to manage offenders.

- Probation and parole which must supervise offenders who may be unable to afford expensive treatment and medication.

MISSION AND MEMBERSHIP

Mission of the Committee

"To review and make recommendations to all branches of government concerning the interaction of people who suffer with mental illness and the criminal justice system. The intent of the committee is to:

- o identify the issues that arise from the intersections of the criminal justice system and mental illness;
- o examine relevant data, models, policies, protocols and resources available for addressing those issues throughout the state in both urban and rural contexts
- o improve the system response in these cases."

Membership

The group is a collaborative effort involving all three branches of government and includes representatives of state and local agencies.

Patrick Anderson
Salt Lake Legal Defenders

Judge Judith Atherton
Third District Court

Judge John Baxter
Salt Lake City Justice Court

Ron Bruno
Salt Lake City Police Dept
Crisis Intervention Team

Craig Burr
Department of Corrections

Rollin Cook
Salt Lake County Jail

Kevin Eastman
Weber County Human Services

Sim Gill
Salt Lake City Prosecutor

Senator Lyle Hillyard
Utah State Senate

Creighton Horton
Utah Attorney General's Office

Brian Miller
Salt Lake County Mental Health
Chair UBMN Committee

Elder Alexander Morrison
Community Member

Judge Dane Nolan
Third District Juvenile Court

Mark Payne
Director, Utah Div of Substance Abuse/Mental Health

Allan Rice
Valley Mental Health

Dr. David Stein
Utah State University Faculty

Sheriff James Tracy
Utah County Sheriff Office

Adam Trupp
Utah Association of Counties

Rep. Stephen Urquhart
Utah State House of Representatives

Sherri Wittwer
Utah Chapter, Nat'l Alliance for Mental Health

Bob Yeates
Commission on Criminal & Juvenile Justice

PROGRESS

The committee has been meeting for about one year and has heard from practitioners and researchers representing most of the intersections between criminal justice and mentally ill individuals. The following is a summary of the findings to this point.

Law Enforcement

Law enforcement is limited to three options when they respond to a disturbance involving a mentally ill individual.

1. De-escalate and release at the scene
2. Transport to a facility designated by the local mental health authority and make application for commitment of the individual to the local mental health authority. This is a cumbersome process.
3. Book the individual into jail. This option has the advantage of a 24/7 operation which is relatively easy for law enforcement to access.

Jail

Offenses charged to mentally ill individuals who are booked into jail in Salt Lake County are generally in the following categories:

1. Trespass
2. Disorderly conduct
3. Public intoxication
4. Assault on a police officer
5. Possession of a controlled substance
6. Resisting arrest

The typical mentally ill offender booked into jail:

- Was homeless
- Had multiple cases in multiple courts
- Off his/her medication
- Self-medicating with illegal substances
- Had numerous prior bookings
- Spent high number of days in jail
- Often suffering from co-occurring substance abuse disorders

Mentally ill offenders in jails are at high risk for suicide and are difficult to manage.

Prisons

Nationally, jails and prisons lack the financial, clinical, and philosophical resources to provide adequate treatment for mentally ill offenders. Their mission is to protect the public and operate safe and secure facilities, not to treat the mentally ill. Studies estimate that only one in three of inmates with a history of mental illness receive treatment while incarcerated. The vast majority of mentally ill offenders are released from prison to community supervision which may also not be able to provide needed treatment.

What works

The most effective models of dealing with these individuals seem to avoid the “one-size fits all” model. An a la carte approach which can offer whatever services are needed in the individual case appears to be the most effective. Needed services include:

- Crisis intervention:
  - Acute/crisis stabilization centers
  - Mobile crisis teams
  - Crisis receiving centers
- Assessment
- Case management
- Follow-up and after-care services
- Medications
- Housing
- Mental health courts such as the one operated in Third District Court in Salt Lake County with a model similar to drug courts

MENTAL HEALTH COURTS

Work has already started with communities interested in establishing mental health courts in their areas.

A 2007 report by the Rand Corporation which studied the impact of a mental health court in Pennsylvania suggests that these courts may save the government money in the long run.

- In the first year in the program, the savings created by the decreased use of jail time "…mostly offsets the cost of the treatment services."
- During the second year, the cost of treatment decreased while the use of jail time remained low.
- The long term savings appeared to be greater for more individuals convicted of more serious crimes or with more serious mental illnesses.
- The Rand report states that over the longer time frame, "…mental health court programs may actually result in net savings to government…" through recidivism reductions and less use of expensive treatment services such as hospitalization.

FUTURE PLANS

While it is clear that there are no easy answers to these problems, the committee plans to develop a model and a series of recommendations for addressing the issues identified. It is believed that the ultimate outcome of the process will be a model for improving services and reducing the impact of mentally ill offenders on the criminal justice system across the state. Recommendations will be made for coordination and service delivery at all levels of government and in both urban and rural parts of the state as the model is implemented. We welcome and seek your input into this initiative as we move forward. We look forward to keeping you informed of our progress.

CCJJ Mental Health Initiative
White Paper

Concept: NAMI (National Alliance on Mental Illness) is a group that works to ensure the dignity and improve the lives of individuals (consumers) and families affected by mental illness. NAMI offers *free* education, support and advocacy for the public. Our work focuses on these things: helping individuals with mental illness to be able to live full and productive lives, strengthening families, educating the community and raising awareness, and affecting positive change in our systems of care and communities.

NAMI's education and support programs provide relevant information, valuable insight, and the opportunity for consumers and families to engage in support networks. These programs draw on the lived experience of mental health consumers and family members who have learned to live well with their illnesses and have been extensively trained to help others, as well as the expertise of mental health professionals and educators. NAMI programs use a peer-to-peer model (taught by consumers for consumers; taught by family members for family members). This enables those in need of services to benefit from the "lived experience" of others and get resource information and support from others who have "been there."

NAMI programs are offered in many mental health centers, hospitals, community centers and other locations throughout the State. In addition, NAMI is very involved with the Criminal Justice System and is involved on a variety of levels.

- Crisis Intervention Team Training (CIT) – NAMI is involved with the training of specially trained law enforcement officers and encourages these trainings to take place statewide. NAMI fully supports and promotes the CIT Program and works to raise awareness about this program in our communities.

- NAMI provides a Mentor at the Salt Lake County Day Reporting Center to work with individuals released from the Salt Lake County Metro Jail. The Mentor works with those released either individually or as a group to help them get the assistance in the community, a connection to free NAMI programs, and the support they need.

- NAMI teaches our BRIDGES Consumer Education Course in the Salt Lake County Metro Jail, Utah County Jail and the Utah State Prison. These courses are taught by trained consumers who are in recovery. The course material includes information on mental

illness, the treatments, the importance of compliance, developing a relapse prevention plan, advance directives and recovery.

- NAMI Mentors attend and participate in the Mental Health Court in the First and Third Districts, the C3 Juvenile Mental Health Court in the Third District, and the Federal Mental Health Court.

- NAMI Peer Mentors are full participants in the Jail Diversion Outreach Team (JDOT Team) in Salt Lake County.

- NAMI Consumer and Family Mentors take calls from the public to offer a listening ear, referrals to free NAMI programs and to get information and assistance in accessing local resources.

- The NAMI Connection Support Group for Consumers, BRIDGES Education Course and Progression Course (for youth) are available in many communities statewide.

- NAMI provides a "Coffee Group" for individuals who graduate from mental health court who are in need of continued support in the community.

- Family Support Groups, Family-to-Family Education Course and NAMI Basics Course (for families with children and adolescents with mental illness) are available in many communities statewide.

- NAMI provides trainings for correctional officers, probation officers, and various other groups within the Criminal Justice System.

For more information on NAMI Utah: 801-323-9900, visit www.namiut.org or the NAMI National website at www.nami.org.

Questions or further information: Sherri Wittwer at 323-9900.

People with Mental Illness in the Criminal Justice System: Fiscal Implications

Criminal justice, mental health, and substance abuse systems that do not provide a coordinated response to individual with serious mental illness end up using expensive and ineffective safety and emergency services to respond to some of those individuals.

People with mental illness are significantly overrepresented in the criminal justice system	The rate of mental illness in the jails in Utah (30%) is 6 times as high as for the general public (5%). (Extrapolated from Salt Lake County data). In a jail survey from Davis, Weber, Tooele and Washington Counties, all the jails reported that the number of inmates with a serious mental illness had increased over the past two years and the average percentage of inmates with a serious mental illness in the jails at the time of the survey was 28%. In Utah, nearly 8 out of 100 jail inmates have a mental illness so severe that it is debilitating. In most of these cases, the offense was a direct result of a mental illness. Men with mental illness are *four* times more likely to be incarcerated than those who are not mentally ill. Women with mental illness are *six* times more likely to be incarcerated.
Many of them have committed minor crimes	Most of the offenses for which persons with mental illness are incarcerated are non-violent offenses. Most typically, mentally ill persons in Utah are jailed for public trespass, public intoxication, and failure to appear citations.
They stay longer in prison & in jail	New York City found that the average stay for all offenders in 42 days; for inmates with serious mental illness, the average stay is 215 days. Utah jails report the same problem: mentally ill inmates are more likely to be released because they are homeless, because their condition is unstable, and because they are less likely to succeed with jail rules.
They are extremely expensive to incarcerate	Pennsylvania has found that the cost to incarcerated a person with serious mental illness is nearly double that for a non-mentally ill inmate. Utah Sheriffs deal with the cost of the jail beds plus added costs for suicide precautions, mental health assessments, and in-jail mental health treatment.
Without a coordinated response, many will be treated through expensive public safety and crisis services.	Hospitals throughout Utah report they incur significant uncompensated costs for treating these same individuals with mental illness in emergency rooms and inpatient units. Studies in both Washington State and Ohio each found that the cost to taxpayers for only 20 of the "frequent fliers" exceeded one million dollars a year. In addition to jail and medical costs, each arrest incident costs $1700. Incurring this expense are the courts and law enforcement agencies. Many of these individuals will experience 30-50 arrest incidents each year due to minor offenses.

MENTALLY ILL OFFENDERS

SUMMARY OF RESEARCH

THE SENTENCING PROJECT REPORT "MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM" 2002

Since 1972, the population of state and federal prisons has increased by 7 times--the population of public psychiatric hospitals has decreased by 92% since 1955.

E.g., in the 1970's, Michigan had 28,000 individuals in mental hospitals and 8,000 in prisons. In 2002, there were 3,000 in mental hospitals and 45,000 in prisons.

The L.A. County Jail is believed to be the largest mental institution in the U.S.

Reasons for the change:

- ✓ Deinstitutionalization
- ✓ Lack of community based treatment
- ✓ Legal barriers to involuntary commitment

BUREAU OF JUSTICE STATISTICS REPORT "MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES" 2006

BJS staff visited prison and jails between 2002 and 2004 and interviewed a sample of inmates to determine their mental health status.

14,499 inmates in state facilities, 3,686 in Federal prisons, and 6,982 in jails were interviewed using a structured clinical interview for diagnosing mental disorders based on the DSM-IV.

The study found:

- ✓ 56% of state prison inmates, 45% of Federal inmates, and 64% of local jail inmates had some history of mental health problems.
  - Recent history of receiving care–24% state, 14% Federal, 21% local
  - Symptoms–49% state, 40% Federal, 60% local
- ✓ 43% of state prisoners and 54% of jail inmates reported symptoms of mania.
- ✓ 23% of state prisoners and 30% of jail inmates reported symptoms of major depression.
- ✓ 15% of state prisoners and 24% of jail inmates met the criteria for a psychotic disorder.
- ✓ Overall, jail inmates had the highest rate of mental health problems.
- ✓ The criminal history of mentally ill offenders was different from that of other offenders, with a higher rate of prior incarcerations and violent convictions.
- ✓ Substance abuse and homelessness were more common among the mentally ill.
- ✓ Mentally ill offenders were more likely to have been victims of abuse and had a higher rate of problems while incarcerated.

	State Prison		Local Jail	
	With mental problem	Without	With mental problem	Without
Violent offense	61%	56%	44%	36%
3 or more prior incarcerations	25%	19%	26%	20%
Substance abuse	74%	56%	76%	53%
Drug use in month before arrest	63%	49%	62%	42%
Homelessness in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27%	10%	24%	8%
Charged with facility rule violation	58%	43%	19%	9%
Injured in a fight since admission	20%	10%	9%	3%

- ✓ Female inmates had higher rates of mental health problems–73% of women and 55% of men in state prisons and 75% of women and 63% of men in local jails had mental health problems.
- ✓ State prisoners with mental health problems had longer sentences than those without–probably as a result of crime of conviction.
- ✓ One third of state prisoners with mental health problems had received treatment, compared to 24% of Federal, and 17% of jail inmates.

BUREAU OF JUSTICE STATISTICS REPORT "MENTAL HEALTH TREATMENT IN STATE PRISONS, 2000"

- ✓ Almost 90% of state prisons reported that they provide some type of mental health services to inmates.
- ✓ 70% reported that they screen inmates at intake for mental health problems.
  - Psychiatric assessments 78%
  - 24-hour care 79%
  - Therapy/counseling 84%
  - Psychotropic medications 83%
  - Assist releasees in obtaining care 72%
- ✓ 10% of state prison inmates were receiving psychotropic medications on June 30, 2000–22% of women and 9% of men.
- ✓ 13% were receiving therapy or counseling–27% of women and 12% of men.

BUREAU OF JUSTICE STATISTICS REPORT "MENTAL HEALTH TREATMENT OF INMATES AND PROBATIONERS", 1999

- ✓ Rates of mental illness among probationers were similar to those of inmates in state prisons and local jails.

PSYCHIATRIC SERVICES, "PATTERNS AND PREVALENCE OF ARREST IN A STATEWIDE COHORT OF MENTAL HEALTH CARE CONSUMERS", 2006

- ✓ Followed more than 13,000 individuals receiving services from the Massachusetts Department of Mental Health for 10 years.
- ✓ 28% of these individuals were arrested at least once–most commonly for public order offenses, although also had a number with serious violent offenses.
- ✓ 50% of mentally ill persons 18 to 25 years of age were arrested.

PSYCHIATRIC SERVICES, "INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM AMONG NEW CLIENTS AT OUTPATIENT MENTAL HEALTH AGENCIES", 2005

- ✓ 673 clients of outpatient mental health agencies were interviewed and their criminal records examined.
- ✓ 45% had at least one contact with the criminal justice system before arriving at the agency–36% had at least one conviction and 19% had a felony.
- ✓ Clients with criminal justice histories were more likely to be homeless and have a drug dependency.

TIME TO RETURN TO PRISON FOR SERIOUS MENTALLY ILL OFFENDERS RELEASED FROM UTAH STATE PRISON 1998-2002

A RESEARCH REPORT PRODUCED FOR THE STATE OF UTAH DEPARTMENT OF CORRECTIONS
AND THE UTAH COMMISSION ON CRIMINAL AND JUVENILE JUSTICE
BY THE UTAH CRIMINAL JUSTICE CENTER

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CONTENTS

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I. EXECUTIVE SUMMARY

Problem Statement

In 2001, the Department of Corrections and the Utah Commission of Criminal and Juvenile Justice identified the following as a priority area of research: To determine recidivism rates for offenders with mental illness returning to the Utah State Prison. This identified problem was based on the perception of prison administrators and clinical staff that the prison population had undergone a perceptible change in the past decade, in that more offenders with serious forms of mental illness were being incarcerated in state prison. Additionally, there was an increasing sense that more offenders with mental illness were returning to prison, and at higher and faster rates than offenders without mental illness. The presence of the mentally ill in the prison system represents serious challenges to prison administration and management, including critical resource issues and substantial practical as well as philosophical differences between correctional and therapeutic management.

Due to turnover in University of Utah research faculty, this project, originally approved by the UCCJ, was dropped for several years. In 2006, in conjunction with the Utah Criminal Justice Center gaining University Center status, the project was adopted by the present research team based in the College of Nursing. Also in that timeframe, the US Bureau of Justice adjusted its report on the number of mentally ill offenders incarcerated in US state prisons from 300,000 or 16% in 1999 to over 700,000 or 56% in 2005. Clearly, offenders with mental illness are being incarcerated in unprecedented numbers across the US and the issues associated with this situation, including recidivism, mandated treatment, and fiscal as well as human cost, continue to multiply.

Study Aims

This report describes the first stage in a program of research examining the effects of prison-based and community-based mental health treatment on the length of time that offenders with serious mental illness (SMI) in Utah State remain out of prison. The preliminary study reported here analyzed recidivism (defined as return to prison) in offenders with SMI released from Utah State Prison 1998-2002 compared with non-SMI offenders released in the same period.

This study involved two distinct tasks:

1) Identifying and quantifying the portion of the Utah State Prison population 1998-2002 who met criteria for serious mental illness
2) Comparing time from prison release to re-incarceration for the SMI offenders compared with the non-SMIO offenders. We explain both these procedures in detail in this report.

In addition, we

3) Compared data on women offenders with SMI with data for men and all offenders together, to begin an investigation of gender differences related to mental health, treatment and incarceration.

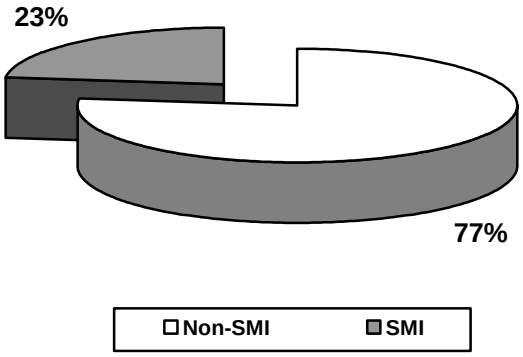
Major Findings

Significant results of this pilot study include: 1) The identification of a distinct subgroup of offenders with SMI released from Utah State Prison 1998-2002; 2) The findings that

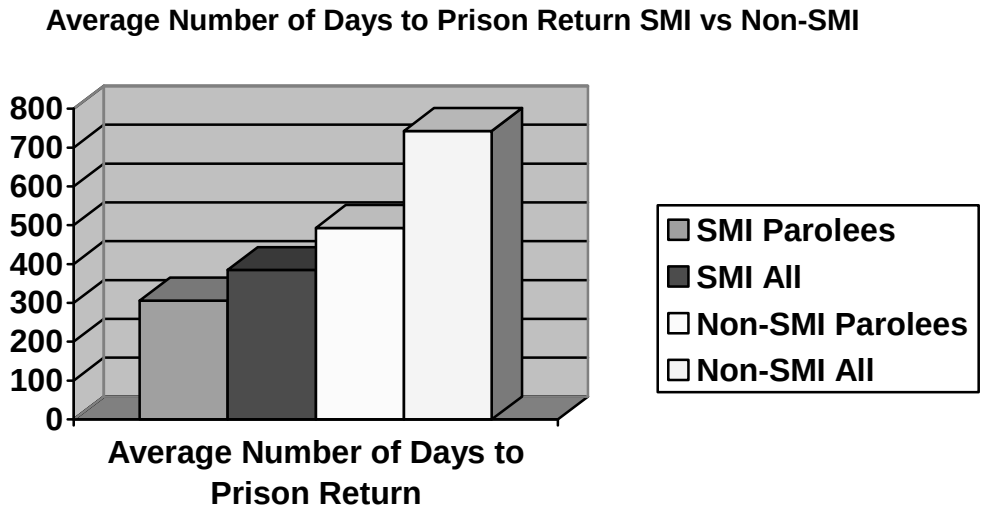
offenders with SMI return to prison much more quickly and in greater numbers than non-SMI offenders; 3) The finding that women are over-represented in the SMI group, and that women offenders with serious mental illness represent a uniquely vulnerable, at-risk group.

1) Among all offenders released from Utah State Prison 1998-2002 (N = 9,245 individuals and 14,652 events of actual release) we identified a subpopulation of 2,127 individuals (23%) who met study criteria for SMI as described in this report. These pilot data, including a systematic review of O-Track and medical record data for each SMI case, indicate the existence of a distinct group of male and female offenders with SMI among the Utah State Prison population. This SMI group is significantly different from the non-SMI group by factors related to mental illness (psychotropic medication use, acute and long-term mental health related housing, psychiatric diagnosis) but not by demographics, offense category, type or degree, or condition of return (technical versus new commitment). It is important to note that 23% represents offenders with *serious mental illness*, not just any form of mental health disorder or psychiatric diagnoses.

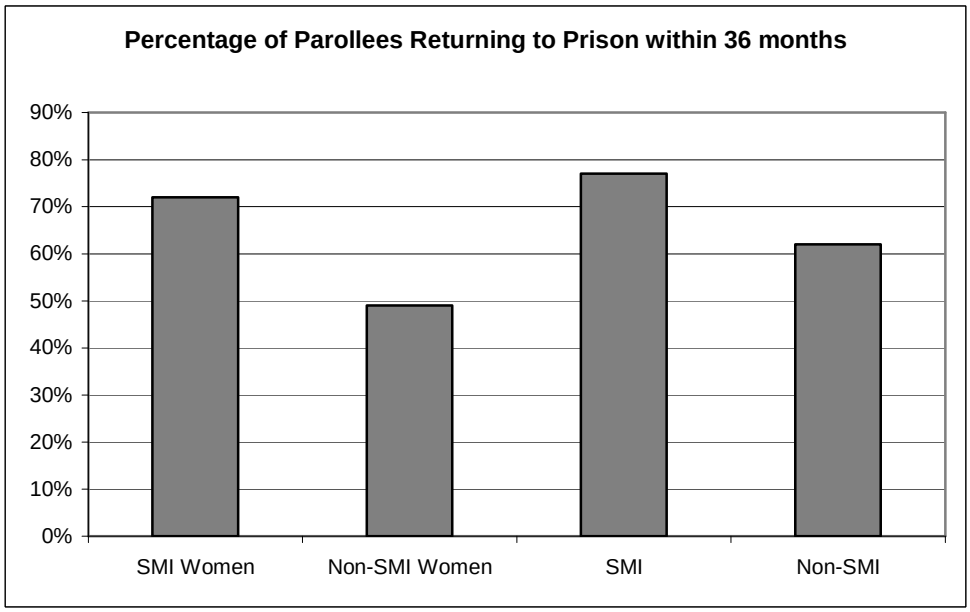
Utah State Prison Population 1998-2002



2) When comparing the number of days from prison release to return to prison for parolees 1998-2002, the SMI group had a significantly shorter return to prison time (306 days) than the non-SMI group (493 days), a very statistically significant finding. In short, parolees with SMI return to prison an average of 200 sooner than all other parolees. When comparing all offenders (not just parolees) this difference jumps strikingly: The median time for all SMI offenders to return to prison was 385 versus 743 for all non-SMI offenders, over 350 days sooner. Further, 77% of the SMI group returned to prison within 36 months compared with 62% for the non-SMI population.



3) Looking at women separately, we found that 72% of women with SMI returned within 36 months, nearly one and a half times the percentage for non-SMI women (49%) and . The average age of first incarceration in Utah State Prison for women with SMI was 30 years of age, with a range from 17 to 61—much higher than the average first age for men. However, the most frequent age of first incarceration in our sample was 24 (20 women or 8.2%) and the next most frequent was 31 (6.9%) with 33 (6.5%) and 34 (6.1%) close behind. This distinct bimodal pattern, with age of first admission clustering in the mid-twenties and the early to mid-thirties, also corresponds to likely child-bearing and child-rearing ages for these women. Women in Utah are likely to have had children by 25 and multiple children by the time they are in their thirties. This point out how incarceration and mental illness of women presents issues that affect not just individual women, but dependent children and families.



Conclusions

Prisons and jails have become the de facto public and community mental health system of the 21st century. The US correctional system is currently responsible for more than 10 times the number of mentally ill patients receiving treatment in state psychiatric hospitals, despite the fact that most state prison systems are neither clinically nor materially equipped to deliver effective or even adequate mental health care. Serious mental illness (SMI) is recognized as a major risk factor in incarceration and re-incarceration, and it is often those persons with serious mental illness (SMI) who are caught in a "revolving door" between limited or inadequate treatment while in prison and insufficient treatment and support in the community.

The findings that 23% of the 1998-2002 Utah State Prison population qualifies as seriously mentally ill has major implications for institutional policy and practice, including staff training, staffing models, prison-based treatment and programming and transitional services. Of equal significance is the rate that these offenders return to prison, and the costs of providing mandated treatment services as well as additional correctional management in an institution not primarily designed for these purposes.

Combining these findings with data provided by the Department of Corrections Bureau of Research and Planning on the average daily cost per inmate of incarceration in Utah State Prison, we can estimate the fiscal costs of the striking difference in recidivism rates between offenders with and without SMI. If the current rate of recidivism for offenders with SMI was simply brought to the same rate as all other offenders, the estimated savings would amount to over $5 million per year, or nearly $26 million during a 5 year period.

Additionally, our preliminary analyses of a subset of our SMI sample show important differences in the ways that men and women experience both SMI and risks related to reincarceration. For example, the most frequent ages of incarceration for women with SMI released from prison 1998-1999 are significantly older than related ages for SMI men, with a far greater range. The most frequent age of first incarceration for SMI women is 24 (8.2)%, with ages 31 (6.9%) and 33 (6.5%) close behind. Women with SMI are coming to prison for the first time at age when they are likely to have already become mothers (in 2000, the average age of Utah mothers at the birth of their first child was 23.3). With the second most frequent ages of incarceration at 31 and 33, this also means that many women in this group are likely to be mothers of small children and/or young families. These women are experiencing two extremely disruptive situations—mental illness and incarceration—when they are also responsible for raising children and maintaining families. It also means that these experiences are not affecting individuals, but dependent children and families. This has critical implications for treatment and transitional services.

II. Introduction to Problem

A. Increasing Numbers of Mentally Ill in Jails and Prisons

Prisons and jails have become the de facto public and community mental health system of the 21st century. According to the most recent US Department of Justice special report on the mental health status of US prison and jail inmates, over 700,000 report symptoms of mental disorder or a history of treatment for mental disorder in the past year[1]. Fifty six percent of state prisoners meet these criteria, with 43% reporting symptoms of mania, 23% reporting symptoms of major depression and 15% reporting psychotic symptoms such as hallucinations and delusions [1]. More than 75% of these individuals served time in prison or jail prior to their current sentence [1, 2]. In many US states, prison systems have become the primary providers of psychiatric and mental health treatment, outstripping the numbers served through state and local hospitals in a number of states including California, New York, Illinois, and Washington [2-6]. Researchers in the forensic mental health and public health fields have noted this latest "re-institutionalization" movement, a considerable shift of persons from state hospitals and community-based mental health services into local, state and federal penal institutions [2, 3, 5, 7-16].

The general trend toward the increased incarceration of individuals with mental illness is well cited in the scientific literature, particularly in terms of patterns of repeated incarceration and gaps in treatment that are theorized to lead to further decompensation, as well as the factors that drive this trend [7, 17-34]. The deinstitutionalization movement that began in the late 1970s and continued throughout the 1990s is perhaps the most widely cited factor that initiated this trend [4, 7, 16]. As increasing numbers of persons with mental illness were released from state hospitals, the community centers and clinics that were intended to provide services failed to fully materialize [9, 10]. Years later, the continued erosion of community psychiatric clinics, inpatient hospitals and outpatient

services due to underfunding, changes in reimbursement schedules and closures has created a situation in which persons with mental illness lack adequate medical and social support and are thus more likely to come under the purview of criminal justice systems [7, 20-22, 26-28, 35-37]. Changes in the legal system at the federal and state levels have also contributed to present conditions. The broadening of categories of illegal activities, including stricter drug laws, means that behaviors of persons with mental illness are more likely to meet criteria for criminality, or what some researchers have termed “the criminalization of mental illness” [38]. Additionally, the widening net of illegality has developed in tandem with determinate sentencing practices that have moved toward sentencing individuals for longer terms of incarceration [13].

B. Prisons as the “New Asylums”

This trend has recently been acknowledged as a burgeoning public health crisis with a number of profound clinical, legal, and ethical implications for those individuals who are among the most vulnerable members of US society [7, 12, 14, 17, 24, 39-43]. Corrections officials argue that jails and prisons lack the financial, clinical, and philosophical resources necessary to provide adequate treatment for this population, when their mandate is to maintain the safety and security of their institutions [44-45].

Mental health providers argue that prisons provide less-than-ideal conditions for adequate and effective mental health treatment [12, 15, 35, 46]. Treatment delivered within a prison setting is generally the minimum necessary to maintain order and safety within the prison population. The goals of prison mental health treatment are oriented toward security, management and population safety, with outcomes evaluated in terms of decreasing time and resources spent on inmate management [46-47]. Therefore, reduction in symptoms, overall severity of illness or suffering within individuals is not necessarily a primary focus of prison mental health intervention [48]. Only one in three state prisoners reporting symptoms or history of mental disorder receive treatment during

their incarceration [1] and this may be due to the fact that only those persons presenting the severest clinical symptoms or behavioral challenges to prison administration reach a critical level for services. A federal report released in 2001 indicates that 70% of state prisons perform intake screening for mental illness; 65% conduct psychiatric assessments, 71% provide some form of therapy or counseling by mental health professionals; 73% provide psychotropic medications and 66% assist prisoners being released to the community in accessing mental health services [2]. However, only 51% of state prisons provide 24 hour mental health care [1].

Lack of adequate treatment during incarceration is compounded by the fact that the vast majority of mentally ill prisoners (over 95%) will return to the community [2, 18], where adequacy and continuity of treatment is also extremely problematic [14, 24, 28, 38, 49, 50]. Due to the lack of community-based resources, for some mentally ill individuals prison may be the only place where they receive consistent treatment [17], and judges are now reporting a practice of sentencing mentally ill offenders to prison in the hope that they will receive at least psychopharmacological treatment [51]. This of course assumes that a particular institution has a system in place for the delivery of mental health treatment to prisoners, and that the system itself is adequate.

The intersection of prison incarceration and mental illness is also associated with homelessness, substance abuse, marked gender differences in rates of mental illness, and higher rates of recidivism [1, 12, 19, 39]. The US Bureau of Justice Statistics also reports the following: 13% of state prisoners with mental disorder reported being homeless in the year prior to incarceration; 74% reported alcohol or substance dependency or abuse; 77% of female state prisoners reported symptoms or history of mental disorder compared with 55% of male prisoners; and roughly 25% of state prisoners with symptoms of mental disorder had 3 or more prior incarcerations [1]. Further, just as the US

population as a whole is aging, so are the overlapping populations of prisoners and persons with mental illness. We do not yet know the full implications of this trend.

C. Incarceration and Recidivism in Offenders with Serious Mental Illness

Although a number of studies (including the US Bureau of Justice study) have examined these issues as they relate more generally to persons with symptoms of mental disorder or any Axis I diagnosis [9, 36, 52, 53], a smaller body of literature highlights the particular vulnerability of persons with serious mental illness (SMI). The increased incarceration of individuals with mental illness presents special problems for those persons with SMI, who are caught in a "revolving door" between limited or inadequate treatment during incarceration and insufficient treatment and support once released to the community [5,29, 31, 54].

Our study demonstrates that of those released from Utah State Prison 1998-2002, 23% meet criteria for SMI [2]. In 2003, there were 12 trained mental health professionals on staff to provide treatment for these prisoners, representing a prisoner-provider ratio of 177:1. Lack of treatment leads to continued or increased behaviors that are likely to lead to repeated episodes of re-incarceration [43]. Therefore, a significant segment of the SMI population most in need of consistent and effective mental health intervention fails to receive adequate support and treatment either in prison or in the community [17]. This lack of treatment is in turn associated with further decompensation [10, 11, 14, 17, 40, 41, 55, 56], drug and alcohol use [12, 18, 25, 50, 57] and, for a significant percentage of this population, incarceration [28-31, 33, 41, 52, 55, 58, 59].

Offenders with SMI are also at increased risk for ending up in "the prison's prison", or supermaximum security control units that enforce the most restrictive conditions of confinement in the correctional system [60, 61]. The number of state and federal prison control units has risen sharply in the past decade, where prisoners are locked in solitary cells at least twenty-three hours daily, isolated from the general prison population and

each other [13]. The explicit function of a control unit is to house those prisoners who are deemed too dangerous, disruptive, or unpredictable to live anywhere else. As supermaximum security prison control units proliferate, people diagnosed with SMI are increasingly housed in these units [10, 11, 60, 61]. The challenging behaviors associated with psychosis, self-injury and decompensation are seen as a threat to the safety and security of prison units [45, 60]. As a result of both actual and anticipated behaviors, individuals with SMI who enter a prison system are more likely to be directed into these units, especially if the prison system does not have a long-term residential unit for mentally ill offenders. Further, once there, the isolative conditions of the control units may lead to further decompensation and social debilitation [10, 14]. Our study of the Washington State prison system found that as many as 29% of prisoners living in control units met diagnostic and institutional criteria for SMI [60].

Researchers and clinicians who work in both correctional and public health sectors predict that this situation will likely continue or grow worse as the incarcerated population grows, and more persons with serious mental illness do not receive effective, consistent or adequate treatment [5, 9, 12, 25, 32, 41-43, 46, 49, 62]. However, relatively few studies have focused on criminal recidivism among specifically SMI offenders, and how these data relate to mental health treatment and services received both while incarcerated and after release.

D. SMI and Mental Health Disparities: Gender, Race and Reincarceration

In addition to becoming primary providers of mental health treatment for those with SMI in the US, prison mental health systems also often treat groups that are marginalized in other ways and who do not receive care anywhere else [17, 65]. Previous work points toward systematic effects of racial, ethnic and gender differences on rates of incarceration, and the overrepresentation of vulnerable groups in the US State prison population [62, 66]. People of racial and ethnic minority status and those who are poor represent a

disproportionate number of the US incarcerated population [4, 39, 67]. They also represent the subgroup of persons diagnosed with mental illness who are least likely to have access to or receive adequate mental health treatment [3, 12, 17, 20, 35]. The scientific literature base suggests that persons of minority demographic and lower socioeconomic status receive systematically inadequate mental health treatment, and are disproportionately burdened with clinically significant correlates of SMI [4, 62] This overlap means that a significant segment of the population most in need of consistent and effective mental health intervention, particularly those who are poor, are of ethnic and minority status, and are seriously, chronically mentally ill, fail to receive adequate support and treatment [12, 39, 65- 66].

Racial and Ethnic Distribution of Utah State Prisoners with SMI. As of May 2006, the Utah Department of Corrections incarcerated 5707 men and 570 women in its prison system, a total of 6,277 prisoners. The percentage of men is 90.92, while women represent 9.08% of the total prison population. The total percentage of persons of minority status is 35.78%, with men of minority status representing 33.6% and women of minority status representing 2.2%. These totals are further described by racial and ethnic categorization. Of male prisoners: 18% identified as Hispanic; 7.1% identified as African American; 4.3% identified as Native American/Alaskan Native; 2.8% identified as Asian/Pacific Islander and 67.4% identified as White. Of female prisoners: 14% identified as Hispanic; 5.3% identified as African American; 3% identified as Native American/Alaskan Native; 1.9% identified as Asian/Pacific Islander; and 75.8% identified as White.

Table 1 Gender, Racial, Ethnic Distribution of Utah Prisoners May 2006

Gender	Race	Count	Percentage of Prisoners
F	ASIAN/PACIFIC	11	0.18%
F	BLACK	30	0.48%
F	HISPANIC	80	1.27%
F	NATIVEAMER/ALASK	17	0.27%
F	WHITE	432	6.88%
M	ASIAN/PACIFIC	157	2.5%
M	BLACK	407	6.48%
M	HISPANIC	1025	16.33%
M	NATIVEAMER/ALASK	246	3.92%
M	UNKNOWN	27	0.43%
M	WHITE	3845	61.26%
Total Percentage Men	90.92%	Total Percentage Women	9.08%
Total Percentage Minority Men 33.58% Total Percentage Minority Women 2.2%			

Comparably, persons of racial and ethnic minority status comprise 15.6% of the total population of Utah. Persons of minority status are therefore significantly over-represented in the Utah State prison system (35.78%) as compared with community demographic data: 12% of Utah residents identify as members of racial or ethnic minority groups; 9% identify as Hispanic [2]. These numbers accord with nationwide data and show evidence of the claim individuals of minority status disproportionately interact with the criminal justice system burdens [67]. In our sample of persons with SMI paroled from Utah State Prison 1998-2002 (N = 1,965) 84.6% identified as White, 4.5% as African American, 0.4% as Asian, 1.8% as Native American or Alaskan Native, 0.2% as Pacific Islander and 9.8% as Hispanic.

Women Offenders and SMI. Women are the fastest growing segment of the incarcerated population [68]. The US Bureau of Justice Statistics (BJS) reported that in 2005, 95,096 women were incarcerated in state prisons, compared to 82,058 in 2001 and 57,263 in

1994 [69]. Women in State prisons have higher rates of mental health issues compared with male prisoners, with 73% of the female state prisoner population expressing symptoms of mental disorder, compared to 55% of the male population [1]. Further, in 1999 the BJS reported the highest frequency of mental illness among white women in State prison. In State facilities, approximately, 29% of white women, 22% of Hispanic women, and 20% of African American women were categorized as mentally ill [35].

In 2004, Utah ranked 35th in its female incarceration rate, with 42 female inmates per 100,000 female residents [70]. In 2006, 570 women were housed in Utah's State prisons compared with 30 women in 1977 [70]. While presently only 9% of prison inmates in Utah are women, this reflects a higher ratio than the national average, reported by the US Bureau of Justice to be 7.0% across US prisons in 2004 [67]. Although majority of the SMI population are men [69], women with mental disorders may [35] tend to fare worse than their male counterparts [69,71- 72], as services geared to offenders are not designed to recognize or accommodate gender-related differences. Women represent 24.3% of offenders with SMI paroled from Utah State Prison 1998-2002. Our study findings, reported below (p. 37) determined that 60% percent of these women were screened for mental illness as part of the prison admission process while 40% were not. Of those screened, 9% were flagged as positive for mental illness requiring follow-up evaluation. Further, 98% of those who received follow-up clinical evaluation were diagnosed as mentally ill. We found that 72% of women with SMI released from Utah State Prison between 1998 and 2002 returned within 36 months, nearly one and a half times the percentage for women without SMI (49%).

E. Summary Statement of Problem

Despite these stats and facts, a number of major issues related to SMI and (re)incarceration remain largely unexamined. First, although recidivism and repeated incarceration are described as significant problems, relatively little data exists that

compares rates for offenders with SMI with the general offender population [27, 29, 55, 63]. This lack of data and analysis persists despite the fact that recidivism rates are widely used throughout the US as markers of program success. Related discussion often fails to acknowledge how, as many persons with SMI are trapped in a cycle of repeated incarceration, the vast majority also repeatedly transition between prison and the community, and between prison-based and community-based mental health services. Over 95% of all US State prisoners will return to the community; in 2001 592,000 prisoners nation-wide were released to the community after serving time in prison [18, 58].

In Utah, between 1993 and 2000 an estimated 3000 mentally ill offenders received some form of psychiatric treatment while incarcerated. Until now, there has been no research completed on recidivism rates for these persons, despite data indicating that roughly 25% of US State prisoners with mental illness have returned to prison three or more times, compared to 20% for prisoners without mental illness. Further, very little research has systematically described how recidivism rates relate to prison and community-based mental health treatment and social services among those persons with serious mental illness released from prison. The present study aims to define and describe associations between serious mental illness and rates of prison return, with an ultimate aim of decreasing recidivism rates and improving continuity and effectiveness of care for this population.

III. Study Aims, Design, Methods

A. Study Aims

The question of whether there are significant differences in recidivism rates, defined by the Utah Department of Corrections as return to prison, was first raised by Utah State Prison mental health administrators and staff in 2001, when it was perceived that an increase in the number of mentally ill prisoners seemed to be taxing Prison resources while also demanding close attention in order to maintain institutional standards of safety, security and integrity.

This query begged further questions as to whether a distinct sub-group of prisoners with SMI exists in the Utah State Prison population, and what criteria should be used to identify this group. We believe we provide plausible answers to these questions here.

The immediate goal of the preliminary research reported here is to better understand and describe associations among serious mental illness and recidivism rates for persons released from Utah State Prison. The specific aims of the proposed study are: 1) To calculate recidivism rates among persons with SMI released from Utah State Prison system as compared with non-SMIs; 2) To explore the relationship of recidivism rates to patterns of mental health treatment delivered both in prison and in the community; 3) To identify those features which offenders with SMI who successfully transition back the community describe as the most salient supports and challenges to remaining out of prison.

One long-term goal of this research will be to develop a model of community survival time that shows which mental health and substance abuse treatment factors and social services, and in what combinations, contribute to lengthening community survival time for persons with SMI released from prison. Further, this model could be used to analyze how the relative contributions of these factors differ from state to state, and how this reflects philosophical and practical differences in legislation, policy and treatment.

B. Study Design

This is a multiple-methods study integrating statistical and textual analysis of secondary and primary data. Specific methods include records review, research interviewing, descriptive statistics, and the advanced statistical techniques of survival analysis and latent class analysis. This study is planned in three phases. Phase 1 is now complete, and has focused on applying the study algorithm identifying cases of SMI among all persons released from Utah State Prison between 1998 and 2002. Once these cases were identified we conducted survival analyses to compare rates of recidivism for our SMI sample with all other released in the study period. This report will focus on our Phase 1 results.

Phase 2 of the study will integrate and analyze secondary study data from UDC, community mental health agencies, the Utah Department of Human Services, and local agencies providing social and treatment services. UDC has helped us gain direct research access to O-Track and their archived medical databases, through which we are conducting a manual retrospective record review for all study cases to gather data related to demographics, prison career, and mental health treatment during incarceration. The various state and local agencies who have agreed to support this study will provide study data for each SMI case on community mental health and substance abuse treatment and social services received while residing in the community. These data will be compiled, reduced and statistically analyzed for their relative effects on community survival time in this population.

In Phase 3, a sample of 30 SMI participants who have successfully transitioned back to the community from prison will be solicited for interviews. These semi-structured interviews will focus on participants' perceptions of supports and challenges to remaining out of prison. Interview data will be content and thematically analyzed and integrated with statistical findings, to enrich and inform statistical findings.

C. Methods Used in Preliminary Study

In this section we briefly describe the process through which we completed Phase 1 of this study and met our first study aim, to calculate recidivism rates among persons with SMI released from Utah State Prison system as compared with those without SMI. This section is intended to provide detail to other researchers and statisticians interested in how these results were achieved.

Sample selection. Our initial sample consisted of every release from Utah State Prison system between 1/1/1998 and 12/31/2002. This five year timeframe was chosen for two reasons. First, it provided enough cases to ensure our ability to detect significant differences given the large number of variables involved in the study. Second, a 2002 cut-off provided enough follow-up time for those released in 2002 to progress through new charges and convictions so we could have a natural cut-off point for related data (i.e. crime of conviction for return to prison for cases released in 12/2002). We excluded those cases that did not result in actual meaningful release from prison (release to custody, unsuccessful discharge, death). This initial sample consisted of 14,621 actual events of meaningful release, or 9,245 unique cases by individuals.

Identification of SMI. We generally define SMI as a major thought disorder, mood disorder, or organic brain syndrome that fits well-established DSM-IV categories, substantially impairs functioning, and requires treatment. Our study inclusion criteria adapted and applied a previously published algorithm developed in earlier Washington State studies of rates of SMI in the State prison population [60].

Our study criteria for SMI reflects this definition and is based on both clinical and practical indicators utilized within the DOC system and cut-off points for mandated services recognized in both the correctional and public health sectors. This algorithm therefore uses a practical and operational approach to defining serious mental illness. Conceptual and operational definitions based on both clinical factors and data related to

prison management and resource demand are combined in order to triangulate data on indicators of SMI. This algorithm is explained in detail below.

Survival analysis. This method of analysis allowed us to calculate the predictive power of various factors (SMI vs. non-SMI, gender, race, ethnicity, criminal code, degree, etc.) on the length of time between meaningful release form prison and return. For these preliminary analyses, we used actual return to prison (date of physical return) as the outcome variable. While we recognize that there are numerous ways to define an event of recidivism, this is the definition of recidivism most frequently used by the UDC Bureau of Research and Planning in their own studies, and therefore our results are directly comparable to data and analyses already in use by the Department.

We conducted survival analyses by event rather than by individual, allowing for multiple events per subject. This approach is consistent with previous literature using survival analyses to calculate recidivism rates. Our survival analysis included all cases of release to parole between January 1, 1998 and December 31, 2002 (N = 14,621 events). The survival event (recidivism) was determined by a subject's return to prison either by parole violation or new offense. Multiple events were allowed per subject, and time out pf prison was measured in days. The rates of recidivism between the SMI and non-SMI groups were compared by survival analysis, conducted with Statistical Package for the Social Sciences (SPSS, 14.0 for windows).

We compared SMI and non-SMI, as well as release to parole and all other meaningful release. We also compared these groups' survival time. The length of the analysis period was three years (1095 days) from each subject's date of release from prison. This censor point is again consistent with the three-year cut-off point used by the UDC Bureau of Research and Planning in their calculation and interpretation of recidivism rates. Subjects that did not return to prison in the three-year time period were deemed non-returnees; they were handled as censored data. There were 4,192 cases of censored

data (34.3%). Finally, for the purposes of a clean comparison we extracted our SMI sample cases from all cases of release from Utah State Prison 1998-2002 and recalculated recidivism rates for non-SMIs by year and across the 5 year study period.

Latent Class Analysis. As part of this study, we tested the feasibility of using summary indicators of serious mental illness, based directly on prison data, to develop a meaningful index of severity (i.e. an ordinal measure of how symptomatic and resource intensive individual cases are). These data were synthesized into an ordinal measure of severity of illness, an ISMIS score, based on a 0-6 ordinal measure of summary indicators.

To test the validity of the index we used M Plus software to perform Latent Class Analysis as a confirmatory cluster analysis, based on summary indicators of prison mental health data on diagnoses, symptoms, psychotropic medication, mental health acute and residential housing collected for all cases of SMI in the 1998-1999 Utah State Prison population (N = 1,074) (see Table X below for description of data). LCA results indicated a 4 class solution fit well (χ^2 (964) = 705.74, p = 1.00). The BIC statistic decreased with each model, minimized with the 4 class model, and then increased with a 5 class solution. Therefore the results of the 4 class model are reported below.

Other analyses. In addition to conducting survival analysis, we also calculated simple descriptive statistics and performed simple statistical comparisons (t-tests and chi square tests) between the SMI group and the non-SMI group for significant differences.

IV. Major Study Findings

A. Time to Return to Prison for Offender with SMI Compared with non-SMI

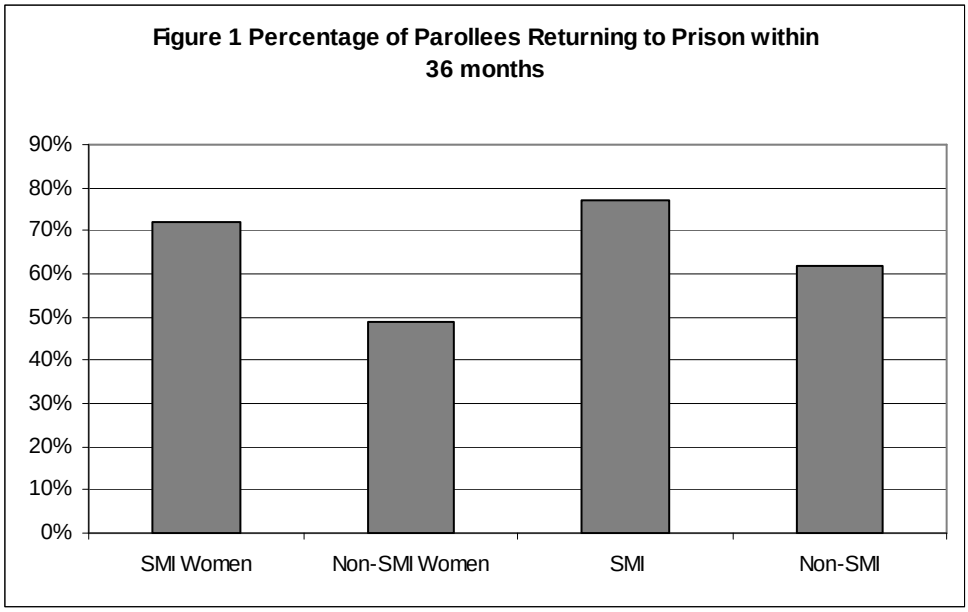
In section B, beginning on p. 24 below, we explain how we identified a distinct group of 2,127 offenders with SMI in the population of offenders released from Utah State Prison between 1/1/1998 and 12/31/2002. Based on this systematic identification, we were able to then calculate recidivism rates for this group as compared with all others released in the same timeframe. Again, the SMI group we identified is significantly different from the non-SMI group by factors related to mental illness (psychotropic medication use, acute and long-term mental health related housing, psychiatric diagnosis) but not by demographics, offense category, type or degree, or condition of return (technical versus new commitment), other than the findings that women were overrepresented in the SMI group, while people of Hispanic origin were underrepresented.

As described in the methods section, we performed survival analyses on these data, comparing SMI and non-SMI groups. Further, we compared SMI and non-SMI parolees in a separate analysis.

Recidivism Rates for SMI vs Non-SMI Parolees. Most of the cases of 1998-2002 prison release in the SMI sample were release to parole (87% of women with SMI and 84% of men with SMI). Overall, recidivism rates for both women and men are higher in Utah than the national average, due in part to stricter and more intensive monitoring of parolees than might be practicable in states with larger offender populations. Our analysis examines 14,621 events of return to prison in the 5 year study timeframe, distributed over 9, 425 people. Of these total events of return to prison, 84% of the return events for offenders with SMI and 80% of events for all other offenders represent return to prison after parole. For these reasons we began our comparison with parolees.

For 1998-2002, the average percentage of men and women with SMI released to parole who returned to prison within 36 months of release was 77%, compared with 62%

for non-SMI men and women. Analyzing the women's data separately, 72% of women with SMI released from Utah State Prison between 1998 and 2002 returned within 36 months, nearly one and a half times the percentage for women without SMI (49%).



When comparing the number of days from prison release to return to prison for parolees 1998-2002, the SMI group had a significantly shorter median return to prison time than the non-SMI group—306 compared with 493 days, a very statistically significant finding (Kaplan-Meier survival analysis, χ^2 (1) = 270.77, p<.001). In short, parolees with SMI return to prison an average of 200 sooner than all other parolees.

Recidivism Rates for all SMI vs Non-SMI Offenders. When comparing all offenders (not just parolees) this difference jumps strikingly: The median time for all SMI offenders to return to prison was 385 days versus 743 for all non-SMI offenders, over 350 days sooner (χ^2 (1) = 276.46, p < .001).

Figure 2 Cumulative Probability of Staying Out of Prison SMI vs. Non-SMI

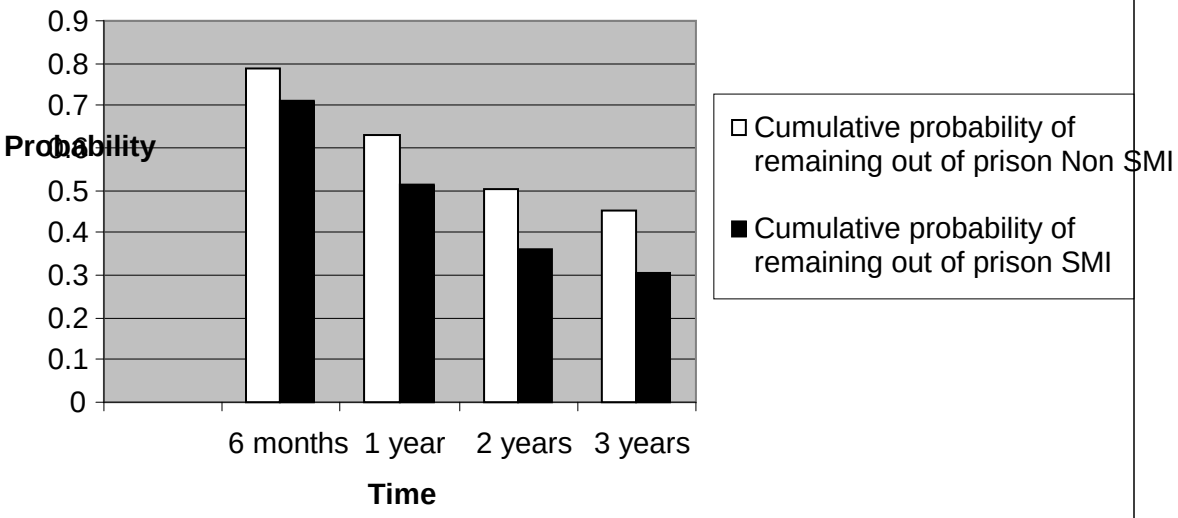
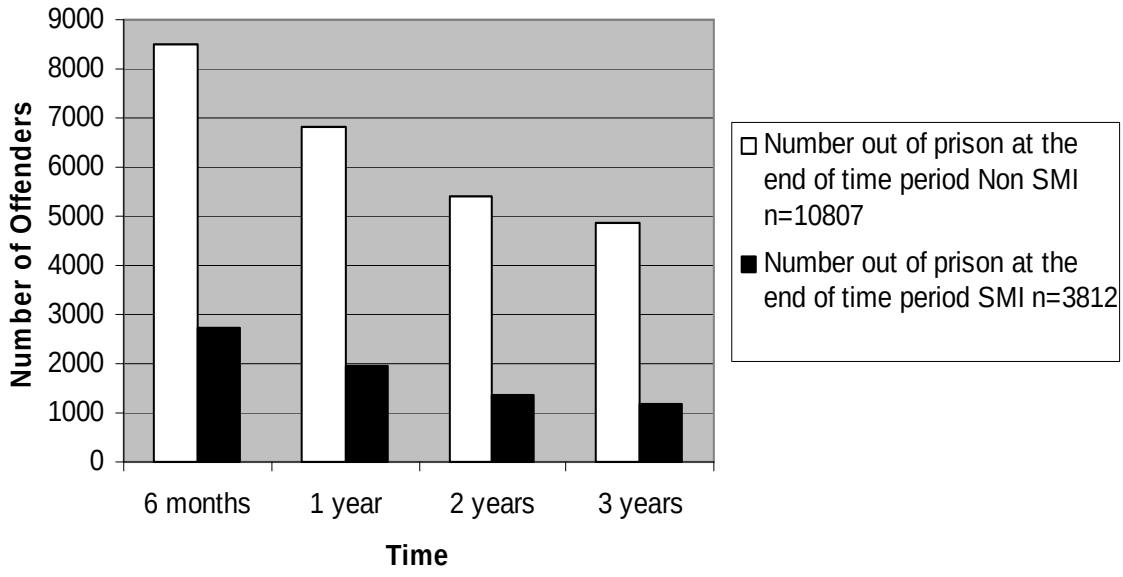


Figure 3 Number Staying Out of Prison



To emphasize the difference in recidivism rates for SMI vs. non-SMI offenders both released to parole and in all instances of meaningful release, the differences are summarized here:

Table 2 Number of Days Difference in Median Time* to Return to Prison

SMI vs. Non-SMI

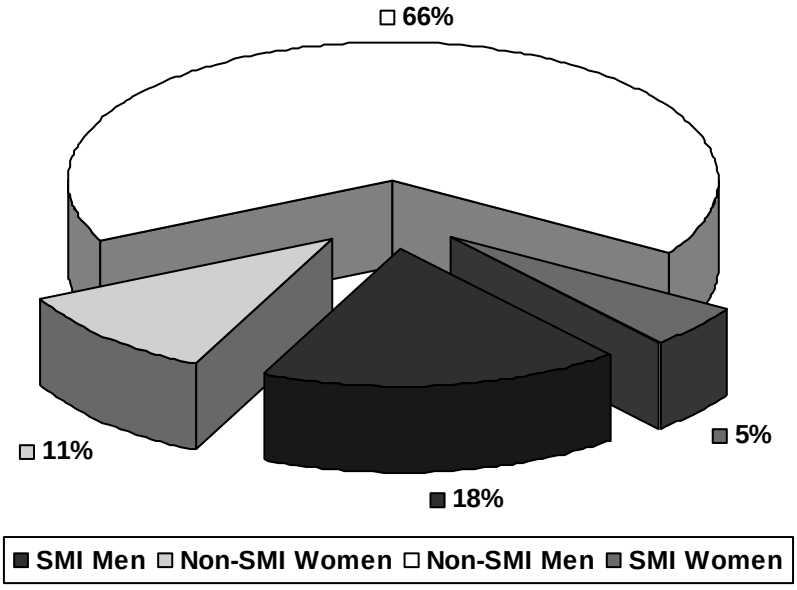
Condition of Release	Median Days to Prison Return: Non SMI	Median Days to Prison Return: SMI	**Difference in Days**
Parole	493	306	**187**
All Other	743	385	**358**

*The values reported here are median times (not average) because median time is what is used in survival analysis in the calculation of survival function.

B. Identification of Offenders with Serious Mental Illness

Identification of SMI Population and SMI Criteria. One of the most important results of this preliminary study, and a necessary first step to the recidivism analysis just reported, includes the identification of a distinct subgroup of offenders with SMI released from Utah State Prison 1998-2002. Among all offenders released from Utah State Prison 1998-2002 (N = 9,245 individuals and 14,652 events of actual release) we identified a subpopulation of 2,127 prisoners (23%) who met study criteria for SMI. In terms of percentages, men without SMI comprised 66% of this population, while women without SMI comprised 11%; men with SMI represented 18% of the population and women 5%.

Figure 4 Prisoners Released from Utah State Prison 1998-2002 (N=9,245)



We also found that this SMI group is significantly different from the non-SMI group on factors related to mental illness (psychotropic medication use, acute and long-term mental health related housing, psychiatric diagnosis). However, the SMI group does not systematically differ from the non-SMI group by demographics, offense category, type or degree, or condition of return (technical versus new commitment) with two exceptions: Based on expected counts, Caucasian women are overrepresented in the SMI group while

Hispanic persons are underrepresented (statistical significance levels of p> 0.001). In short, it appears that what distinguished this group so strikingly (with very high statistical levels of significance) are factors related to mental illness, not those related to criminal, sentencing or release history or other demographic factors aside from the 2 mentioned here. These findings certainly bear further investigation, but we believe such investigation is unlikely to refute the contribution of SMI factors in defining this group as a distinct subgroup within the prison population.

The selection criteria for SMI included a positive history, according to prison data recorded in both O-Track and electronic medical records, for two out of three of the following:

- A qualifying DSM-IV diagnosis [Schizophrenia (all 295s except 295.4 and 295.7), Schizoaffective Disorder (295.7), Psychosis NOS (298.9), Bipolar Disorders I and II (296, 296.4, 296.5, 296.6, 296.7, 296.89). Major Depression (296.2, 296.3), Mood Disorder NOS (296.9), Organic Brain Syndromes and Dementia (293.8, 293.9, 294) and Borderline Personality Disorder (301.83)]
- More than 30 days of significant mental health housing (long term and acute); includes both infirmary admits related to psychiatric events such as self-harm or suicide attempts as well as longer term residential housing in mental health units
- A history of qualifying psychotropic medication use; includes all antipsychotics, antidepressants, mood stabilizers and anticonvulsants currently used in psychiatric treatment (does not include psychiatric medications prescribed solely for sleep)

Based on these criteria, results indicate the existence of a distinct group of male and female offenders with SMI among the Utah State Prison population.

Table 3 Initial Algorithm for SMI Status and Study Inclusion

Indicator	Description	Data Source
Qualifying Axis 1 Psychiatric Diagnosis*	Inmate evaluated and assigned Axis 1 diagnosis by mental health professional; Qualifying diagnoses include schizophrenia, schizoaffective disorder, bipolar disorder, major depression, borderline personality disorder, psychosis NOS	Prison archived electronic medical database
Prescription of Qualifying Psychotropic Medication**	Record of prescription and use of qualifying psychotropic medications including antipsychotics, mood stabilizers and antidepressants	Prison archived electronic medical database
Mental Health Related Housing	30 ≥ days in residential mental health unit and/or mental health-related infirmary housing	Prison O-Track electronic database
Note: Cases must be positive for 2 out of 3 of these selection criteria to be included in initial SMI study sample		

*Qualifying diagnoses as assigned by psychiatric and/or psychological evaluation include: schizophrenia, schizoaffective disorder, psychosis NOS, organic brain disorder, dementia, borderline personality disorder **Qualifying psychotropic meds prescribed include antipsychotics, mood stabilizers, antidepressants, and anticonvulsants

Description of SMI Offender Population**.** The following items provide demographic and descriptive data for two samples used in this study: our entire SMI sample (N = 2,127) and a subset of this sample for which research staff have already completed detailed prison records reviews (N = 1,074).

Table 4 Distribution of SMI Sample by Racial and Ethnic Categories

Racial/Ethnic Category	Count	Percent
ASIAN	9	.4
BLACK	98	4.6
CAUCASIAN	1797	84.5
HISPANIC BLACK	8	.4
HISPANIC CAUCASIAN	162	7.6
HISPANIC NATIVE INDN	8	.4
NATIVE AMER/ALASKAN	41	1.9
PACIFIC ISLANDER	3	.1
UNKNOWN	1	.0
Total	2127	100.0

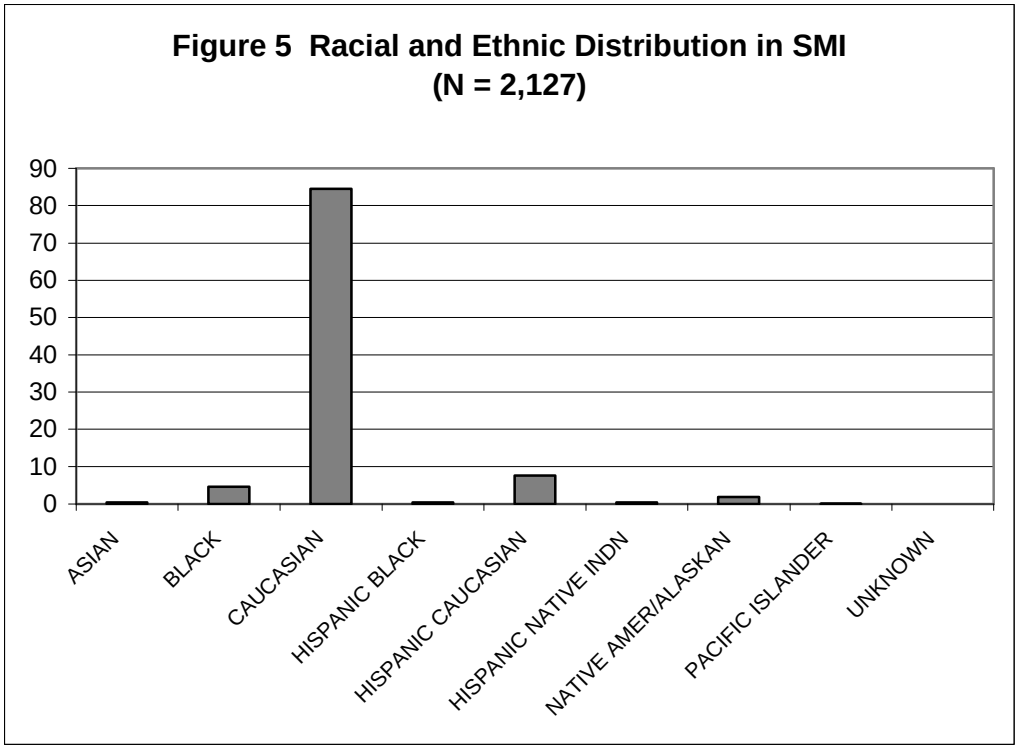
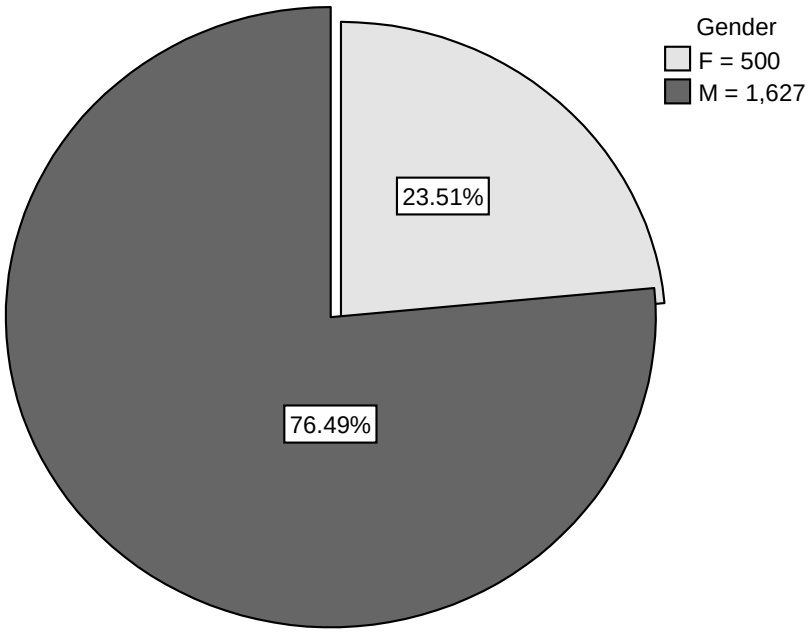


Figure 6 Distribution of SMI Sample by Gender



Data on psychiatric disorders was collected through individual prison medical chart reviews, and includes both DSM-IV Axis I and II diagnoses for major mental illness and

personality disorders made on multiple dates by qualified psychiatric clinicians. These data will eventually be collected for the entire SMI sample. The average number of Axis I psychiatric diagnoses recorded in medical charts was 1.19, with some offenders receiving up to 4 different diagnoses in the course of prison treatment. Further, despite widely accepted expectations of the high prevalence of antisocial personality disorder (ASPD) in prison settings, this Axis II diagnosis was not common in the charts we reviewed. This perhaps reflects the fact that while ASPD is seen as a major risk factor for incarceration and a ubiquitous aspect of prison populations, its has less clinical relevance in the treatment of mental illness in this setting than other symptoms and patterns of disorder.

Note that diagnoses related to substance abuse or dependence, while officially part of the DSM-IV Axis I mental illness category, are not being recorded in prison records as psychiatric diagnoses for this population. This therefore grossly under represents the number of offenders who are diagnosed with both SMI and substance abuse or dependence disorders. While epidemiological data on rates of dual diagnosis with both SMI and substance use disorders can vary widely according to criteria and setting, SAMHSA reports that in 2002, 4.0 million US adults with SMI had a co-occurring substance use disorder, representing 23.2 percent of all adults with SMI and 20.4 percent of all adults with a substance use disorder (cite).

Table 5 Psychiatric Diagnoses for Offenders with SMI Released 1998-1999 (N = 1,074)

Axis I Diagnosis	Count	Percent
Schizophrenia (all 295s except 295.4 and 295.7)	101	9.4%
Schizoaffective Disorder (295.7) and Psychosis NOS (298.9)	67	6.2%
Bipolar I and II (296, 296.4, 296.5, 296.6, 296.7, 296.89)	234	21.85%
Major Depression (296.2, 296.3)	822	76.5%
Mood Disorder NOS (296.9)	20	1/9%
Organic Brain Syndromes, Dementia (293.8, 293.9, 294)	16	1.5%
Substance Abuse or Dependence	1	0.84%
Other Axis I Major Mental Disorders (Including Anxiety, PTSD)	58	5.4%
Borderline Personality Disorder	96	8.9%
Other Axis II Personality Disorders Including Antisocial PD)	11	1%

Table 6 Previous Incarcerations, Months Served and Admits to Infirmary or Mental Health Housing for Offenders with SMI Released 1998-1999 (N = 1,079)

Variable	Range	Average
Previous months in state prison	2-235	52
Number of releases prior to 1/1/1998	1-5	2
Total number of mental health-related infirmary admits	0-99	1
Total number of admits to mental health housing	0-2500	54

Index of Serious Mental Illness Severity. We also aimed to develop a useful index of serious mental illness severity (ISMIS) based on prison data related to symptoms and treatment, and to test this index by comparing numerical scores for severity with a more qualitative picture of clinical presentation. We wanted to see whether clinically distinct classes of prisoners with SMI emerged from prison treatment and management data, and whether these classes represented meaningful differences in illness severity as evidenced by use of medication, special housing and acute intervention needs, diagnoses, and symptoms. Such an index, based on readily available data generated in the course of prison treatment and prisoner management, could a be more contextual, situation-sensitive and practical estimate of SMI severity and institutional impact than psychometric measures that are more costly, require advanced credentials to administer and interpret, and are normed on clinical populations in therapeutic settings.

To develop the index, we used summary indicators of illness severity based on prison mental health data on diagnoses, symptoms, patterns of psychotropic medication use, and mental health acute and residential housing collected for all cases of SMI in the 1998-1999 Utah State Prison population (N = 1,074) (see Table X for description of data). These data, gathered through individual records review for all cases, were synthesized into an overall measure of severity of illness, generating a 0-6 score based on summary indicators (a score of 0 represents lack of evidence of SMI, and a score of 6 represents much evidence of extreme disorder).

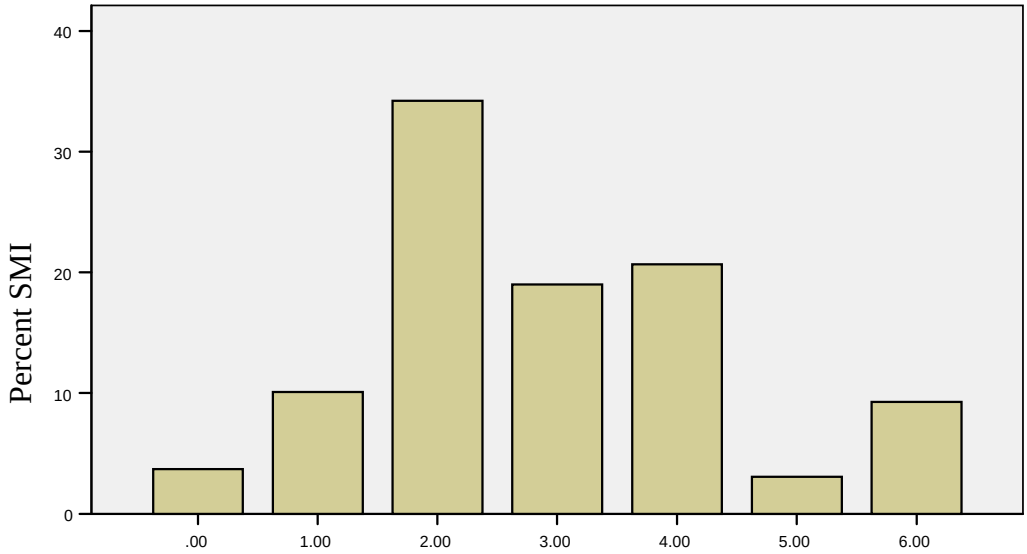
Table 7 Index of Serious Mental Illness Severity (ISMIS) Algorithm

Variable	Description
Behavioral Evidence	Chart indicates hallucinations, delusions, poor hygiene, disorganization, mania, self-isolation, smearing, compulsive behaviors or antipsychotics or mood stabilizers
SMI Diagnosed*	SMI diagnosis confirmed by provider evaluation
Residency + Medication**	Positive for both >30 days of mental health residency and > sporadic pattern of qualifying medication use
Residency + Diagnosis	Positive for >30 days mental health residency and qualifying diagnosis
Diagnosis + Medication	Positive for qualifying diagnosis and > sporadic pattern of qualifying medication use
Steady Medication	Pattern of continuous use of qualifying medications
Summary of SMI Indicators	Summary score based on previous 6 indicators (0-6); Indicates pattern of positive behavioral, housing, medication and diagnostic data in chart

*Qualifying diagnoses as assigned by psychiatric and/or psychological evaluation include: schizophrenia, schizoaffective disorder, psychosis NOS, organic brain disorder, dementia, borderline personality disorder**Combines data on type of psychotropic meds prescribed alone and in combination (0 = none, 1 = antipsychotic, 2 = mood stabilizers, 4 = antidepressants, 8 = anticonvulsants and data on pattern of use (0 = none, 1 = sporadic, 2 = discontinuous, 3 = steady

Computation of severity of serious mental illness scores based on summary indicators indeed showed a range of severity in this sample from 0-6. This demonstrated variability and a reasonably normal distribution curve within the SMI sample on severity scores, indicating that this index is working reasonably well to identify a range of illness severity in the SMI population. The mean score was 2.9.

Figure 7 Distribution of Severity of Serious Mental Illness Scores (N = 1,074)



We ran another survival analysis based on severity score (N = 1,074) and found that higher severity score were predictive of shorter time out in community after prison release. Severity scores were significantly negatively associated with community survival time. That is, offenders appearing to have more or more severe levels of indicators of serious mental illness, based on the criteria outlined in Table 7 above, returned to prison more quickly than persons who had fewer or less severe levels, and therefore lower severity scores.

Classes of SMI. Our confirmatory analysis of index of illness severity scores used latent class analysis based on prison mental health data before these data were summarized to compute severity scores. Latent Class Analysis (LCA) is a statistical method for finding subtypes of related cases (latent classes) from multiple variables and classificatory data, often used in clinical and social-behavioral research to find distinct diagnostic categories given the presence or absence of several key symptoms [cite]. In this study, we used it to

find whether there were distinct subtypes of Utah offenders with SMI, based on the prison data collected and severity scores generated for each case (Table x, above). Again, for each of these operations, prison record review data from a 1998-1999 subset of our SMI sample was used (N = 1,079). We intend to perform these same analysis again when we have reviewed records and collected data for all cases 1998-2002 (N = 2,127 records).

This analysis produced 4 distinct classes of offenders with SMI, with probabilities assigned to the likelihood of members of each class being positive or negative on our SMI indicators. Next, the average index of severity score for each class was compared with analysis of variance (ANOVA). Results showed a significant difference between all 4 classes in severity of mental illness scores [$F(3, 1074) = 452.073$, $p < .001$]. Table 8 presents the 4 classes in terms of their likelihood to show evidence of the summary SMI indicators used in the study, as well as their average index of severity score.

Table 8 Four Classes of Serious Mental Illness Based on SMI Indicators for Offenders Released 1998-1999 (N = 1,079)

SMI Indicator	Class 1 (N = 290)	Class 2 (N = 206)	Class 3 (N = 530)	Class 4 (N = 52)
Percent of 1998-1999 sub- sample	27%	19%	49%	5%
Evidence of psychotic illness in chart	Yes*	Yes*	No	No
Mental health housing	No**	No*	No	No
Pattern of at least discontinuous or steady psychotropic medication use	Yes*	Yes*	Yes	No
SMI Diagnosed	Yes*	Yes*	Yes*	No
History of antipsychotics	Yes*	No	No	No
History of antidepressants	Yes	Yes	Yes*	Yes**
History of mood stabilizers	No	Yes*	No	No
History of anticonvulsants used as mood stabilizers	No	No	No	No
Class average severity of serious mental illness score (0-6 possible)	4.3***	3.6***	2.1	0.38

* An asterix indicates a statistically near or perfect probability (0.9-1.0) of members of the class being positive indicator.
** Probabilities of being positive of negative for these indicators were closely split for this class.
*** Severity of serious mental illness score higher than sample average of 2.9

In summary, we found 4 distinct classes in our SMI group. Please note that these results and the analysis are tentative as we continue to work with and add to these data. However, provisional clinical interpretation of the 4 class solution is interesting, and indicates the following qualitative patterns for each Class:

- Class 1 members (27%) had significant behavioral evidence of mental illness in their charts, including evidence of hallucinations, mania, self-harming behaviors and gross disorganization. Members of this class were highly likely to have a history of steady, long term antipsychotic medication use. This was also the class with greatest likelihood of a positive history of residency in mental health units (0.43 percent positive probability on the housing indicator, compared with only .048 - .096 probabilities for Classes 2-4). The average severity of serious mental illness score for this class was 4.3, higher than the SMI sample average. The overall clinical impression of this class is one of more severe psychotic and disorganized symptoms requiring long-term, close clinical management.
- Class 2 members (19%) also showed significant evidence of psychotic and/or disorganized behaviors. Members of this class were likely to be taking either anti-depressants and/or mood stabilizing medication on a regular basis, and to be clinically managed outside of residential mental health housing. This group had an average severity of serious mental illness score of 3.6, also higher than the overall average. The overall clinical impression of this class is that of mood disorder with significant psychotic and behavioral features.
- Class 3 members (49%) were likely to be taking antidepressant medication in either a steady or a discontinuous fashion. Members of this class did not evince significant evidence of psychotic symptoms, but recognized by clinicians as

SMI and clinically managed outside of mental health residential housing. The severity of serious mental illness average score for this class is 2.1, just below the sample average. The overall clinical impression of this class is that of major depressive disorder, with predominantly vegetative and cognitive symptoms. This is by far the largest class, with 530 cases.

- Class 4 members (5%) showed significant evidence of psychotic symptoms, and had patterns of limited or discontinuous use of antidepressant medication. The average severity score for this group is 0.38, well below the SMI sample average. While members assigned to this class showed enough evidence of SMI to be included in the sample in our preliminary studies, compared with cases in the other classes this class seems to present a less symptomatic and resource-intensive group. The general clinical impression seems to be one of moderate anxious and depressive symptoms serious enough to warrant treatment, but not as severe as those psychotic and mood symptoms evidenced in the other classes. This is by far the smallest class, with only 52 cases.

C. Special Issues for Women Offenders with SMI

The information reported in this section was recently published in Utah's Health: An Annual Review Volume 12: Special Supplement on Women's Health in Utah (full report available at http://uuhsc.utah.edu/coe/womenshealth).

Descriptive Statistics and Incarceration Patterns 1998-1999. The descriptive statistics reported in this and the next section were generated from a sub-sample of women offenders with SMI who were released from Utah State Prison 1998-1999 (N = 246). Of these women, 226 were identified as White (92%), 11 as African American (4.5 %), 1 as Asian (0.4%), 1 as Pacific Islander (0.4%), and 5 as Alaskan Native (3.3 %). Fourteen percent of this sub-sample was identified as Hispanic, while 86% were not.

The average and median age of first incarceration in state prison for women with SMI was 30 years of age, with a range from 17 to 61. However, the frequency distribution for age of first incarceration had a distinct bimodal pattern, with age of first admission clustering in both the mid-twenties and the early to mid-thirties (Figure 8). The most frequent age of first incarceration in our sample was 24 (20 women or 8.2%) and the next most frequent was 31 (6.9%) with 33 (6.5%) and 34 (6.1%) close behind. For male offenders with SMI released from prison 1998-1999 the average age of first incarceration was younger, with an average age of first incarceration at 28, and most first incarcerations occurring between 19 and 21 years of age (Figure 9). The most frequent ages of first incarceration for males was 19 (7.7%) followed by 21 (7.5%).

Figure 8 Age of First Incarceration in Utah State Prison for Women with SMI 1998-1999

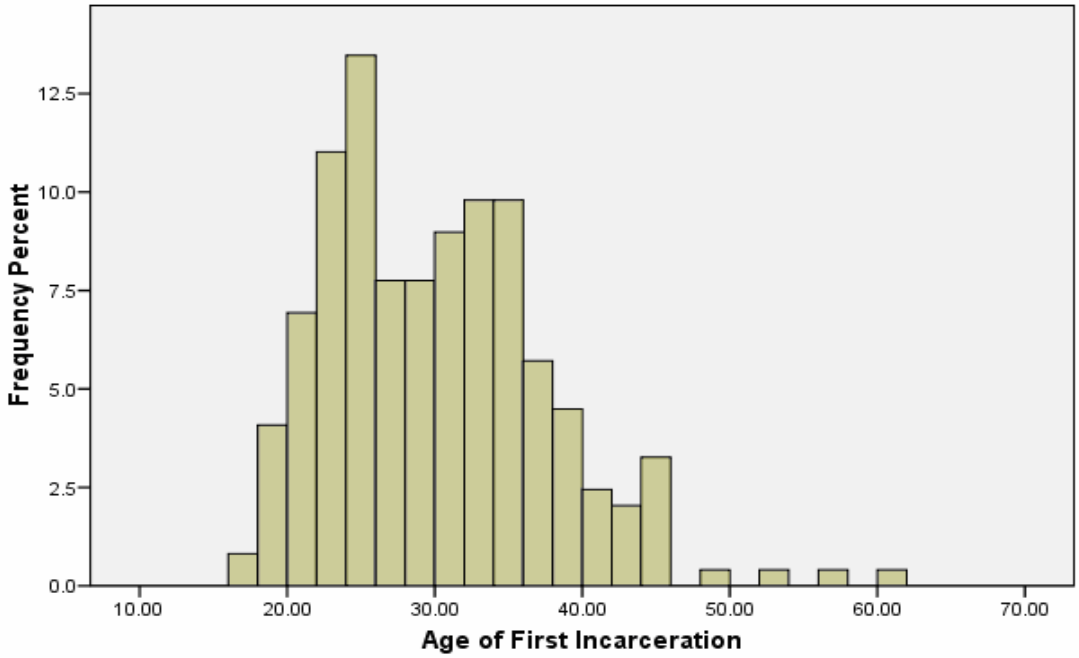
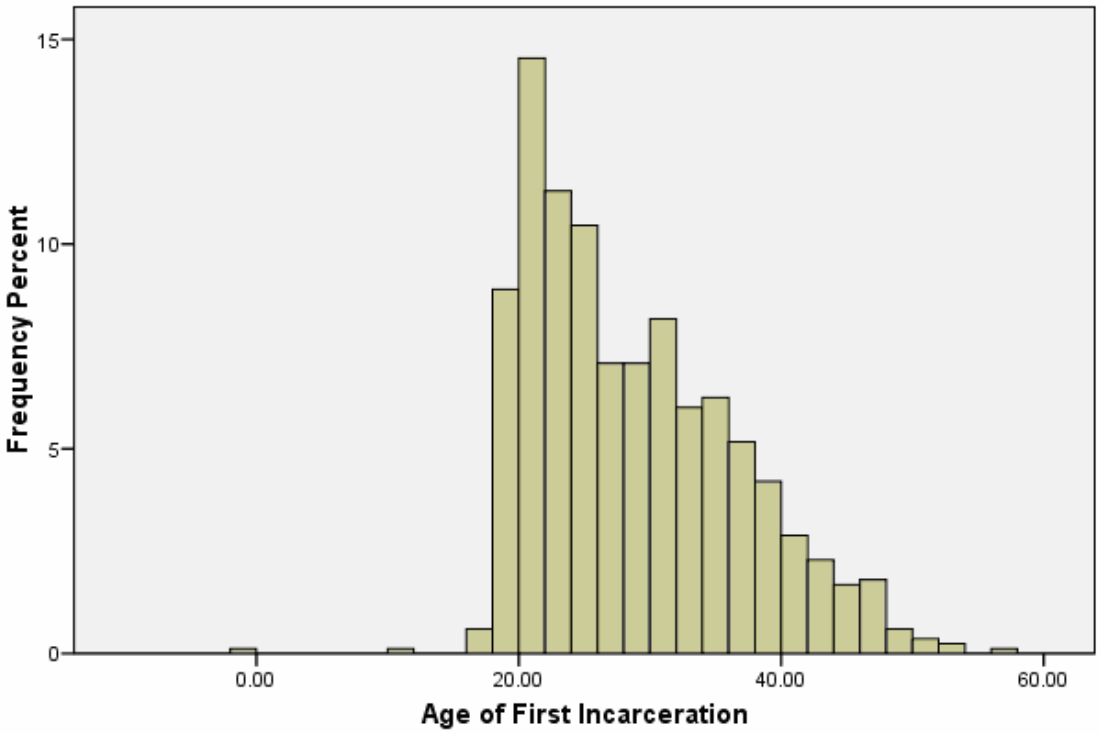


Figure 9 Age of First Incarceration in Utah State Prison for Men with SMI Released 1998-1999



Psychiatric Diagnoses and Symptoms. In addition to collecting data related to demographics, incarceration patterns and recidivism, we also collected data related to psychiatric diagnoses, symptoms and treatment for women with SMI in our 1998-1999 sub-sample:

- Sixty percent of women prisoners with SMI were screened for mental illness as part of the prison admission process while 40% were not.
- Of those screened, 9% were flagged as positive for mental illness requiring follow-up evaluation.
- 98% of those who received follow-up clinical evaluation were diagnosed as mentally ill.
- By far, the most common DSM-IV psychiatric diagnosis of these women is Major Depressive Disorder, with 144 or 59% of women in our sample having this diagnosis recorded in their prison medical charts.
- The second most common psychiatric diagnosis in this sample was Bipolar Disorder (55 women or 22%).
- Finally, individual chart reviews for all women with SMI showed that in 44% of charts, staff had recorded significant symptoms of serious mental illness such as mania, hallucinations, delusions, disorganization, self-isolation, poor hygiene and compulsive behaviors.

Alcohol and/or Drug Related and Violent Offenses. Across the US, the crimes for which women are primarily incarcerated are alcohol and drug-related offenses. A 1999 Bureau of Justice Special Report on women offenders states that 1 in 3 women are incarcerated for a drug-related crime, and roughly 50% of women imprisoned in State prisons were under the influence of drugs or alcohol at the time of their offense [73]. A Utah Commission on Criminal and Juvenile Justice Study (CCJJ) report filed in 2006 found that 62.5% of Utah women are incarcerated for a drug- related offense, and 77.6% of women committed their

crime while under the influence of alcohol or drugs [74]. When examining the data related to primary offense for our sample of women prisoners with SMI, we found the following:

- For the five year period 1998-2002, the average percentage of women parolees with both SMI and an alcohol and drug related primary offense was 56%, compared with 63% for women parolees without SMI, 29% for men parolees with SMI, and 38% for men parolees without SMI
- Thus percentages of alcohol and/or drug related primary offenses are high for both SMI and non-SMI women when compared with the male population.
- During 1998-2002, the average percentage of women parolees with SMI and violent offenses was 11%, compared with 8% for women without SMI.
- The difference in percentages of women parolees both with and without SMI who committed violent offenses is notable, when compared with male parolees, with average percentages of 32% (SMI) and 28% (non-SMI), respectively.

Table 9 Percentage of Parolees with Alcohol or Drug Related or Violent Offenses

	% Alcohol/Drug Offense	% Violent Offense
Females with SMI	**56%**	**11%**
Non SMI Females	**63%**	**8%**
Males with SMI	**29%**	**32%**
Non-SMI Males	**38%**	**28%**
Total SMI	**36%**	**27%**
Total Non-SMI	**40%**	**27%**

V. Discussion: Implications of Findings

This report focuses on results from one year of preliminary work and the first stage in a program of research examining the effects of prison-based and community-based mental health treatment on the length of time that offenders with serious mental illness (SMI) in Utah State remain out of prison. Significant results of this pilot study include:

1) The identification of a distinct subgroup of offenders with SMI released from Utah State Prison 1998-2002;
2) The findings that offenders with SMI return to prison much more quickly and in greater numbers than non-SMI offenders;
3) The finding that women are over-represented in the SMI group, and that women offenders with serious mental illness represent a uniquely vulnerable, at-risk group.

Stages of the Research Process. The research process proceeds in a series of stages. In a field where systematic and rigorous examination of critical issues lags behind the issues and challenges experienced in everyday practice, the first step is often to establish empirically *that a particular situation indeed exists, and whether or not it is a problem.* Once this problem or situation is defined and described, then the next stage of the research process is an inquiry into the conditions that foster the situation or problem, with a goal to explore those interrelated factors that contribute to and sustain the problem. The third stage is focused intervention, or those methods and strategies that will generate the knowledge to inform policy and action and change the situation for the better. This approach to the research process can be summarized, briefly but fittingly, as a process to establish three things about a problem or situation: *that it is, why it is, and how to fix it*. All three stages are necessary to generate data and analysis that can inform and affect policy in meaningful ways.

The data reported here answer the first stage of the process—that there is a distinct group of offenders with SMI living in the Utah State Prison population, that compared with other offenders they are significantly burdened by higher recidivism rates and quicker return to prison, and that these issues seem to be related to their illness, and not to other systematic differences from the general prison population. In the rest of this report, we focus on a few major implications of these first-stage findings.

High Cost of Higher Recidivism for Offenders with SMI. We can now estimate the fiscal costs of the striking difference in recidivism rates between offenders with and without SMI. Combining these findings with data provided by the Department of Corrections Bureau of Research and Planning on the average daily cost per inmate of incarceration in Utah State Prison, we can calculate the costs of this difference in real dollars, keeping in mind that the unit of analysis is each event of recidivism 1998-2002:

- Number of events of recidivism for offenders with SMI 1998-2002 = 3,183
- Average number of SMI return-to-prison events per year = 637
- Average (mean) number of days to return to prison across all non-SMI study events = 668
- Average number of days to return to prison across all SMI study events = 542
- Difference in average number of days to return to prison = 126
- Average cost per day across all units of incarceration in Utah State Prison for fiscal year 2006= $64.48
- Cost of difference in Non-SMI vs SMI events [126 x $64.68] = $8149.68
- Cost of difference in events per year [637 x $8149.68] = $5,191,346.16

Therefore, if the current rate of recidivism for offenders with SMI was simply brought to the same rate as everyone else, the estimated savings would amount to over $5 million per year, or nearly $26 million during a 5 year period. The average daily cost of maintaining an offender in the Olympus mental health unit during fiscal year 2006 was even higher, at

$80.69 per day. Although the majority of offenders with SMI live in general population units, if only 30% of offenders with SMI returning to prison were housed in this unit, these estimated costs would increase by nearly $400,000 per year: [637 x .3 = 191 (one third of average number of SMI events) x 126 (difference in average number of days to return SMI vs. non-SMI) x $16.21 ($80.69 – 64.48, or difference in average Olympus cost per day – average cost per day across units)] = $390,109.86 additional cost per year for SMI in mental health housing.

Special Issues Facing Women Offenders with SMI. It bears repeating that women are the fastest growing segment of the incarcerated population [68]. In 2005, 95,096 women were incarcerated in state prisons, compared to 82,058 in 2001 and 57,263 in 1994 [69]. Women in State prisons have higher rates of mental health issues compared with male prisoners, with 73% of the female state prisoner population expressing symptoms of mental disorder, compared to 55% of the male population[2]. In the highest frequency of mental illness among white women in State prison. Currently about 9% of prison inmates in Utah are women, higher than the 2004 national average of 7.0% across US state prisons [67]. Women with mental disorders [35] tend to fare worse than their male counterparts [69,70, 71], as services geared to offenders are generally designed with males in mind, including those services focused on mentally ill offenders.

Women represent 24.3% of offenders with SMI paroled from Utah State Prison 1998-2002. According to our chart reviews, in which we examined medical charts for recorded evidence of mental health screening, 60% percent of these women were screened for mental illness as part of the prison admission process while 40% were not. Of those screened, 9% were flagged as positive for mental illness requiring follow-up evaluation. Further, 98% of those who received follow-up clinical evaluation were diagnosed as mentally ill. This suggests that when screening is done, it is effective in identifying those women in need of further mental health evaluation and follow-up

treatment. The finding that 40% are not being screening, coupled with evidence in the literature on the special challenges of women with SMI in the prison system, points toward a need to ensure systematic and regular mental health screening for women coming into the prison system.

Not only is the average age of first incarceration for women with SMI significantly higher than their male counterparts, but the overall pattern of ages of first incarceration in also unlike the males. For the men in our sample, the most frequent age of first incarceration spikes at age 19, then declines slowly but steadily throughout the twenties and thirties, and dwindles as the ages increase. For women, the first spike in most frequent age of first incarceration occurs at age 24 (8.2%), then spikes again at ages 31 (6.9) and 33 (6.1) before the frequency begins to decline in women aged 37 and older.

While we have not yet begun to examine reasons for this, we suspect that the relatively older average age of women with SMI coming to prison for the first time, as well as the spike in numbers of women with SMI aged 30-35 at their first incarcerations, may be related to substance abuse issues, particularly methamphetamine use. Despite the reasons, these patterns raise important considerations regarding these women:

- Women with SMI are coming to prison for the first time at age when they are likely to have already become mothers. In 2000, the average age of Utah mothers at the birth of their first child was 23.3. Compare Figure 10, the frequencies of age at first incarceration for women with SMI released from Utah State Prison 1998-1999 with Figure 11, the frequencies of age of Utah mothers at the birth of their first child. Note the co-occurrence of the first spike in each at age 24.

Figure 10 Distribution of Age of First Incarceration in Utah State Prison For Women with SMI 1998-1999

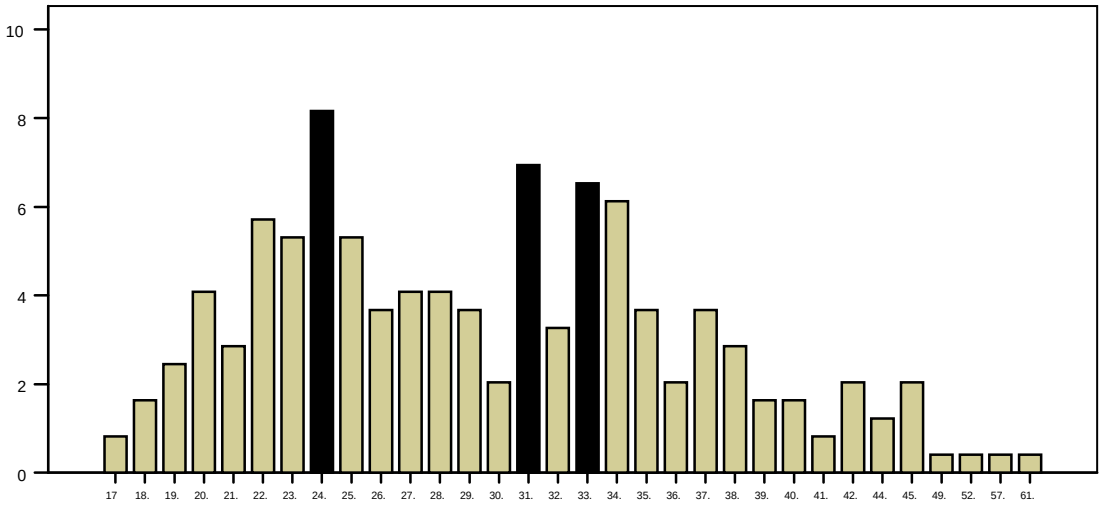
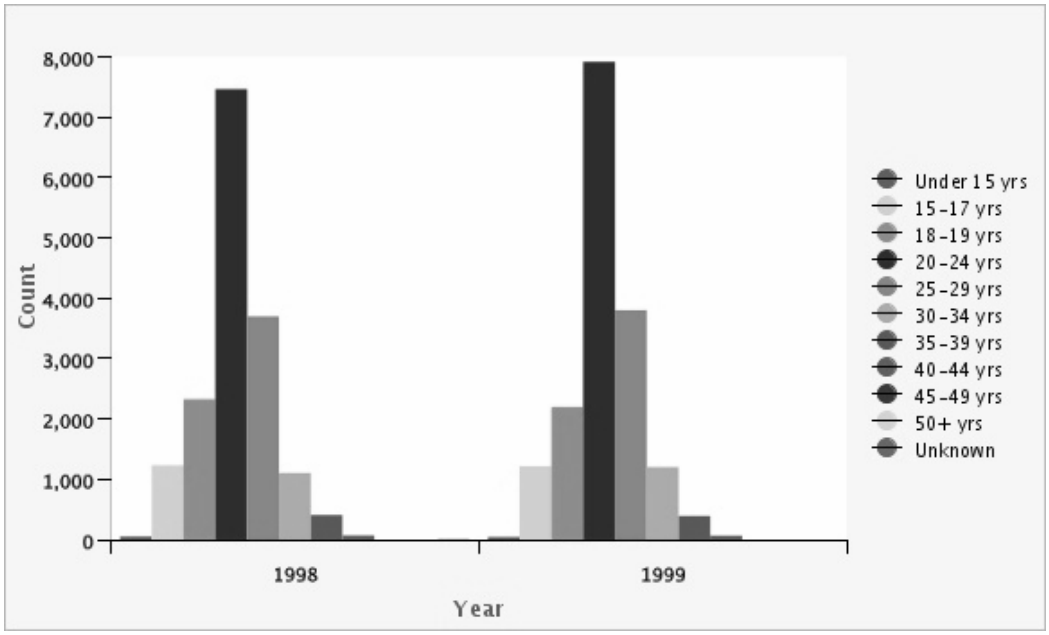


Figure 11 Age of Mother at Birth of First Child for Utah Women 1998-1999



- The bimodal pattern of age at first incarceration for women with SMI, particularly with the second most frequent ages of incarceration at 31 and 33 also means that many women in this group are likely to be mothers of small children and/or young families.

- These women are experiencing two extremely disruptive situations—mental illness and incarceration—when they are also responsible for raising children and maintaining families. It also means that these experiences are not affecting individuals, but dependent children and families. This has critical implications for treatment and transitional services.

Utility of Severity of Serious Mental Illness Index. The severity of serious mental illness index we developed for this study is unique, and could potentially be used to identify those offenders released from prison most at risk of recidivism related to their severity of mental illness. Our preliminary work showed that higher severity scores were significantly associated with decreased time out in the community after prison release.

As opposed to a psychometric tool or measure normed in a non-correctional population and administered by trained professionals, this measure incorporates context-specific clinical and prison data already generated in the course of treatment and management. Also, this measure is specifically tailored to those individual and contextual features that particularly impact offenders with mental disorders. This algorithm for indexing severity and predicting risk of recidivism could therefore be developed for use by prison staff that has access to these data. Such a measure could be combined with already-used measures of risk and recidivism to describe the unique and specific factors that affect offenders with mental illness, and contribute to their significantly higher rates of prison return.

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THE DANGEROUS MENTALLY ILL OFFENDER PROGRAM:
THREE-YEAR FELONY RECIDIVISM AND COST EFFECTIVENESS[†]

Significant reductions in felony recidivism rates for participants enrolled in Washington State's "Dangerous Mentally Ill Offender" (DMIO) program are observed three years after their release from prison. The reduction in felonies associated with the program is valued, by taxpayers and crime victims, at approximately $33,500 per participant minus program costs; this represents a return of about $1.24 for every public dollar spent on the program. Approximately 165 clients are enrolled in the DMIO program in a given month.

In 1999, legislation was passed to better identify and provide additional mental health treatment for mentally ill offenders released from prison who pose a threat to public safety and agree to participate in the program.[1] A dangerous mentally ill offender is defined as a person with a mental disorder who has been determined to be dangerous to self or others. Through interagency collaboration and state-funded mental health treatment and support services, the legislation intends to promote the safe transition of these individuals to the community.

The original legislation directed the Institute and the Washington Institute for Mental Illness Research and Training to evaluate the program. The 2005 and 2007 evaluations examined the 1.5- and 2.5-year outcomes of DMIO participants.[2] The legislature has budgeted funds for the Institute to continue the evaluation. The DMIO program is intended to serve participants up to five years after prison release; this analysis re-examines recidivism outcomes three years post-release. A detailed report on program costs and implementation was published in 2007.[3]

Summary

Washington State's DMIO program, enabled by the 1999 Legislature, identifies mentally ill prisoners who pose a threat to public safety and provides them services and treatment up to five years after their release from prison. This analysis of 172 DMIO participants three years after release from prison indicates that the program:

- ✓ **Reduces overall felony recidivism rates 37 percent;**
- ✓ **Does not significantly reduce new misdemeanor offenses; and**
- ✓ **Has not demonstrated a statistically significant reduction in new violent felonies.**

Using methods developed by the Institute for previous crime studies, the felony recidivism outcomes were used to estimate the total economic impact of the program for both taxpayers and victims of crime. The state spends $26,982 (in 2007 dollars) per DMIO participant over three years. **For taxpayers and victims**, the DMIO program generates:

- ✓ **$33,548 in benefits per participant.**
- ✓ **$1.24 for every dollar spent.**

[1] SSB 5011, Chapter 214, Laws of 1999.

[2] D. Lovell, G. Gagliardi, & P. Phipps. (2005). *Washington's Dangerous Mentally Ill Offender Law: Was community safety increased?* Olympia: Washington State Institute for Public Policy, Document No. 05-03-1901; and J. Mayfield. (2007). *The Dangerous Mentally Ill Offender Program: Cost effectiveness 2.5 years after participants' prison release*. Olympia: Washington State Institute for Public Policy, Document No. 07-01-1902.

[3] D. Lovell & J. Mayfield. (2007*). Washington's Dangerous Mentally Ill Offender Law: Program costs and developments.* Olympia: Washington State Institute for Public Policy, Document No. 07-03-1901.

[†] Suggested citation: Jim Mayfield and David Lovell, Ph.D. (2008). *The Dangerous Mentally Ill Offender Program: Three-year felony recidivism and cost effectiveness.* Olympia: Washington State Institute for Public Policy, Document No. 08-02-1901.

Previous Findings

The 2005 and 2007 reports demonstrated that the DMIO program significantly reduced recidivism after 1.5 years and continued to do so after 2.5 years.[4] Overall, the program appeared to be accomplishing its other principal objectives such as improving social services delivery and participant living situation. The 2007 benefit-cost analysis indicated that the reductions in DMIO recidivism generated slightly more financial benefits to taxpayers than program costs. This report re-estimates the total economic benefits to taxpayers and crime victims based on three-year recidivism rates. The report also provides an improved estimate of program recidivism outcomes based on comparisons with a more similar group of mentally ill offenders.

Key Methodological Issue: Selecting a Similar Comparison Group

This analysis includes 172 DMIO program participants who were released between the beginning of the program and December 31, 2003.[5] Program participants who died (3), moved out of state (5), or were deported (3) or civilly committed (9) were not available for a three-year follow-up in the community and were therefore excluded from the analysis.

To evaluate the program, it is necessary to compare DMIO participants to a group of offenders with similar characteristics (comparison group) who were released without the interagency coordination and supplemental funding for services created for the DMIO program. Due to ethical and political concerns about denial of service and public safety, a random assignment research design was not used for this study. Rather, we used a quasi-experimental approach that compares outcomes between closely matched pairs of individuals in the DMIO and comparison groups.

The 2005 and 2007 studies used a comparison group of 287 mentally ill offenders who were part of the Community Transitions Study (CTS). There were, however, considerable differences in the felony recidivism risk of individuals in the DMIO and CTS groups (29 percent and 41 percent respectively).[6] While statistical adjustments were made in those analyses, the recidivism outcome estimates from those studies may still have been biased. A considerably more similar comparison group was identified for this recidivism analysis.

Individuals with characteristics that closely resemble DMIO program participants were selected from a pool of 1,356 offenders released from prison between January 1, 1996, and December 31, 2000, and who met specific mental health criteria.[7] These individuals were matched with DMIO program participants based on similarities among eight variables that predict the likelihood of recidivism *and* the propensity for being a DMIO program participant.[8]

Exhibit 1 shows the eight variables used to pair DMIO participants with their counterparts in the comparison group. There are no statistically significant differences in seven of the eight characteristics that predict felony recidivism or participation in DMIO. The only statistically significant difference is the younger age at release of individuals in the comparison group.[9]

Exhibit 1
Pre-Release Characteristics of DMIO Participants and Matched Comparison Group (Average/Percent)

	DMIO Group (n=172)	Comparison Group (n=172)
Past felonies	3.7	3.3
Residential mental health days	429	392
Past drug offenses	.67	.56
Non-white	30%	26%
Past violent offense index	72%	72%
Age at release*	37	35
Annual infraction rate	4.0	3.4
Female	13%	11%

* Statistically significant at p<.05.

[4] Lovell et al. (2005); Mayfield (2007).
[5] This study relied on databases maintained by the Administrative Office of the Courts; Department of Corrections; Department of Social and Health Services Mental Health Division, Division of Alcohol and Substance Abuse, and Research and Data Analysis Division; and Department of Health.
[6] G. Gagliardi, D. Lovell, P. Peterson, & R. Jemelka. (2004). Forecasting recidivism in mentally ill offenders released from prison. *Law and Human Behavior 28*(2): 133-155.
[7] Details on inclusion criteria are provided in the appendix.
[8] The method used to select members of the matched comparison group is available in the appendix.
[9] Additional multivariate analyses controlling for the difference in age did not alter the results presented in this report.

Because individuals in the DMIO and comparison groups are so similar, differences in actual recidivism are assumed to be attributable to participation in the DMIO program. There are, however, several limitations to the research design adopted for this study:

- Some individuals in the comparison group were released from prison more than four years before DMIO participants were released. During the intervening period, changes in factors such as interagency coordination and community supervision could account for some effects attributed to the DMIO program.

- Using a statistically matched control group minimizes observable differences between the study groups. Possible unobserved differences, however, such as motivation, may still bias the estimate of program effects. Consequently, for the benefit-cost analysis, we discount the estimated effect size to arrive at a more conservative estimate of the economic outcomes.

- This analysis of DMIO participants' criminal recidivism only reports three-year recidivism rates. The DMIO program is available to participants for up to five years.

Criminal Recidivism After Three Years

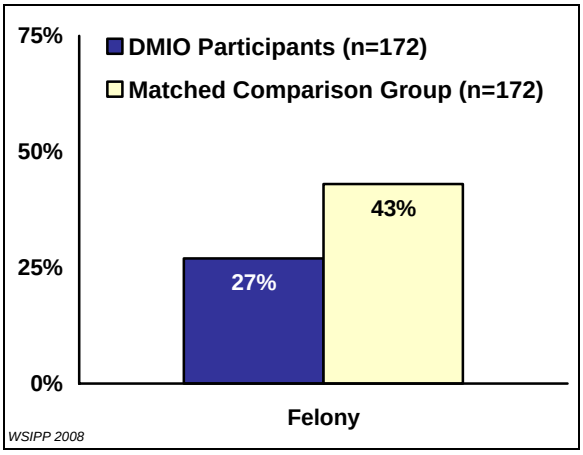
Significant Reductions in Overall Felony Recidivism. We define recidivism, in all Institute reports, as a reconviction in a Washington court for any offense during the follow-up period.[10] We examined three categories of recidivism: any new offense (including all felonies and misdemeanors), overall felony, and violent-only felony recidivism.[11] There were statistically significant differences in overall felony recidivism but not in any new offenses or violent-only felonies.

Compared to other mentally ill offenders with similar potential to reoffend (Exhibit 2), individuals participating in the DMIO program were significantly less likely to commit a new felony (43 versus 27 percent).[12]

DMIO participants were about 37 percent less likely to be convicted of a new felony than individuals with similar characteristics in the comparison group. That is, the comparison subjects were about 1.6 times more likely to be reconvicted of a felony than DMIO participants.

Other Recidivism Measures. Similar analyses were conducted for two other measures: "any new offense," which is a composite of misdemeanor and felony recidivism, and violent felony recidivism. Relative to the comparison group, DMIO participants were about 90 percent as likely to commit any new offense, but the difference between the groups was not statistically significant. Similarly, the number of violent felonies was lower in the DMIO group (24) than the comparison group (30).[13] The difference, however, was not statistically significant.

Exhibit 2
Overall Felony Recidivism Rates
DMIO Participants versus Comparison Group*
(Three-Year Follow-up)



* McNemar test, $\chi 2=11.458$, p=.0004

Program Costs and Recidivism Savings

Benefit-Cost Analysis. The Institute has developed methods of economic analysis to assess program benefits in terms of reduced costs to taxpayers for law enforcement, adjudication, and corrections, and for the victims of crime. To calculate benefits, the reductions in recidivism attributable to the DMIO program were applied to the lifetime distribution of criminal offenses expected from those released from prison. Per-person program costs were estimated based on a review of provider billing records.

[10] R. Barnoski. (1997). *Standards for improving research effectiveness in adult and juvenile justice.* Olympia: Washington State Institute for Public Policy, Document No. 97-12-1201.
[11] Violent felonies are crimes with Criminal Justice System Law Category codes of 100 and above.
[12] Based on pairwise comparison of recidivism outcomes for 172 pairs of DMIO participants and matched members of the comparison group.
[13] During the follow-up period, there were two murder convictions in the comparison group and none in the DMIO group. A December 31, 2007 murder in Seattle did not fall within the follow-up period of this study.

Program Costs. The state compensates Regional Support Networks (RSNs) and other providers who contract with the Department of Social and Health Services (DSHS) to provide additional support services for DMIO program participants. The program funds up to $10,000 per DMIO participant per year, for a maximum of five years. The specific funding formula established by DSHS-Mental Health Division is as follows:

- Providers of special services during the three months just before and just after prison release are reimbursed $6,000 to engage the participant.
- After the first three months, providers are reimbursed $700 per month for special DMIO services for Medicaid-eligible participants and $900 per month for non-Medicaid-eligible participants.

Per-person program costs over the three-year follow-up period are estimated at $26,982 per participant (in 2007 dollars). This estimate is based on a detailed review of billing records for agencies serving DMIO participants released between July 1, 2002, and December 31, 2003.[14]

Cost Savings of Reduced Recidivism. Does the value of the reduction in crime attributed to the DMIO program outweigh the costs? To answer this question, we turned to the Institute's benefit-cost model.[15] When there are fewer crimes, there are fewer victims and taxpayers spend less on the criminal justice system. We estimate the present value of crime-related costs avoided over the lifetime of a participant for both taxpayers and crime victims. To determine the economic "bottom line" of the program, we subtract the cost of the DMIO program from the present-value sum of its benefits (including avoided costs).

When research is based on a less-than-randomized research design, we know the results have a larger margin of error than a randomized design. Since random assignment was not possible for this study, we reduced the estimated effect on recidivism by 25 percent when calculating cost savings.[16] That is, since we cannot control for selection bias that may result in an overestimation of the effectiveness of the program, we apply a 25 percent discount factor to the program effect when we perform our benefit-cost analysis.

Exhibit 3
DMIO Program Benefits and Costs
(In 2007 Dollars)

	Taxpayers and Victims	Taxpayers Only
Benefits (lifetime)	$33,548	$15,247
Costs (over 3 years)	$26,982	$26,982
Benefit/Cost Ratio	$1.24	$0.57
Net Benefits	$6,566	-$11,735

We estimate that the DMIO program costs about $26,982 per participant over the first three years post-release and produces about $33,548 in crime-reduction benefits (Exhibit 3). Of these total benefits, $15,247 accrues to taxpayers in the form of reduced criminal justice system expenditures; another $18,301 accrues to society because there are fewer crime victims. The result is an overall return to society of $6,566, or $1.24 per dollar spent on a DMIO participant.

Conclusion

The reductions in DMIO criminal recidivism found during the first 2.5 years after prison release hold up at the three-year mark. Participation in the DMIO program is associated with statistically significant decreases in felony recidivism three years after release. The analysis was unable to identify statistically significant effects on recidivism for combined felony or misdemeanor offenses or violent felony recidivism. A benefit-cost analysis indicates that the reduction in criminal recidivism attributed to the DMIO program is a net economic benefit to crime victims and taxpayers, providing net benefits comparable to other adult offender programs.

[14] D. Lovell & J. Mayfield. (2007).
[15] S. Aos, R. Lieb, J. Mayfield, M. Miller, & A. Pennucci. (2004). *Benefits and costs of prevention and early intervention programs for youth*. Olympia: Washington State Institute for Public Policy, Document No. 06-10-1201.
[16] The rationale for this discount is explained in Aos et al. (2004). Previous studies used a 50 percent discount because of the dissimilar comparison group.

TECHNICAL APPENDIX: SELECTION OF PROGRAM AND CONTROL GROUPS[‡]

DMIO Participant Group. After removing those who had died, moved out of state, or been deported or civilly committed, there were 172 DMIOs released between the beginning of the program and December 31, 2003.

Control Group. Control subjects consisted of all qualifying offenders released from prison from January 1, 1996, through December 31, 2000, who met the qualifying criteria:

- Membership in the original community transition study,[17] with serious mental illness certified by OBTS screening criteria, archived chart reviews, and Regional Support Network enrollment records: n=287.
- Or one of the following:
  1) Certification in Department of Corrections tracking system, "Interview Confirms SMI" ("serious mental illness");
  2) More than one year of residential mental health treatment while in prison; or
  3) Both of the following:
     - Over 30 days of residential mental health treatment in prison; and
     - A qualifying diagnosis in offender tracking records (primarily the following: schizophrenia, schizoaffective, psychosis NOS, bipolar I, major depression, mood disorder NOS, organic mood or thought disorder, borderline personality).

Exclusion Criteria. Control subjects were excluded if they had a release zip code less than 98000, indicating probable out-of-state placement. For potential control subjects released in 1997 and 1998, there were data indicating whether they were released to an immigration detainer; these control subjects were excluded also. Because a previous study showed that almost two-thirds of releasees identified as Hispanic had immigration detainers, Hispanic control subjects released after 1998 were also excluded from the control pool. There were 1,356 members of the control pool after the inclusion and exclusion criteria were applied.

Selection of Matching Variables. A number of studies of general offenders and mentally ill offenders in Washington and elsewhere have identified a set of variables significantly correlated with recidivism.[18] Many of these were tested against the control subject dataset to determine which subset of eight variables provided optimal accuracy in predicting recidivism. Following the method of Lovell et al. (2007), we recoded continuous variables as ordinal variables with two to three values, using cut points that would provide significant numbers of subjects in each category and clear differences in average recidivism rates for each category. (The cut points for ordinal variable values are shown in Exhibit A2.) The reason for this procedure is that relationships to recidivism are non-linear: for variables such as number of previous offenses or time in mental health programs, the precise number of offenses is not as important as whether one is a first-time, repeat, or chronically repetitive felony offender; nor is the exact number of days of program residency as important as the difference between weeks, months, and years. As a result, the ordinally recoded variables generally showed stronger univariate correlations to recidivism than did the original continuous variables. Using ordinally recoded variables allowed us to maximize the number of variables on which we could match subjects and control subjects. We refer to "pairs" and "mates" to distinguish the 172 matched control subjects from the broader pool of 1,356 control subjects from which they were drawn.

[‡] This technical appendix is adapted from D. Lovell. (December 10, 2007). *DMIO program evaluation, 2007*. Seattle: University of Washington, Department of Psychosocial & Community Health. Memorandum to the Washington State Institute for Public Policy.

[17] D. Lovell, G. Gagliardi, & P. Peterson. (2002). Recidivism and service use among mentally ill offenders released from prison. *Psychiatric Services 53*(10):1290-1296.

[18] Ibid.; D. Lovell, L. Johnson, & K. Cain. (2007). Recidivism of supermax prisoners in Washington State. *Crime and Delinquency 53*(4); Gagliardi et al. (2004); R. Barnoski & S. Aos. (2003*). Washington's Offender Accountability Act: An analysis of the Department of Corrections' risk assessment.* Olympia: Washington State Institute for Public Policy, Document No. 03-12-1202; A. Beck. (1997). *Recidivism of prisoners released in 1983.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; and P. Gendreau, T. Little, & C. Goggin. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology 34*: 575-607.

Since the index offenses of participants were felonies, control subjects were matched with participants in terms of the likelihood of felony recidivism. Because not every potentially relevant characteristic could be matched, and some predictors (such as age of admission to prison and age of release) are correlated with each other, logistic regression and Area Under the Receiver Operating Characteristic (AUC) analyses were used to identify an optimal set of control variables, each of which made significant contributions to a prediction equation for felony recidivism. The AUC curve describes the extent to which a set of variables yields predictions better than chance (an AUC value of .50). Exploratory logistic regression analysis with the control pool yielded a set of eight ordinal demographic, correctional, and criminal history variables that together yielded an AUC of .777 for felony recidivism, better than many well-established, more complex recidivism prediction instruments. Exploratory analysis of the combined control-DMIO sample also indicated that an overlapping group of variables strongly predicted membership in the DMIO group (AUC=.773).

Exhibit A1 presents average scores (for continuously distributed variables) and rates (for categorical variables) of DMIO participants, matched-control mates, and the entire control pool on the eight predictor variables. The demographic, criminal history, and age-related variables in this set are well established predictors of recidivism. As noted above, many studies have found associations between recidivism and socioeconomic disadvantage, youth, prison misbehavior, and extensive criminal history. Involvement in residential mental health treatment while in prison makes this set distinctive; note that having an index violent offense is *negatively* correlated with felony recidivism.

Exhibit A1
Recidivism Predictors for DMIO Subjects, Matched Control Mates, and All Control Subjects

Variable	DMIO (n=172)	Mates (n=172)	All Control Subjects* (n=1,356)	DMIO vs. All Control Subjects p-value
Past Felonies (+)	3.67	3.30	4.20	.021
Residential Mental Health Days (-)	429	392	169	.000
Past Drug Offenses (+)	.67	.56	1.35	.000
Non-White (+)	30%	26%	30%	1.000
Index Violent Offense (-)	72%	72%	38%	.000
Age at Release (-)	37.3	35.3	34.4	.000
Annual Infraction Rate (+)	4.00	3.36	2.80	.098
Female (-)	13%	11%	32%	.000

Note: plus or minus signs indicate the direction of association with recidivism.
* Hispanic origin not a control variable.

Felony Risk Scores. Exhibit A2 displays the variable ranges used for coding ordinal variables. Except for age of release, which was recoded into only two levels to reduce the number of mismatches between DMIO participants and mates, continuous variables were recoded into three levels, with cut-offs designed to create clear differences in recidivism rates between levels. Following Gagliardi et al. (2004), risk scores of –1, 0, or 1 were assigned to each level to reflect rates of recidivism that were lower, approximately equal, or higher compared with the entire control pool (the three-year felony recidivism rate for all control subjects was 53 percent). Gender did not contribute to risk scores.

Felony risk scores were computed in two stages: (1) a raw total was calculated by summing scores on the individual variables and adding 5 points to ensure that all totals were positive; and (2) due to small numbers and random variations causing small differences or slight fluctuations in recidivism rates between some scores, the raw totals were rescored into an 8-point scale reflecting differences in recidivism. Felony risk scores and associated recidivism rates are displayed in Exhibit A3.

Exhibit A2
Prediction Variable Ranges, Risk Scores, and Recidivism Rates for Control Subjects (n=1,356)

Variable	Range	Risk Score	New Felony Rate
Past Felonies	0 – 1	-1	22%
	2 – 5	0	53%
	6 or more	1	73%
Residential Mental Health Days	0	1	62%
	1 – 89	0	55%
	90 or more	-1	33%
Past Drug Offenses	0	-1	41%
	1	0	54%
	2 or more	1	68%
Race	White	-1	46%
	Person of color	1	69%
Index Violent Offense	Yes	-1	41%
	No	1	60%
Age at Release	35 or younger	1	61%
	36 or older	-1	42%
Annual Infraction Rate	0 – 1	0	45%
	1 or more	1	59%

Exhibit A3
Felony Risk Scores and Felony Recidivism Rates for Control Subjects (n=1,356)

Risk Score	Recidivism Rate (Mean=54%)
1	2%
2	23%
3	33%
4	40%
5	56%
6	60%
7	71%
8	80%

DMIO Propensity Scores. A similar process was followed to select variables associated with likelihood of participation in the DMIO program. Five of the original eight risk variables made substantial contributions: felonies, drug offenses, age of release, mental health time, and index violent offense. Two further variables were used in place of racial classification and infraction rates: past violent (non-sex) felonies, and past sex felonies. Exhibit A4 displays the propensity values assigned to ranges of these variables.

Exhibit A4
DMIO Propensity Variable Ranges, Scores, and DMIO Membership Rates for DMIO and Control Subjects (n=1,529)

Variable	Range	Propensity Score	DMIO Rate (Mean=11.3%)
Past Felonies	0 – 1	1	15%
	2 or more	0	10%
Residential Mental Health Days	0 – 30	0	7%
	31 or more	1	18%
Past Drug Offenses	0	1	15%
	1	0	12%
	2 or more	-1	5%
Index Violent Offense	Yes	1	19%
	No	-1	5%
Age of Release	25 or younger	-1	7%
	26 – 35	0	10%
	36 or older	1	14%
Violent Felonies	0	-1	5%
	1	0	15%
	2 or more	1	25%
Sex Felonies	0	0	10%
	1 or more	1	16%

Matching DMIO Participants With Mates. The combination of eight predictor variables (Exhibit A1) was used to match control subjects to DMIO participants.

- A 1:1 match was achieved for 142 cases. If multiple matches were available, mates were assigned at random from the group of control subjects closest to the DMIO participants in an additional variable: number of past violent or sex offenses.
- For the 30 cases without an exact match on all eight variables, control subjects were matched according to the felony recidivism risk scale and then assigned at random to the closest DMIO participants in propensity for DMIO membership.

Results of the matching in terms of risk and DMIO propensity are displayed in Exhibits A5 and A6. DMIO participants and mates closely resembled each other in risk of recidivism; DMIO participants had higher scores than mates in DMIO propensity, but differences between groups were not statistically significant.

Exhibit A5
Distribution of DMIOs and Mates by Felony Recidivism Risk Scores

	DMIOs (n=172)		Mates (n=172)	
Risk Score	n	Pct	n	Pct
1	24	14%	25	15%
2	23	13%	23	13%
3	46	27%	46	27%
4	23	13%	23	13%
5	22	13%	22	13%
6	15	9%	14	8%
7	17	10%	17	10%
8	2	1%	2	1%

DMIO participants vs. Mates: $\chi^2 = 1.03$, df=7, p=.998

Exhibit A6
Distribution of DMIOs and Mates by DMIO Propensity Scores

	DMIOs (n=172)		Mates (n=172)	
Propensity Score	n=172	Pct	n=172	Pct
1	11	6%	17	10%
2	18	11%	21	12%
3	23	13%	18	11%
4	87	51%	84	49%
5	33	19%	29	17%
6	0	0%	3	2%

DMIO Participants vs. Mates: $\chi^2 = 5.44$, df=5, p=.365

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Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription

The Sentencing Project

January 2002

This report represents the contributions of many people. The investigation and research of the treatment of mentally ill people in the criminal justice system began as a project of the Campaign for Effective Crime Policy, spearheaded by Beth Carter, the Campaign's National Coordinator. A first draft of findings and recommendations was reviewed by the Campaign's Steering Committee and advisors whose experience and insights contributed greatly to the work. These include: Mark Cunniff, Jonathan Ezekial, Lois Fisher, Frank Hall, Nolan Jones, Gil Kerlikowske, Andy Sonner and Andrea Weissman.

Subsequent drafts of the report were completed by Jenni Gainsborough, Senior Policy Analyst of The Sentencing Project, and reviewed by Malcolm C. Young, Executive Director, and Marc Mauer, Assistant Director.

The Sentencing Project is a national non-profit organization engaged in research and advocacy on criminal justice issues. This report, the first in a series focusing on better ways to address problems that are now processed and punished within the criminal justice system, was funded by individual contributions to The Sentencing Project, and funding from the Open Society Institute, and the John D. and Catherine T. MacArthur Foundation.

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FOREWORD

At the beginning of the new century, the United States is the world leader in incarceration, with a higher proportion of its population behind bars than any other country. This distinction is primarily the result of policy decisions, in many areas and at various levels of government, and not rising crime rates. Incarceration has not proven to be the most effective strategy in reducing crime, and brings with it significant financial and social costs.

In response to this situation, The Sentencing Project is investigating sentencing, court and corrections options for specific groups of offenders which are contributing to the burgeoning prison and jail population. For many of these groups – including offenders who are children, elderly, mentally ill, learning disabled, or terminally ill – there exist alternative approaches – "a better way" – within and outside the criminal justice system that are more effective and less costly.

This report, an analysis of the "criminalization" of people with mental illness and its impact on the criminal justice system, is the result of work by The Sentencing Project's Campaign for an Effective Crime Policy. The Campaign was initiated in 1992 as a national effort of concerned criminal justice officials who issued "A Call for a Rational Debate on Crime and Punishment." The Call was subsequently endorsed by more than 1,400 criminal justice officials and policymakers throughout the country, and the Campaign produced a series of policy reports analyzing trends in the justice system and proposing recommendations for more effective public policy. The Campaign's functions have now been incorporated within The Sentencing Project. The purpose of the information and recommendations presented in this report is to inform the public debate and to be of use to criminal justice practitioners and state and local policymakers who are working to improve the effectiveness of government services.

OVERVIEW

The Bureau of Justice Statistics has reported that 283,800 individuals with mental illnesses were confined in U.S. jails and prisons in 1998.[1] Overall, 16% of all inmates self-reported current mental illness or an overnight stay in a mental hospital, and an additional 14% had received other mental health services in the past. Almost one quarter of incarcerated women were identified as mentally ill. Of the ten million adults booked into local jails each year, approximately 700,000 have active symptoms of serious mental illness, and most of those have co-occurring substance abuse disorders.

Significant as these numbers are, many mental health experts believe they understate the problem due to under-reporting by people who might not want to disclose the information or are unaware of their illness.[2] Clearly, the "criminalization"[3] of people with mental illnesses is a phenomenon affecting many thousands of individuals and their families, as well as those who work within law enforcement, the courts and corrections systems, and mental health and substance abuse service providers.

This report will examine why so many people with mental illness are caught up in the criminal justice system and the effects this has on them and on the system. We also offer recommendations for changes in services, policies and practices to be implemented at each stage of the justice system -- from first police contact through release from prison -- to promote better outcomes both for individuals and the community as a whole. These include program models currently being implemented in various jurisdictions. The recommendations are focused on limiting the number of mentally ill people who are brought into the criminal justice system while providing better treatment and links between prison and community services for those who are incarcerated. In short, to offer a better way than reliance upon the institutions of punishment to address mental health problems.

Recommendations for changes include:

- Expanded and improved community services.
- Integration of systems to meet the needs of people with mental illness and other co-occurring disorders.
- Training for police to improve initial response to contacts with the mentally ill.
- Increased diversion from the criminal justice system for people with mental illness.
- Improvements in correctional mental health services for those who cannot be diverted.
- Pre-release planning for transition from prisons and jails back into the community with appropriate medical and support services.

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[1] P.M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, July 1999, Bureau of Justice Statistics, US Department of Justice.

[2] Fox Butterfield, "Experts Say Study Confirms Prison's New Role as Mental Hospital," *The New York Times*, July 12, 1999.

[3] The term "criminalization of the mentally ill" refers to the increased likelihood of people with mental illness being processed through the criminal justice system instead of through the mental health system.

THE RISING NUMBER OF MENTALLY ILL PERSONS BEHIND BARS

The Population Shift from Psychiatric Hospitals to Prisons

In 1972, state and federal prisons in the United States held 200,000 people. Since then the prison population has experienced an unprecedented rise. By 2000, more than a million additional people had been added to the nation's prisons for a total of nearly 1.4 million, or nearly seven times the number of three decades ago. With an additional 620,000 people in local jails, the total number of people behind bars reached over 1.9 million and was predicted to reach 2 million by the end of 2001.[4]

State mental hospital populations peaked at 559,000 persons in 1955. By contrast, 70,000 individuals with severe mental illnesses are housed in public psychiatric hospitals today, 30% of whom are forensic patients remanded by the courts.

Forty state mental hospitals have closed during the past decade while more than 400 new prisons have been opened. As a result, jails and prisons have become the institutions most likely to house the mentally ill.

- In the early 1970s, Michigan's mental institutions held about 28,000 patients, while its prisons held 8,000 inmates. Today there are fewer than 3,000 patients in Michigan mental hospitals, while the state's prisons hold more than 45,000 inmates.

- Los Angeles County Jail, reputed to be the largest *de facto* mental institution in the United States, holds an estimated 3,300 seriously mentally ill inmates on any given night.[5]

- In 1997, 15,000 inmates were treated for serious mental illness in New York City's jail on Riker's Island.[6]

- The Cook County Jail holds the largest number of institutionalized mentally ill people in Illinois, where 1,000 of the 11,000 people confined have been identified as mentally ill.[7]

- In Florida, mentally ill inmates in jail and prison outnumber patients in state mental hospitals by nearly five to one. In November 1999, state mental hospitals held 2,671 patients, while county jails housed 5,300 individuals with mental illnesses, and state prisons an additional 6,800.[8]

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[4] A.J. Beck, and J.C. Karberg, *Prison and Jail Inmates at Midyear 2000*, March 2001, Bureau of Justice Statistics, US Department of Justice.
[5] *Sacramento Bee*, "Treatment, Not Jail: A Plan to Rebuild Community Mental Health," March 17, 1999.
[6] Heather Barr, *Prisons and Jails: Hospitals of Last Resort*, The Correctional Association of New York and The Urban Justice Center, 1999.
[7] Mark J. Heyrman, "Mental Illness in Prisons and Jails," *Roundtable*, Volume 7, The University of Chicago Law School, 2000.
[8] Debbie Salamone Wickham, "Society Criminalizes Their Mental Illness," *Orlando Sentinel*, October 31, 1999.

Driving Forces of the Population Shift

Prisons and jails have always held people who are mentally ill. Given the dramatic rise in the overall incarcerated population, it could have been expected that the number of incarcerated mentally ill persons would have risen. However, other factors have brought the proportion of mentally ill within the criminal justice system to a vastly higher level than their proportion within the general population. Mental disorders among prisoners are estimated to be at least five times more prevalent than in the general population.[9] Much of the problem has arisen from deliberate policy decisions and can therefore be remedied by changes in policies and procedures.

Untreated Mental Illness in the Community

The number of mentally ill people in the community who are not receiving adequate treatment has increased as a result of deinstitutionalization without a corresponding development of community-based mental health services. At the same time additional restrictions have been placed on involuntary commitment.

- *Deinstitutionalization* – The deinstitutionalization of state mental hospital populations, beginning in the 1960s, developed in response to a number of factors: legal advocacy on behalf of people "warehoused" in state mental hospitals, in some cases for a lifetime; the development of more effective psychotropic medications promising better symptom control; and federal legislation establishing "Community Mental Health Centers" to help released patients establish new lives in caring communities. In response, state governments dramatically accelerated the release of patients and the "downsizing" of state mental hospitals during the 1970s and 80s.

  The transfer of former hospital patients to community care represented an important effort to provide new opportunities for integration in community life, as well as more humane and cost-effective care for people with mental illnesses. Unfortunately, planning was flawed and implementation uneven. One major problem was the failure to anticipate and address the "Not In My Back Yard" syndrome that soon developed in many communities. In some places, local neighborhood organizations fought attempts to establish group homes. Local mental health systems struggled to provide an adequate array of services, but were generally unprepared to meet the basic needs of a population that had long been dependent on institutional care. Due in part to communities' lack of preparedness and resources, the needs of many of the deinstitutionalized mentally ill have not been met. As a result, growing numbers of released patients drifted toward life on the streets and many of the mentally ill have ended up exchanging hospitalization for institutionalization in prison or jail.

- *Reductions in Treatment Spending and Availability* – While treatment enables many people with serious mental illnesses to function effectively in community life, access to treatment and other essential services often falls short of the need. Barriers to treatment include fragmentation of treatment services (mental illness, substance abuse, general medical care),

[9] Terry Kupers, M.D., *Prison Madness*, Jossey-Bass, 1999, p. 11.

homelessness, lack of transportation and difficulties in accessing key government-funded health coverage and income supports.

State governments have traditionally been the major funders for public mental health services, and remain so today. But according to the Bazelon Center for Mental Health Law, total state spending for treatment of the seriously mentally ill is one third less now than in the 1950s.[10] According to a 1998 study by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration, a comprehensive analysis of nationwide spending on mental health, alcohol and drug abuse treatment services found that the growth of spending for the treatment of mental illness and substance abuse has been lower than for health care generally.[11]

Long-term hospitalization in private mental health facilities has also declined due to cost increases, restrictions on insurance coverage for mental illness, and time-limits imposed by insurers on length of in-patient treatment.

- *Barriers to Involuntary Commitment* – Families and others seeking to force the mentally ill into treatment are faced with changes in mental health law that have made involuntary commitment more difficult. Most state mental health codes require psychiatric hospitals to show clear and convincing evidence that patients being committed involuntarily are either a danger to themselves or others or are so gravely disabled by their illnesses that they are unable to care for themselves. People cannot be hospitalized against their will without legal representation and a full judicial hearing.

  Some critics of these laws have called for a relaxation of commitment standards so that the untreated mentally ill can be returned to hospitals. However, laws regarding both involuntary treatment and involuntary commitment are controversial and advocacy groups and service providers working on behalf of the mentally ill are deeply divided on them (see box on next page).

[10] The Bazelon Center for Mental Health Law, *Position Statement on Involuntary Commitment*, 1999.
[11] Substance Abuse and Mental Health Services Administration (SAMHSA), *Press Release*, Sept. 15, 1998, p. 2.

Involuntary Treatment and Civil Commitment:
Policy Perspectives

Few issues in the field are more controversial than involuntary treatment and civil commitment of people who refuse medication. For example:

According to the **Treatment Advocacy Center**, approximately 40% of all individuals with severe mental illnesses are not receiving treatment at any given time. Many are homeless, in jail on misdemeanor charges, and "responsible for increasing episodes of violence." A major reason is that "because of the effects of the illness on their brain, they lack awareness of their illness…. Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases, they will take medication only under some form of assisted treatment." The Center strongly supports a policy of mandatory treatment when indicated, citing "violent crimes committed by delusional individuals who might not have lashed out if they had been detained and forcibly medicated."*****

The **Bazelon Center for Mental Health Law** opposes involuntary *inpatient* civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when less restrictive alternatives are unavailable. The Center also opposes all involuntary *outpatient* commitment as an infringement of an individual's constitutional rights and supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. "The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. At best, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services."******

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* Treatment Advocacy Center, "Assisted Outpatient Treatment Will Help Reduce Preventable Episodes of Violence, Homelessness and Incarceration" in New York, May 19, 1999.
** Op. cit., The Bazelon Center for Mental Health Law.

Criminalization of Mental Illness

Police, courts and legislatures have adopted an increasingly punitive approach to the treatment of people who do not fit within societal norms. Policies such as "zero tolerance" policing, mandatory sentences that carry harsh penalties for drug offenses, and restrictions on access to support systems such as welfare are all reflections of a punitive, rather than problem-solving, approach which has led to the criminalization of the mentally ill.

Criminalization implies that people are being inappropriately processed through the criminal justice system rather than through the mental health system. However, if people with mental illness commit serious violent crimes, then a criminal justice response may be necessary in order to preserve public safety. Studies suggest that the crimes committed by the mentally ill fall under three broad categories:

- Illegal acts which are a byproduct of mental illness; e.g., disorderly conduct, criminal trespass, disturbing the peace, public intoxication.
- Economic crimes to obtain money for subsistence; e.g., petty theft, shoplifting, prostitution.
- More serious offenses such as burglary, assault and robbery.

Offenses in the first two categories might be avoided, or at least reduced, by better community resources providing treatment and other support services. Crimes in the third category are likely to continue to involve the criminal justice system. However, the mentally ill in prisons and jails need treatment and services to ensure that their condition is not exacerbated by imprisonment. They also require specialized prerelease planning to ensure a successful transition back into the community.

The "revolving door" between jail and the street is propelled largely by untreated mental illness and co-occurring substance abuse disorders among individuals who have committed relatively minor crimes. This population includes homeless and mentally ill people whose untreated mental illnesses lead to repeated "nuisance crimes" and jail.

People with mental illness are more likely to exhibit the kinds of behaviors that will bring them into conflict with the criminal justice system, particularly under current policies of "zero tolerance" and arrests for "quality of life" crimes. According to the Bureau of Justice Statistics prisoners with mental illnesses were twice as likely as other inmates to have been homeless prior to their arrest; forty percent were unemployed; and nearly half said they were binge drinkers.[12]

Many people who suffer from both mental illness and substance abuse (referred to as co-occurring disorders) are particularly at risk of incarceration. Estimates of the proportion of people with mental health disorders who also have a substance abuse disorder range between 25-50%.[13] Almost 60% of mentally ill state prisoners reported using drugs in the month before their arrest.[14]

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[12] Ditton, op. cit.
[13] The National GAINS Center, *Treatment of People with Co-Occurring Disorders in the Justice System.*
[14] Ditton, op. cit.

Co-occurring disorders in particular are strongly associated with poor social functioning, homelessness, violence, arrest and incarceration.[15] The population of individuals with substance abuse problems as well as mental illness is considered hard to serve and is chronically underserved in most communities. Some providers are unwilling or unable to work with persons whose illnesses are so difficult to manage. Hospital emergency rooms, homeless shelters and jails are often used as *de facto* service centers for troubled, indigent and vulnerable mentally ill/substance-abusing individuals. An overloaded system and the lack of adequate treatment resources for co-occurring mental illness and substance abuse disorders have severely restricted many individuals' access to treatment, increasing the likelihood of offending and incarceration of these individuals.

While some of the more serious offenses committed by the mentally ill may be driven by the same factors that lead people without mental illness to commit crime, some violent acts may be attributable to untreated mental illness. About 53% of inmates with mental illnesses in state prison have been convicted for a violent offense, compared to 46% of other inmates. Among mentally ill jail inmates, 30% were charged with a violent offense, compared to 26% of other inmates.

Attitudes toward Mental Illness and Violence

Public perceptions of the dangerousness of mentally ill people and doubts about the use of insanity pleas have encouraged policies that blur the boundary between treatment and punishment.

- *The link between mental illness and violence* – Some of the more punitive approaches to the mentally ill are driven by fear of their potential to commit violence. This fear has been fueled by recent sensational and widely-reported violent attacks such as the shooting of two guards inside the U.S. Capitol. The relationship between mental illness and criminal behavior has been extensively studied.[16] Older studies were conducted on institutionalized populations but more recent ones have looked at those discharged from hospitals and compared them to the general population. (See inset, page 10). These studies have found a statistically significant relationship between mental illness and violence. However, the link of mental disorders to violent behavior is not based on a diagnosis of mental illness but on current psychotic symptoms,[17] and can be mitigated through appropriate medication and treatment. Violent behavior is most likely to occur when people with mental illness have a co-occurring substance abuse problem. Alcohol and drug abuse also raise the likelihood of violence by the non-mentally ill, but to a lesser extent. However, the contribution of mental illness to overall levels of violence in the United States is considered to be very small. One estimate is that the seriously mentally ill commit 4% of all homicides.[18] The misunderstanding of the level of violence among mentally ill persons contributes to a

[15] The National GAINS Center, op. cit.
[16] For a review of many of these studies and a summary of their results, see Arthur J. Lurigio, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness," and James A. Swartz, in *Criminal Justice 2000*, Volume 3.
[17] National Institute of Justice Research Preview, *Mental Illness and Violent Crime*, October 1996.
[18] E. F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, Wiley & Sons, 1997.

climate of fear in which confrontational police tactics, intervention of the criminal justice system and prolonged periods of incarceration are seen as acceptable, even necessary, steps.

- *"Guilty but Mentally Ill" Laws* – Use of the insanity defense has been increasingly under attack, particularly since John Hinckley was found not guilty by reason of insanity for the attempted assasination of President Reagan in 1982. The perception that mentally ill people were "getting away with crime" by hiding behind their claims of illness has resulted in 13 states adopting "guilty but mentally ill" laws. These laws allow for the finding of mental illness but still impose the same sentence as would have been given to someone who was not ill. Although these laws may make provision for some treatment during the period of incarceration, their main purpose is to elevate the principle of retribution above that of treatment.

Lack of Pre-Release Planning and System Integration

Lack of coordination between systems results in people who have been incarcerated leaving prison or jail without any connection to support services such as community agencies or federal entitlement programs to provide health coverage or money to live on.

Once the mentally ill are within the criminal justice system, their condition may deteriorate as a result of inadequate treatment and because the circumstances of life behind bars are likely to exacerbate their condition. For example, the overcrowding that is endemic in prisons today leads to greater levels of violence, a lack of privacy, excessive noise, and other stressful conditions that are hard on everyone but particularly so on those subject to emotional and psychiatric problems. When they leave prison or jail, if no appropriate arrangements are made for treatment and services on the outside, they are likely to return to the lifestyle and disruptive behavior that brought them into the system in the first place and the cycle will be repeated.

This issue has been the subject of litigation filed by the Urban Justice Center on behalf of mentally ill inmates discharged from the New York City jail system. The lawsuit contends that of the 30,000 inmates who have received treatment for mental illness who are discharged from the city's jail system only 7% have received any discharge planning. The remaining 93% are either released from court or dropped off at a subway station between 2 a.m. and 6 a.m. with two subway tokens and $1.50 in cash. Individuals who were on psychotropic medication while in jail are not given a supply of medication, nor are mentally ill inmates given referrals to Medicaid, SSI, housing, or other supportive services. In March 2001, the Appellate Division of the State Supreme Court required the city to provide ongoing mental health services to inmates until the lawsuit is decided.

The MacArthur Research Network on Mental Health and the Law conducted a *Violence Risk Assessment Study,* to determine which former psychiatric hospital patients would be considered dangerous. It followed 1,000 people between the ages of 18 and 40 for one year after discharge, interviewing them and at least one person who was most familiar with their behavior in the community, every ten weeks. Researchers also examined police and hospital records.

The study classified approximately three quarters of the patients they assessed into one of two risk categories: "High violence risk" patients were defined as being at least twice as likely as the average patient to commit a violent act within the first 20 weeks following hospital discharge. "Low risk" patients were defined as being, at most, half as likely as the average patient to commit a violent act within the first 20 weeks following hospital discharge. Over a year's time, researchers estimated the occurrence of violence to others in the community based on patients' self-reports, reports of family members, arrest records and mental hospital records.

Researchers found that 18.7% of all patients committed at least one violent act during the first 20 weeks following hospital discharge. "High violence risk" patients had a 37% likelihood of being violent, while "low violence risk" patients had, at most, a 9% chance.

In order to address the question of how the rate of violence by other members of the community compares with the rate of violence by former mental patients, researchers conducted a *Community Violence Risk Study* in three sites. Five hundred adults between the ages of 18 and 40 living in the same neighborhoods in which the former patients resided were recruited as subjects. Measures for estimating the occurrence of violence to others included patients' and families' self-reports, arrest records and mental hospital records.

Findings include the following:

- People diagnosed with a major mental disorder and without a substance abuse diagnosis are involved in significantly less community violence than people with a co-occurring substance abuse diagnosis.

- The prevalence of violence is higher among people – discharged psychiatric patients or non-patients – who have symptoms of substance abuse. People who have been discharged from a psychiatric hospital are more likely than other people living in their communities to have symptoms of substance abuse.

- The prevalence of violence among people who have been discharged from a psychiatric hospital and who have symptoms of substance abuse is significantly higher than the prevalence of violence among other people living in their communities who have symptoms of substance abuse, for the first several months after discharge.

- When people discharged from a mental hospital turn violent, they will typically strike a family member in their own home, not unlike the violence committed by other people living in their communities.

The MacArthur Violence Risk Assessment Study, Executive Summary, updated April 2001. Available online at http://www.macarthur.virginia.edu/risk.html

Many low-income and indigent individuals with disabling mental illnesses rely upon federal entitlements for income support, medications and mental health care in the community. These benefits are terminated when mentally ill individuals land in jail. Under current federal law, Medicaid funds cannot be used to pay health care providers for health care costs of incarcerated individuals. While federal law does not require state or local governments to terminate benefit eligibility for these individuals, many states and localities terminate inmate eligibility for Medicaid, Supplemental Security Income and other entitlements such as Social Security Disability Insurance (SSDI) when mentally ill individuals are released from jail. As a result, many former inmates must reapply for benefits upon release to the community, a process that can take weeks or months. The long wait for a Medicaid card is particularly problematic, since it is often the only means of obtaining mental health services and treatment of co-occurring mental health and substance abuse disorders. The potential for recidivism can reasonably be expected to increase under such circumstances. And, due to their indigent condition, released individuals with mental illnesses are likely to constitute a cost to the county, without the federal assistance to which the county is entitled. Local social services can also be hard to access, due to lack of transportation and difficulty in dealing with the complexities of qualifying for aid.

DEVELOPING SOLUTIONS

The following section offers recommendations for steps that can be taken at each stage of the criminal justice system to limit the number of mentally ill persons coming into the system and to ensure optimal treatment and outcomes for those who do end up in jail or prison. However, the most important changes that are needed have a much wider focus. People with serious mental illness require a comprehensive community-based treatment approach that provides essential services, ensures public safety and reduces recidivism in criminal justice institutions.

While law enforcement, criminal justice and correctional officials increasingly recognize the need to work closely with mental health, substance abuse, and social service practitioners to address the special needs of people with mental illnesses and co-occurring disorders, the necessary resources are generally not available. As a result, large numbers of people with mental illnesses and substance abuse disorders are repeatedly recycled through jails and prisons, providing little if any benefit to the individual or the community.

One major problem arises from the splintered nature of many of the mental health and treatment options that are provided. Many psychiatric programs are designed to treat either the mentally ill or the developmentally disabled, or people with a chemical dependency. Many substance abuse programs do not accept people with mental illness. As a result, many people with multiple conditions, who constitute a large percentage of the mentally ill within the criminal justice system, are precisely the group who find it hardest to obtain appropriate treatment in the community. They also present a particular problem for police who are called to incidents involving people with more than one problem as they are often faced with no alternative but arrest. For example, mental health centers often decline to treat alcoholics, drug treatment programs find the mentally ill too disruptive and so refuse them entry, and emergency rooms are often unwilling to treat the mentally ill who are intoxicated or threatening. So they end up by default in the local jail.

The main challenge in the effort to build more effective community based service systems is to overcome political and agency inertia. A 1999 report from the Open Society Institute and the National GAINS Center outlined the need for system integration in communities to link mental health, substance abuse and criminal justice systems.[19] As the report acknowledged, "System integration …. [is] a powerful mechanism for communities to improve service delivery and to treat people, not just problems. System integration can benefit everyone. However, for integration to work, the old ways of doing things need to be challenged and new ways created. Integrated services that provide treatment, case management and housing serve the entire community's interests by reducing homelessness and public disturbances, as well as reducing inappropriate detention and the number of detainees, increasing treatment involvement, and breaking the cycle of decompensation, arrest and incarceration."[20]

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[19] Open Society Institute's Center on Crime, Communities & Culture, and the National GAINS Center, *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*, December 1999.
[20] Ibid.

Community Services

If lack of adequate community resources and services is one of the main reasons for the criminalization of the mentally ill, then the improvement of community services is obviously key to making systemic change. Diversion from the criminal justice system to civil or treatment systems must be designed to protect the community and the individual, and ensure ongoing treatment of people with co-occurring disorders. Diversion not only benefits the offender, but it can also help save money by lowering the recidivism rate of mentally ill offenders who frequently return to the system because their symptoms lead to continued arrests and incarceration. The Substance Abuse and Mental Health Services Administration (SAMHSA), described the intent and importance of diversion this way:

> *The best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health and substance abuse treatment, housing, and social services. Diversion programs are often the most effective means to integrate an array of mental health, substance abuse and other support services to break the cycle of people who repeatedly enter the criminal justice system.*[21]

Community services are important at the beginning of the process to prevent the development of the crises that lead to law enforcement involvement, to provide alternatives to incarceration when problems arise, and to ensure support for people returning to the community from prison and jail.

Among the necessary steps:

- Develop community resources, particularly the availability and accessibility of emergency mental health services, to reduce the likelihood that persons with mental illnesses will come in contact with police and be arrested.

- Allocate funding for community-based alternatives to incarceration and increased capacity to deliver essential services to probationers and others with mental illnesses.

- Work closely with mental health consumers, families and advocacy groups to improve services, develop new initiatives and involve all relevant agencies.

- Develop a program of aggressive outreach to homeless mentally ill individuals in the community to assess needs, engage individuals in treatment and provide case management services. Recognize that co-occurring disorders are the norm and not the exception. Long-term housing support for homeless mentally ill offenders is a critical need.

- Encourage local Social Security district offices to work with jails and local community mental health programs to facilitate both the re-instatement of benefits as individuals leave jail or prison, and the filing of applications on behalf of individuals in correctional facilities who have serious mental illnesses and may be eligible for SSI or SSDI but are not currently on the rolls.

[21] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Jail Diversion Knowledge Development and Application Program*, 1999.

- Create awareness among community leaders that every state has a State Protection and Advocacy Agency that is mandated to protect and advocate for the rights of people with mental illnesses and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illnesses. These facilities may be public or private, including hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails and prisons.

Police Contact/Pre-Booking

Police are generally the first on the scene when a person with mental illness creates a disturbance or commits a crime. To some extent they have the discretion to determine the subsequent course of events – arrest, hospitalization or informal disposition – depending on their view of the severity of the disturbance, the behavior of the offender, and the resource options available to them.

In most jurisdictions, the police can in theory initiate emergency hospitalizations for people who are either a danger to themselves or others. In practice, however, this discretionary power is significantly restricted by the stringent legal criteria surrounding involuntary commitment, the unavailability of community-based treatment slots, the unwillingness of mental health facilities or emergency rooms to accept patients who are perceived as intoxicated or recalcitrant, and the time and bureaucratic procedures required for admission.

- The appropriate use of discretion also requires police officers to understand the problem they are faced with and how best to react. Police agencies should provide in-service training to enable officers to recognize the signs and symptoms of serious mental illness.

- Specialized police units, such as the Memphis Police Crisis Intervention Team (CIT), can provide an immediate response to a crisis involving mentally ill people. Officers in these units, who have been trained to interact with the mentally ill, focus on defusing potentially volatile situations by gathering relevant history, assessing medication information, and evaluating the individual's social support system.

- Where possible, the mentally ill should be diverted from the criminal justice system at the initial point of contact with law enforcement officers. Pre-booking diversion will only occur if police are provided with options other than placing mentally ill arrestees in jail, such as placement in an environment where individuals can be properly screened, diagnosed and treated:

    - Pre-booking programs in Memphis, Tennessee, Multnomah County, Oregon and Montgomery County, Pennsylvania, intensively train police to handle calls involving individuals with mental health or substance abuse problems. Each site has a 24-hour crisis center with a no-refusal policy for persons brought in by police.

    - In Hillsborough County, Florida, officials established a Crisis Center to which police can bring criminal offenders suspected of having serious mental illnesses. In a similar effort, Seattle has proposed a "no refusal" triage center that can be used by police officers as an alternative to jail booking for individuals with mental illness or chemical addictions.

Post Booking

Overall, diversion from jail and re-entry into the community should be the primary objective for people with mental illnesses whose arrests result from symptoms of their illnesses. Individuals with mental illnesses who have been arrested for less serious, non-violent crimes should be diverted from jail to community-based mental health programs whenever possible. People receiving appropriate treatment in the community generally have a better long-term prognosis and are less likely to return to jail for a similar offense.[22]

- When mentally ill people are arrested, the jail system should provide for their specific needs, beginning with a process for early screening, classification and referral. For example, a three-tiered screening system in Summit County, Ohio, consists of an initial evaluation of mental status by a booking officer, a cognitive function examination administered by a mental health worker, and an evaluation by a clinical psychologist.

- Facilitating the bail decision so that defendants spend their pre-trial time in the community or an appropriate facility other than jail will limit the mentally ill offender's time in a particularly stressful environment.

- Supervised pretrial release programs are needed to include involvement of all the relevant agencies, including both mental health and criminal justice practitioners, prosecutors, defense counsel and the courts, along with community service providers, the individual with mental illness, and his or her family.

- People arrested for misdemeanors should be diverted to appropriate mental health treatment centers. A post-booking diversion program should screen individuals who may be eligible for diversion; evaluate their eligibility; negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a disposition outside the jail in lieu of prosecution, or as a condition of a reduction in charges.

    - In Wicomico County, Maryland, the Maryland Community Criminal Justice Treatment Program's case manager works with a diversion candidate to develop a treatment plan. The plan is discussed with the Assistant State's Attorney, the public defender, and the judge assigned to the case. When all parties agree that diversion is appropriate, the judge places the case on the "stet" docket, which leaves it open for one year. The defendant is then released to the community to complete his or her treatment program.

[22] Policy Research Associates, Inc., *Jail Diversion – Creating Alternatives for Persons with Mental Illnesses*, Del Mar, New York.

Trial and Sentencing

At sentencing hearings, judges and others involved in the court process need to be aware of the role that serious mental illness may have played in a person's current charges. Traditionally, mental illness is considered only if it is a salient feature of the case (i.e., if there is a question about insanity or fitness to stand trial). To ensure that this happens:

- The defense bar needs training on mental health issues, including:
  - interviewing techniques.
  - use of social worker and staff trained in mental health issues.
  - practice of obtaining records and tracking down discharge summaries or physician's evaluations for a client with a mental health history.
  - staff with familiarity with treatment issues, epecially medications and their various impacts.

- Mentally ill individuals need timely access to counsel, preferably attorneys who have experience in working with individuals with mental illnesses.

- Judges must have information on offenders' mental health status available to them so that they can make a determination regarding: the defendant's competence to stand trial; whether medication is needed in order to achieve competency; the viability of developing specific plans to address offenders' mental health needs and establish referral mechanisms.

- State criminal codes should authorize or permit judges to divert non-violent offenders with mental illness away from incarceration to appropriate treatment, including the authority for judges to defer entries of judgment pending completion of treatment programs and to dismiss charges and expunge records of individuals who successfully complete treatment programs.

- Jurisdictions can establish sentencing alternatives for mentally ill offenders. The Nathaniel Project in New York City was created by the Center for Alternative Sentencing and Employment Services to provide a sentencing option for mentally ill prison-bound felony offenders. Program clients have committed serious offenses, including burglary, robbery, assault, and sexual assault. Once accepted into the program, a comprehensive treatment and supervision program is developed, generally including residential treatment, services for co-occurring substance abuse disorders, and intensive community integration support.

Probation and Parole

Services for mentally ill probationers can be most effective when they are provided through special programs staffed by officers with specialized training and experience. For probation services to be successful with the mentally ill, they must address the broad range of offenders' needs and work in collaboration with other agencies and services to ensure that these needs are met.

- Increase access to mental health professionals. According to the National Institute of Justice, 82% of probation and parole agency directors indicated the need for such access. One such effort, the Maryland Community Criminal Justice Treatment Program, is a multi-agency collaborative providing shelter and treatment services to mentally ill offenders on probation and parole, or in jail. Each local program has case managers on staff who link mentally ill offenders with screening and needs assessment services, counseling and discharge planning, and referral and monitoring in the community.

- Provide specialized cross-training to parole and probation officers about the characteristics of serious mental illnesses, the effects that these illnesses have on daily functioning, and the goals and desired outcomes of treatment. Include crisis intervention, screening, counseling, discharge planning and community follow-up in case management services.

- Understand the requirements of confidentiality statutes and mental health law. Identify mental health and other services available in the local area and learn how to access them, along with the government-funded benefits available to these individuals.

- Screen individuals for social, medical, clinical and criminal justice factors that would place the client at risk of failing his or her reintegration into the community. Include crisis intervention, screening, counseling, discharge planning, and community follow-up in case management services.

- Allow for continuous monitoring, increased communication between community supervision and other provider agencies, greater client responsibility, and more flexible sanctions that allow for some mistakes without an immediate return to jail or prison.

- Provide training for culturally competent community corrections.

- Help individuals with multiple problems (mental health, co-occurring substance abuse, poverty, housing, other social services) and focus on preventing persons with co-occurring disorders from relapsing into substance abuse. Encourage small caseloads and frequent interaction between case management staff and client.

- Fund transition services for parolees. Evaluate the effectiveness of specialized divisions or units with specific responsibility for coordinating and administering services for people with mental illnesses who are on probation.

Jail and Prison

Correctional facilities are poor settings for providing mental health care. The earliest possible diversion of individuals to the community or to residential treatment services is generally in the best interests of all concerned. Community based treatment and case management services are more likely than jail admissions to stabilize individuals and reduce recidivism. Offenders who may present a danger to the public should receive treatment in secure forensic facilities, not in settings that only worsen their condition.

Suicide Prevention

Suicide rates among mentally ill inmates who have made previous attempts are more than 100 times higher than the rate in the general population. Over 50% of jail suicides are committed within the first 24 hours in jail. More than 95% of those who commit suicide in correctional facilities have a treatable psychiatric illness. Suicide prevention in jail depends upon the ability of corrections and mental health staff to cooperate in identifying inmates at risk, and providing the treatment and monitoring necessary to ensure their safety.

Mental Health Services

Jail mental health professionals are needed to recognize and respond to inmates experiencing psychiatric symptoms and to ensure access to appropriate medication in the proper dosage. Services should include the following:

- Identify service providers for incarcerated mentally ill persons, including suicide assessment, screening, crisis intervention, classification and referral, prevention and intervention, in-jail counseling, discharge planning and community follow-up.

- Provide specialized services for subgroups of mentally ill inmates, such as those who are homeless and/or have co-occurring substance abuse disorders.

- Develop a discharge planning program for mentally ill inmates to be released from State prison to ensure that they are connected to appropriate community resources, including supervision, treatment and housing.

- Develop liaison with local Social Security offices to facilitate reinstatement of Federal disability benefits (SSI, SSDI, Medicaid) for mentally ill inmates when they are to be released from jail or prison.

CONCLUSION

The number of mentally ill persons confined in prisons and jails has increased dramatically over the past several decades. This has been the result in part of the expansive growth of these institutions generally, but has also been a function of factors relating to the care of mentally ill people in community settings. As deinstitutionalization became a guiding policy in regard to mental hospitals the failure to simultaneously support community-based mental health services led almost inevitably to a host of problems which ultimately came under the jurisdiction of the criminal justice system.

This set of factors has resulted in a situation which is unsatisfactory to all involved. Mentally ill persons often do not receive appropriate services, which may contribute to behaviors that bring them into contact with the criminal justice system Criminal justice practitioners are faced with limited resources with which to confront issues that would often be better suited to other institutions. And communities are not well served by the negative consequences of untreated mental illness.

As the programs and policies recommended in this report demonstrate there are often more constructive options available by which to respond to the challenges posed by mental illness. Foremost among these is the need to provide more intensive services in communities in order to aid mentally ill individuals to lead functional lives and to reduce the incidence of criminal behavior. Within the criminal justice system policymakers and practitioners can develop new means of working collaboratively with other community institutions to assess, diagnose, and respond appropriately to criminal involvement by mentally ill offenders. Such a framework would help communities develop systemic responses that both promote public safety and reduce the inappropriate confinement of individuals with mental illness.

CCJJ Mental Health Initiative
White Paper

I. Sequential Intercept Model

Concept

The "sequential intercept model" (Munetz and Griffin, 2006) provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness.

The model defines a series of critical points at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. The intercept points can be viewed as a series of "filters", with the goal of intercepting most people at early points, with decreasing numbers at each subsequent point.

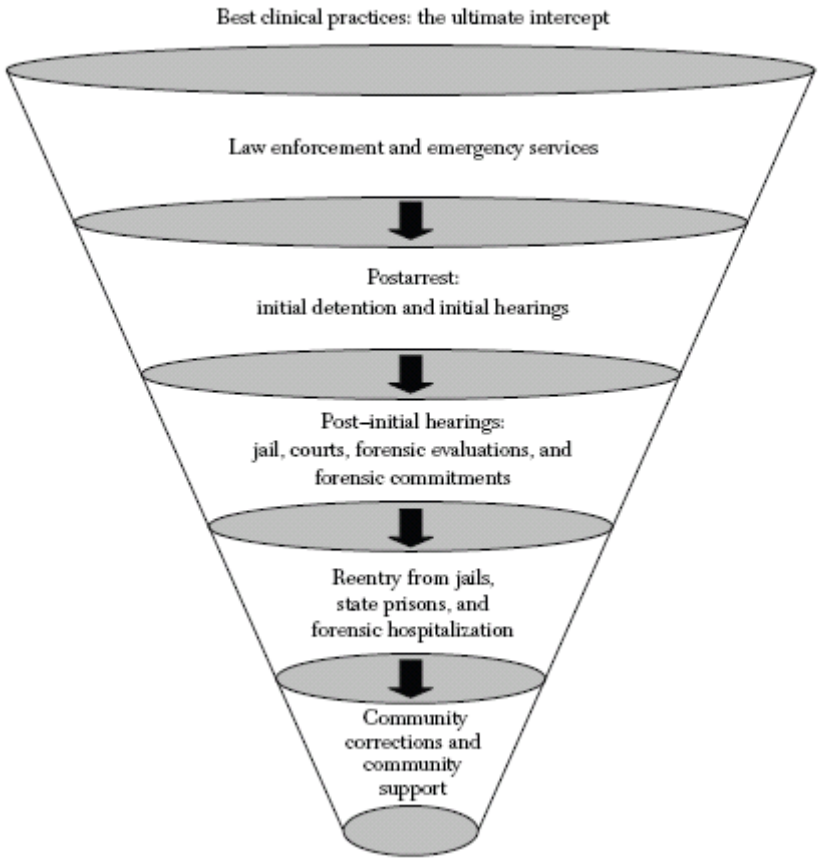
The interception points are:

- Law Enforcement and Emergency Services;
- Initial detention and initial hearings;
- Jail, courts, forensic evaluations, and forensic commitments;
- Reentry from jails, state prisons, and forensic hospitalization; and
- Community corrections and community support.

The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.

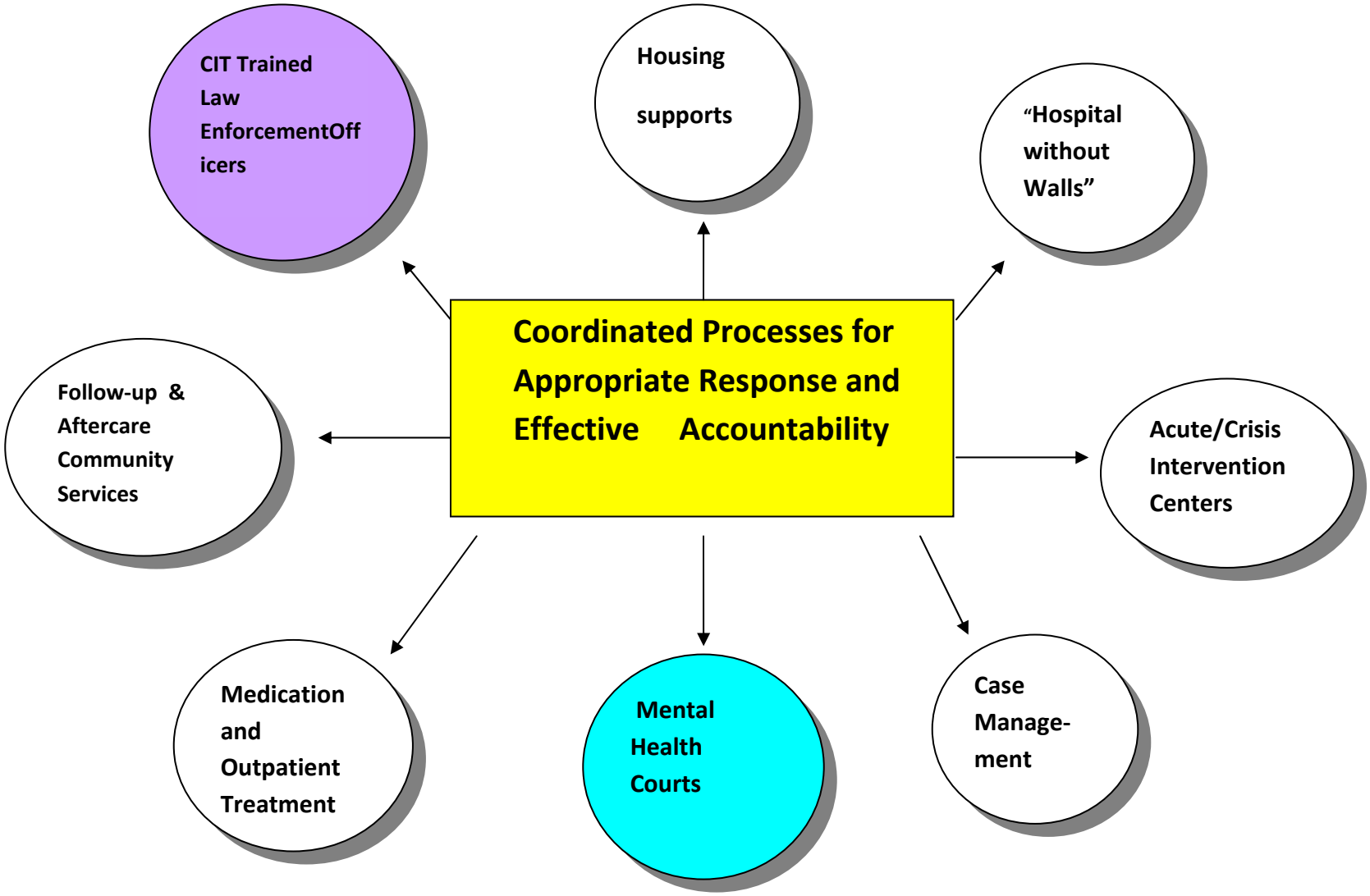
Figure 1

The Sequential Intercept Model viewed as a series of filters



Coordinated Community Response

for Mentally Ill Offenders



CCJJ Mental Health Initiative
White Paper

Crisis Intervention Team (CIT)

Concept

A Crisis Intervention Team (CIT) includes specially trained law enforcement officers. These officers are trained in tactics to effectively deal with a person experiencing a mental crisis, as well as every day interaction. They have successfully completed state authorized training, and passed required testing, to become certified as a Crisis Intervention Team Officer by the State of Utah, Division of Substance Abuse and Mental Health.

CIT Officers are law enforcement officers from uniformed patrol divisions. These officers still maintain their responsibilities as patrol officers, but become primary responding units to situations involving a mental health consumer, or persons experiencing a mental health crisis. A CIT Officer is trained in identifying characteristics of various mental health disorders, techniques to de-escalate a person in crisis, resources to find longer term resolutions, and the ability to decide the most appropriate dispositions of mental health related incidents.

The CIT Program is a statewide program that builds strong working partnerships between law enforcement agencies and the resources they utilize. These partnerships bring law enforcement and mental health services together instead of working independently on mental health issues.

Benefits

CIT Programs have been implemented in numerous jurisdictions throughout the Nation as well as being introduced in other countries. The program is backed and supported by CIT International that provides annual training for those overseeing state, regional, and local CIT Programs. Some of the benefits of a CIT Program include:

- Criminal recidivism by mental health consumers is reduced.
- Relationships between mental health providers and law enforcement agencies are improved.
- Dispositions of mental health calls for service are more appropriate.
- Officer injury rates and use of force are reduced.
- Officers are better trained in mental health legal and liability issues.
- Mental health consumers and their family members report having more positive experiences when dealing with CIT Officers.

Implementation Plan

The Salt Lake City Police Department is the administrating agency of the CIT Program. The Salt Lake City Police Department is responsible for coordinating and promoting the CIT Program efforts throughout the state. Member rosters, participating agency rosters, and all aspects of the CIT Program are maintained by the Salt Lake City Police Department.

The CIT curriculum and all aspects of the program were developed through the Salt Lake City Police Department based on the Memphis Police Department model. The Academy and instruction were refined through the first sixteen academies held in Salt Lake City. Officers from across the state attended these academies. This began to accomplish the program goal of establishing a cadre of Crisis Intervention Team law enforcement officers within all Utah jurisdictions. However, it did not truly address the second program goal of establishing a "system" that includes law enforcement as a "team member" of mental health care.

To achieve the second goal, officers would need to interact and become "partners" with the mental health providers, hospitals, resources, and other agencies in their communities. Officers in and around the Salt Lake Valley were able to become partnered with these individuals and their resources through the activities provided during the CIT Academy. Officers from other counties did not receive this benefit. With this in mind, regional academies were implemented to address the rest of the state.

The State of Utah Division of Substance Abuse and Mental Health is the state's mental health authority and oversees the public mental health system. The state's twenty-nine counties provide or contract with independent mental health providers to become the mental health authority of their counties. This has formed eleven mental health catchment areas also known as mental health centers.

To facilitate a regional academy, at least one law enforcement agency and the area's mental health center need to identify a person of their organization as a CIT Regional Coordinator and become partners in promoting a Regional CIT Program. The Salt Lake City Police Department's State Program Director and State Program Coordinator will provide training to the Regional Coordinators, assist the region with the development of the training academy, and help build the required partnerships for the program. All instructors, site locations, and participants will be from the local area. The Salt Lake City Police Department will continue to maintain the role of administration for the State CIT Program; however, all advancements of the CIT Program in the region will be the responsibility of the Regional Coordinators.

Resource/Contact Information

For questions or further information, contact:

Detective Ron Bruno
CIT Program Director
Salt Lake City Police Department
(801) 799-3709
CIT@slcgov.com
www.citutah.com

CCJJ Mental Health Initiative
White Paper

II. Community Response Teams

Concept

A ***community response team*** is a staff of mental health workers who provide immediate, short-term response to the jail when an inmate has been identified as seriously mentally ill and is being diverted or discharged from jail. The team provides rapid assessments, linkages to community mental health treatment, and relationship building. Community response teams have the following capabilities:

- 24 hour availability;
- Can respond quickly on-site to the jail or justice services to assess a client and link into community mental health services;
- Can conduct jail "in-reach" visits to establish a community discharge plan and to establish relationships with inmates with mental illness;
- Available to CIT officers (Crisis Intervention Team) in the community who are dealing with a mental health disturbance. Provides consultation and assistance to officers on issues of inpatient hospitalization, involuntary commitment, and on-site follow-up.
- Provides assessment and referrals, case management, medication assessments to persons who are being diverted or released from the jail on-site, wherever the client may be in the community.

Benefits

Crisis Response Teams offer tremendous benefits to the communities that establish them:

- CIT law enforcement officers can be assured of consultation and follow-up assistance when dealing with a mental health disturbance in the community;
- Jail inmates have an established relationship with community mental health, and a defined discharge plan prior to release from jail, which greatly enhances this linkage.
- Jails have mental health supports when releasing mentally ill offenders;
- Recidivism in mentally ill offenders is reduced

Implementation Plan

Communities who wish to develop a mental health community response team may wish to consider:

- Convening a roundtable discussion of community stakeholders at the policy-making level. Consider including:
    - Mental health advocacy organizations such as NAMI-Utah;
    - County Commissioners/Council (essential, as they are the local mental health authorities)
    - Sheriff
    - Executive Director of the local community mental health center

    - Adult Probation and Parole
    - Public Defenders
    - County Attorney's Office
- Funding the team will require a combination of funds that is likely to include:
    - Medicaid funding
        - Develop a process for assessing insurance/entitlement eligibility, with specific focus upon Medicaid eligibility
        - Develop an agreement with the local mental health center to accept Medicaid clients based upon *presumptive eligibility*
        - Medicaid providers apply for retroactive payment for services rendered before Medicaid became active
    - State/local funds
        - Use of local funding will require prioritization of the *local mental health authorities*, who are statutorily defined as the county commissioners/council in the region covered by the mental health center. The local authorities will need to determine jail diversion activities are a priority for use of state and local mental health funding. They can then identify this as a funding priority in the *local area mental health plan* which is submitted to the State in May of each year.
    - Grant Funding
        - At various times, grant funding may be available for start-up criminal justice diversion projects
        - Grant funding for jail diversion projects may be offered by a large variety of foundations, or from SAMHSA; http://www.samhsa.gov/newsroom/advisories/0803145354.aspx ; the Gains Center; http://www.gainscenter.samhsa.gov/html/default.asp ; or the Bureau of Justice Assistance http://www.ojp.usdoj.gov/BJA/funding/current-opp.html
- The CRT function can be initiated with as little as one case manager who can make linkages into the community treatment programs and work as liaison between the jail, court, and mental health. As resources allow, the optimal is for a multi-disciplinary team consisting of:
    - Licensed mental health worker(s)
    - Case manager(s)
    - Registered Nurse
    - Psychiatric medication assessment

Resource/Contact Information

For questions or further information, contact:

Richard Hatch
Valley Mental Health
263-7100

Project RIO

Right People In Right People Out

CJAC

Subcommittee

Span Committee

SL Co Metro Jail

Third District Court

State CIT Program

Criminal Justice Services

NAMI - UTAH

SL Co Mental Health

SL Co Substance Abuse Services

Primary Mental Health Consumer

District Attorney's Office

SL City Prosecutor's Office

Legal Defender's Association

CJAC Coordinator

Serving as staff to the committee:

A Jail Mental Health Discharge Planner
and a Boundary Spanner

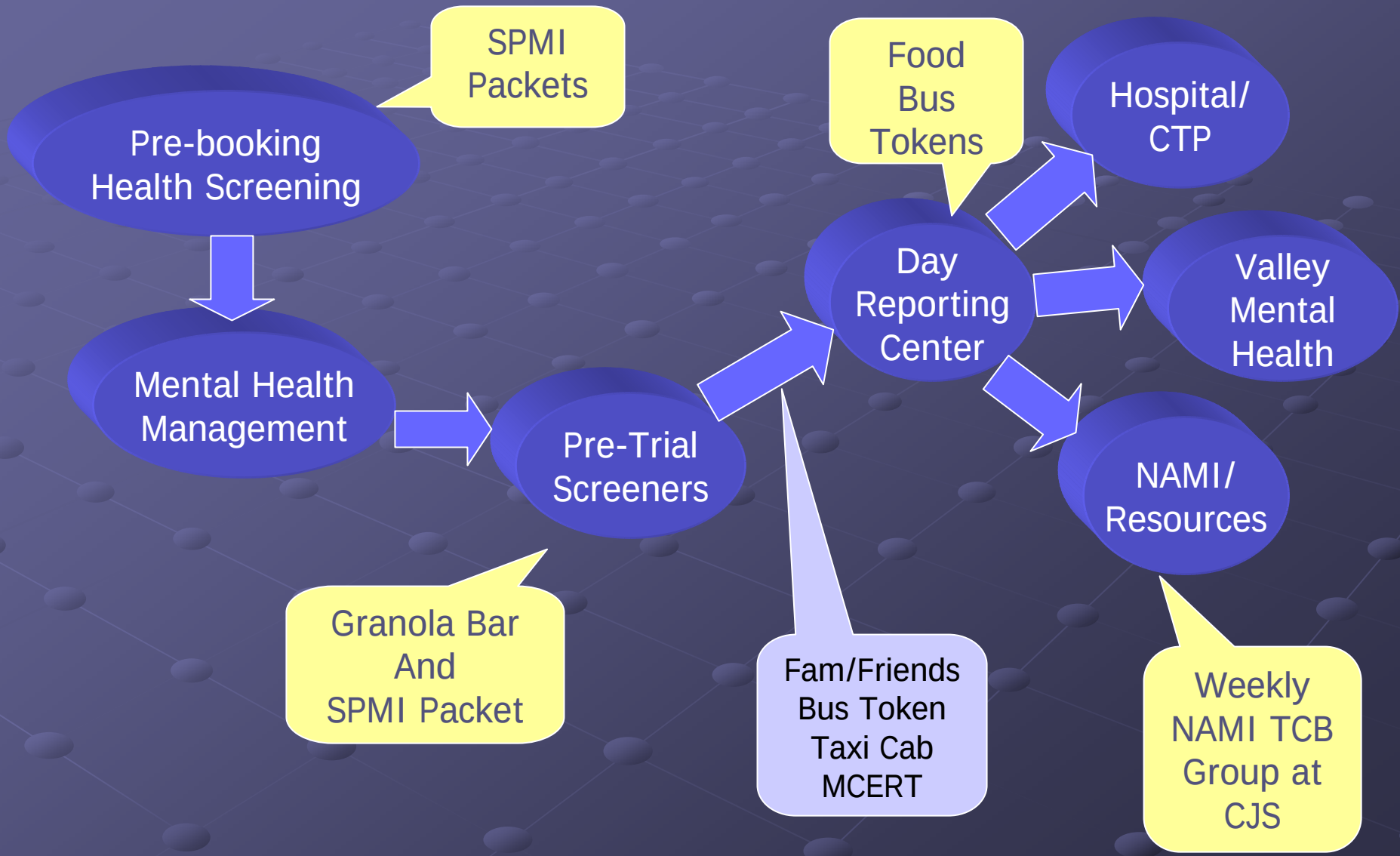
Grand Rounds Process

- Frequently homeless
- Multiple cases in multiple courts
- Off medications
- Self medicating with illegal substances
- Numerous bookings
- High numbers of days spent in jail
- Typical crimes: trespass, disorderly conduct, intoxication, assault on a police officer, possession, etc.
- Frequently an overcrowding release from jail
- Example……

Objectives

- Mental Health Release Process
- RIO Housing Program
- JDOT – Jail Diversion Outreach Team
- MHC Expansion
- Mental Health Docket
- Receiving Center

Mental Health Release Process



RIO Housing Program

- Housing first model (housing is not used punitively)
- Seriously and persistently mentally ill
- High recidivism
- Intensive Case Management through JDOT

Current Stats: 9 individuals housed
average = 25 bookings per person
average = 813 days in jail per person
total = 7,319 days in jail

Since JDOT began assisting this group (September 2007), 1 person has been arrested and served 2 weeks in jail

Additional Housing Programs: Master Leasing MHC units (17), HARP (80), Sunrise Metro (100), Grace Mary Manor (84), etc.

JDOT – Jail Diversion Outreach Team

- Assertive Community Treatment Team
- Mobile
- 24/7 assistance
- 7 members: 2 LCSW's
  1 Case Manager
  1 APRN
  1 RN
  2 NAMI Mentors
- Approximately 50 clients on their caseload
- In-reach into the jail

Assistance Provided:

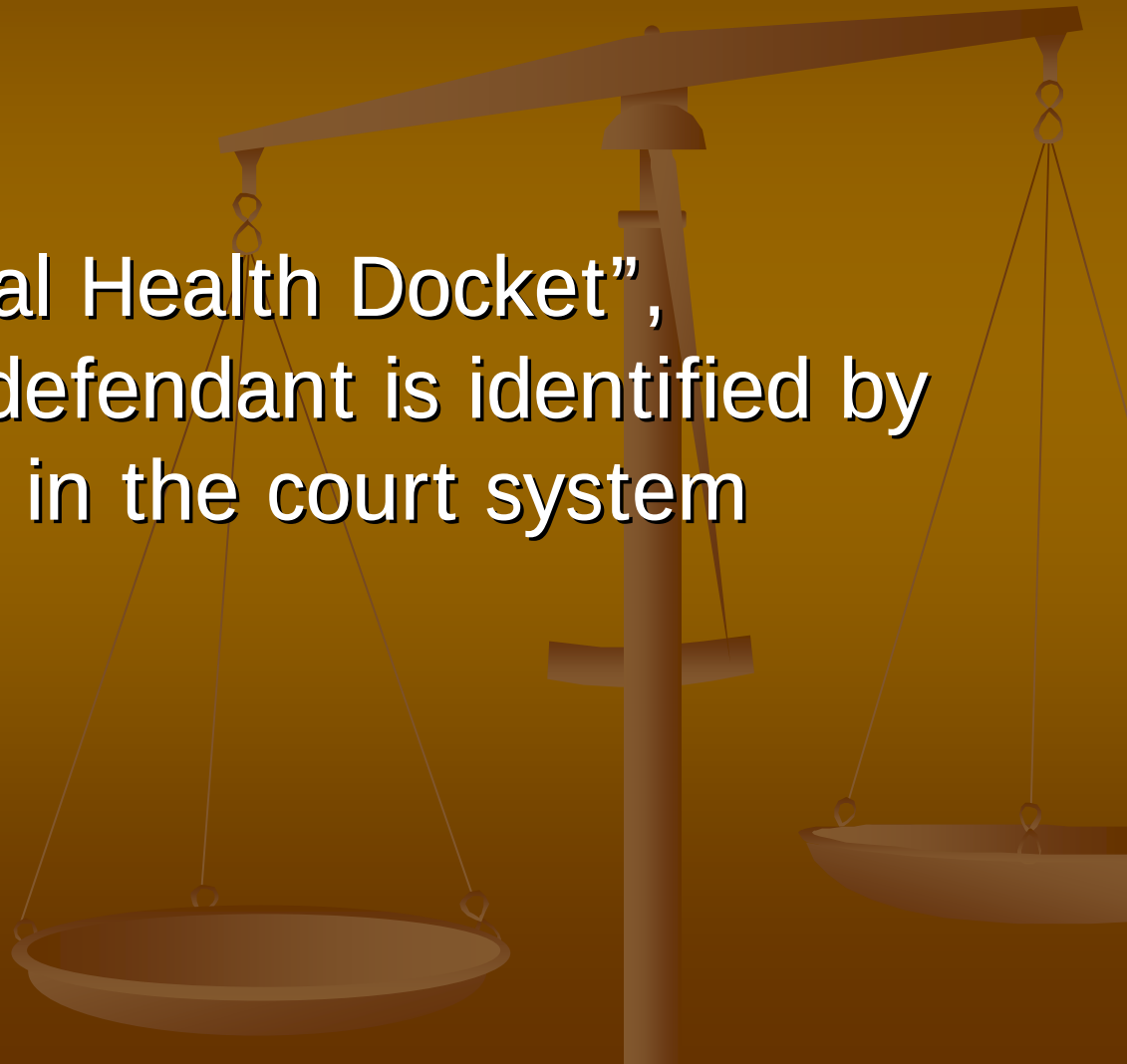
- Housing
- Entitlements
- Medication
- Payee assistance
- Life skills (shopping, etc.)
- Court assistance/case clearing

Mental Health Court Expansion

- To expand MHC so that all 16 Justice Courts may transfer cases into MHC
- Approved by the County Council
- Expansion plans are still “in progress”

Note: a recent study of the San Francisco Behavioral Health Court found that eighteen months after graduation, the group had an estimated 39 percent lower risk of being arrested for a new offense and 54 percent lower risk for a violent crime (American Journal of Psychiatry)

Mental Health Docket



- Establish a “Mental Health Docket”, whereby a SPMI defendant is identified by a time/special file in the court system

Receiving Center

- A pilot program has been funded for 2008, that will have a total of 5 beds through Volunteers of America for receiving persons who are being diverted by local law enforcement personnel due to substance abuse, mental illness, or other behavioral conditions

Boundary Spanner

- Assist with the implementation of these new programs
- Communicate with all agencies to identify failures in the system and try to remedy them
- Outreach into the community (Road Home, VOA, 4th St. Clinic, Pathways, Storefront, etc.)
- Assist these agencies with individual cases as they arise

The National Institute of Mental Health has confirmed that people with severe depression, bipolar disorder, schizoaffective disorder and schizophrenia have a chemical imbalance in their brains that distorts their moods and impairs their thoughts.

Jeannie Edens

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The Applicability of

Housing First Models to Homeless Persons with Serious Mental Illness

U.S. Department of Housing and Urban Development
Office of Policy Development and Research

The Applicability of

Housing First Models to Homeless Persons with Serious Mental Illness

FINAL REPORT

Prepared for:

U.S. Department of Housing and Urban Development
Office of Policy Development and Research

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The findings and views herein are those of the authors and do not necessarily reflect the views or policies of the U.S. Department of Housing and Urban Development.

Foreword

Understanding homelessness is a necessary step toward ending it, especially for those persons living with a chronic condition such as mental illness, an addiction, or physical disability. Ending chronic homelessness remains a national goal for President Bush, the Department of Housing and Urban Development (HUD), and many within the homeless advocacy community.

In recent years, an approach known as Housing First has emerged as one model for serving chronically homeless people. HUD began this study as a first step in describing how Housing First programs actually work and what sorts of short term outcomes are realized by the people they serve.

This report, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, provides a basic description of several programs that represent a Housing First model. The report should help clarify the issues and inform the policy discussion about how best to address the most vulnerable in American society.

Darlene F. Williams
Assistant Secretary for
Policy Development and Research

Preface

This report presents the findings from an exploratory study of the Housing First approach of providing permanent supportive housing to single, homeless adults. Those served have mental illness and co-occurring substance-related disorders, and frequently come directly (or nearly directly) off the streets. Congress and the U.S. Department of Housing and Urban Development (HUD) have encouraged the development of permanent supportive housing for homeless people since the inception of the McKinney-Vento Act in 1987. In recent years, increased public attention has been focused on the hardest-to-serve, chronically homeless population, a substantial number of whom are mentally ill. Because it addresses this population and its needs, the Housing First approach has emerged as a favored policy response among many in the advocacy and practitioner communities.

Each of the three Housing First programs studied here use a low demand model to respond to substance abuse among their chronically homeless target populations.[1] What is low demand? This report defines it in this way:

> The [low demand] approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of [low demand] for those who want to quit using drugs, but for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and to educate users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

One recent review of the literature indicates that the fundamental assumption of low demand "is that substance use falls along a continuum from abstinence to problematic use or abuse. While abstinence and a substance-free life represent long-term goals, any immediate step in that direction, such as reducing the quantity and/or frequency of use, should be viewed positively and reinforced." (Connors et al. (2001)

Clearly, any public program or policy that countenances the use of illegal drugs under any circumstance runs the risk of violating other Federal, state and local laws and policies. The Department then must weigh competing social values to arrive at a policy relating to low demand approaches.[2] This is not the place to set that policy, but we do believe that clarifying what is at

[1] Throughout this report and this preface we shall use the term "low demand" where others might use "harm reduction". As Zerger (2002) observes, "…[P]olitically, the harm reduction approach has been aligned with the contentious debate of drug legalization, resulting in rhetoric which has implications for the clarity of any pursuant discussion on which drug policies might actually work." In this regard, it is difficult, if not impossible, for the government to support a set of policies, some of which are objectionable on legal grounds, that have been grouped under the category of "harm reduction". Under the circumstances, it is necessary to use the less politically and emotionally freighted term "low demand".

[2] Recent studies document that keeping homeless people housed benefits society quite apart from the person directly assisted. For example, Kidder et al. (upcoming) find that keeping someone housed reduces the incidence of risky sexual behavior, thereby reducing significantly the risk of HIV/AIDS transmission. Graham et al. (upcoming) conclude that keeping an ex-offender housed after a stay in prison or jail reduces substantially the likelihood that

stake will further the debate and ultimately work to reconcile what might be preferred practice by some providers and public law.

Certainly current research challenges the presumption that substance abusers can't and won't change. Beyond that, though, the reasons why people change addictive behaviors are still not well understood. As one close observer writes, "The simplistic account that people change because they receive treatment is wanting in many ways. Many people who recover do so without formal treatment. Even relatively brief interventions seem to trigger changes, and the dose of treatment delivered is surprisingly unrelated to outcomes. Client compliance with many different approaches, including placebo medication, has been linked to better outcomes." [Miller (1998)] One of the most prominent theories outlines a series of phases through which addicts proceed. What is clear, though, is that the rehabilitative process is neither unidirectional nor regular. For the vast majority of those dependent on drugs and alcohol, in fact, the process of choice and change is characterized by fits and starts, occasional relapse and, for some, chronic failure. Substance abuse policies, to be effective, must accommodate these dynamics. Clearly existing research, divergent as it is, does not recommend a single program or policy.

On the other side are the realities of chronic homelessness. We know, for example, that a significant portion of those living on the streets use drugs and alcohol; frequently, they suffer from mental illness as well. We also understand that for some part of that number getting them off the street will require at least temporary accommodation to drug and alcohol use in the facilities in which they are housed. On the other hand, the statutory purposes of the McKinney Vento Act homeless programs are to move homeless people toward stable housing and the greatest independence of which they are able. Persistent dependence on drugs and alcohol, whatever it is, is not a manifestation of independence.

The McKinney-Vento Act provides for a variety of HUD housing options to help stabilize the lives of homeless persons. These include emergency, transitional and permanent supportive housing. The law further allows for tenant-based and project-based assistance. A common tie to all these housing options is the principle that HUD's homeless housing programs are intended to help persons through the provision of services to address their special needs in order to become more independent. For instance, in describing the purpose of the Supportive Housing Program (SHP), the McKinney Act states that the program is to "promote the provision of supportive housing to homeless persons to enable them to live as *independently as possible*." (Title IV, C Section 421; emphasis added.) This emphasis on assisting clients with housing and services in improving their lives is also highlighted in the Act's provisions for the Emergency Shelter Grants Program. By law, this program requires that *applicants assist homeless individuals to obtain "appropriate supportive services*, including permanent housing, medical and mental health treatment, counseling, supervision, and other services essential for *achieving independent living*…." (Title IV, B Section 415 (c) (3) (A)) (emphasis added). These provisions are mirrored in the Code of Federal Regulations. HUD further reinforces this principle in its program grant application and grantee performance reports.

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he/she will return to a criminal justice facility. Culhane, Metraux and Hadley (2002) make a compelling case that providing appropriate housing and services is cost-neutral when the alternative is the street and all the public costs that entails.

With this focus on helping persons become more independent—emphasized in the law, regulation, application, and performance reporting—grantees are to assist clients in achieving this goal and to provide environments in which this progress can take place. By law, HUD's permanent supportive housing programs for homeless persons are designed to serve persons who are disabled, including those who are currently seriously mentally ill and/or who have chronic problems with alcohol, drugs, or both. For example, the fact that Shelter Plus Care statute specifies substance and alcohol abuse services as eligible supportive services for matching purposes presumes that some clients will be actively using drugs and/or alcohol at program entry, either before or during occupancy of the Shelter Plus Care housing.

Given these conditions that exist at the time of entry into housing, providers need to work individually with clients to address and resolve these issues. The law (SHP law) requires that the applicant "provide such *residential supervision* as the Secretary determines is necessary to facilitate the adequate provision of supportive services to residents and users of the project." Accordingly, HUD requires in its grant agreement that providers cannot knowingly allow any illegal activities, including illicit drug use, to be conducted in the project. This provision was added expressly to maximize the likelihood that clients struggling to overcome substance abuse addictions would have the most supportive environment possible in which to succeed in rehabilitating their lives. Many providers also prohibit the use of any alcohol while in a HUD homeless project and find this to be a necessary and effective approach for rehabilitation.[3]

It is important in this connection to distinguish Departmental policy related to public and assisted housing from that for McKinney-Vento Act homeless programs. Homeless people affected by substance abuse are a **target** population for the Department's homeless programs. They are **not** for the Public Housing or Housing Choice Voucher programs. When Congress sets forth a target population and the Administration subsequently proposes to end chronic homelessness, there is an underlying presumption that a not inconsiderable part of the target population will be using those drugs/alcohol at entry and perhaps for some time thereafter. Similarly, Congress has instituted such policy initiatives as safe havens as intentionally "low demand" alternatives to more orthodox approaches. [Note that safe haven is probably the closest statutorily-based conception to the Housing First concept]. The presumption is that such low demand programs will "do anything it takes" to engage chronically homeless people and then maintain them in housing. And, "doing anything it takes" presumes acceptance that some of those who are agreeing to come in off the street have not agreed or are not able to stop an existing addiction upon entering the program.

[3] Illegal drug use is no guarantor of eviction even when that is the housing provider's intent. For example, the Corporation for Supportive Housing, in its *Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing*, comments, "The use of illegal drugs should generally be sufficient grounds for eviction; however, it is advisable that leases contain a provision prohibiting the use of illegal drugs so the eviction is based on a lease violation. Most jurisdictions allow eviction for criminal activity, including illegal drug use. Housing providers should be prepared for the resident to assert the need for a reasonable accommodation in any eviction. Although it is difficult to think of what the reasonable accommodation would be in the instance where the housing provider has clear evidence of illegal drug use, providers should be prepared for creative defenses asserted by tenants who are being evicted for drug use.

Housing providers may have difficulty obtaining convincing evidence of the tenant's drug use. Rarely will a tenant use drugs in front of staff and other tenants are often reluctant to testify against fellow residents. Evidence based on behavior may not be convincing or explained away by the tenant."

Even here, though, the statute specifically prohibits the use of illegal drugs and alcohol in a HUD-assisted safe haven: "The Secretary may not provide assistance under this [Safe haven] subtitle for any safe haven program unless the applicant agrees to prohibit the use of illegal drugs and alcohol in the facility."[4]

These instances constitute a contrast to HUD-supported public and assisted housing where the target population is low income families with no presumption of disability and where the multifamily setting and, in the case of assisted housing, the future of the program is bound up with the ongoing satisfaction of landlords. For example, the Housing Choice Voucher rules permit an owner to terminate tenancy for criminal activity or alcohol abuse by any household member or guest. Such activity includes: Criminal activity which threatens the health, safety or peaceful enjoyment of the premises by other tenants or by people residing in the immediate vicinity; or drug-related criminal activity on or near the premises. Likewise, if, among other reasons, any member of the family commits drug-related criminal or violent criminal activity, PHAs may deny or terminate for this reason if the preponderance of evidence indicates a family member engaged in the activity whether or not the member was arrested or convicted. If any family member is illegally using, or possessing a controlled substance for personal use within one year before the date the PHA provides the notice of termination, the PHA may terminate assistance.

[4] The results of a recent survey of safe haven providers illustrate the paradoxes that pervade substance use in safe havens specifically and low demand programs generally. Based on returned surveys from 79 of 118 identified safe havens, the Ward Family Foundation found that:

- 86 percent of all surveyed providers received HUD funding for their safe haven programs;
- 79 percent of the responding providers indicate that they would accept residents who were active substance abusers;
- 47 percent of the providers reported low demand-oriented alcohol and drug treatment services were available on-site, and another 34 percent reported that, although they did not have such services on-site, they were committed to support them for their clients off-site;
- With all this in mind, 100 percent of the providers report that use of illegal substances on the safe haven premises is prohibited; 95 percent ban use of alcohol in the safe haven;
- 77 percent of respondents reported that they would terminate any client if they used drugs on-site; and 62 percent indicated that they would terminate any safe haven resident for use of alcohol on-site.

What appears evident from these numbers is that safe haven providers are faced daily with the task of reconciling house rules and expectations with the realities of the population they are serving and provider commitment, to the best they are able, to keep their clients from returning to the streets. In *In from the Cold: A Toolkit for Creating Safe Havens for Homeless People on the Streets*, a joint technical assistance document sponsored by HUD and HHS, the authors advise: "Safe Havens need to consider whether they will be a 'dry', 'damp', or 'wet' facility. While Save Havens do not assist or support residents in using alcohol or illegal drugs, some may have chosen to work with their residents toward a better understanding of their substance use and toward abstinence of reduced use and dependence."

We cannot deny the realities of homeless people abusing substances. The great majority of them, when sheltered, are going to be living in multi-unit buildings in which their ongoing substance use will affect others. Persistent drug use, for example, will offer an ongoing temptation to others who are themselves at various phases of change or recovery. Even if homeless clients do not sell illegal substances themselves, their use ensures that they are caught up in the crime and violence that accompanies drug and alcohol abuse. For many people, substance abuse brings changes in behavior (belligerence, noise, bizarre behavior) that undermine social/therapeutic health. Moreover, ongoing use of alcohol and drugs leads to progressive debilitation and adversely affects the capacity of those so afflicted to make good decisions. Acquiescence in active substance use does have consequences. On the other hand, as this study documents, some Housing First programs can ameliorate some of the worst social effects of persistent drug abuse through close and proactive contact with the client and steady commitment on the part of an interdisciplinary team to meet the needs of landlords as well as clients. On the other hand, there are certainly not enough cases in this research effort to conclude persuasively that the staff-intensity evident in these examples is widely replicable.

To the extent that projects using low demand acknowledge these social realities, then low demand may well comprise a feature of a viable response to chronic homelessness. However, the Department cannot in the name of low demand condone or acquiescence in the continued, unabated use of harmful substances or accept the ultimate expendability of people who do not recover.

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EXECUTIVE SUMMARY

This report presents the findings from an exploratory study of the Housing First approach of providing permanent supportive housing to single, homeless adults with mental illness and co-occurring substance-related disorders. In recent years, Congress and the leadership of the U.S. Department of Housing and Urban Development (HUD) have encouraged the development of permanent housing for homeless people. Concurrently, there has been a shift toward committing a greater proportion of HUD McKinney-Vento Act funds toward housing as opposed to supportive services and an increase in attention toward the hardest-to-serve, chronically homeless population, a substantial number of whom are mentally ill. Because it addresses this population and its needs, the Housing First approach is currently experiencing increased attention as a method of serving this population consistent with the above-stated goals.

WHAT IS THE HOUSING FIRST APPROACH?

Housing First programs may be constructed in a number of ways, but share the following features:

- The direct, or nearly direct, placement of targeted homeless people into permanent housing. Even though the initial housing placement may be transitional in nature, the program commits to ensuring that the client is housed permanently.

- While supportive services are to be offered and made readily available, the program does not require participation in these services to remain in the housing.

- The use of assertive outreach to engage and offer housing to homeless people with mental illness who are reluctant to enter shelters or engage in services. Once in housing, a low demand approach accommodates client alcohol and substance use, so that "relapse" will not result in the client losing housing (Marlatt and Tapert, 1993). [5]

- The continued effort to provide case management and to hold housing for clients, even if they leave their program housing for short periods.

The first and most well known Housing First model is Pathways to Housing, located in New York City. Established in 1992, Pathways to Housing offers individuals, who are homeless and have psychiatric or substance-related disorders, direct access to permanent, independent apartments without requiring participation in psychiatric treatment or sobriety as a precondition

[5] The low demand approach addresses the harms caused by risk-taking behavior without forcing clients to eliminate the behavior altogether (Marlatt and Tapert, 1993). For example, abstinence is a form of low demand for those who want to quit using drugs, but for those who are not ready, case managers must start with interventions that can help a substance user improve his or her life. Interventions might include reminding the client to eat, drink water, sleep, pay rent and other bills before spending money on drugs, and to educate users about the negative effects of drugs and encourage them to use less frequently, if not quit using entirely.

for entering housing (Tsemberis, Gulcur, and Nakae, 2004). Housing and treatment services are separated. Clients rent apartments—with the lease held by Pathways to Housing—from landlords who do not have a direct relationship with the treatment agency. The program uses a low demand approach that does not prohibit substance use as a condition for obtaining or retaining housing. The program requires that clients pay 30 percent of their income for rent and participate in two home visits by their case manager each month. Following housing placement, interdisciplinary Assertive Community Treatment (ACT) teams are available 24 hours a day, 7 days a week to provide treatment, support, and other needed services to the client in a neighborhood office or in the client's home.[6]

Previous evaluations of the Housing First approach have concentrated on Pathways to Housing and have been conducted by the originator and director of the program. Independent evaluations, of which the present study is one of the first, are appropriate to assess both Pathways to Housing's program and other ways to implement the Housing First approach.

This exploratory study identifies the existing permutations of the Housing First approach, which appear to respond effectively to the needs of homeless people with serious mental illness. It examines and compares three programs that are implementing the Housing First approach in slightly different ways and describes the characteristics of programs that seem to be influential in housing tenure, stability, and other positive outcomes for clients.

OVERVIEW OF THE METHODOLOGY

HUD contracted in 2003 with Walter R. McDonald & Associates, Inc. (WRMA), and its partner Abt Associates Inc., to conduct this study. The goals of the study were to provide an overview of Housing First programs in the United States that serve individuals with a serious mental illness, as well as a detailed analysis of the program characteristics and client outcomes at three of these programs. The overall approach to this study included the following research activities:

- Conduct a telephone canvass of Housing First programs in the United States that serve individuals with a serious mental illness and develop criteria to select two study sites, in addition to Pathways to Housing, for in-depth analysis of program characteristics and client outcomes;

- Explore program implementation at the three selected Housing First programs by conducting baseline and followup site visits, interviewing program staff, and gathering detailed information about the operation of the program; and

[6] The ACT approach at Pathways to Housing is modified from the original ACT teams developed in Madison, Wisconsin, by Stein and Test (1980). The goals of the ACT teams are to enhance the client's community adjustment, decrease time spent in institutions, and prevent the development of a chronic "patient" role. Key features include small caseloads with low staff-to-client ratios, neighborhood proximity for client monitoring, and easy access for needed services or assistance with activities of daily living and community integration.

- Assess program outcomes in the three study sites by selecting and tracking 25 new or recently enrolled, formerly homeless study participants over a 12-month period at each site, engaging local researchers to interview the participants who left the program within 12 months of placement, and conducting focus groups with participants.[7]

HOUSING FIRST STUDY SITES

To identify variations in the Housing First approach, the study team conducted a telephone canvass to identify existing Housing First programs and collect basic information on their program features. Through this process, the study team contacted every agency that the study team, HUD staff, and advocates identified as operating a Housing First program for individuals with serious mental illness.

The canvass provided a wealth of information about the current status of Housing First programs across the country (as of late 2003). The study team conducted canvass discussions with 33 programs—nine incorporated the key features of the Housing First model and 14 incorporated many of the key features, but did not target single unaccompanied adults with a serious mental illness. The study team did not consider the remaining 10 programs to be examples of a Housing First program because clients were required to participate in treatment prior to placement, or because the program did not primarily serve homeless people.

The nine programs (including Pathways to Housing) that were found to incorporate the key features of the Housing First model were:

- Community Housing Network, Columbus, Ohio;
- Direct Access to Housing, San Francisco, California;
- Downtown Emergency Service Center (DESC), Seattle, Washington;
- Horizon House, Philadelphia, Pennsylvania;
- Lamp Community, Los Angeles, California;
- Pathways to Housing, New York City, New York;
- Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego County AB 2034, San Diego, California;
- Sunshine Terrace, Columbus, Ohio; and
- The Village, Los Angeles County AB 2034, Long Beach, California.

An important purpose of the nationwide canvass was to identify and recommend two study sites, in addition to Pathways to Housing, which met the criteria for the study. In addition to choosing study sites that incorporated the key features of the Housing First approach, the programs also needed to be large enough to meet the study's enrollment target of 25 clients within the 12-month period. The study team also excluded programs that were involved in another research

[7] Study participants were not randomly selected. Instead, the study team instructed the three study sites to work backwards, beginning with the most recently enrolled clients, to select the first 25 homeless clients who entered the Housing First program and were unaccompanied (not part of a homeless family), seriously mentally ill, and willing to participate in the study. For further information on study enrollment, see Appendix A.

effort underway at the same time as this study. This was done to avoid over-burdening programs with two different data collection efforts.

The two programs most suitable for further study—DESC and REACH—had the most key features of the Housing First approach, the best comparability to the Pathways to Housing program model, and commensurability with the other study requirements. These three sites are briefly described below.

Downtown Emergency Service Center (DESC), Seattle, Washington
DESC started a permanent supportive housing program with a Housing First approach in May 1994. DESC serves more than 300 clients at one time and places three to six new clients each month. Approximately 30 percent of clients come directly from the streets, with the remainder coming from emergency shelters. The Annual Progress Report submitted to HUD in 2003 indicated that almost all of the new clients who entered DESC housing had a mental illness and the majority had a substance-related disorder.[8] Of the 25 clients tracked for this study, 84 percent (n = 21) met the HUD criteria for chronic homelessness. [9]

The majority of DESC clients enter the Housing First program as a result of engagement by DESC's outreach workers. A worker may offer a client housing at any point during the engagement process. Because vacancies are rare, staff maintain a waiting list with the most impaired candidates (that is, those at greatest risk due to their mental illness as well as other vulnerabilities such as substance abuse or physical health problems) receiving the highest priority for housing. Applicants for housing do not have to agree to participate in services or maintain sobriety as a condition of receiving or retaining their housing.

DESC maintains 306 units of permanent supportive housing in four buildings that it owns or controls. Each building serves slightly different populations and has 24-hour, on-site staff trained in property management and supportive services. Kerner-Scott House is a 25-unit safe haven for seriously mentally ill people referred through DESC's homeless outreach program. It serves the most impaired and least engaged of DESC's clients. The other three buildings are single room occupancy (SRO) hotels. The Morrison Hotel has 180 residential units and a 203-bed emergency shelter operated by DESC. The Lyon Building has 64 units and serves people with HIV/AIDS, mental illness, or a substance-related disorder. The Union Hotel is a 52-unit SRO building serving seriously mentally ill clients referred from Kerner-Scott House or DESC's outreach team. All of the buildings provide private apartments with kitchenettes and baths, on-site meals, staff offices, and community rooms. Units can be held for 90 days for residents who leave, but are expected to return. If the client returns after 90 days, DESC will place the client in another unit as quickly as possible.

[8] Grantees operating HUD competitive homeless assistance programs submit annual reports that provide information necessary to assess project performance, including participant entry and exit information.
[9] Chronic homelessness is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of homelessness during the past 3 years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) or in an emergency shelter during that time. An episode is a separate, distinct, and sustained stay on the streets or in an emergency homeless shelter.

DESC case managers each carry a caseload of 34 people. DESC's service model emphasizes working with clients where they live, as well as coordinating between housing-based clinical service coordinators and the community case managers associated with DESC's licensed mental health and substance abuse treatment programs. Service plans are developed collaboratively by the housing-based staff, the community case manager, and the client.

Pathways to Housing, New York City, New York

Established in 1993, Pathways to Housing serves 450 individuals with histories of homelessness, severe psychiatric disabilities, and co-occurring substance-related disorders. Referral sources include several of New York City's outreach teams, drop-in centers, jails, hospitals, and shelters. Averaging three to five new enrollments per month, institutional discharges accounted for 50 of Pathways to Housing's new enrollments over the past 2 years and psychiatric discharges constitute 42 percent (n = 11) of the current study sample.[10] Despite the large proportion of psychiatric discharges, Pathways to Housing staff reported that most of the clients who participated in this study met the joint federal definition of chronically homeless and 92 percent (n = 24) had met the definition at some point in the last 3 years.[11]

Upon enrollment, the client may reside in a shelter or be placed in a hotel or at the Young Men's Christian Association (YMCA) while working with the Housing Department at Pathways to Housing to secure an apartment. Because Pathways to Housing was at full enrollment at the time of the study, referrals depended on the referral source, availability of a housing subsidy, and ACT team capacity. Clients are not required to be drug or alcohol free, acknowledge they have a mental illness, or participate in treatment programs. Clients must agree to two case manager visits per month and pay 30 percent of their income—usually Supplemental Security Income (SSI)—for rent. Most clients agree to allow Pathways to Housing to act as representative payee for this purpose, but refusal to accept Pathways to Housing as a representative payee does not disqualify a person from the program.

All housing units are privately owned, independent apartments in the community secured through Pathways to Housing's network of landlords, brokers, and managing agents. Housing units are located in low-income neighborhoods in Queens, East and West Harlem, Westchester County, and Brooklyn. The Pathways to Housing Housing Department and ACT team members work with each client to find an acceptable apartment. Clients are offered a choice among up to three apartments. Pathways to Housing holds the lease and sublets the apartment to the client. The program assumes that housing tenure is permanent. Housing rules resemble standard lease requirements.

Pathways to Housing has six ACT teams that provide a range of intensive clinical, rehabilitation, and support services to clients in their neighborhood areas. These nine-person interdisciplinary teams consist of a substance abuse specialist, nurse practitioner, part-time psychiatrist, family

[10] Pathways to Housing confirmed that the sample is representative of the larger program with the following exception: 42 percent of the sample entered the program from psychiatric hospitals, which reflects the addition of funding from psychiatric hospitals to provide housing to homeless patients upon discharge.

[11] Pathways to Housing reported that 24 clients in the study met the joint federal definition of chronically homeless. It should be emphasized, however, that this interpretation assumes that nine of the eleven clients who enrolled from psychiatric hospitals met the criteria for chronic homelessness prior to a short-term psychiatric hospital stay and were determined on a case-by-case basis most likely to become homeless upon discharge.

systems specialist, wellness specialist, employment specialist, social workers, and an administrative assistant. Each ACT team is available 24 hours a day, seven days a week to monitor and respond to the needs of 60–70 clients. Clients choose the array and sequencing of support services offered by the ACT team. If a client requires inpatient treatment, Pathways to Housing will hold the apartment for 90 days; if the absence is longer, the apartment will be released and the client is guaranteed access to a new apartment upon program reentry.

Reaching Out and Engaging to Achieve Consumer Health (REACH), San Diego, California
REACH was established in 2000 out of concerns that vulnerable homeless people risked being displaced by the construction of a new sports stadium in downtown San Diego. In response, the San Diego County Mental Health Services Division successfully applied for a $10.3 million competitive state grant under California's AB 2034 program. The grant gave the county the resources to design integrated services for seriously mentally ill homeless people.[12] The San Diego County Mental Health Services Division contracted with Telecare Corporation to engage, house, and provide case management within 6 months to 250 chronically homeless individuals with mental illness. The program has been fully leased since June 2001, and now averages five or six new cases a month.

REACH requires that clients have an axis I diagnosis of mental illness, have been homeless at least 6 months during the past year, and want to be housed through REACH. Eighty-six percent (n = 25) of program enrollees tracked for this study met HUD's definition of chronic homelessness. The majority of REACH clients come directly from the streets through a Homeless Outreach Team (HOT), which is sponsored by the San Diego Police Department and made up of a police officer, benefits specialist, and mental health counselor. REACH also has an outreach specialist who works with mentally ill people on the streets to help them move into housing. After the client agrees to come into housing and a unit is available, the HOT accompanies the client to REACH for screening and formal enrollment.

While the REACH program offers placement into housing without requirements for treatment or sobriety, many of the housing options have strict requirements or rules restricting substance use. Most clients first enter either a safe haven or an SRO hotel.[13] Most housing agreements have requirements regarding visitors, disruptive behavior, and substance use. REACH staff make it clear to clients, however, that the program will help them maintain permanent housing. Some clients who experience difficulty with the housing requirements may need additional case management support to either solve the problems or move to another housing location with fewer rules. Some clients demonstrate housing stability in the safe haven or SRO and may stay for long periods. Depending on housing stability, some clients are placed in scattered-site apartments within a few months of enrollment.

[12] California Assembly Bill (AB) 2034 allocated funds to expand and provide services for homeless persons, parolees, and probationers with serious mental illness. The California Department of Mental Health awarded funds to 32 counties to provide housing and supportive services to this population. After a demonstration year in three counties under AB 34, AB 2034 made funding available statewide to provide integrated services for homeless people with mental illness.

[13] Out of a total of 29 REACH clients who participated in this study, 31 percent (n = 9) stayed in the safe haven for a range of five nights to up to 12 months, with the majority (n = 6) of clients staying less than 3 months.

One case manager is assigned to each client at enrollment. There are no treatment requirements other than meeting with the case manager biweekly. Case managers assess each client, develop a service plan, and provide assistance to obtain medical and psychiatric services, crisis response, money management, self-help and community resources, substance abuse intervention, education and counseling, vocational services, assistance with entitlements, and support and education of family and significant others. Each case manager carries a caseload of 23 clients and works as part of a team dually certified in mental health and substance abuse treatment. Under a separate contract with the county, the Community Research Foundation provides employment, psychiatric, rehabilitative, and nursing services to REACH clients.

Key Similarities and Differences among Housing First Study Sites

The three Housing First programs selected for this study share a commitment to serve homeless individuals who are seriously mentally ill and have co-occurring substance-related disorders. A large majority of clients enrolled in the study had met the federal definition of chronic homelessness, though a portion did not technically meet that definition at entry, since they had at that point already spent some time in a setting other than the streets or in an emergency shelter. The programs also share a commitment to place people in permanent housing without service participation or sobriety requirements. The service approaches emphasize helping clients remain stably housed. Case managers continue to followup with clients who leave program housing to maintain engagement in services and encourage them to return to housing. Key differences among the programs are the type of housing offered (including the use of transitional placements) and the structure for delivering services.

Pathways to Housing offers scattered-site housing secured through a network of private landlords and management companies. The Pathways to Housing model includes the ability to offer clients more choice in housing and neighborhoods. In addition, the program limits the number of clients housed in any given building, thus encouraging community integration. This approach is contingent on continued landlord willingness to lease to program clients. Pathways to Housing encourages landlord participation by holding the lease and subletting the apartment to the client. ACT teams are assigned to neighborhood-based offices so they can more easily maintain contact with clients and landlords and quickly resolve any issues that may arise.

DESC owns or controls the housing where its clients live and serves as the primary service provider. This approach allows staff to provide a high level of supervision and offers the greatest latitude among the three programs in responding to the challenges of housing this population. Staff are located on site and can respond immediately to issues that may arise. However, with housing located in a small number of buildings in a limited geographic area, this approach minimizes community integration and limits client choices in housing.

At REACH, separating housing assistance from the case management function helps create distance between lease enforcement—which a housing provider must pursue—and the case management support that may help clients address problems that could threaten their housing. REACH does not own or control any housing and staff are based in a central office, but work with sizeable caseloads that are geographically dispersed. However, a number of the housing providers that lease to REACH clients have strict lease requirements prohibiting drug or alcohol use, and therefore REACH clients experience frequent moves before achieving housing stability.

REACH case managers spend quite a bit of time addressing problems that occur due to substance abuse.

STUDY FINDINGS

Housing First programs are intended to target the hardest-to-serve homeless individuals who have a serious mental illness, often with a co-occurring substance-related disorder. Moreover, these programs are designed to increase housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing. The presumption is that once housing stability is achieved, clients are better prepared to address their mental illness and substance-related disorders. In addition, program housing combined with support services can stabilize a client's financial status and promote self-sufficiency.

This study collected information on demographic and client characteristics at baseline, as well as 12-month outcomes, including housing tenure, changes in impairment related to psychiatric symptoms and substance use, and changes in clients' income and self-sufficiency. Demographic and client background information was based on case managers' knowledge of the clients and administrative records. Case managers in each of the programs reported the outcomes data at baseline and each month during the 12-month study period.[14] Although these data were subject to case managers' judgment, the case managers in all three programs gave every evidence of knowing their clients' situations very well and seemed to make informed judgments. Furthermore, the same case manager made the judgments over time for each client, diminishing any inter-rater variability issues (i.e., issues arising from different raters using different scales). Nevertheless, the judgments were necessarily subjective, and there is no guarantee that a case manager was entirely consistent across the 12-month period.

The study sample included 25 clients at DESC, 26 clients at Pathways to Housing, and 29 clients at REACH for a total sample size of 80 clients. Study clients enrolled in the three Housing First programs between June 2003 and August 2004, with two-thirds entering between December 2003 and May 2004.[15]

Client Characteristics at Enrollment

The clients enrolled in this study represent the severely impaired homeless population that Housing First programs intend to target. The majority of clients were chronically homeless (88 percent), had a primary diagnosis of mental illness (91 percent), exhibited symptoms of mental illness or psychiatric problems (83 percent), and were at least moderately impaired by their symptoms at enrollment (97 percent of those with symptoms). Three-quarters of the clients had a history of substance abuse, and one-half of the clients were abusing substances at the time of enrollment. More than two-thirds of the sample (69%) had co-occurring mental illness and history of substance abuse. In addition, these clients had limited work histories, low educational attainment, and a high incidence of criminal records.

[14] Case managers collected baseline data upon a client's enrollment into the Housing First program. For clients who were part of the retrospective data collection effort, case managers also collected their baseline information retrospectively using administrative records. Case managers collected data for month 1 following the end of the first month after the client entered the program. Case managers collected data for month 12 following the end of the client's 12th month in the program.

[15] Much of the study data were collected retrospectively. Clients included in the study sample entered the Housing First programs as early as June 2003, but the programs reported baseline data during June and July of 2004.

Clients who entered the Housing First program from different living situations often demonstrated different service needs. Those entering the program directly from the streets were more likely to have criminal records and more severe levels of psychiatric and substance-related impairment. Clients from shelters also had a high frequency of criminal records, but were less likely to be currently abusing drugs or alcohol. These clients were also less likely to have a primary diagnosis of mental illness, possibly indicating a lack of psychiatric assessment, rather than the absence of psychiatric problems. Finally, those who entered the program from a psychiatric hospital were typically older, had little education and no employment history, and had severe psychiatric impairment, presenting unique challenges to increase levels of self-sufficiency. A large majority (86 percent) of those who entered the program from a psychiatric hospital were defined by their programs as having been chronically homeless.[16]

Housing Tenure

The Housing First approach is designed to improve housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing. The primary indicator of a program's ability to improve clients' housing stability is the percentage of clients who stay in the program. It is important to note, however, that in all three programs "staying in the program" meant that case managers and other program staff were in contact with the client, even if the client left the program housing for short periods. In most cases, a client was not considered to have left the program until he or she had been absent from their housing for 90 days. Thus, housing stability is viewed somewhat differently in Housing First programs compared to other homeless assistance programs where such absences would more quickly result in clients losing their housing.

The majority of clients tracked for this study remained enrolled in the Housing First program for 1 year following program entry. Of the total sample of 80 clients, 43 percent of the clients who stayed in the program were characterized as "stayers" because they spent the entire 12-month period in program housing. Another 41 percent of the clients who stayed in the program were characterized as "intermittent stayers" because they experienced at least one temporary departure to another living environment during the course of the 12-month period, but then returned to Housing First housing. The remaining 16 percent of clients left the program or died within the first 12 months—these clients were referred to as "leavers."

The differences in outcomes for stayers, intermittent stayers, and leavers were modest, but some patterns emerged. Clients who entered the Housing First program from the streets were most likely to leave the program within 12 months (69 percent) and were also most likely to experience temporary program departures (36 percent). The clients with the highest levels of housing stability were those who entered the program from shelters, jail or a psychiatric hospital, or some other location, including crisis houses and living with friends. Clients with the lowest levels of housing stability were those who entered the program from the streets and experienced higher levels of impairment related to psychiatric symptoms during their last month in housing.

While the majority (69 percent) of the sample overall had a co-occurring psychiatric diagnosis

[16] These clients came from a short psychiatric hospital stay (less than one year) but were continuously homeless for a year or longer, or had at least four homeless episodes during the last 3 years before hospitalization.

and history of substance-related disorders, such dually diagnosed clients were even more prevalent among intermittent stayers (70 percent) and leavers (77 percent).

Outcomes
Program staff in the three Housing First programs cautioned that, given the severity of their clients' symptoms, they would expect limited improvements in levels of impairment within 12 months. This was consistent with the findings from the present analysis. Although clients may experience month-to-month variation in their levels of impairment, the data do not demonstrate any substantial trends in impairments related to psychiatric symptoms or related to substance use over the course of the first year in program housing. However, clients' incomes did increase slightly over the period (from non-employment sources), although their incomes were still well below the poverty line.

SUMMARY AND IMPLICATIONS

Pathways to Housing, DESC, and REACH were selected for this study in part because they share a commitment to serving homeless people with chronic mental illness and emphasize placement into permanent housing without requirements for sobriety and treatment compliance. The programs differed on a number of dimensions, including the type of housing utilized, the location and intensity of services, and the use of representative payees. The study's findings lead to several conclusions about the program features that appear to promote housing stability and other positive outcomes and suggest implications for HUD policy.

Program Elements
With only three sites and broadly similar outcomes across sites, it is difficult to say definitively which program features are essential to program success. However, based on patterns in outcomes observed in the client-level data, interviews with program staff, and focus groups with program participants, a number of program elements emerge as important contributors to program success in the three study sites.

- ***Access to a substantial supply of permanent housing—***The key similarity among the housing strategies at the three programs was access to a substantial stock of permanent housing for their clients. However, the three programs differed substantially in the types of housing offered to clients, and each approach offered benefits and challenges. The dispersed housing and neighborhood-based ACT teams at Pathways to Housing offer consumer choice and intensive services, but require developing a large network of landlords and supporting the highly skilled professionals that comprise the ACT team. The DESC model, where the primary service provider owns or controls the housing and provides a high level of supervision, can respond to the challenges of housing this population, but this approach limits client choices in housing and seems to limit community integration. The REACH model poses certain challenges—the service provider does not own or control housing, case managers have sizeable caseloads, the program is geographically dispersed—but has the advantages of flexible state funding and Medicaid billable services that allow the program to provide housing assistance as well as community-based client support.

- ***Providing housing that clients like—***Evidence from this study indicates that clients are satisfied with the permanent supportive housing offered in these programs. Forty-three percent of clients did not leave their housing at all during the first year and only a few of the leavers left voluntarily. Focus group participants at DESC and Pathways to Housing cited the privacy, independence, safety, and quality of their housing as positive features of their program experience. There were some complaints from focus group participants at REACH about the quality and safety of some of the housing locations, but REACH staff independently acknowledged these concerns and described how they were working toward possible solutions. Regarding the importance of housing choice, DESC and REACH clearly offer less choice than Pathways to Housing, but clients reported that the choice of housing over homelessness was important to them.[17] Nevertheless, clients' perceptions about the extent to which they have choices in their housing may influence their housing stability.

- ***Wide array of supportive services to meet the multidimensional needs of clients***—Each of the three programs offers a wide array of supportive services to help clients maintain their housing and meet other needs. These services include comprehensive mental health services, substance abuse treatment, medication assistance, as well as help with independent living skills, such as money management and housekeeping.[18] Staff are available around the clock to assist clients. At DESC, each housing location is staffed 24 hours per day and clinical staff are on call during overnight hours. Similarly, a staff member at REACH and Pathways to Housing is always on call to respond to issues that may arise.

- ***Service delivery approach that emphasizes community-based, client-driven services—*** Common features of service delivery across the three programs include a low demand approach to substance use, integrated substance abuse and mental illness treatment services, and a focus on helping clients develop skills for independent living. All three programs emphasize providing services primarily in the housing where people live. Program staff from all three programs emphasize the importance of client-driven service planning. Focus group participants expressed appreciation for the "do whatever it takes" attitude with which case managers approached their work.

- ***Staffing structure that ensures responsive service delivery—***The staffing structure for delivering services differs across the three programs, but in all cases is designed to make sure clients' needs are met. Access to multidisciplinary staff is clearly important, but the experience of DESC and REACH indicate that services can be delivered using a service model different from the ACT teams used at Pathways to Housing. The nine-member ACT teams at Pathways to Housing include specialists in mental health, substance abuse, and employment who meet regularly to discuss clients' needs and decide how to respond most appropriately. REACH and DESC offer similarly diverse services, but do not use the ACT team model. Staff from REACH and DESC report that their service delivery structures offer

[17] Additional research on client satisfaction in these three programs is currently underway, and preliminary results indicate that clients are very satisfied with their housing (P. Robbins and J. Monahan, Housing Leverage Pilot Study by the John D. and Catherine T. MacArthur Foundation on Mandated Community Treatment).

[18] In the three study sites, the use of representative payees seems to be a useful tool for working with some clients, but programs do not require this and payees do not seem to be a mechanism for exerting leverage over clients. Roughly two-thirds of the sample had a payee for at least one month during the tracking period. Some 59 percent of those who had a payee had a staff member from the Housing First program as their payee.

a cost-effective alternative to the highly credentialed (and seemingly more costly) ACT team model. While caseloads differ across programs, the availability of staff response 24 hours a day is a key similarity among the sites. The use of daily team meetings and collaborative case planning further enhance coordination and consistency so that staff resources are immediately responsive to client needs.

- ***Diverse funding streams for housing and services—***The three Housing First programs serve clients with extremely low incomes and limited resources to pay for housing, services, and other needs. The programs rely on a variety of funding streams to meet the needs of their clients. To fund mental health case management services, each of the programs seek Medicaid reimbursement, which requires licensing and administrative sophistication to document and bill for services appropriately. All three programs also receive funding for clinical services from state or county sources. HUD programs subsidize a substantial portion—but not all—of the housing. Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation for SRO programs are used to assist clients.[19]

Policy Implications for HUD

The Housing First programs in this study achieved the important outcome of housing stability for a number of the clients in this hard-to-serve population. Although the authors understand that the limited sample of clients constrains the confidence within which we can draw policy implications, we would commend the following suggestions to the Department.

- ***The HUD priorities of addressing chronic homelessness and providing permanent housing are furthered by Housing First programs***—The programs predominantly serve people who meet HUD's definition of chronic homelessness and achieve substantial housing stability for this population, although the most impaired clients, including persons coming directly from the streets, are still the most likely to leave.

- ***Lack of conditions on housing may be less important than the direct access—***DESC and Pathways to Housing offer direct access to housing without customary service requirements. At REACH, however, many clients enter housing at a safe haven with occupancy rules, including a prohibition on drugs and alcohol, a curfew, and assigned chores for all residents. Despite these requirements, clients preferred to accept this housing, rather than to continue the hardships of homelessness. It is important to acknowledge, however, that all three programs use transitional stays for at least some clients.

- ***Housing stability does not come without challenges—***The advantage of the Housing First approach for the chronically homeless people served is that direct placement in housing solves the elemental problem of homelessness. The dilemma is that it does not necessarily resolve other issues that may impede housing success. Findings from this study indicate that housing problems do occur, including problems that would result in the loss of housing in many programs. In addition, a substantial proportion of the clients tracked left their program

[19] The scope of work for this study did not call for an analysis of program costs, but each of the three program sites were asked to provide a rough estimate of the annual per client cost of housing and services. The costs reported seemed low and likely understated services costs. Future research that would collect and analyze program costs would be very valuable in assessing the replicability of these programs.

housing for short periods during their first year. Housing stability requires a service approach that focuses on helping people keep their housing, as well as subsidy mechanisms that permit holding units for people who leave temporarily.

- ***HUD resources are an important source of housing subsidies in these programs, but tensions exist between a low demand approach to substance use and HUD's concerns about any criminal activity, in particular drug activity, in HUD-supported housing—***This tension may be less pronounced in a program like DESC where the primary service provider also owns or controls the housing. It is more pronounced in programs like Pathways to Housing and REACH that lease housing from private landlords. Program staff in these programs work diligently with clients to show them how their behavior may jeopardize their housing. Pathways to Housing also works to normalize clients' living situations in scattered-site housing, ensuring that no more than 10 percent of a building is occupied by program clients. Responding to landlord concerns regarding housing problems is important to fostering good relationships and maintaining access to a supply of scattered-site apartments.

- ***Serving this population requires a long-term commitment to providing housing assistance—***Provision of housing did not result in substantial improvements in mental illness or substance-related disorder symptomology within the 12-month study period. These clients have long-standing mental illnesses and, in most cases, co-occurring substance-related disorders. While the housing provided by the programs increased housing stability and afforded the opportunity to receive treatment, substantial progress toward recovery and self-sufficiency often takes years and is not a linear process. Longitudinal tracking of clients both within and after leaving Housing First programs is needed to identify the factors that contribute to long-term housing stability of chronically homeless people with serious mental illness and co-occurring substance-related disorders.

CCJJ Mental Health Initiative
White Paper

VI. Jail Diversion Outreach Team
(Forensic Assertive Community Team)

Concept

The forensic assertive community team, or F/ACT , is a team of mental health professionals that function as a "hospital without walls". The team can take deliver clinical support services into the community wherever the client may be in order to provide a high level of service without requiring that the client be in a hospital. These teams have demonstrated benefits in supporting persons with mental illness and reducing the number of inpatient hospitalizations, use of emergency rooms, homelessness, re-offense rates, and substance use.

The distinguishing characteristics of a F/ACT are:

- **TEAM AVAILABLE 24/7:** The team is always available to assist clients with crisis situations and urgent needs, is always aware of the condition of the client.
- **TEAM IS PRIMARY PROVIDER OF SERVICES:** The multidisciplinary make-up of each team (psychiatrist, nurses, social workers, rehabilitation, etc.) and the small client to staff ratio, helps the team provide most services with minimal referrals to other mental health programs or providers. The team members share offices and their roles are interchangeable when providing services to ensure that services are not disrupted due to staff absence or turnover.
- **SERVICES ARE PROVIDED OUT OF OFFICE:** Services are provided within community settings, such as a person's own home and neighborhood, local restaurants, parks and nearby stores.
- **HIGHLY INDIVIDUALIZED SERVICES:** Treatment plans, developed with the client, are based on individual strengths and needs, hopes and desires. The plans are modified as needed through an ongoing assessment and goal setting process.
- **ASSERTIVE APPROACH:** Team members are pro-active with clients, assisting them to participate in and continue treatment, live independently, and recover from disability.
- **LONG-TERM SERVICES:** Services are intended to be long-term due to the severe impairments often associated with serious and persistent mental illness. The process of recovery often takes many years.
- **SUBSTANCE ABUSE SERVICES:** The team coordinates and provides substance abuse services.
- **COMMUNITY INTEGRATION:** Staff help clients become less socially isolated and more integrated into the community by encouraging participation in community activities and membership in organizations of their choice.

Benefits

Assertive Community Teams are a demonstrated "evidence-based practice" that have been shown for many years to improve client outcomes:

- Reduced Hospital Inpatient Usage;
- Retention of Housing;
- Recidivism in mentally ill offenders is reduced;
- Overall community costs are lower

Implementation Plan

Clients served by F/ACT: are individuals with serious and persistent mental illness with severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Persons served by F/ACT often have co-existing problems such as homelessness, substance abuse problems, and are selected for the team because of multiple involvements with the criminal justice system.

Implementation Guidelines:

Allness, D. J., & Knoedler, W. H. (2003). ***A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses.*** **Arlington, VA: NAMI.**

Order at: www.nami.org

This "how to" manual provides practical information on how to develop and implement ACT teams, including recommended admission criteria, staffing configuration and roles, hours of operation, administrative requirements, team communication and organization, client-centered comprehensive assessment and individualized treatment planning, service array, and development of a steering committee and stakeholder advisory group. This manual also includes all sample forms (e.g., assessments, staff scheduling).

SAMHSA ACT Toolkit

Find at:

http://mentalhealth.**samhsa**.gov/cmhs/communitysupport/toolkits/community/

Based on the Manual for ACT Start-Up (see above), this ***toolkit*** *provides similar practical information for ACT implementation. In addition, the ACT* ***Toolkit*** *includes background information sheets for various stakeholder groups (consumers, families and natural supports, practitioners and clinical supervisors, mental health program leaders, and public mental health authorities), introductory videos, practice demonstration videos, and a workbook for practitioners. An updated version is in the process of development by* ***SAMHSA****.*

Resource/Contact Information

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Evaluation of the Salt Lake County Mental Health Court

Final Report

June 2008

THE UNIVERSITY OF UTAH

Utah Criminal Justice Center

COLLEGE OF SOCIAL WORK
COLLEGE OF SOCIAL & BEHAVIORAL SCIENCES
UTAH COMMISSION ON CRIMINAL AND JUVENILE JUSTICE
S.J. QUINNEY COLLEGE OF LAW

Evaluation of the Salt Lake County Mental Health Court

Final Report

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June 2008

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Executive Summary

The Salt Lake County Mental Health Court (SLCo MHC) began operations in 2001. Although originally accepting only misdemeanor level cases, in 2002 it expanded the acceptance criteria to include felony charges. This expansion occurred when the City Prosecutor was cross designated as a Deputy District Attorney, thereby granting him authority over both felony (State) and misdemeanor (City) cases. CJS requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of the MHC. Answers to the seven research questions are as follows:

Who does the program serve?

The MHC has served 263 participants who have a long history of mental health problems and criminal justice system involvement. DSM-IV diagnoses revealed an average of 8.3 years with Schizophrenia and/or Bipolar Disorder diagnoses prior to MHC. Similarly, participants had an average of 10 years from first VMH admission to MHC start. Most (92.7%) had at least one arrest (BCI) in the three years prior to MHC, while 91.3% had a booking in the Salt Lake County jail in the two years prior to MHC. The age of MHC participants at intake ranged from 18 to 64, with median age being 34.3 years old. Most were male (67.3%), White (86.0%), single (88.3%), and unemployed (90.1%). Nearly a quarter of all MHC participants (59, 22.4%) experienced homelessness at some point while in MHC.

What services are MHC participants utilizing during participation?

MHC participants are receiving regular supervision through court hearings, case management, and probation officer contacts; various forms of mental health (MH) treatment; and additional housing and support services. MHC clients appear before the judge every 9.9 days (Median (Md)), have appointments with their case manager at VMH every 4.6 days (Md), and meetings with their probation officer every 18.6 days (Md) over the course of MHC participation. Most (86.6%) had service records at VMH. Of those, approximately 90% had case and medication management and outpatient treatment, while just over half had residential treatment, and one in ten received inpatient treatment (psychiatric hospitalizations). Just over half (59.4%) had drug testing and nearly half (47.5%) received some form of housing assistance or residential treatment while in MHC. Nineteen (19) participants have been served by the JDOT team since its inception in August 2007 and many have participated in NAMI's Bridges program.

What is the structure of the MHC?

The structure of the MHC closely adheres to the Bureau of Justice Assistance's (BJA) 10 Essential Elements of MHCs. Although program elements and procedures are not consistently defined in program documents, the MHC team has a thorough and consistent knowledge of the operation of the program. Practices for referral, screening, assessment, participant progress, rewards, sanctions, and graduation/termination were similarly described by most MHC team members.

Is MHC succeeding?

On the whole, participants are compliant with MHC requirements, experiencing reductions in offending and increased treatment participation and frequency both during and post-MHC. Clients attend most of their scheduled status hearings (93.3%); however, many clients do have some form of noncompliance, such as a failure to appear at court (Md = 3.3% of hearings per client) or absconding from the program for short periods of time (41.7% had at least one bench warrant). Participants with a new charge booking in the jail dropped from 66.9% in the year prior to MHC to 19.8% during MHC and 18.2% in the year following MHC exit, while only ten individuals were sentenced to prison after starting MHC (7 at exit; 3 post-MHC exit). This suggests that the reduction seen in jail bookings for new charges is due to an actual decrease in criminal involvement, rather than an artifact of increased incarceration. Lastly, use of VMH services ranged from 46% to 61% in the three years pre-MHC, but remained somewhat higher in the three years following MHC exit (71% to 60%).

Who has the best outcomes in MHC?

MHC clients who were most likely to graduate were older at MHC start and had less extensive criminal histories (total arrests, jail bookings, and charge degree severity). Similarly, clients who were less likely to recidivate (48.6% did not recidivate) following MHC exit also had fewer arrests pre-MHC. Furthermore, they were less likely to have experienced homelessness during MHC and more likely to have graduated. In fact, graduation status was one of the strongest protective factors against recidivism and time to re-arrest (grad, Md = 435 days to first new charge jail booking post-MHC; terminated, 262 days).

What program components and services lead to the best outcomes?

The most consistent MHC program predictors of exit status were program compliance variables, with increased noncompliance, failures to appear, and bench warrants all being associated with negative termination from MHC. However, these factors did not significantly predict post-MHC recidivism. Predictors of post-MHC recidivism were any jail bookings during MHC (regardless of reason, such as for a sanction, new charge, etc.) and total days in jail, with more days in jail increasing odds of re-arrest post-MHC. Although the sample size was small, NAMI Bridges participation was associated with graduation and decreased likelihood of re-arrest.

How does the SLCo MHC compare to the mental health court model?

The MHC as observed by the research team and described in program documents and by MHC team members compares quite favorably to the BJA's 10 Essential Elements of MHCs. Nevertheless, some recommendations for improvements include creating a MHC participant handbook and putting individualized terms of participation in writing for each client at intake. It is also suggested that the MHC continue to address the need for aftercare planning.

Introduction and Background

Mental Health Courts (MHC) have been proliferating across the United States since their establishment in 1997 (Steadman, Redlich, Griffin, Pertila, & Monahan, 2005). This movement was in response to inequities in the experiences of mentally ill offenders. The development of therapeutic jurisprudence and the drug court movement also influenced the formation of MHCs. A recent Bureau of Justice Statistics (BJS) survey found that 16% of state prison inmates, 7% of federal inmates, 16% of jail inmates, and 16% of probationers reported having a serious mental illness or a mental hospital stay at some time in their lives (Steadman et al., 2005). Jails have become hospitals of sorts and the need to develop an alternative to treating mentally ill offenders has clearly been supported in the literature. Despite this, little outcome research on the effectiveness of MHCs has been conducted.

The Salt Lake County MHC (SLCo MHC) began operations in 2001. Although originally accepting only misdemeanor level cases, in 2002 it expanded the acceptance criteria to include felony charges. This expansion occurred when the City Prosecutor was cross designated as a Deputy District Attorney, thereby granting him authority over both felony (State) and misdemeanor (City) cases. The MHC operates out of Salt Lake County Criminal Justice Services (CJS) in conjunction with Utah Third District Court and Valley Mental Health (VMH). SLCo MHC states several goals and objectives in their program documents. After a thorough review of these documents, it was determined that the court's goals are essentially the following:

Salt Lake County Mental Health Court Goals

Protect public safety by reducing criminal recidivism of offenders with an identified mental illness

This goal has been the primary goal of all MHCs under review, for example, Fort Lauderdale, FL; Seattle, WA; San Bernardino, CA; and Anchorage, AK. MHCs all give a high priority to concerns of public safety, in arranging for the care of mentally ill offenders in the community (Goldkamp & Irons-Guynn, 2000). This concern for public safety explains the predominant focus on misdemeanant and other low-level offenders and the careful screening or complete exclusion of offenders with histories of violence. King County MHC is open to defendants with a history of violent offenses which have been triggered by mental illness. However, it is believed that these defendants are provided with a level of supervision that is sufficient to protect the public.

In reviewing the available research on MHCs, it is apparent that MHCs are achieving public safety by reducing recidivism. Many courts have demonstrated no more risk of re-offending when compared to traditional courts. For specific courts see the following: Christy et al., 2005; Teller, 2004; O'Keefe, 2006; and Cosden et al., 2005. Other courts have gone farther and shown that MHC contributes to less risk of reoffending when compared to traditional court participation (see Trupin & Richards, 2003; Herinckx et al., 2005; McNiel & Binder, 2007; Morin, 2004).

Reduce jail use both during and after MHC participation by reducing criminal recidivism

Several MHCs in the literature have reported reductions in jail use and recidivism; at least while participants are actively participating in the MHC program. These include the following courts: Christy et al., 2005; Teller, 2004; O'Keefe, 2006; and Cosden et al., 2005. Although they have seen a reduction in offending, some courts note that these reductions are not significantly different than results obtained in traditional case processing (Trupin & Richards, 2003; Herinckx et al., 2005; McNiel & Binder, 2007; Morin, 2004). See the following "*The Effectiveness of Mental Health Courts"* section of this report for details on type and size of reductions in jail use and recidivism.

Increase mental health treatment compliance of MHC participants by connecting and re-connecting mentally ill persons with needed mental health services

MHC participation has been shown to increase defendant's access and utilization of mental health services. Two separate reviews of the Broward County MHC demonstrated that the use of behavioral health services by misdemeanants increased significantly when participating in MHC, whereas the likelihood of using services among similar defendants in a traditional criminal court was virtually unchanged. Additionally, MHC participants were not only seeking treatment more often than traditional court defendants, but were also receiving a greater volume of services. For specific study information see the following: Boothroyd, Calkins-Mercado, Poythress, Christy, and Pertrila, 2005; Boothroyd, Poythress, McGah, and Petrila, 2003.

While these results are encouraging, some concern has been raised that increased treatment access seen in MHC participation is short-lived (Boothroyd, Poythress, McGah, & Petrila, 2003). An additional concern is that while MHC participants may be getting more mental health services, they are not always showing psychiatric improvements (Boothroyd et al., 2005). However, this may not always be the case as participants in Brooklyn showed significant improvements in various psychosocial areas (O'Keefe, 2006).

Improve the likelihood of treatment success by addressing access to housing and linkages with other critical supports

Little research has been conducted regarding housing services and related outcomes. However, it has been demonstrated that MHCs can lead to decreased homelessness (O'Keefe, 2006). While no research specific to MHCs regarding the relationship between treatment success and stable housing has been conducted, extensive research exists demonstrating how the provision of secure housing contributes to treatment retention and improved mental health (Wasylenki, Goering, Lemire, Lindsey, and Lancee, 1993; Tsemberis, Gulcur, & Nakae, 2004; Morse, Calsyn, Klinkenberg, Trusty, Gerber, & Smith, 1997).

Continue a forum of providers, prosecutors, defenders, judges, and State Corrections officials to discuss mental health court issues

There is little description of these processes in the MHC literature on existing programs. However, the ten essential elements document from BJA does advocate for these forms of continued networking, cross-training, and sustainability efforts (Thompson, Osher, & Tomasini-Joshi, 2007). For more information, see the "*Essential Elements of Mental Health Courts"* section of this report, specifically elements #8, Court Team, and #10, Sustainability.

The Effectiveness of Mental Health Courts

Because of their relatively recent development, little data exists on the effectiveness of mental health courts. What we do know comes mainly from descriptive articles that rarely focus on MHC-related outcomes. The research that exists on MHCs will be presented and contrasted with the SLCo MHC in this section of the report.

Recidivism

Trupin and Richards (2003) compared mentally ill defendants who opted in or opted out of the two MHCs in Seattle. Those who participated in the MHC had significantly fewer bookings after nine months of participation, compared to those who chose not to participate.

A study of Broward County MHC found that the average number of arrests participants accrued after one year of participation was significantly less than during the year prior to MHC participation. However, when these participants were compared to similar defendants in a traditional court, MHC participants were not more improved on measures of re-arrest, felony arrest, and time to re-arrest. It should be noted, however, that MHC defendants spent significantly less time in jail for index offenses. Meaning, one way to account for the similar rates of re-arrests seen in both types of participants is that MHC participants had a greater risk for re-offending because they spent more time out of jail (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005).

A review of the Clark County MHC found more improved outcomes among a sample of MHC participants. Measuring criminal activity prior to and one year after MHC participation, they found that the average number of arrests was significantly less post enrollment. They also found that those classified as "frequent offenders" due to an excessive amount of arrests, had significantly less arrests post enrollment. Probation violations were also significantly decreased post enrollment. Participants who graduated the program or were still enrolled after 12 months of participation were also significantly less likely to be arrested post enrollment (Herinckx, Swart, Ama, Dolezal, & King, 2005).

Arrest rates in the Akron Municipal MHC were similar to the above study. Tracking jail and state prison arrest rates prior to and after MHC participation found that after one year of MHC participation, county jail arrest rates decreased steadily. However, the incidents

leading to state prison, while rare, stayed virtually the same with or without MHC participation (Teller, Ritter, Salupo-Rodriguez, Munetz, & Gil, 2004). Results in Brooklyn were similar to that of Clark County and Akron Municipal MHC. Here, it was found that arrest rates decreased after 12 months of MHC participation by 11%. While suggestive, these results were not statistically significant (O'Keefe, 2006).

The most recent evaluation of an MHC was conducted by McNiel and Binder (2007). A retrospective observational design was used to compare the incidents of new criminal charges for participants who entered the San Francisco Mental Health Court to other defendants with mental disorders who were booked into an urban county jail during the same time period. In comparing all individuals who enrolled in the program (regardless of completion), it was found that mental health court participants showed a longer time without any new charges or new charges for violent crimes compared with similar individuals who did not participate in the program. Interestingly, it was also found that reductions in the likelihood of new charges were more substantial with follow-up of more than one year after enrollment in MHC. For example, after 18 months, the likelihood of MHC participants being charged with any new crimes was about 26% lower than those participating in regular jail treatment, and the likelihood of mental health court participants being charged with new violent crimes was 55% lower. Additionally, analyses showed that persons who graduated from the mental health court program maintained decreased recidivism after supervision by the court had ceased. This was not the case for similar participants in jail. After 18 months of treatment, the risk of MHC graduates being charged with a new offense was about 34 out of 100, compared with about 56 out of 100 for regular jail participants. Furthermore, the risk of mental health court graduates being charged with a new violent crime (6 out of 100) was about half that of jail participants (13 out of 100).

Cosden and colleagues (2005) went further than the previously mentioned studies by conducting an experimental design in Santa Barbara where subjects were randomly assigned to either MHC with assertive community treatment (MHTC) or to traditional court with less intensive case management (treatment as usual, or TAU). After one year, MHTC participants had fewer convictions for new crimes than TAU participants (charges for MHTC participants were usually related to probation violations while TAU participant's charges were usually new offenses). However, after two years, the proportion of participants sent to jail (while small) was about the same for both groups. Additionally, after two years, it was found that both MHTC and TAU participants had increased jail bookings. After two years, Cosden encountered a problem that most evaluative studies encounter; there was a small group of offenders that disproportionately accounted for the majority of bookings, convictions, and jail days (often known as "frequent flyers"). The problem with including this "frequent flyers" group in the participant pool is that it makes it more difficult for researchers to isolate the *actual* improvements seen in one court versus another for the majority of participants; recidivism rates are essentially weighed down by a few participants. By conducting a separate analysis excluding this type of chronic offender, it was found that both MHTC and TAU participants showed a significant decline in jail days from the two years prior to participation to the two years after study entry. However, the number of bookings did not

significantly decrease for either court. Additionally MHTC and TAU participants did not differ significantly on any of the aforementioned measures after two years (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005).

Morin's (2004) dissertation evaluating the Hennepin County MHC dealt with issues similar to Cosden and colleagues (2005). After controlling for the few individuals who had a large number of arrests, results showed a correlation between court-ordered mental health treatment and a reduction in overall offenses. Such findings, however, were not statistically significant (Morin, 2004).

These studies are important in demonstrating that mentally ill offenders are at no more increased risk of re-offending when diverted from jail to a MHC compared to similar offenders seen in traditional court. Additionally, some studies show decreased arrest rates with the onset of MHC participation when samples are compared with similar defendants in traditional court settings. One study went so far as to demonstrate that graduating from a MHC put individuals at a substantially lower risk of re-offending. Thus, the studies show that MHCs are meeting their obligation of protecting public safety. However, when collectively analyzed, these studies do not clearly demonstrate the influence of MHCs on recidivism above that of traditional criminal courts.

Treatment and Related Outcomes

A review of the Broward County MHC found that that use of behavioral health services by misdemeanants increased significantly when participating in MHC, whereas the likelihood of using services among similar defendants in a traditional criminal court was virtually unchanged. The overall findings were that MHC enhances treatment access and involvement for its clients (Boothroyd, Calkins-Mercado, Poythress, Christy, & Pertrila, 2005).

An additional review of the Broward County MHC found that MHC participants (as compared to traditional court participants) had significantly more treatment utilization. However, this increase in services declined over eight months. While MHC participants still sought treatment more frequently than traditional court participants, the increase was no longer significant after 8 months. Nonetheless, the volume of service utilization (of those who got treatment, how much treatment they actually got) increased significantly when compared to traditional court participation. Another noteworthy result indicated that MHC clients' subsequent use of mental health services is independent of the court's expressed expectations about treatment. Meaning the type of services participants chose to seek out was typically different than the type of services the judge (and other MHC professionals) suggested. This finding reveals the possibility that the judge and other MHC professionals may not be as influential as expected (Boothroyd, Poythress, McGah, & Petrila, 2003).

Similar support for the finding that MHC leads to increased treatment was seen in a review of Clark County MHC. Tracking treatment participation prior to and one year following MHC participation, it was found that linkages to services were improved for

case management, medication management, group therapy, intake evaluation, and days of outpatient services. However, MHC clients had fewer days of crisis services, inpatient treatment, and individual therapy. These results generally indicate that MHC participation contributes to increased usage of most types of mental health services, except individual therapy. The lack of usage of crisis treatment and inpatient services could be interpreted as a positive finding as usage of these types of services is usually indicative of a highly distressed clientele (Herinckx et al., 2005).

All in all, these results are encouraging. They suggest that MHC participation can lead more people to seek out treatment and use it frequently. However, measures should be taken to retain such participants as results indicate that treatment gains may not be long lasting. An additional caution suggested through this research is that courts not rely too heavily on the persuasion of the judge, as their influence may not be as influential as initially thought.

Although MHCs have been found to increase defendants' access to mental health services, they have little control over the type and quality of services that defendants receive. This was clearly evident in the Broward County MHC. Symptoms of mental illness as indicated by the BPRS and administrative self report were measured in MHC participants and traditional court participants before and up to eight months after enrollment. It was found not only that MHC defendants did not show more improvements in symptom reduction than traditional court defendants, but that both types of defendants showed *increased* symptoms after eight months of court participation (Boothroyd et al., 2005). These results illuminate the concern that linkage to treatment does not necessarily equate to mental heath improvements. These findings support the suggestion made by the BJS that MHCs actively work to develop and improve the mental health services in a given area.

The lack of improvements seen in Broward may not be the case in all MHCs. In a program evaluation of the Brooklyn Mental Health Court, clinical staff completed the Health of the Nation Outcome Scale (HoNOS) at intake and after one year. The HoNOS is comprised of 12 scales that measure various health and social domains (psychiatric symptoms, physical health, functioning, relationships, and housing). After one year of participation, it was found that participants improved their functioning on nearly every scale. Specifically, participants showed statistically significant improvement on the scales measuring problems with cognition, depressed moods, living conditions, occupations, and activities (O'Keefe, 2006).

Cost Effectiveness

Cost effectiveness data for MHCs are sparse. The Rand Corporation, a non-profit research organization, attempted to evaluate cost data on the Allegheny MHC by comparing the cost of an arrest for MHC participants prior to their MHC participation to the cost of their current arrest which led to MHC treatment. They also made some hypothetical data comparisons by evaluating the expected cost for these participants had they not enrolled in a MHC. In all types of comparisons, it was found that the MHC program did not lead to overall cost savings. However, this finding should be interpreted

carefully. The finding was that MHC led to an increase in the use of mental health treatment services but a decrease in jail time for participants during the first year after entry. In comparing the costs, the decrease in jail expenditures almost offsets the increase in the outlays for treatment services. One way to interpret this is that because mental health treatment is primarily funded by Medicaid, when commonwealth costs are considered, the extra estimated cost of the MHC program for the commonwealth is eliminated. Additionally, using hypothetical sentences and cost data provided by the court system, it was estimated that, if there were no MHC program, the jail costs for these participants would have been almost double (Ridgely, Engberg, Greenberg, Turner, DeMartini, & Dembosky, 2007).

When looking at overall dollars spent, these findings indicate that in terms of all costs, MHC is not more cost effective than traditional courts. However, when looking at the specific areas by which costs were accrued, it is clear that MHCs' cost were similar to traditional court because more money was being spent on treatment as opposed to confinement. If MHC had not led to more treatment, it would be most cost effective. However, it is the general opinion of most professionals that the increased money spent for treatment is well spent and in keeping with the basic goals of most MHCs. Furthermore, when considering the cost to the general public, MHC costs were significantly less than traditional courts.

Hospitalizations

Few MHCs track the extent to which their participants are hospitalized. Attention to this outcome however has gained increased attention as it provides crucial insight into the relative function of clients within MHC treatment. There are many possible reasons for psychiatric hospitalizations, not all of them with negative connotations. However, a decrease in the percentage of participants hospitalized can be viewed positively as an indicator that participants were actively engaged in treatment

A review of Akron MHC found interesting distinctions between the hospitalizations of their clients in general hospitals versus psychiatric hospitals. By tracking hospitalizations before and after MHC treatment, they found that hospitalizations in general hospitals (typically through Emergency Services) *increased* in the first two years of MHC participation. However, the number of general hospitalizations decreased in the final year of MHC treatment. This result suggests that it may take several years to improve the overall functioning of clients. This finding is contrasted by the number of psychiatric hospitalizations seen over the three years in MHC. Interestingly, psychiatric hospitalizations stayed the same in the first year and decreased significantly in the second and third year (Teller et al., 2004). These results combined could suggest that while it may take up to three years to see improvements in functionality, necessitating visits to the emergency room, MHC participation after only one year improves functionality to the point that a longer and more restrictive stay in a psychiatric hospital may no longer be needed.

A different suggestion was found in the data presented from a review of the Brooklyn MHC. By tracking clients one year prior to and after MHC enrollment, a significant decrease in psychiatric hospitalizations (50% to 19 %) was seen after only one year. Additionally, the incidents of emergency room visits decreased from 44% to 25% after one year of MHC participation. This finding suggests something somewhat different from the above study; that decreases in hospitalization can be seen as early as one year after MHC enrollment and that psychosocial functioning can be improved to the point that even emergency room visits are no longer necessary. Both Akron and Brooklyn programs use Axis I diagnoses in their eligibility criteria. The Brooklyn MHC, in contrast to the Akron program, accepts felons. Discrepancies in hospital use changes across these studies suggest that additional research is required to better understand the impact of MHCs on hospitalizations (O'Keefe, 2006).

Substance Abuse

Brooklyn MHC participants also showed dramatic decreases in drug and alcohol use (per self report) after one year of participating in MHC. Additionally, a significantly higher percentage of participants were reportedly abstinent at follow-up than at MHC intake (O'Keefe, 2006).

Other research on clients with a dual diagnosis of mental illness and substance abuse has yet to be conducted. However, various MHCs endorse substance abuse disorders in their eligibility criteria including, Santa Barbara, California; Santa Clara, California; Allegheny County, Pennsylvania; and Orange County, California.

Homelessness

While it is presumed that many MHCs have services designated for assisting clients in obtaining housing, little has been written about such policies. The Brooklyn MHC, however, is known for their services geared towards securing housing. In Brooklyn, a primary emphasis of the clinical team is to work with treatment providers and family members to return detained participants to pre-arrest housing (either with a community-based provider or family members) if clinically appropriate and agreeable to the court. Clinical team members also find housing in residential substance abuse therapeutic communities and supported housing. In Brooklyn, supported housing is accessed through a New York State Office of Mental Health pilot program, Single Point of Entry (SPOE). The MHC has worked closely with the program to reserve a few beds specifically for MHC participants (O'Keefe, 2006).

Despite the provision of such services, the reviewers note that, for the Brooklyn MHC, obtaining housing for MHC participants is a continual struggle. In fact, the reviewers found that despite contracts made with various treatment facilities to reserve beds for MHC participants, MHC participants are continually denied housing and given the lowest priority when beds are available. Additionally, it was noted that through the SPOE program, very few beds are made available for defendants in need of supportive housing.

It is believed that this barrier largely exists because treatment facilities do not want individuals with a criminal history in their facilities.

While it is clear that securing housing is not an easy task, it has been determined in Brooklyn that housing services provided by the MHC contribute to decreased homelessness. Specifically, outcome data showed that homelessness rates improved with the onset of MHC treatment. A total of 16% of participants were homeless in the year preceding enrollment compared to 11% during their first year of enrollment. Additionally, the average number of days homeless declined from 60 to 35 days. However, none of these differences were significant statistically.

Evaluation Overview

The Salt Lake County Division of Criminal Justice Services (CJS) has requested that the Utah Criminal Justice Center (UCJC) provide a process and outcome evaluation of the Salt Lake County Mental Health Court (hereafter referred to as MHC). The objectives of the MHC evaluation are to answer the following research questions:

1. Who does the program serve?
2. What services are MHC participants utilizing during participation?
3. What is the structure of the MHC?
4. Is MHC succeeding?
5. Who has the best outcomes in MHC?
6. What program components and services lead to the best outcomes?
7. How does the SLCo MHC compare to the mental health court model?

Methods

Data Sources

Data for this study were collected from a variety of sources. Because of the collaborative nature of mental health courts, it was important to collect information from as many sources as possible. This section outlines the data that was received from each agency. Table 1 provides a brief snapshot of the MHC participant sample size that was obtained from agencies; some data on screened only participants were also requested and received. The following paragraphs further explain the data requested from each agency and the resulting data matches and samples obtained.

Table 1 Data Sources and Sample Sizes

	Sample Size Obtained	
	N	% of Total
Criminal Justice Services	263	100.0
Valley Mental Health	220	83.7
Salt Lake County Adult Detention Center	256	97.3

	N	% of Total
Utah Department of Corrections	200	76.0
Bureau of Criminal Identification	245	93.2
National Alliance on Mental Illness	110	41.8

Criminal Justice Services. Criminal Justice Services (CJS) periodically provided researchers with a regularly updated Excel spreadsheet containing program participation lists for MHC. Variables included current and former participant names, Sheriff's Office number (SO), date of birth, gender, status (e.g., active, graduated, terminated), treatment/residence location, intake date, plea date, probation expiration date, and exit date. CJS staff also took notes in a Word document at each MHC hearing (hereafter referred to as Court Notes). Court Notes described any actions taken by the court (e.g., booked in jail, released from jail, bench warrant issued, graduated), whether or not the participant was on the Rocket Docket, and notes about the participants' progress, as described by the participant and/or team members in court. Researchers obtained weekly Court Notes for all MHC hearings between June 2004 and April 2008 (145 participants). Court Notes were transferred into an Excel spreadsheet and recoded in an attempt to gain a better understanding of program components, such as the use of sanctions, bench warrants, and the Rocket Docket.

Valley Mental Health. Identifying information for 259 Mental Health Court individuals (244 participants, 15 screened only) was sent to Valley Mental Health (VMH) in early 2008 to locate in their database. The following selection criteria were employed by VMH research staff: Using the Excel file provided with a list of MHC participants, VMH used name and birth date of those participants to look them up in VMH files to see if they had a Valley ID number. Those MHC participants that did have a Valley ID were then entered into data runs which would pull the requested information, if available, for those participants. Some ID numbers, such as screening numbers, may not pull any requested data; however, those cases were rare. For example, for service data runs, the MHC participants with Valley IDs were entered into a data run that would pull services for all those participants whose ID number matched services associated with that particular ID. Some participants with a Valley ID may not have matched back to any services for a particular year. Services were sorted by service date and the number of service in order to pull all unique services for that client. This method was similar for matching back to the admissions, diagnoses, and client characteristics files. Of those searched in VMH records, a Valley ID was located for 233 individuals (220 participants), or 90.3% of those requested. VMH data presented in the Results section of this report are out of those 220 participants that were identified and queried from their datasets.

Salt Lake County Adult Detention Center. A query of the Salt Lake County Adult Detention Center (ADC, jail) JEMS database for all bookings between July 1, 2000 and May 22, 2008 was received in May 2008. MHC participants were identified in ADC bookings by several combinations of name, date of birth, and Sheriff's Office number (SO, the identifier used by ADC). Some SOs for MHC participants were also located in participant files for the various CJS programs. These data were used to examine pre- and

post-MHC bookings by charge types and booking types (e.g., warrant, new charge, commitment), as well as days in jail while participating in MHC. SOs were found for 256 of the 263 MHC participants (97.3%). The remaining seven MHC participants that were not located in JEMS files were either not booked into the ADC between July 2000 and May 2008, or were booked under an alias that did not match any of the search parameters. JEMS statistics presented in this report are out of the entire group of MHC participants (N = 263) searched for in JEMS data, unless otherwise noted.

Bureau of Criminal Identification. Over the course of the evaluation, attempts were made to locate and verify MHC participants' State ID numbers (SID), the identifiers used by the Bureau of Criminal Identification (BCI). SIDs came from several sources including the: Salt Lake County Adult Detention Center (ADC) database (JEMS), Utah Department of Corrections records, and CJS program files. These searches resulted in the identification of SIDs for 245 of the 263 MHC participants (93.2%) and 41 of 49 (83.7%) screened only individuals. These identifiers were sent to BCI for query of the state criminal history record in May 2008. The criminal history data was used to examine pre-MHC criminal histories, as well as recidivism for those who had a sufficient follow-up period following exit from MHC. Unless otherwise stated, descriptive statistics presented for BCI data are out of the 245 MHC participants who had BCI records. Additionally, BCI arrests for participants were not recorded for the time period during MHC, as inaccuracies in the BCI data have been identified. For instance, while participants are under AP&P supervision, probation/parole violations are sometimes recorded in BCI as a new offense. To avoid misrepresenting during-MHC offending, no BCI data were examined while participants were active in the program due to the majority (72.5%) also being under AP&P supervision.

Utah Department of Corrections. UDC records were hand searched for 244 out of the 263 MHC participants (92.8%) by various spellings and combinations of last and first names and date of birth. This resulted in 200 (82.0%) MHC participants that had O-track numbers, indicating involvement with UDC. UDC records provided information for these participants on legal status changes (e.g., probation, prison, parole), probation officer contacts, urinalysis testing, programming, and Level of Service Inventory (LSI) scores. Descriptive statistics on MHC participants' UDC involvement are presented as a percentage of the total 244 participants included in the data queries, unless otherwise specified.

Additional Sources. Identifying information for 110 MHC participants was sent to the Utah Chapter of the National Alliance on Mental Illness (NAMI) in March 2008 to locate in their program records. NAMI staff identified 46 out of the list of 110 MHC participants (41.8%) who participated in their Bridges program. Both Fisher House and the Housing Authority of the County of Salt Lake (HACSL) provided researchers with a list of previous and current participants in their programs as well as the intake and exit dates, and exit status for each. Researchers hand searched these lists to identify MHC participants by name.

Analyses

Quantitative. Descriptive and statistical analyses were conducted using SPSS 15.0®. Analyses were limited by availability of data, both in terms of sample size and follow-up periods. Statistical analyses were chosen based on the level and characteristics of the data. The use of the appropriate test based on the characteristics of the data and the assumptions of the test increase the "power," the ability to correctly identify group differences (Pett, 1997). Normally distributed data (e.g., days to failure event) were examined using parametric tests (e.g., t-test), while nominal variables (e.g., presence or absence of recidivism) and non-normally distributed variables were examined using nonparametric tests (e.g., Chi-Square, Mann-Whitney U Test). All statistically significant results are presented with their test statistic and p value in a footnote or table. The p value is compared to a standardized alpha (ά, significance level). Statistical significance was set at $\acute{\alpha} < .05$, which is standard in the social sciences. This means that the likelihood that the observed difference between groups is due to chance is less than five in 100. Primarily bivariate (comparisons between two variables) tests are reported; however, a multivariate analysis (logistic regression) was conducted to predict likelihood of recidivism.

Qualitative. Work flow analysis is designed to gain a qualitative understanding of how the work of a program is conducted. This model has been used in qualitative evaluations of other problem-solving courts (Byrnes, Hickert, & Kirchner, 2007a; Byrnes, Hickert, & Kirchner, 2007b). In this specific analysis, the focus was on how cases move through the MHC, what program components (e.g., the judge, attorneys, case managers, probation officers, clinical service providers, local law enforcement) are involved, and what inputs are important at these decision points.

UCJC staff interviewed nine key MHC team members. These team members included the judge, defense and prosecuting attorneys, clinician, case managers, and probation officers. Additional information was gathered through phone conversations with representatives of and document collection from partnering agencies, including Criminal Justice Services, Salt Lake Police Department Crisis Intervention Team (CIT), Valley Mental Health Jail Diversion Outreach Team (JDOT) and Community Treatment Program (CTP), Housing Authority of the County of Salt Lake (HACSL), Legal Defenders Association (LDA), Utah Chapter of the National Alliance on Mental Illness (NAMI), and Salt Lake County Jail Mental Health Services. Responses to a fixed set of interview questions were analyzed to identify trends and themes within the answers. These results were combined with additional information from program documents and input from partnering agencies.

Results

Who does the program serve?

Intake and Demographics

Since its inception in 2001, MHC has served a total of 312 participants. However, closer

review of court note records identified 49 of these participants who were screened for MHC, but exited the program prior to entering a plea. Most of these individuals were deemed ineligible for the program (75.5%), and the remainder chose not to participate (24.5%). Most individuals in this group spent limited time in MHC court with a median of 14 days between their first and last MHC appearances, compared to more than a year for participants. The 49 individuals who were only screened were compared to MHC participants (N=236) on gender, race, and age (see Table 2). No statistically significant differences were noted between the two groups. Additionally, screened only individuals did not differ statistically significantly from participants on criminal history either. Approximately three-quarters of screened only (71.1%) and participants (78.5%) had a new charge booking in JEMS in the two years prior to MHC. Of those with a new charge in BCI records in the three years prior to MHC, participants had 4.6 on average, compared to 3.7 for screened only individuals.

A small group (N=19) was identified as participating in MHC a second time. Most of these repeat participants (63.2%) were still active in MHC at the time of the last data query, but two had successfully completed the program the second time around. Individuals who were screened but never pled into MHC and participants' second time in MHC (if applicable) were excluded from the remainder of analyses. Therefore, the remaining analyses are based on the 263 first-time individuals who entered a plea.

Table 2 Comparison of Screened Only and Participants

	MHC Intake Status	
	Screened Only	Participated
N	49	263
White	91.1%	86.0%
Male	61.2%	67.3%
Age at Intake (Md.)	39.4	34.3

The age of MHC participants at intake ranged from 18 to 64, with 25% of participants 26 years old or younger, and 75% of participants 42 years old or younger. Median age for MHC participants was 34.3 years old. A majority of participants (67.3%) were male and White (86.0%). The remainder identified themselves as Hispanic (6.2%), Black (5.4%), Native American (1.2%), Pacific Islander (0.8%), or Asian (0.4%).

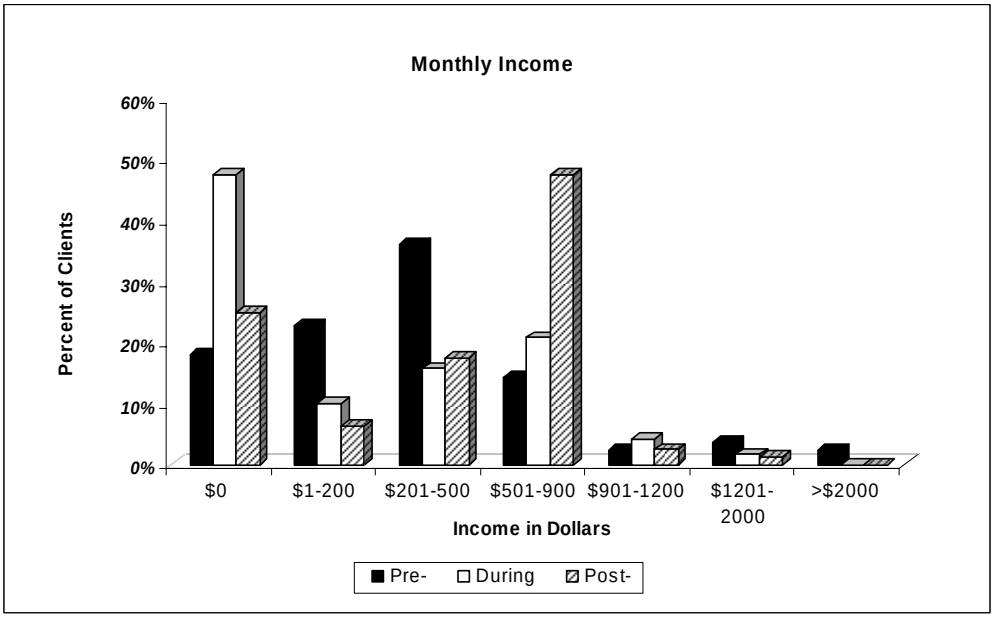
According to court note records, most participants (88.2%) were ordered to complete MHC as a condition of probation. The remaining individuals entered a plea in abeyance, which held the possibility of a dismissal of charges upon successful completion of the program. Length of probation ordered ranged from six to 36 months, with a median of 36 months on probation. However, the MHC judge has the option of shortening probation length by up to six months as a reward for program compliance.

According to Valley Mental Health (VMH) assessment records, 22.9% of participants were ever identified as disabled. A variety of sources including court notes, VMH assessment records, and JEMS data, were consulted to determine the number of

participants who were homeless at any time during MHC. By combining these sources, researchers determined that nearly a quarter of all MHC participants (59, 22.4%) experienced homelessness while in MHC. Participants who were identified as being homeless while in MHC were found to be more likely to receive housing assistance or residential treatment while in MHC.

Most participants were single (88.3%) and unemployed (90.1%) at least part of the time while in MHC. Although the number of people receiving services from VMH decreased slightly after MHC exit, the percent of participants identifying themselves as unemployed post-MHC was similar to that during MHC. Of those with reported income, many reported an increase in monthly income from during to post-MHC. Half of participants (52.5%) reported having no income while in MHC, although some participants' only form of income may have been public assistance. Figure 1, below, displays participants' monthly income pre- (N=166), during (N=120), and post-MHC (N=80).

Figure 1 Participants' Monthly Income



Mental Health History

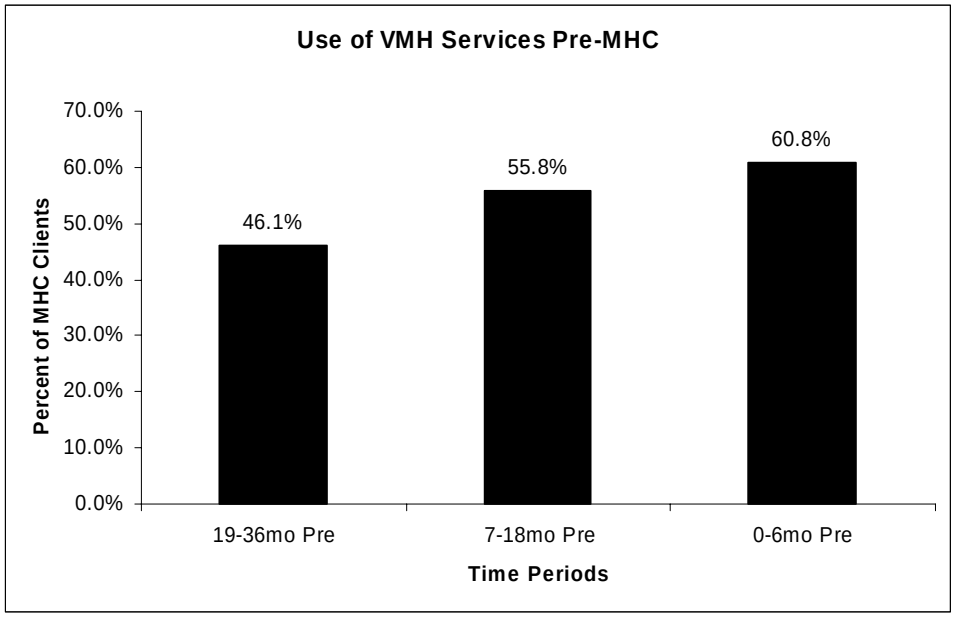
Mental Health and Substance Abuse Diagnoses. Participants' history of Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) diagnoses revealed a long history of MHC-eligible mental illnesses. Of the participants with diagnoses prior to MHC start (N = 169, 76.8%), nearly three-quarters (70.4%) met MHC diagnoses eligibility by having one of the following diagnoses: Schizophrenia and Other Psychotic Disorder or Bipolar Disorders. In addition, over half (57.4%) met criteria for a substance use disorder, while one quarter (27.2%) met criteria for depression. If participants who had a diagnosis within 180 days pre- or post-MHC start were included with those who had a diagnosis prior to MHC (N = 204, 92.7%), nearly all (86.3%) met MHC eligibility

criteria and 62.7% had a substance use disorder. These problems had been identified, on average, several years prior to MHC start (Median (Md) = 6.8, Mean (Mn) = 8.3 years for Schizophrenia and/or Bipolar Disorder; Md = 5.8, Mn = 6.7 for Substance Use Disorders). MHC criteria requires that all participants have a documented history of mental illness; therefore, those without records in VMH were either not identified due to the data querying techniques, or had diagnoses recorded at other mental healthcare providers.

Treatment History. MHC participants typically had a long history of MH treatment involvement at VMH. Of the participants whose information was sent to VMH for treatment data, 82.8% (N = 202) had at least one admission prior to MHC start. On average, these individuals had three admissions (Md = 3.0; Mn = 3.5) before MHC. The first of these admissions was generally several years (Md = 8.7; Mn = 10.0) prior to beginning MHC. Participants' age at this first admission was typically in the mid-20's (Md = 22.8; Mn = 24.6). Of those with admissions prior to MHC, type of admission included youth (23.3%), adult (72.3%), forensic (34.7%), and UMed (24.3%); of course, participants could have more than one admission type in the pre-MHC period.

Service records also indicate that individuals who later participate in MHC have substantial use of VMH services and resources in the years immediately prior to starting MHC. As shown in Figure 2, below, over half of future MHC participants received VMH services in the three years leading up to MHC participation.

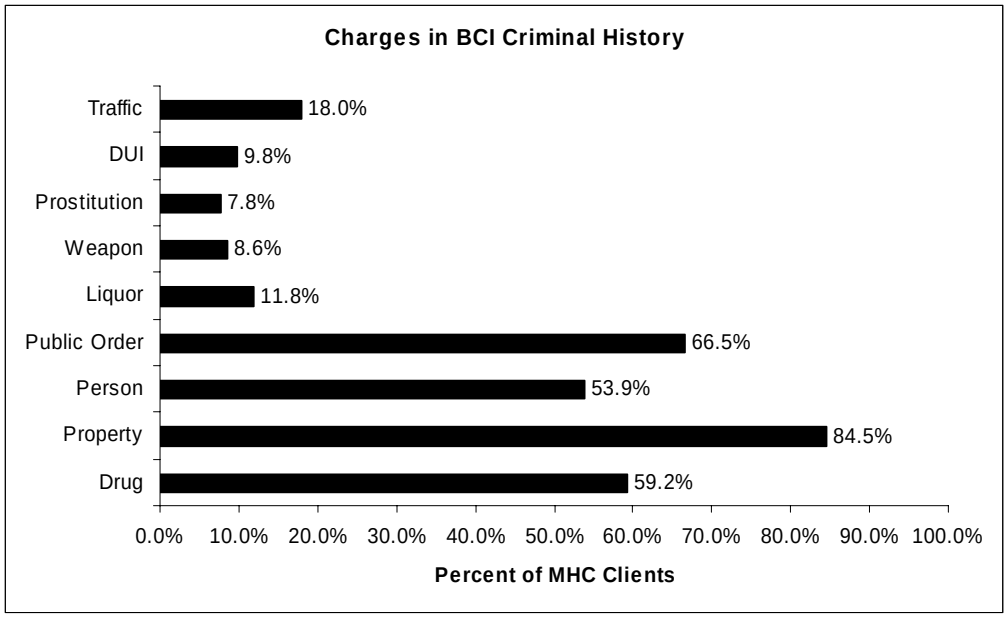
Figure 2 VMH Service Use Pre-MHC



Criminal Justice System Involvement

Bureau of Criminal Identification. MHC participants had extensive criminal histories recorded in the statewide criminal history record. Nearly every participant (92.7%) had at least one arrest in the three years prior to MHC, while they had on average nine (Mn, Md = 6) arrests prior to MHC. For those that had a new charge in the year prior to MHC (86.1%), median number of new arrest dates was 2.0 (Mn = 2.7). It should be noted that some inaccuracies have been identified in BCI data regarding probation violations being recorded as new offenses. As over one-quarter of MHC participants were on AP&P supervision prior to MHC, some of these recorded arrests could be probation violations, not unique new charges. With that caveat, Figure 3, below, displays the type of charges MHC participants committed prior to MHC. Most had at least one property crime in their criminal history, while over half had committed drug and person crimes. Prostitution offenses also included solicitation charges. Of those with a DUI, median time from DUI to MHC start was 8.5 years, meaning that the MHC policy of not accepting anyone with a current DUI offense is being met.

Figure 3 Types of Charges in BCI Criminal History Pre-MHC

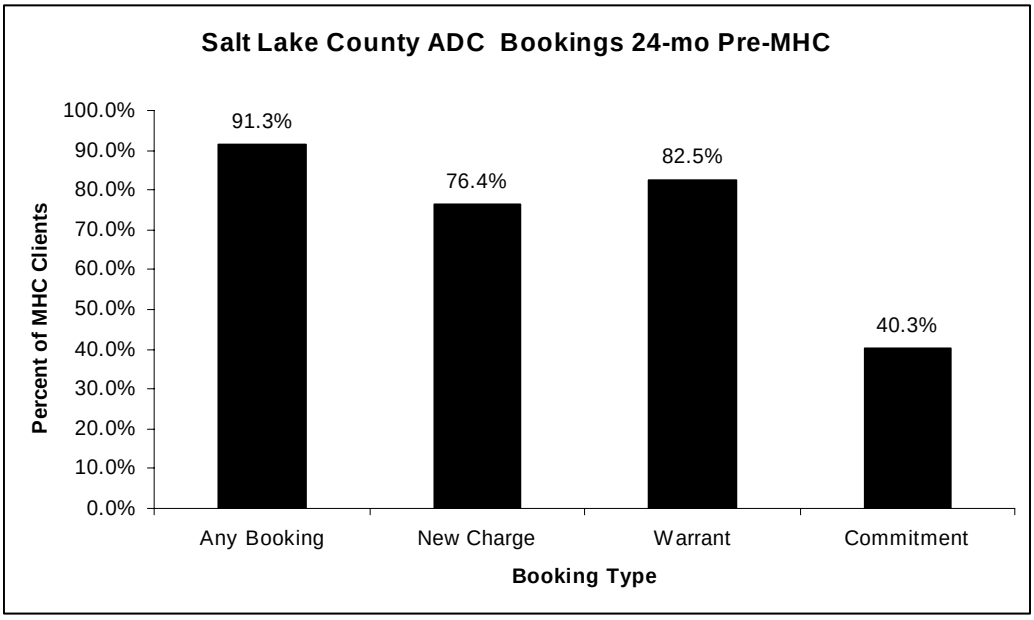


Adult Detention Center[1]. The MHC serves participants who are booked into the jail often and are therefore consumers of considerable criminal justice resources. Nearly every MHC participant (91.3%) had at least one jail booking in the two years prior to MHC, with an average of 3.0 bookings (Mn; Md = 2.0). As shown in Figure 4 the most common

[1] Reference to "jail bookings" only includes bookings into the Salt Lake County Adult Detention Center (ADC) and do not include bookings into any other jails.

types of bookings were for warrant and new charge bookings[2]. Median time from most recent jail booking to MHC start was 101 days (Mn = 145), while time from most recent new charge booking to MHC start was 151 days (Mn = 261). Of those with a booking in the two years prior to MHC, median days in jail was 70 per person (Mn = 98). A total of 21,765 jail days were utilized by MHC participants in the two years prior to MHC start.

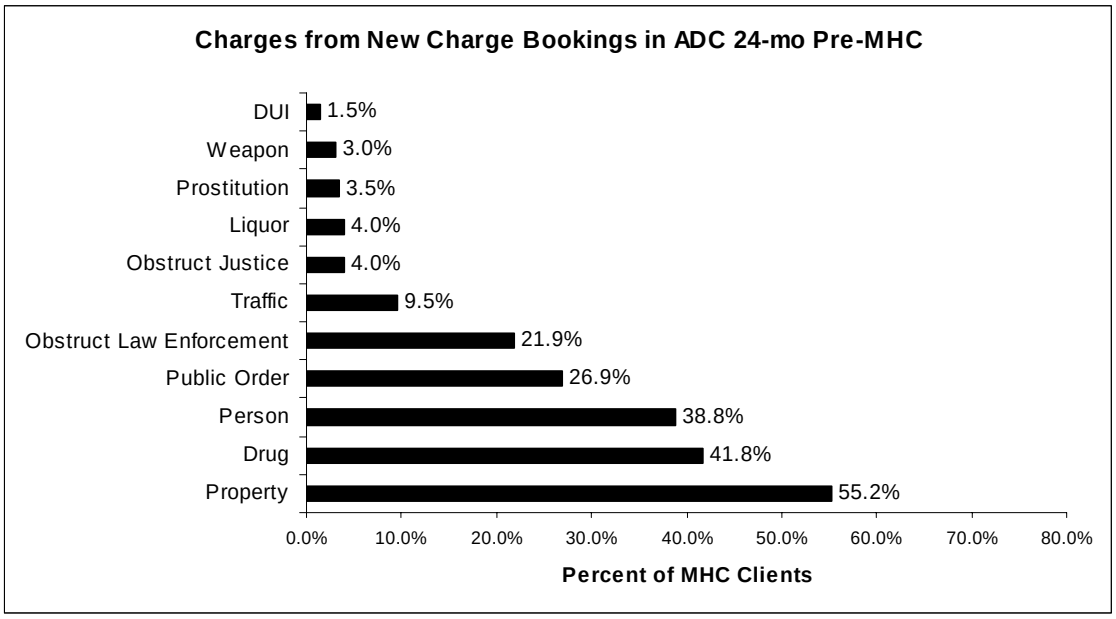
Figure 4 Type of Jail Bookings in 24-mo Pre-MHC



Of those with a new charge booking in the two years prior to MHC, most had a 2nd Degree Felony (37.0%) or 3rd Degree Felony (27.0%) as their most severe charge. The most common types of offenses were property, drug, person, and public order. Public order offenses included disorderly conduct, public intoxication, and disturbing the peace. Obstructing law enforcement offenses included interfering with or resisting arrest and providing false information to police. Figure 5, on the following page, shows the percent of MHC participants who had each type of new charge in the two years prior to MHC – out of those that had at least one new charge booking during that period.

[2] Each booking could be for more than one booking type. For example, an offender could be picked up on a new charge, but have two outstanding warrants at the same time. That booking would be flagged as both a warrant and a new charge booking

Figure 5 Types of Charges from New Charge Jail Bookings 24-mo Pre-MHC



Utah Department of Corrections. Some MHC participants have had past involvement with Utah Department of Corrections (UDC). Just over one-fourth (27.0%) had a placement on probation with Adult Probation and Parole (AP&P) prior to the one associated with MHC, while 8.2% had been in prison prior to MHC (and also on parole). Nearly three-quarters (72.5%) were on AP&P supervision during MHC (all probation, except one person on parole). Of those on AP&P supervision during MHC, 17.0% were already on probation when they entered MHC, 20.0% started probation and MHC on the same day, and 39.4% started probation within 30 days of beginning MHC. The remainder started probation more than 30 days after starting MHC. The risk level for MHC participants with Level of Service Inventory (LSI) screenings within 180 days pre- or post-MHC intake was 25 on average (Mn, Md = 25). An LSI score of 25 out of 54 is defined as high risk by UDC.

What services are MHC participants utilizing during participation?

Living Situation and Ancillary Services

Housing Assistance. Nearly half of participants (125, 47.5%) received some form of housing assistance or residential treatment while in MHC. More than half of these participants (60.3%) utilized two or more housing resources while in MHC. The majority of other participants resided in private residences during this time. Table 3, on the following page, provides a list of the housing units and residential placements most frequently used by MHC participants, as well as the median length of stay, when available.

Table 3 Most Frequently Used Housing Units/Residential Placements

Housing/Residential Treatment Option	N	Length of Stay (Md. days)
Fisher House	45	178.4
Master Leasing	20	------
Fremont	16	111.0
HARP	16	260.9
John Taylor House	13	------
Orange Street	13	147.0
Timmins House	13	------

Median length of stay was not available for all housing/residential placements and varied greatly, ranging from two to 376 days per participant. MHC participants spent an average of 140 days in these units, with the longest stays reported for participants in the HARP program. Exit status data was provided for those participants who exited HARP housing and Fisher House. Both programs reported mixed outcomes, with approximately half of MHC participants exiting the program successfully (HARP, 40.0%; Fisher House, 48.1%).

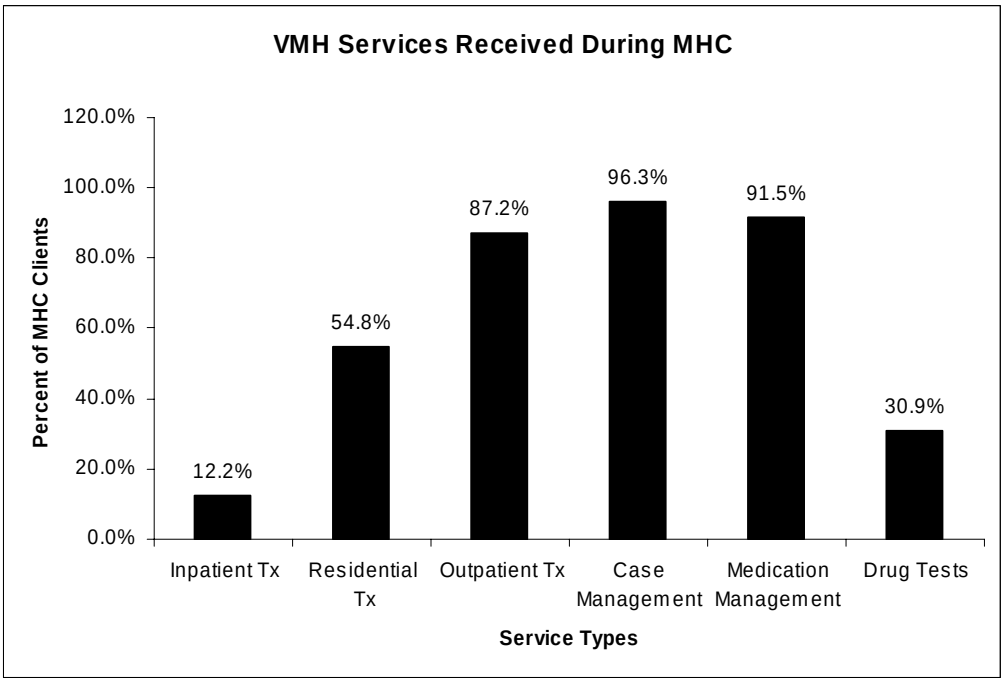
JDOT. The Jail Diversion Outreach Team (JDOT) was formed in August 2007 and as of April 2008, had served 19 MHC participants. Team members consider the group of individuals served by JDOT to be the most challenging and therefore in need of this increased level of assistance. Based on an examination of court note records, the amount of time individuals have been served by JDOT ranges from a few days for participants just placed on JDOT's caseload to 154 days for the longest served client. Additional analyses on this sub-sample were not conducted at this time due to the small sample size.

National Alliance on Mental Illness. A search of National Alliance of Mental Illness (NAMI) records identified 48 MHC participants (of 110 participant records queried, 43.6%) who had participated in NAMI's Bridges program. This number includes both the version conducted in the jail as well as the one offered in the community. Of those who participated in NAMI, records indicated that 41.7% graduated from the program. MHC participants often have contact with NAMI for reasons other than the Bridges program; however, records on these other contacts were not kept by the organization, and therefore can not be reported on. Additionally, as described further in the Participant Compliance subsection of "*Is MHC succeeding?*", many MHC participants are ordered by the court to complete community service as a sanction. NAMI is one of the sites where community service can be completed, creating another opportunity for MHC participants to make contact with this valuable resource.

Treatment and Case Management

While active in MHC, 86.6% of participants had service records at VMH[3]. Of those, Figure 6, below, shows the percent who received various types of treatment and services. It was most common that MHC participants received case management and medication management services from VMH and less common to receive drug testing[4] and inpatient treatment. Inpatient treatment was defined as psychiatric hospitalization and would include hospital stays at the University of Utah or University Neuropsychiatric Institute (UNI). Over half of MHC participants received residential treatment services through VMH at some point during MHC. Residential treatment included stays at Community Treatment Program (CTP), Safe Haven, Valley Plaza, and similar placements.

Figure 6 VMH Services Received During MHC



As well as being the most commonly utilized services, case management and medication management were also the longest used services during MHC participation, along with outpatient treatment. Among those that received inpatient treatment, stays were typically only two weeks long. Table 4, on the following page, displays the median days in each service type and between services for individuals who used these services during MHC. Not surprisingly, inpatient and residential treatment services were received daily for

[3] Individuals who did not have VMH services during MHC (N = 29) were hand checked. Of those, 18 (62.1%) were not found in the VMH database using the name, date of birth look-up query. Eleven were found in VMH records; of those, 9 had no services recording during the MHC years and 2 started MHC in spring 2008 so were not included in the service data query.

[4] Drug testing was also conducted by AP&P. A total of 59.4% of MHC participants had a drug test with either VMH or AP&P.

individuals in those treatment modalities, while outpatient treatment was received approximately weekly. Due to the calculation methodology used to compute average time between services, it is believed that the frequency of the longest-received services (case management, outpatient treatment, and medication management) is slightly underestimated.[5]

Table 4 Use of VMH Services During MHC

Service Types	N	Median Days In	Median Days between Services
Inpatient Tx	23	14	0*
Residential Tx	103	185	0*
Outpatient Tx	164	358	7.5
Case Management	181	364	4.6
Medication Management	172	358	10.4
Drug Tests	58	153	6.9
Overall	188	441	2.0

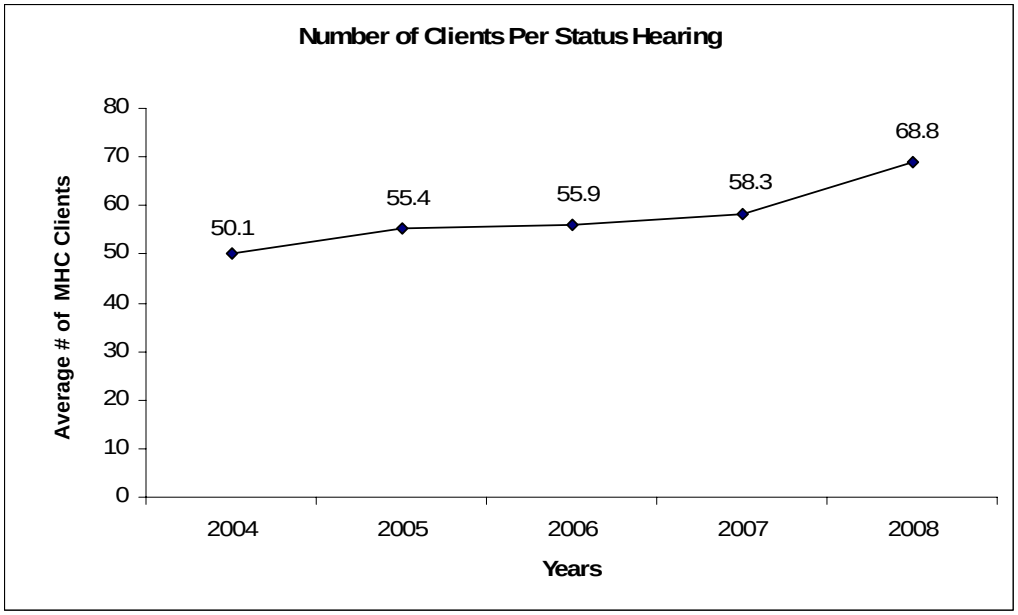
*Services were received daily

Court Appearances

An examination of Court Notes yielded information regarding the number of participants appearing at each status hearing. The average number of participants appearing before the judge per session has been slowly increasing over the years, and is currently about 70 participants per session (see Figure 7, on the following page). Court status hearings are held every Monday afternoon, with the exception of holidays, and participants are required to appear weekly for the majority of their time in MHC. Court Note records confirm this claim, with half of participants having status hearings every 9.9 days or more often, and three-quarters of participants with status hearings at least every 12.0 days. According to information gathered from key informant interviews (see the Clients' Progress, Rewards, and Sanctions subsection of the *"What is the structure of the MHC?"* section of the report), previous attempts at extending court appearances to less often than every two weeks had been unsuccessful. The vast majority of hearings were held post-plea (94.6%). This is not surprising, due to the fact that potential participants typically completed Orientation during their first court appearance and entered a plea at their second court appearance. This is in line with the program's policy giving potential participants a week, following Orientation, to think about whether or not to participate prior to entering a plea and signing the MHC Agreement.

[5] Frequency of services was computed by dividing the number of days from first to last service by total days of services. This means that if a MHC client had outpatient treatment recorded from January to December of one year, but did not participate during a 3 month period within that timeframe, the frequency of treatment would still be calculated for the entire year.

Figure 7 Changes in Number of Clients Per Status Hearing



AP&P Supervision

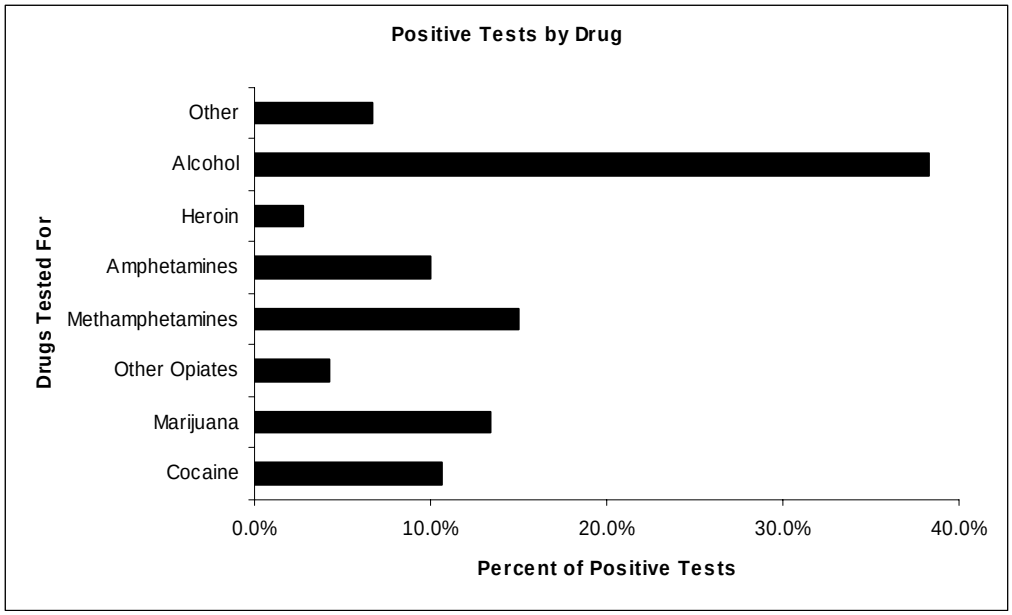
Probation Officer Contact. As previously noted, nearly three-quarters (72.5%) of MHC participants were on AP&P supervision while in MHC. Median days between completed probation officer (PO) contacts was 18.6 (Mn = 21). Scheduled but not completed contacts were not included in these calculations. Due to the methodology used to compute average time between PO contacts, the overall frequency may be underestimated.[6] However, a review of some individual case files indicated that participants met with their probation officers bi-weekly at the start of MHC and approximately monthly toward the end. These examples were consistent with the average frequency of every 2-3 weeks. The majority of each participants' visits were in the PO's office (Md = 78.6%), but a fair amount were home visits (Md = 14.3%). Only 16.9% of participants on supervision did not have a home visit recorded.

Drug Testing. Over one-third (37.7%) of participants included in the UDC record query had drug tests recorded with UDC. When drug testing from VMH and UDC were combined, over half (59.4%) of MHC participants had drug testing from at least one of those locations. Drug testing at AP&P was not very frequent (Md = 47.6 days between tests), but did result in a fair percent of tests per person being identified as high (Md = 14.3%). However, nearly half (45.3%) of those tested did not have a positive drug test on record. Figure 8, on the following page, shows the percent of tests identified as high out

[6] Frequency of PO contacts was computed by dividing the number of days from first to last PO contact by total completed PO contacts. This means that if a MHC client had PO contacts recorded from January to December of one year, but did not meet with their probation officer during a 3 month period within that timeframe, the frequency of treatment would still be calculated for the entire year.

of the total number of tests conducted for each substance. It was most common that alcohol tests would detect use, while heroin was the least detected substance.

Figure 8 Percent of High Drug Tests by Substance



What is the structure of the MHC?

Various sources were consulted in an attempt to develop an understanding of the structure of MHC. These sources included: participant and court note records, program documents, and academic literature. However, researchers were concerned that these sources were not providing an adequate picture of this particular MHC, and in some cases were creating more questions than answers. As a result, researchers decided to conduct semi-structured interviews with MHC team members and representatives from partnering agencies. The following questions were asked during the key informant interviews:

1. Could you describe your role in the MHC and how long have you been involved with the program?
2. How are potential participants referred to MHC?
3. How are potential participants screened for (legal) eligibility for MHC?
4. How are potential participants assessed for appropriateness for MHC?
5. How are participants oriented to MHC?
6. Can you describe the MHC program and how progress through the program is determined?
7. How is participants' progress rewarded while they're in MHC?
8. How does MHC address participants who are not making progress?
9. Do you think MHC is successfully treating its clients? Why, why not?
10. How does the MHC recognize successful completion of the program?
11. How does the MHC address unsuccessful participation in the program?
12. After a participant leaves MHC, what, if any, resources are available to them?

13. Are there current barriers to service delivery or are there any changes that need to happen within MHC?

Interviewers asked follow-up questions to clarify responses to these questions and elicit team members' opinions on the court's processes and functioning. Follow-up questions did not alter the substantive focus of the original questions posed.

The results are grouped here according to workflow categories of court team and partnering agencies; referral, screening, and assessment; clients' progress, rewards, and sanctions; graduation and termination; aftercare; and challenges.

Court Team and Partnering Agencies

More than half of the current MHC team has been involved with the program either during its planning stages or since its inception. Only one member has recently joined the team. The team has a thorough understanding of the MHC model and related issues. For example, nearly every member independently described the "individualized" nature of the program and the importance of this feature. Additionally, more than half described the clientele using clinical terms, including seriously persistently mentally ill (SPMI) and co-occurring disorders/dual diagnosis. Furthermore, several described non-traditional roles taken on by various team members, such as the prosecutor advocating for increased treatment options or the treatment provider suggesting criminal justice responses (i.e. jail) to non-compliance. This was also witnessed by researchers during pre-court staffings and status hearing observations. In fact, observations suggest that the prosecutors were equally likely as the judge or treatment team to offer the clients praise and support for their accomplishments. Team members also described the function of the MHC within the broader context of addressing mental illness within the criminal justice system and the need for reform and innovations. A couple noted the use of a "harm reduction" model in the MHC, where incremental gains are acknowledged and the program seeks to decrease likelihood of harmful behaviors while understanding it may not be possible to completely eliminate recidivism or relapse.

In addition to the core MHC team, several ancillary agencies provide valuable input and necessary services to the program. For instance, representatives from the Housing Authority and Jail Mental Health Services attend pre-court staffings and status hearings weekly. They also provide important updates to team members regarding clients, as well as help problem-solve any issues clients may be having. Nearly every team member identified the availability of housing options as a key component of the MHC program. A few expressed the belief that housing is the number one resource for clients, while a couple viewed housing as a reward for participation. In contrast, some team members said that safe, decent housing was a right, not a reward for clients' participation.

Representatives from the Jail Diversion Outreach Team (JDOT), Community Treatment Program (CTP), and Utah Chapter of the National Alliance on Mental Illness (NAMI) also often attend court to inform the team about clients' progress and challenges. JDOT is a relatively new resource, implemented in August 2007, yet it has become a critical

component of the MHC. JDOT provides the most at-risk clients with daily medication monitoring, home visits, and case management following the Assertive Community Treatment (ACT) model that has been shown to be highly effective with a multi-need mentally ill population. More than half of the MHC team specifically mentioned JDOT as an important resource for the program. CTP has a 16-bed residential unit that the MHC utilizes when patients need to be stabilized following release from jail or in lieu of jail. Although it is a limited resource, it has become invaluable to the MHC in addressing clients who are in crisis. A couple team members noted the need for additional resources like CTP to help stabilize clients without the use of jail. NAMI provides classes for MHC clients (Bridges, Gathering) and families (Family to Family) in a peer-directed environment where clients take an active role in their recovery. One team member suggested that more peer-to-peer support would benefit the MHC clients. Clients also complete some court-ordered community service hours at NAMI, as well as at VMH and other MHC partners.

Although they do not have representation in court every week, the Salt Lake Police Department Crisis Intervention Team (CIT) is another critical resource for the MHC program. CIT was developed around the same time as the MHC. This team of certified officers is specially trained to respond to mentally ill offenders, as well as build a system where law enforcement is part of a continuum of entities that deal with mental health (MH) issues. The CIT team makes referrals to the MHC and also responds to requests from the MHC to intervene with clients who may be getting into trouble or putting themselves or others at risk. A few MHC team members mentioned that MHC clients are a vulnerable population that can be easily victimized. CIT has been identified as a valuable resource to deal with these issues.

Referral, Screening, and Assessment

There was a consensus in describing the referral process. Nearly every team member told researchers that the referral process begins with a MH screening by the staff at Legal Defenders Association (LDA). Consistent with program documents, most team members indicated that referrals can come from several sources, including private attorneys, LDA, judges, law enforcement, the jail, and other specialty programs (such as drug court). However, LDA was identified as the primary referral source. After a referral is made, the potential client signs release forms for the requisite MH and legal records so that eligibility can be determined. Two components of legal eligibility were noted by the team. The attorneys indicated that legal competence was a pre-requisite for voluntary participation, while both legal and non-legal team members listed the following charge-related criteria: no sex, weapons, or active DUI offenses. Violent offenses are considered on a case-by-case basis, examining the type and level of violence involved. Although the entire team staffs cases for potential clients, it was noted that the prosecutors make the final decision on meeting legal criteria for participation, since they are ultimately accountable for ensuring public safety. Most team members also described the requirement of meeting MH criteria for participation, while a couple indicated that an Axis I diagnosis, specifically, is required.

Nearly everyone indicated that the orientation is conducted by the prosecutors, legal defender, and clinician, although some team members were not aware of what steps comprise the orientation. Of those team members who were familiar with the process, it was noted that the orientation consists of: attending court hearings prior to intake, reviewing an agreement, and returning a week after the orientation to sign the agreement and enter a plea. Many team members indicated that the reward for successful completion, either a 402 reduction of charges or dismissal through a plea in abeyance, is specified to the client upon intake.

Clients' Progress, Rewards, and Sanctions

The weekly structure of status hearings was the primary response of the MHC team when asked to describe the MHC program and how progress is determined. Nearly every member indicated that clients are required to attend court weekly, at least at first, and that this structure becomes very important in the lives of clients. At these weekly hearings, clients are reminded of their responsibilities, offered praise for their progress, and given reprimands or sanctions for non-compliance. One team member indicated that the routine of the weekly status hearings may be a more powerful influence on the clients than was actually intended. Several respondents noted that when frequency of court appearances has been reduced to every two weeks clients seem to have more issues of relapse and non-compliance. Other main components of progressing through the program are drug testing, housing, and medication. As previously mentioned, many team members noted that requirements, progress, and success are all determined on an individual basis. Some other program components mentioned by members were weekly in-office meetings with probation officers and VMH case management staff, monthly home visits by probation officers, classes and treatment groups at VMH, and assignments. The length of MHC participation is limited by the maximum probation length for the severity of clients' charges at intake. Although some team members indicated that probation can be revoked and reinstated to extend their probation period in order to provide clients with more opportunities for success.

The primary reward, mentioned by every team member, was placement on the "Rocket Docket" and verbal praise. Clients who are compliant and making progress are placed on the Rocket Docket, which means they are acknowledged for their hard work and are allowed to appear before the judge at the beginning of the status hearings and leave court earlier than those who are in custody or non-compliant. The Rocket Docket and verbal praise were considered by the court team to be very effective means of rewarding clients. Several stated that clients look forward to their weekly interaction with the judge and the positive comments they receive from team members both in and out of the courtroom. Several team members noted that the ultimate rewards for participation are a shortening of probation length by 3-6 months and a reduction or dismissal of charges upon successful completion of MHC. Some other types of rewards that were less frequently identified were a lessening of program structure (groups, supervision) for good behavior, the opportunity to be in MHC in lieu of jail, have housing and medications provided, and developing new skills. Again, in contrast, some team members were clear that housing and medications are not rewards, but rights of MHC participants. Lastly, a couple of team

members indicated that tangible rewards had been tried in the past, but were met with little success. It was expressed that the current reward options are sufficient for the program.

Several MHC team members specifically mentioned "sanctions" and "graduated sanctions" when asked how the MHC addresses clients that are not making progress. The most frequently identified sanctions were changing program structure and jail. The next most commonly noted sanction was community service. Less frequently mentioned sanctions were removal from the Rocket Docket, verbal warnings, temporarily holding clients in custody during court, and drug testing during court. Observations of status hearings and review of court notes indicate that the most frequently mentioned sanctions by the court team were not necessarily the most frequently utilized. For example, verbal warnings and removal from the Rocket Docket are the most often used sanctions for minor non-compliance. The next most commonly used sanction was a change in program structure, which was mentioned by the team. Clients are often given additional assignments, classes, or groups; a change in housing; or stricter supervision. It should be noted that nearly every team member who indicated that jail was a sanction, qualified that statement by saying that jail is actually used as a way to stabilize clients on their meds and ensure their safety, rather than to punish them. However, one team member said that jail was also sometimes used specifically as a punishment and another noted that although jail was used to stabilize clients it was still a punishment.

Graduation and Termination

The most common response to "How does the MHC recognize successful completion of the program?" was "graduation." Graduation ceremonies are held approximately once a month at the beginning of the weekly status hearings. Graduates are called to the front of the court where they are addressed by the clinician, judge, and prosecutor who all offer the client praise for his/her accomplishments. The client is then presented with a certificate and reminded by all that they are welcome to visit the court any time. The client is then given the opportunity to address the court. During the graduation observed by the researchers, the clients generally thanked the judge and program for their support and the opportunity to participate. Once the client is through addressing the court, the prosecutor forwards a motion to either reduce or dismiss the client's charges (based on the agreement at intake). If there are no objections by the defense, the motion is granted, and everyone in the courtroom claps for them.

When probed for details regarding what comprises successful completion, nearly all team members noted it was "individualized," while a few said it was remaining mostly compliant for the probation period. Observations suggest that progress is routinely assessed at the pre-court staffing and that all team members provide input on clients' progress. A consensus is reached prior to graduating or terminating clients. One team member defined success as everything but a probation revocation with return to jail or prison. This comment was similar to something mentioned by other MHC team members when asked how the court addresses unsuccessful participation. It was noted that clients are given multiple chances for success, often including revocation and reinstatement of

probation, prior to being terminated from the program. Several team members said that prison sentences had been used in the past, but that it was extremely rare (although team members listed different numbers of participants who had been sentenced to prison, all described it as being in the single digits). More frequently, they are sentenced to jail with credit for time served while in MHC. Another option mentioned was a neutral case closure for clients whose probation period was set to expire, but who had not earned graduation.

When asked if the MHC was successfully treating its clients, the overwhelming response was "Yes." The most commonly mentioned indicator of the program's success was an improvement in "quality of life" observed among clients. Over half of the team suggested that the program had a marked impact on clients' quality of life and that they had experienced more stability while in MHC than at any other time in their life. The other key indicators of the courts success noted by the team were the collaboration of the MHC team (great communication, supporting and trusting each other) and the integration of resources (especially housing and medications). Two somewhat dissenting opinions were offered. One respondent said that it isn't the court that is successful in treating clients, but that clients are ultimately responsible for their own success, the court simply provides the opportunity. Similarly, another team member said that the court itself is not in the business of providing treatment, but helps provide the authority that gets people into and remaining in treatment.

Aftercare

Most MHC team members noted that nearly every resource that clients have available to them during MHC remains available after graduation or termination; however, they described the difficulty of connecting clients with resources post-exit and keeping them engaged when they are no longer court ordered to do so. Specific resources that were mentioned included: VMH, NAMI, housing/RIO, JDOT, Department of Workforce Services (DWS), and the VMH Payee Program. Because of the difficulty of connecting former clients to existing resources, some team members noted that the MHC case manager is currently working on formalizing an aftercare process.

Challenges

A few challenges were consistently noted by the MHC team. Several noted issues of funding and capacity, specifically that MHC and partnering agencies, such as CTP and housing, were unable to serve more clients at this time. Because the team views the MHC as an important criminal justice option for mentally ill offenders, it was a frustration that more clients cannot be served. A related issue was securing long-term funding for mental health medications. Several agencies provide some medications, including the jail and AP&P, but long-term solutions are needed. To address this, Medicaid specialists at VMH and other partnering agencies have begun working on helping clients secure benefits. However, some team members noted that more education and advocacy are needed – specifically that clients should apply for Medicaid prior to Social Security benefits to decrease waiting times. A few respondents described the challenge of getting clients

stabilized on medications when they are booked into the jail. This process can take several days, requiring the client to be in jail at least a week. Team members indicated that it is important to use the least restrictive options with clients and this related to the limited capacity at CTP, JDOT, and other resources that may be used to stabilize clients in the community and avoid unnecessary jail stays. Observation of the pre-court staffing and status hearings do show that the jail representative is actively working with the MHC team to problem-solve issues regarding medication access in the jail.

Two issues were raised in relation to the program's target population: how can the court serve low-functioning (low IQ) mentally ill offenders and how can the court ensure that it is serving dual-diagnosis clients whose primary issue is mental illness rather than substance abuse. Only a couple of team members indicated that the court was having difficulty in identifying dual-diagnosis clients whose primary issue was mental illness. However, they did express that this was a key concern since the purpose of the court is to serve those most in need of mental health resources, specifically SPMI. These team members offered suggestions such as re-assessing clients after they have been stabilized in the program for a few months, as well as working more closely with the drug court to transfer inappropriate clients to them. In contrast, nearly every team member indicated the challenge of working with developmentally disabled or low-functioning clientele. The general sentiment was that "if we don't serve them, who will?" Some progress has been made by partnering with the Utah Division of Services for People with Disabilities (DSPD) to get this population services. Although there is no clear policy on how the MHC will serve low-functioning clients, the team indicated that they will continue to do so on an ad hoc basis.

Workflow Summary

An analysis of the MHC program's operations indicates that the court is operating efficiently. The team is experienced and knowledgeable about the MHC model and a wide array of quality resources are being utilized. However, as often noted by innovative programs, increased resources and capacity would be welcomed. Team member interviews, court and staffing observations, and document reviews all indicate that the program is operating largely in compliance with the Bureau of Justice Assistance's (BJA) essential elements of MHCs. See the "*How does the SLCo MHC compare to the MHC model*?" section of this report for a detailed comparison of the Salt Lake County MHC to BJA's ten essential elements. However, some challenges noted by the program, such as identifying the target population and linking participants to post-exit resources, could be addressed through the creation and documentation of more formalized policies and procedures.

Is MHC succeeding?

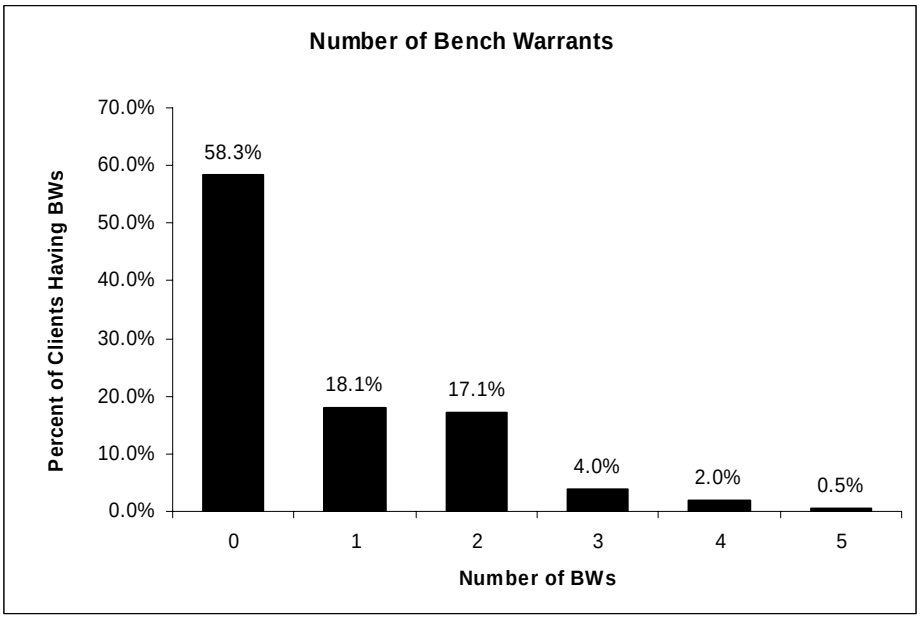
Participant Compliance

Court Attendance. MHC participants appeared for a majority (Md = 93.3%) of their scheduled status hearings and nearly a quarter of participants (41, 20.9%) attended all of

their scheduled status hearings. On average clients only failed to appear (FTA) at 3.3% (Md) of scheduled hearings. Additionally, participants were on the Rocket Docket for slightly more than half (52.3%) of their status hearings (see the Clients' Progress, Rewards, and Sanctions subsection of the *"What is the structure of the MHC?"* section of this report for a description of the Rocket Docket). Half of participants had their first unexcused absence from court within the first 83 days. Not surprisingly, the time between last "failure to appear" in court and program exit was much longer for graduates than unsuccessfully terminated participants (grad, Md = 206.5 days; term, Md = 77.0 days).

Bench Warrants. Bench warrants (BWs) are issued by the court for participants who fail to appear in court or fail to comply with court orders. BWs are most frequently issued in MHC when a participant misses a scheduled status hearing and, in many cases, absconds from the program for a period of time. However, the decision of whether or not to issue a BW is at the discretion of the judge. As was noted above, court attendance was very high for this sample, and half of participants missed 3.3% of their scheduled status hearings or less. As you can see in Figure 9, below, nearly 60% of participants had no BWs. Of those participants with any BWs, nearly half (43.4%) had only one while in MHC and participants averaged two BWs per person. Most BWs took place post-plea (90.2%).

Figure 9 Number of Bench Warrants Per Client



As shown in Figure 10, on the following page, nearly half (42.9%) of all bench warrants ended when participants turned themselves in. Likewise, on an individual level, 31.3% of participants with at least one BW always turned themselves in and 41.7% were always arrested on their BW(s). The amount of time spent out on BW varied, but three-quarters of BWs lasted no more than 17 days and half lasted 7 days or less. Half of participants with at least one BW had their first BW within their first 133 days in the program. As would be expected, the time from last BW to program exit was substantially longer for graduates (Md = 245 days) than unsuccessfully terminated participants (Md =140.5

days). Figure 11, below, shows the distribution of the number of days between participants last BW and exit date for both graduates and unsuccessfully terminated participants.

Figure 10 Reasons for Bench Warrants Ending

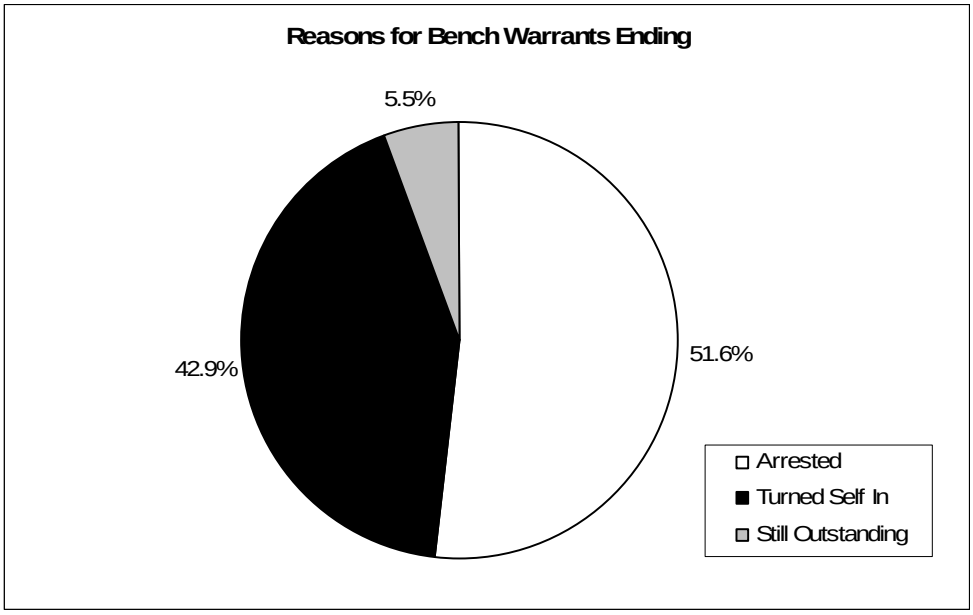
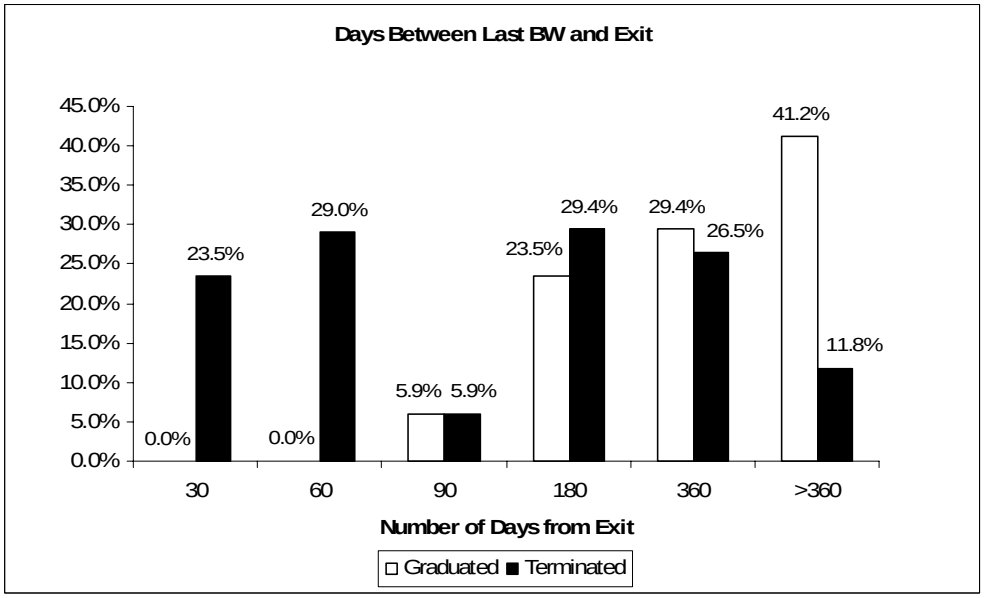


Figure 11 Number of Days Between Last Bench Warrant and Exit Date by Exit Status



Sanctions. Since June 2004, a total of 1,346 sanctions were given in response to non-compliant events. Non-compliant event were defined as violations of the participant's MHC Agreement and/or Probation Agreement. For the purposes of this study, non-

compliant events were coded into the following categories: missed or misused medications, violation(s) at residential placement, missed appointments (including doctor, treatment, groups, classes, etc.), missed drug tests, drug use (including positive UAs and admitted use), alcohol use (including positive UAs/breathalyzer, or admitted use), missed court, new charge(s), contact with restricted person(s), missed check-in with AP&P, and other. As you can see in Table 5, the most common non-compliant events were missed appointments, missed/misused medications, drug use, and missed court.

Table 5 Frequency of Non-Compliant Events

Non-Compliant Event	Frequency	% of Total
Missed Tx/Appts	574	28.8
Drug Use	260	13.1
Missed/Misused Meds	239	12.0
Missed Court	231	11.6
Missed UAs	191	9.6
Violation(s) at Residential Placement	123	6.2
Missed Check-In w/ AP&P	114	5.7
Other	82	4.1
Alcohol Use	72	3.6
New Charge(s)	55	2.8
Contact w/ Restricted Person(s)	36	1.8
Missed Breathalyzer	13	0.7

A majority (84.9%) of participants had at least one non-compliant event noted in their Court Notes, and 83.9% were sanctioned at least once. For those participants with sanctions, number of sanctions per participant varied, ranging from one to 42, with three-quarters having ten or fewer. The median time to first non-compliant event was 70.0 days from first court appearance. Not surprisingly, median time from last non-compliant event to MHC exit was longer for graduates than for unsuccessfully terminated participants (grad, 105 days; term, 18.5 days).

Sanctions varied greatly in type and severity, ranging from verbal reprimands from the judge to termination from the program, and in many cases jail incarceration. A full list of type and frequency of sanctions used is provided in Table 6, on the following page. The most common sanction was a verbal reprimand from the judge. This code was only used in the absence of any other sanction. As you can see, a few non-compliant events were noted that resulted in no sanction and were not even verbally acknowledged in court. However, it is possible that these issues were resolved prior to court and therefore there was no need to address them in court. Some participants were ordered to complete community service as a sanction for non-compliance. A total of 1,014 hours were ordered as a sanction, with half of participants ordered to complete 5 hours or less per sanction, and 75% ordered 10 hours or less per sanction.

As seen in Table 6, the third most frequent sanction imposed was jail; however, it still only represented 14.7% of all sanctions ordered. Nonetheless, the use of jail as a sanction

accounted for a total of 8,273 jail days served by MHC participants while in the program. This figure does not include any additional days served in jail post-exit. The non-compliant events most often associated with a jail sanction were drug use (45.3% of jail sanctions), missed court (33.3%), missed appointments (22.8%), and missed/misused medication (21.4%). As was described in the "*What is the structure of the MHC?"* section of this report, jail is often used to stabilize participants who have gone off of or are misusing their medications. Some team members claimed that the use of jail to stabilize a person on their medications is not considered a sanction by the team; however other team members acknowledged that serving jail time is a sanction, regardless of intent of the program. Therefore, due to the unpleasant and disruptive nature of incarceration, researchers decided to include these bookings as a sanction. On the individual level, jail sanctions ranged in length from one to 204 days, with a median of 17 days, and 75% of jail sanctions lasting 33.8 days or less. Some of the bookings were extended in length due to residential placement or CTP waiting lists.

Table 6 Frequency of Sanctions Used

Sanction Type	Frequency	% of Total
Verbal Only	494	26.0
Off Rocket Docket	443	23.3
Jail	280	14.7
UA in Court	227	12.0
Community Service	132	7.0
Increase Groups	61	3.2
No Sanction Noted	44	2.3
Increase Tx	41	2.2
Daily Monitored Meds	40	2.1
Termination	31	1.6
Revoke & Reinstate	27	1.4
Hold & Release	21	1.1
Increase UAs	15	0.8
Other Sanction	14	0.7
Breathalyzer Tests	12	0.6
Increase Court	7	0.4
Meet with NAMI Mentor	5	0.3
Not Graduate as Set	4	0.2
Jail + CATS	1	0.1

Exit Status

At the time data was queried for the final report (late April 2008), there were 67 active MHC participants. This group includes participants who may be in jail or out on bench warrant, but have not officially exited the program. Most participants who were on bench warrant at the time of this report were included in the active group because this status is considered temporary. However, a few participants who had been on bench warrant for

multiple years were coded as "other" due to the extended length of absence. Three people who died while in the program were also coded as "other" and four former participants were coded as "missing" because no data was available regarding their exit status. Participants coded as "missing" or "other" were excluded from the remainder of analyses. The rest of participants who exited MHC were coded as having a positive (graduated), negative (unsuccessfully terminated), or neutral exit status.

Figure 12, below, presents the percent of participants who graduated (93, 52.6%), were unsuccessfully terminated (70, 39.5%), or exited for neutral reasons (14, 7.9%). Court notes were examined to confirm that negatively terminated participants were both non-compliance during MHC and had a non-compliant event recorded in conjunction with their termination from the program. Most negatively terminated participants were referred back to the regular court calendar (22, 31.4%) or sentenced to jail (28, 40.0%) or prison (7, 10.0%) by the MHC judge. Neutral exit statuses included cases where a participant's probation expired before they could graduate, transfers to other programs or jurisdictions, commitments to State Hospital, and instances where participants' case(s) were dismissed shortly after MHC start. Table 7, below, shows the minimum, maximum, and median number of days in MHC for each group. Length of time in program was determined by calculating the difference between the first and last court appearances.

Figure 12 Participant Exit Status

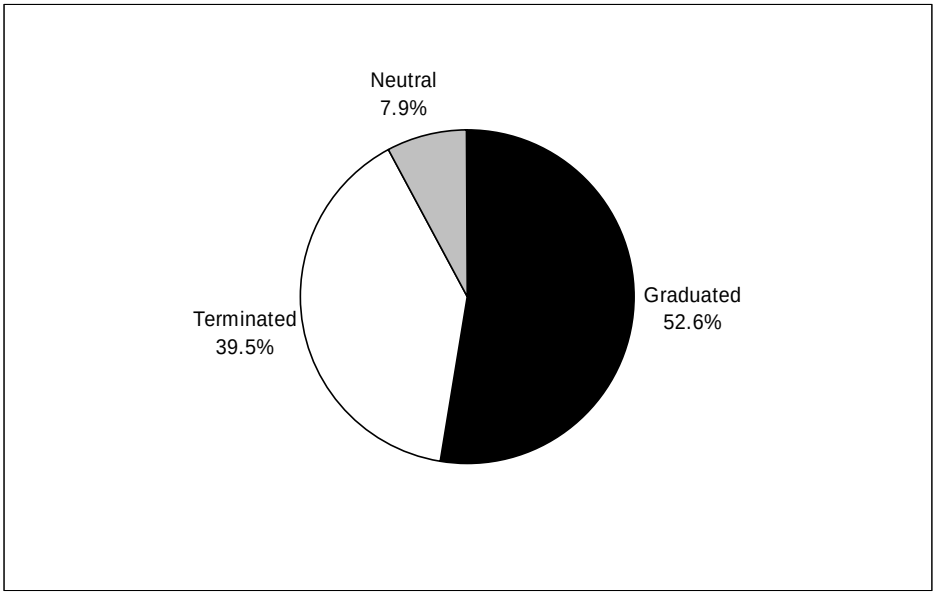


Table 7 Days in Program by Exit Status

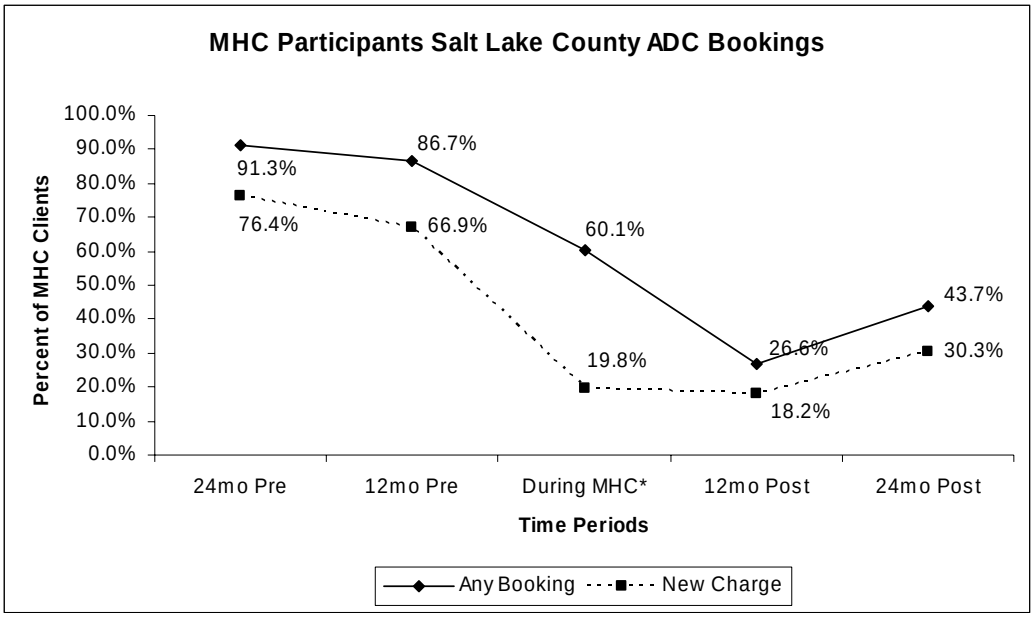
Exit Status	Min	Max	Md
Graduated	126.0	1431.0	518.0
Terminated	0.0	1402.0	388.5
Neutral	28.0	805.0	427.0

Criminal Justice System

Utah Department of Corrections. The rate of successful completion of probation mirrored the graduation rate of MHC. Of the participants under AP&P supervision while in MHC, over half (54.8%) had their probation terminated near their MHC exit date (within 30 days pre- and post-MHC exit). Of those, just over half 56.7% were successfully terminated from probation, while 43.3% were unsuccessfully terminated from probation. All but one graduate who were on probation had a successful discharge, while all but two terminated participants who were on probation had an unsuccessful discharge. Of the participants who exited MHC on a neutral status, two-thirds (66.7%) had an unsuccessful discharge from probation. Seven (7) MHC participants were sentenced to prison at MHC exit, while three additional participants went to prison following MHC exit. Of those who went to prison post-MHC, median days from MHC exit to prison was 331 (Mn = 387). For all ten participants who went to prison, median time in prison on the first placement was 254 days (Mn = 299), while total time in prison[7] was a median of 651 days (Mn = 650).

Adult Detention Center. The percent of MHC participants with jail bookings, especially new charge bookings, decreased significantly following MHC start and remained low following MHC exit (regardless of exit status). As shown in Figure 13, below, nearly every MHC participant had at least one jail booking in the two years prior to MHC (91.3%; 76.4% with a new charge booking), while less than half had a new booking in the two years following MHC exit (43.7%, 30.3% for new charge bookings).

Figure 13 Total Jail Bookings and New Charge Bookings by Time Period

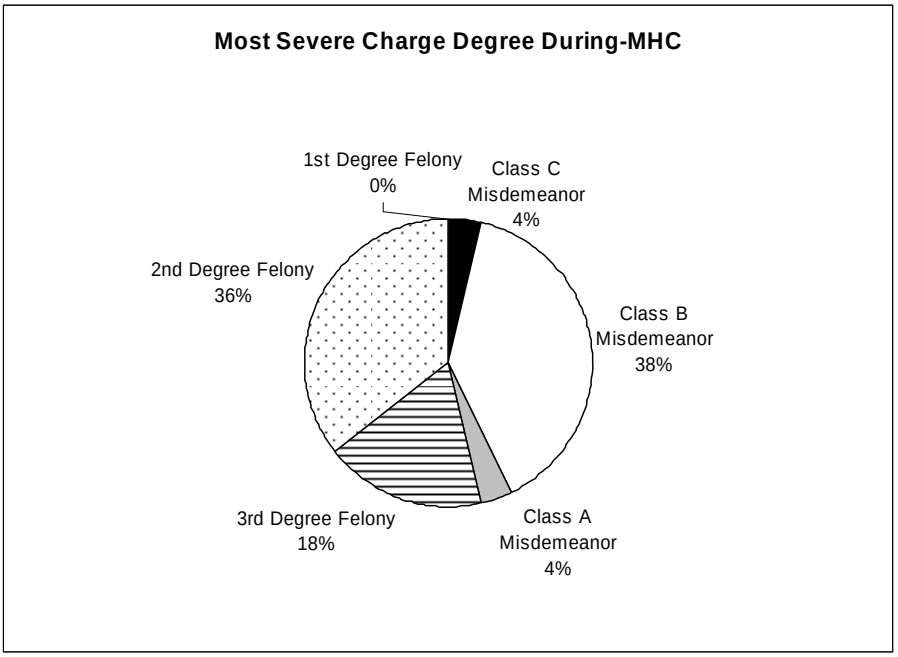


[7] Could be more than one prison placement or a move from prison new inmate status to prison incarcerated status. This is the measure of total days in prison from first prison status start date following MHC start.

The during MHC new charge booking statistic shown in Figure 13 (19.8%) includes any new charge booking recorded in JEMS while a participant was active in MHC (excluding in jail charges). When those bookings were checked against MHC notes for confirmation, only 42.3% were confirmed. However, an additional group of offenses were noted in MHC records (from court notes) that did not correspond with a new charge jail booking (most often charges/citations that did not result in a jail booking). If confirmed new charge bookings are combined with new charges only found in MHC notes, the during-MHC recidivism rate for participants was 16.0%. Due the slight discrepancy in the data sources, it is believed that between 15-20% of MHC participants recidivated (new charges) while active in the program.

Charge severity remained fairly high for those who offended during MHC. Figure 14 shows the most severe charge degree per person for participants who had a new charge confirmed during MHC or detailed in the court notes. The type of charges committed during MHC remained similar to the types committed prior to MHC. For example, property, drug, person, and public order offenses remained the most common (in that order), while only one person had a DUI during MHC and none had prostitution or weapon offenses.

Figure 14 Most Severe Charge Degree During MHC



Median time from MHC start to the first during MHC booking was 101 days (Mn = 164). This is not surprising, as jail is often used as a sanction and a way to stabilize participants who are off of their medications. Median time from MHC start to the first during MHC new charge booking was 150 days (Mn = 203). Of those new charge bookings that were confirmed in the MHC court notes, median time from MHC start to the first new charge booking was 161 days (Mn = 219). Median time from the final during MHC jail booking

to MHC exit was 70 days (Mn = 146). Time from final during MHC jail booking to MHC exit varied statistically significantly[8] by exit status. For graduates there was a median of 224 days between final during MHC jail booking and graduation; whereas terminated participants had only a median of 28 days from final during MHC jail booking to termination (see Table 8, below).

Table 8 Median Days from Last Jail Booking to MHC Exit

Days to Events	All Participants	Exit Status	
		Graduated	Terminated
Last During MHC Jail Booking to MHC Exit	70	224*	28
Last During MHC New Charge Booking to MHC Exit	229	454*	97
Last During MHC Confirmed New Charge Booking to MHC Exit	343	435	262
*Graduates significantly different than Terminated Participants ($p < .05$)			

Of those participants who had a new charge booking in the year following MHC exit, the most common types of charges remained consistent prior to and during MHC. Property, public order, and person offenses (in that order) were the most common charge types post-MHC. Drug offenses dropped to the fourth most common charge type. Most severe charge degrees for recidivists were 2nd Degree Felonies for 22.6% of re-offenders and Class B Misdemeanors for 25.8% of re-offenders.

The final examination of jail data demonstrated the frequent and extensive use of jail resources by MHC participants. As shown in Table 9, on the following page, MHC participants utilized over 21,000 jail days in the two years prior to MHC. While active in MHC, participants used just over 16,000 days. While this is not a substantial decrease from pre-MHC levels, closer examination of during-MHC jail stays indicate that most of these days are not because of a new charge booking. During-MHC bookings were further divided into those instances where participants were on a program wait list (which may have delayed their release from jail), and those who were not. Although only a small proportion of participants were on a program's wait list while booked into the jail, their mean and median days in jail were slightly longer than for those who were not on a wait list. However, it should be noted that participants were not necessarily on the wait list for their entire booking. In fact, in most of these cases, these individuals were not placed on a wait list until after they had already spent a significant amount of time in jail.

Nonetheless, the use of jail resources during MHC remains considerable. In the period following MHC, the number of jail days utilized dropped dramatically from 16,000 days during MHC to 5,200 in the year following MHC and 7,600 in the two years following MHC. Although not all former MHC participants have accrued the full 12- and 24-month follow-up periods, this substantial decrease in jail days is consistent with the decrease in percent of MHC participants with jail bookings following MHC, as shown in Figure 13 on page 35. As explained in under the Utah Department of Corrections Heading in the "*Is MHC Succeeding?*" section of this report, only 10 MHC participants went to prison following MHC start. This suggests that the decrease in jail use (both overall bookings

[8] $t = -8.538$, $p < .01$

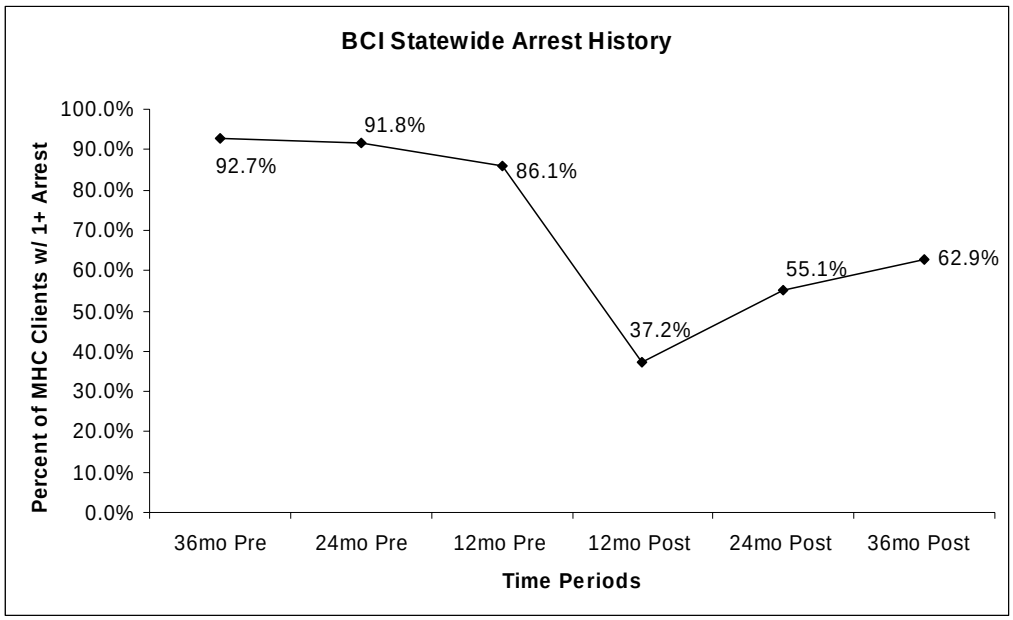
and days in jail) represents a true decline in incarceration, rather than being an artifact of a higher prison incarceration rate.

Table 9 Jail Days by Time Period

Days in Jail	N	Mean	Median	Sum
24-mo Pre-MHC	221	98	70	21,765
12-mo Pre-MHC	210	72	59	15,098
During MHC	191	84	63	16,023
-During - New Charge - Confirmed	17	45	12	761
--During New Charge - no wait	11	15	6	167
--During New Charge - waitlist	6	99	117	594
-During - No Charge	191	80	60	15,262
--During No Charge - no wait	168	61	38	10,277
--During No Charge - waitlist	74	67	55	4,985
12-mo Post-MHC	66	79	41	5,207
24-mo Post-MHC	78	98	50	7,612

Bureau of Criminal Identification. Statewide criminal history records indicate that arrest rates for MHC participants are lower following MHC than they were prior to entering MHC. As shown in Figure 15, below, nearly every MHC participant had an arrest during the three years prior to MHC; however, only 37.2% of participants were arrested in the year following MHC exit. After three years post-MHC exit, 62.9% of former MHC participants (who had three full years of follow-up) had a new arrest. This level remained below pre-MHC criminal involvement. Not surprisingly, arrest rates following MHC exit differed by exit status, see Figure 20 on page 44.

Figure 15 BCI Arrests by Time Period

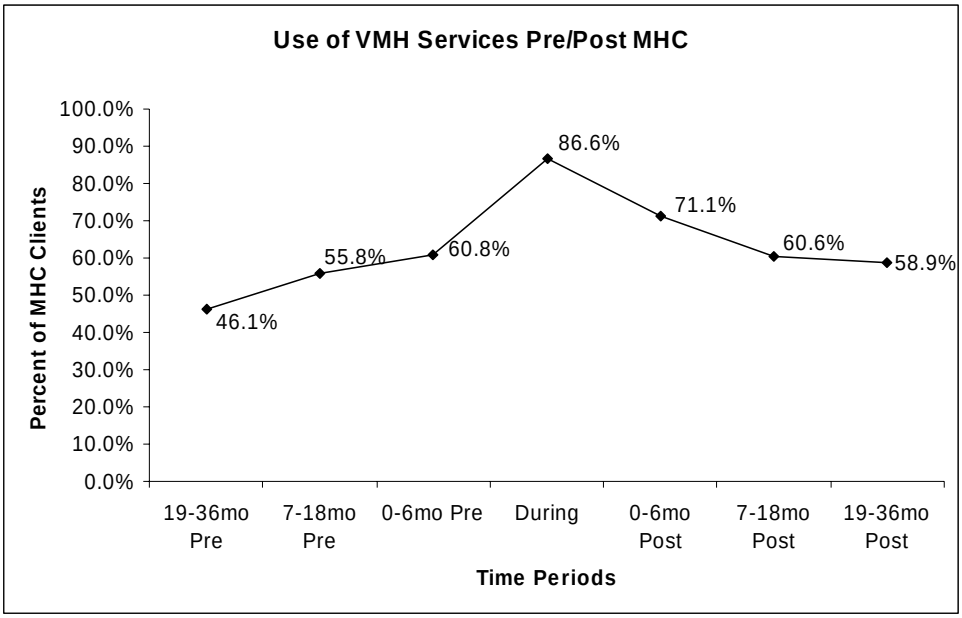


Of those with new arrests in the year following MHC exit, the average was 2.6 arrests (Md = 1.5), compared to 2.7 arrests on average (Mn; Md = 2.0) for those with a new charge in the year prior to MHC. For those who continued to offend following MHC, the average number of arrests remained similar to pre-MHC averages. Lastly, for any MHC participant with a new charge in the BCI record following MHC exit, median days from exit to the first new charge was 262 days (Mn = 350).

Treatment Retention

Following MHC exit, use of VMH services remains higher than it was prior to MHC participation. As shown in Figure 16, below, use of VMH services increased from just under half of participants in the 19-36 months pre-MHC, to nearly 60% in the 19-36 months post. All post-MHC statistics are for those individuals who had the full length of follow-up period available (no recently exited participants). Although the use of VMH services following MHC was higher for all former participants than it was prior to MHC, there were some group differences. In the first six months following MHC exit, graduates were statistically significantly[9] more likely to utilize MHC services (77.3%) than terminated participants (60.0%). Additionally, graduates continued to have a slightly higher percent of involvement with VMH services both at 7-18 and 19-36 months after exiting; however, these differences were not statistically significant.

Figure 16 Use of VMH Services by Time Period

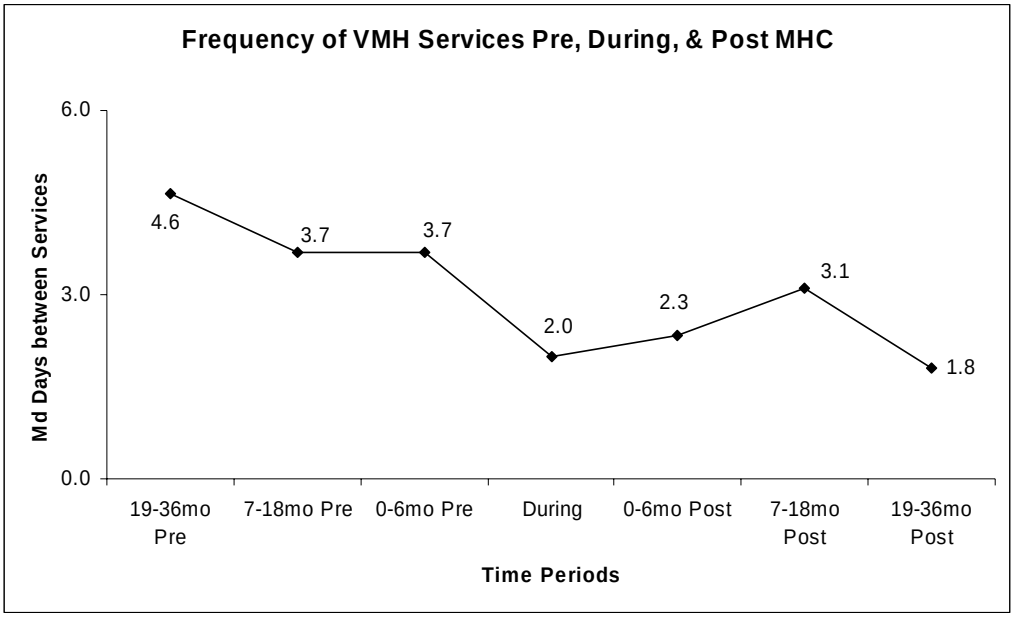


Of those who received VMH services during each time period, services were received more frequently during the post-MHC periods than prior to MHC. Figure 17, on the following page, displays the frequency of VMH service utilization by time period. For those participants who remained in services up to three years following MHC exit, the

[9] $\chi^2 = 4.216$, $p < .05$

frequency of services was at least as often as during MHC. Retention in VMH services (which included three types of treatment (inpatient, residential, and outpatient), case and medication management, and drug testing) is viewed as an indicator of continued stability following MHC exit.

Figure 17 VMH Frequency of Service Use by Time Period



Who has the best outcomes in MHC?

Exit Status

As reported in the *"Is MHC succeeding?"* section of this report, 196 of 263 participants (74.5%) have exited the MHC program. Of those, the greatest number (93, 47.4%) were graduates, followed by negatively terminated participants (70, 35.7%), other (15, 7.7%), neutral (14, 7.1%), and unknown (4, 2.0%). In this section we will be primarily focusing on two outcomes: graduates and negatively terminated participants. As shown in Figure 18, on the following page, when examining just these two outcomes groups, the MHC's success rate was 57.1%. Where sample size is sufficient, graduates and terminated participants will also be compared to those with a neutral exit status.

Not surprisingly, less criminally involved participants were more likely to graduate. Graduates and terminated participants were compared on several participant characteristics, including demographics, criminal history, and mental health history. As shown in Table 10, on the following page, the two groups did not differ statistically significantly on most of the participant characteristics. One exception was criminal history, where participants who were eventually terminated unsuccessfully from MHC were typically more criminally involved prior to MHC than participants who went on to graduate from the program. Graduates had significantly fewer lifetime prior arrests,

arrests in the three years pre-MHC, total jail bookings in the two years pre-MHC, and less severe charges in the two years pre-MHC. Charge degree, presented in Table 10, is scored as 1 = Class C Misdemeanor and 6 = 1st Degree Felony. Therefore, most severe charge for graduates pre-MHC was just above a Class A Misdemeanor, compared to just over a 3rd Degree Felony for terminated participants.

Figure 18 MHC Exit Status for Outcome Analyses

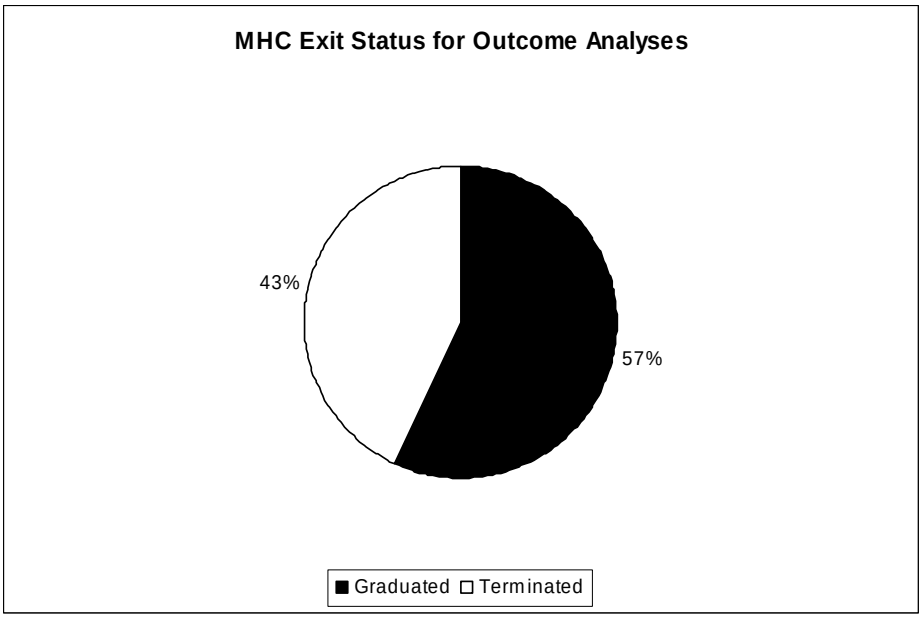


Table 10 Participant Characteristics by MHC Exit Status

	Graduated	Terminated
DEMOGRAPHICS		
Minority	14.3%	10.0%
Male	73.1%	60.0%
Ever Homeless During MHC	19.4%	24.3%
Age at MHC Start (Mn)	35.4*	32.3
CRIMINAL HISTORY		
Lifetime BCI Arrests Pre-MHC (Mn)	6.8*	9.4
BCI Arrests 3 years Pre-MHC (Mn)	3.2*	4.3
LSI Risk Score at Intake (Mn)	23.5	25.6
Jail Booking 2 years Pre-MHC	92.1%	95.7%
Total Jail Bookings 2 years Pre-MHC	2.1**	2.9
New Charge Jail Booking 2 years Pre-MHC	74.2%	80.0%
Total New Charge Bookings 2 years Pre-MHC	1.2	1.5
Most Severe New Charge Degree 2 years Pre-MHC	3.7*	4.1
MENTAL HEALTH HISTORY		
Youth Admission at VMH	22.1%	28.3%
Age at First VMH Admission	25.0	23.4
Number of VMH Admissions Pre-MHC	3.5	3.5

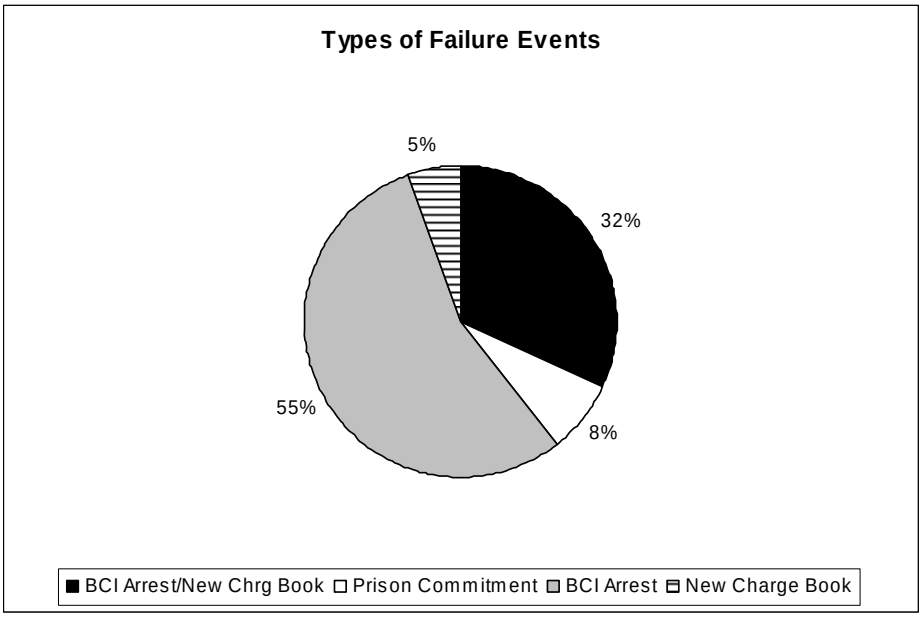
	Graduated	Terminated
MENTAL HEALTH HISTORY CONT.		
Years with Schizophrenia/Bipolar Disorder Pre-MHC	8.5	6.5
Drug Use Disorder Diagnosis Pre-MHC/At Start	59.3%	66.7%
Years with Drug Use Disorder Pre-MHC	6.8	6.3
Depression Diagnosis Pre-MHC	29.2%	28.0%
*Statistically significant at p < .05		
**Statistically significant at p < .01		

Recidivism

Recidivism can be defined in several ways, including jail bookings post-MHC, new charge jail bookings during or post-MHC, new arrests in the statewide criminal history file post-MHC, or new prison commitments. All of these recidivism outcomes were examined. In this section the recidivism variable will be the first "failure event" defined as the presence or absence of any of these events: 1) prison post-MHC start, 2) new charge jail booking post-MHC exit, or 3) new BCI arrest post-MHC exit. If a MHC participant has more than one of these events, the first one is captured and subsequent ones are ignored.

Just over half (91 of 177 exited participants (with graduate, neutral, or terminated exit status), 51.4%) had a failure event. Figure 19, below, shows type of first failure event for exited participants. Very few exited participants had a prison commitment, but most had a new arrest that was recorded in BCI only, new charge jail booking, or both. Median time to first failure event was 221 days (Mn = 300), meaning of those with a failure event, first new arrest/prison commitment was between 6 months and a year following MHC exit.

Figure 19 Types of Failure Events



MHC participants who had a failure event were quite similar to those who did not recidivate on most participant characteristics, including demographics, mental health history, and criminal history (see Table 11, below). However, exited participants who had more arrests prior to MHC, were ever homeless during MHC, or did not graduate from MHC were all more likely to recidivate. As shown in Table 11, just over one-third of graduates recidivated versus over half of neutral exit participants and 70% of terminated participants. Additionally, survival analyses demonstrated that time to failure event varied statistically significantly[10] by exit status. Graduates had an estimated 1,341 days (Md) from MHC exit to first failure event (recidivism), compared to 559 days estimated for neutral exit status participants, and only 243 estimated days for terminated participants.[11] These comparisons indicate that graduates have less recidivism and when they do have a new charge or prison commitment, it is after a longer delay.

Table 11 Participant Characteristics by Failure Event

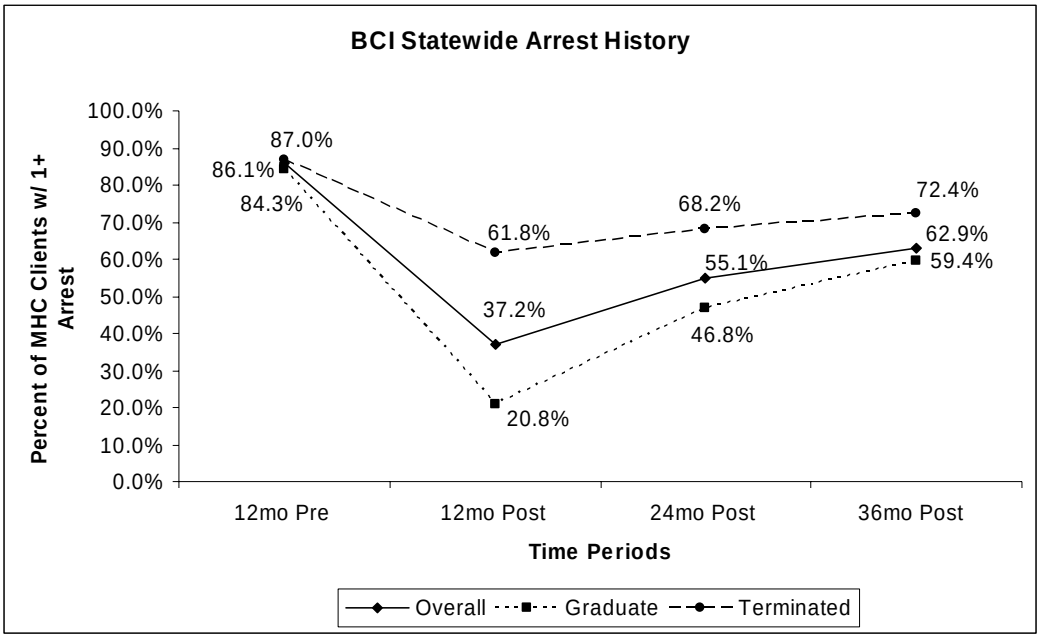
	Failure Event	
DEMOGRAPHICS	No	Yes
Minority	10.7%	14.3%
Male	61.6%	70.3%
Ever Homeless During MHC	17.4%	29.7%*
Age at MHC Start (Mn)	33.6	34.5
CRIMINAL HISTORY		
Lifetime BCI Arrests Pre-MHC (Mn)	6.7	9.3*
BCI Arrests 3 years Pre-MHC (Mn)	3.7	3.8
LSI Risk Score at Intake (Mn)	23.7	25.3
Jail Booking 2 years Pre-MHC	96.3%	91.2%
Total Jail Bookings 2 years Pre-MHC	2.3	2.7
New Charge Jail Booking 2 years Pre-MHC	76.8%	74.7%
Total New Charge Bookings 2 years Pre-MHC	1.4	1.4
Most Severe New Charge Degree 2 years Pre-MHC	3.8	3.9
MENTAL HEALTH HISTORY		
Youth Admission at VMH	24.6%	23.1%
Age at First VMH Admission	23.6	25.0
Number of VMH Admissions Pre-MHC	3.1	3.8
Years with Schizophrenia/Bipolar Disorder Pre-MHC	8.7	7.2
Drug Use Disorder Diagnosis Pre-MHC/At Start	56.9%	66.7%
Years with Drug Use Disorder Pre-MHC	5.8	7.0
Depression Diagnosis Pre-MHC	24.1%	32.3%
EXIT STATUS		
Graduated	63.4%	36.6%**
Neutral	42.9%	57.1%**
Terminated	30.0%	70.0%**
*Statistically significant at $p < .05$		
**Statistically significant at $p < .01$		

[10] Mantel-Cox $\chi^2 = 28.558$, $p < .01$

[11] Estimated time to recidivism is from Kaplan-Meier Survival Analysis, which estimates time to event based on those who have the event (e.g., recidivism) and those who do not have the event for the entire follow-up period.

Graduation status was consistently linked to better post-MHC criminal justice outcomes. For example, comparisons made by exit status showed that graduates and terminated participants did not differ on BCI arrests at intake, but differed on new BCI arrests post-MHC (see Figure 20, below). In the year prior to MHC start, there were no statistically significant[12] differences between graduates, terminated participants, and those with neutral exit status (78.6%, not shown in Figure 20) on arrest rates. In the year following exit, however, terminated participants were statistically significantly[13] more likely than neutrally exited participants (41.7%, not shown in Figure 20) and graduates to have a new arrest. The difference between terminated participants and graduates on new arrests remained statistically significant[14] at the two year follow-up, but failed to reach statistical significance[15] after three years. Time to recidivism varied by exit status as well, with terminated participants recidivating statistically significantly[16] sooner (Mn = 271 days) following MHC exit than graduates (Mn = 468 days). Therefore, not only were graduates recidivating less often than terminated participants, but even when they were picking up new charges it was significantly delayed compared to terminated participants. It should be noted that sample size decreased across each follow-up period, as fewer former participants had accrued the entire length of longer follow-up periods. Due to this, participants with neutral exit status were only included in the 12-month follow-up analyses.

Figure 20 Comparison of BCI Arrests by Exit Status



[12] χ^2 =.687, p > .05
[13] χ^2 = 22.091, p < .01
[14] χ^2 = 4.239, p < .05
[15] χ^2 =1.146, p > .05
[16] t = -2.607, p < .05

Graduates had more days between MHC exit and new jail bookings (overall and for new charges); however, these differences failed to reach statistical significance. Table 12, below, displays time to booking events from MHC exit for all participants and for the subgroups: graduates and terminated participants. Median time from MHC exit to first new jail booking for neutral exit status participants (not shown in Table 12) was 269 days, which was similar to that for terminated participants. However, neutral exit status participants' time to a new charge booking (Md = 541 days) was more in line with that of graduated participants.

Table 12 Median Days from MHC Exit to First New Jail Booking

Days to Events	All Participants	Exit Status	
		Graduated	Terminated
MHC Exit to First Post-MHC Jail Booking	291	429	261
MHC Exit to First Post-MHC New Charge Booking	343	435	262
*Graduates significantly different than Terminated Participants ($p < .05$)			

What program components and services lead to the best outcomes?

Exit Status

MHC program compliance and services received were examined in relation to exit status (graduated vs. terminated). As shown in Table 13, on the following page, participants who graduated from MHC differed most from terminated participants on program compliance variables, but did not differ much on services received. Not surprisingly, graduates had more days in the program (Mn = 567) than terminated participants (Mn = 462); however, terminated participant were in the program for more than a year on average (Md = 389). Fewer graduates than terminated participants had a jail booking during MHC (for any reason, including sanctions, warrants, or new charges), new charge jail bookings (total and confirmed), total days in jail, failures to appear in court, or bench warrants. All of these measures suggest that graduates were more compliant with MHC while active in the program, which confirms that the appropriate participants (non-compliant ones) are being terminated from the program. However, as shown in Table 13, a fair percentage of graduates had jail bookings during MHC (42.7%), failures to appear (52.9%), and bench warrants (24.3%). Of those who had at least one bench warrant, graduates did not differ from terminated participants on total number of bench warrants or days away from the program while out on bench warrant. This finding indicates that these forms of non-compliance are not necessarily grounds for termination and that MHC participants are given several opportunities to succeed. These data reflect the harm reduction policies of the MHC as described by team members. Graduates had court hearings that were slightly more frequent than terminated participants, but this difference was not statistically significant. It should be noted that this comparison of frequency of court hearings was for all scheduled hearings, whether the participant appeared or not.

Table 13 Program Components by Exit Status

	Graduated	Terminated
PROGRAM COMPLIANCE		
Days in MHC (Mn)	567*	462
Any Jail Booking During MHC	42.7%**	91.4%
New Charge Bookings During MHC (Mn)	.12**	0.46
New Charge Bookings During MHC (Confirmed) (Mn)	0.03*	0.28
Days in Jail During MHC (any reason) (Mn)	46.4**	117.1
Failure to Appear (at court)	52.9%**	85.1%
Bench Warrant	24.3%**	76.6%
Days between Scheduled Court Hearings (Mn)	10.6	12.5
Noncompliance Events (of those w/ 1 or more) (Mn)	7.1	10.3
Total Bench Warrants (of those w/ 1 or more) (Mn)	1.7	1.9
Days out on Bench Warrant (of those w/ 1 or more) (Md)	14.0	23.5
SERVICES RECEIVED		
Housing Assistance and/or Residential Tx	44.1%	58.6%
Drug Testing	67.5%	74.2%
AP&P Supervision	66.7%	78.6%
Inpatient Treatment	10.1%	13.1%
Residential Treatment	55.7%	59.0%
NAMI Bridges	58.6%*	23.8%
Days between Outpatient Treatment Services (Md)	8.6	6.7
Days between Case Management Services (Md)	4.6	4.6
Days between Medication Management Services (Md)	12.6	10.0

*Statistically significant at $p < .05$
**Statistically significant at $p < .01$

Graduates and terminated participants were equally likely to receive housing assistance, drug testing, AP&P supervision, inpatient treatment, and residential treatment. Significantly more graduates participated in NAMI's Bridges classes than terminated participants; however, this comparison was limited to the 50 MHC participants who had both exited MHC and had their records queried at NAMI. Lastly, there was no difference in frequency of outpatient treatment, case management, or medication management services for graduates and terminated participants who received those services during MHC (nearly every participant received these services; see Figure 6 on page 20, in the "*What services are MHC participants utilizing during participation?"* section). A logistic regression was conducted to look at the relationship between both participant and program characteristics and likelihood of graduation; however, sample size was too small to report on the results.

Recidivism

The only program compliance variables significantly related to a failure event[17] (recidivism) were jail use measures (see Table 14, below). More MHC participants who recidivated had at least one jail booking during MHC (for any reason, including sanctions and warrants) and new charge booking(s). Furthermore, participants who recidivated following MHC spent significantly more days in jail during MHC (Mn = 104.6 days) than those who did not re-offend post-MHC (Mn = 67.9 days). These measures may indicate that use of jail during MHC should be limited as presence of bookings for any reason (including when participants do not have a new charge) and increased days in jail during MHC are associated with post-MHC recidivism.

Several of the program compliance measures that were significantly related to exit status (i.e. days in MHC, failures to appear, bench warrants) were not significantly related to recidivism. This suggests that individuals who are not compliant will not succeed in the program, but they may still benefit from reduced recidivism following MHC exit. As shown in the comparisons of graduated and terminated participants on recidivism measures in the "*Who has the best outcomes in MHC?*" section, graduates do have better outcomes than terminated participants. However, all MHC participants, regardless of during program compliance and exit status, show reductions in criminal involvement following MHC participation.

The only program services variable significantly related to recidivism (failure event) was participation in NAMI's Bridges program, where non-recidivists had a significantly higher rate of Bridges participation. It should be noted that this analysis was only for 53 MHC participants who had exited MHC and had their NAMI records queried.

Table 14 Program Components by Failure Event

	Failure Event	
PROGRAM COMPLIANCE	No	Yes
Days in MHC (Mn)	559	476
Any Jail Booking During MHC	54.9%	75.8%**
New Charge Bookings During MHC (Mn)	0.13	0.38*
New Charge Bookings During MHC (Confirmed) (Mn)	0.05	0.21
Days in Jail During MHC (any reason) (Mn)	67.9	104.6**
Failure to Appear (at court)	63.8%	70.2%
Bench Warrant	37.1%	51.7%
Days between Scheduled Court Hearings (Mn)	11.7	12
Noncompliance Events (of those w/1 or more) (Mn)	8.4	8.8
Total Bench Warrants (of those w/ 1 or more) (Mn)	1.9	1.8
Days out on Bench Warrant (of those w/ 1 or more) (Md)	20.5	19.0

[17] Failure event "recidivism" is defined as having any of the following a) a prison commitment at MHC exit or post-exit, b) a new charge booking in JEMS post-MHC exit, or c) a new arrest in the BCI record post-MHC exit

	Failure Event	
SERVICES RECEIVED	No	Yes
Housing Assistance and/or Residential Tx	41.9%	53.8%
Drug Testing	69.9%	70.5%
AP&P Supervision	72.1%	70.3%
Inpatient Treatment	14.1%	14.1%
Residential Treatment	57.7%	59.0%
NAMI Bridges	54.1%	25.0%*
Days between Outpatient Treatment Services (Md)	8.4	7.2
Days between Case Management Services (Md)	4.7	4.4
Days between Medication Management Services (Md)	11.6	12.3

*Statistically significant at $p < .05$
**Statistically significant at $p < .01$

Participant and program predictors of recidivism. A logistic regression was conducted to look at the relationship between both participant and program characteristics and likelihood of failure event. The variables significantly related to recidivism in the bivariate analyses (lifetime pre-MHC arrests, homelessness during MHC, presence of jail booking during MHC, and exit status), as well as days in MHC were included in the model. Although not significant in the bivariate analyses, length of time in MHC was included to examine whether time in MHC program and exit status were both significant in predicting recidivism, or if one was more important than the other.

When all of the factors were considered together, the statistically significant[18] predictive model demonstrated that having a jail booking during MHC and length of time in MHC both were significantly related to recidivism. As shown in Table 15, below, having any jail booking during MHC was associated with a 23% increased likelihood of post-MHC recidivism, while each additional day in MHC was associated with a decreased likelihood of recidivism (of 0.2% per day). Because time in MHC remained significantly related to likelihood of failure event, but MHC exit status did not, it is believed that the strong relationship between exit status and recidivism seen in the bivariate analyses is an artifact of length of time in the program. Where graduates spend more time in MHC than terminated clients, they see increased benefits post-exit. This interpretation is consistent with the overall positive findings for reduced recidivism for all MHC participants, considering that even terminated clients spend a substantial amount of time in the program.

Table 15 Significant Predictors of Failure Event from Combined Logistic Regression

Variable	B	Wald	p	Exp(B)
Any Jail Booking During MHC	.207	4.50	0.03	1.23
Days in MHC	-.002	8.37	< 0.01	0.998

[18] Model $\chi^2 = 27.263$, $p < .01$; Nagelkerke $r^2 = .205$; Hosmer & Lemeshow $\chi^2 = 9.995$, $p = .265$

How does the SLCo MHC compare to the mental health court model?

The Essential Elements of Mental Health Courts

Introduction

In a recent national survey of MHCs, Erickson, Campbell, and Lamberti (2006) found that little consistency in the policies and procedures of MHCs exist. The implications of such variability are vast when attempting to evaluate the effectiveness of a MHC. To address this and other concerns regarding the implementation of MHCs, the Bureau of Justice Assistance (BJA), in collaboration with various MHCs and professionals in the fields of criminal justice, mental health, and substance abuse, identified 10 essential elements of mental health courts (Thompson, Osher, & Tomasini-Joshi, 2007)**.** The following section gives a brief summary of each element and how each compares to current research available on MHCs and the Salt Lake County Mental Health Court, specifically. A table in Appendix B further contrasts the basic elements of the most commonly documented MHCs in the literature.

1. Planning and Administration

The development and operation of a MHC should encompass a broad-based group of stakeholders from systems including: criminal justice, mental health, substance abuse treatment, and the community. All systems should take part in guiding the planning and administration of the court. All MHCs should identify agency leaders and policymakers to serve on an "advisory group" responsible for tasks such as, monitoring the court's adherence to its mission and supporting the "court team," that is involved with day-to-day operations. MHCs are advised to operate the MHC within the "context of broader efforts to improve the response" of the criminal justice system to mentally ill offenders.

Salt Lake County. A review of the SLCo MHC's history shows that the planning and pilot operation of the MHC began with collaboration from key stakeholders in the judicial, mental health, police, and corrections fields, as well as political leaders. The SLCo MHC has participation from a diverse set of professionals including a county clerk, case managers, Utah Chapter of the National Alliance on Mental Illness (NAMI) representatives, law enforcement agencies, the Legal Defenders Association, jail personnel, and Valley Mental Health (VMH).

Interviews with the court team indicate that several current team members have been involved with the court since its inception. Additionally, several team members acknowledge the importance of operating the MHC within the broader context of the criminal justice system and advocate for improved responses to mentally ill offenders throughout the system in accordance with the BJA recommendations.

2. Target Population

A great deal of consideration and emphasis should be placed upon the target population, with clearly defined clinical eligibility criteria. MHCs should target defendants whose current offenses are a result of their mental illness and only consider a client if their specific need for mental health treatment can be met with existing treatment options. However, the MHC team should improve access to treatment and advocate for increased capacity whenever possible. MHCs should also coordinate closely with drug courts and other problem-solving courts as clients may overlap.

Other MHCs. A review of eight MHCs: 1) Broward County, FL; 2) King County, WA; 3) San Bernardino, CA; 4) Anchorage, AK; 5) Santa Barbara, CA; 6) Clark County, WA; 7) Seattle, WA; and 8) Marion County, IN found that seven of the eight courts focus primarily on misdemeanor cases (Redlich, Steadman, Petrila, Monahan, & Griffin, 2005). Additionally, in a survey of over 100 MHCs it was found that most (98%) indicated that they accept misdemeanant defendants, while 27% accept those charged with felonies, and only 4% accept defendants charged with violent felonies (Erickson et al., 2006).

It is apparent that the majority of courts require mental illness as a prerequisite (Redlich et al., 2005). This, however, does not provide much insight into the types of illness typically seen in MHCs. In a survey of over 100 MHCs, it was found that 28% of MHCs required *any* diagnosis of ‘‘mental illness” while another 38% required that participants have an ‘‘Axis I’’ diagnosis for admission. Only 21% require the presence of a severe and persistent mental illness (SPMI) and 18% of courts did not provide any diagnostic eligibility criteria (Erickson et al., 2006). These findings clearly indicate that while a “mental illness” diagnosis is generally a prerequisite for participation, the way the illness is defined for eligibility varies across courts.

Lastly, three out of eight courts included defendants with developmental disabilities and all eight courts allowed defendants with substance abuse disorders (Redlich et al., 2005). One study indicated that MHC clients are more likely to be older, white, and female when compared to individuals in traditional courts; however, this over-representation occurs at the point of referral, rather than at the point of the court’s decision of eligibility (Steadman et al., 2005). These findings clearly indicate that there is a wide variation in the types of clients served through MHCs. Such variations are implicated heavily in the findings of recidivism and public safety and should be considered when evaluating the effectiveness of any MHC. It should also be noted that the differences among MHCs may be a product of financial and logistical constraints.

Salt Lake County. In regards to BJA’s essential elements, SLCo MHC’s clinical criterion for inclusion is clearly defined: presence of a DSM Axis I diagnosis of Schizophrenia, Bi-Polar Disorder, or Schizo-Affective Disorder. Also in accordance with the BJA recommendation on target populations, the MHC team described a thorough review of clients’ historical records and a complete clinical assessment prior to acceptance into the court. Similarly, the team discussed the practice of only accepting clients that can be

served with existing treatment resources and also mentioned several efforts to improve treatment and service options. Team members provided examples of MHC clients transitioning into and out of the local drug court as either substance abuse or mental illness are identified as a client's primary problem.

In comparison to other MHCs, SLCo's MHC clinical criterion (Axis I, Schizophrenia, etc.) are similar to MHCs in Clark County, WA; Marion County, IN; and Akron, OH. Similar to other courts reviewed in the literature, they also serve several dual-diagnosis clients with substance abuse issues. SLCo MHC team members discussed that the court has occasionally tried to serve lower-functioning and developmentally disabled individuals; however, there is no clear policy on this.

SLCo MHC's acceptance of both misdemeanants and felons differentiates them from the majority of other MHCs. As previously mentioned, in a survey of over 100 MHCs, only 27% of courts accepted offenders charged with felonies for participation. It seems that a new trend is arising with the acceptance of low-level felons (e.g., property crimes) but that the majority of courts still only address misdemeanants. This finding is noteworthy as the acceptance of felons is accompanied with increased responsibly regarding supervision and attention to public safety. Other courts that accept felons include: San Bernardino and Santa Barbara, CA; Orange County, NC; Washoe County, NV; and Bonneville County, ID.

Lastly, the SLCo MHC is similar to all courts, and in compliance with BJA guidelines, in their requirement that participants be mentally competent and participate voluntarily.

3. Timely Participant Identification and Linkage to Services

MHCs have a duty to identify participants quickly and should welcome referrals from many sources (such as, law enforcement, jail staff, defense, judges, and family members), but select one or two agencies to be primary referral sources. Additionally, primary referral sources must be well educated on procedures and eligibility criteria.

The other best practice guidelines outlined by BJA are:

- Prompt review by the prosecutor, defense counsel, and a licensed clinician for eligibility.
- Ensuring that the time required to accept someone into the program does not exceed the length of the sentence that the defendant would have received in a traditional court.
- Final determination of eligibility by the team.
- Minimize the time needed to identify appropriate services.

Other MHCs. In reviewing various courts in practice, it was found that each court identifies possible participants within the first 24 to 48 hours of arrest, although the actual review process may take longer (Redlich et al., 2005). Additionally, a review of Fort

Lauderdale, FL; Seattle, WA; San Bernardino, CA; and Anchorage, AK; found that all four MHCs seek to expedite early intervention through timely identification of candidates. In these courts, screening and referral of defendants takes place within timeframes ranging from immediately after arrest to a maximum of three weeks after the defendant's arrest, depending on the jurisdiction (Goldkamp & Irons-Guynn, 2000).

A somewhat different finding was seen in a review by Steadman and Redlich (2005). In their review they found that the length of time that elapsed from referral to disposition varied widely, ranging from an average of one day to more than 45 days. In 39 cases, courts were found to make the dispositional decision on the same day as the referral. When removing these cases from consideration, the average length of time from referral to disposition was 32 days (Steadman & Redlich, 2005).

One factor that influenced timely intake into MHC programs was acceptance rate. In a review of seven MHCs, it was also found that the courts differed significantly in terms of dispositional decisions**.** In regards to dispositional decisions, the proportion of all referrals ultimately accepted by the courts ranged from 20 to 100%. Bonneville County, ID and Orange County, CA MHCs had the lowest rate of acceptance (approx. 20%). Three MHCs accepted approximately half of the cases referred to their court, while the remaining two courts accepted all or nearly all of their referrals. It is important to note the Bonneville MHC has a low acceptance rate because they are linked with an ACT team that can only accommodate a maximum of 20 defendants at a time (Steadman & Redlich, 2005).

Salt Lake County. During individual interviews, the MHC team members identified a variety of referral sources, including defense (private and Legal Defenders Association (LDA)) attorneys, judges, jail personnel, law enforcement, and AP&P. The consensus was that LDA is the primary referral source. LDA attorneys get ongoing education about MHC criteria and have in-house personnel to assist with the evaluation of potential clients for legal and clinical criteria. Team members have expressed some challenges with getting clients into the court in a timely manner. One option they are exploring to speed up the process is helping clients apply for treatment funding (Medicaid) while they are in the jail awaiting placement in MHC. This would allow for treatment resources to be made available to them immediately following release from jail. In cases where it has not been possible to thoroughly determine a client's clinical appropriateness for MHC within one to two months (e.g., out-of-state records), their case is sent back to regular court. Lastly, the team provides input on acceptance into the MHC, but final approval rests with the prosecutors, as they are ultimately responsible for public safety.

4. Terms of Participation

Parameters for legal agreements, program duration, supervision conditions, and the impact of successful and unsuccessful program exit should be clearly defined. Best practices include:

- Individualized plans put in writing prior to decision to enter the program
- Informing potential clients of consequences of noncompliance and potential effects of a criminal conviction
- Keeping the length of MHC within the maximum period of incarceration or probation received if found guilty in a traditional court
- Use of the least restrictive supervision conditions
- Providing successful participants with positive legal outcomes, such as plea in abeyance, reduction or dismissal of charges, or early terminations of supervision

Plea Agreements & Other MHCs. Some variability was observed in the way the courts deal with the criminal charge(s) against an individual. While no courts under review dropped criminal charges at the time a defendant voluntarily agreed to participate in the mental health court, courts varied considerably in terms of how they managed the disposition of criminal charges. Marion County, Seattle, and Broward County MHCs employed pre-adjudication mechanisms for disposition of charges, whereas other courts required guilty pleas as an eligibility criterion.

Additionally, some courts are not fixed in their adjudication and have either changed their model due to prosecutor's preferences or have shifted between two different models depending on the participant. For example, Clark County uses pre-adjudication methods for City of Vancouver cases but requires a guilty plea for non-residents of their city (because of county prosecutor preferences). Additionally, Santa Barbara began with a pre-adjudication approach but has shifted to a greater emphasis on a post-plea approach due to prosecutor preference. It is interesting to note that this shift has resulted in increased recruitment into their mental health court (Redlich et al., 2005).

While these findings suggest that there is considerable variability in MHC courts, a review of over 100 courts found that plea bargains were required for admission in nearly half (43%) of the courts surveyed (Erickson et al., 2006). Thus, these studies indicate that while there is some variability in the plea agreement policies seen in MHC courts, a considerable amount of courts rely on a pre-adjudication strategy for eligibility. It should also be noted that changes in the plea agreement policies are possibly due to logistical factors.

The Decision to go to Trial & Other MHCs. The implications of a participant's decision to go to trial also differ across MHCs. In King County, during the first year of operations, defendants were required to waive their right to a trial in order to participate in MHC. Therefore, the option to participate in MHC was no longer available to defendants following conviction. Currently, defendants are not required to waive this right and admission can be granted following a trial that led to conviction. Many other MHCs have no strict policy against accepting individuals who have opted for a trial, been convicted, and then requested admission to the MHC. However, in these cases, admission is not guaranteed, and is decided on a case-by-case basis (Steadman & Redlich, 2005).

Resolving Criminal Charges & Other MHCs. In the resolution of criminal charges, a review of several courts found that 26% dismissed criminal charges upon completion of

the program; while 15% used probation and 13% employed suspended sentences (Redlich et al., 2005).

The nation's first four MHCs differ in their method of resolving criminal charges. Successful participants in Broward often have no conviction on their records, as charges are generally resolved through a "withheld adjudication" or a dismissal of the charges. In King County, a significant policy adjustment has recently been made. As such, deferred prosecutions and deferred sentencing are now granted liberally, increasing the likelihood that successful completion will result in a dismissal of charges. The remaining two MHCs generally require pleas of guilty or no contest in order to enter the program, with the option of deferred disposition or deferred adjudication offered rarely to defendants with few or no prior contacts. In Anchorage, only these few defendants may end up without a conviction. In San Bernardino, however, successful completion may result in a withdrawal of the plea and expungement of the participant's criminal record (Redlich et al., 2005).

Supervision & Other MHCs. For most courts, the duration of mental health treatment and court supervision is determined by the state's maximum sentence allowed for misdemeanors—one year in the case of Broward County and Marion County and two years in the case of King County, Seattle, San Bernardino, and Clark County. San Bernardino has a fixed duration of three years for felony cases and Santa Barbara has a fixed duration of 18 months for all cases (Redlich et al., 2005).

In this review, three primary models of supervision used by MHCs were identified. The first uses existing community treatment providers, with reports back to the court when there are difficulties (Broward County, Anchorage, and most Clark County cases) or on a regular basis (Marion County). The second model uses staff from the MHC or the probation or parole office to monitor care in the community (Seattle has specialized mental health probation officers, King County has probation officers, and Anchorage has a Jail Alternative Services Project caseworker). The third model (San Bernardino and Santa Barbara) combines the use of probation and mental health staff to provide supervision.

Finally, the literature indicates that most MHCs provide supervision of participants that is more intensive than would otherwise be available in regular court participation. All types of supervision have an emphasis on accountability and monitoring of the participant's performance. For example, four representative MHCs share the core role of the judge at the center of the treatment and supervision process. Here the judge has overall accountability for the treatment direction and process (Griffin, Steadman, & Pertila, 2002).

Salt Lake County. SLCo MHC follows most of the BJA recommendations for terms of participation. Legal outcomes for successful participation are clearly defined at the time of intake into the program. Clients are informed by the defense attorney of the consequences of noncompliance and ramifications of unsuccessful participation. The MHC uses the least restrictive treatment and supervision options necessary and tailors terms of participation to each client. They have a formalized process for presenting

general terms of participation to potential clients in writing, but do not individualize these signed MHC Agreements. It is recommended that the MHC explore options for individualizing the signed agreements if possible. It is also suggested that they provide clients with a complete MHC Handbook/Policy Manual at intake. This reference document would provide a single source of program information, such as requirements, sanctions, incentives, and contact information for partnering agencies. An Example Participant Handbook was compiled from other MHCs is provided in Appendix C. Additionally, SLCo ensures that clients are not held in MHC longer than they would have been incarcerated or in an alternative program. In fact, the length of participation in MHC is restricted by the length of probation that is required for the presenting charges.

In comparison to the other MHCs reviewed, SLCo accepts clients post-plea. Most clients participate under the conditions that their charges may be reduced or probation supervision terminated early upon successful participation. Team members indicated that plea in abeyances are used less frequently. SLCo MHC's supervision model is most similar to that of San Bernardino and Santa Barbara, using both treatment staff and probation agents to report clients' compliance and progress to the court.

5. Informed Choice

MHC participation should be voluntary and informed, which requires legal competency. It is recommended that individualized terms of participation be put in writing and reviewed with defense counsel.

Other MHCs. The importance of competency and voluntary participation in the context of MHCs is well document in the literature (Poythress, Petrila, McGaha, & Boothroyd, 2002; Redlich, 2005; Stafford & Wygant, 2005). However, research on competency and voluntary participation in MHCs is limited (Redlich, 2005). Existing research does demonstrate the need to better document and formalize these processes (Boothroyd, Poythress, McGaha, & Petrila, 2003). Research on voluntary participation and mental health treatment outcomes typically demonstrates that voluntary participation leads to better outcomes (Winick, 1997). A thorough review of these issues and how they have been addressed in other MHCs is provided in Appendix A.

Salt Lake County. The SLCo MHC's procedures follow the BJA recommendations closely. Attorneys on the MHC team indicated that legal competency was required for participation in the program and that the state hospital is used to restore a person to competence, when necessary. In some instances, clients have been found competent at intake, but later decompensated and were sent to the state hospital until their competence was restored. The state hospital is used by the MHC for this purpose during all phases of the program. There was consensus among the team that participation is informed and voluntary. This is ensured through several processes, including the attorneys (defense and prosecution) and treatment representative discussing the program with potential clients and gauging their interest and awareness of the risks and benefits. Most importantly,

nearly all clients are required to wait until a week after orientation before entering a plea and signing the MHC agreement.

6. Treatment Supports and Services

Courts need to ensure access to a wide variety of treatment options, including medications, counseling, substance abuse treatment, benefits, housing, crisis intervention services, and peer support groups. Ongoing and frequent communication between the court and treatment is necessary. Case management, with appropriate caseload size, is also essential. Additionally, the MHC and case manager should help prepare clients for exit by linking them to resources that will be available to them after they leave MHC.

Other MHCs. Several MHCs, such as Orange County, NC; Brooklyn, NY; and Bonneville County, ID, provide treatment through the Assertive Community Treatment (ACT) model. ACT provides team-based intensive services in a community setting for people with mental illness. The ACT team consists of outreach providing psychiatric and nursing services, case management, peer counseling, and family support. The literature has consistently shown ACT as being one of the most effective treatment modalities for people with mental illness. For more information on ACT, see the following studies: Tsemberis, Gulcur, and Nakae, 2004; Dixon, Friedman, and Lehman, 1993; Dixon, Krauss, Myers, and Lehman, 1994; Morse, Calsyn, Klinkenberg, Helminiak, Wolf, and Drake, 2006; Calsyn, Klinkenberg, Morse, and Lemming, 2006.

The research indicated that courts differ significantly in terms of caseload size. The Bonneville County, ID MHC serves approximately 20 defendants at a time while Santa Clara County, CA allows more than 600 in at a time (Steadman & Redlich, 2007). Appropriate caseload size has been consistently correlated to the effectiveness of treatment programs (Rapp, 1998).

When assessing the strategies of treatment provisions in MHC courts, it was found that a core ingredient of the MHC approach is an emphasis on creating a new and more effective working relationship with mental health providers and support systems. Goldkamp and Irons-Guynn (2000) noted that the absence of such relationships, in part, accounts for the presence of mentally ill offenders in the court and jail systems. This relationship can take form in many ways. Steadman and Redlich (2005) observed MHC staff developing individualized treatment plans, reviewing and adjusting such plans regularly, attending scheduled court review hearings, meeting with vocational training officers, assisting in finding and maintaining employment, and assisting in various other tasks.

Salt Lake County. The SLCo MHC provides the variety of services and supports recommended by BJA. Funding for medications has been provided by several sources, including VMH and AP&P. Specialized staff at VMH immediately begin working with MHC clients to access benefits (e.g., Medicaid & Social Security) to help pay for their medications, treatment, and other needs. Mental health and substance abuse treatment is

provided through several VMH programs, including the Forensic Unit, JDOT, and CTP. JDOT follows the ACT model which has been identified as an effective practice for serving the mentally ill in the community. CTP at VMH provides crisis intervention services, while NAMI provides peer supports. Case management is provided by dedicated MHC staff at both CJS and VMH. Some team members indicated that the caseload size at the MHC is becoming too large; however, the addition of the JDOT team, that provides extra support to the most difficult MHC cases, may help alleviate some of this stress. As suggested by BJA, all members of the treatment and supervision teams frequently communicate with one another and the court. One area along the continuum that the MHC is currently struggling with is developing a sufficient transition plan and resource linkages for exiting clients. Several team members identified a number of resources, such as VMH and NAMI, that are still available to clients after exiting MHC; however, they have found it difficult to keep clients engaged once they are no longer court ordered to participate. The team is currently working toward improving this transitional piece, with the case manager at CJS spearheading the movement.

7. Confidentiality

"A well-designed procedure governing the release and exchange of information is essential to facilitating appropriate communication among members of the mental health court team and to protect confidentiality" (Thompson, Osher, & Tomasini-Joshi, 2007, p. 7). Release forms should be used, but only necessary information should be provided. Additionally, courts should keep criminal and clinical files separately.

Salt Lake County. It appears that the SLCo MHC fulfills the above criterion in ensuring confidentiality. A review of the various release of information forms appear to be in compliance with this goal. The release forms allow for safe exchange of information between key players in Salt Lake, including the Salt Lake County Metro Jail Mental Health Services, Valley Mental Health, and Criminal Justice Services. Of particular importance is the section of SLCo's release of information that requires a designation of the type of information disclosed. Requiring informants to authorize the separate disclosure of: 1) mental health diagnosis and treatment, 2) medical diagnosis and treatment, 3) legal issues/records, 4) jail/custody data, and 5) alcohol and substance abuse treatment, appears to be an effective means of fulfilling the above recommendation; that only necessary information be provided.

8. Court Team

The court team must work collaboratively and should include the following: judge, treatment provider or case manager, prosecutor, defense attorney, and, perhaps, a probation officer. A court coordinator can help the court's operations, but the judge's role is central to the success of the MHC. It is recommended that team members are willing to adapt to non-traditional roles and cross-train.

Other MHCs. The majority of courts rely on a court team for various court-related tasks including the determination of eligibility. For example, in a review of ten courts, all courts reported relying on a court team to inform the judge regarding decisions of eligibility. Additionally, in San Bernardino, a consensus by all court team members is required for eligibility (Goldkamp & Irons-Guynn, 2000; Redlich et al., 2005). These finding highlight the important role court teams play in MHC processes.

Additionally, many courts have been identified as making use of a dedicated team approach. These MHCs rely on representatives of the relevant justice and treatment agencies to form a cooperative and multidisciplinary working relationship with expertise in mental health issues. Key players often include the judge, prosecutor, court monitor, court clinician, case manager, and mental health court liaisons (Goldkamp & Irons-Guynn, 2000).

Salt Lake County. As recommended by BJA, the SLCo MHC team is comprised of a diverse group of professionals, including the judge, defense attorney, two prosecutors (misdemeanor and felony), clinician, case managers, additional treatment staff, probation officers, a representative from the jail MH services, county housing representative, NAMI mentors, court clerk, and administrative staff. A specialized law enforcement team that deals with the mentally ill also collaborates with the team regularly. These individuals are involved with all of the recommended tasks, from referring and screening cases through supervision and preparing clients for exit. The SLCo MHC does not have a specialized court coordinator. Team members indicated that the judge's role and dedication to the program is central to its success.

Observations of pre-court staffings and interviews with the team members make it abundantly clear that they work collaboratively and are comfortable with taking on non-traditional roles. It is not uncommon for the prosecutors to advocate for more creative treatment options, while the treatment staff suggest criminal justice responses to a client's noncompliance. Additionally, several of the court team members have been involved with the MHC since the planning stages and its inception. The team is viewed as a major asset of the local court.

9. Monitoring Adherence to Court Requirements

Monitoring compliance should begin with information sharing from a variety of sources. Regular status hearings will allow the court to respond to participants' behavior and apply incentives or graduated sanctions as necessary. Modification of treatment plans should often be the first response to noncompliance and use of jail should follow specific protocols. Options for incentives should be as broad as the range of graduated sanctions, and should include things such as praise, coupons, phase completion certificates, and decreased frequency of appearances. All incentives and sanctions should be individualized.

Status Hearings & Other MHCs. Schedules for court review of individual participants' progress vary. Seattle and Anchorage hold status review hearings as needed, depending on the participants' needs, compliance, and stability. Marion County reviews every month. Broward County and King County review at regular intervals and as needed. Participants in San Bernardino are seen every three to four weeks. Clark County and Santa Barbara see participants weekly and then less frequently if they are stable. However, schedules for court reviews are more a product of limited court resources than a preference of frequency (Redlich et al., 2005).

Incentives & Other MHCs. It was found that many of the courts use dismissal of charges after successful completion of the mental health court program as an incentive to participate in community treatment and avoid reoffending. Clark County allows the plea to be withdrawn and charges dismissed upon successful completion of the program. Santa Barbara may terminate probation early or dismiss the probation violation with successful completion. San Bernardino dismisses charges, and the defendant may petition for an expungement of the charges from their record. A common incentive is for the court to provide verbal praise, such as a congratulatory announcement by the judge in open court (Steadman & Redlich, 2005). Such forms of incentives can be very reinforcing to participants and encourage further success.

Use of Sanctions & Other MHCs. A review of eight MHCs under operation since the late 1990's shed some light on the typical procedures employed by longstanding MHCs to address noncompliance. The courts differed in their use of sanctions; however, it was found that jail time as a sanction was used sparingly. Only one court, which targets felony cases, reported frequently using jail as a sanction. Other sanctions include returning the person to court for hearings, reprimands, and admonishments, as well as stricter treatment conditions and changes in housing. San Bernardino is different from the other courts in its use of community service as a sanction (Redlich et al., 2005).

In the aforementioned survey of over 100 MHCs, findings were that sanctions for treatment noncompliance varied as well, with 24% using incarceration as a sanction; 22% modifying treatment plans; 14% using other methods, such as community service; and 14% terminating them from the program and sentencing them on their original charge (Erickson et al., 2006).

Lastly, in their review of four primary MHCs, Goldkamp and Irons-Guynn (2000) also found that mental health courts can differ significantly in their handling of noncompliant participants. While each court accepts relapse as a part of the treatment given the population of mentally ill offenders, courts vary in the way they impose sanctions for noncompliance. The most severe sanction is generally seen as program termination followed by jail confinement. The use of this sanction is reportedly least likely in Broward and Anchorage, somewhat more likely in King County, and relatively commonplace in San Bernardino. The authors note that the difference in approach is accounted for in part by philosophical differences among the sites regarding the appropriate response to noncompliance; however, it is also related to differences in the

type of candidate admitted to the courts. San Bernardino is the only site that accepts low-level felony offenders.

Salt Lake County. The SLCo MHC monitors compliance through regular and thorough staffing of each client's case. Observations of pre-court staffing demonstrated that the entire court team is very knowledgeable of clients' compliance, successes, and challenges in all aspects of their lives (e.g., treatment, housing, family). Regular status hearings, with the clients present, are also held in the courtroom. Reducing the frequency of status hearings from every week to every two weeks is used as an incentive. However, team members noted that they have not had much success when decreasing the appearances to less often than once every two weeks. Regular court appearances and interactions with the judge become very important to the clients. Other MHCs that serve felony offenders generally have more frequent review hearings than courts that serve misdemeanors only.

It appears that SLCo is similar to most courts in their use of verbal praise as an incentive. Nearly every court team member also indicated the use of the "Rocket Docket" as a powerful incentive for clients. At the beginning of each court session, clients who are doing well are called on the Rocket Docket list. These clients get to go before the judge before the clients who are not doing as well and get to leave court earlier. They also receive individual praise during the interaction, followed by applause from the judge, team members, clients, and spectators. Some team members indicated additional resources provided to clients, such as paying for medications or housing options, as other forms of reward for participation. However, other team members indicated that these supports and services were "rights" and not rewards. Other types of tangible rewards had been tried in the past (such as coupons, certificates), but team members expressed that they had found that these were not as effective with the MHC population. As with the other MHCs reviewed in the literature, the ultimate reward for participation can be the dismissal (if plea in abeyance) or (more frequently) reduction of charges upon successful completion of the program. Clients may also have three to six months cut from their probation upon successful completion. It appears that the range of incentives may not be as broad as the options for sanctions; however, the team expressed that the current incentives are sufficient.

Several team members used the phrase "graduated sanctions" when describing the court's response to participants who are not making progress. Removal from the Rocket Docket and increased structure and treatment are often the first responses to noncompliance. Depending upon the infraction, community service can be utilized next. Clients often complete their community service at MHC partnering agencies, such as treatment and housing providers or NAMI. This allows them to contribute back to the program and remain connected with supporting agencies while completing their sanction. The next level of sanctioning can include in-court drug testing and taking a client into custody during the court hearing, but releasing them at the end of the session. Jail is the final sanction that the team tries to use sparingly; however, data suggest it is the third most commonly used sanction after verbal warnings and removal from the Rocket Docket. One problem with booking MHC clients into the jail is that they have to stay at least three days and up to a week just to get their medications to them and to get them re-stabilized

before release. This was a frustration voiced my many team members, as jail cannot be used as a brief sanction. It was also noted that jail may not be an effective sanction for some MHC clients "if there is no difference to clients between 5 and 50 days" for them. Most team members viewed the use of jail, and all sanctions, not as punishments, but as a way to stabilize clients. The team is also careful to reward incremental success and acknowledges that relapse and set backs are a normal part of working with this population.

10. Sustainability

To ensure long-term sustainability, courts should have detailed policies and procedures and document the court's history, goals, eligibility criteria, information-sharing protocols, referral and screening procedures, treatment resources, sanctions, and incentives. Another aspect is collecting quantitative data on outputs (i.e., number of persons served) and outcomes (i.e., recidivism), complementing it with qualitative evaluations of the program. Also essential to sustainability are securing and cultivating relationships with long-term funders and outreach to the community and key stakeholders.

Salt Lake County. A review of program documents shows that the SLCo MHC has formalized and documented goals; eligibility criteria; partnering agencies; referral, screening, and information sharing protocols; client MHC Agreement; and a list of typical program requirements. It is recommended that they document treatment and support service resources as these have expanded and changed recently. It would also benefit the program to have a more formalized array of sanctions and incentives. Good record keeping on the program's components is essential for sustainability, especially if key team members depart. This evaluation is the first comprehensive study of the program. It includes quantitative data on outputs and outcomes, as well as a qualitative analysis of the courts processes.

Recommendations

Some suggestions for program improvements resulted from the process of conducting this evaluation, as well as from the results obtained. The recommendations divided into two general areas: a) program operations and b) records and future evaluations.

In regards to program operations, it is suggested that the MHC consider the following eight suggestions for improvements.

1. Continue to refine and document their target population. Although the data suggest that the MHC is serving the appropriate clientele (criminally involved with long history of mental illness), some team members expressed concern regarding serving low functioning clients (DSPD) and dual diagnosis clients whose primary issue is substance abuse, and not mental illness.

2. Improve timely placement of potential participants in MHC by working to access treatment and medication funding (such as Medicaid) as early as possible.

3. Formalize policies and procedures for clients and document these in a participant handbook that is given to clients upon screening into the program. There is a great consensus among MHC team members regarding the policies and practices of the MHC; however, it would benefit clients to have this information in a written format.

4. Create individualized participant agreements. Clients currently sign a standardized MHC agreement, but best practices suggest that individualized agreements be signed by clients so they are aware of the specific requirements for participation and successful completion.

5. Update partnering agency listings, including treatment and support service listings, as new partners have been recently added (i.e. JDOT). BJA best practices for MHCs suggest that good documentation of MHC operations is essential to garner additional support (funding) and ensure sustainability (especially when team members leave the program).

6. Formalize policies regarding sanctions and incentives. Although responses to clients' non-compliance and successes in the program will always be individualized, it would benefit the program to have a formalized list of possible incentives and graduated sanctions. This document would serve a couple of purposes. First, a list of graduated sanctions may help the MHC team to choose less restrictive options when responding to non-compliance. Currently MHC team members indicated that jail was the last resort sanction, but data from court notes indicated that it is the third most frequently used sanction following the least severe responses of verbal warnings and removal from the Rocket Docket. Secondly, a formalized list of incentives may help the team to develop more creative options of rewarding clients and an array of incentives that is comparable to the breadth of sanctions currently used. BJA recommends that at least as many incentives as sanctions be offered in a MHC program.

7. Carefully consider the use of jail as a sanction. As previously noted in item # 6, jail is the third most commonly used sanction. However, data indicate that any jail bookings during MHC (regardless of reason, including for sanctions or warrants) and increased number of days in jail during MHC are associated with post-MHC recidivism. Although jail needs to remain available as an option for both non-compliance and stabilizing clients on their medications, it may have a detrimental effect on participants that is not realized until after exit from the program.

8. Continue efforts to improve transition and aftercare plans for exiting clients. Several MHC team members raised this issue as a concern. Furthermore, although arrest rates remain lower post-MHC than pre-MHC and treatment usage remains higher, these figures could be enhanced with a more formalized aftercare plan.

The process of conducting this evaluation revealed several inconsistencies in data sources and a lack of various types of information on participants. With any program that is a collaborative effort between several agencies, it is difficult to find a single source of records. Nevertheless, the MHC should undertake the following recommendations to improve records on their program and provide more comprehensive data for future evaluations:

1. Identify a single agency to store primary program information.

2. Primary program information should include, at the very least, all names, demographics (date of birth, gender, ethnicity, race), unique identifiers from criminal justice and treatment agencies (e.g., SOs, SIDs), screening, intake, plea, and exit dates and statuses (intake status of plea in abeyance vs. probation, exit status of graduation, termination and reason).

3. Keep a database of participants' progress, similar to information already recorded in court notes documents.

It is believed that these record keeping recommendations can be implemented without too much effort, as the partnering agencies already have data sharing agreements and information kept in court notes documents could be entered into a database that has already been developed for this purpose by the research team. Consistent program records will both improve future evaluation efforts and requests for funding.

Discussion and Conclusion

Many studies of other MHCs found that MHC participants were no more at risk of re-offending than mentally ill offenders handled in the traditional courts (Morin, 2004; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005). Additionally, a few noted a decrease in arrest rates post-exit among MHC participants (Herinckx, Swart, Ama, Dolezal, & King, 2005; McNiel and Binder, 2007). With this literature in mind, outcome analyses of the Salt Lake County Mental Health Court (SLCo MHC) participants is very encouraging.

The MHC serves participants who are booked into the jail often and are therefore consumers of considerable criminal justice resources. MHC participants utilized over 21,000 jail days in the two years prior to starting MHC. Although still high, this number dropped to just over 16,000 while this group was in MHC. It should be noted that few of these booking were for new charges, and only 19.8% of participants had a new charge while in MHC. In fact 8,273 jail days during MHC were for sanctions for non-compliance. Additionally the number of jail days used post-MHC dropped even further to 5,200 in the year following MHC-exit and, and although it increased slightly from the year prior, at two years post-MHC was still well below that of two years pre-MHC (7,600 days).

VMH records suggest that MHC participants have long histories of diagnosed mental illness prior to starting MHC. Most also had long histories of mental health treatment, and a trend of gradually increased treatment leading up to MHC start was observed. Type and frequency of mental health services received during MHC increased dramatically from the pre-MHC levels. Most participants (86.6%) received services through VMH; however, it is likely that the remainder received treatment services through a private provider. Some research has voiced the concern that increased utilization of mental health treatment through MHCs is short-lived and does not extend beyond MHC-exit (Boothroyd, R., Poythress, N., McGaha, A., & Petrila, J., 2003). The difficulty of keeping MHC participants engaged in treatment and various community resources once they exit the program was also noted by a number of team members during key informant interviews. Although services received through VMH did decrease some post-MHC, the percent of participants receiving services through VMH after exiting MHC was still higher than pre-MHC levels, often for multiple years.

Research supports the notion that the provision of secure housing contributes to treatment retention and improved mental health (Wasylenki, Goering, Lemire, Lindsey, and Lancee, 1993). A number of housing assistance options are available to MHC participants, and records indicate that nearly half (47.5%) of participants received housing resources or residential treatment while in MHC. Almost a quarter of all MHC participants (59, 22.4%) were identified as homeless at some point while in MHC; however, these individuals were more likely to receive housing assistance or residential treatment while in MHC. Additional resources to MHC participants include JDOT and NAMI. JDOT provides the most at-risk participants with daily medication monitoring, home visits, and case management following the Assertive Community Treatment (ACT) model that has been shown to be highly effective with a multi-need mentally ill population. The Utah Chapter of NAMI also provides classes for MHC participants and families in a peer-directed environment where participants take an active role in their recovery. Preliminary analysis found that more graduates participated in NAMI's Bridges classes than terminated participants; however, this was based on a relatively small sample.

One of the most promising findings of this study is the reduction in recidivism among participants. MHC participants have extensive criminal histories and nearly all (92.7%) had at least one arrest in the three years prior to MHC. This went down to 37.2% with new arrests in the year following MHC exit, and although it increased at three years post-MHC, it was still substantially lower (62.9%) than at three years pre-MHC. Similarly, the percent of clients with new charge bookings in the jail decreased from 66.9% in the year pre-MHC to 19.8% during MHC (16% from different record source) and 18.2% in the year post-MHC. These reductions compare favorably to other evaluations of MHCs. For example, Herinckx et al. (2005) showed a reduction from every participant having an arrest in the year prior to MHC to only 45.9% having an arrest in the year following MHC intake (during participation). Likewise, McNeil and Binder (2007) reported a 42% recidivism rate 18-months post-start (during MHC, all participants) and a 34% recidivism rate in the 18-months post-exit (for graduates only).

Graduation from MHC was associated with better post-MHC outcomes. Although not different in number of pre-MHC arrests, graduates had far fewer post-MHC arrests. In fact the difference remained statistically significant at two years following exit. Not only were graduates less likely to recidivate, but the length of time until recidivism (new charge bookings) was delayed (grad, Md = 435 days; term, Md = 262 days). Findings also suggest that individuals who are not compliant will not succeed in the program, but they may still benefit from reduced recidivism following MHC exit. Although graduates do have better outcomes than terminated participants, all MHC participants, regardless of during program compliance and exit status, showed reductions in criminal involvement following MHC participation.

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Appendix A Importance of Competency and Voluntary Participation

Although few studies have examined the competency of MHC participants (Redlich, 2005; Stafford & Wygant, 2005), the importance of competency and voluntary participation is well understood. Bonnie (1992) notes the importance of competency in the legal system in general, citing three independent rationales for barring adjudication on grounds of incompetence: *dignity*, *reliability*, and *autonomy*. The *dignity* of the court is at risk when defendants who do not understand their wrongdoing or the punishment are prosecuted. The *reliability* of the court is at stake when the details of the case are incorrect or misleading due to the inability of the defendant to share relevant information. Lastly, the court system requires *autonomy* of the defendant to make decisions regarding representation, entering a plea, and testifying.

Assessing defendant competency in MHCs is especially important. First, because of the purpose of the MHC, they are more likely to serve defendants who are impaired and lack competence to stand trial (Redlich, 2005; Stafford & Wygant, 2005). Second, many MHCs, including Salt Lake County's MHC, specifically target clients with schizophrenia. Research has indicated that persons diagnosed with schizophrenia are more impaired than persons diagnosed with other mental disorders. For example, persons with schizophrenia scored lower than those with affective disorder, other psychiatric disorders, or no disorder on measures of competency, such as understanding, reasoning, and appreciation of the court process (Hoge, et al., 1997). These differences were present after controlling for factors such as age, socioeconomic status, criminal history, contact with attorney. Additionally, MHCs are informal by design and may require participants to give up some rights that are protected in the traditional court process (e.g., speedy trial, due process) (Poythress, Petrila, McGaha & Boothroyd, 2002; Redlich). Many MHCs also require clients to plead guilty to their charges in addition to agreeing to comply with court orders, treatment, medication, and other requirements. Because of the enormity of responsibility placed on clients, "voluntary, knowing, and intelligent decisions" to participate are especially important (Redlich). This issue was addressed by Stafford and Wygant who stated, "The defendant needs to understand the risks and the benefits of mental health court, and the constitutional rights waived by choosing mental health court, prior to making an informed decision about participation." Furthermore, Redlich posits that "the level of comprehension at entry may predict future success or failure in the court"; therefore adding a practical implication to the legal ones for assessing competency and voluntary participation.

Definition of Competency

Redlich (2005), citing Bonnie (1992) and Appelbaum and Grisso (1995), provides a concise definition of legal competency based on past studies. Legal competency is most often defined as comprising the following two constructs: competence to assist counsel and decisional competence (Bonnie). Several abilities comprise the construct of competency. Three abilities that are required for both competence to assist counsel and decisional competence are a) capacity for understanding the charges, the nature of the court, relevant information, etc.; b) capacity for reasoning as it relates to one's case

(recognizing pertinent information, weigh risks and benefits, etc.); and c) appreciating one's situation as a defendant. A fourth ability required for decisional competence is the ability to communicate a preference (Bonnie). Appelbaum and Grisso similarly define competency to make treatment decisions as comprising elements of understanding, reasoning, and appreciation.

MHC Research and Competency

As previously mentioned, there is a dearth of research regarding competency and voluntary participation in mental health courts. Redlich (2005) states that it is unknown if decisions to enter MHCs are made "knowingly and intelligently." There is little documentation on when (and if) the process and procedures of MHCs are explained, who provides this information, and whether practices are followed consistently.

The few studies of MHCs that have addressed competency and voluntary participation have shown that court procedures for informing clients and the percent of clients found competent to participate can vary widely. Stafford and Wygant (2005) examined trial competency evaluations from the Akron Ohio MHC and noted the surprisingly high percentage of MHC referrals who were identified as incompetent. Out of 80 evaluations, more than three-quarters (77.5%) were found incompetent to stand trial. Of the 18 (22.5%) found competent to stand trial, only two entered the MHC program. Out of the 62 initially found incompetent, mean time in the state hospital for competency restoration was 48.9 days and only 29 (46.8%) were restored to competence. Of those restored to competence, only two were placed in the MHC. Group differences showed that incompetent defendants were more likely to have a psychotic diagnosis, but less likely to have a personality disorder or substance abuse diagnosis, felony convictions, or a history of juvenile arrests. Characteristics associated with MHC referrals' competence may have implications for the population that these specialty courts target.

In a study of court processes in the Broward County MHC, it was found that official records of clients' competence-to-proceed was found in only 29.4% of cases (Boothroyd, Poythress, McGaha & Petrila, 2003). Of those, 73.3% of the defendants were declared competent, in contrast to the approximately 75% who were found incompetent in the Stafford and Wygant (2005) study of the Akron MHC. In regards to informed consent, only 28.4% of the Broward County cases had an explicit description of the court's purpose and focus in the transcripts, while only 15.7% of cases had specific mention of the voluntary nature of the court. However, the authors did note that in-court observations showed that the judge generally made a "blanket statement" at the beginning of the court session describing the treatment approach of the court and voluntary nature to all who were present. A higher percentage of MHC clients (53.7%) self-reported knowledge of the voluntary nature of the MHC; however, of those 54.7% said they were told about the voluntary nature after their first hearing. They reported getting information about the court's purpose and voluntary nature from a variety of sources: defense attorney (31.8%), judge (28.8%), and mental health professionals (25.8%). Nonetheless, the authors noted that the lack of discussion about voluntary participation in the official court record was troubling (Boothroyd et al.). In an earlier study of the Broward County MHC, it was

found that lack of awareness of the voluntary nature of the court was related to more feelings of coercion (Poythress et al., 2002). However, overall coercion ratings for the entire sample of MHC participants were still quite low.

Trupin and Richards (2003) studied the King County and Seattle Municipal MHCs. The procedures for informing clients of the voluntary nature of the court were more clearly defined in these MHCs than in Broward County. For both King and Seattle courts, the court monitory (clinical social worker) informs referred clients about the court, their responsibilities, risks, and the benefits of participation. During their initial hearing, the judge further explains that participation is voluntary and confirms that the defendant understands the court. Defendants "at some point" make a decision to opt-in or out of the MHC (Trupin & Richards, 2003). Although the process of information sharing is well documented for these courts, the exact timing of when defendants enter the court willingly and whether or not they meet criteria for legal competence are not detailed.

Slightly more research is available on voluntary participation and mental health treatment outcomes. Redlich (2005) reviewed several studies linking competence and voluntary participation to improved outcomes among the mentally ill. First, the Swartz, Swanson, and Monahan (2003) study found that positive endorsement of treatment (e.g., outpatient commitment mandates, OPC) at intake, was related to greater likelihood of positive mental health outcomes (improved GAF scores and fewer hospitalizations and violence). Second, Winick (1997) in his work on the right to refuse mental health treatment reported that patients who entered treatment with complete understanding and voluntarily had better treatment-related outcomes. Third, in a study of mentally ill probationers, Solomon, Draine, and Marcus (2002) found that those who believed their psychiatric medications were helpful were nearly five times less likely to be arrested for new charges and more than three times less likely to be jailed on technical violations than those who did not think medications were helpful. Lastly, Kaltiala-Heino, Laippala, and Salokangas (1997) showed that patients who initially felt coerced were less likely to take medications, use mental health services, and show improvements in functioning. In contrast, Rain, et al. (2003) did not find any relationship between perceptions of coercion and adherence to treatment. Although this research does not directly involve MHC populations, their findings may demonstrate the importance of competency and voluntary participation in a MHC environment, since better treatment and criminal justice outcomes are associated with increased awareness of mental illness and willingness to endorse treatment as a viable option.

Recommendations and Conclusion

Although the body of literature on competence, voluntary participation, and mental health courts is limited, there is near unanimous agreement within the field about the importance of these issues. In fact, Thompson, Osher, and Tomasini-Joshi (2007) list "informed choice" as one of the ten essential elements of a MHC. Potential clients should be determined competent to participate and fully understand terms of participation. Furthermore, choices should be informed both before and during program participation. These authors indicate that specific terms should be put in writing and reviewed with the

counsel. They also emphasize the important role the defense attorney plays at intake into the MHC as well as during status hearings where there is a risk of sanctions or dismissal.

Given the importance of competency to the court process in general, and to MHCs specifically, MHCs should strive to address these issues and carefully document their efforts so that future research can further examine the role these constructs play in individuals' success and the effectiveness of MHCs in general.

Appendix B Overview of Mental Health Courts in the Literature Table

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Broward County, FL	1997		daily	Axis I serious mental illness, brain impairment, or developmental disability	1 year max	Misdemeanors (w/ the exception of DV & DUIs). Battery eligible w/ victim consent only	most pre-plea	Extremely rare	Community tx providers	
King County, WA	1999	36	daily	Serious mental illness or developmental disability	2 years, DUIs extended to 5 years	Misdemeanors	most pre-plea	Sparingly	Probation	Community-based behavioral tx
San Bernardino, CA	1999		weekly	History of severe and persistent Axis I mental illness; previous diagnosis req.	2 years for misdemeanors, 3 years for felonies	Misdemeanors & low-level Felonies	post-plea	Liberally	Team, probation, MH staff	
Anchorage, AL	1998	80	Part time, as needed	Diagnosis or obvious signs of serious mental illness, or organic brain syndrome that contributed to crime	3-5 years, 10 year max	Misdemeanors	most pre-plea	After repeated non-compliance	Court monitor	
Santa Barbara, CA		600	1.5 days per week	Any mental illness or SA disorder		Misdemeanors & some Felonies	most pre-plea	Occasionally	Team, probation, MH staff	
Clark County, WA	2000		3 times per week	Axis I diagnosis of schizophrenia, bipolar, or major depression. No Axis II of development disabilities.		Misdemeanors	pre & post-plea	With violent charges	Community Tx providers	

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Seattle, WA	1999	781 (in 2004)	weekly	Axis I diagnosis of schizophrenia, bipolar, or major depression	2 year max	Misdemeanors	most pre-plea	Rarely	Probation	Court Monitor arranges for services, including housing & tx
Marion County, IN	1996		weekly	Axis I diagnosis of schizophrenia, bipolar, or major depression		Misdemeanors	pre-plea	Rarely	Community tx providers	
Santa Clara County, CA				Dual-diagnosis of mental illness & SA disorder		Felonies	post-plea	With discretion only	Team	Various SA and MH services
Orange County, NC	2000	65	2 times per month	Any mental illness (priority given to severe mental illness diagnosis)	6 months	Misdemeanors & Felonies	pre-plea	With discretion only	Tx Staff	ACT & other MH services
Allegheny County, PA	2001	36	weekly	Any mental illness or SA disorder		Misdemeanors & Property Felonies	post-plea	Rarely	Probation	
Washoe County, NV	2001	37	weekly	Major mental illness, developmentally disabled, & individuals w/ an aging disorder or an organic brain injury	2 years max	Misdemeanors & Felonies	post-plea	With discretion only	Team	

MHC	Year Began	Average Active Caseload	Team Meeting Schedule	Degree of Mental Illness	Length of MHC	Types of Cases Accepted	Type of Adjudication Model	Use of Sanctions	Type of Supervision	Tx Approach
Brooklyn, NY	2002	40-50 (since inception)	weekly	Axis I diagnosis of schizophrenia, bipolar disorder, major depression, or schizoaffective disorder	12 months for misdemeanors, 12-24 months for felonies	Nonviolent Felonies & some Misdemeanors	post-plea	Rarely	Court Case managers	Community-based services: ACT & services for co-occurring SA & MH disorders
Bonneville County, ID	2002	13 (max 20 at one time)	weekly	Axis I diagnosis of schizophrenia, bipolar disorder, major depression, or schizoaffective disorder		Misdemeanors & Felonies	post-plea	With discretion only	ACT team & Probation	ACT
Orange County, CA		47		Dual-diagnosis of mental illness & SA disorder		Felonies	post-plea	With discretion only	Probation	Various SA and MH services
Akron, OH	2001	100 (per year)	weekly (judge is only present every 6 weeks)	DSM diagnosis of bi-polar disorder, schizoaffective disorder, or schizophrenia	1 year min, average 1.5 years	Misdemeanor	pre-plea	No protocol for sanctions or incentives	Tx team	Residential program, assistance w/ benefits, linkage to SA and MH services

UTAH THIRD DISTRICT COURT
SALT LAKE COUNTY

MENTAL HEALTH COURT
PARTICIPANT HANDBOOK

2008

This document was compiled by Utah Criminal Justice Center researchers during a program evaluation of the Salt Lake County Mental Health Court in an attempt to provide an example participant handbook, based on examples from other MHCs nationwide.

TABLE OF CONTENTS

BACKGROUND

MISSION

The mission of the Mental Health court is to address the needs of the offender who has a mental illness in the criminal justice system.

PURPOSE

The purpose of the Mental Health Court is to provide a structured link for the offender who has a mental illness with: treatment, rehabilitation, social support services, and the criminal justice system to enhance the functioning of the participant, protect the public and more effectively utilize public resources.

PROGRAM GOALS

Program Goal #1

Reduce criminal recidivism of offenders with an identified mental illness by providing a psychological evaluation and three phases of Mental Health Court intervention to eligible defendants

Program Goal #2

Expand the capacity of Mental Health Court

Program Goal #3

Secure psychiatric medications for all Mental Health Court participants from jail release until funding can be secured so that participant can pay for medications

Program Goal #4

Increase mental health treatment compliance of Mental Health Court participants

Program Goal #5

Continue a forum of providers, prosecutors, defenders, judges, and state correction officials to discuss Mental Health Court issues.

INTAKE INFORMATION

ELIGIBILITY

Mental Health Criteria

1. Axis I Diagnosis (such as Schizophrenia, Bipolar Disorder, or Schizoaffective Disorder)

Legal Criteria

2. Legally Competent
3. Misdemeanor or Felony charge
4. No weapons offenses
5. No sexual offenses
6. No active DUI offenses.
7. Offenses involving violence are reviewed on a case by case basis

Other Criteria

8. Salt Lake County residence
9. Voluntarily choose to participate rather than remain in the traditional court system

MHC PARTICIPANTS ACCEPTED CRIMINAL CHARGES – MISDEAMENORS

Property Crimes

1. Criminal Mischief
2. Trespass
3. Retail theft
4. Theft

Substance Crimes

5. Public intoxication
6. Illegal possession
7. Unlawful open container/possession of alcohol in a public place

Person Crimes

8. Disturbing the peace
9. Disorderly conduct
10. Assault
11. Domestic violence
12. Sex solicitation
13. Telephone harassment
14. Assault on a police officer
15. Interfering with an arrest
16. False information to the police
17. Mischievous conduct
18. Battery

MHC PARTICIPANTS ACCEPTED CRIMINAL CHARGES – FELONIES

Property Crimes

1. Forgery
2. Burglary
3. Possession, forgery writing device
4. Joy riding
5. Theft by deception
6. Reckless burning

Substance Crimes

7. Illegal possession
8. Operation of clandestine laboratory
9. Possession with intent to manufacture

Person Crimes

10. Protective order violation
11. Aggravated assault
12. Threat of use of a dangerous weapon

REFERRAL

Referral into the MHC program may be made by your attorney, the prosecuting attorney, the judge, probation officer, the jail, or a mental health professional. An Intake/Screening Form, Inter-Agency Release of Information, and Authority to Release Records form must be completed to begin the screening process.

Legal Defender Referral

1. Refers client to the legal defender social workers
2. Sends referral to MHC case manager
3. MHC case manager screens client on JEMS
4. Case manager informs MHC Clinician of problems such as DUIs, aggravated crimes, etc. Also if client self-reports a mental illness
5. MHC Clinician checks to see if client is already involved in treatment with Valley Mental Health and decides if client is clinically eligible for MHC
6. If eligible, MHC Clinician informs the District Attorney and City Prosecutor who will decide if client is legally eligible
7. Client is put on court docket and told to report to MHC for orientation
8. If client decides he/she wants to participate in MHC, he/she will plea into the court.
9. Client will be court ordered to report to MHC case manager for intake

Private Referral

1. Lawyer will make telephone call to MHC case manager
2. MHC case manager will fax referral forms
3. When referral forms are received, screening process above (#3, etc.) will take place
4. When screened, MHC Clinician will check on clinical appropriateness and inform the attorney of the result
5. If found eligible clinically, lawyer must get approval of District Attorney
6. Client is put on court docket and told to report to MHC for orientation
7. If client decides he/she wants to participate in MHC, he/she will plea into the court.

8. Client will be court ordered to report to MHC case manager for intake

SCREENING AND ACCEPTANCE

Following legal, clinical, and probation screening, your application for acceptance into the MHC program will be submitted to the staffing team for acceptance or denial. If accepted into the MHC program, you will be represented by the MHC public defender in a non-adversarial manner during your participation in the program.

GUILTY PLEA AND SENTENCING

If you have been charged with a new crime, you will be required to enter a guilty plea to the charge before participating in the MHC program. If you are terminated or voluntarily withdraw from the MHC program, you will be sentenced based on your guilty plea to the charge. If you successfully complete the MHC program, you may potentially be offered a 402 reduction of charge (ex: Class A to Class B Misdemeanor) or a dismissal of a charge through a plea in abeyance. These conditions will be specified in writing upon admission into the program. Successful completion of the program may also include a 3-6 month reduction of your probation period.

Formal entrance into the MHC will begin when you sign the Mental Health Court Agreement and enter a plea before the court. An example MHC Agreement is provided at the end of this handbook.

CONFIDENTIALITY

The MHC makes an effort to protect the confidentiality of its participants. However, participants must sign an Inter-Agency Release of Information form as a condition of participation in the court. Your records will not be released or shared with the MHC team unless a specific release of information has been signed by you to provide that type of information (ex: legal issues/records, mental health diagnosis) to the MHC program.

PARTICIPATION

GENERAL TERMS OF PARTICIPATION

The length of participation in the MHC is determined by the maximum probation sentence for the presenting charge severity, but is typically 12 to 36 months. The specific length of your MHC participation is specified on the MHC Agreement. Non-compliance can result in revocation and reinstatement (extension) of probation.

Successful discharge criteria include:

- a stabilized psychiatric condition
- abstinence from drugs and alcohol for at least a [*insert number*] month period
- successful completion of the treatment program
- compliance with court orders, probation agreement, and MHC agreement
- successful transitioning from treatment to independent living

Your individualized MHC requirements will be specified in your MHC Agreement and treatment plan.

Participants may be expelled from the program if no community-based treatment is likely to restore them to stability, the likelihood of serious physical harm to self or others becomes unmanageable in the community setting, the participant refuses to comply with program requirements, a treatment placement cannot be found, or the client withdraws or is rearrested.

COURT APPEARANCES

Status hearings are held weekly on Monday afternoons at 3 p.m., except on holidays. Each participant generally attends court once a week, but the frequency of these hearings can be reduced to twice a month based on participant progress and the decision of the MHC team. Prior to the hearings the MHC team staffs the cases and discusses participant progress. During the court hearing, clients are called before the judge and given an opportunity to report on progress and discuss issues with the Court. Incentives for compliance and sanctions for non-compliance may be issued during status hearings. The most successful clients are placed on the "Rocket Docket" and are allowed to appear before the Judge at the beginning of court.

INCENTIVES

Incentives are provided for clients that are compliant with the MHC requirements and making progress in their treatment plan. Incentives may include, but are not limited to the following:

1. Verbal Praise
2. Being on the "Rocket Docket"
3. Reduction in frequency of status hearings to twice a month
4. Reduction in treatment or supervision requirements

Sustained successful participation may result in a 3 to 6 month reduction in your probation period. In addition, upon successful completion of the program you may be offered a 402 reduction of charges or a dismissal of charges as outlined in your MHC agreement and plea at intake.

SANCTIONS

The MHC employs graduated sanctions for non-compliance with MHC program requirements. Examples of non-compliance include not adhering to medication and treatment regimens, using alcohol and non-prescribed drugs, or committing new offenses. Sanctions for non-compliance may include, but are not limited to the following:

1. Removal from the "Rocket Docket"
2. Assignments
3. Increased classes
4. Increased drug testing
5. Community service
6. Jail

PROGRAM FEES

[*Insert Salt Lake County MHC Program Fee requirements here*]

PHASES

Phase One - Pre-screening / Arraignment
If incarcerated, the jail mental health unit will assess defendants for competency, suitability, mental health diagnosis, and residence prior to referral to Mental Health Court. Defendants can also be referred from arraignment or pre-trail court appearances.

Phase Two - Entry – 1 Week

During the first week of participation in Mental Health Court the client will make their initial appearance in court. The Valley Mental Health Clinic Coordinator will arrange services between Criminal Justice Services (CJS) and Valley Mental Health (VMH) or Veteran Administration (VA). If the client is currently under the care of a private provider, steps will be taken to coordinate with that provider.

Phase Three – Stabilization – 2-8 Weeks

During this two to eight week phase clients will enter a plea, sign the Mental Health Court agreement, and make weekly appearances in court. The client will be referred to CJS and VMH or VA to do an intake. VMH or VA will provide each client with an individualized treatment plan and medication management. The client will maintain weekly contact with the CJS case manager and attend counseling and other services deemed appropriate by CJS and VMH or VA. Clients with a substance abuse problem may also be required to attend substance abuse treatment and to submit to drug testing.

Phase Four – Maintenance – Remainder of Probation Period

Client will continue treatment as determined by the treatment plan, addressing issues such as education

and employment. Client will continue making court appearances as deemed necessary by the judge. Program completion is determined by a minimum of twelve months to three years of successful participation in Mental Health Court. Upon completion of the program the client will participate in a graduation ceremony at which time charges will be reduced or dismissed, if appropriate.

TREATMENT AND RELEASE PLAN

[*Insert Salt Lake County MHC Treatment and Release Plan here – this is a suggested plan from other MHCs*]

During Phase Four, MHC participants will receive case management services. The case manager works with the defendant and defense counsel to determine whether the individual is eligible for community treatment services, identifies an individualized community treatment plan, and determines if the defendant is willing and able to participate in the plan. The case manager will appear with the defendant and present a formal Treatment & Release Plan to the court to be approved prior to graduation. Elements of this individualized plan may include, but are not limited to:

- Crisis intervention and stabilization
- Safe and affordable housing
- Mental health and substance abuse treatment services
- Initial and/or ongoing psychological assessment
- Intensive case management
- Medication management
- Anger management
- Group therapy
- Individualized therapy
- Family therapy
- Parenting classes
- Individualized “wraparound” services
- Supportive, transitional, or independent housing
- Assistance with entitlements
- Protective payeeship, conservatorship, and guardianship
- Employment, training, and vocational services
- Transportation services
- Linkages to other support services

MENTAL HEALTH COURT CONTACTS

MHC Case Manager
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Case Manager
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Probation Officer
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Probation Officer
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Public Defender
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Housing Specialist
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

Community Treatment Program (CTP)
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MHC Drug Testing Hotline
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

Utah Chapter of National Alliance on Mental Illness (NAMI)
[*Contact person name*]
[*Organization name*]
[*Address*]
[*City*], [*State*] [*Zip*]
Office: [*insert number*]
Fax: [*insert number*]
Cell: [*insert number*]

MENTAL HEALTH COURT PARTNERS

1. Salt Lake Third District Court

2. Valley Mental Health, including
    - Forensic Unit
    - Supported Employment
    - Community Treatment Program (CTP)
    - Jail Diversion Outreach Team (JDOT)

3. Veterans Administration

4. Salt Lake County Criminal Justice Services

5. Utah Commission on Criminal and Juvenile Justice (UCCJJ)

6. Mental Health Management Services at the Jail

7. Salt Lake County District Attorney

8. Salt Lake City Prosecutors

9. Legal Defenders Association

10. Salt Lake City Police Crisis Intervention Team (CIT)

11. Adult Probation and Parole

12. Utah Chapter of the National Alliance on Mental Illness (NAMI)
    - NAMI Bridges Program

13. Supported Housing, including
    - Veteran's Administration Valor House
    - Orange Street
    - Fremont
    - First Step House: Fisher House
    - Volunteers of America (VOA)
    - Valley Mental Health Housing: Timmins House
    - HACSL Housing: RIO, HARP

THIRD DISTRICT MENTAL HEALTH COURT
PARTICIPANT AGREEMENT

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt.# City State Zip

PHONE: _____ DATE OF BIRTH:_____

CASE NUMBER: _____ SSN: _____

I have chosen to pursue treatment in the Mental Health Court program. To assure my full participation in this program, for a period of_____ months, I agree to the following:

1. Immediately report to a caseworker/case manager to be identified by the Court for an intake interview.

2. Maintain residence of record within Salt Lake County and get approval of the caseworker/case manager before changing residence. Notify caseworker/case manager of any change in phone number (or contact phone number) within 24 hours of change.

3. Follow all rules and regulations of his/her residence.

4. Attend all Court hearings as directed by the Court and all appointments as scheduled by caseworker/case manager.

5. Take all medications as prescribed.

6. Refrain from use of alcohol and non-prescribed drugs and comply with random urinalysis as ordered by the Court and/or requested by the caseworker/case manager.

7. Commit no criminal law violations and possess no dangerous weapons. If/when contacted by law enforcement, I shall report such contact to my caseworker/case manager within 48 hours regarding any potential charges and the receipt of any new citations.

8. Sanctions may include but are not limited to modification or treatment, administrative sanctions, community service, fines or a specific jail term.

9. I understand I have been accepted into the Mental Health Program as a condition of probation. This will require an entrance of a plea(s) of guilty and a subsequent sentence being imposed by the Court. If I am in compliance with the other conditions of my probation, I will be successfully discharged and terminated fro probation. If I fail to satisfactorily complete the Mental Health Court Treatment Program, the Court will remove me from the program, revoke my probation and sentence me in accordance with the provisions of the law.

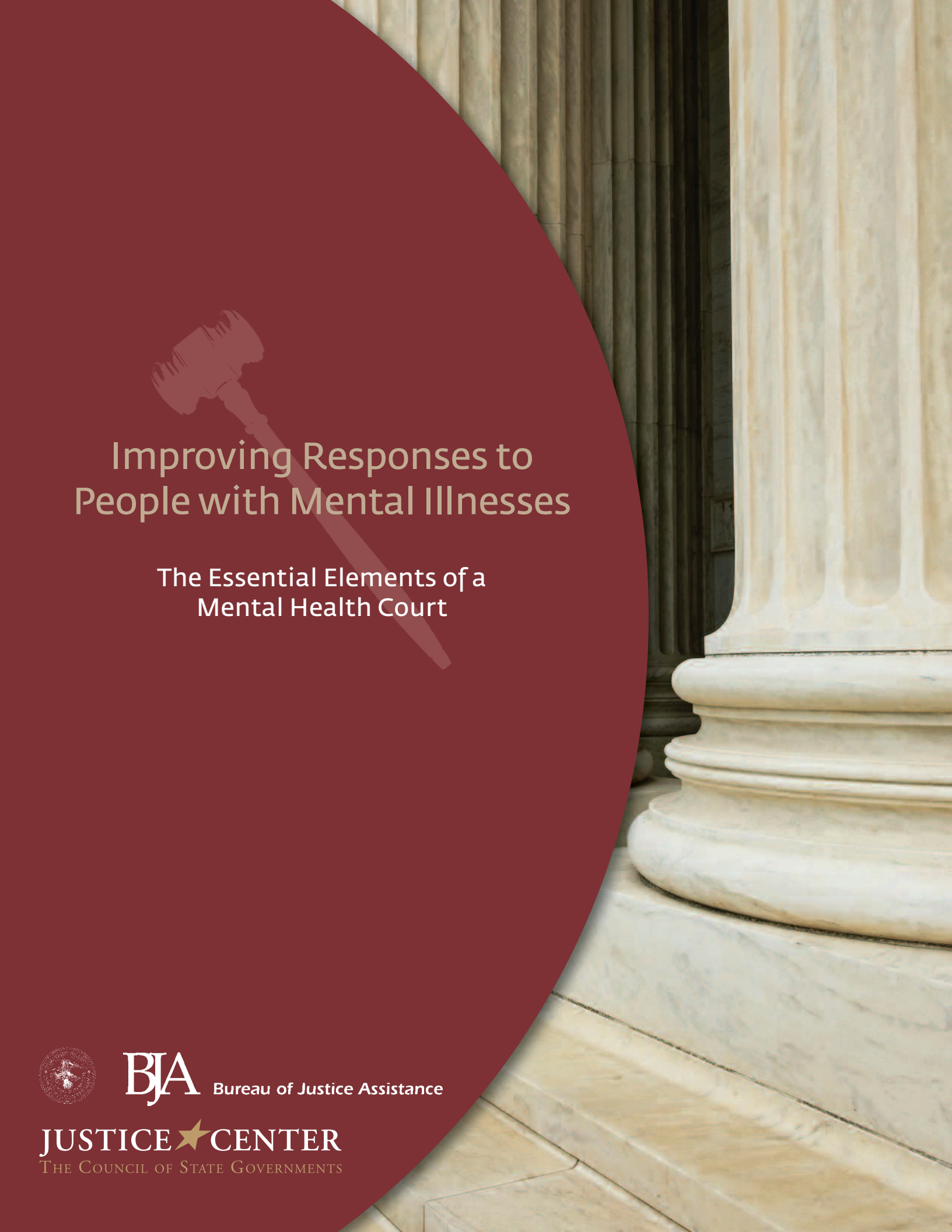
10. Other conditions _____

11. If it is claimed that I have failed to comply with the rules, policies, or requirements of the Mental Health court, I give up the right to a hearing or an attorney and agree to proceed with imposition of any sanction except removal from Mental Health Court. Before I can be terminated from Mental Health Court I am entitled to a full hearing with counsel.

DATED this _____ day of _____, 20_____

_____ _____

Defendant Signature Attorney for Defendant Signature



Improving Responses to People with Mental Illnesses

The Essential Elements of a Mental Health Court

BJA Bureau of Justice Assistance

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Improving Responses to People with Mental Illnesses

The Essential Elements of a Mental Health Court

A report prepared by the
Council of State Governments Justice Center
Criminal Justice/Mental Health Consensus Project

for the

Bureau of Justice Assistance
Office of Justice Programs
U.S. Department of Justice

Michael Thompson
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JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

BJA Bureau of Justice Assistance

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Council of State Governments Justice Center, New York 10005

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Contents

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Introduction

Mental health courts are a recent and rapidly expanding phenomenon. In the late 1990s only a few such courts were accepting cases. Since then, more than 150 others have been established, and dozens more are being planned. Although early commentary on these courts emphasized their differences—and their diversity is undeniable—the similarities across mental health courts are becoming increasingly apparent. In fact, the vast majority of mental health courts share the following characteristics:

- A specialized court docket, which employs a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses
- Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement
- Regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation
- Criteria defining a participant's completion of (sometimes called graduation from) the program

The reasons communities give for establishing mental health courts are also remarkably consistent: to increase public safety, facilitate participation in effective mental health and substance abuse treatment, improve the quality of life for people with mental illnesses charged with crimes, and make more effective use of limited criminal justice and mental health resources.

As the commonalities among mental health courts begin to emerge, practitioners, policymakers, researchers, and others have become interested in developing consensus not only on what a mental health court *is,* but on what a mental health court *should be*. The purpose of this document is to articulate such consensus in the form of 10 essential elements.

About the Elements

This publication identifies 10 essential elements of mental health court design and implementation.[1] Each element contains a short statement describing criteria mental health courts should meet, followed by several paragraphs explaining why the element is important and how courts can adhere to it. Ultimately, benchmarks will be added, enabling courts to better assess their fidelity to each element.

Although both adult and juvenile mental health courts have emerged in recent years, this publication pertains only to adult mental health courts. There are two primary reasons for this focus. First, as of this writing, there are only a handful of mental health courts targeting juveniles. Second, the significant differences between the provision of mental health and criminal justice services for juveniles and that for adults makes it difficult to develop a document that encompasses both populations.

Just as the success of local drug courts prompted the development of many mental health

1. *Essential Elements* was developed as part of a technical assistance program provided by the Council of State Governments (CSG) Justice Center through the Bureau of Justice Assistance (BJA) Mental Health Courts Program. The BJA Mental Health Courts Program, which was authorized by America's Law Enforcement and Mental Health Project (Public Law 106-515), provided grants to support the development of mental health courts in 23 jurisdictions in FY 2002 and 14 jurisdictions in FY 2003. The Justice Center currently provides technical assistance to the grantees of BJA's Justice and Mental Health Collaboration Program, the successor to the Mental Health Courts Program.

courts, *Defining Drug Courts: The Key Components,* a 1997 publication of the U.S. Department of Justice, inspired this document. Although there are significant differences between drug courts and mental health courts, the *Key Components* document provided the foundation in format and content for *Essential Elements*.

Two key principles underlie the 10 essential elements. First, at the heart of each element is collaboration among the criminal justice, mental health, substance abuse treatment, and related systems. True cross-system collaboration is necessary to realize any of these elements and, for that matter, to successfully operate a mental health court. It is generally accepted that achieving this type of collaboration is difficult, particularly in regard to breaking down institutional barriers and eschewing the adversarial process. Second, the elements make clear, both explicitly and implicitly, that mental health courts are not a panacea. Reversing the overrepresentation of people with mental illnesses in the criminal justice system requires a comprehensive strategy of which mental health courts should be just one piece.

Though these elements are drawn in large part from the experience of existing courts, they are not research-based. Only a few studies have been completed, though more are underway, to better understand the operation and impact of mental health courts. Proponents of mental health courts hope that these investigations will substantiate the relative importance of different elements for court functioning and client outcomes. In the meantime, these elements should prove useful for communities interested in developing a mental health court or reviewing the organization and functions of an existing court program.

The elements described in this document will not be present in every mental health court. When the elements are present, they will manifest differently across jurisdictions. In addition, some mental health court practitioners may disagree with some of the statements below, identify elements that may be missing, or argue that some of these elements are unrealistic. This debate will drive stronger efforts in the field and maximize the effectiveness of America's mental health courts.

Because mental health courts will continue to mature and new research will become available, changes to this publication are inevitable. *Essential Elements* will periodically be updated to reflect innovative thinking from the field and to include the benchmarks that mental health court administrators can use to assess their progress in implementing the essential elements in their courts.

Methodology

The essential elements are culled from a variety of sources, including interviews with former BJA Mental Health Courts Program (MHCP) grantees, on-site visits to grantee and non-grantee mental health courts, and a review of the scholarly literature.[2] An original draft of the elements document was prepared for the 2004 BJA MHCP conference. Comments from the conference attendees were incorporated into a second draft, which served as source material for the *Guide to Mental Health Court Design and Implementation,* a BJA-sponsored publication.

This latest version was informed by comments from the field transmitted through a well-publicized web-based discussion forum. A group of practitioners and experts reviewed and discussed these comments and suggested revisions to the draft. This version incorporates those suggestions.

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2. The first major investigation of mental health courts was "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage," by John Goldkamp and Cheryl Irons-Guynn, April 2000. Since then, several studies about mental health courts have been published, including the BJA-sponsored report entitled *Guide to Mental Health Court Design and Implementation,* July 2005, and the Rand study *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court,* March 2007. Readers interested in these and other resources related to mental health courts should visit www.consensusproject.org/mhcourts.

Ten Essential Elements

1 PLANNING AND ADMINISTRATION

A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.

Mental health courts are situated at the intersection of the criminal justice, mental health, substance abuse treatment, and other social service systems. Their planning and administration should reflect extensive collaboration among practitioners and policymakers from those systems, as well as community members. To that end, a multidisciplinary "planning committee" should be charged with designing the mental health court. Along with determining eligibility criteria, monitoring mechanisms, and other court processes, this committee should articulate clear, specific, and realizable goals that reflect agreement on the court's purposes and provide a foundation for measuring the court's impact (see Element 10: Sustainability).

Ideally, the development of a mental health court should take place in the context of broader efforts to improve the response to people with mental illnesses involved with, or at risk of involvement with, law enforcement, the courts, and corrections. Such discussions should include police and sheriffs' officials, judges, prosecutors, defense counsel, court administrators, pretrial services staff, and corrections officials; mental health, substance abuse treatment, housing, and other service providers; and mental health advocates, crime victims, consumers, and family and community members.

The planning committee should identify agency leaders and policymakers to serve on an "advisory group" (in some jurisdictions members of the advisory group will also make up the planning committee), responsible for monitoring the court's adherence to its mission and its coordination with relevant activities across the criminal justice and mental health systems. The advisory group should suggest revisions to court policies and procedures when appropriate, and should be the public face of the mental health court in advocating for its support. The planning committee should address ongoing issues of policy implementation and practice that the court's operation raises. Committee members should also keep high-level policymakers, including those on the advisory group, informed of the court's successes and failures in promoting positive change and long-term sustainability (see Element 10). Additionally, by facilitating ongoing training and education opportunities, the planning committee should complement and support the small team of professionals who administer the court on a daily basis, the "court team" (see Element 8).

In many jurisdictions, the judiciary will ultimately drive the design and administration of the mental health court. Accordingly, it should be well represented on and take a visible role in leading both the planning committee and advisory group.

2 TARGET POPULATION

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

Because mental health courts are, by definition, specialized interventions that can serve only a portion of defendants with mental illness, careful attention should be paid to determining their target populations.

Mental health courts should be conceptualized as part of a comprehensive strategy to provide law enforcement, court, and corrections systems with options, other than arrest and detention, for responding to people with mental illnesses. Such options include specialized police-based responses and pretrial services programs. For those individuals who are not diverted from arrest or pretrial detention, mental health courts can provide appropriately identified defendants with court-ordered, community-based supervision and services. Mental health courts should be closely coordinated with other specialty or problem-solving court-based interventions, including drug courts and community courts, as target populations are likely to overlap.

Clinical eligibility criteria should be well defined and should be developed with an understanding of treatment capacity in the community. Mental health court personnel should explore ways to improve the accessibility of community-based care when treatment capacity is limited and should explore ways to improve quality of care when services appear ineffective (see Element 6: Treatment Supports and Services).

Mental health courts should also focus on defendants whose mental illness is related to their current offenses. To that end, the planning committee should develop a process or a mechanism, informed by mental health professionals, to enable staff charged with identifying mental health court participants to make this determination.

3

TIMELY PARTICIPANT IDENTIFICATION AND LINKAGE TO SERVICES

Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.

Providing safe and effective treatment and supervision to eligible defendants in the community, as opposed to in jail or prison, is one of the principal purposes of mental health courts. Prompt identification of participants accelerates their return to the community and decreases the burden on the criminal justice system for incarceration and treatment.

Mental health courts should identify potential participants early in the criminal justice process by welcoming referrals from an array of sources such as law enforcement officers, jail and pretrial services staff, defense counsel, judges, and family members. To ensure accurate referrals, mental health courts must advertise eligibility criteria and actively educate these potential sources. In addition to creating a broad network for identifying possible participants, mental health courts should select one or two agencies to be primary referral sources that are especially well versed in the procedures and criteria.

The prosecutor, defense counsel, and a licensed clinician should quickly review referrals for eligibility. When competency determination is necessary, it should be expedited, especially for defendants charged with misdemeanors. The time required to accept someone into the program should not exceed the length of the sentence that the defendant would have received had he or she pursued the traditional court process. Final determination of eligibility should be a team decision (see Element 8: Court Team).

The time needed to identify appropriate services, the availability of which may be beyond the court's control, may constrain efforts to identify participants rapidly (see Element 6: Treatment Supports and Services). This is likely to be an issue especially in felony cases, when the court may seek services of a particular intensity to maximize public safety. Accordingly, along with connecting mental health court participants to existing treatment, officials in criminal justice, mental health, and substance abuse treatment should work together to improve the quality and expand the quantity of available services.

4 TERMS OF PARTICIPATION

Terms of participation are clear, promote public safety, facilitate the defendant's engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.

Mental health courts need general program parameters for plea agreements, program duration, supervision conditions, and the impact of program completion. Within these parameters, the terms of participation should be individualized to each defendant and should be put in writing prior to his or her decision to enter the program. The terms of participation will likely require adherence to a treatment plan that will be developed after engagement with the mental health court program, and defendants should be made aware of the consequences of noncompliance with this plan.

Whenever plea agreements are offered to people invited to participate in a mental health court, the potential effects of a criminal conviction should be explained. Collateral consequences of a criminal conviction may include limited housing options, opportunities for employment, and accessibility to some treatment programs. It is especially important that the defendant be made aware of these consequences when the only charge he or she is facing is a misdemeanor, ordinance offense, or other nonviolent crime.

The length of mental health court participation should not extend beyond the maximum period of incarceration or probation a defendant could have received if found guilty in a more traditional court process. In addition, program duration should vary depending on a defendant's program progress. Program completion should be tied to adherence to the participant's court-ordered conditions and the strength of his or her connection to community treatment.

Least restrictive supervision conditions should be considered for all participants, especially those charged with misdemeanors. Highly restrictive conditions increase the likelihood that minor violations will occur, which can intensify the involvement of participants in the criminal justice system.

When a mental health court participant completes the terms of his or her participation in the program, there should be some positive legal outcome. When the court operates on a pre-plea model, a significant reduction or dismissal of charges can be considered. When the court operates in a post-plea model, a number of outcomes are possible such as early terminations of supervision, vacated pleas, and lifted fines and fees. Mental health court participants, when in compliance with the terms of their participation, should have the option to withdraw from the program at any point without having their prior participation and subsequent withdrawal from the mental health court reflect negatively on their criminal case.

5 INFORMED CHOICE

Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant's competency whenever they arise.

Defendants' participation in mental health courts is voluntary. But ensuring that participants' choices are informed, both before and during the program, requires more than simply offering the mental health court as an option to certain defendants.

Mental health court administrators should be confident that prospective participants are competent to participate. Typically, competency determination procedures can be lengthy, which raises challenges for timely participant identification. This is especially important for courts that focus on defendants charged with misdemeanors (see Element 3: Timely Participant Identification and Linkage to Services). For these reasons, as part of the planning process, courts should develop guidelines for the identification and expeditious resolution of competency concerns.

Even when competency is not an issue, mental health court staff must ensure that defendants fully understand the terms of participation, including the legal repercussions of not adhering to program conditions. The specific terms that apply to each defendant should be spelled out in writing. Defendants should have the opportunity to review these terms, with the advice of counsel, before opting into the court.

Defense attorneys play an integral role in helping to ensure that defendants' choices are informed throughout their involvement in the mental health court. Admittedly, the availability of defense counsel varies from one jurisdiction to another. In some communities, defendants' access to counsel depends on the crime with which they were charged or the purpose of the hearing. Recognizing these constraints, courts should strive to make defense counsel available to advise defendants about their decision to enter the court and have counsel be present at status hearings. It is particularly important to ensure the presence of counsel when there is a risk of sanctions or dismissal from the mental health court. Defense counsel participating in mental health courts—like all other criminal justice staff assigned to the court—should receive special training in mental health issues (see Element 8: Court Team).

6 TREATMENT SUPPORTS AND SERVICES

Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of—treatment and services that are evidence-based.

Mental health court participants require an array of services and supports, which can include medications, counseling, substance abuse treatment, benefits, housing, crisis interventions services, peer supports, and case management. Mental health courts should anticipate the treatment needs of their target population and work with providers to ensure that services will be made available to court participants.

When a participant is identified and linked to a service provider, the mental health court team should design a treatment plan that takes into account the results of a complete mental health and substance abuse assessment, individual consumer needs, and public safety concerns. Participants should also have input into their treatment plans.

A large proportion of mental health court participants have co-occurring substance abuse disorders. The most effective programs provide coordinated treatment for both mental illnesses and substance abuse problems. Thus, mental health courts should connect participants with co-occurring disorders to integrated treatment whenever possible and advocate for the expanded availability of integrated treatment and other evidence-based practices.[3] Mental health court teams should also pay special attention to the needs of women and ethnic minorities and make gender-sensitive and culturally competent services available.

Treatment providers should remain in regular communication with court staff concerning the appropriateness of the treatment plan and should suggest adjustments to the plan when appropriate. At the same time, court staff should check with community-based treatment providers periodically to determine the extent to which they are encountering challenges stemming from the court's supervision of the participant.

Case management is essential to connect participants to services and monitor their compliance with court conditions.[4] Case managers—whether they are employees of the court, treatment providers, or community corrections officers—should have caseloads that are sufficiently manageable to perform core functions and monitor the overall conditions of participation. They should serve as the conduits of information for the court about the status of treatment and support services.

Case managers also help participants prepare for their transition out of the court program by ensuring that needed treatment and services will remain available and accessible after their court supervision concludes. The mental health court may also provide post-program assistance, such as graduate support groups, to prevent participants' relapses.

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3. Evidence-based practices (EBPs) are mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R. E. Drake, et al., "Implementing Evidence-Based Practices in Routine Mental Health Service Settings," *Psychiatric Services* 52 (2001): 179–182. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management.
4. The term "case management" has multiple definitions. Moreover, specific interventions such as assertive community treatment (ACT) and intensive case management (ICM) are themselves case management models. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) "any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether they are social workers, nurses, or case management specialists" (see SAMHSA's Treatment Improvement Protocol [TIP] #27, "Case Management for Substance Abuse Treatment"). The definition of a particular case management approach can be derived from its functions and objectives. Case management functions include assessing, planning, linking, coordinating, monitoring, and advocating. For example, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the U.S. Department of Justice in its publication *Drug Identification and Testing in the Juvenile Justice System,* defines case management as "an individualized plan for securing, coordinating, and monitoring the appropriate treatment interventions and ancillary services necessary to treat each offender successfully for optimal justice system outcomes."

7

CONFIDENTIALITY

Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants' court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.

To identify and supervise participants, mental health courts require information about their mental illnesses and treatment plans. When sharing this information, treatment providers and representatives of the mental health court should consider the wishes of defendants. They must also adhere to federal and state laws that protect the confidentiality of medical, mental health, and substance abuse treatment records.

A well-designed procedure governing the release and exchange of information is essential to facilitating appropriate communication among members of the mental health court team and to protect confidentiality. Release forms should be part of this procedure. They should be developed in consultation with legal counsel, adhere to federal and state laws, and specify what information will be released and to whom.[5] Potential participants should be allowed to review the form with the advice of defense counsel and treatment providers. Defendants should not be asked to sign release of information forms until competency issues have been resolved (see Element 5: Informed Choice).

When a defendant is being considered for the mental health court, there should not be any public discussions about that person's mental illness, which can stigmatize the defendant. Even information concerning a defendant's referral to a mental health court should be closely guarded—particularly because many of these individuals may later choose not to participate in the mental health court. To minimize the likelihood that information about defendants' mental illnesses or their referral to the mental health court will negatively affect their criminal cases, courts whenever possible should maintain clinical documents separately from the criminal files and take other precautions to prevent medical information from becoming part of the public record.

Once a defendant is under the mental health court's supervision, steps should be taken to maintain the privacy of treatment information throughout his or her tenure in the program. Clinical information provided to mental health court staff members should be limited to whatever they need to make decisions. Furthermore, such exchanges should be conducted in closed staff meetings; discussion of clinical information in open court should be avoided.

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5. For information on complying with the Health Insurance Portability and Accountability Act (HIPAA), please visit SAMHSA's Web site at www.hipaa.samhsa.gov/hipaa.html.

8 COURT TEAM

A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.

The mental health court team works collaboratively to help participants achieve treatment goals by bringing together staff from the agencies with a direct role in the participants' entrance into, and progress through, the court program. The court team functions include conducting screenings, assessments, and enrollments of referred defendants; defining terms of participation; partnering with community providers; monitoring participant adherence to terms; preparing for all court appearances; and developing transition plans following court supervision. Team members should work together on each participant's case and contribute to the court's administration to ensure its smooth functioning.

The composition of this court team differs across jurisdictions. These variations notwithstanding, it typically should comprise the following: a judicial officer; a treatment provider or case manager; a prosecutor; a defense attorney; and, in some cases, a court supervision agent such as a probation officer. Many courts also employ a court coordinator responsible for overall administration of the court, which can help promote communication, efficiency, and sustainability. Regardless of the composition of the team, the judge's role is central to the success of the mental health court team and the mental health court generally. He or she oversees the work of the mental health court team and encourages collaboration among its members, who must work together to inform the judge about whether participants are adhering to their terms of participation.

Mental health court planners should carefully select team members who are willing to adapt to a nontraditional setting and rethink core aspects of their professional training. Planners should seek criminal justice personnel with expertise or interest in mental health issues and mental health staff with criminal justice experience. Planners should also work to ensure that the judge who will preside over the mental health court is comfortable with its goals and procedures.

Team members should take part in cross-training before the court is launched and during its operation. Mental health professionals must familiarize themselves with legal terminology and the workings of the criminal justice system, just as criminal justice personnel must learn about treatment practices and protocols. Team members should also be offered the opportunity to attend regional or national training sessions and view the operations of other mental health courts. New team members should go through a period of training and orientation before engaging fully with the court.

Periodic review and revision of court processes must be a core responsibility of the court team. Using data, participant feedback, observations of team members, and direction from the advisory group and planning committee (see Element 1), the court team should routinely make improvements to the court's operation.

9

MONITORING ADHERENCE TO COURT REQUIREMENTS

Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery.

Whether a mental health court assigns responsibility for monitoring compliance with court conditions to a criminal justice agency, a mental health agency, or a combination of these organizations, collaboration and communication are essential. The court must have up-to-date information on whether participants are taking medications, attending treatment sessions, abstaining from drugs and alcohol, and adhering to other supervision conditions. This information will come from a variety of sources and must be integrated routinely into one coherent presentation or report to keep all court staff informed of participants' progress. Case staffing meetings provide such an opportunity to share information and determine responses to individuals' positive and negative behaviors. These meetings should happen regularly and involve key members of a team, including, when appropriate, representatives from the prosecution, defense, treatment providers, court supervision agency, and the judiciary.

Status hearings allow mental health courts publicly to reward adherence to conditions of participation, to sanction nonadherence, and to ensure ongoing interaction between the participant and the court team members. These hearings should be frequent at the outset of the program and should decrease as participants progress positively.

All responses to participants' behavior, whether positive or negative, should be individualized. Incentives, sanctions, and treatment modifications have clinical implications. They should be imposed with great care and with input from mental health professionals.

Relapse is a common aspect of recovery; nonadherence to conditions of participation in the court is common. But nonadherence should never be ignored. The first response should be to review treatment plans, including medications, living situations, and other service needs. For minor violations the most appropriate response may be a modification of the treatment plan.

In some cases, sanctions are necessary. The manner in which a mental health court applies sanctions should be explained to participants prior to their admittance to the program. As a participant's commission of violations increases in frequency or severity, the court should use graduated sanctions that are individualized to maximize adherence to his or her conditions of release. Specific protocols should govern the use of jail as a consequence for serious noncompliance.

Mental health courts should use incentives to recognize good behavior and to encourage recovery through further behavior modification. Individual praise and rewards, such as coupons, certificates for completing phases of the program, and decreased frequency of court appearances, are helpful and important incentives. Systematic incentives that track the participants' progress through distinct phases of the court program are also critical. As participants complete these phases, they receive public recognition.

Courts should have at their disposal a menu of incentives that is at least as broad as the range of available sanctions; incentives for sustained adherence to court conditions, or for situations in which the participant exceeds the expectation of the court team, are particularly important.

10 SUSTAINABILITY

Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.

Mental health courts must take steps early in the planning process and throughout their existence to ensure long-term sustainability. To this end, performance measures and outcome data will be essential. Data describing the court's impact on individuals and systems should be collected and analyzed. Such data should include the court's *outputs,* such as number of defendants screened and accepted into the mental health court, as well as its *outcomes,* such as the number of participants who are rearrested and reincarcerated. Setting output and outcome measures are a key function of the court's planning and ongoing administration (see Element 1).[6] Quantitative data should be complemented with qualitative evaluations of the program from staff and participants.

Formalizing court policies and procedures is also an important component of maintaining mental health court operations. Compiling information about a court's history, goals, eligibility criteria, information-sharing protocols, referral and screening procedures, treatment resources, sanctions and incentives, and other program components helps ensure consistency and lessens the impact when key team members depart. Developing additional plans for staff turnover helps safeguard the integrity of the court's operation.

Because sustaining a mental health court without funding is difficult, court planners should identify and cultivate long-term funding sources early on. Court staff should base requests for long-term funding on clear articulations of what the court plans to accomplish. Along with compiling empirical evidence of program successes, mental health court teams should invite key county officials, state legislators, foundation program officers, and other policymakers to witness the court in action.

Outreach to the community, the media, and key criminal justice and mental health officials also promotes sustainability. To that end, mental health court teams should make community members aware of the existence and impact of the mental health court and the progress it has made. More important, administrators should be prepared to respond to notable program failures, such as when a participant commits a serious crime. Ongoing guidance from, and reporting to, key criminal justice and mental health leaders also helps to maintain interest in, and support for, the mental health court.

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6. The next edition of this document will include benchmarks that will help courts determine whether this is taking place in their jurisdictions. For guidance on collecting outcome data, please see Henry J. Steadman, *A Guide to Collecting Mental Health Court Outcome Data,* May 2005, published by the CSG Justice Center and available at www.consensusproject.org/mhcourts/MHC-Outcome-Data.pdf.

Conclusion

In courtrooms across the country, judges, prosecutors, and defense attorneys are seeing increasing numbers of defendants who have serious untreated mental illnesses charged with committing low-level crimes. Traditional court processes do little to improve outcomes for many of these people. They cycle again and again through jail, courtrooms, and our city streets.

As an alternative to the status quo, court officials, working in partnership with leaders in the mental health system and local and state policymakers, have designed problem-solving mental health courts. These courts depart from the traditional model used in most criminal proceedings. Instead, as a team and under the judge's guidance, prosecutors, defense attorneys, and mental health service providers connect eligible defendants with community-based mental health treatment and, in lieu of incarceration, assign them to community-based supervision.

The number of mental health courts in the United States has grown significantly. These programs share much in common from one county to another. There are also aspects of each mental health court's design and operation that are unique, as variation is the hallmark of this country's criminal justice system, and one of its strengths. At the same time, experts in criminal justice and mental health practice agree that there are essential elements to mental health courts, which enable them to span both the criminal justice and mental health systems effectively and to ensure that the rights of participants and community members are respected. This publication describes and explains these essential elements of a mental health court.

To design and implement a mental health court with attention to each of these elements is a challenge for those just starting a conversation about a possible mental health court, as well as for those who have operated a mental health court for years. Yet seasoned and new mental health court teams alike have demonstrated a willingness to address such complicated challenges. The essential elements described in this document are written for them and others following in their footsteps, all of whom work tirelessly to make communities healthier and safer, promote the efficient use of public resources and tax dollars, and improve outcomes for people with mental illnesses who are involved in the criminal justice system.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The Criminal Justice/Mental Health Consensus Project is an unprecedented national effort coordinated by the CSG Justice Center to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

Council of State Governments
Justice Center

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Austin, TX 78701
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fax: 512-474-5011

www.justicecenter.csg.org

Attachment #1

Offender ReEntry
APPD Contacts

Region	# DRC # CCC # MHC	MH Services Contract/ In-House	Project Contact Date	Regional Admnstrtor	Phone Number	Contact Name	
R1 Rural		N/N	07/18/08	Larry Chatterton lchatter@utah.gov	Office: (435) 713-6241 Mobile: (435) 770-9909	Same	
R2 Urban Rural	1 DRC 1 CCC	Y/Y	07/23/08	Sally Powell spowell@utah.gov	Office: (801) 626-3701 Mobile: (801) 633-9415	Heidi Wilcox, sup Steve Yeates, CA	
" "	1 DRC	N/Y	07/23/08	" "	" "	Kimberly Holden, sup Karl Kennington, CA 801-451-4701	
R3 Urban	2 DRC 3 CCC 1 MHC	Y/Y Y/Y	07/22/08	Micheal Mayer mmayer@utah.gov	Office: (801) 239-2121 Mobile: (801) 330-8969	Craig Greenberg, sup Brett Varoz, sup Larry Hines, CA Rolina McQuiston, CA Leslie Miller, CA	
R 4 Urban Rural	1 DRC 1 DU	N/Y N/Y	07/23/08	Larry Evans levans@utah.gov	Office: (801) 374-7651 Mobile: (801) 592-7365	Martene Mackie, sup Annabelle Brough, sup	
R 5 Rural		N/N	07/22/08	Stuart McIver smciver@utah.gov	Office: (435) 636-2801 Mobile: (435) 650-4151	Same	
R 6 Rural		N/N	07/18/08	Richard Laursen rlaursen@utah.gov	Office: (435) 867-7616 Mobile: (435) 590-9771	Same	
IPO Prison		N/N	07/16/08	DD Geri Miller gmiller@utah.gov	801-576-8261 Office: (801) 545-5608 Mobile: (801) 633-9373	Wendy Horlacher, CA	

CA – Correctional Administrator or Asst Regional Administrator
CCC – Community Correctional Center
DD – Deputy Division Director
DRC – Day Reporting Center
DU – Diagnostic Unit
IPO – Institutional Parole Office
MHC – Mental Health Court
Sup – Supervisor

BONNEVILLE COMMUNITY CORRECTIONAL CENTER
1141 South 2475 West
Salt Lake City, UT 84104
(801) 977-5440, 977-5443, 977-5444

FREMONT COMMUNITY CORRECTIONAL CENTER
2588 West 2365 South
West Valley City, UT 84119
(801) 978-4500

NORTHERN UTAH COMMUNITY CORRECTIONAL CENTER
2445 South Water Tower Way
Ogden, UT 84401-1264
(801)

ORANGE STREET COMMUNITY CORRECTIONAL CENTER
#80 South Orange Street (1900 West)
Salt Lake City, UT 84116
(801) 801-977-6300
FAX 801-363-8317

DAY REPORTING CENTER - Farmington
883 W 100 N (Clark Lane), 2nd Floor
Farmington, UT 84025
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or 239-2294
fax 239-2114

DAY REPORTING CENTER - Ogden
2445 South Water Tower Way
Ogden, UT 84401-1264
(801)

DAY REPORTING CENTER - Provo
150 E Center St, L100
P.O. Box 239
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(801) 374-7633

DAY REPORTING CENTER - Salt Lake
36 West 1100 South
Salt Lake City, UT 84101
(801) 239-2199
or 239-2294
fax 239-2114

WOMENS' TREATMENT RESOURCE CENTER
#80 South Orange Street (1900 West)
Salt Lake City, UT 84116
(801) 596-6300
Fax 363-8317

Attachment #2

Utah Department of Corrections
Division of Programming - Statewide
Division of Institutional Operation - Prison Facilities
Adult Probation and Parole Regions – By Counties

Programming – Director Craig Burr

Substance Abuse, DORA, Therapeutic Communities	Deputy Director Nori Huntsman
Sex Offenders, Education, Life Skills, Women's Issues	Deputy Director Dale Wright

Prison Facilities – Director Lowell Clark

Draper	Utah State Prison Warden Steve Turley
Gunnison	Central Utah Correctional Facility Warden Alfred Bigelow

Adult Probation and Parole Regions – Director Brent Butcher

Region 1	Box Elder, Cache, and Rich Counties Regional Administrator Larry Chatterton
Region 2	Davis, Morgan, Tooele, and Weber Counties Regional Administrator Sally Powell
Region 3	Salt Lake and Summit Counties Regional Administrator Micheal J. Mayer, Jr.
Region 4	Juab, Millard, Utah, and Wasatch Counties Regional Administrator Larry Evans
Region 5	Beaver, Iron, and Washington Counties Regional Administrator Stuart McIver
Region 6	Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Kane, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne Counties Regional Administrator Richard Laursen

Institutional Parole	Statewide – Deputy Director Geri Miller

Attachment #3

ADULT PROBATION & PAROLE
O.D. PHONE NUMBERS FOR REGION

REGION 1

BRIGHAM CTY	888-332-0005
LOGAN	435-713-7201

Box Elder, Cache, and Rich Counties

REGION 2

FARMINGTON	801-329-2103
TOOELE	435-241-0031
NUCCC	801-522-1122
OGDEN	801-543-0915

Davis, Morgan, Tooele, and Weber Counties

REGION 3

SALT LAKE	801-386-6121
PARK CITY	
CCCS	801-978-4500

Salt Lake and Summit Counties

REGION 4

PROVO	801-371-9517

Juab, Millard, Utah, and Wasatch Counties

REGION 5

CEDAR CTY	888-332-0819
HURRICANE	888-332-1257
BEAVER	888-332-0819

Beaver, Iron, and Washington Counties

REGION 6

PRICE VERNAL ROOSEVELT MOAB	435-637-0890 (dispatch)
CARBON, EMERY, GRAND, SAN JUAN	(435) 637-0890 (dispatch)
SEVIER, SANPETE, PIUTE WAYNE, GARFIELD KANE	(435) 896-6471 (dispatch)
UINTAH, DUCHESNE, DAGGETT	(435) 789-4222 (dispatch)

Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Kane, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne Counties

Attachment #4

RE-ENTRY PROGRAMS

Re-Entry of Mentally Ill Offender (MIO) From Prison To Parole In Urban And Rural Communities

CONCEPT Seamless mental health service delivery transition from institution to community

BENEFITS Reduction in recidivism, population, stability and access to services by mentally ill offender, increased collaboration

IMPLEMENTATION PLAN:

Plan A

Cooperate/collaborate/facilitate non-UDC field service connections

RESOURCE /CONTACT INFORMATION
Plan A:
Regional list (Attachments #1 and 2)

Plan B

Clinical Services provides mental health services to Fremont Community Correctional Center (FCCC); 18 beds, 60 beds total capacity.

FCCC - mentally ill offender supervision agent collaboration with community mental health in Salt Lake

Potential expansion of FCCC mentally ill offenders by 6-8 beds

RESOURCE /CONTACT INFORMATION

Plan B:

Gary Blair	Clinical Services
Larry Hines	Director, Fremont Community Correctional Center
Mark Holding	Supervisor, Fremont Community Correctional Center
Jerry Collins	Mentally Ill Offender agent
Lance Edwards	Mentally Ill Offender agent

Plan C

Clinical Orange Street Community Correctional Center – Region III mentally ill offenders agents 1-6 beds (combined beds with sex offender contract); 60 bed total capacity

OSCCC - mentally ill offender supervision agent collaboration with community mental health in Salt Lake

Potential expansion of OCCC mentally ill offenders by 5 beds.

RESOURCE /CONTACT INFORMATION

Plan C

Gary Blair	Clinical Services
Leslie Miller	Director, Orange Street Community Correctional Center
Holly Simmons	Supervisor, Orange Street Community Correctional Center
Alyssa Davenport	Shift Leader, Orange Street Community Correctional Center
Lance Edwards	Mentally Ill Offender agent
Jerry Collins	Mentally Ill Offender agent

** Combined cost estimate for treatment increase for the FCCC & OSCCC expansion proposal is $92,000. Estimate provided by UDC Clinical Services. Budget not available through UDC.

Plan D

Mental Health treatment track at Provo DRC would require $98,735 to cover salary and benefits for a licensed clinical therapist to provide initial services and coordinate hand off to community. Budget not available through UDC.

RESOURCE /CONTACT INFORMATION

Plan D:

Martene Mackie	Supervisor, Provo Day Reporting Center

Plan E

Mental Health treatment track at Farmington DRC would require $98,735 to cover salary and benefits for a licensed clinical therapist to provide initial services and coordinate hand off to community. Budget not available through UDC.

RESOURCE /CONTACT INFORMATION

Plan E:

Karl Kennington	Correctional Administrator, Farmington Day Reporting Center
Kimberly Holden	Supervisor, Farmington Day Reporting Center