The Clark County Mentally Ill Re-arrest Prevention (MIRAP) Program

Final Evaluation Report

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Executive Summary

MIRAP Program Description

Since April 2000, the Clark County Mental Health Court (MHC) has worked to improve outcomes for people with mental illnesses caught up in the criminal justice system. In October 2001, the Clark County Department of Community Services and Corrections was awarded a Targeted Capacity Expansion Grant from the Center for Mental Health Services (CMHS) to improve the MHC's capacity to provide mental health services. The Mentally Ill Re-arrest Prevention Program (MIRAP), as the TCE was called, enhanced services by increasing the number of MHC coordinators from two to three, increasing the MHC judges from one to two and, contracting with two local mental health providers to provide intensive case management to MHC clients.

MIRAP goals were: 1) to reduce the number of mentally ill people arrested, 2) to improve the quality of life for mentally ill offenders by addressing their basic needs and providing the support and supervision they need to stabilize their lives, 3) to reduce service barriers between mental health, community-based agencies, the courts, law enforcement, and corrections.

Monthly Oversight Committee meetings were held to enhance collaboration and service coordination among stakeholders and ensure MIRAP program goals were met. The Regional Research Institute at Portland State University conducted a comprehensive evaluation of the MIRAP program and this report provides the evaluation findings.

MIRAP Evaluation Methodology

A comprehensive evaluation of the Clark County Mental Health Court was conducted by the Regional Research Institute (RRI) at Portland State University. The evaluation design for the Clark County Mental Health Court involved a mix of qualitative and quantitative methods to describe and evaluate the operation of the MHC and to assess its impact on clients. The 5 main components were: 1) secondary analysis of mental health service and jail data containing information on MHC clients; 2) participant observation of the Mental Health Court process; 3) MHC consumer interviews; 4) stakeholder interviews and 5) monthly review of the MHC assessment, jail triage and enrollment process.

Major Findings

Secondary Analysis of Jail Data. The MHC demonstrated success in both reducing the number of MHC clients who re-offended, the number of crimes committed and number of probation violations post-enrollment in MHC compared to pre-MHC.

- Most MIRAP clients 71% (85 individuals) had no criminal justice contact in the six months post-enrollment in MHC.

- The overall crime rate of mental health court participants was reduced 3.8 times six months after enrollment in MHC as compared to the six months prior to MHC. In the six months prior to enrollment, the 119 MHC participants were booked 288 times for new charges. Six months post enrollment in mental health court, only 34 individuals (29%) were rearrested on new crimes and booked a total of 76 times. Most clients (89%, n = 116) had reduced number of bookings after enrollment in MHC.
- There was a 56% reduction in probation violations pre-MHC compared to post-MHC. Pre-MHC, 54 clients committed 110 probation violations. In the six months post-enrollment, 32 individuals committed 62 probation violations.
- MHC appears to help break the cycle of the "repeat offender." Twenty-two percent (22%) of program participants had 4 or more arrests in the six months pre-enrollment in MHC. After enrollment in MHC, only 5% of program participants were arrested 4 or more times.

Consumer Interviews. Fifty-seven of the 119 consumers served by the MIRAP program consented to participation in the consumer interview. The MIRAP program met clients' needs by providing them with the MH and physical health services that they most needed. Clients reported positive experiences with MHC. Clients felt the relationships and supports they received from the judge, court coordinators, and mental health providers were instrumental in successfully completing MHC program requirements. Consumers reported that the concrete services as well as the emotional support of MHC staff were key to helping them get off the streets, stop committing crime, and better their lifestyles. Consumers reported an increased quality of life including, enhanced social relations and living situation; improved self-esteem; increased ability to manage their mental illness (staying on medications and following through with treatment plans); and decreased involvement with the legal system.

Stakeholder Interviews. The MIRAP Oversight Committee represented stakeholders from the Clark County Mental Health Court, Clark County Jail, Clark County Prosecutor's Office, two local mental health agencies, a consumer advocacy group, and the Vancouver City Housing Authority. All members of the Oversight Committee (n=14) were interviewed by the RRI evaluation team. Stakeholders appreciated the increased inter-agency collaboration brought about by the MIRAP project, but admitted the group could still improve collaboration in some areas. Stakeholders plan to continue to meet occasionally as an Oversight Committee after the MIRAP grant ends but acknowledge the Committee does not have the authority to enforce policy recommendations. All stakeholders would like to see the MHC continue in the future and most suggested that MIRAP had met the goals it had initially intended to reach.

Court Observations. The RRI evaluation staff attended the MHC on 12 occasions and recorded observations of MHC operations. Overall, MHC procedures ran smoothly, providing a pleasant environment that helped clients feel comfortable and provided them the support they needed. MHC proceedings, on the other hand, were occasionally delayed or cancelled due to other commitments the judge had with other court proceedings. Client graduation ceremonies appeared to encourage other non-graduating clients to work

towards completion of the program. Court coordinators and mental health professionals were available to assist clients through court proceedings. Friendly interactions between judge and client appeared, for the most part, to keep clients at ease through the process.

Conclusions

Overall the Clark County MHC has demonstrated success in reducing re-arrest and probation violations of MHC clients. Consumers reported positive outcomes from participation in MHC, which included increased quality of life, increased self-reliance and ability to manage their own lives, increased stability and self-awareness. The MHC provided clients with a network of caring professionals that assisted and encouraged clients to make positive life changes.

At the programmatic level, the MIRAP project was successful in improving service coordination among key stakeholders. Improved coordination added to the success of the MHC operation. The Oversight Committee meetings provided a valuable forum for stakeholders to voice their concerns and to make recommended changes and improve the MHC process.

Overall, the results from this comprehensive evaluation of the Clark County MHC suggest that the Clark County community benefits greatly from the MHC program in several ways. The MHC reduces the burden on the criminal justice system of repeatedly booking the same clients over and over again. It helps break down the “revolving door syndrome” by providing clients with a valuable support structure that adds stability and redirects clients to better meet their treatment plan goals. MHC consumers report improvements in their quality of life. Stakeholders report that MHC improves public safety and should certainly be continued in the future and perhaps be expanded.

Recommendations

Client Recommendations for Improving MHC: In personal interviews, MHC clients made the following recommendations for changing or improving MHC:

- Better integration of mental health and substance abuse issues in treatment and in the Mental Health Court
- Some MHC clients perceived the court process as “too chaotic.” These clients suggested reducing the waiting time in court before appearing before the judge and increasing privacy when discussing matters with the judge as ways to improve their experiences.
- Increase communication between court coordinator, judge, case manager, and client
- More help with transportation

Stakeholders’ Recommended Improvements to MHC included:

- Many stakeholders felt that eligibility should be expanded to include felons.
- Better service coordination/unified message to the clients. Many stakeholders stated that there could be improvements in the service coordination efforts and

communication between the court coordinators, mental health providers, the judge and client. To address this issue, the MHC implemented a MHC Legal Contract that addresses client specific legal concerns and treatment plan goals so that all MHC professionals are aware of client needs. In addition the client signs this contract committing to working on the issues outlined. The MHC Legal Contract was implemented in July 2003.

- Improve documentation describing the MHC program requirements: A document is needed, like a brochure or manual that describes eligibility criteria, graduation requirements, time it takes to complete the program, and program expectations. In response to this issue, Judge Fritzler informed the Oversight Committee in May 2003 that he is compiling a MHC manual for Clark County.
- Both judges reported that they could benefit from more mental health training.

Recommendations from the Evaluation team based on MHC observation and attending the MHC Oversight Committee Meetings:

- Graduates or successfully enrolled MHC participants could be invited to continue their involvement in MHC by acting as peer mentors to newly enrolled clients. Peer mentors could help engage clients in services and provide added supports that may lower the post-enrollment opt-out rate and help clients complete the program.
- To ensure that MHC starts on time and to reduce the time clients have to wait to be seen before the judge, dedicate a judges' schedule to Mental Health Court on a given day.

Introduction

MIRAP Targeted Capacity Expansion Grant Program Description and Program Goals

The Mental Health Court (MHC) in Clark County was established in April 2000 by the District Court, in collaboration with the Department of Community Services and Corrections and other key system players to improve outcomes for mentally ill people who are caught up in the criminal justice process. In September 2001, the Clark County Department of Community Services and Corrections was awarded a Targeted Capacity Expansion Grant from the Center for Mental Health Services (CMHS) to build its capacity to provide mental health services to mental health consumers in the criminal justice system. The CMHS Targeted Capacity Expansion Grant, entitled the Mentally Ill Re-arrest Prevention Program (MIRAP) enhanced services by increasing mental health court coordination staff, increasing the number of mental health court judges from one to two, and contracting with two local mental health service providers to provide intensive case management to consumers. Mental health court clients were referred to Columbia River Mental Health to receive Intensive Case Management (ICM) Services and to Mental Health Northwest (formerly Peace Health) to receive the Program for Assertive Community Treatment (PACT).

History of the Clark County Mental Health Court. After eleven years as a trial lawyer and fifteen years as a judge, Clark County Judge, Randal B. Fritzler, identified a disturbing trend in the local legal climate. He recognized that many individuals with severe and persistent mental illness and substance abuse issues were continually cycling through the local criminal justice systems (Fritzler, 2001). National estimates of individuals in the criminal justice system with severe mental illness and substance abuse disorders are as high as 60% (Ditton, 1999). In 1998, it was estimated that 13 to 17% of Clark County's jail population had a serious mental illness and there was growing concern that this number was increasing rapidly as a result of de-institutionalization, limited affordable housing and rapid population growth (Fritzler, 2001). Judge Fritzler recognized that individuals with mental illness typically clog the jails and criminal justice system by repeated criminal justice contacts for minor offenses and repeated probation violations. Additional jail resources are spent for medications and medical care. Often jails are ill equipped to handle the clinical needs of the mentally ill, leading to rapid decompensation of individuals and perpetuating the cycle of re-arrest. Judge Fritzler saw no attempt by the conventional criminal courts to get to the root of the problem.

In 1999, Clark County formed an interdisciplinary team of stakeholders (consumer advocates, substance abuse treatment experts, mental health care providers, managed care experts, county officials, community service organizations, prosecutors, defense attorneys and the judiciary) to discuss alternatives to better address the needs of mentally ill offenders. After reviewing other Mental Health Courts in Broward and King Counties, Clark County decided to adopt a MHC model that relied "upon a carefully developed support structure and dedicated team to educate the judge and create therapeutic

outcomes." This MHC model differed from conventional court in three key ways (Fritzler, p. 4, 2001).

- *First, the cases are heard on a separate calendar and are all handled by the same core team of professionals.*
- *Second, there is an increased emphasis on linking the criminal justice system and the mental health treatment system.*
- *Third, the participants in this program receive increased court supervision.*

By January of 2000 the Clark County stakeholder group had developed the District Mental Health Court (misdemeanants only) based on the concepts of therapeutic jurisprudence, dynamic risk management and long term follow-along supports. Therapeutic jurisprudence investigates the law's impact on the emotional lives of participants in the legal system by encouraging sensitivity to therapeutic consequences that may result from the legal rules, procedures, and the roles of legal actors (Casey & Rottman, 1998; Wexler, 1999; Hora, Schma, & Rosenthal, 1999). Dynamic risk assessment promotes the building of community service relationships with clients and to provide the needed follow-through to stabilize clients in the community and stop the revolving door. Key to this approach is a system of proactively scheduled court reviews and non-adversarial interactive hearings. MHC clients are evaluated at least monthly and assessed to determine the proper level of support and court intervention. To achieve positive outcomes, the court also serves as a clearinghouse for resources and attempts to coordinate services available for the MHC client. One of the immediate goals of the Clark County Mental Health Court was to reduce the number of individuals with mental illness in the criminal system and the jails and provide the necessary community services to sustain MHC clients in the community.

The Clark County MHC was initially offered on a pre-plea basis (clients could enroll in Mental Health Court in lieu of sentencing) the program is now offered post-plea (clients must plead guilty to their charges which are expunged upon graduation from the Mental Health Court). The impact of pre-plea versus post-plea policy on whether or not mentally ill offenders choose to enroll in MHC is unknown. MHC participation is voluntary, future research is needed to know what the impact of a pre-plea versus post-plea policy is on an offender's decision to participate in MHC.

In its current form, the Clark County Mental Health Court shares a number of common attributes with other MHC's around the country as sited by Goldkamp & Iron-Gyunn (2000) including: a) MHC is voluntary; b) the defendant must consent to participation; c) the defendant is better served by mental health services in the community than jail time; d) screening and referral of defendants is completed usually within the first 24 hours after arrest to expedite the release from jail and link to appropriate treatment; e) MHC is seen as a problem solving court operating under the philosophy of therapeutic jurisprudence; f) cases are under judicial supervision of structured community-based mental health treatment; g) all MHC cases are handled on a single court docket and clients appear at regularly scheduled hearings to monitor treatment progress and compliance. The detailed description of the specific operational procedures of the Clark County MHC has been

described by Judge Randal Fritzler, the presiding Judge over the MHC in Vancouver Washington (in Moore, J.M. 2003).

Steadman and colleagues (2001) caution that that the commonalities among mental health courts across the nation have stemmed mostly from “mirror-imaging” of the existing mental health courts rather than the adoption of common conceptual underpinnings; and that the commonalities are as numerous as the differences. They state that existing mental health courts are largely idiosyncratic and have not yet established a common set of operation criteria nor a structured model. To address this issue, presiding judges of mental health courts such as Judge Ginger Lerner- Wren of Broward County and Judge Fritzler of Clark County and others are working to outline the specific goals of Mental Health Courts and detail their unique and innovative features (Lerner-Wren, 2003; Fritzler, 2003).

The Mentally Ill Re-arrest Prevention (MIRAP) Program. In September 2001, the Clark County Department of Community Services and Corrections was awarded a Targeted Capacity Expansion Grant from the Center for Mental Health Services (CMHS) to build its capacity to provide mental health services to mental health consumers in the criminal justice system. The grant was entitled the Mentally Ill Re-arrest Prevention Program (MIRAP). The overall goals of the MIRAP project were 1) to reduce the number of mentally ill people arrested, 2) improve the quality of life for mentally ill people who are arrested by addressing their basic needs and providing the support and supervision they need to stabilize their lives, 3) reduce service barriers between mental health, community-based agencies, the courts, law enforcement, and corrections to enhance the ongoing operation of services developed through MIRAP.

A number of quality assurance and feedback processes were established as part of the MIRAP project to ensure that program goals were met. Monthly Planning and Oversight meetings were held among stakeholder to ensure that community partners’ interests were brought to the table and addressed by the MIRAP program. Systems linkages were enhanced by these problem-solving meetings. New policies to improve the MHC operation, systems level coordination, and strategies to secure adequate financial support for sustainability were among the main agenda items.

In addition, the Regional Research Institute at Portland State University conducted a comprehensive evaluation of the MIRAP project. The evaluation team from PSU utilized continuous quality assurance techniques and continuous feedback to provide the Planning and Oversight Committee with the most up to date information on program performance. The evaluation team produced MIRAP monthly reports focusing on various components of the program, made recommendations to improve client outcomes, and documented the MIRAP program’s progress in meeting program goals.

This final evaluation report details the MIRAP project outcomes and results. This report focuses on data for the MIRAP Program from April 2002 through July 2003. During 17 months of operation, the MIRAP program enrolled and served 119 consumers. The major findings presented in this report are organized into 7 Sections. Section 1 discusses the demographic and clinical characteristics of clients served by MIRAP. Section 2

provides assessment and enrolment information. Section 3 discusses the linkage into mental health services and mental health service utilization. Section 4 provides data available on re-arrest rates and criminal justice activity. Section 5 provides a description of the MHC process. Section 6 summarizes consumer interview results. Finally, Section 7 discusses stakeholder interviews, followed by the conclusions and recommendations to Clark County for continued success in the operation of the Mental Health Court.

Overview of Evaluation Methodology

In the original TCE grant proposal, the following three evaluation goals were outlined: 1) Conduct a comprehensive process evaluation of the planning and implementation process; 2) Assess PACT fidelity over three years; 3) Evaluate PACT client outcomes over time and as compared to clients enrolled in alternative case managed services. However, over the course of the study, the evaluation goals and methodology was expanded and modified to better serve the evaluation needs of the program. Due to the limited capacity of the established PACT program (capacity to serve 40 clients total), only 6 MIRAP clients were enrolled and served by the PACT program during the grant year. The limited use of the PACT program made the need to assess program fidelity and compare client outcomes between ICM and PACT impractical. A review of the MHC literature and feedback from Hank Steadman and Patty Griffin during a site visit early in the first year of the program helped redefine the evaluation goals. The two outstanding questions regarding the effectiveness of MHC are: 1) does MHC help facilitate linkage to MH services and 2) do clients enrolled in MHC have reduced criminal justice contacts or re-arrests. This evaluation focused on these two primary questions as well as a comprehensive process evaluation. It has been argued by McGaha and colleagues (2002) that because there are yet no established guidelines for determining which clients are appropriate for mental health court, what services are needed and how the court interfaces with the mental health system, it is important to include a process component to any evaluation of MHCs. The revised evaluation design for the Clark County Mental Health Court involved a mix of qualitative and quantitative methods to describe and evaluate the operation of the court and to assess its impact on clients. The 5 main components were: 1) secondary analysis of mental health service and jail data containing information on MHC clients; 2) participant observation of the Mental Health Court process; 3) MHC consumer interviews; 4) stakeholder interviews and 5) monthly review of the mental health court assessment, jail triage and enrollment process.

Variables, Data Sources and Data Collection Methods

1) Secondary Analysis of Mental Health and Jail Data for MIRAP Clients.

Two outstanding questions regarding the effectiveness of Mental Health Courts are: 1) Does the Mental Health Court successfully link clients to mental health services? and 2) does MHC reduce re-arrest rates? To address these questions the evaluation team used secondary analysis of mental health and jail administrative data for MIRAP clients as described below.

Mental Health Service Utilization. Administrative level data was collected from the Clark County Department of Community Services for all Mental Health Court clients. Variables included: DSM-IV diagnosis, priority code, drug and alcohol assessment information, and mental health service utilization. The Regional Services Network (RSN) data set captures all mental health services delivered by agencies within Clark County and even includes services paid for by Clark County but utilized outside the county- such as hospitalization of intensive services delivered in Portland Oregon, the neighboring city across the Columbia River.

Service utilization data was tracked by the RSN though daily activity logs in which service providers recorded the type of service activity, minutes (in 15-minute increments), and location of services provided for all clients and all services each work day. The type of activities tracked included: assessment, case management, medication management, crisis related services, intake, employment, other outpatient services, inpatient services and day step-down diversion from the hospital.

RSN data was acquired for all Mental Health Court clients for 2 years prior to enrollment in mental health court. The original evaluation plan was to look at mental health service utilization 18 months pre- enrollment in MHC compared to 18 months post-enrollment in MHC. Unfortunately, because the third year of this grant was cut, the ability to track client outcomes in the follow-up period is limited to only approximately 6 months post-enrollment in MHC on average.

Demographic and enrollment data. Demographic information on all MHC clients served (e.g. age, race/ethnicity, gender, marital status, highest education) was extracted from enrollment records. These data were used to describe the number of clients served by age race gender and disability categories. Data also included diagnosis-all 5 axes of the DSM; level of functioning measured by GAF scores; living situation at intake, dual diagnosis status, and referral source.

Arrest Data. Arrest data were provided by the Clark County Department of Community Corrections. The Corrections Management Information System (MIS) tracks all charges brought against an offender on the date that he/she is booked, the court case number, and the status of the offense. From these data, the number of arrests, the type of crime, class (felony versus misdemeanor), parole and probation variables were created.

2) Participant Observation of the Mental Health Court Process.
Evaluation staff from the RRI attended Mental Health Court on a regular basis to describe the MHC operation. The focus of the observations were to record how the court process affected clients, the relationship between the clients and judges, lawyers, court coordinators, and case managers. The role of the MHC staff was assessed to describe how MHC functions. The MHC observations also provided information on the strategies the court used to influence clients to change behaviors and the use of sanctions. Observations of the Mental Health Court were valuable in helping to interpret information provided by consumers through personal interviews about their experience with the court. Twelve MHC sessions were observed in all and are reported here.

3) MHC Consumer Interviews.

The evaluation team from the RRI conducted personal interviews with MHC clients at baseline and 6 months. Because the third year of the grant was cut, we were not able to finish the full compliment of 6 month interviews or to collect 12 month follow-up data as planned. Interview measures assessed consumer quality of life, consumer perspectives on the operation of MHC and the impact in their lives, consumer satisfaction with mental health services received, consumer choice and level of symptomatology. Interview questions were both quantitative and qualitative in nature to give a more complete picture of consumer experiences. Several standardized measures were also used. To measure quality of life, we used portions of the Lehman's Quality of Life Scale (1993). To measure consumer choice, we used the Consumer Choice Questionnaire, developed by the RRI (Paulson, Post, Herinckx, 2003) and modified for this project. Finally, for level of symtomatology, we used the Brief Symptoms Inventory (BSI, Derogatis, 1974). During the interview, the interviewer read questions aloud to the interviewee and recorded client responses. The length of most interviews varied from one to two hours long.

From April of 2002 to July of 2003, the evaluation team interviewed 57 MHC clients. Members of the evaluation team contacted clients via phone or before/after MHC proceedings to invite MHC participants to participate in the evaluation interview. Interviews were scheduled with consenting MHC clients at a time and location based on a client's preference. Most interviews were conducted in the MHC office, inside a client's home, or somewhere in the community (i.e., in a restaurant, coffee shop, or mental health agency).

4) Stakeholder Interviews.

The evaluation team from the RRI conducted personal interviews with all 14 members of the Planning and Oversight Committee. The goal of the interviews were to assess stakeholder perceptions of the purpose of MHC, the role of the Oversight Committee and its ability to make decisions that improved the function of the MIRAP program, how MHC benefited each stakeholder's agency or organization, whether they felt MHC is serving the appropriate target population, and sustainability of MHC in the future.

5) Monthly Review of the Mental Health Court Assessment, Jail Triage and Enrolment Process.

Each month, the evaluation team generated a report for the Oversight Committee detailing the MHC jail triage and enrolment process. Data reported included the number of individuals arrested each month who were screened for eligibility by MHC coordinators, the source of referrals into MHC, the number of MHC assessments conducted, the outcomes of the assessments, and the number of clients enrolled per month. These data were recorded by court coordinators as part of the jail triage and assessment process in referral and assessment logs for the evaluation team.

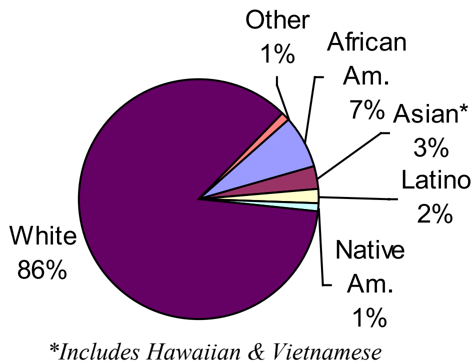
*Analytical techniques***.** Paired t-tests, chi-square and other descriptive statistics are provided to illustrate differences within client pre-enrolment in MHC and post-MHC. Due to the abbreviated follow-up period, multivariate analyses were not conducted.

Major Findings and Outcomes

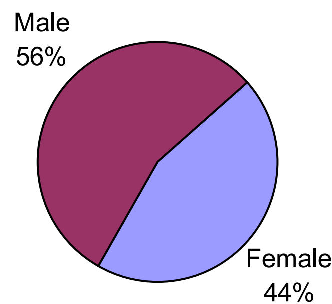
Section 1: MIRAP Client Demographics and Clinical Characteristics

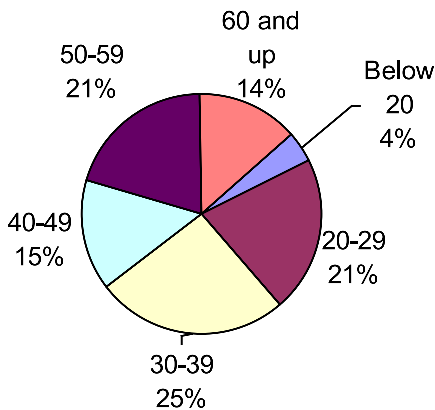
The target population served by the MIRAP program was severely and persistently mentally ill people arrested in Clark County on misdemeanors or felonies that were reduced to misdemeanors. All individuals enrolled had received mental health services from Clark County's Regional Services Network (RSN) and met a diagnostic criteria of Axis I major mental illness (bipolar disorders, major depression, schizophrenia, and other disorders generally with psychotic features). The MIRAP program began recruiting clients in April 2002 and through July 2003 had enrolled and served 119 clients. Figures 1-4 provide demographic information for all 119 MIRAP clients. Most clients (81%) served by the MIRAP program were Caucasian, a little over half of clients were male (56%) and the average age was 35.4.

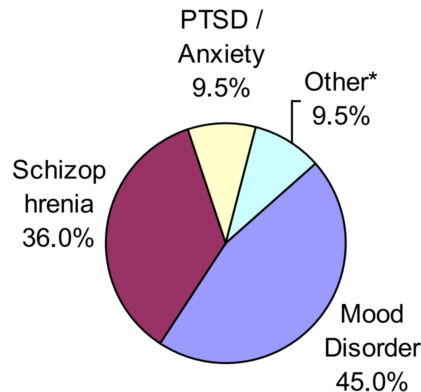
Figures 1-4: Demographics of MIRAP Program Participants



**Includes Hawaiian & Vietnamese*





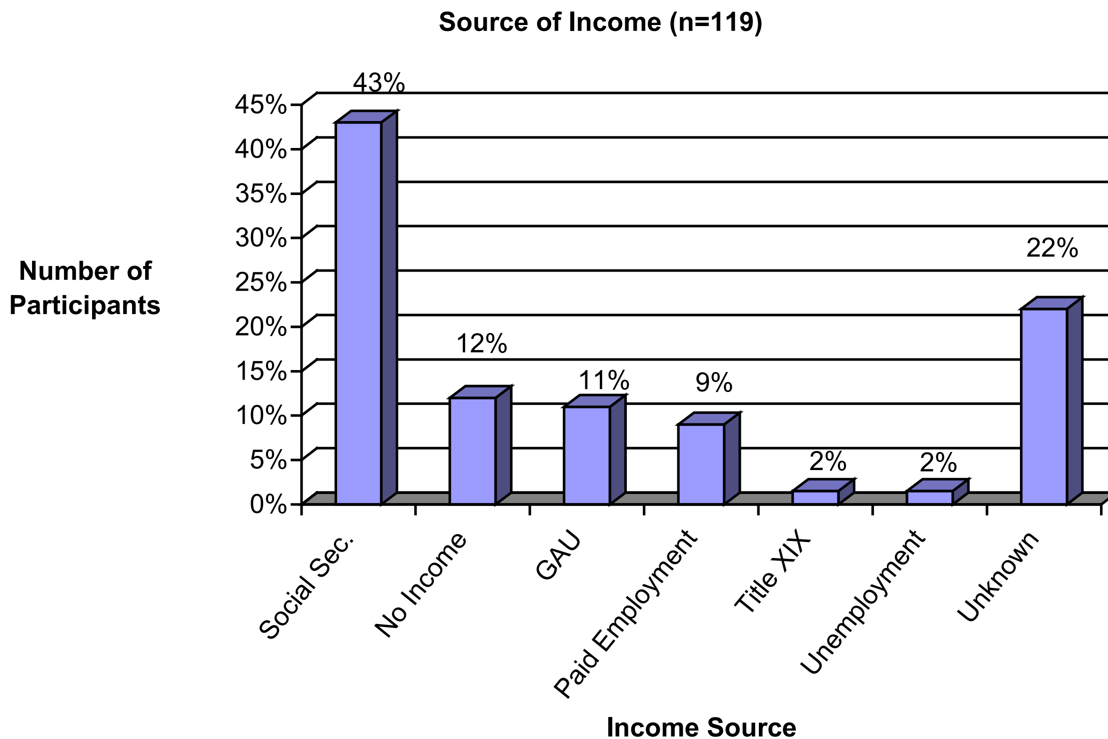


**Other includes: Attention Deficit Disorder, Disruptive Behavior disorder/Impulse Control Disorder, Dual Diagnosis and Unknown*

Diagnosis. Most clients served by the MHC had a diagnosis of Major Affective Disorder or Bipolar Disorder (45%) followed by Schizophrenia (36%) and Anxiety or PTSD (9.5%). Other clients served had disruptive disorders, impulse control disorders and attention deficit disorder (See Figure 4).

Employment status and source of income at time of enrollment. Only 9% of MHC consumers were employed at the time of enrollment, an additional 1.5% received unemployment benefits. The primary source of income for most clients (43%) was social security. Twelve percent of MHC clients reported no source of income and 11% received general assistance. Unfortunately 22% of the data for this variable was missing or listed as "unknown" in the database.

Figure 5: Source of Income



Housing Status at time of enrollment. Approximately 11% of those enrolled in MHC were listed as homeless. An additional 14% listed their last known address as a 24-hour residential care facility. Thirty-percent of all MHC clients stated that they lived in a private residence. An additional 12% lived with friends or roommates. Residential history or living arrangement was missing in the RSN database for 33% of the clients.

Education Status at time of enrollment. Twenty-four percent (24%) of all MIRAP clients had less than less than 12 years of education. Thirty-seven percent (37%) had a

high school diploma or GED. Approximately 12% had completed some college or held an Associates Degree and 4% had a BA degree or higher. Education status was missing for 21% of MIRAP clients.

Section II: Assessment, Enrollment into MHC

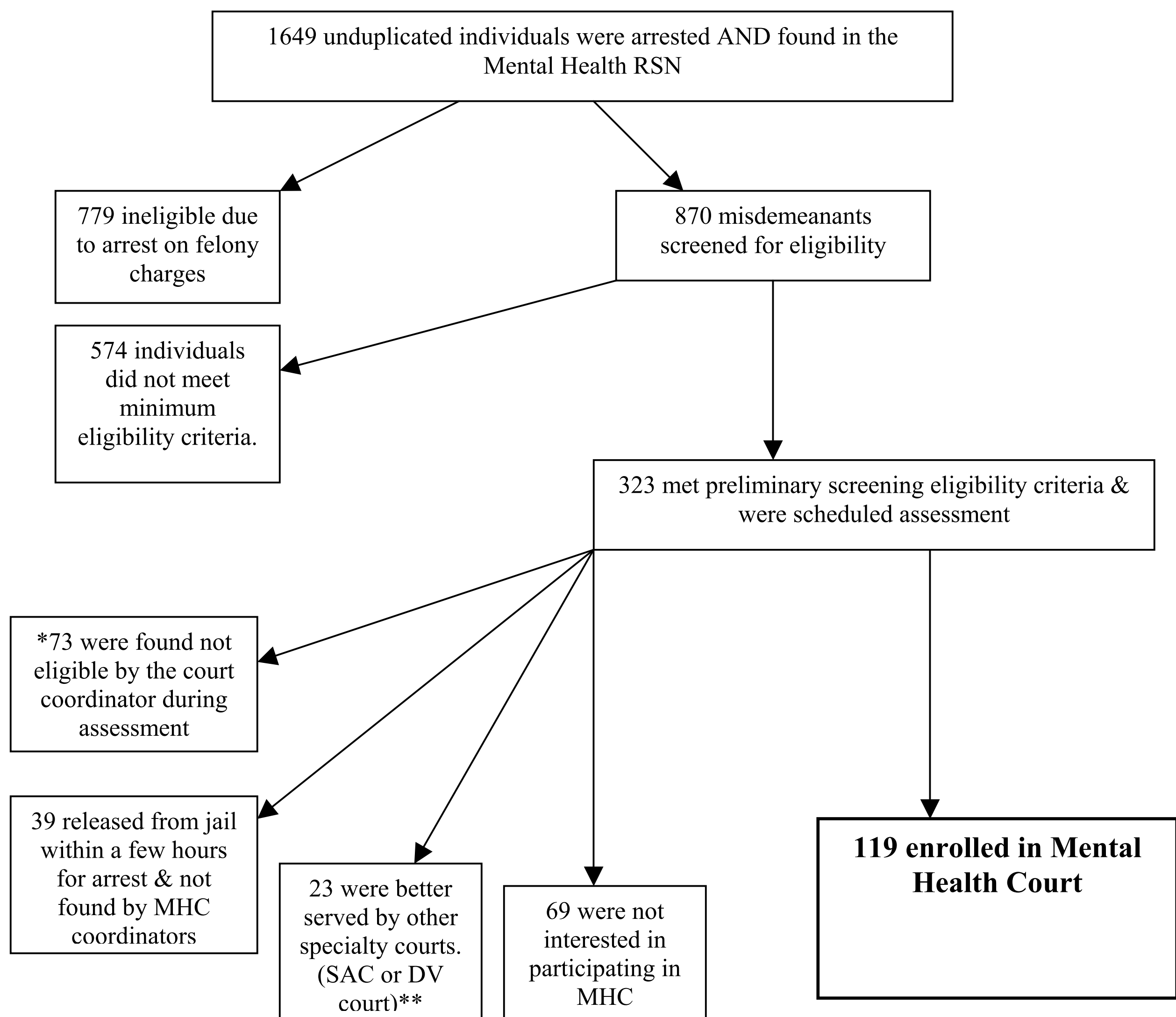
Enrollment in MIRAP Through the Jail Triage Process. The first several months of the MIRAP program were spent developing a smoother, more streamlined referral process into Mental Health Court. Prior to MIRAP, referrals into the program came predominately from district court judges, the prosecutor's office, and mental health providers. Because one of the primary objectives of the MIRAP program was to reduce the number of individuals with a mental illness in jails, a new triage process was developed and implemented to screen new inmates for eligibility into MIRAP. A diagram of the original client flow into MHC is presented in Appendix I. The more efficient streamlined client referral and jail triage process is presented in a diagram in Appendix II. The MIRAP program began enrolling clients in April 2002, with the new jail triage process.

Each morning, a MHC coordinator reviewed the jail booking report and crosschecked the name and other identifying information against the county mental health RSN database. Eligibility into MHC included an Axis I, DSM-IV diagnosis serious and persistent mental illness (Major Depression, Bi-polar Disorder, or Schizophrenia), a history of contact with a mental health provider, and no outstanding felony charges. Clients were also excluded if they had Axis II diagnoses or significant developmental disabilities (e.g. IQ<70). Enrollment data for the MIRAP program are provided from April 2002 through July 2003. The flow chart presented in Figure 6 illustrates the identification of potential MHC clients, the initial screening process, assessment process and outcomes of the assessments. In the 17 months of MIRAP program operation, 1649 individuals who were arrested and held in jail were also found in the mental health RSN. The first exclusion criterion was if the crime charged was a misdemeanor or felony. A total of 870 offenders were charged with misdemeanors. However, upon initial screening 574 did not meet minimum eligibility criteria to be assessed by MHC coordinators (insufficient diagnosis- did not have an Axis I, DSM-IV diagnosis of Major Depression, Bi-polar Disorder, or Schizophrenia or had insufficient history of mental health treatment, the client resided outside Clark County, or had violent crime history). The court coordinators assessed 323 individuals to confirm that the offender met criteria, present the MHC program and invite the offender to participate.

Assessment Outcomes. Of the 323 individuals assessed for enrollment in MHC, 39 offenders (12%) were booked and released within only a few hours and could not be assessed or followed up by court coordinators. An additional 73 offenders (24%) were not eligible due to outstanding Superior Court charges or insufficient diagnostic or mental health service history. Almost one-quarter of the clients (69 individuals, 21%) were not interested in participating, or "opted out". Twenty-three offenders (7%) were found to be better served by another specialty court (Substance Abuse or Domestic Violence Court). Finally, 119 clients assessed (36%) "opted in" and were enrolled in Mental Health Court.

The MHC coordinator assessed clients for eligibility in MHC in the jail, where the court coordinator presented a client with the basic expectations of the MHC, legal counsel, and the pros and cons of participation in MHC. The client was then left to make his or her decision about enrollment before the client was arraigned. Each offender found eligible and enrolled in MHC was assigned a MHC court coordinator, whose role was to act as a liaison between the Court, the client, and the mental health providers. Clients who "opted-in" to MHC were referred to appropriate mental health services by their court coordinator. Both the court coordinators and mental health service providers provided ongoing supervision to clients throughout their participation in the MIPAP program. Of the 119 consumers enrolled in MH Court, 62% (71 individuals) were enrolled directly from jail, while 38% (48 individuals) were referred into the program by judges, prosecutors, and other referral sources.

Figure 6: Mental Health Court Client Eligibility Screening Flow Chart

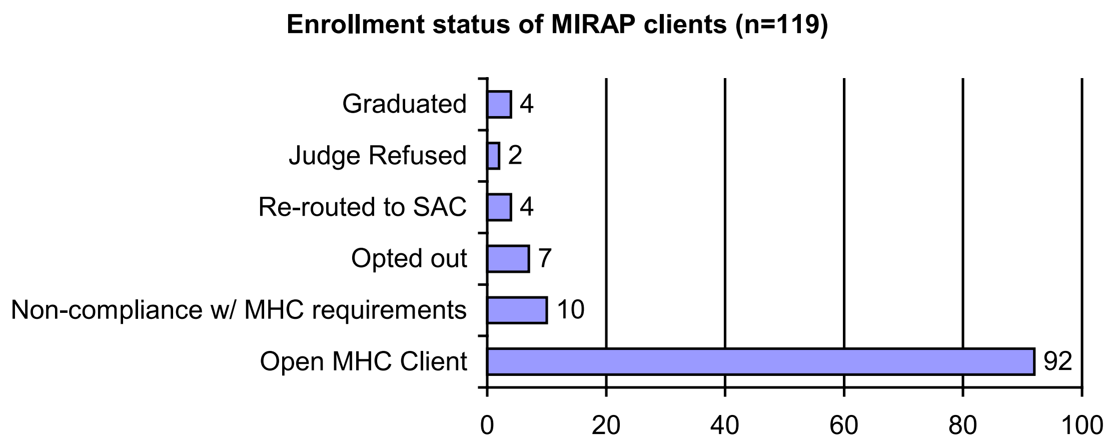


** Individuals found not eligible due to severity of diagnosis insufficient or outdated.*
***SAC=Substance Abuse Court, DV= Domestic Violence Court*

It was projected in the grant application that 15 individuals per month would be identified as eligible MHC clients based on a match of jail and mental health data for the year 2000. The number of individuals arrested and who had received mental health services in the RSN averaged 47 per month with 8 individuals on average per month who met the eligibility criteria (misdemeanor crime, diagnosis of severe and persistent mental illness and voluntarily enrolled in Mental Health Court) per month. Therefore, actual number of individuals eligible and enrolled per month was slightly lower than expectation. As noted in Figure 6, a number of individuals were released from jail and were not available for assessment (12% of those eligible for assessment) and an additional 21% were not interested in participating in MHC. Increased participation may result from increased incentives to enroll in the program, or a modified "selling" approach by the court coordinators to increase client interest in the program.

MHC Enrollment and Graduation Status. As of July 2003, of the 119 consumers enrolled in MHC, 92 were "open" MHC clients actively involved in the program. After 12-14 months of participation, 4 MIRAP clients had graduated successfully from the program. An additional 10 individuals did not comply with MHC requirements and were closed from the program, 7 individuals refused participation or dropped out of MHC prior to meeting all the requirements of the program, 4 clients were re-routed to Substance Abuse Court due to substance abuse issues and 2 were closed by the MHC judges due to Superior Court charges. Over the past 17 months, the MHC retained 81% of MIRAP clients in the program (See Figure 7).

Figure 7: Enrollment Status of MIRAP Clients



Section 3: Linkage to Mental Health Services and MH Service Utilization

Linkage to Mental Health Services. After the initial interview and assessment, MIRAP clients who "opted-in" to the MHC program were linked with appropriate Mental Health

Services by the MHC coordinators. Two primary MH Service programs in Clark County provided the mental health treatment services for the MIRAP program. Columbia River Mental Health, provided Intensive Case Management Services and Mental Health Northwest provided the Program for Assertive Community Treatment.
MIRAP clients were linked to MH services within 3-10 days of enrollment in MHC. The protocol of MHC established was that the MH provider appeared with the newly enrolled client before the judge either at the time of arraignment (which occurred on the day following the arrest), or the following court date. The next court date is scheduled within one week following arraignment.

Mental Health Service Utilization. Both the PACT team and the intensive case management program offer a wide array of services including case management, crisis assessment and intervention, symptoms assessment, individual and daily living support, medication management, employment services, interpersonal relationship support and other support services. Of the 119 consumers enrolled in MHC, only 6 were assigned to the PACT program (due to limited capacity), the remaining clients were served by the ICM team at Columbia River Mental Health.

Mental health service utilization data was provided by the Clark County RSN for all MHC participants from June 2001 through June 2003. The average number of days that MHC participants received mental health services after enrollment in MHC was 122 days (range of 7 to 352). It appears that 12 clients did not connect with mental health services post-enrollment in MHC because the total number individuals for which there were recorded services in the RSN after MHC enrollment date was 107. Of the 119 clients served by MHC, 69 clients had recorded services in the RSN prior to enrollment in MHC.

Type of Services Utilized. Service activity was coded into 11 service categories. The service categories are listed in Table 1 along with the total number of hours of service utilization pre-MHC, post-MHC and the number of MHC clients who utilized each service after enrollment in MHC.

Table 1: Number of Individuals and Average Hours by Service Category

	Service Category	Six months pre-MHC		Six months post-MHC	
		Number of Individuals (n=69)	Average Hours Per Client	Number of Individuals (n=107)	Average Hours Per Client
1	Intake/Evaluation*	58	1.6	99	3.9
2	Medication Management *	35	2.6	87	4.7
3	Individual Therapy	46	9.9	67	5.9
4	Group/Family Therapy	34	13	21	8.8
5	Acute/Crisis/Imminent* Services	44	77	39	43
6	Case Management*	47	13	96	25.5
7	Employment	12	6.8	25	9.7
8	Education	1	.7	6	1.1
9	Telephone	63	1.5	110	1.9
10	Residential*	7	1428 (59.5 days)	6	256 (3.5 days)
11	Overnight Crisis Beds*	9	56 days	24	44 day

* Indicates statistically significant difference pre versus post MHC in average hours of service.

MIRAP clients received more hours of medication management, greater intake/assessment, and case management services post-MHC enrollment compared to pre-MHC enrollment. The number hours of residential services, acute/crisis services, over night crisis bed days were significantly reduced post-MHC compared to pre-MHC. Inpatient intensive services such as psychiatric hospitalization was not available through the RSN.

Section 4: Re-arrest Rates, Criminal Justice Activity

Section 4 provides re-arrest data for the 119 MIRAP clients. Because the third year of the MIRAP grant was cut, we are only able to provide re-arrest data for 6 months follow-up on MIRAP clients enrolled since April 2002. Most clients enrolled since April, (89 clients, 75%) were enrolled at least 180 days. However, 13 clients (11%) were enrolled less than 90 days with the remaining clients (14%) enrolled between 90-180 days. The range of days in the follow-up period was 26 to 485 days with a median of 178 days. This short follow-up period limits our ability to determine "success" in MHC. In addition, the brief follow-up period precludes the use of multivariate analysis to determine factors that predict success in MHC. For example, we would expect that MHC clients who successfully graduate from MHC (i.e. stay in the program for 12-14 months and meet all MHC requirements) would be more successful (have fewer re-arrests) than clients who were terminated from MHC for other reasons. However, with the limited follow-up period, there are only 4 graduates of MIRAP to date and we are unable to make this comparison.

Research Questions. Jail booking data was analyzed to address these questions:

- Do individuals who enroll in MHC have fewer arrests in the six months post-enrollment as compared to six months pre-enrollment in MIRAP?
- Do MHC clients have fewer probation violations in the six months post-enrollment compared to six months pre-enrollment in MIRAP.
- What are the types of crimes committed by MHC participants before enrollment in MHC compared to post-enrollment?

Arrest History in Clark County. Each offender enrolled in the MIRAP program had been arrested in Clark County an average of 7.9 times prior to enrollment in MHC (data going back to 1984). In addition, almost two-thirds of the sample (63%, 75 individuals) had prior probation violations. The average number of prior probation violations per client was 5 (Standard deviation=5.04), with 11 consumers having between 10 and 20 prior probation violations.

Study Question 1: *Do individuals who enroll in MHC have fewer re-arrests in the six months post-enrollment as compared to six months pre-enrollment in MIRAP?*

Re-arrest: In the six months prior to enrollment, the 119 MHC participants were booked 288 times for new charges. **Six months post enrollment in MHC, 85 clients (71%) had NO RE-ARRESTS**. Only 34 individuals (29% of the sample) were rearrested on new crime and were booked a total of 76 times, post-enrollment in MHC. There was a significant 26% reduction in the number of crimes committed by MHC clients. The average number of bookings per MIRAP client in the 6 months pre-MHC was 2.4 (sd=2.0, min.=1; max=12). In the six months post-MHC the average number of bookings per client was 0.6 (sd=1.2, min.=0; max=8; paired t-test=-8.3; df=118, $p<.0001$).

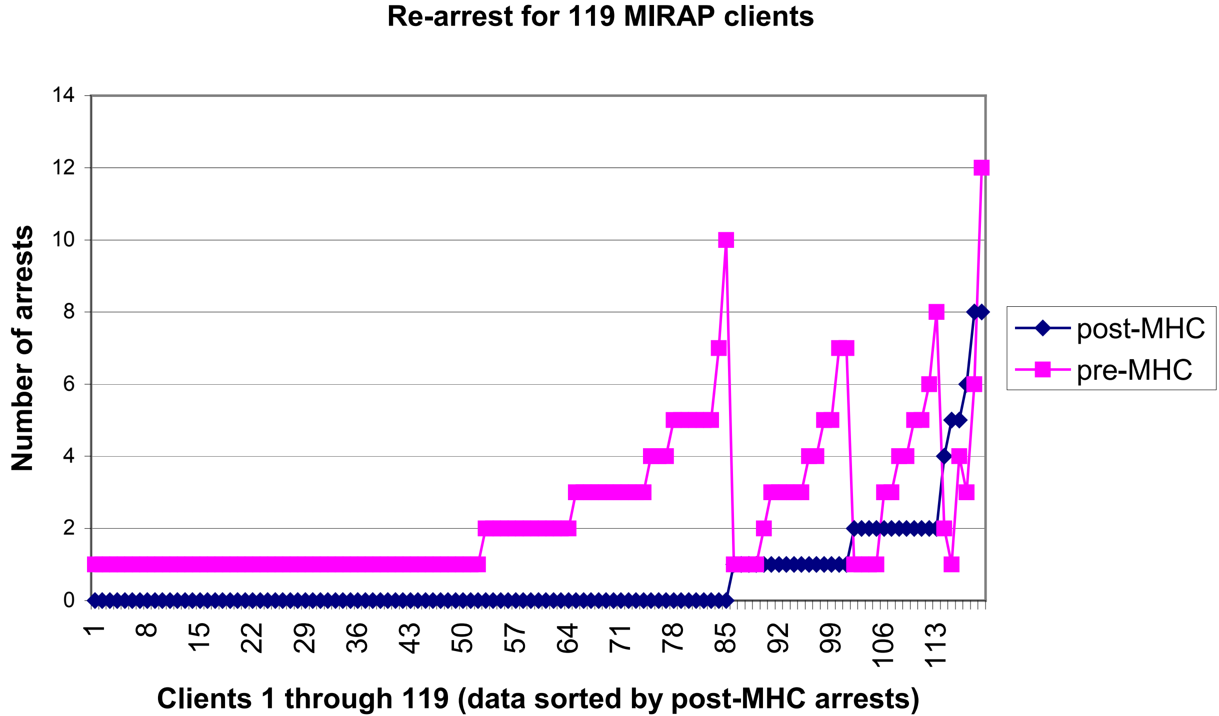
Table 2 provides a summary of the number of arrests in the 6 months prior to enrollment in MHC compared to the 6 months post-MHC. Pre-MHC, approximately one-quarter of the sample (22%) could be characterized as "frequent offenders;" they had 4 or more bookings in the 6 months prior to enrollment in MHC. In the six months post-enrollment in MHC only 5% were "frequent offenders" with 4 or more arrests (See Table 2).

Table 2: Number of Arrests in 6 months Pre-enrolment in MHC compared to Post-enrolment

	Times Arrested in 6 months pre-MHC		**Times Arrested in 6 months post -MHC**	
0 times	0	0%	85	71%
1 time	61	51%	16	13%
2 times	14	12%	12	10%
3 times	18	15%	0	0%
4 + times	26	22%	6	5%
Total	119	100%	119	100%

Figure 8 illustrates the reduction in total number of arrests of the MHC participant for six months post-enrollment compared to six months pre-enrollment. The line with squares indicates the number of arrests in the 6 months prior to enrollment in MHC and the line with triangles indicates the number of arrests post-enrollment in MHC. The 119 MHC clients are represented on the x-axis and the number of times each individual was arrested both pre and post is represented on the y-axis. Data are sorted in order of the number of arrests for each MHC participant in the post-MHC period. For example all clients who were arrested 0 times post-MHC are listed in order as client 1 through 85 (illustrated by the line with triangles). The number of crimes these 85 clients committed prior to enrollment in MHC are illustrated by the line with squares (the first 52 clients were arrested once, the next 12 clients were arrested 2 times, the next 10 clients were arrested 3 times pre-MHC and so on up to the 85 client who was arrested 10 times prior to enrollment in MHC. In the six months post-MHC, 116 individuals (89% of the sample) had reduced number of bookings, while the remaining 11% had no change in number of arrests or an increase in number of arrests after enrollment in MHC compared to the pre-MHC period.

Figure 8: Re-arrest for MIRAP clients



***Study Question 2:** Do MHC clients have fewer probation violations in the six months post-enrollment compared to six months pre-enrollment in MIRAP?*

Probation violations. In the 6 months prior to enrollment in MHC, 46% of the MIRAP sample had at least one probation violation. These 54 offenders averaged 2 violations each, for a total of 110 in the 6 months prior to enrollment in MHC. In the 6 months post-enrollment, there was a significant 56% reduction in the number of probation violations compared to pre-MHC (paired t-test= -3.0, df=118, $p<.003$). Only 32 individuals (28% of the sample) committed 62 total probation violations (See Table 3).

Table 3: Number of Probation Violations in 6 months Pre-enrolment in MHC compared to Post-enrolment

	Number of Probation Violations in 6 months pre-MHC		**Number of Probation Violations in 6 months post - MHC**	
0 times	65	55%	86	72%
1 time	27	23%	17	14%
2 times	14	12%	8	6%
3 times	5	4%	5	4.5%
4 + times	8	6%	3	2.5%
Total	119	100%	119	100%

Study Question 3: *What are the types of crimes committed by mental health court participants before enrollment in MHC and after enrollment in MHC?*

While the Clark County MHC currently only enrolls misdemeanants or offenders whose felony charges can be reduced to misdemeanors, there was ongoing debate throughout the MIRAP program among the stakeholders whether to expand eligibility to those charged with felonies. Currently, MHC is a district court process and expanding into Supreme Court raises several logistical and policy problems. However a review of the class of offenses committed by MHC participants indicates that several MHC clients had prior felonies on their records. If these MHC participants are successful in MHC, this may support the inclusion of those with current felony charges. In the six months pre-MHC, most offenders (65%) committed only misdemeanor offenses. However, approximately one-third, (30%) had both felony and misdemeanor charges on their record; and 5% had only felony charges, which were reduced to misdemeanors (see Table 4). Results from the re-arrest data suggest that clients with both felony and misdemeanors on their record perform equally will in MHC as those with misdemeanors only.

Table 4: Type of Crime committed Six Months pre-MHC

Charge Type Pre-MHC		
Misdemeanor Only	77	65%
Felony	6	5%
Both	36	30%
Total	119	100%

Table 5 provides a description of the most common type of crimes committed in 6 months pre-enrollment in MHC and the 6 months post-enrollment. The data were summarized using the following decision rule. Within each individual, the type of crime that appeared with the highest frequency was chosen to represent a "typical" type of crime committed by that offender. The frequencies of these "typical" crimes were summarized for the entire sample in Table 5 in order of most common to least common charge type. It is important to note that only 34 of the 119 clients enrolled in MHC re-offended in the 6 months post-enrollment in MHC, so that the number of individuals in each category is reduced considerably. However, while the frequency of the crimes is greatly reduced post-enrollment in MHC, the overall ranking of the 7 crime categories does not substantially change. In the 6 months pre-MHC and post-MHC, domestic violence charges were committed most frequently by MHC participants, followed by driving violations/hit and run, property crime, drug and alcohol related offences, public nuisance offences, assault/violent crimes, and lastly obstructing justice. A list of charges that fell into each charge category can be found in Appendix III.

Table 5: Rank Order of Charge Types 6 months pre-MHC and Post-MHC

Charge Category	Pre-MHC (n=119)		Post-MHC (n=34)*	
	N	%	N	%
Domestic Violence	40	34	9	27
Driving Violations/Hit and Run	19	16	7	21.5
Theft/Property Crime	17	14	7	21.5
Alcohol and Drug Related	15	13	5	15
Disorderly Conduct/Public Nuisance	14	13	2	6
Assault/Violent Crime	12	10	2	6
Obstructing justice	2	1	1	3
Total	**119**	**100**	**34**	**100**

*Note that only 34 individuals were rearrested in the 6 months post-MHC.

Summary of Findings From Re-arrest Data:

The key findings from this preliminary analysis of 119 MHC clients are listed below.

- The overall crime rate of MHC participants was reduced 3.8 times six months after enrollment in MHC as compared to the six months prior to MHC. In the six months prior to enrollment, the 119 MHC participants were booked 288 times for new charges. Six months post enrollment in MHC, only 34 individuals (29% of the sample) were rearrested on new crimes and booked a total of 76 times.
- All offenders enrolled in MHC had been booked on at least one occasion prior to enrolling in MHC. One year post-enrollment in MHC, 71% of participants had no further criminal justice contacts and 89% had a reduction in number of times booked.
- Findings indicate that MHC helps break the cycle of the "repeat offender." Prior to MHC, 22% of program participants had 4 or more arrests within six months. After enrollment in MHC, only 5% of program participants were arrested 4 or more times within six months.
- Probation violations were also significantly reduced by 56% post-enrollment in MHC compared to pre-enrollment. Pre-MHC, 54 clients committed 110 probation violations. In the six months post-enrollment 32 individuals committed 62 probation violations.
- While the frequency of the crimes was greatly reduced post-enrollment in MHC, the overall ranking of the types of crimes committed did not substantially change. In both the 6 months pre-MHC and post-MHC, participants were arrested on domestic violence charges most frequently, followed by driving violations and property crime, drug and alcohol related offences, public nuisance offences, and lastly assault/violent charges and obstructing justice violations.

These data indicate that the Clark County Mental Health Court is serving the intended target population- individuals with mental illness and substance abuse with repeated contact with the criminal justice system. The MIRAP program served mentally ill offenders, many of whom were not only repeat offenders, but also consumed criminal justice time and resources by not following through with the court process, repeatedly violating probation, community supervision, and failing to appear in court.

The MIRAP program was successful in reducing both the number of individuals who committed crimes AND the number of crimes committed by MIRAP clients. In addition, the number of probation violations was reduced, lessening the burden of court time, monitoring and supervision by the criminal justice system.

Section 5. Mental Health Court Observations

This section provides information about Mental Health Court observations including the general court process, facilitation of court staff, a summary of evaluation team's observations, and future court procedure recommendations.

From April of 2002 to July of 2003, the evaluation team has attended twelve Mental Health Court proceedings. Most of the evaluation observations were mainly conducted in one of the two MHC judge's courtroom. The team recorded observational information in the courtroom including the judge's interactions with consumers, the role of court coordinators and mental health providers, and the function of prosecuting and defense attorneys. Observations were also completed to get a sense of the overall atmosphere of the MHC between consumers and court professionals.

I. Court Process

Court schedule. MHC clients are scheduled to appear in court regularly (ranging from weekly to monthly), depending upon client progress and stage of participation in the MHC program. A clients' individual court date is set during each appearance. All consumers are asked to appear in court at the same time, however they are called separately to appear before the judge. General court process and client circumstances are deciding factors in determining the order each client is called. For example, the judge may follow a consumer sign-in sheet or court coordinators may make the request on the behalf of their clients to appear before the judge in a certain order.

Court appearance. When consumers arrive to the court they are asked to sign-in to inform court coordinators and the judge of their presence. Court coordinators are found in the front of the courtroom close to prosecuting and defense attorneys and mental health providers sit in the general seating area with consumers.

At the beginning of the court's proceedings, the judge starts with MHC graduations, which consist of graduation cake and recognition of a client's accomplishments and successes in the MHC program. The judge generally begins court with consumers who are currently in jail. As court proceeds, clients are called one by one. All MHC clients

have a case manager and/or a court coordinator who join them as they are asked to appear before the judge. The judge engages in an informal and friendly conversation with each client. The judge asks clients about their current life situations, follows up with clients about goals such as seeking employment, entering school or other activities. The judge reviews any outstanding legal issues and progress made to resolve them such as paying fines or doing community service. If clients are having legal or other issues, the judge, court coordinators or mental health providers may make recommendations about what are the most appropriate next steps for the client to take. Finally, the client is given the next MHC date to appear. Clients new to the program are asked to appear before the judge on a weekly or bi-weekly basis and as clients become more stable and are making good progress, the time between court appearances is lengthened.

For, offenders who are new to the MHC program, prior to appearing before the MHC judge for the first time, the offender has completed several steps in the enrollment process (See Appendix II Client Flow for a detailed description of the steps to enrollment in MHC). The first step in the enrollment process is the assessment completed by the MHC coordinator on the day of or day after the offender's arrest. Second, if the MHC coordinator finds that the offender is eligible, the MHC coordinator presents the MHC programs and asks the offender whether he/she would like to participate in the MHC program. Third, if the offender consents to participation, the MHC coordinator connects the offender with a mental health service provider. Fourth, the MHC coordinator and mental health provider appear before the arraignment judge and recommends that the offender be referred into MHC. In most cases, the judge accepts the recommendation. However, the arraignment judge can refuse the recommendation if the offender's prior criminal record indicates that he/she may be a threat to the public. At the arraignment, the lawyers also consult with the offender and explain their legal rights and possible sentencing. At this point the client may "opt out" and accept the sentence. In order for the client to enroll in MHC, the client must plead guilty. Once the plea is determined, the client is scheduled to appear before the MHC judge.

At the first MHC appearance, the MHC judge decides whether to accept or reject the offender into MHC. If an offender is accepted, the offender is asked to think about the commitment he/she is about to make to the MHC program. If the judge accepts and the client still wishes to participate in MHC, next, the MHC Legal Contract is drafted by the MHC coordinator and may be reviewed by the mental health service provider and judge (See Appendix IV for a copy of the MHC Legal Contract). Second, the MHC Legal Contract is reviewed with the client. Third, at the second MHC appearance before the judge, the judge asks the offender if he/she fully understands the MHC Legal Contract and asks the client to sign the contract committing to adhere to the terms outlined.

When the court process has ended for the day, the staff has a brief meeting to discuss any issues or concerns. If there were clients who did not show up for their scheduled court date (with the exception of clients who were dismissed by MHC staff), a warrant is issued for each consumer. However, as long as clients arrive before the court adjourns, there is no warrant issued.

II. Court Facilitation

The interaction between clients and court staff varies from case to case. Generally, all parties participate in communication when a client stands before the judge. Each MHC professional has a different role in the process. These roles are discussed below.

Judge. The judge's interaction with clients appears to be friendly, supportive and positive. The rapport between the client and the judge seems to be highly valued by both parties. The judge frequently asks clients questions about his/her current life situation, update on program compliance, and future short and long-term goals. Most relationships that are developed between the clients and the judge appear to be constructive and meaningful. As time spent in program elapses, personal rapport grows. The judge elicits updates and feedback from court coordinators and case managers, information which helps the judge make necessary decisions and legal recommendations for clients. If attorneys are involved in a client's case they often participate and provide feedback to the judge about any legal concerns or requests.

Court coordinators. The court coordinators generally converse with their clients before the court process begins. They do a check-in with each client and take an active role in participation when clients are asked to appear before the judge. The court coordinators provide words of encouragement, they may coach a client on what to say before the judge, may calm a client's nerves or clarify information or issues to be discussed. The court coordinators report information about client progress in the program and provide input for next course of action to the judge. Furthermore, the court coordinators advocate for clients who may have difficulties or concerns such as discomfort or time conflicts so that alternative accommodations may be arranged. Court coordinators serve as liaisons between the client and the legal system.

Case managers. Many MHC clients have a case manager who comes to court with them to provide support. They advocate for consumers by being present in the courtroom, report to the judge about mental health issues that a client may experience, and they offer feedback to the court about general needs and concerns of consumers. Most case managers are from Columbia River Mental Health Services, but a few case mangers from Mental Health Northwest were present at MHC sessions. Overall, between the two agencies, there was an average of approximately 4 to 5 case managers present each time court is in session. Case managers took advantage of the time in court by meeting with clients and problem solving specific needs such as housing, facilitating employment services, and resolving financial issues.

Attorneys. Prosecuting and defense attorneys were present in court if there were specific cases in which their involvement was needed. Defense attorneys generally accompany clients who have their first court date and formally accepted into MHC. The prosecuting attorney represented the community by advocating for public safety and legal responsibility.

III. Court Summary

MHC Court Process. Overall, the evaluation team observed that the MHC operated smoothly, providing a pleasant, welcoming environment that allowed clients and court staff to communicate and interact with each other. Court coordinators and mental health providers were readily available to engage with clients before and during court to meet clients' needs. A concern observed by the evaluation team was that on numerous occasions the court did not start on time because the judge was late, which significantly delayed regular MHC proceedings. This may have been due to the judge's limited time constraints. Occasionally, however, clients waited for up to two hours before the judge appeared in court.

The environment in court provided clients with the opportunity to learn and share each other's situations, which in many cases appeared to provide a as support network for the client and motivate them to make positive changes and stay in the program. For example, when a client graduated, other MHC consumers had the opportunity to witness the occasion, and it may have encouraged clients to obtain a positive outlook toward completing personal requirements in the MHC program. During a consumer interview, a client reported, "*It* [when a client graduates] *makes me want to get there too it is good to see people graduate because it's motivating".*

Interaction and facilitation. Interactions between clients and the judge appeared to be positive as the judge often offered constructive feedback and exhibited personal characteristics such as being friendly, supportive, non-judgmental, and caring to clients. Several consumers expressed verbal satisfaction via gratitude and appreciation (comparable information is supported by consumer interviews, see Section 6 for details). Humor and laughter were welcomed inside the courtroom, specifically as demonstrated by the judge, who often seemed to ease tension or apprehension of clients through humor. For example, a consumer stated, "*He's [the judge] really cool, nice and funny. [He] makes it easy to be there"* (information disclosed in a consumer interview). However, it is also important to note that on several occasions, the evaluation team observed that inappropriate use of humor by the judge could be construed as insensitive and hurtful to clients. A rare, but notable situation is an example in which the judge attempted to use humor to shine light on a client's unfortunate situation. The client began to cry while the crowd inside the courtroom laughed at the joke. It was clear the humor used in this case was very upsetting to the client, not only in her misinterpretation of the judges statement, but also in the crowd laughing at her expense.

Although clients had an active role in communicating with the judge and were openly engaging about personal life issues, it created situations in which client confidentiality was of concern. Several times during MHC observations, discussions about clients' psychiatric medications were elicited from the judge, bringing up client confidentiality issues and may be harmful to the client to disclose in the open court. Mental health services are sensitive information to many clients. Disclosure of medications often reveals diagnostic information. Clients are not informed of what type of information they are obligated to supply to the judge, creating a situation of "forced disclosure."

In addition, mental health service details are discussed openly in court and become part of the requirements for completing MHC. Case managers often get requests from the judge about what services need to happen next. The relationship between the case manager and client may be harmed if a provider supplies information that clients are not prepared to reveal.

Stakeholders also raised this concern. In a stakeholder interview, a person stated, "*There have been several times when a client doesn't know how much information to reveal before the judge…It can be very confusing and scary for clients because they often don't know if it is a program expectation, therefore a requirement, or if personal disclosure is not necessary".*

Confusion about Program Requirements. When a client opts into the program, general expectations and requirements are described. However, clients are asked to commit one to two years before they are eligible to graduate and are not provided something in writing stating personal goals and program compliance, which may create some confusion and uncertainty from a client's perspective. For example, a stakeholder reported, *"There seems to be lack of communication about expectations between court staff and relying information to clients and providers*" (information revealed in a stakeholder interview).

Inappropriate Treatment Advise. Another issue observed by the evaluation team included a few instances in which the judge gave firm orders regarding mental health treatment such as using Anabuse or requiring change of psychiatric medications. Since the judge does not have formal training in mental health, it complicates matters between clients and their mental health treatment. Requirements of the MHC program and goals of mental health treatment can easily be confused with each other by clients and MHC professionals.

Use of sanctions. When clients did not follow MHC requirements, the judge seldom imposed the use of sanctions, but did give verbal warnings against future noncompliance. On rare occasions, in response to perpetual program noncompliance, the judge implemented sanctions including sentencing clients to spend time in jail. While the evaluation team observed few instances in which sanctions were imposed, it was beyond the scope of this evaluation to measure the effectiveness of various sanctioning strategies. It was noted by the evaluation team (and confirmed by the two MHC judges themselves) that the judges hold different philosophical viewpoints on the use of sanctions. In one judge's opinion, sanctions and the court's authority are not to be used as a "negative reinforcement" and MHC clients should not face sanctions. The other MHC judge felt that under certain circumstances, sanctions were necessary to imprint upon the client the severity of their actions. Future research is needed to determine whether a judge's philosophical view point in the use of sanctions effects client outcomes, and whether different sanction strategies work with certain MHC clients but perhaps not with others.

Section 6: Consumer Interviews: Experience with MHC and Impact from Consumer Perspectives

This section provides information from MHC consumer interviews including a description of the MIRAP sample interviewed, quantitative and qualitative findings, and a section summary.

The Consumer Interview Sample*.* Approximately 48% of MIRAP clients consented to participate in the evaluation interview. The evaluation team collected 57 baseline interviews and 21 follow-up interviews. Because the rate of intake was slower than expected, the study was over before 11 follow-up interviews could be completed. Other clients were lost to follow up because they had moved (n=5), their phone was disconnected and could not be contacted (n=13), or the client declined participation (n=7).

Of the 57 MHC clients who participated in the consumer interviews, 61% were male. The mean age of the interview sample was 33.09 years old, and ranged from 18.3 to 55.7 years (SD = 10.50). Fifty consumers (88%) were Caucasian, and the remaining 12% were African American, Asian Pacific, Native American, and/or other race. Most clients interviewed (56%) had a primary diagnosis of Bipolar Disorder, followed by Schizophrenia (28%), Anxiety Disorders (10%) and other major mental illness (6%). Of those interviewed, 14 clients were also in treatment for drug and/or alcohol abuse, and 11 clients had been in treatment at some point in the past year. The substance abuse treatment status for the remaining 32 consumers was listed as unknown, no prior treatment, or not identified. Substance abuse treatment involvement was not collected by self-report in the consumer interview, but provided by the Regional Support Network (RSN) administrative data. Overall, the demographic and clinical characteristics of the MHC clients who agreed to participate in the evaluation interview did not differ significantly from those who declined participation.

Quantitative Data. Four standardized measures were collected as part of the consumer interview. These measures were: the Brief Symptom Inventory (BSI), the Brief Quality of Life (BQL), the Services Needed and Received Questionnaire (SNR) and the Consumer Choice Questionnaire (CCQ). The BSI was collected at baseline only to assess level of symptomatology; the remaining three questionnaires were collected at baseline and follow-up.

Client symptomatology measured by the Brief Symptom Inventory (BSI). This 53-item instrument was used to measure a client's level of severity of physical and psychological symptoms upon enrollment into the MHC. Intensity of symptom distress ranged from 0 (not at all) to 4 (extremely) on the five-point BSI scale. Symptom scores were added and combined into 9 dimensions, which included Somatization, Obsessive-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism (between 4 to 7 items per dimension). Major findings of the BSI indicated that Anxiety, Somatization, and Obsessive-Compulsion were dimensions where clients scored higher. See Table 6 for details. The severity of these BSI symptoms are comparable the severity of symptoms in two adult psychiatric inpatient samples

(reported in Allen, Coyne & Huntoon, 1998 and Hale, Cochran, Hedgepeth, 1984) indicating that this sample mental health consumers was highly symptomatic upon enrollment in MHC.

Table 6: BSI Dimension Scores

Dimension of the BSI	MIRAP clients	
	M	**SD**
Somatization	2.13	0.88
Obsessive-Compulsion	1.96	0.09
Interpersonal Sensitivity	1.76	1.10
Depression	1.69	1.12
Anxiety	2.71	1.14
Hostility	1.26	0.91
Phobic Anxiety	1.55	1.14
Paranoid Ideation	1.79	1.00
Psychoticism	1.63	1.02
Global Severity Index	1.8	0.84

Brief Quality of Life. This measure was used to evaluate client perception of quality of life. The instrument was divided into sections including global quality of life, feelings toward family members, amount of social contacts, and feelings about social relations. A seven-point scale, ranging from 1 (terrible) to 7 (delighted), was used for the majority of questions on the BQL. Results indicated that there were no statistically significant changes between baseline scores and follow-up scores collected six months after enrollment in MHC. See Table 7.

Table 7: Descriptive Statistics of Sections on the BQL

Sections	**Baseline** Mean (SD)	**6 months** Mean (SD)
Overall Quality of Life	4.84 (1.52)	4.90 (1.45)
Feelings Toward Family Members	3.94 (1.07)	3.83 (1.35)
Amount of Social Contacts	4.57 (1.64)	4.85 (1.28)
Feelings about Social Relations	4.53 (1.40)	4.68 (.98)

Services Needed and Received (SNR). The Services Needed and Received Questionnaire asked consumers if they needed and received 20 specific services related to both physical and mental health needs (see Appendix V for the Services Needed and Received Questionnaire). Consumers were asked the Services Needed and Received Questionnaire at baseline and at 6 months. Two comparisons were conducted. First, comparisons were made between services needed AND services received to determine the "service match." Second, comparisons were made to determine "service mismatches" or, services needed AND NOT received. Table 8 lists the top 4 services in rank order for serviced needed AND received, followed by Table 9 for the top 5 services needed AND NOT received.

Overall the percentage of service needs met by the mental health providers was 74% at the initial interview and 79% at 6 months. The top 4 ranking service matches (service needed AND received) were almost the same at the initial interview and at the 6-month interview. Medication for psychiatric diagnosis ranked first, followed by outpatient individual therapy; medical care was ranked third at the initial interview, but was replaced by information on community resources at 6 months. For both the initial interview and 6-month interview "help with resources" was ranked 4th.

For service mismatches, dental care ranked the highest in the baseline interview and 6-month follow-up interview indicating that consumers continued to need dental care but did not receive it over time. Also, help getting general recourses was ranked second at both time points. Housing assistance, outpatient individual and family therapy were other needed services (see Table 8 for details).

It is noteworthy that housing assistance was ranked fourth at baseline but moved to third at the 6-month time point. While it is difficult to determine whether this is a significant change in overall need for housing services among MHC clients, it does speak to the ongoing housing support needed by adults with severe and persistent mental illness to maintain stability in the community.

Table 8: Service Matches: Top 4 Ranked of Services Needed AND Received at Baseline and 6-months

Baseline Interview	Number of Clients who Needed Service and DID NOT Receive it	6-Month Follow-up	Number of Clients who Needed Service and DID NOT Receive it
1. Medication for a Psychiatric Diagnosis	**40**	**1. Medication for a Psychiatric Diagnosis**	**19**
2. Outpatient Individual Therapy	**26**	**2. Outpatient Individual Therapy**	**12**
3. Medical Care	**25**	**3. Information on Community Resources**	**9**
4. Help Getting Resources	**22**	**4. Help Getting Resources**	**7**

Table 9: Service Mismatches: Top 4 Ranked of Services Needed AND NOT Received

Baseline Interview	Number of Clients who Needed Service and DID NOT Receive it	6-Month Follow-up	Number of Clients who Needed Service and DID NOT Receive it
1. Dental Care	**13**	**1. Dental Care**	**9**
2. Help in Getting Resources	**10**	**2. Help in Getting Resources**	**6**
2. Outpatient Family Therapy	**10**	**3. Housing Assistance**	**5**
3. Outpatient Individual Therapy	**9**	**4. Outpatient Individual Therapy**	**3**
3. Medical and Financial Counseling	**9**	**4. Outpatient Family Therapy**	**3**
4. Assistance with Employment	**8**	**4. Information on Community Resources**	**3**
4. Housing Assistance	**8**	**4. Help in Planning Leisure Time**	**3**

Consumer Choice Questionnaire (CCQ). The CCQ was used to measure general consumer satisfaction of mental health services and consumer choice. There were 12 items on the instrument and response choices ranged from 1 (strongly disagree) to 5 (strongly agree). At the baseline interview, the mean score of overall satisfaction was 3.87 (SD= .60), and at the follow-up interview, the average score was 3.94 (SD= .47). There was no statistically significant changes in scores on the CCQ. Consumers rated staff highest on items such as "my choices were respected by staff," "staff encouraged me to do things on my own," and "staff provided services that I needed most."

Consumer perspectives of MHC: Qualitative Data. This section reports client's experiences with the MHC as told by the clients themselves. This section will discuss 1) why clients agreed to participate in the MHC, 2) clients perceived benefits (what participation in MHC 'did for them'), 3) clients' descriptions of their relationships with MHC professionals and 4) recommended changes or improvements to MHC.

Why clients agreed to participate in the Mental Health Court. Clients reported that the Mental Health Court gave them a *second chance* to *take control of their lives*, helped them *get off the streets, stop committing crime,* and *better their lifestyles*. One client explained the process*, "They [the court coordinators] came to me in jail and offered parole/probation; They felt that this would benefit me; so I agreed to do it in lieu of jail."*

Diversion from jail, as this client suggests, was a huge incentive for many. There was, however, some confusion for a few clients about their legal status. *"[I agreed] because I didn't want to be on probation,*" one client told us*,* but, in fact, participation in MHC is a sort of probation. Clients must plead guilty with the understanding that their conviction will be expunged upon successful completion of the program. Instead of reporting to a parole officer, clients must report to the MHC judge, a court coordinator, a mental health practitioner, and various legal counsels depending on the case. Perhaps, this

arrangement, although it involves many more people, simply does not seem like probation.

Others were more specific about other "benefits" they might receive through participation. "*My attorney suggested it because of my mental health issues,*" one client reported. Another client identified a need to try something new. "*I knew that I needed some kind of mental help. I was depressed and always running away from my Parole Officer.*" Still others enrolled in MHC because they knew they needed some sort of assistance. When one client was referred to the court through a Camas court (on which one of the MHC judges also serves) the MHC was "*seen as an opportunity to get the help that I need*[ed]." Another client was more direct. "[I joined] *because I was crazy and they said they would help*."

Client Perspectives on Participation – What MHC Did for Them. It is also clear that clients felt MHC helped them a great deal (with the exception of two clients who said it was too soon to tell). What, specifically, had the MHC done to help clients? Two predominant themes were evident in clients' responses. The first theme was help with concrete services and the second theme was providing emotional support.

The kind of concrete services clients received and found helpful included linkage to resources such as housing, employment and mental health services. By far the most common type of assistance that consumers sited as helpful was getting on, and sticking with, an appropriate medication schedule. Consumers also reported that they appreciated the assistance with legal matters - such as reducing fines or charges and reinstating their drivers license and that this assistance prompted them to "*stay on the right track*." In addition to these concrete services, many said they needed helpful reminders – even the possibility of sanctions – to stay on a medication regimen or treatment plan. As one client explained, "[Participation] *kept me on my meds and from doing stupid stuff*."

The emotional support that MHC clients reported to be most helpful included encouragement from court coordinators, "*they let me know I am ok and problems can be handled*", and from the judge, "*he just took time for me, he inspired me*." Consumers felt the level of support they receive from all the MHC staff and MH staff, "*I found people that cared about me and gave me a lot of support*." Perhaps most importantly, consumers reported that the MHC staff expected them to be responsible for their actions, and to follow through with their treatment plan. The expectations of the court and support clients received encouraged clients to make positive changes in their lives. Some clients reported that MHC increased their self-awareness. As one client stated, "[MHC] *gave me time to figure out what was best for me; helped educate me about my mental illness*." Another client said, "*Participation in MHC has made me stop and take a hard look at myself*." Being held responsible, clients said, helps them adhere to schedules and appointments both within and without the MHC proceedings. *"There are consequences,"* one client explained, *"[*for*] not following through."* Sanctions, or the threat of sanctions, reminded many clients to follow through with the requirements of the program. "[Sanctions were] *always in the back of my mind; made me more accountable, if I didn't follow* [MHC guidelines], *a penalty gets slapped on me*."

Clients not only mentioned sanctions as a motivation for complying with MHC but also sited the positive reinforcement and acknowledgement by MHC staff for their individual successes as a strong motivator. *"It* [MHC] *helps*," one client reported*, "because there is a lot of positive reinforcement and recognition."*

Being in contact with other clients in similar situations also helped clients reach their own goals. From a life of reported isolation, clients expressed gratitude to the MHC for bringing them a sense of community. As one client described, "*Seeing brief glimpses of other people's lives, other people's problems to view and hear about has been wonderful*." As clients go through a difficult phase in their lives (arrests, confrontation of mental health issues) seeing others in similar situations and professionals committed to helping them appears to assist clients to overcome their own problems. The presence of judges, lawyers, and mental health professionals who "*really seem to care*," added to the perception that clients were not alone. "[I was] *going through a change*; [MHC] *helped me go through it."*

On the other hand some MHC clients complained that there was not enough privacy in the open MHC for discussing some of their issues with the judge. One client explained, *"It would be nice to be able to talk to the judge alone, I didn't say some stuff that I wanted to say to him because of privacy issues."*

A better understanding of the legal processes the MHC clients were going through allowed them to take advantage of the help they were being offered. [MHC] *Helped me understand the court system` better and how to straighten out my life*. Once clients became comfortable with the MHC process, many reportedly began to thrive in other areas of their lives. One client, when asked if he had benefited from his participation in MHC, said, "*At this point, yes! The fact that I am facing up to reality -- by going to court and doing things in between.* Doing 'things in between' included a long list of goals for the MHC clients we interviewed. Some were able to regain their driver's license, others took on a job, and still others reported the ability, at last, to pay their own rent. For some, who may have only recently enrolled in MHC, their enrollment goals were simpler. One client said her participation in MHC helped her *"get out of bed more so I'm taking another step out of the deep hole."*

Most clients (90%) believed that the MHC program had made positive changes in their lives. Most clients, 71.4% found MHC to be "extremely helpful," while the remaining 28.6% reported their participation to be "somewhat helpful." Yet it is the story behind the numbers that truly explain how clients feel about their participation in the MHC. "*I stayed off drugs,"* one client reported. [I've] *gone to all of my appointments…"* and almost with surprise at the realization, *"I've become responsible."*

Client relationships with MHC professionals: When MHC clients were asked to identify the "most helpful aspect of MHC," 38% identified "meetings with the judge" as most helpful, 43% said the "mental health services they received" were the most help, the remaining 19% reported the "advocacy from the court coordinator."

There were many glowing endorsements of all professionals concerned. When asked how their court coordinator had helped, one client responded, "*in every way, he is very supportive, I can't say enough about him. He treats everyone with respect -- he's incredible."* Inline with this response, another client said of his court coordinator, "[He is a] *good support system and* [is] *encouraging. He recognizes my success. I believe that he is on my side and cares about me.*

When asked to describe their relationship with the MHC judge, most clients spoke of the judge's fairness and respect for those who came before the court, an attitude that helped many relax in court and better focus on their goals. Many clients also used "caring" to describe the judge. Another said "[He is] the *best judge that I have ever seen. If you're honest to him, he is honest to you."* One client claimed to consider a MHC judge their "*best friend,"* while another rated a judge as "*awesome."* There was even a proposal of sorts from one client. "*I'd marry the man,"* one client said when asked about the judge. Yet another client stated, "*He's wonderful. Feel that he saved my life*."

Another important relationship between MHC clients was with their mental health practitioners. Most clients, (73% of this group) said they liked their case manager "a lot, " 24% reported to like their case manager "somewhat," and the remaining 3% reported to like their case manager "not at all." Again, the story behind the numbers is more illuminating. "*We talk about our past,"* one client said of her case manager. [My case manager] *and I have a lot in common. He's constantly asking how I am doing. He's almost like a dad to me."* More common are the stories of case managers helping clients with their daily lives. "[She] *takes me to my appointments, get* [my] *meds and helps me get resources. Very helpful, knowledgeable, caring, professional, she is great.* Others said they received help managing their medications, getting to job sites, buying clothing and finding a suitable place to live.

Client recommended changes or improvements to MHC. Some clients stated that they would like to see the Substance Abuse Court and the Mental Health Court combined so that both issues could be addressed in one court.

Some clients reported that the MHC process is "too chaotic." One client stated, "I would like the location of the court to be more low key. The Courthouse is stressful to me." Stressful elements of MHC reported by clients included that there were too many people reporting to the judge at one time. When the judge does not appear to court on time it makes people feel stressed. Clients recommended a scheduled times for people to appear before the judge or stronger adherence to the sign in sheet, so that clients could be seen on a first come first serve basis.

One client observed that there appeared to be inconsistency in the judge's role. She states, "*It is not clear what expectations are and they do not follow through. Not consistent in their recommendations, regulations and enforcing their expectations.*" Another client expressed confusion about the requirements of MHC and the length of participation. Other clients expressed the need for help with transportation to and from MHC.

Summary. From consumer interviews we learned that consumers felt a sense of increased quality of life including enhanced social relations and living situation, improving self-esteem and individual respect, increased sense of control of mental illness including medication management, and decreasing involvement with the legal system. The majority of consumers were very content with the MHC program, and they especially expressed positive attitudes toward the MHC professionals involved in their lives. Data suggested that a client's relationship with the judge, court coordinators, and mental health providers was extremely important in successfully completing program requirements.

The evaluation team was able to learn a great deal about the effectiveness of MHC from consumers participating in the program. The rich interview data complemented other MHC data collected as part of this evaluation. However, a limitation of the consumer interview portion of the evaluation was the low follow-up response rate. It was unfortunate that the third year of this grant was cut which limited our ability to follow-up with more MHC consumers. Also, the clients interviewed at follow-up were clients who stayed in the program and were thus more likely to have positive experiences with the MHC. We were unable to reach a significant number of MHC clients who opted-out or were disqualified from the program. In future studies, it would be beneficial to compare clients who successfully complete the MHC program to clients who opt-out or are disqualified to determine whether there are differences in re-arrest rates and other client outcomes.

Section 7: Stakeholder Interviews

Stakeholder data was collected from February through April 2003. Fourteen participants answered open-ended questions in short qualitative interviews. Both judges (n=2) participated, as did all court coordinators (n=3), members of the prosecutor's office (n=2), a County Jail official (n=1), mental health practitioners (n=3) and consumer advocates (n=3). Participant stakeholders represented several agencies involved with MHC including: the Clark County Mental Health Court, Clark County Jail, Clark County Prosecutor's Office, Mental Health Northwest, Columbia River Mental Health, Consumer Voices are Born and the Vancouver City Housing Authority.

Interviews were designed to gather stakeholders' perceptions of MIRAP and the Mental Health Court. The three main questions addressed by stakeholders were: 1) What are the benefits of the MHC and how could it be improved? 2) Is the MHC serving the appropriate population? 3) Are the monthly Oversight Committee meetings effective?

Benefits of MHC and How Can It Be Improved. Stakeholders identified three key benefits of MHC: a) improving the lives of MHC clients, b) improving service coordination between agencies thereby relieving burden on any one agency, and c) benefits to the community. The stakeholders were split with regard to whether the MHC led to cost savings, but most stakeholders noted that cost savings is not where the emphasis should be. Stakeholders reported that they valued the benefits of the MHC to clients and the local community most.

Improving Clients Lives. Most stakeholders believed that the MHC program increased the quality of life for clients by allowing them to "*better manage their own lives outside the criminal justice system.*" What about the MHC allowed clients to better manage their lives? "[Client] *accountability is a big one*," one stakeholder reported. "[The clients are…] *not just… accountable to one person but to a variety of people*," and "*this may be the first time* [clients] *feel the system is working for them instead of against them*." Another stakeholder explained the effect accountability could have on a client.

> *MIRAP has been very beneficial. It gives clients an authority figure rather than parents having to bother them… The judges are very gifted. Overall, it provides an authority that makes clients responsible for their behaviors.*

Another stakeholder states that it is not only the authority of the MHC that motivates change but the supports provided by MHC professionals to clients who are seeking help.

> *Once engaged* [in MHC] *many* [clients] *are proud. Many want to see themselves as normal. Many are doing better than they ever have. Case management provides support* [and] *for the first time in their lives a person like a judge -- who knows them* [personally] -- *treats them as a person,* [is] *not trying to lock them up. This is a paradigm shift in the criminal justice system.*

The 'paradigm shift' has not come without consequence. While many reported a more streamlined and cooperative approach where "*interventions come more frequently*," stakeholders also reported some confusion about the roles of various agencies.

> *We need better cooperation between systems*, "one stakeholder responded. "*I don't give recommendations in front of clients, that is not my job (for example, if the judge asks me how many days in jail I think that a client should spend, I don't want to be the person giving such a recommendation). I am* [in court] *to support clients and not to punish them;* [everyone] *needs to recognize this…*

Improved agency collaboration to serve offenders with mental illness. While some stakeholders talked about MHC as a work in progress, they generally reported satisfaction that MHC was moving in the right direction with a common goal. "*Systems*

are all trying to find ways to meet the needs of clients with mental health needs and are open to different ways of serving clients."

This working together and increased collaboration benefited the entire service system for offenders with mental illness. Most stakeholders (n=13) perceived a lightened workload due to MIRAP, by lowering the recidivism rate for participating clients, and sharing client service responsibilities across agencies. One suggested there might still be some "*repetition"* but on the whole, stakeholders believed MIRAP brought needed improvements to MHC. MIRAP allowed stakeholders to become pro-active. "*There are more people* [available]," one stakeholder reported " *to address* [individual] *problems before they* [got] *out of control*," one stakeholder reported. The inter-agency cooperation encouraged by MIRAP also streamlined the process and even, according to one stakeholder, helped "*improve some work within* [their own agency].

While stakeholders generally sited the 'process' of refining the MHC as positive, a few stakeholders stated that there is still room for improvements. Stakeholders reported the need to create clearer definition of the expectations of MHC as illustrated by the statement below.

> *Clients feel that* [Mental Health Court] *is a humane process; however there has been talk about inconsistencies of judges when it comes to sanctions and involvement. There seems to be a lack of communication about expectations between court staff and relaying information to clients and providers.*

Another issue raised by stakeholders was protection of client confidentiality. Different systems have different values and rules for maintaining confidentiality. The shared database between the criminal justice system and the mental health agency's (a cornerstone of the MHC) raised concerns among mental health and jail staff early in the implementation of the MIRAP program but was resolved through common agreements about limiting access to the Mental Health Court Coordinators.

Other stakeholders expressed concern about confidentiality issues in MHC where clients discuss their cases and clinical information is shared in a public forum. However, many stakeholders felt these problems were being properly addressed through the monthly meetings of the Oversight Committee that is part of the MIRAP program. "*MIRAP*," one stakeholder reported, "*brought much needed structure to the MHC sessions*." In addition, Judge Fritzler is working on a Mental Health Court Manual to develop guidelines to address client confidentiality issues, as well as develop consistency in the imposing of consequences or sanctions.

Stakeholder Perception of Benefit to the Community. Many stakeholders felt MHC benefited the community as a whole by increasing public safety. Several stakeholders expressed that MHC is "the right thing to do." They reported a sense of pride that comes from being a part of an innovative approach to better serving mentally ill offenders. Stakeholders had an expressed interest in both making a difference for the population they serve and the community as a whole. When asked whether the MHC

provided services that 'benefits the community,' all stakeholder agreed that it did. One response was typical of stakeholders' perceptions.

> *Absolutely, clients have a higher quality of life. Re-offends* [occur] *less often. We have less people on the streets, which reduce costs, court and police involvement, and frees up space in jails. It makes the city more beautiful.*

While this stakeholder felt that MHC reduced costs, there was mixed perceptions among stakeholders about true cost savings. Many stakeholders pointed out how difficult it would be to truly ascertain cost effectiveness.

Cost Savings or No Cost Savings. There was little debate among stakeholders about the benefit of the Mental Health Courts on the lives of those served by the program. There was some question about the cost effectiveness of such a program. Although not directly asked during the interview many stakeholders (n = 10) discussed the issue of cost savings. Seven of the ten who introduced the topic of cost believed MIRAP freed up resources and thereby saved the county money. One stakeholder explained that "*MIRAP has done a good job to take resources and applying them to consumers…It saves tax payers money,"* but also added another, possibly more important, "*benefit to the community*. [MHC] *is more humane to our citizens. It recognizes that this is a better way of handling incarcerated citizens. It reduces the revolving door syndrome."*

Stakeholders felt that MHC was *"more appropriate*" than jail for the mentally ill offenders and increased the overall *"quality of life"* for the entire community.

> *Mental illness is not a good reason for someone to go to jail . . . jail makes some people worse. People with PTSD* [Post Traumatic Stress Disorder], *for example…* [We are] *intervening with people to help manage their lives better. It saves money and makes mentally ill people better.*

While no stakeholder disagreed MHC helped some clients better manage their lives, not everybody was convinced of the Court's cost effectiveness. Three stakeholders remained unsure of any savings for the county. For example, when one stakeholder was asked whether he would you like to see Mental Health Court continue in the future, he was undecided.

> *Yes,* [I'd like to see the Court continue] *but I am cautious, for we have to realize that it is an expensive proposition to make. In the best of both worlds, yes it is a great program, but in terms of choices and cost effectiveness, resources and expense, I have my doubts and concerns.*

One stakeholder pointed out how difficult it would be to see savings in the jail system. "*Those who volunteer* [for MHC]," he said "*are not necessarily those that cause the most problems in jail*." As cells are vacated by MIRAP participants they are immediately filled with new inmates. The jail sees no decrease in the population and in the end, "*the*

jail is left with those inmates who cost the system the most." Another stakeholder commented that the jail operates on an "economy of scale" and a few less inmates is not likely to really save money in terms of daily operation costs. This stakeholder said that the cost savings would only occur- "*if by not filling the jail with severely mentally ill offender- this can prolong the need to build another jail- then this is a capital savings to the county.*" However, he admitted a more direct savings to the jail could be measured in terms of savings in costly medical care and psychiatric medication needs of the severely and persistently mentally ill.

Another stakeholder commented on how difficult it would be to account for all the costs and determine cost effectiveness of the MHC program. There appear to be hidden costs in the system that most people don't account for.

> *I don't know if specialty courts are cost-effective. Are costs really accounted for? For example, there is a lot of support staff that have to pull files each week in the prosecutor's office, which are costs that are not included in grant money. There is a lot of staff time and cost is not factored into running a specialty court.*

Perhaps, cost-effectiveness, as can be measured by dollars and cents, is not the most important goal. While the stakeholders were most divided on the issue of whether MHC is cost-effective, the stakeholders were more universal in their belief that MHC is beneficial to the clients served, the community and the network of agencies that serve this population. One final quote from a stakeholder relaying a client's experience in MHC illustrates how the many benefits of the MHC program.

> *The client was a high end user of services and he had committed an assault. The client had multiple arrests and inpatient visits. After MHC, he has not been in the hospital in eight months. We haven't had to have Health and Welfare checks sent to him. This has freed up Emergency Room, police, and fire department staff -- the client often called 911 before MIRAP. This person is going to school and volunteering. Now that he's going to school there is much more engagement. He still struggles but his quality of life has improved and that's what this is all about. Improving the quality of life for individuals and decreasing costs to the community. When* [a client's] *record keeps getting longer and longer it just gets tougher* [for the client] *to get a job. It continues to perpetuate the problem.* [The Mental Health Court] *is preventative instead of constantly hospitalizing* [clients].

Is MHC serving the Appropriate Population? Most stakeholders (n=12) believed MIRAP was serving the appropriate population. However, over half (n=8) thought, at least, some felons could be served well in the Mental Health Court.

> *We need to expand the program to felons. More study is needed to see how to address this population.*

On the other hand, one stakeholder had a false impression of the clients enrolled in MHC and felt "inappropriate" felons (sex offenders, for example) got into the program in the beginning of Mental Health Court's existence, however, data do not support this perception.

The voluntary nature of the program was also seen as a barrier to serving the appropriate population. "*We miss people who don't voluntarily engage.*" Another respondent added:

> *I'd like it to serve more clients. The people who decline in the beginning, I would like to see them join the program. Presentation of the program needs to be clearer to give people the chance to join.*[1]

Many stakeholders felt that greater efforts should be made to reach potential clients who opt out of the program, "*For some people its just easier to do the [jail] time*." Another stakeholder identified the post-plea arrangement (clients must plead guilty to their crimes, then have them expunged upon graduation) as a barrier to increasing participation. Others recommended offering other incentives (notably, housing and employment services) as strategies for, not only, increasing participation but as a means for helping clients successfully complete the program. Using graduates or successfully enrolled clients as peer mentors was another strategy to encourage more clients to enroll and help them complete MHC requirements and graduate.

The Effectiveness of the Oversight Committee Meetings. Stakeholders appreciated the oversight committee meetings for a variety of reasons. "*One of the key benefits,*" one stakeholder explained "*is getting people* [within the system] *together.*"

> [Oversight Committee Meetings] *allow us to share information.* [The meetings] *have enlightened me to address special problems, broadening my perspective of why the need for special courts is prevalent, and it has brought together different disciplines to address problems.*

Cooperation between the criminal justice system and the various mental health agencies was highly valued among participant stakeholders. Before the Oversight Committee meetings, many of the agencies had very little contact with each other and, in some cases, did not understand how all of the pieces fit together. Simply "*getting to know other people in the system,*" was seen as a positive step for members of the committee.

Oversight meetings gave stakeholders a view of the big picture, serving to "*widen* [my] *understanding of why there is a Mental Health Court,*" one participant reported, *"*[and

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[1] As a result of Oversight Committee Meeting discussions, the Mental Health Court created a brochure to help address the presentation problem.

what] *our roles* [are] *and* [why our] *jobs are in existence*." Understanding the slightly different interests of other stakeholders helped some do their jobs more effectively.

While the Oversight Committee Meetings were seen as a valuable forum to share information and ideas and learn more about other partners in the system, stakeholders commonly sited the committee's inability to decide policy changes and lack of authority as a weakness. *"Having no teeth,"* as one stakeholder described it, *"is a limitation of the current Oversight Committee.*" Oversight meetings were viewed as opportunities to identify problems within the Mental Health Court, however the Committee lacked the authority to turn policy recommendations into practice implementation. "*At times* [during meetings]*,"* one stakeholder admitted, *"I feel a bit like an old lady at a tea party."* Without a policy or authority figure in place to enforce policy changes, stakeholders reported barriers to meaningful collaboration in Oversight Committee Meetings.

An example of an impasse among stakeholders was regarding the administering of medications in jail. The issue was raised by some stakeholders that clients were not given prescribed psychiatric medications in jail. As one stakeholder stated:

> *Clients won't get* [their medications] *in jail. It's taken months to get correct combination of meds. People will sit there for weeks before meds even start. Corrections people will say, "There under the influence, we cannot give them meds because they are in a 'wash out period'* [inmates are given nothing in order to detox] . *Every officer should have extensive training in mental health. They're sitting there they come in and make* [inappropriate] *cracks…I listen to the language used. . . We tried hard to change the procedure of getting meds to consumers in jail. We tried to fax over medical records but the jail would ignore them or say they never got the fax. Nothing will change… Every complaint we made was ignored...*

In response, another stakeholder stated:

> *[The jail] takes the brunt of criticism. The OC meetings have helped. On the flip side, people will ask, "Why are there no meds given in jail?" [The jail] needs to have a wash out period. Say a person's an alcoholic, you don't know what could happen. Jail staff don't know what they're dealing with. Why no meds? People are worried about the decompensation. But* [Clients might have] *been decompensating on a meth binge for months, then they come here…*

By looking at both sides, what is a matter of proper medication for one is a problem of safety and liability for the other. While the medication in jail issue was brought up in several Oversight Committee Meetings, the committee had neither the authority nor a procedure in place to successfully get to the root of the problem and make a policy change. Until the Committee has this authority, stakeholders said it would have difficulty changing entrenched procedures and biases.

Many stakeholders explained that the lack of authority stemmed from the loss of the MIRAP Project Manager. Her role on the project was seen by stakeholders as an administrative leader to enforce policy recommendations and provide incentive for all stakeholders to take an active part in meetings. Unfortunately, she left the county mid-way through the project and she was not replaced. Members felt that the vacancy in her position had several negative consequences including: a) the feeling that the committee was left without the glue that held its members together, b) lack of authority to make decisions and effectively span across agencies to make policy changes, c) reduced interest in the MHC program among some key stakeholder groups such as the City of Vancouver's attorney's office, and the City of Vancouver Housing Authority.

In lieu of bringing back the key leadership position, stakeholders recommended other means of combating the lack of authority in the Oversight Committee. Many recommended a rotating position (among Oversight Committee meeting members) that would be responsible for implementing policy recommendations across the agencies. Sharing implementation responsibility would further foster inter-agency collaboration and also ensure representation of all Committee members in policy decisions.

Summary. As a result of the MIRAP program, stakeholders have an expanded view of inter-agency collaboration and problem solving. The Oversight Committee was effective in bringing about a number of changes to improve the MHC. In July 2003, a MHC Legal Contract was implemented that addresses client specific legal concerns and treatment plan goals so that all MHC professionals are aware of client needs. In addition, the client signs this contract committing to working on the issues outlined. Other positive improvements include improving MHC proceedings closer working relationships among the stakeholders to streamline the process for clients. Most stakeholders interviewed were generally happy to be a part of the program as one stakeholder expressed a popular point of view, "*In general, I am pleased with the program; we have a good group of people here…*" However, as stakeholders from agencies with different perspectives and separate vocabularies work toward collaboration, there are bound to be disagreements and misunderstandings. The need for more Oversight Committee authority to bridge these gaps was a common theme among stakeholders. All fourteen stakeholders want MHC to continue into the future. A universal perception was that the MHC court should not only continue but should be expanded.

Conclusions

Overall the Clark County MHC has demonstrated success in reducing re-arrest and probation violations of MHC clients. Consumers reported positive outcomes from participation in MHC, which included increased quality of life, increased self-reliance and ability to manage their own lives, increased stability and self-awareness. The supports provided by the MH providers, court coordinators and judge provide the client with a network of caring professionals that assisted and encouraged clients to make positive life changes.

At the programmatic level, the MIRAP project was success in improving service coordination among key stakeholders which added to the success of the MHC operation. The Oversight Committee meetings provided a valuable forum for stakeholders to voice their concerns and to make recommended changes and improve the MHC process. Both clients and stakeholders stated that the MHC expectation of accountability- mentally ill offenders taking responsibility for their actions- was an important feature of MHC. They acknowledged that the legal authority of the judge influenced clients to comply with their treatment plans and generally stay out of trouble. The threat of sanctions is motivation for some and for others, the positive reinforcement and support provided by a network of caring MHC professionals motivate others to make positive changes in their lives.

Overall, the results from this comprehensive evaluation of the Clark County MHC suggest that the Clark County community benefits greatly from the MHC program in several ways. First, the MHC reduces the burden on the criminal justice system of repeatedly booking the same clients over and over again. It helps break down the "revolving door" by providing clients with a valuable support structure, which adds stability, and redirects clients to meeting treatment plan goals. MHC consumers report improvements in quality of life. Stakeholders report that MHC improves public safety and should certainly be continued in the future and perhaps be expanded.

Recommendations

Client Recommendations for Improving MHC:

In the personal interviews, MHC clients made the following recommendations for changing or improving MHC:

- A dual diagnosis court where substance abuse issues could be integrated into the Mental Health Court
- Decrease the wait time in court
- Need More Follow-Through with Court-Ordered Requirements
- Increase communication between court coordinator, judge, case manager, and client
- More Privacy When Discussing Matters with the Judge
- More help with Transportation

Stakeholders' Recommended Improvements to MHC included:

- Many stakeholders felt that eligibility should be expanded to include felons.
- Better service coordination/unified message to the clients. Many stakeholders stated that there could be improvements in the service coordination efforts and communication between the court coordinators, mental health providers, the judge and client. To address this issue, the MHC implemented a MHC Legal Contract that addresses client specific legal concerns and treatment plan goals so that all MHC professionals are aware of client needs. In addition the client signs this contract committing to working on the issues outlined. The MHC Legal Contract was implemented in July 2003.
- Improve documentation describing the MHC program requirements: A document is needed, like a brochure or manual that describes eligibility criteria, graduation requirements, time it takes to complete the program, and program expectations.

In response to this issue, Judge Fritzler informed the Oversight Committee in May 2003 that he is compiling a MHC manual for Clark County.

- Both judges reported that they could benefit from more mental health training.

Recommendations from the Evaluation team based on MHC observation and attending the MHC Oversight Committee Meetings:

- Graduates or successfully enrolled MHC participants could be invited to continue their involvement in MHC by acting as peer mentors to newly enrolled clients. Peer mentors could help engage clients in services and provide added supports that may lower the post-enrollment opt-out rate and help clients complete the program.
- To ensure that MHC starts on time and to reduce the time clients have to wait to be seen before the judge, dedicate a judges' schedule to Mental Health Court on a given day.

Literature Citations

Axelson, G.L., & Wahl, O.F. (1992). Psychotic versus nonpsychotic misdemeanants in a large county jail: An analysis of pretrial treatment by the legal system. International Journal of Law and Psychiatry, 15, 379-386.

Casey, Pamela & Rottman, David B. (1998). National Center for State Courts, Therapeutic Jurisprudence in the Courts 1

Clark County GIS. **http://www.rtc.wa.gov/.** accessed on September 17, 2003.

Derogatis, Leonard R; et al. (1974) The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*. 19(1), 1-15.

Ditton, Paula. (1999). Mental Health and Treatment of Inmates and Probationers: Special Report. Washington, DC: Bureau of Justice Statistics.

Fritzler**,** Randal B. (2001) Best Practices in Mental Health Courts. Unpublished paper based, in part, on the papers co-authored with Dr. Leonore M. J. Simon presented at the American Society of Criminology meeting, Washington, D.C. (November, 11-14, 1998) and the joint meeting of the American Psychology and Law Society and the European Psychology - Law Society, Dublin, Ireland (July 6 - 9, 1999) and a summary entitled "Principles of an Effective Domestic Violence Court" published by *Court Review*, the Journal of the American Judges Association, volume 37, issue one, spring 2000, p.28, also co-authored by Dr. Leonore M.J. Simon.

Fritzler, Randal B. (2003), Chapter 14: How One Misdemeanor Mental Health Court Incorporates Therapeutic Jurisprudence, Preventive Law and Restorative Justice. in J.M. Moore (Ed.) *Management and Administration of Correctional Health Care*.

Goldkamp, John S. and Irons-Guynn, Cheryl. (2000) Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts. Washington, DC: U.S. Dept. of Justice, Bureau of Justice Assistance.

Hora, P.F., Schma, W.G. & Rosenthal, J.T.A. (1999). *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV 439, 442-448.

Lehman, Anthony F; Postrado, L. T; Rachuba, L. T. (1993) Convergent validation of quality of life assessments for persons with severe mental illnesses. *Quality of Life Research*. 2(5), 327-333.

Lerner-Wren, G. (March 28, 2003) Broward County Mental Health Court: An innovative approach to the mentally disabled in the criminal justice system. Lecture presented at the Symposium on Mental Health, New Jersey's Institute of Law & Mental Health, Seton Hall Law School, Newark New Jersey.

McGaha, A., Boothroyd, R., Poythress, N.G., Petrila, J., Ort, R. Lessons from Broward County Mental Health Court Evaluation. Evaluation and Program Planning, 25: 125-135.

National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System.

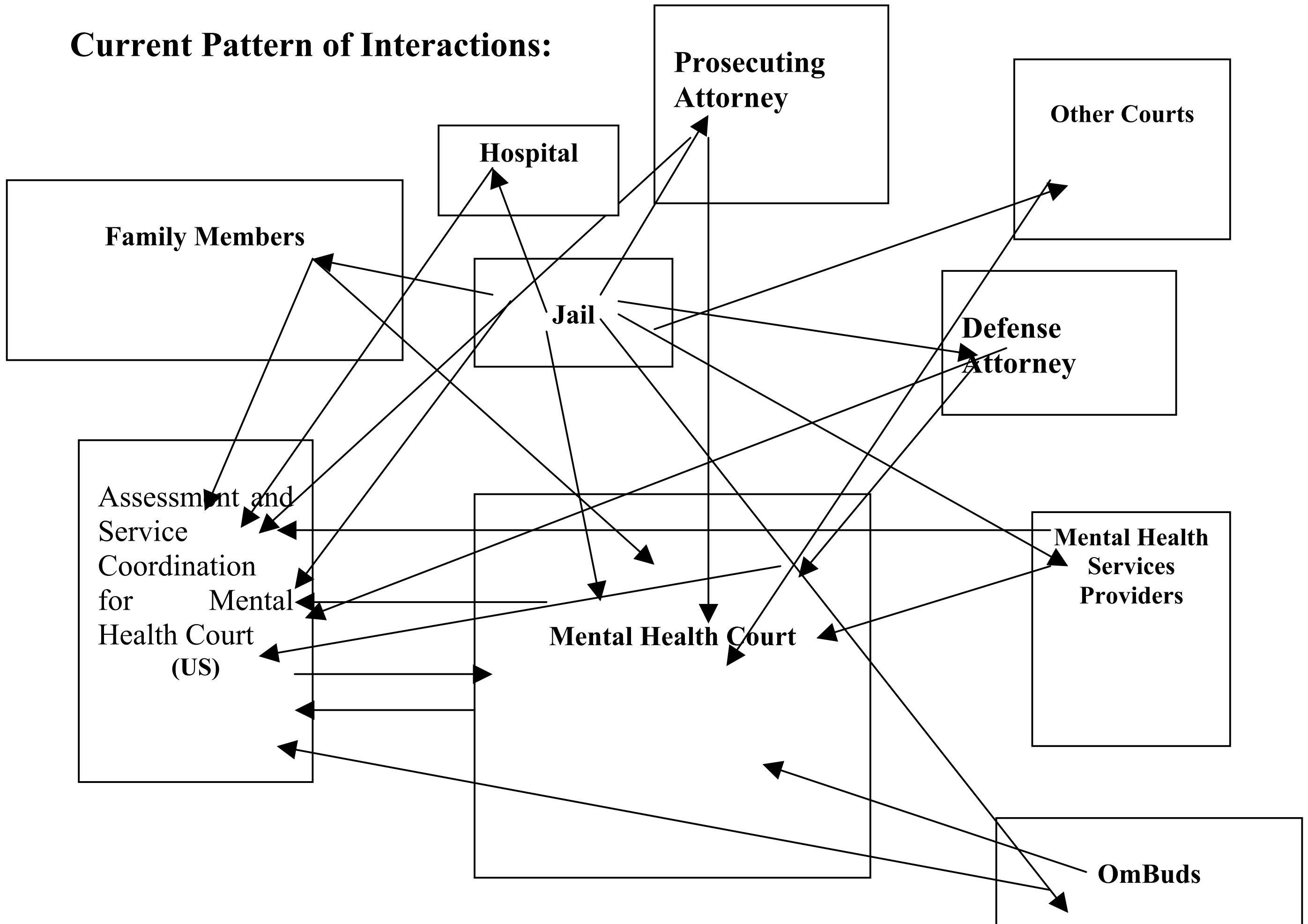
Paulson, R.I., Post, R., Herinckx, H.A. (2002) Beyond Components: Using Fidelity Scales to Measure and Assure Consumer Choice in Program Implementation and Quality Assurance. *Community Mental Health Journal,* 38 (2), 119-128.

Steadman, H.J., Davidson, S., & Brown, C. (2001). Mental health courts: Their promise and unanswered questions. Psychiatric Services, 52. 457-458.

Wexler, David. (1999). *The Development of Therapeutic Jurisprudence From Theory to Practice*, 68 REV. JUR. U.P.R. 691

APPENDICES

Appendix I: Original Pattern of MHC client Referral pre-MIRAP



Process:

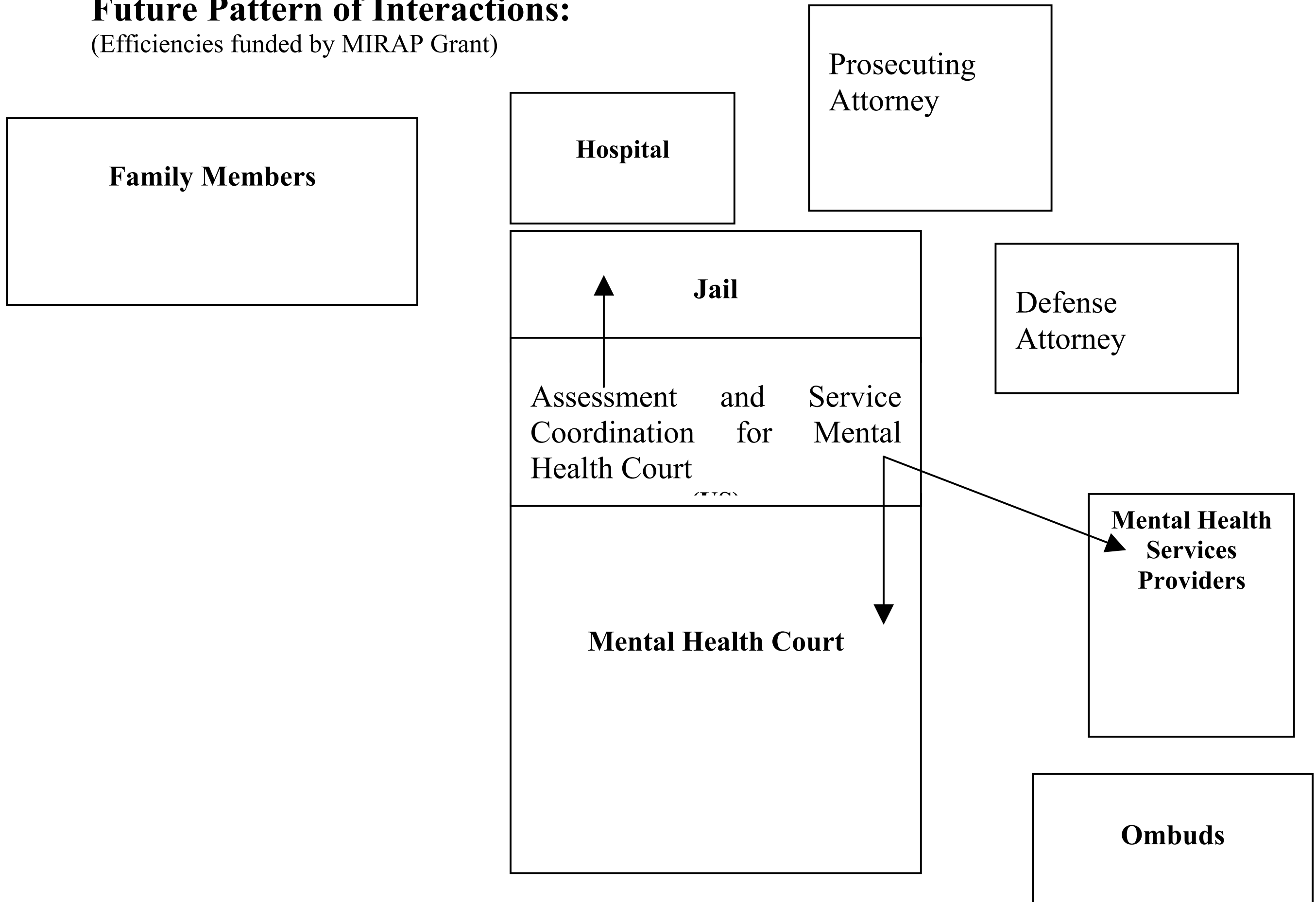
Mental Health Court currently is receiving requests for assessments of potential clients from many sources. When a person is incarcerated the family members, the defense attorney, the prosecuting attorney, the mental health provider, the Ombuds, hospital, other courts or the Judges refer clients. Because of the current complex system of referrals, many court appearances must be rescheduled and delayed until the assessment is completed, or reschedule until all of the appropriate parties can be brought together for disposition of the matter.

Client Flow document created 3/10/2002- illustrating fragmented referral process into MHC.

Appendix II: Post-MIRAP Pattern of MHC Client Referral and Jail Triage post-MIRAP

Future Pattern of Interactions:

(Efficiencies funded by MIRAP Grant)



Process:

We propose to screen jail bookings twice a day Monday through Saturday to quickly find people (24 hours) who have received mental health services. By proactively locating people with mental illness who have been incarcerated, most clients, who would qualify for the service, will be found before they come to the attention of the current referral sources. By being present in the jail each day for assessments, clients new to our area or with a newly developed illness can be referred to us by the jail.

Jail triage and MHC client referral model illustrating improved referral process to be implemented in April 2002.

Appendix II: Client Flow for Mental Health Court

1) Person is arrested
   a) Charge is misdemeanor or gross misdemeanor
   b) Charge is felony – see exception to general flow (Section 8)
   c) Arrest and release – see exception to general flow (Section 8)

2) Person is booked into jail
   a) Booked and held
   b) Booked and released – see exception to general flow (Section 8)
   c) Booked and bailed – see exception to general flow (Section 8)

3) Team compares booking data with Mental Health database twice each day Monday through Saturday
   a) Information available in MIS on current and past clients reviewed by team
      i) Assessment – five Axis diagnosis
      ii) Service activities
      iii) Hospitalizations
      iv) Financial entitlements
      v) Other
   b) Status of person determined
      i) Open client receiving intensive services
      ii) Open client receiving limited services
      iii) Client not open, but received services in the passed
      iv) Client not in database (Section 8)

4) Open clients who are receiving intensive services (not necessarily PACT or ICM)
   a) Team visits in jail and assesses (limited assessment) for interest in Mental Health Court
      i) Client is not interested and opts out
      ii) Client interested and would like to opt in
      iii) PACT or ICM decision made
         (1) Release of information signed
         (2) County charge (Section seven)
         (3) City charge (Section seven)
         (4) Team notifies provider case manager or intake worker for PACT or ICM
         (5) Provider case manager or intake worker contacts client within 24 hours to assess for modifications to level of service and service package
         (6) Services adjusted, if necessary to meet increased needs

5) Open clients who are receiving limited services or clients who are closed but have received services in the past
   a) Team visits in jail and assesses (full assessment) for eligibility and interest in Mental Health Court
      i) Client not eligible – see eligibility criteria
      ii) Client is not interested and opts out

iii) Client eligible and interested and would like to opt in
iv) PACT or ICM decision made
(1) Release of information signed
(2) County charge (Section seven)
(3) City charge (Section seven)
(4) Team notifies provider case manager or intake team (PACT or ICM)
(5) Provider case manager contacts client within 24 hours to assess for modifications to level of service and service package
(6) Services adjusted, if necessary to meet increased needs

6) Person has not previously received mental Health services in Clark County – see exception to general flow (Section 8)

7) Person would like to opt in
a) County Case (build protocol)
i) Team notifies Court Docketing Clerk
ii) Team notifies prosecutor
iii) Team notifies ___________________
b) City Case (build protocol)
i) Team notifies Court Docketing Clerk
ii) Team notifies prosecutor
iii) Team notifies ___________________

8) Exception to flow
a) From jail
i) Person with no local mental health history
ii) Medical team, Rita, or Barbara refer to team on next scheduled visit
b) From community
i) Arrested
(1) Released
(2) Booked and released
(3) Booked and bailed
(4) Felony charge pled to misdemeanor
ii) Interested party submits request for assessment to team
c) Team assesses (full assessment) for eligibility and interest in Mental Health Court
i) Client not eligible – see eligibility criteria
ii) Client is not interested and opts out
iii) Client eligible and interested and would like to opt in
iv) PACT or ICM decision made
(1) Release of information signed
(2) County charge (Section seven)
(3) City charge (Section seven)
v) Team notifies provider case manager or intake team
vi) Provider case manager contacts client within 24 hours to assess for modifications to level of service and service package
vii) Services adjusted, if necessary to meet increased needs

Appendix III: Types of Crimes

Charge Categories. Criminal charges were grouped into 7 categorized: domestic violence, driving violations, theft and property crimes, alcohol and drug related crimes, disorderly conduct/ public nuisance, assault/violent crime, and obstructing justice. Each charge was assigned to one category, and all categories included misdemeanor and felony crimes.

Domestic Violence: Domestic violence charges included by assault and other charges listed with a domestic violence component. These included: simple assault DV, assault 4 DV, assault 1 DV, assault 2 DV, and assault 3 DV, reckless endangerment/domestic violence, criminal trespass/domestic violence, harassment/domestic violence, and malicious mischief/domestic violence, interfering with a report of domestic violence and burglary-residential/domestic violence.

Driving Violation/Hit and Run: Driving violations and hit and run charges were grouped together in this category. Driving violations included: negligent driving, reckless endangerment, reckless driving, reckless driving/racing, driving while suspended, driving while revoked, driving while revoked/habitual. Other charges in this category were: failure to acquire a Washington driver's license, expired license, no valid operators license, failure to acquire a special permit, failure to stop and give information, failure to sign infraction, failure to give name and address to attending officer, failure to produce vehicle registration certificate, failure to acquire Washington vehicle license, and seat belt violations. Hit and run violations included: hit and run unattended vehicle, hit and run unattended vehicle/property damage, hit and run attended vehicle/no injury, hit and run attended vehicle/physical injury, hit and run felony, attempting to elude police, and vehicular assault.

Theft and Property Crime: The theft category included charges such as theft, possessing stolen property, forgery, identity theft, welfare fraud, unlawful issue of bank checks, and fishing without a license or fishing within a closed area. Arson, vehicle prowling, and trespass were grouped as property crimes.

Alcohol and Drug: Alcohol and drug charges were grouped together. These charges included: possession of various drugs and drug paraphernalia, forged prescription, manufacturing a controlled substance, furnishing alcohol to a minor, and other alcohol charges. The driving violations that included use or possession of drugs or alcohol while driving were categorized as the alcohol and drug type of crime.

Disorderly Conduct/Public Nuisance: Disorderly conduct and public nuisance charges were grouped together in this category. The charges included: disorderly conduct, park curfew violations, camping in city park, unlawful dumping solid waste/garbage, public disturbance/noise, urinating in public, unlawful bus conduct, Malicious Mischief I, Malicious Mischief III, malicious mischief more than $50, malicious mischief less than $50.

Assault/Violent Crimes: Assault charges included in this category were: Simple Assault, Simple Assault/Not DV, Assault IV, Assault I, Assault II, and Assault III. Other violent crimes in this category were: harassment, stalking, child molestation, failure to register as a sex offender, and rape charges.

Obstructing Justice. Charges grouped in this category were giving false information, false reporting, false information to an officer, contempt of court, failure to

pay fine, obstructing public servant, resisting arrest, attempting to elude, bail jumping, and escape.

Appendix IV: MHC Legal Contract

IN THE DISTRICT COURT OF CLARK COUNTY, WASHINGTON

_____ STATE OF WASHINGTON
_____ CITY OF VANCOUVER,)
_____ CITY OF CAMAS) CAUSE NO. ________________________
_____ CITY OF WASHOUGAL)
Plaintiff,)
vs.)**PROBLEM SOLVING COURT CONTRACT**
)
________________________________) MENTAL HEALTH COURT
Defendant.)

Based on the stipulation of the parties herein for a Deferral of sentencing or entry of a stay in this case, Further sentencing proceedings in this case, may be deferred while the above named defendant successfully participates in the above entitled problem solving court. The defendant acknowledges that problem solving courts are partnerships of people interested in helping him or her to make changes in their life. These changes will enable the defendant to live productively and peacefully within his or her community. The judge will encourage the defendant and hold them accountable. Case coordinators will assess and refer the defendant to needed services. The case manager will assist the defendant to achieve their goals. Participation in a problem solving court is voluntary. However, all defendants must agree to abide by the following contract in order to participate:

I must either enter a plea of guilty or be granted a stay of prosecution in order to participate in a problem solving court. If I have entered a plea, my sentence has been postponed, and my compliance with the following conditions is required and the Judge may impose sanctions if I fail to meet any of these conditions. In consideration of being accepted in the Clark County Problem solving court indicated above, I agree to the following terms and conditions while I am a participant of this problem solving court:

1. I will obey all laws.
2. I will appear at all hearings as ordered by the Judge.

3. I will meet keep all appointments with my case manager and work diligently with him or her to complete an appropriate rehabilitation or treatment program.

4. I will promptly inform my case manager and the court of any change in my address and phone number.

5. I will attend all scheduled appointments with my treatment providers.

6. I authorize my treatment providers to release any medical information regarding my treatment or testing to my case manager, the court, my defense counsel and the prosecutor.

7. I waive confidentiality of my medical records, to include any test results, and authorize my treatment providers to discuss my case with the court, my defense counsel and the prosecutor in my case.

8. I understand and agree that there may be discussions about my case, my treatment program, and my condition which will take place out of my presence or the presence of my attorney.

9. I understand that if I miss court appearances, a warrant may be issued for my arrest. If the warrant is outstanding for more than 30 days, I may be terminated from the problem solving court. If terminated from the problem solving court, the Judge may sentence me for my offenses.

10. I must report any new arrests or criminal proceedings which arise against me to my case manager and to the court.

11. I understand that I am giving up the right to a speedy trial. I give up my right to confrontation and to cross examine witnesses against me. I do not give up the right to testify on my own behalf. I do give up the right to contest the stop, and or search in my case. I am stipulating to the admissibility of the police reports on my case(s). These rights have been explained to me by my attorney and the court.

12. If I comply with the terms of this contract, and graduate from the problem solving court, the sentence on my case will be suspended, absent any mandatory fines or fees indicated in this contract.

13. I understand that failure to meet any of the conditions listed above, or checked below, will be cause for termination from the problem solving court. In addition to following the above terms, I am responsible for complying with any of the conditions listed below:

_______ Other conditions:

I understand that the court may impose fees and costs including a filing fee, Program/Monitoring Fee, attorney recovery fees, restitution or Other fees. If imposed, the court will set a payment plan on these fees to be paid as indicated below. Other fees for testing may be imposed by the court at the Judge's Discretion.

Fees to be Paid: $____

Amount to be Paid: $__________________________

Amount Defendant is to pay per month: $ ___________________

Dated this ___________day of ____________ 20______

____

Defendant

________________________,
Assistant City Attorney , WSBA #______________

Deputy Prosecuting Attorney, WSBA #____________

________________________,

Attorney for Defendant WSBA #_________________

Entered this _________________ day of __________________ 20 _______

____,
District Court Judge

Appendix V

Services Needed & Received:

The following is a list of services. As I go through this list of services, please tell me if you needed this service and if you received these services within the past two weeks.

Within the past two weeks, did you (need, receive) . . .	I **needed** this service 1	2	I **received** this service 1	2
1. Help getting resources such as, food, clothing, shelter, food stamps, or benefits.	No	Yes	No	Yes
2. Medical care (for physical health problems)	No	Yes	No	Yes
3. Dental care	No	Yes	No	Yes
4. Inpatient psychiatric hospitalization	No	Yes	No	Yes
5. Outpatient individual therapy or counseling	No	Yes	No	Yes
6. Outpatient family therapy or counseling	No	Yes	No	Yes
7. Outpatient group therapy or counseling	No	Yes	No	Yes
8. Mental Health Day Program (such as ADAPT)	No	Yes	No	Yes
9. Outpatient alcohol treatment program	No	Yes	No	Yes
10. Inpatient or residential alcohol treatment program	No	Yes	No	Yes
11. Outpatient drug treatment program	No	Yes	No	Yes

Within the past two weeks, did you (need, receive) . . .	I **needed** this service		I **received** this service	
	1	2	1	2
12. Inpatient or residential drug treatment program	No	Yes	No	Yes
13. Medication for a psychiatric diagnosis	No	Yes	No	Yes
14. Crisis assistance (e.g., emergency room visit, telephone crisis line, crisis residence)	No	Yes	No	Yes
15. Skills training to help you take care of yourself (e.g., managing medication, planning a diet, taking care of your personal hygiene, going shopping, using transportation)	No	Yes	No	Yes
16. Medical and financial benefits counseling or assistance (money management, payee, SSI, medical insurance)	No	Yes	No	Yes
17. Assistance with employment	No	Yes	No	Yes
18. Housing Assistance	No	Yes	No	Yes
19. Help in planning how to use your leisure time, plan social and recreational activities.	No	Yes	No	Yes
20. Information on community resources or support groups (consumer voices are born)	No	Yes	No	Yes
21. Are there any additional services you needed? Other (specify) ___________________.			No	Yes