The Allegheny County Mental Health Court Evaluation

Process and Impact Findings

By Amanda B. Cissner, Ashmini Kerodal, & Karen Otis

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The opinions, findings, and recommendations expressed in this publication are those of the authors and do not necessarily represent the positions or policies of the Bureau of Justice Assistance or the Allegheny County Mental Health Court.

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Executive Summary

The Allegheny County (Pennsylvania) Mental Health Court (ACMHC) has been in operation since 2001. The current project, funded through the Bureau of Justice Assistance's Adult Drug Court Discretionary Grant Program, includes three components: (1) a **process evaluation**, documenting and critically assessing program practices; (2) a **strategic plan**, informed by process evaluation results and developed collaboratively by technical assistance staff at the Center for Court Innovation and ACMHC personnel; and (3) an **impact evaluation**, measuring program impact on recidivism. This report documents findings from the process and impact evaluations.

Process evaluation results were informed by a policy survey completed by program staff, stakeholder interviews, program observations, service provider interviews and surveys, and review of program data covering the period from January 2010 through September 2016. The impact evaluation compared recidivism outcomes between the sample of ACMHC participants and a matched contemporaneous comparison sample up to three years post-conviction (and/or program entry).

Major Findings

Program Impacts

Mental health court participants had significantly *fewer* new arrests during the post-program (i.e., three-year) period (1.10 v. 1.53 new arrests, $p<.05$).

Otherwise, the Allegheny County Mental Health Court saw modest impacts on official measures of recidivism. Program participants were somewhat less likely than those in the matched comparison group to be re-arrested on *any* new charge (50% v. 61%) or a new drug charge (12% v. 20%) in the post-program period. Correspondingly, participants were slightly less likely to have a new drug *conviction* at three years (6% v. 11%). However, none of these findings reached statistical significance.

No other measures of recidivism—broken down by time period, new charge type, or outcome (i.e., re-arrest, re-conviction, new incarceration sentence)—differed significantly between the two groups. The time until a recidivism event was not significantly longer among program participants.

ACMHC Caseload

- **Charges at Entry** Half of participants (51%) enter the mental health court on a felony charge; nearly half (47%) enter on a misdemeanor. The most common top charges of participants are theft (21%), assault (16%), aggravated assault (7%), burglary (6%), and trespassing (6%).

- **Demographics** Participants are 38 years of age, on average. More men (69%) enter the program than women. Most participants identify their race as black (58%) or white (39%).[1] The majority of participants were unemployed at the time of program entry (72%) and have never been married (75%).

- **Behavioral Health** Participants enter with an array of behavioral health diagnoses; many (66%) have more than one diagnosis. The most common diagnoses seen in the court include major depressive disorder, substance use disorder, and bipolar disorder.

  Some stakeholders reported that co-occurring disorders have become more prevalent among participants in recent years; there was some interest in establishing separate dockets for those participants seen as having a primary substance use disorder versus those with other primary diagnoses.

- **Criminal History** Participants have extensive criminal histories, with an average of eight prior arrests.

Screening

The court does not use a comprehensive risk-needs assessment to screen potential participants. Probation assigns a rudimentary proxy risk score based on current age, age at first arrest, and number of prior arrests. Following a previous cost analysis, stakeholders report that the program intentionally sought to target higher risk and need offenders, but also enjoy the flexibility afforded by a case-by-case screening process. More than one-third of participants (38%) are rated low risk based on the proxy risk score; 15% are rated high risk.

[1] Hispanic ethnicity is not tracked by the program.

Program Requirements

- **Post-Plea Model** At the time of the evaluation, all defendants were required to enter a plea before entering the program.

- **Community Supervision & Case Management** All participants are assigned to a mental health court probation officer. In addition, each participant has a case manager—either through the Department of Human Service's Justice-Related Services (JRS) or, less commonly, through a Community Treatment Team.

- **Compliance Monitoring** Participants return to court for graduated judicial monitoring appearances. The initial frequency of monitoring appearances was reported to be twice a month.

- **Program Completion** There is no definitive participation length requirement, though in practice, average participation length is more than two years (785 days). Of those whose cases were closed at the time of the evaluation, 56% had graduated successfully.

Treatment

Allegheny County enjoys a relatively large pool of treatment providers. JRS liaisons are charged with developing treatment plans and coordinating with treatment providers. Results of a survey of the local treatment providers reveal variability in provider adherence to evidence-based practices (e.g., use of a validated risk-needs assessment to inform treatment, cognitive behavioral approaches, assessment for trauma, trauma-informed programming). In part due to the large number of providers, ACMHC personnel were not entirely certain which programs were implementing evidence-based practices.

Procedural Justice

- **Understanding** Particularly with individuals with a serious mental illness, achieving transparency and comprehension can be challenging. Multiple stakeholders—the judge, dedicated public defender, probation and JRS representatives—explain program rules and expectations.

  In some cases, participant understanding may have been undermined by a program structure developed to prioritize flexibility and case-by-case decision making. There was

a tension between the desire to incorporate the flexibility to respond appropriately to a population with varied needs and the need for transparency in program requirements. For instance, the program does not define clear implications for program graduation or failure from the outset. Neither is the program length clear when participants enter the program.

- **Respect** The research team observed compassion and respect during program observations. The judge spoke to participants about their specific circumstances, gave encouragement, and made touching speeches during an observed graduation ceremony. Likewise, other program personnel spoke to and about participants with respect and compassion.

Collaboration

Collaboration was cited by stakeholders as a major program strength; cross-agency collaboration was apparent throughout the site visit.

Chapter 1

Introduction & Methodology

As part of the Bureau of Justice Assistance's Adult Drug Court Discretionary Grant Program, the Allegheny County (Pennsylvania) Mental Health Court (ACMHC) was awarded $166,605 to fund a Mental Health Court Enhancement Initiative beginning in October 2015. This funding would be directed to three primary deliverables, each conducted by staff at the Center for Court Innovation (CCI):

1. A **process evaluation** documenting and critically assessing the program's case-flow, service delivery, and resources in relation to its planned target population, policies, and procedures.
2. A **strategic plan**, informed by the results of the process evaluation and outlining clear goals, objectives, and action steps for addressing identified areas of need; and
3. An **impact evaluation** measuring program impact on recidivism by comparing outcomes between mental health court participants to those of a matched comparison group whose cases were routed through a traditional criminal court process.

This report presents results of the process and impact evaluation components of the project. Following the initial process evaluation activities, the court implemented changes based on the recommendations contained herein; however, this report is limited to the policies and practices already in place during the evaluation period.

Process Evaluation Methodology

Pre-Site Visit Activity

Developing the Project Scope The project team, comprised of one member of the Center's research department, two members of the Treatment Court Programs technical assistance team, and the Director of Mental Health Court Programs, worked together with members of the ACMHC team to develop the project scope and finalize the deliverables and budget. A series of introductory calls with members of the ACMHC team were conducted to inform the project scope and familiarize Center staff with basic background concerning the ACMHC program. With feedback from the technical assistance team, research staff developed process evaluation protocols and instruments, including a policy survey (see below), site visit interview scripts, and a structured courtroom observation form. In addition,

members of the project team worked with the ACMHC and coordinators from problem-solving courts across Allegheny County to create a list of stakeholders to include in in-person interviews during the site visit and to identify dates for the process evaluation site visit. Protocols for the process and impact evaluations were reviewed and approved by the Center's Institutional Review Board (IRB).[2]

ACMHC Document Review Prior to the site visit, Center staff reviewed documents received from members of the Allegheny County Mental Health Court team, including the participant handbook, a preliminary analysis of ACMHC cases (conducted by the Allegheny County Department of Probation), the court policy on narcotic medications, attorney responsibilities for mental health court clients, and a cost analysis of the court conducted by the RAND Corporation (Ridgely et al. 2007). This review provided project staff with important background information about the structure and operations of the court.

Mental Health Court Policy Survey A comprehensive policy survey was sent to the ACMHC team in advance of the site visit (see Appendix A). The survey is intended to help identify the court's policies and practices as well as to assess the extent to which the court is engaged in evidence-based practices.

The 120-question instrument includes questions across a range of domains, including legal and clinical eligibility; clinical assessment; possible legal outcomes for program graduates as well as participants who fail; interim responses to problems and progress; judicial supervision; case management; treatment strategies; service provision; program staffing; team collaboration; and data tracking.

The survey was completed by the then-Problem Solving Court Coordinator and the Mental Health Court Coordinator, with input from other ACMHC stakeholders as needed. Survey responses inform the findings below.

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[2] The protocol was considered minimal risk and was approved after an expedited review. Justification for expedited review included the nature of the information to be collected during stakeholder interviews—i.e., stakeholders were to be asked about their professional role in the court. In addition, no personally identifying information was collected during either courtroom observations or review of program data. Neither will personally identifying information be reported as part of the impact evaluation and all findings will be reported in the aggregate. Identifying information will be collected only insofar as it is required to merge data across systems; all personal identifiers will be removed from the final data files.

Onsite Evaluation Activities

In June 2016, a three-day site visit was conducted by a two-person process evaluation team. Site visit activities included:

- **Team Member Interviews:** Multiple interviews were conducted with ACMHC team members. They included interviews with the ACMHC judge; the ACMHC Coordinator; the Allegheny County Problem Solving Court Coordinator; both the manager and one of the three Justice Related Services (JRS) Mental Health Court liaisons, who serve a case management role for most mental health court participants; the public defender and assistant district attorney dedicated to the ACMHC; two of the dedicated ACMHC probation officers; a representative of one of the community treatment teams (CTTs) utilized by the court for services and select case management; and the administrative judge overseeing the criminal division of the Allegheny Court of Common Pleas. In addition, a telephone interview was conducted with the unit director from another of the local service providers—this one serving clients with co-occurring disorders as they reenter their communities.

- **Staffing and Court Observation:** The process evaluation team observed an ACMHC team staffing meeting, during which the team reviewed a list of 71 active clients. After staffing, the evaluation team observed a graduation ceremony for 14 participants who had successfully completed their program mandate. A discussion of the graduation is included in the findings below. The evaluation team also observed a regular afternoon compliance calendar of the ACMHC, completing a structured court observation form (see Appendix B) for 27 of the 28 cases on the calendar. In particular, the structured observations sought to document a variety of measures associated with procedural justice (e.g., judicial eye contact, tone, and demeanor; certainty and clarity of response to compliance and infractions). Finally, the evaluation team observed the calendar reserved for new pleas and revocation hearings. The five new pleas into the ACMHC and one probation revocation observed during this calendar were not documented using the structured courtroom observation form; instead, the team took detailed notes on each case.

- **Service Provider Site Visit:** The evaluation team, accompanied by the ACMHC Coordinator, toured Mercy Behavioral Health Crisis Recovery Center, one of the providers commonly used by the court. A supervisor at Mercy led the tour and spoke with the group about the available services and provider policies.

Follow-Up Activities

Provider Telephone Interviews In the week following the in-person site visit, researchers separately conducted telephone interviews with representatives from two housing providers utilized by the court and with representatives from the Allegheny County jail, including the jail's Director of Mental Health.

Service Provider Policy & Practices Survey Missing from the in-person and telephone interviews was a comprehensive account of the practices utilized by local service providers. Toward gaining a better understanding of the practices of providers, research staff developed an online providers survey. Survey domains included a general overview of the provider's services; risk and needs assessment; clinical assessment; client treatment characteristics, and case management services.[3] Of the 34 service providers identified by the ACMHC Coordinator, a total of 18 (53%) completed the survey.

Program Data Analysis The Research Manager at the Allegheny County Department of Probation and Parole provided program data from the statewide Common Pleas Case Management System (CPCMS) and the countywide Adult Probation Case Management System (APCMS). The program began electronically capturing data using these systems beginning in 2012, but old cases are gradually being back-entered; the final dataset provided for this project began in January 2010. Data fields included basic demographic and charge information on ACMHC participants, as well as information on diagnoses, in-program service referrals, judicial and probation supervision, technical violations and new arrests during program participation, and jail sanctions. The raw data was cleaned, merged, and manipulated by Center research staff. Resulting program information presented throughout the report, as well as conclusions drawn, are the result of these data manipulations and do not necessarily reflect the positions of the Allegheny County Mental Health Court or the Department of Probation and Parole.

Impact Evaluation Methodology

The impact evaluation sought to determine whether the mental health court significantly reduced recidivism among program participants. Criminal justice data was supplied by the Allegheny County Department of Probation and Parole, using CPCMS and APCMS.

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[3] The treatment provider survey contains many of the same items as the court policy survey (Appendix A) and is, therefore, not included. The instrument is available by request.

Additional behavioral health data were provided by the Allegheny County Department of Human Services (DHS).

Sampling Frame

The Mental Health Court Participant Sample The participant sample was limited to the 227 participants who had at least one year of post-entry data over which to track recidivism outcomes as of the time the data was requested (November 2016). Due to the length of the mental health court program (785 days to completion, on average), recidivism up to two years primarily measures in-program recidivism—while participants are still under court supervision.

Though the mental health court program began accepting cases in 2001, data was not uniformly tracked electronically until 2013. Since then, some historic data has been added to the data management system. Based on the unreliability of earlier data, coupled with the potential for bias created by including older cases (e.g., due to changes in the mental health court model over time), we limited eligibility to those participants who entered the program in 2013 or later. Participants who entered the program between January 2013 and November 2016 were eligible to be included in the participant sample, with a subset of participants eligible for longer two- or three-year post-entry recidivism analyses (see Table 1.2 for a breakdown of sample size by time period).

The Comparison Sample The comparison sample was drawn from a contemporaneous pool of cases that were not routed to the mental health court with a minimum of two years of post-conviction data over which to track recidivism. Potentially eligible defendants may not be referred to the mental health court for a variety of reasons; the potential pool was large enough that we were able to stipulate a two-year recidivism requirement without sacrificing sample size. For program participants, we identified cases with a program start date from January 2013 through November 2016. Although there was no program start date for those in the comparison pool, program start date was nearly identical to conviction date in the participant sample. Therefore, cases with a conviction date between January 2013 and November 2015 were included in the comparison pool.

To narrow down the initial pool of comparison cases, we asked the probation department to submit only those cases with criminal charges observed in the participant sample. Because the mental health court accepts a wide array of criminal charges, this did not greatly reduce the potential comparison pool. Probation then submitted the charge-limited pool to DHS, where behavioral health diagnoses were supplied for the full pool. All mental health court

participants have received a behavioral health diagnosis. Accordingly, only those individuals in the comparison pool who had a behavioral health diagnosis within the five years prior to their conviction date were study eligible. While the decision to exclude diagnoses further than five years back was somewhat arbitrary, we felt that *some* cut-off point was needed, based on the belief that a childhood diagnosis or a diagnosis, for example, twenty years prior was less meaningful than a more recent diagnosis in terms of identifying appropriate comparison cases. Once we had limited the pool to only those with any behavioral health diagnosis in the previous five years, we were left with 8,356 potential comparison cases.

Adjustment for Selection Bias

Once the comparison pool was narrowed to only those with marginally comparable criminal charges and a recent behavioral health diagnosis, we utilized propensity score adjustment techniques to reduce any remaining differences in background between the mental health court and comparison samples. Propensity score adjustments typically eliminate the need to control for specific background characteristics when performing the actual impact analysis (see, *e.g.,* Bryson, Dorsett, and Purdon 2002; Rubin 1973).

To create the adjusted samples, we examined the p-values for all bivariate comparisons of defendant baseline characteristics. Next, we entered all characteristics with any evidence of a possible difference between the samples ($p<.50$) into a backward stepwise logistic regression model, for which the dependent variable was sample membership (0 = comparison, 1 = mental health court). Then, we implemented a one-to-one matching strategy (i.e., each participant was matched to the single comparison subject with the closest propensity score that had not previously been matched). Table 1.1 demonstrates that the adjustment strategy was successful at reducing background differences between the mental health court and comparison sample.[4] That is, following propensity score matching, the samples were nearly identical across an array of available background measures. The only significant difference remaining after performing the match is the year of the instant case arrest; in part, this difference is due to our methodological decision to require two years of recidivism follow-up for all comparison cases while maximizing the participant sample by only requiring a one-year follow-up period for mental health court participants.

Analytic Plan

We examined three primary outcomes: re-arrest, re-conviction, and incarceration stays. All outcomes were examined over up to three years following program entry (or equivalent for

[4] Table 1.1 presents an abbreviated list of background variables included in the propensity score adjustment calculations. For the full list, see Appendix C.

the comparison sample). Re-arrest and re-conviction at three years were further distinguished by offense type (i.e., felony, person, property, or drug). In addition, we examined select count variables including the number of new arrests and convictions and conducted survival analysis to determine whether the mental health court delayed onset of recidivism.

Table 1.1. Comparison of Sample Differences, Before & After Propensity Matching

	Original Samples		p<.50?	Matched Samples [2]	
	Mental Health Court	Comparison Group [1]		Mental Health Court	Comparison Group
Number of Cases	227	8,356		227	227
Nagelkerke R-Squared			0.362***		
DEMOGRAPHICS					
Mean Age	36.98*	35.12	✓	36.98	37.48
Male	69%	71%		69%	70%
Race/Ethnicity [3, 4]					
White	63%	60%		63%	65%
Black/African American	37%	40%		37%	35%
Risk Score	5.08	5.05		5.08	4.96
Risk Level [5]					
Low	31%	34%		31%	33%
Medium	47%	47%		47%	50%
High	21%	19%		21%	17%
BEHAVIORAL HEALTH DIAGNOSIS [6]					
Diagnosis (5 Years)					
Any Adjustment Disorders	11%	8%	✓	11%	12%
Any Alcohol Use Disorders	24%*	18%	✓	24%	26%
Any Anxiety Disorders	26%***	13%	✓	26%	20%
Any Behavioral Disorder	9%	7%	✓	9%	9%
Any Impulse-Control Disorders	4%*	2%	✓	4%	5%
Any Mood Disorders	88%***	46%	✓	88%	89%
Any Personality Disorders	2%**	0%	✓	2%	1%
Any Psychotic Disorders	39%***	8%	✓	39%	37%
Any Substance Use Disorders	54%	54%		54%	57%
Any Unspecified Disorders	59%***	30%	✓	59%	53%
Any Other Disorder	1%	1%		1%	2%
CRIMINAL HISTORY (5 Years Prior) [7]					
Prior Arrests					
Any Prior Arrests	81%*	73%	✓	81%	85%
# prior arrests	2.75**	2.02	✓	2.75	2.95
Any Person Arrest	35%*	28%	✓	35%	36%
Any Property Arrest	46%**	38%	✓	46%	49%
Any Drug Arrest	22%+	27%	✓	22%	24%
Any Other Arrest [8]	32%	30%		32%	33%
Any Felony Arrest	53%***	41%	✓	53%	58%
Any Violent Felony Arrest	18%*	12%	✓	18%	21%
Any Misdemeanor Arrest	61%	57%		61%	66%
Any Weapons Arrest	3%	4%		3%	3%

Table 1.1. Comparison of Sample Differences, Before & After Propensity Matching *(Continued)*

	Original Samples		p<.50?	Matched Samples [2]	
	Mental Health Court	Comparison Group [1]		Mental Health Court	Comparison Group
Number of Cases	227	8,356		227	227
Nagelkerke R-Squared			0.362***		
CRIMINAL HISTORY (5 Years Prior) [7]					
Prior Convictions					
Any Prior Conviction	57%***	39%	✓	57%	63%
# prior convictions	1.08***	0.63	✓	1.08	1.23
Any Person Conviction	12%*	8%	✓	12%	12%
Any Property Convictions	33%***	17%	✓	33%	35%
Any Drug Convictions	15%	12%	✓	15%	15%
Any Other Convictions [8]	16%	13%	✓	16%	20%
Any Felony Convictions	36%***	22%	✓	36%	38%
Any Violent Felony Convictions	7%+	4%	✓	7%	7%
Any Misdemeanor Convictions	35%***	24%	✓	35%	41%
Any Weapons Convictions	2%	1%		2%	1%
Any Prior Incarceration Sentences [9, 10]	28%***	16%	✓	28%	30%
Any Prior Probation Sentences	35%**	27%	✓	35%	37%
INDEX EVENT					
Index Event Year	***		✓	***	
2013	36%	43%	✓	36%	47%
2014	30%	35%	✓	30%	34%
2015	27%	23%	✓	27%	19%
2016	7%	0%	✓	7%	0%
Index Arrest Charge Type [10]					
Person top charge	37%***	20%	✓	37%	39%
Property top charge	43%***	29%	✓	43%	46%
Drug top charge	3%***	26%	✓	3%	1%
Other top charge	16%**	26%	✓	16%	13%
VFO top charge	27%***	11%	✓	27%	28%
Weapon top charge	2%	2%		2%	2%
Index Arrest Charge Severity					
Felony	76%***	46%	✓	76%	78%
Misdemeanor	24%***	53%	✓	24%	23%

+p<.10 * p<.05 ** p<.01 ***p<.001

[1] The comparison pool was limited to those persons with a mental health diagnosis in the 5 years prior to the Index Event (first arrest after 2013) and to those individuals with at least two years of recidivism data, with information on gender, race, age, proxy risk level and a proxy risk score.

[2] Three logistic models were used to match mental health court participants and comparison groups: the full model contained persons with no missing data for the variables included in the model (R^2=362, p <0.000); a second logistic model was used to match the five participants with no race information (R^2=.360, p<0.000); and a third logistic model was used to match the single participant with missing risk level information (R^2=.361, p<0.000). R^2 presented in the table heading reflects the primary model, which matched 221 Mental Health Court participants to suitable members in the comparison group.

[3] Five mental health court participants have missing/unknown race information. A separate logistic model excluding race was used to match these persons.

[4] Hispanic ethnicity data was not available.

[5] One mental health court participant has missing/unknown risk level information. A separate logistic model excluding risk level was used to match this participant.

[6] Persons could have more than one diagnosis in the past five years and percentages do not sum to 100%; each type of diagnosis was counted only once.

[7] Separate three year criminal history variables were included in the full PSM model (see Appendix C). Sums arrest/convictions by most serious charge, ranked in the following order: Person felony, property felony, drug felony, other felony, person misdemeanor, property misdemeanor, etc. Weapons charge and violeny felony charges only included if they were the top/most serious charge. Arrests that occurred on the same day count as a single arrest; similar logic applied to convictions.

[8] Other charges includes weapons, criminal-other, DUI, public order, and motor vehicle-other.

[9] Sentencing data should be interpreted with caution. Sentence data is tracked by charge rather than by case; charge sentences were collapsed to create a single case-level variable.

[10] Based on top or most serious charge, ranked in the following order: Person felony, property felony, drug felony, other felony, person misdemeanor, property misdemeanor, etc. Person, property, durg and other charges are mutually exclusive categories. Violent felony and weapons charge only included if they were the most serious charge in the arrest.

Table 1.2 presents the valid sample sizes for the one-, two-, and three-year analyses. When any individual was unavailable for a specific analysis period, the individual to which they were matched was likewise dropped from that analysis. In this way, the sample sizes for the participant and comparison samples remain identical across the three periods.

Table 1.2. Available Sample Size for 1-, 2-, and 3-Year Analyses

	Mental Health Court	Comparison Group
1 Year Recidivism Analyses	227	227
2 Year Recidivism Analyses	210	210
3 Year Recidivism Analyses	142	142

In addition to examining program impacts on key outcomes, we conducted logistic regression to examine other predictors of re-arrest beyond participation in the mental health court. While many of these factors will be beyond the control of the mental health court—or *any* court-based program—findings may shed light on high risk populations and assist program personnel in thinking through responsive programming.

Chapter 2

The Allegheny County Program Model

Eligibility Criteria and Participant Profile

Table 2.1 presents the profile of participants entering the ACMHC between January 2010 and September 2016.

Participant Demographics

Participants are 38 years of age on average—a relatively older participant population, given general criminal desistance with age. The majority of participants (69%) are male. Nearly all participants (97%) identify as black (58%) or white (39%) race; the court does not track ethnicity information, so it is unknown how many participants also identify as Hispanic/Latino. Nearly three-quarters of participants are unemployed at intake; of those with available data, the average time spent unemployed was greater than one year. More than three-quarters (77%) have a minimum of a high school-level education (or equivalency). Most participants are unmarried; 75% are single and an additional 16% are divorced, separated, or widowed. Just over half (54%) of participants have children; one-quarter (27%) have children living with them. Participants have an average of 2.5 children.

Legal Eligibility

The ACMHC admits offenders charged with felony, misdemeanor, and summary offense level offenses.[5] While those charged with a violent felony may be admitted on a case-by-case basis, in general, offenders charged with arson, registerable sex offenses, offenses with a firearm, drug sales, charges against a minor victim, homicide and attempted homicide, and offenses that carry a state minimum sentence are not eligible. Additionally, those with a history of violent offenses are not ACMHC eligible. Offenders with criminal histories deemed too extensive may also be omitted on a case-by-case basis. Offenders can enter the court with a new charge; those previously sentenced to probation may also enter the court due to a probation violation.

[5] In Pennsylvania, summary offenses are the least serious level criminal offense. The maximum penalty for a summary offense conviction is 90 days jail and a $300 fine; commonly, conviction results in a fine only (1 Pa. Code §15.66). Examples of summary offenses include disorderly conduct, loitering, and harassment.

Table 2.1. Mental Health Court Participant Profile

Number of Participants	557
Demographics	
Average Age at Intake	38
< 25 Years of Age	14%
25-40 Years of Age	46%
> 40 Years of Age	40%
Male	69%
Race[1]	
Black	58%
White	39%
Asian / Pacific Islander	1%
Unknown	2%
Employment Status	
Unemployed at Intake	72%
Average Time, Current Employment[2]	391 days
Education	
% with High School Diploma/GED	77%
Ever in Military	4%
Currently in Military	0.04%
Marital Status	
Single	75%
Married	9%
Divorced/Separated	14%
Widowed	2%
Has Children[2]	54%
Average Number of Children	2.5
Has Children Living at Home	27%
Criminal History	
Average Age at First Arrest	22
Average # Prior Arrests at MHC Entry	8.4
No Prior Arrests	2%
1 Prior Arrest	14%
2 Prior Arrests	18%
3-5 Prior Arrests	22%
6-10 Prior Arrests	17%
>10 Prior Arrests	28%
Average Proxy Risk Score[3]	4.79
% of Participants Low Risk	38%
% of Participants Medium Risk	47%
% of Participants High Risk	15%

Table 2.1. Mental Health Court Participant Profile *(Continued)*

	Number of Participants 557
Index Event Leading to MHC Participation	
Top Arrest Charge Severity	
Felony	51%
Misdemeanor	47%
Violation	2%
Top Arrest Charge Type	
Person Offense	28%
Property Offense	45%
Drug Offense	3%
Other	24%

[1] The program does not track Hispanic/Latino ethnicity data.

[2] Less than 10% of data is missing across all measures *except*: duration of employment (15% missing); number of children (11% missing); children at home (15% missing).

[3] Proxy Risk Score calculated based on age at first arrest, number of prior arrests, and current age.

According to stakeholder interviews, the court initially accepted more low-level misdemeanants, but the results of a cost analysis conducted by the RAND Corporation (Ridgely et al. 2007) led the court to target higher-level offenders. This decision was driven by findings from that study, which suggested that higher risk and need groups (dubbed "more-seriously distressed subgroups" in the report) experience greater cost-savings than lower risk and need participants.

Despite the parameters described above, stakeholders acknowledged some flexibility in formal program eligibility criteria. The judge, in particular, was said to be interested in opening the program to offenders she thought would potentially benefit—even when, in some cases, they fell outside the defined eligibility criteria. Repeatedly, stakeholders stressed the importance of case-by-case considerations and flexibility to the ACMHC model—in terms of eligibility criteria as well as other program practices. For instance, stakeholders reported that the judge has accepted offenders facing domestic violence, sexual misconduct (fondling), and arson on a case-by-case basis. The judge also allows previous ACMHC participants to re-enter the court on a case-by-case basis.[6] The judge was also reported to

[6] A total of nine participants who had previously participated in the mental health court program were included in the official program data. In order to streamline analysis and make for easier comprehension, only the initial mental health court case of these participants is included in the results presented herein.

transfer cases from her regular calendar to the mental health court when she felt there was a need for services and supervision not typical for a standard court calendar.

Table 2.1 shows characteristics of cases transferred to the mental health court. Participants enter the court on serious charges: Just over half (51%) of participants enter the ACMHC on a felony charge and more than a quarter (28%) of participants are charged with a crime against a person (more severe charges with harsher penalties than property or drug charges). Participants are *most* likely to enter the court on property type charges (45%). Specifically, the most common top criminal charges of those entering the mental health court are theft[7] (21%), assault (16%), aggravated assault (7%), burglary (6%), and trespassing (6%) charges (results not shown). The relatively low proportion of drug charges (3%) in Table 2.1 should not be interpreted as an indicator that drug charges are uncommon among the population; rather, drug charges among participants are accompanied by more serious criminal charges and, thus, do not rank as the *top* charge. In addition to the initial case resulting in screening by the court, participants with additional pending cases may have those cases transferred ACMHC.

Some stakeholders reported that the court's decision *not* to implement a comprehensive risk-needs assessment to screen potential participants was a tactical one, designed to provide the court some flexibility in accepting participants on a case-by-case basis. At the time of the evaluation, the court did not utilize a comprehensive assessment, but creates a proxy risk score (proxy score calculation algorithm is included as Appendix D).[8] However, this score is based on only three factors (current age, age at first arrest, number of prior arrests) and was reported not to enter the consideration of whether the mental health court is offered. The score was previously validated with a general criminal justice population in Hawaii (Wong 2009) and locally. Mental health court participants have extensive criminal histories; nearly all participants (98%) have at least one prior arrest and participants average more than eight prior arrests (see Table 2.1). On average, participants were arrested for the first time at 22 years of age. The ACMHC assigns a proxy risk score based on current age, age at first arrest, and number of prior arrests. According to the ACMHC proxy risk calculation, 38% of participants are considered low risk, 47% are considered moderate risk, and 15% are high risk.

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[7] Includes theft and receipt of stolen property charges.
[8] Beginning in January 2018—after the period covered in this report—the court adopted the LSI-R for all participants at program entry. LSI-R results are reportedly used to inform individual supervision plans.

Clinical Eligibility & Screening

All mental health court participants must have a current psychiatric evaluation by a licensed psychologist or psychologist, conducted within one year of program entry. Participants must be diagnosed with a serious mental illness prior to program entry. In addition, offenders diagnosed with post-traumatic stress disorder are program eligible; as are those with substance use disorder, personality disorders, developmental disabilities, and traumatic brain injury when co-occurring with a serious mental illness diagnosis. The program does not conduct clinical assessments, but potential participants may be referred out to service providers if a diagnosis has not already been made. For offenders who are incarcerated, the Allegheny County jail has a mental health unit with dedicated staff who perform a clinical evaluation. Because numerous agencies are charged with clinical assessment of potential participants, information communicated to the program is not always uniform; moreover, program staff reported uncertainty with regard to the specific assessment tools used by various agencies. The court does not require re-administration of the psychological assessment as part of program participation; a trauma assessment is not a standard component of the assessment process.

Table 2.2 presents lifetime behavioral health diagnoses for ACMHC participants. Clinical records for 103 (18%) of the participants were not found in the data file, which came from the Allegheny County Department of Human Services. Given the court policy requiring a diagnosis, this is likely due to missing data, rather than to a lack of clinical diagnosis for those participants. Two-thirds of participants had more than one clinical diagnosis. The most common diagnoses include major depressive disorder (58%), substance use disorder (50%), bipolar disorder (43%), and schizophrenia/schizoaffective disorder (35%).
In addition to the clinical evaluation, JRS, which provides case management for the court, conducts a rapid assessment including psychosocial measures. Results of the clinical psychological evaluation and brief screen are used by the court to inform most aspects of participation, including initial mental health court eligibility; service needs (e.g., mental health treatment, substance use treatment, criminal thinking interventions, ancillary service needs); selection of appropriate treatment modalities and programs; and case management frequency.

One interviewee explained that the diagnostic eligibility criteria exist for participants' benefit, expressing that participants with a diagnosis of a personality disorder are less likely to do well in mental health court; clients diagnosed with a serious mental illness or thought disorder were thought to be more likely to be successful and get the services they need through the program. This stakeholder noted that it is crucial to weigh the pros and cons on a

case-by-case basis. Another interviewee felt that clients with more severe mental health issues fare better in mental health court, explaining that the more compromised their mental health is at intake, the more services they need and the greater progress they stand to make. For higher functioning clients, this stakeholder reported that the court requires more strict compliance and imposes sanctions for smaller infractions.

Table 2.2. Participant Behavioral Health Diagnoses

Number of Participants	557
Participants with at Least 1 Diagnosis	**82%**
> 1 Diagnosis	66%
Ever Received Diagnosis of:[1]	
Major Depressive Disorder	58%
Substance Use Disorder	50%
Bipolar Disorder	43%
Schizophrenia/Schizoaffective Disorder	35%
Anxiety/Phobias	14%
Other: Unspecified Thought Disorder	14%
Other: Unspecified Mood Disorder	13%
PTSD/Acute Stress	6%
Adjustment Disorder	6%
ADHD	5%
Conduct Disorder	4%
Personality Disorder	1%
Other: Unspecified Neurodevelopmental Disorder	1%
Other Diagnosis[2]	35%

Note: Diagnostic data comes from the Allegheny County Department of Human Services.

1 Of those with at least one diagnosis (n=454). Diagnosis categories are not mututally exclusive; participants may have more than one diagnosis.

2 "Other" diagnoses include those coded as other/unspecified in the original data, organic affective syndrome, paranoia (unspec), delirium (unspec).

Several stakeholders believed that the mental health court population had changed over time, with co-occurring disorders more prevalent now than at court startup. One interviewee also noted that the court was seeing more opioid users; younger, more disenfranchised populations; and more participants with developmental delays. Many interviewees discussed the idea, promoted by the JRS manager, for developing two separate mental health court tracks: (1) a more traditional mental health court track for those with pervasive mental health diagnoses (who may self-medicate with drugs and alcohol); and (2) a secondary track for participants with high substance use needs and low mental health needs. According to

stakeholders, while participants in the second track might be routed to drug court in other jurisdictions, the Allegheny County Drug Court policies render many of these individuals ineligible for that program. But stakeholders in the mental health court recognize the seeming disparities created by having a different set of standards for the two groups of participants, who are reportedly already entering the court. By creating separate tracks, stakeholders hoped they could implement different standards without undermining procedural justice. For the second, high substance use need/low mental health need track, there would be additional reporting requirements specifically to monitor drug use; with fewer serious mental health concerns, accountability for this group might also look different.

Deterrence

Entering the Program

Mental health court referrals come from a variety of sources, including the ACMHC judge; probation; defense counsel; the Allegheny County jail; and local service providers. Once potential participants are identified, they meet with JRS; cases deemed clinically appropriate are then reviewed during twice-monthly mental health court team meetings. The dedicated assistant district attorney (ADA) must obtain victim consent for the referral to be approved. The ADA also reports complete criminal history information during the referral review. Stakeholders report that determining legal eligibility is a collaborative process; there is discussion between the judge, law enforcement, the prosecution, and probation when considering cases for the court. The District Attorney's office serves as the gatekeeper with regard to what cases are legally appropriate for the court, but the ACMHC team makes final decisions through group discussion. Probation may have already worked with potential participants and therefore report that they may have special insight into how successful a potential participant may be in the program. Whereas probation has the final ability to exclude a case from the adult drug court in the jurisdiction, probation does not have final veto power in the mental health court. The dedicated defense attorney may advise clients against entering the court if participation is not thought to be in their best interest. However, several stakeholders noted the willingness of the current dedicated public defender to work with the mental health court to the benefit of her clients; previous public defenders assigned to the court were reportedly less inclined to collaborate in the model. Once the team agrees to accept a program referral, all sign acceptance paperwork and set two dates on the court calendar: one for the participant's first appearance in mental health court and a trial date in the original court of record in case the defendant rejects the offer to enter the program.

All participants currently enter the ACMHC post-plea. The dedicated public defender contacts eligible defendants either in jail or in the community and provides an extensive review of the mental health court rules and regulations. Very rarely, participants retain private counsel; most are represented by the dedicated public defender. Both interviewees and responses to the policy survey indicate that eligible defendants rarely decline to participate in the mental health court.

The mental health court is a voluntary program; defendants who are deemed eligible must agree to enter the program. Defendants who do accept the offer to enter the mental health court enter a plea on their next court date and are then sentenced to special probation, provided by a dedicated unit of mental health probation officers. Participants who are already on probation are transferred to a mental health court probation officer. Typically, sentences in the mental health court includes close supervision by a specialized mental health court probation officer, mandated treatment, and case management by a JRS probation liaison, who coordinates between treatment providers, probation, and the court. Both the dedicated public defender and a JRS case manager provide an overview of the court policies and procedures prior to program entry, participants are also provided with a copy of the ACMHC participant handbook.

In addition to participants entering the court through a new plea, some referrals come from cases already on probation. The referral of such cases can come from any number of sources—the assigned probation officer, JRS, the judge's regular calendar. Initially, one stakeholder reported, such cases were viewed as a way to build caseload. Several interviewees noted the mental health court judge's dedication to helping as many people as possible and maintaining flexibility to extend program services to a broad population.

During our site visit, two stakeholders mentioned the possibility of adding a pre-plea diversion track to the program. In such a track, participants would be released on bond into the mental health court and then monitored by the court. A specific timeline would need to be specified, but one stakeholder suggested a timeline of completion in 18 to 24 months, with the promise of reduced charges upon successful completion. Pre-plea cases would be ineligible for monitoring by the Department of Probation and it was reported that the mental health court judge was wary of involving pre-trial services for monitoring and case management. Both stakeholders who mentioned this potential source of cases agreed that the mental health court team—in particular, the District Attorney's office—would need to agree to a pre-plea option and that clear guidelines for a pre-plea track would need to be established before such an addition could be made.

Program Completion

There is not a universally required time to program completion in the mental health court. The ACMHC participant handbook specifies that in order to successfully complete the program, participants must:

- Complete a minimum of two-thirds of their probation sentence;
- Complete all recommended treatment;
- Refrain from drug and alcohol use; and
- Comply with all probation requirements.

Additionally, participants may be required to be engaged in employment or training; pay fines, fees, and restitution; and maintain a lifestyle supporting clean and sober living (ACMHC Participant Handbook). In reality, several stakeholders told us that participants must serve at least half of their probation term before they can be considered for graduation. While probation sentences are reportedly comparable to sentence lengths in traditional court, interviewees say the completion process of the mental health court is typically shorter, due to early termination for successful participants. However, interviewees also noted that the requirements of mental health court probation are more onerous than traditional probation.

One interviewee reported that there have been clients with ongoing cases in the mental health court for as long as six or seven years, saying that as long as JRS is willing to find them programming, the court will keep the cases open. Given the nature of clients' mental health issues, stakeholders frequently noted the need for flexibility and review on a case-by-case basis. For this reason, new participants are not told how their case will be resolved or how much incarceration they will face in the instance of unsuccessful program termination. Both extremely lengthy program stays and the uncertainty of the legal consequences of program failure were mentioned by multiple stakeholders as a potential area of concern for the public defender's office. Survey responses indicate that program failure may result in an immediate return to incarceration, resentencing to probation, or further hearings in front of the ACMHC judge. Policy survey responses further suggest that while each on a list of infractions (i.e., new arrest, new arrest for a serious offense, poor treatment attendance, failure to take medication, breaking provider rules, positive drug screen) could *sometimes* result in termination, none would universally signal program failure.

Several stakeholders shared the perception that participants with more serious mental health issues are the most likely to succeed in the program. In part, stakeholders suggested this is because such participants have so much to gain from being linked to appropriate services. In contrast, noncompliance in participants with less acute mental health symptoms may be harder to defend to the mental health court team, some members of which may need to be reminded of the mental health component of the case. According to stakeholders, participants with severe co-occurring substance use face additional challenges that make success more difficult.

Table 2.3. Mental Health Court Completion

Number of Participants	557
Final Program Status	
Case Still Pending	162 (29%)
Case Closed	395 (71%)
Graduated Successfully	*56%*
Unsuccessful Due to New Offense	*15%*
Unsuccessful, Other Reason	*17%*
Administrative Closure	*7%*
Other [1]	*5%*
Time in Program	
Average Time, Intake to Completion (All)	785 days
Average Time, Intake to Unsuccessful Completion	791 days
Average Time, Intake to Successful Completion	780 days

[1] Includes closed due to death (3%), transferred to another jurisdiction (1%).

Table 2.3 presents the final program status for the 557 participants included in the official program data. Of these, 29% were ongoing, open cases and 71% had successfully completed the program. The program categorizes one-third (32%) of these as program failures; 59 participants failed due to a new offense. While not considered program failures, another 7% were granted an administrative closure. As it was explained to us by court personnel, such cases are generally participants who, while not reoffending, cannot achieve the level of full compliance required to successfully graduate, despite best efforts. Participants whose cases are closed administratively are not sentenced to incarceration or further sanctions. On average, cases in the mental health court lasted just over two years and one month (785 days).

Table 2.4 presents bivariate comparisons between those who successfully completed the program (i.e., graduates) and those who did not complete the program. The differences

highlighted here include both background characteristics (risk score, diagnoses, charge on the index event leading to mental health court participation) and some in-program measures (number of and rating of court appearances, service referrals). Participants who successfully complete the program are significantly lower risk based on the ACMHC proxy risk score. Successful completers are also less likely to have a diagnosis of major depressive disorder, personality disorder, substance use disorder, and/or adjustment disorder.

Successful completers are more likely to have entered the court on a person charge (e.g., assault) and less likely to have entered the court on a property charge (e.g., theft). There was no difference in charge severity on the index event between completers and non-completers. Based on the greater legal consequences facing participants charged with a felony, we might anticipate a greater deterrent effect among such participants. However, this hypothesis is not borne out by the data.

Program non-completers appear more frequently in court across their program participation. This may be due to increased compliance monitoring appearances mandated when participants are noncompliant. Not surprisingly, successful program completers had significantly more positive court appearances and fewer neutral and negative court appearances.

Case Management

Case management in the ACMHC is primarily conducted by JRS, except for those participants who receive treatment through a Community Treatment Team (CTT), who receive case management through the CTT. CTT also provides case management and reports back to the court for participants who are in jail.

JRS clients in the mental health court initially start with the JRS support unit. The JRS support unit will help those participants who need assistance to access benefits. Once they have received two positive reports, they are transferred to a JRS mental health court liaison—a lower level of case management—for continued monitoring for the duration of the case. At the time of the site visit, JRS employed three mental health court liaisons—including one new hire—and the JRS supervisor, who was planning to retire in summer 2017. The normal caseload of liaisons was said to be 45, split across the three liaisons; however, one liaison we interviewed indicated her current caseload was 58 clients. JRS liaisons may meet in-person with clients every four to six weeks. In addition, clients have weekly telephone check-ins and receive community visits from the liaison assigned to their case. Liaisons contact treatment providers monthly based on when clients are scheduled for a

court appearance; the liaison is then able to provide an up-to-date compliance report to the court. If participants relapse, experience symptoms of behavioral change, or are otherwise noncompliant with program rules, treatment providers contact the liaisons in between regular updates.

Table 2.4. Successful Program Completers v. Non-Completers

	Program Completers	Program Non-Completers[1]
Number of Participants	221	155
Risk Score at Intake		
Average Proxy Risk Score		
% of Participants Low Risk	51%***	28%
% of Participants Medium Risk	42%*	54%
% of Participants High Risk	7%**	17%
Clinical Diagnosis		
Ever Received Diagnosis of:		
Schizophrenia	34%	28%
Bipolar	31%	30%
Major Depressive Disorder	37%*	48%
PTSD/Acute Stress	3%+	7%
Personality Disorder	0%*	2%
Anxiety/Phobias	8%	7%
Substance Use Disorder	25%***	45%
ADHD	2%	5%
Adjustment Disorder	2%*	7%
Conduct Disorder	3%	5%
Other Diagnosis	38%	41%
Index Charge		
Index Charge Severity		
Felony	49%	49%
Misdemeanor	50%	48%
Violation	2%	3%
Index Charge Type	***	
Person Offense	37%	15%
Property Offense	37%	55%
Drug Offense	2%	3%
Other	24%	28%
Court Appearances (In-Program)		
Average Number of MHC Appearances	14.51*	17.70
Average Number of Positive Appearances	10.63***	6.50
Average Number of Neutral Appearances	0.92***	2.49
Average Number of Negative Appearances	1.17***	3.51

+p<.10 *p<.05 **p<.01 ***p<.001

[1] Includes those who closed due to a new offense, administrative closures, and those closed due to an unspecified "other" reason. Deceased participants and transferred cases are excluded.

JRS clients in the mental health court initially start with the JRS support unit. The JRS support unit will help those participants who need assistance to access benefits. Once they have received two positive reports, they are transferred to a JRS mental health court liaison—a lower level of case management—for continued monitoring for the duration of the case. At the time of the site visit, JRS employed three mental health court liaisons—including one new hire—and the JRS supervisor, who was planning to retire in summer 2017. The normal caseload of liaisons was said to be 45, split across the three liaisons; however, one liaison we interviewed indicated her current caseload was 58 clients. JRS liaisons may meet in-person with clients every four to six weeks. In addition, clients have weekly telephone check-ins and receive community visits from the liaison assigned to their case. Liaisons contact treatment providers monthly based on when clients are scheduled for a court appearance; the liaison is then able to provide an up-to-date compliance report to the court. If participants relapse, experience symptoms of behavioral change, or are otherwise noncompliant with program rules, treatment providers contact the liaisons in between regular updates.

JRS liaisons work closely with probation.

Probation

At the time they plead into the ACMHC, participants are assigned a probation officer. Participants entering on a probation violation, or those who are already on probation for another case, are typically re-assigned to one of the dedicated mental health court probation officers. Participants are assigned to an officer based on geographic location. At the time of the site visit, there were six probation officers assigned to the mental health unit. Officers in the unit have special training and more experience working with clients with behavioral health issues. The probation officers we spoke with currently had between 50 and 55 clients on their caseload; caseloads are a mix of mental health court participants and other probationers with behavioral health issues.[9]

Probation generally sees clients mandated to outpatient treatment monthly in the community. The mental health unit operates out of the day reporting center (DRC), where toxicology screens are conducted. Participants are screened for drug use both in treatment and at the

[9] ACMHC stakeholders report that, since the evaluation period, the probation department has dedicated a seventh officer to the mental health court and, consequently, caseloads have decreased to 40 to 45 clients per officer.

DRC. Interviewees reported that screens are not always random and that a system for implementing random screens might be of interest.[10]

Officers also contact treatment providers monthly or bi-monthly and are involved in treatment team decisions (all mental health court participants are required to sign a release granting probation access to their treatment records). Officers visit treatment providers for treatment team meetings and regular monitoring visits with participants in residential programs. Probation shares information with the mental health court team, including JRS and the judge.

Participants are required to follow through with all conditions of probation, including signing treatment and medical releases, medication adherence (including injectable medication if recommended by the treating psychiatrist), staying in contact with JRS and other case managers, consenting to toxicology screens, attend 12-step groups as recommended, and, in the event of relapse, attend mandated treatment. Probation representatives reported that they use an array of sanctions for noncompliant participants, including increased frequency of court appointments and electronic monitoring. Short term jail sanctions may be used by probation to hold clients when there is not an appropriate treatment bed immediately available or when clients have exhausted the available options.

Probation officers reported that they are more connected to the clients in the mental health unit than they would be in a more traditional unit. They see their role as a combination of traditional probation supervision, counselor, and social worker. Interviewees reported that the approach to clients is better and more open than traditional supervision; clients are provided with a real opportunity to grow and change and officers have options to help them in the process with sanctions beyond standard probation violations.

Judicial Monitoring

According to the court policy survey, new mental health court participants are typically scheduled for judicial status review hearings in court twice a month, on average. The first status hearing is typically scheduled between two weeks and one month post-plea, but varies depending on the client. For those participants who are incarcerated—either awaiting placement or on a short-term jail sanction—during their scheduled monitoring appearance, there is a direct video conference link between the court and the jail, so participants do not

[10] Following the evaluation plan, the court is reported to have implemented a color coding system for randomizing drug testing.

need to miss treatment and the program does not incur costs associated with transport between court and jail.

Participant progress is characterized as positive, neutral, or negative during review hearings. This characterization is discussed during the team staffing meeting prior to the court calendar and was described by stakeholders as a team decision, but with probation, JRS (with feedback from treatment providers), and the judge weighing in most heavily. Participants who receive a neutral score can have their status upgraded to positive (and back-dated) if they show deliberate improvements to their behavior following the review hearing.

The interaction between participants and the judge during status hearings was cited by stakeholders as a program strength. One interviewee explained that the judge teaches participants cause and effect—while they may not have absolute control over what happens with them, they have some control. The same stakeholder felt that the judge's ability to learn of noncompliance and behavior problems quickly and respond with swift consequences further helps with this type of consequential thinking, which may be new to participants in the mental health court. Judicial interaction with participants is discussed further below (see Procedural Justice).

Treatment and Other Service Referrals

Table 2.5. Service Referrals During MHC Entry

Number of Participants	557
Ever Received:	
Therapy Referral[1]	65%
Rehab Referral	44%
Intensive Outpatient Tx Referral	35%
Residential Tx Referral	29%
Halfway House Referral	23%
Acute Care/Crisis Referral	22%
Partial Outpatient Tx Referral	18%
Outpatient Tx Referral	18%
Group Home/Housing Support Referral	17%
Detox Referral	10%
Vocational/Employment Referral	5%
Medication Assisted Tx Referral	4%
Forensic Support/Peer Support Referral	3%

[1] Includes individual, group, and family therapy referrals.

Information on available treatment services available to ACMHC participants was derived from several sources. As with previous sections, information came from the ACMHC policy survey, site visit interviews, and official program data. However, due to the relatively large number of treatment providers available to the court, court stakeholders were not able to provide detailed account of *all* provider policies and practices. (Information on provider policies is not captured at all by official program data.) Therefore, treatment providers utilized by the ACMHC were asked to complete a supplementary online survey, describing their reliance on a variety of evidence-based practices. Court personnel identified a total of 34 service providers for follow-up surveys: Three community treatment teams (CTTs); 12 treatment (behavioral health and/or substance use) providers; 12 housing providers; and seven alternative housing providers (including jail). Of these, two CTTs, five treatment providers, six housing providers, and five alternative housing providers completed the supplemental survey. Results in Tables 2.6, 2.7, 2.8, and 2.9 represent the policies and practices of only those providers who responded to the survey; it is possible that the remaining 16 providers implement more (or fewer) evidence-based practices.

Participant Service Needs and Referrals

The ACMHC generally refers participants to a set list of providers available in the jurisdiction; these are providers with which the court has worked in the past and which are believed to adhere to principles supporting the goals of the program. There are available programs that have been removed from the referral list, either because they are not willing to work with the court or because they do not provide the appropriate information to the court in a timely manner.

JRS is the primary player in determining individual treatment plans; the JRS liaisons have relationships with both treatment and insurance providers. The liaison assigned to each case reviews available diagnostic information and spends time with the clients to assess their strengths and risks, treatment history, and other considerations and matches clients to the most appropriate treatment program based on the specific needs of the participant. The court defers to the JRS recommendation, and the team will discuss any need for changes to treatment with the JRS liaisons. Participants do have some say in their treatment provider and may be allowed to choose their provider from a limited list of options deemed appropriate by the court and JRS. Particularly for participants who are stable and are already engaged with a provider, the program may allow the client to remain with the same provider. In that instance, the JRS liaison works to incorporate the existing provider into the participant's treatment plan. None of the agencies—treatment, JRS, or probation—utilize standardized reporting forms for regular client updates. Instead, participants must sign

releases allowing probation and JRS access to treatment provider records. Treatment providers then provide written and/or verbal reports to probation (or JRS); updates are shared with the mental health court team during staffing meetings.

Several stakeholders noted that Allegheny County is relatively rich in high quality treatment providers—a sizeable asset for the mental health court. However, other services were said to be lacking. In particular, housing was said to be a community need; interviewees noted a shortage of affordable permanent housing. JRS provides some short-term housing assistance; Section 8 and HUD do not sufficiently address client need. Housing for special populations—for instance, transgender participants, those on the sex offender registry—was said to be particularly challenging. Assistance qualifying for and accessing benefits was another service need noted by stakeholders. The need for treatment providers who can oversee injectable medication for those participants who do not reliably take their prescribed medications was noted as an arising need, as the court increasingly encourages participants to use injectable medications.

Table 2.5 presents the services to which participants were referred during the study period. Unfortunately, limitations in the program data mean that it was not always possible to discern whether providers offer behavioral health treatment, substance use treatment, or both. Most common service referrals include therapy, rehab, intensive outpatient treatment, and residential treatment.

Provider Application of Evidence-Based Practice

The primary question leading us to incorporate the treatment provider survey into the previous study design was whether the court was using an evidence-based risk-needs assessment to prescribe either supervision or service provision. Interviewees during the site visit reported that treatment providers were using such tools, but could neither point to the specific tools being used nor to how results were informing treatment provision. The court itself was not reported to utilize assessment results from any source other than the jail at the time of the evaluation.

Table 2.6 presents the results of the treatment provider survey with regard to use of a validated risk-needs assessment tool. Only one of the responding providers (the Allegheny County Jail) reported using such a tool and that tool—the Montgomery County Assessment—is neither automated not scored. More than half of responding providers (56%) report implementing a full *clinical* assessment. Given that 11 of the 18 providers completing the survey were housing or alternative housing providers, it is perhaps not surprising that

they do not perform their own full clinical assessment (or brief screen). In fact, 84% of responding providers indicate that clients always (56%) or very often (28%) already have a clinical diagnosis at referral. Asked how they use results of the clinical assessment, providers indicate that results are used to determine ancillary service needs (e.g., housing, vocational training), additional behavioral health needs (e.g., medication, family therapy), and appropriate behavioral health treatment modality (e.g., inpatient, intensive outpatient). Half of providers using a clinical screen (i.e., n=5) report that they use the *clinical* results to determine whether to send clients to an intervention to address criminogenic thinking. Not surprisingly, given the primary case management roles of JRS and probation, treatment providers are less likely to report using clinical results to inform case management.

Table 2.6. Provider Survey: Assessment Practices

Total Treatment Providers Responding	18
Risk Assessment	
Provider Uses Criminogenic Risk/Needs Assessment	1 (6%)
Provider Assesses for Risk of Violence	11%
Clinical Assessment	
Provider Administers Brief Clinical Screen	44%
Provider Administers Full Clinical Assessment	56%
Clinical Assessment Used to Determine:[1]	
Ancillary Service Needs	*100%*
Additional Behavioral Health Needs	*90%*
Appropriate MH Treatment	*70%*
Need for Criminogenic Thinking Intervention	*50%*
Case Management Frequency	*40%*
Provider Administers Assessment for Trauma	17%

[1] Of those providers that administer a full clinical screen.

Only three of the treatment providers (17%) report assessing clients for trauma. According to the court policy survey, some participants are linked to evidence-based trauma treatment (specifically, Trauma-Focused Cognitive Behavioral Therapy or TF-CBT); as shown in

Table 2.7, 50% of the providers responding to the treatment survey report using evidence-based trauma treatment.[11]

Other evidence-based programs utilized by responding providers (Table 2.7) include Motivational Enhancement Therapy (78%) and CBT for criminogenic thinking (56%)—though the latter is frequently not informed by the use of a formal risk-needs assessment. Thinking for a Change and Interactive Journaling were the most commonly reported criminogenic thinking curricula in use.

As shown in Table 2.7, most providers report offering drug and alcohol (72%) and/or mental health (61%) treatment; half (50%) offer integrated treatment. Asked what treatment modalities their agency provides, half reported offering some sort of medication-assisted treatment, either for opioids (50%) or alcohol (33%) or both. However, the ACMHC policy requires that participants reduce to abstinence in order to successfully graduate the program.[12] In fact, the court has a fairly strict prescription drug policy, which all participants are required to sign and is strictly enforced.

Table 2.7. Provider Survey: Available Treatment Services

Total Treatment Providers Responding	18
Available Services	
Mental Health Treatment Available	**61%**
Drug & Alcohol Treatment Available	**72%**
Inpatient treatment services	*28%*
Partial hospitalization	*11%*
Outpatient treatment services	*39%*
Detox services	*22%*
Medication assistance therapy: Heroin/Opioids	*50%*
Medication assistance therapy: Alcohol	*33%*
Integrated Mental Health/Drug & Alcohol Treatment	**50%**
Uses Motivational Enhancement Therapy	**78%**
Uses CBT for Criminogenic Thinking	**56%**
Need Based on Formal Risk-Needs Assessment	28%
Uses Evidence-Based Trauma Treatment	**50%**

[11] The specific trauma treatment curricula used include TF-CBT (22%), Seeking Safety (22%), Trauma, Addictions, Mental Health, and Recovery (TAMAR, 11%); and Trauma Recovery and Empowerment Model (TREM, 11%).

[12] A representative of ACMHC subsequently indicated that medication assisted treatment (MAT) *is* permitted when indicated; for such participants, MAT must be included in the treatment plan.

Table 2.8 presents a range of other evidence-based practices. Most—though, notably, not all—responding programs report conducting regular training for line treatment staff (83%); frequent and regularly scheduled supervision meetings between line staff and clinical supervisors (78%); and extensive use of cognitive behavioral approaches (72%). Other practices were less commonly employed. Looking at the *number* of evidence-based practices employed by each of the responding providers, half of the providers employ at least nine of the 13 practices; nearly a quarter (22%) employ four or fewer. While scoring program components in this manner does not fully account for variation in terms of implementation *quality*, it does provide a quick measure of the prevalence of evidence-based practices. As such, the findings suggest room for improvement in terms of implementing recommended practices.

Table 2.8. Provider Survey: Other Evidence-Based Practices

Total Treatment Providers Responding	18
Specific Practices Employed	
Regular Training for Line Staff	83%
Regularly Scheduled Supervision of Line Staff	78%
Cognitive Behavioral Approaches	72%
Program is Manualized	72%
Written Manual Created In-House	50%
Written, Research-Based Manual	50%
Treatment for Special Populations	67%
> 50% of Treatment Staff have Bachelor's Degree	67%
Coherent Treatment Philosophy	61%
Program Fidelity Tracking and Accountability	50%
Weekly Individual Meetings with Counselor	50%
Clinical Supervisors Regularly Observe Treatment	44%
Maximum 12 Participants in Group Sessions	44%
> 50% of Treatment Staff have Advanced Certification	33%
Number of Practices Employed	
None	0%
1-4 Practices Employed	22%
5-8 Practices Employed	28%
9-12 Practices Employed	39%
All 13 Practices Employed	11%

Procedural Justice

Prior research has shown the degree to which individuals experience the justice system as fair can impact compliance with court orders as well as criminal recidivism (*e.g.*, Tyler

2003). Promoting a transparent court experience, where participants understand what is expected of them, feel that court responses are fair and proportionate, and have a voice in the process stands to impact immediate and long-term compliance and success.

Particularly with individuals with a serious mental illness, achieving transparency and comprehension can be challenging. According to stakeholders, both the ACMHC judge and the dedicated public defender review service plans with participants before service plans are signed by the clients. Private attorneys—retained by few mental health court participants—may not engage in detailed review, but the judge always reviews the plan. Probation and JRS case managers also explain program rules, and JRS provides participants with the ACMHC participant manual on the day participants plead into the program. Even so, stakeholders acknowledged that clients with serious mental health issues, often in conjunction with drug and alcohol use, can have difficulty understanding the process. At least one previous study found that comprehension of the court process was a challenge for mental health court participants (Redlich, Hoover, et al. 2010).

Response to Non-Compliance

Stakeholders report that the court draws on a range of responses to noncompliant behavior, from a verbal admonishment from the judge during compliance review hearings to more frequent review hearings to short-term jail sanctions. When participants are sent to jail as a short-term sanction, they are never told the specific amount of time they will spend in jail. Likewise, clients who are terminated from residential treatment programs may be sent to jail if there is no other appropriate residential facility available; such participants often have no idea how long their jail stay will be before a residential bed becomes available.

Among participants who ultimately fail the mental health court program, one stakeholder reported that the consequences may be more severe than they would have faced in traditional court. Accordingly, the mental health court public defender may advise clients with a history of previous problem-solving court failures against entering the mental health court.

Repeatedly, interviewees spoke of the mental health court judge's compassion and desire to offer the program to any defendants she felt could potentially benefit from the program. When the judge originally came to the mental health court, there were a number of participants who had not been progressing and who some team members favored failing from the program. The judge felt it was important for all participants to be given a chance to prove themselves to *her* before being closed out of the program. Only once a participant has exhausted all the possible options available does the judge agree to fail them. Even for

unsuccessful completers, the judge may request additional treatment at the state prison if the participant meets criteria.

The judge's desire to extend the program to as many defendants as possible was mentioned by some interviewees as an occasional source of friction among team members, when eligibility criteria was stretched to accommodate participants that not all team members deemed appropriate. Nearly all interviewees mentioned the possibility—promoted by the judge and the JRS supervisor—of developing two distinct mental health court tracks as described above. The proposed structure was, in part, intended to promote procedural justice in light of what many maintained was already happening—i.e., differential treatment of participants with high mental health needs as opposed to those with high substance use/low mental health needs. By creating separate tracks, responses to noncompliance and other accountability measures could be adapted appropriately without undermining participant perceptions of fairness.

Incentives

Four $25 Giant Eagle (grocery store) gift cards are distributed as motivators during each compliance review hearing. The recipient of the gift card is signaled by an alarm on the JRS manager's phone. The alarm is only sounded during positive reviews. Sometimes the alarm is truly random, other times the alarm is intentionally triggered so that a participant who is in particular need of encouragement or who has made notable progress recently receives the gift card. For instance, during the site visit, one participant had recently had a baby and the team agreed that she could use the extra encouragement to stay on track (as well as the small amount of financial help offered by the gift card), so the alarm was sounded during her

Table 2.9. Court Appearances

Number of Participants	557
Court Appearances[1]	
Average Number of MHC Appearances, Pre-Program	7.69
Average Number of MHC Appearances, In-Program	17.72
% of In-Program Appearances Characterized as:	
Positive Appearances	57%
Neutral Appearances	9%
Negative Appearances	15%
Other Appearances[2]	18%
Average Number of MHC Appearances, Post-Program	3.87

[1] Includes scheduled court appearances, regardless of whether the participant actually appeared in court.

[2] Includes failure to appear, plea entered, and emergency appearances.

review. It was not clear from interviews or courtroom observations whether *participants* believe the incentive alarm to be random.

Court Appearances

Table 2.9 shows the total number of court appearances per case, on average, in the mental health court. During mental health court participation, participants make an average of 17.72 court appearances. Based on the average 785-day participation period (see Table 2.3), this averages out to about 44 days between court appearances over the duration of program participation. More than half (57%) of in-program appearances are characterized as positive; 15% are characterized as negative.

During the site visit, we observed a graduation ceremony, a regular compliance review calendar, and new pleas and revocations on a separate calendar. Highlights of those observations are below.

- **ACMHC Graduation Ceremony** A total of 14 participants successfully completed the program and were a part of the observed graduation ceremony. The ceremony began with the judge explaining the legal implications of graduation—probation is closed—and encouraging graduates to continue with their medication, treatment, and sobriety. A previous graduate who has been sober since 2011 gave a touching speech, describing his own journey and encouraging new graduates. The judge then named each graduate and spoke briefly about each graduate's time in the program—their struggles, how hard they had worked, how much she had worried about them. The judge had something personal to say for each graduate, followed by a note of how proud she is of them, a hug, and a diploma. She noted the four participants who were graduating with 100% positive status reviews. Graduates were each given a chance to speak. The graduates and the staff were given a standing ovation. The judge then promised to sign each graduate's release from probation conditions. Following the ceremony, all graduates and staff were invited to enjoy cake in the courtroom. The judge personally provides the cake from her favorite bakery. There was a sizeable audience in the courtroom and many participants specifically mentioned specific staff and family members in attendance. The graduation ceremony lasted for approximately half an hour.

- **Compliance Review Calendar** A total of 27 cases were observed during the compliance review calendar.[13] The time participants spent before the judge ranged from

[13] One additional case was called on the compliance calendar, but was not observed.

two to 20 minutes (mean: 5 minutes). Prior research in drug courts has shown that average court appearance lengths of three minutes per participant are associated with increased graduation rates, decreased recidivism rates, and cost savings (Carey, Mackin, and Finigan 2012). Between appearances, conferences, and administrative tasks, the entire calendar took just under two and a half hours (2 hours, 26 minutes). The first five participants appeared via teleconference from the jail. Most of the reviews (71%) were classified as positive, 21% were classified as negative, and 8% were classified as neutral. The complete team was present for review hearings, including the judge, court coordinator, assigned probation officer, JRS manager, dedicated public defender, and prosecutor. A representative from treatment was present in only a handful of cases (19%).

The judge made regular direct eye contact with all the participants who physically appeared in court. The judge spoke directly to 100% of participants, asked probing questions (i.e., requiring more than a simple "yes" or "no" response) of 85% of participants, and offered advice to 74% of participants. The judge reminded participants of the consequences of future noncompliance in 18% of the reviews; all of these reminders were for participants undergoing a negative review. Participants were provided an opportunity to speak directly to the judge in all appearances.

The judge was well-informed of participant progress in treatment (based on feedback provided during the earlier staffing session) and of important events in participants' personal lives. Her tone from the bench was one of compassion and caring. During positive reviews, the judge engaged with participants and representatives from probation and JRS with a friendly and even, at times, joking approach. However, she also explained participant obligations in a clear and serious manner. The judge offered praise and a slice of the graduation cake to all participants with a positive review. She hugged a participant who was appearing for the first time since having a baby.

Responses were somewhat varied for participants with negative or neutral reviews, based on the severity (and history) of noncompliance. Three participants who violated program rules received a stern verbal admonishment. Another who broke program rules was subject to some joking from the court, but no admonishment. (It was later explained to us that this participant faces developmental disabilities and the minor misunderstanding of program rules was felt to be accidental rather than deliberate.) A participant who had avoided responding to a probation request to come in for a toxicology screen was sent to jail for an unspecified length of time.

Table 2.10 presents more general information on the use of short-term detention in response to program noncompliance. Just under half of participants (48%) never had a short-term detention sanction during their participation. Of those with at least one short-term detention sanction, 58% had multiple sanctions. Forty percent of participants were detained on a technical supervision violation; those detained spent an average of 180 days incarcerated on short-term jail sanctions. Particularly given the length of such incarceration periods, it is likely that some of this time reflects the need for probation and case managers to revise participant service plans and find a new service providers for participants discharged due to noncompliance with their previous program. Just under one-quarter of participants were mandated to short-term detention in response to a new arrest; these participants averaged 84 days incarcerated on short-term jail sanctions.

Table 2.10. Response to Infractions

Number of Participants	557
All Detainers	
Participants with No Detention Sanctions	48%
Participants with 1 or More Detention Sanctions	52%
Average Number of Detention Sanctions[1]	2.17
% with 1 Detention Sanction	42%
% with 2 Detention Sanctions	26%
% with 3 Detention Sanctions	16%
% with 4 Detention Sanctions	9%
% with 5-11 Detention Sanctions	7%
Technical Violations	
Number of Participants Detained for Tech Violation	233 (40%)
Average Time, Detention Sanctions	180 days
New Arrests	
Number of Participants Detained for New Arrest	135 (24%)
Average Time, Detention Sanctions	84 days

[1] Among those with one or more detention sanction.

- **New ACMHC Participants** Five new participants entered the ACMHC during the second day of courtroom observations. Four of the new pleas were calendared as dual pleas, with two defendants appearing simultaneously in front of the judge, but with the cases distinguished by the judge. These dual pleas did not appear to involve cases that were related, but instead, conducted simultaneously as a time-saving tactic. The remaining case was the sentencing of a defendant who was in jail; sentencing occurred via videoconference. The new participant calendar took a total of one hour, 58 minutes.

The pleas were highly scripted, with the judge sticking closely to the legal standard for entering a plea. The judge spoke clearly and directly during the allocution and made eye contact with new participants who were not appearing via videoconference. The judge then reviewed service plans in detail with each new participant.

- **Probation Revocation** One participant was resentenced on a probation violation after new charges. Again, the judge spoke clearly and directly to the participant, using a stern tone and making eye contact.

Collaboration

Across interviews, stakeholders cited collaboration among the ACMHC team as one of the biggest program strengths. Indeed, our experience throughout the site visit underlined how well the group works together. Cross-agency collaboration was apparent at the staffing meeting we attended and team members truly seemed to respect and consider one another's expertise during interviews and the more casual group lunch. As one interviewee described, the judge and the team are supportive of each other and are constantly updating each other on client progress. Ultimately, it is the clients who benefit from having the support of all the agencies; clients also benefit from receiving intervention quickly when necessary. Even traditional adversaries—the public defender and the prosecutor—spoke highly of each other and of the priority of working together to benefit program participants. Both offices attribute the current level of collaboration to increased willingness to refer cases to the mental health court and resulting caseload increase. The current group of stakeholders was identified by several interviewees as particularly effective in terms of collaboration; earlier iterations of the ACMHC team were said to be more adversarial.

The judge was credited with encouraging and improving collaboration by several stakeholders. While the agencies had a relationship prior to the current judge's involvement with the mental health court, the judge has really prioritized collaboration. Stakeholders indicated that they appreciate that the judge is responsive and accessible and believe she makes certain that all players' voices are heard.

The team keeps one another updated using an email tree, which allows all agencies to follow what is happening with each client and to quickly follow any new developments. In addition, weekly staffing meetings are held to review cases scheduled for the compliance review calendar. During these staffing meetings, each participant's progress is discussed by the group. JRS provides treatment updates, probation provides their updates, and the team collaboratively makes any necessary changes to the service plan.

Particularly given upcoming changes to the ACMHC team (the JRS manager is retiring and the coordinator is moving to a new position with probation), the collaboration may serve as a continued program asset. Turnover in key positions poses the potential for strain on such a collaborative project; the team may want to consider specific steps to check in regularly during the transition period.

Chapter 3

Program Impacts

Impact on Recidivism

Official criminal justice records were used to measure re-arrest, re-conviction, and new incarceration sentences at one, two, and three years following entry into the mental health court (or the equivalent conviction date for the comparison group). Table 3.1 presents the rates of recidivism for the two groups.

Re-Arrest As expected, rates of re-arrest increase over the three-year period; just under one-third of participants had been re-arrested at one year, while half had been re-arrested three years after entering the mental health court. The differences in re-arrest rates between the two groups are not statistically significant at the one- or two-year period. However, at the three-year mark, mental health court participants are somewhat less likely to have any new arrest ($p<.10$[14]) and have significantly *fewer* new arrests than those in the comparison sample ($p<.05$). In particular, this difference appears to be driven by fewer new drug arrests among participants ($p<.10$). (While not reaching statistical significance, participants' felony re-arrest rate was also 8% lower than the comparison rate, a similar magnitude difference as the difference in new drug re-arrests.)[15]

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[14] Although not reaching the level of statistical significance, we are highlighting differences at the $p<.10$ level as *suggestive* here—particularly given the smaller sample size at the three-year mark.

[15] It is worth again noting that the average time in the mental health court program is more than two years (785 days), meaning that at both the one- and two-year recidivism periods, most participants would still be under court supervision—and enhanced justice system scrutiny. Under such intensive surveillance, we might anticipate higher detection of non-compliance—and corresponding higher rates of new criminal charges. In fact, such adverse "supervision effects" have been shown in other problem-solving courts (Brown et al. 2006; Hamilton 2010; Miethe, Lu, and Reese 2000; Petersilia 1999; Petersilia and Turner 1993; Travis, Solomon, and Waul 2001), though not specifically in mental health courts, where detection of noncompliance may be approached with a more therapeutic lens. The fact that the differences between the two groups begins to trend toward a significant mental health court impact at three years—after participants complete their more intensive court supervision—may lend suggestive support to the idea that enhanced supervision inflates new charges among participants. Alternatively, it may be that participants only begin to realize the benefits of the mental health court once they have

Re-Conviction Overall, the differences in re-conviction between mental health court participants and those in the comparison group are not significantly different, with one exception: continuing the trend seen with regard to new arrests, participants are somewhat less likely to be convicted on a new drug charge (p<.10).

Future Incarceration There are no differences between the two groups in terms of new incarceration sentences at any of the time periods. Fewer than one-quarter of the samples had returned to jail or prison in the three years following conviction/program entry.

Table 3.1. Impact of the Mental Health Court *(Continued)*

	Mental Health Court	Comparison Group
3. INCARCERATION [2]		
Any Incarceration (1 Year)	8%	8%
Any Incarceration (2 Years)	16%	15%
Any Incarceration (3 Years)	23%	21%

+p<.10 *p<.05 **p<.01 ***p<.001

Note: Follow-up period for all impact analyses begins on program start date for the mental health court participants or the first conviction date after January 1, 2013 for the comparison group; instant case arrest/conviction does not count towards recidivism or criminal history.

[1] Kaplan-Meier Log Rank Mantel-Cox results used to determine significance for time to re-arrest and re-conviction, capped at two or three years, depending on the analysis period. Individuals with a re-arrest/re-conviction were coded status=1 (yes) and time=days to the event; individuals who were not re-arrested/re-convicted in the two year period were coded as status=0 (no) and time=total days observed (i.e., less than or equal to 730/1,095 days). Typically, with variables such as re-arrest that are incredibly right-skewed, the median is reported rather than the mean, which can be difficult to interpret. Kaplan-Meier defines median survival time as the earliest time the survival probability drops to .5 (50%); if the survival curve does not drop to a minimum of .5, the median cannot be computed and is limited to the largest survival time if censored. Consequently, the mean survival time is reported here rather than median; includes cases with two (or three) years of follow-up recidivism data where an arrest/conviction occurred within the follow-up period.

[2] Sample sizes for the three periods are N=227 (1 year), N=210 (2 years), and N=142 (3 years).

Predictors of Re-Arrest

Table 3.2 presents the results of logistic regression models predicting any re-arrest at two and three years. The multivariate analyses were undertaken as a potential tool for the program to identify groups that might be in particular need of responsive programming—that is, groups that, given the standard mental health court program, might be at higher risk of re-arrest.

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completed a significant amount of time in the program and their behavioral health has potentially stabilized.

Table 3.2. Predictors of Re-Arrest

	2 Years	3 Years
Number of Cases	420	284
Nagelkerke R-Squared	0.156***	0.186***
	Odds Ratio	Odds Ratio
MHC Participant	0.766	0.633+
Demographics		
Average Age	0.980+	0.990
Male	1.134	0.886
Black/African American	1.788*	1.770+
Criminogenic Risk (Reference: Low Risk)		
Moderate Risk	2.194**	2.478**
High Risk	2.252*	2.574*
Behavioral Health Diagnosis		
Any Alcohol Use Disorders	1.349	1.275
Any Anxiety Disorders	0.974	1.064
Any Mood Disorders	0.882	0.473+
Any Psychotic Disorders	0.729	0.567+
Any Substance Use Disorders	1.677*	1.270
Index Event		
Felony Charge Severity	0.596+	0.489*
Index Event Charge Type (Reference: Other Top Arrest Charge)		
Person Top Arrest Charge	0.828	1.847
Property Top Arrest Charge	1.509	3.035**
Constant	0.855	1.711

+p<.10 *p<.05 **p<.01 ***p<.001

Note: Follow-up period for all impact analyses begins on program start date for the Mental Health Court participants or the first conviction date after January 1, 2013 for the comparison group; instant case arrest/conviction does not count towards recidivism or criminal history. Analsyis excludes active Mental Health Court cases. Persons can have more than one diagnosis in the past five years and percentages do not sum to 100%; each type of diagnosis was counted only once. Drug charge excluded from the model due to small count. Matched pairs were dropped if data were missing for any variables in the model.

Corresponding to the findings outlined above, mental health court participants are less likely to be re-arrested (3 year model, p<.10). Not surprisingly, given general arrest trends in the country, black defendants are more likely to be arrested than white defendants (both models). Offering some verification of the proxy risk score used by the Allegheny County Department of Probation and Parole, defendants ranked as moderate or high risk are more likely than low risk defendants to be re-arrested. Defendants facing felony level charges—and, likely, more severe sentencing ramifications for a new arrest—are less likely to be re-arrested than those facing lower level index charges. Those arrested on a property charge are more likely to have a new arrest than those arrested on drug or other charges. While not well-researched, this

finding mirrors a finding in two prior studies co-authored by the current author; in two studies of New York State drug treatment courts, those arrested on property crimes were similarly more likely to recidivate. The authors of those studies hypothesized that while the drug treatment courts were relatively successful at curtailing crime directly linked to participants' *addiction* problems, they were less successful at deterring criminal activity driven instead by deeper criminogenic motivations (Cissner et al. 2013; Rempel et al. 2003). Finally—and potentially of greatest interest to programmatic staff—findings suggest that those with a substance use disorder are at a particularly high risk of re-arrest (2 year model), while those with mood and psychotic disorder diagnoses have somewhat reduced risk (3 year model). While the mental health court has limited ability to modify the behavioral health profile of participants, these findings might inform service provision decisions for future participants. For instance, the findings may suggest that the court is relatively adept at addressing the criminogenic needs of participants with psychotic disorders, but might benefit from targeting additional services at those with substance and alcohol use disorders.

Chapter 4

Recommendations & Conclusion

Throughout the process evaluation activities, the ACMHC team demonstrated an interest in incorporating evidence-based practices into its program model. Our conversations with stakeholders, along with observations of program operations, revealed a team dedicated to maximizing both program and participant success. Team members expressed great interest in learning from the experiences of other jurisdictions and in familiarizing themselves with the limited literature on what works in mental health court settings. The judge and other team members demonstrated openness to adapting their policies based on recommendations and interest in adopting strategies that will maximize success for their program. In fact, at the time of this report—more than a year after the initial site visit—the team had already implemented several of the recommendations contained herein. The recommendations have not been modified to represent modified practices, but reflect the practices in place during the evaluation period.

In addition to the dedication of the team and their interest in identifying and incorporating evidence-based practices noted above, the evaluation team noted some specific strengths of the ACMHC program.

- **Collaboration** The mutual regard and collaboration of stakeholders from diverse agencies and backgrounds was clear in the level of communication and coordination the program enjoys. Team members spoke highly of one another and universally held the team to be a program asset.

- **Data Tracking** The program data has some limitations (see Recommendation 16, below), but in general captures a great array of information and appears to be entered carefully and comprehensively. In particular, the characterization of each status review hearing as positive, neutral, or negative provides a helpful tool to easily evaluate participant status quickly and clearly.

- **Quality of Judicial Interaction** The judge undertakes a number of best practices in promoting procedural justice in court. She is well-informed of participant progress, thanks to thorough pre-court staffing sessions. She makes regular eye contact with participants, engages them with dialogue, and allows appearances to feel unrushed (with

an average time of five minutes for regular compliance hearings). Her personal interactions with participants—asking about family and jobs, offering cake for compliant participants, offering individualized and personal praise for each of the graduates—speak to her compassion for participants and her desire to help them to succeed.

Recommendations

Based on the evaluation findings, we have formulated the following recommendation areas for exploration through the strategic planning process. These recommendations are informed by four primary sources: (1) Feedback, challenges, and concerns raised by members of the ACMHC team; (2) technical assistance materials created by the Council of State Governments Justice Center;[16] (3) a burgeoning mental health court literature (e.g., Fisler 2015; Reich et al. 2015; Reich et al. 2016; Rossman et al. 2012) and (4) evidence-based practices drawn from other problem-solving court models, most notably, adult drug courts.[17]

Assessment of Participant Needs

The ACMHC does not use an evidence-based risk-needs assessment tool to make admission and case planning decisions, although there was some discussion about the court possibly adopting the LSI-R as part of a broader countywide initiative. While several stakeholders believed that risk-needs assessments were implemented by treatment providers utilized by the court, only one provider (of 18 responding to the provider survey) reported using such a tool.

Both the court and treatment providers reported that they rely on clinical evaluations for behavioral health disorders and use results to develop individualized service plans. However, clinical assessments too are conducted by a range of providers; no standardized assessment is

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[16] See *Improving Responses to People with Mental Illnesses: Essential Elements of a Mental Health Court*, available at https://www.bja.gov/publications/mhc_essential_elements.pdf; *Mental Health Courts: A Primer for Policymakers and Practitioners*, available at https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf; *Developing a Mental Health Court: An Interdisciplinary Curriculum*, available at https://csgjusticecenter.org /courts/mhc-curriculum/.

[17] While evidence-based practices from the drug court model (and other problem-solving courts) have influenced the analysis and recommendations here, it is worth noting that there is little research specifically indicating which of these practices are applicable in the context of mental health courts.

required. Finally, the court does not assess for trauma, and only three of the responding service providers (17%) reported that they assess for trauma.

1. **Utilize an evidence-based risk-needs and clinical assessment tool to inform admission decisions.** Traditionally, justice system practitioners have used their professional judgment to determine whether potential participants would be a good fit for the court. This approach, however, is not a reliable assessment method. These decisions should be made on the basis of evidence-based risk-need and clinical assessment tools that provide a validated risk classification (e.g., low, moderate, high) and method for classifying the severity of needs. (The ACMHC may ultimately find that more than one tool is needed to cover standard risk-need domains as well as clinical domains that are particularly important for a mental health court population.[18])

    a. **Central Eight assessment** An adequate risk-needs assessment should, at a minimum, assess for the eight risk-need factors that have been shown in more than three decades of research to be associated with recidivism: (1) criminal history; (2) antisocial temperament/impulsive styles of decision-making; (3) criminal thinking/antisocial attitudes/beliefs justifying resort to criminal behavior; (4) pro-criminal social networks; (5) employment and educational deficits; (6) family or relationship deficits; (7) problematic/lack of prosocial use of leisure time; and (8) substance use.

    b. **Trauma assessment** Whereas mental health courts and the treatment providers they use can be assumed to provide for at least some level of clinical assessment for mental health disorders, evidence suggests that trauma in particular, if left untreated, can render treatments for other problems less effective. Accordingly, use of a screener or assessment of some kind for trauma should become standard.

2. **Consider placing responsibility for assessment with members of the ACMHC team, rather than outsourcing.** Rather than relying on an exhaustive list of outside service providers to determine when and how to assess potential participants, the court should consider adopting a universal screening process for all potential participants. The Department of Probation, Justice-Related Services (JRS) liaisons, or a new court-

[18] For further discussion of assessment with mental health court populations, see Peters, Bartoi, and Sherman 2008.

based staff position might potentially assume this role. Alternatively, the court might designate a select number of providers as designated assessing agencies.

3. **Utilize evidence-based risk-needs, clinical, and trauma assessment tools to inform participant service plans.** In addition to using evidence-based tools to decide who enters the program, the ACMHC should base service plans on clinical judgment with support from validated, evidence-based tools. Consider limiting the tools used by the court to a select few in order to streamline training and interpretation. Service plans should reflect not only participant diagnoses and needs, but, where a mix of risk levels are deemed program-eligible, distinct service plans should be developed for low- as opposed to high-criminogenic risk participants. In particular, efforts should be undertaken to curtail the intensity of program requirements for low-risk individuals as well as to incorporate into service plans the use of treatments for any participant needs that extend beyond classic behavioral health disorders (e.g., extending to impulsive decision-making, criminal thinking, employment deficits).

Eligibility Criteria

Stakeholders noted that the ACMHC judge hopes to offer the benefits of the mental health court model to as many participants as possible. Several stakeholders voiced trepidation about eligibility exceptions made to include defendants who present with low need (particularly in terms of mental health) and low risk. Anecdotally, interviewees believe that participants with more severe mental health needs fare better in the current mental health court model than those with severe substance use needs coupled with very low mental health needs. There is a tension between expanding eligibility criteria so that more defendants can potentially benefit from the program and restricting eligibility to those who are most likely to succeed. While we do *not* recommend limiting participation to only those who are likely to succeed, we *do* endorse a systemic, data-based review of the potential costs and benefits—to the court *and* to the clients who may not be well-served by entering a program that cannot appropriately meet their needs—of expanding eligibility criteria.

4. **Weigh the relative costs and benefits of expanding eligibility criteria to lower-risk and lower-need participants.** By engaging in a comprehensive review of the relative risks and benefits of expanding eligibility criteria, the court will enable itself to develop appropriate and distinct policies and practices for varying risk and need levels, rather than adopting a piecemeal approach to developing service plans for exceptions to the general eligibility criteria. Both high- and low-risk participants will benefit from service plans that keep them segregated.

5. **In particular, weigh the benefits of accepting participants with low mental health needs.** Stakeholders frequently mentioned the possibility of creating separate tracks for clients with high mental health needs versus low mental health/high substance use need clients. While the court regularly (and appropriately) serves participants with co-occurring disorders, the proposed expansion would incorporate participants with high substance use needs, but very low mental health needs. Particularly given the existence of a drug court in the jurisdiction, the court should carefully weigh the judiciousness of branching into what would more traditionally be considered a drug court clientele. Stakeholders expressed the belief that the presiding drug court judge is reluctant to accept participants with co-occurring disorders, even when the substance use disorder—and *not* a lower level mental health need—is viewed as driving criminal involvement. The two courts—ideally with input from administrators—should work together to formalize eligibility criteria and develop protocols to determine appropriate placement in cases of potential eligibility overlap.

6. **Consider adjusting the court calendar to accommodate different risk and need levels without compromising procedural justice.** Beyond the often-mentioned separate tracks for high mental health need versus low mental health/high substance use need clients, the court should examine the possibility of creative calendaring of cases to minimize the potentially deleterious audience effect of mixing clients with vastly different risk and need levels. For instance, one case that the process evaluation team observed during the status review hearing stood out for the judge's uncharacteristically lenient response to a violation of program rules. After court, the judge explained that the particular client's developmental delays shaped her response. However, both the judge and other stakeholders noted that it may, at times, be unclear to other participants in the audience why some court responses appear to be disproportionately lenient. Understanding that mental health court—arguably more so than other problem-solving courts—frequently needs to be responsive to clients on a case-by-case basis, the court could explore adjusting the audience effect by scheduling similar risk and need level clients for review hearings during a distinct time period. Such a strategy may also prove useful if and when the court moves forward with a separate track for low mental health/high substance use needs participants. When individualized responses hold the potential for undermining procedural justice, the ACMHC team should bring as much transparency to the process as possible. For instance, it might be appropriate in to explain in open court that one participant has been in the program longer and thus is being held to higher standards, or (without revealing highly personal

information) to explain that the judge and court team recognize that a participant has been facing unique challenges and struggling to overcome them.

7. **Explore the implications of expanding to a pre-plea model.** Two stakeholders mentioned the possibility of expanding to accept some pre-plea cases to attract additional participants. If this possibility is truly of interest, the court should engage in a comprehensive analysis of the implications of expanding to a pre-plea model, including a caseload analysis to assess program capacity for such cases. Some starting considerations would include:

    a. Is data available to support a preliminary caseload estimate for pre-plea cases? If so, does the court have the capacity to handle a likely influx of cases?
    b. What are the benefits to the court program of accepting some participants pre-plea? Are there benefits beyond increasing caseload?
    c. Which defendants/cases (e.g., based on charges, diagnoses, risk) would be eligible for pre-plea entry into the mental health court?
    d. What would case management and supervision look like in these cases (i.e., probation would not be an option, would pre-trial services be a possibility)?
    e. What would the legal ramifications of program failure be for pre-plea participants (e.g., would cases go to trial and, if so, what legal mechanisms would have to be in place for waiving speedy trial)?
    f. What would the legal benefits of successful completion be for pre-plea participants (e.g., outright dismissal, reduction of charges)?

Legal Leverage

The next recommendations are derived from the drug court literature and the general literature on deterrence, stressing the importance of clear and certain consequences for program failure and program noncompliance (e.g., Rossman et al. 2011; Young and Belenko 2002). Granting there is not an extensive evidence-base specifically with a mental health court population *and* the greater need for flexibility when working with such a population, the court should review policies around the use of jail and the threat of jail sentences of unspecified length.

8. **Consider establishing a clear jail (or other sentence) alternative to be given in the instance of program failure.** Currently, neither participants nor the court know the likely sentence participants will incur should they fail to complete the mental health court program. Notwithstanding the need for some flexibility in a mental health

court program—for instance, for those participants who do not reoffend, but who are simply unable to achieve the stability required for successful program completion—a *range* of likely sentencing scenarios to result from a new offense or technical violation, shared with the participant at the outset of the program, would potentially provide leverage for the court and, dispensed as promised, promote procedural justice.

9. **Where at all possible, avoid the use of open-ended short-term jail sanctions.** Understanding the reality of the shortage of appropriate residential beds, sending participants to jail in response to program infractions without any sense of how long they will remain incarcerated goes directly against the principles of proportionality and certainty and stands to undermine participants' perceptions of fairness and justice. The court should explore every possible option for alternative supervision while awaiting placement before relying on incarceration as a waiting room. Other jurisdictions likely face similar challenges and may have developed alternative strategies worth exploring (e.g., intensive community supervision and day reporting coupled with a less-intensive treatment modality). Where a lack of appropriate placement options truly necessitates extended jail stays after an initial jail sanction, the program should explore ways to differentiate—to the incarcerated participants as well as those participants observing status reviews—between the initial, time-limited, sanction period and the subsequent time spent looking for appropriate placement.

10. **Frequently remind participants of program requirements.** During courtroom observations, the ACMHC judge reminded participants of the consequences of future noncompliance in 18% of cases. Only participants receiving negative reviews were given such reminders. Evidence from the drug court literature suggests frequent reminders of program expectations and likely consequences of both program success and noncompliance (Young and Belenko 2002; Zweig et al. 2012). The same evidence-base does not exist for mental health court participants. Indeed, our technical assistance team has expressed concern that strongly-worded warnings of negative consequences may alienate clients who are doing well. Given this concern, the judge might cautiously explore ways to standardize reminders—particularly of the positive consequences of successful program completion—into regular compliance appearances for all participants.

Treatment

Allegheny County draws on a relatively large pool of service providers. In most ways, this is an enormous program asset; however, it also places additional responsibility on the program, which must continually monitor provider practices.

11. **Weigh the relative costs and benefits of medication assisted treatment and assess program requirements for abstinence.** The National Association of Drug Court Professionals (2013) has noted the improved outcomes associated with medically assisted treatment in Volume I of their *Best Practice Standards* and advises drug court programs to engage in a case-by-case analysis of when and how to permit the use of medication assisted treatment. Likewise, the Legal Action Center concludes that medically assisted treatment is an important component in the tool-kit of courts addressing opioid addiction (Friedman and Wagner-Goldstein 2016). Given the prevalence of co-occurring disorders in the ACMHC population, the court should engage in a comparable analysis when medically assisted treatment is *clinically* indicated.

12. **Develop partnerships with service providers that deliver evidence-based treatment.** Among those service providers responding to our survey supplement, implementation of evidence-based practices was highly variable. Providers were particularly deficient in terms of implementing evidence-based assessments and making treatment decisions based on such tools. The mental health court, while under pressures to find placement for participants, must hold providers accountable and engage in continued monitoring to ensure that programs implement evidence-based practices consistently.

13. **Consider whether a standard reporting tool for programs to update case managers and probation might add to program efficiency.** Such a tool might allow for straightforward reporting when there is nothing out of the ordinary to note; it also might increase consistency and accountability among service providers.

Collaboration

14. **Ensure that the team's highly collaborative approach remains in place whenever specific team members change.** The ACMHC team draws on a collaborative model, in which stakeholders genuinely appear to hold each other in high esteem and to work together to maximize program benefits for participants. During interviews, several stakeholders noted that it was not always so, but that the current

judge, public defender, and prosecutor—in particular—have eliminated historic adversarial relationships between team members. In light of upcoming staffing changes (the ACMHC Coordinator is transferring to another position and the JRS manager is preparing to retire), the team should consider mechanisms to ensure the collaborative process is preserved. For instance, allowing for overlap between the outgoing and ingoing personnel and/or increasing team check-ins during the transition period.

Other Recommendations

Two additional points of note arose during the evaluation activities:

15. **Consider implementing protocols for random toxicology screening.** Truly random screening is supported by drug court recommended practices (NADCP 2015) and means that participants have an identical probability of being tested every day—weekends, holidays, concurrent days. In particular, if the ACMHC is to expand to include low mental health/high substance use need clients, random screening may be indicated for such a population.

16. **Address data limitations in the interest of both program operations and future evaluation efforts.** One data limitation noted during stakeholder interviews is that the program currently has no way to track incarceration sentences for participants revoked out of the ACMHC. Another data limitation was revealed during review of the program data: the automated information on service mandates does not allow for distinction between mental health treatment and substance use treatment in many instances. While paper court files most likely contain additional information on the types of treatment participants receive, outside agencies conducting research would be unlikely to access either the paper files or the program staff knowledge to make determinations about program mandates. In order to determine whether, for instance, participants mandated to programs for co-occurring disorders outperform those mandated separately to substance use and mental health treatment, such information would be crucial. Without it, future evaluation efforts will face limitations.

The population served by the ACMHC requires policies that allow for a great deal of individualization. The recommendations above are intended to assist the court to draw on evidence-based practices while preserving flexibility when it is in clients' and the program's best interest. The ACMHC team has shown themselves to be incredibly mindful of maximizing program benefits while providing services to as broad a population as possible. Team members are not only receptive to incorporating evidence-based practices, but sought

the current evaluation and strategic planning assistance toward the end of incorporating such practices.

Study Limitations

The findings presented in Chapter 3 suggest that the Allegheny County Mental Health Court—at the time of the current study—saw few significant impacts on recidivism. Despite trends suggesting that program participants may be somewhat less likely than those in the matched comparison group to be re-arrested in the post-program period (and to have *fewer* new arrests in that period), overall, the impact of the program on official recidivism measures was modest. A few limitations to the current approach to assessing program effectiveness are worth noting. First, as with any evaluation that seeks to measure program impacts through official criminal justice data, an assessment of the Allegheny County Mental Health Court based *solely* on official recidivism data potentially misses some of the nuances of program impact. That is, recidivism is not the *only* potential outcome of interest of any criminal justice intervention. Without the ability to measure other individual outcomes (e.g., physical and behavioral health outcomes, services received, abstinence from substance use, family reunification and stability, employment), recidivism offers a relatively easy-to-assess metric, but a limited one. In part, we sought to overcome the limitations of looking solely at recidivism measures through the detailed program description, informed by conversations with those who work closely with the mental health court. Future research could gain an even deeper understanding through speaking directly with program participants—something that was beyond the scope of the current study.

As noted above, there were limitations to the available data. It is worth noting that the access to behavioral health diagnosis data was critical to identifying an appropriate comparison sample and is not something that many jurisdictions would be able to provide. The specific structure of the DHS data system—along with the realities of overlapping and multiple diagnoses—mean that our behavioral health diagnosis coding was rudimentary. This may have resulted in inaccurate categorization of some individuals.

Ideally, we would have been able to isolate a reasonable amount of post-program time (and comparison analogue) over which to track recidivism, in order to minimize the risk that the increased supervision of the in-program period was not unduly shaping recidivism results. While we were limited to the three-year analysis period and we did not strictly isolate the post-program period, those participants available for the three-year analyses likely represented a post-program period of just under one year (based on the mean time to program completion).

Finally, the current report was written in two phases. First, the process evaluation and resultant recommendations were drafted and submitted to the site. These results informed the strategic planning undertaken by the program in collaboration with the Center's technical assistance team. This strategic plan is now well underway, though the release of the final report was delayed until the impact evaluation was complete. Therefore, some of the processes described in Chapter 2—along with some of the recommendations made in this chapter—may no longer apply to the court's current operations.

References

Brown, Brenner, Robin Campbell, James A. Wilson, Yury Cheryachukin, Robert C. Davis, Jean Dauphinee, Robert Hope, Kajal Gehi. 2006. *Smoothing the Path From Prison to Home,* final report submitted to the National Institute of Justice, Washington, DC (NCJ 213714), available at www.ncjrs.gov/pdffiles1/nij/grants/213714.pdf.

Bryson, Alex, Richard Dorsett, and Susan Purdon. 2002. *The Use of Propensity Score Matching in the Evaluation of Active Labour Market Policies.* LSE Research Online Documents on Economics, London School of Economics and Political Science, LSE Library, http://EconPapers.repec.org/RePEc:ehl:lserod:4993.

Carey, Shannon M., Juliette R. Mackin, and Michael W. Finigan. 2012. "What Works? The Ten Key Components of Drug Court: Research-Based Best Practices." *Drug Court Review* 8(1):6-42.

Cissner, Amanda B., Michael Rempel, Allyson Walker Franklin, John K. Roman, Samuel Bieler, Robyn Cohen, and Carolyn Cadoret. 2013. *A Statewide Evaluation of New York's Adult Drug Courts: Identifying Which Policies Work Best*. New York: Center for Court Innovation.

Fisler, Carol. 2015. "When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts." *The Judges Journal* 54(2):8-13.

Friedman, Sally and Kate Wagner-Goldstein. 2016. *Medication Assisted Treatment in Drug Courts: Recommended Strategies.* New York, NY: Legal Action Center.

Hamilton, Zachary. 2010. *Do Reentry Courts Reduce Recidivism? Results from the Harlem Parole Reentry Court*. New York, NY: Center for Court Innovation.

Miethe, Terance D., Hong Lu, and Erin Reese. 2000. "Reintegrative Shaming and Recidivism Risks in Drug Court: Explanations for Some Unexpected Findings." *Crime and Delinquency* 46(4):522-541.

National Association of Drug Court Professionals. 2013. *Adult Drug Court Best Practice Standards, Volume I.* Alexandria, VA: National Association of Drug Court Professionals.

Peters, Roger H., Marla G. Bartoi, and Pattie B. Sherman. 2008. *Screening and Assessment of Co-Occurring Disorders in the Justice System.* Delmar, NY: CMHS National GAINS Center.

Petersilia, Joan. 1999. “A Decade of Experimenting with Intermediate Sanctions: What Have We Learned?” In *Perspectives on Crime and Justice*. Washington, DC: National Institute of Justice.

Petersilia, Joan and Susan Turner. 1993. “Intensive Probation and Parole.” In M. Tonry (Ed.), *Crime and Justice: A Review of Research, Vol. 17*. Chicago, IL: University of Chicago Press.

Travis, Jeremy, Amy L. Solomon, and Michelle Waul. 2001. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry*. Washington, DC: The Urban Institute.

Redlich Allison D., Steven Hoover, Alicia Summers, and Henry J. Steadman. 2010. “Enrollment in Mental Health Courts: Voluntariness, Knowingness, and Adjudicative Competence.” *Law and Human Behavior* 34(2):91-104.

Reich, Warren A., Sarah Picard-Fritsche, Lenore Cerniglia, and Josephine W. Hahn. 2015. “Predictors of Mental Health Court Compliance and Re-Arrest in Brooklyn, New York.” *Journal of Offender Rehabilitation* 54(6):391-405.

Reich, Warren A., Sarah Picard-Fritsche, Virginia Barber Rioja, and Merrill Rotter. 2016. *Evidence-Based Risk Assessment in a Mental Health Court: A Validation Study of the COMPAS Risk Assessment.* New York, NY: Center for Court Innovation.

Rempel, Michael, Dana Fox-Kralstein, Amanda Cissner, Robyn Cohen, Melissa Labriola, Donald Farole, Ann Bader, and Michael Magnani. 2003. *The New York State Adult Drug Court Evaluation: Policies, Participants and Impacts*. New York: Center for Court Innovation.

Ridgely, M. Susan, John Engberg, Michael D. Greenberg, Susan Turner, Christine DeMartini, and Jacob W. Dembosky. 2007. *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court*. Santa Monica, CA: RAND Corporation.

Rossman, Shelli B., John K. Roman, Janine M. Zweig, Michael Rempel, Christine H. Lindquist. 2011. *The Multi-Site Adult Drug Court Evaluation: Executive Summary*. Washington, DC: The Urban Institute.

Rossman, Shelli B., Janeen Buck Wilson, Kamala Mallik-Kane, KiDeuk Kim, Sara Debus-Sherrill, P. Mitchell Downey. 2012. *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York*. Washington, DC: The Urban Institute.

Rubin, Donald B. 1973. "Matching to Remove Bias in Observational Studies." *Biometrics* 29:159-183.

Thompson, Michael, Fred Osher, and Denise Tomasini-Joshi. 2008. *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court*. New York, NY: Council of State Governments Justice Center.

Tyler, Tom R. 2003. "Procedural Justice, Legitimacy, and the Effective Rule of Law." *Crime and Justice* 30: 283-357.

Wong, Timothy. 2009. *Validation of the State of Hawaii LSI-R Proxy*. Interagency Council on Immediate Sanctions report accessed at http://icis.hawaii.gov/wp-content/uploads/2013/07/copy2_of_copy_of_SARA-DVSI-Exploratory-Study-Oct-2008.pdf

Young, Doug and Steven Belenko. 2002. "Program Retention and Perceived Coercion in Three Models of Mandatory Drug Treatment." *Journal of Drug Issues* 22(2):297-328.

Zweig, Janine M., Christine Lindquist, P. Mitchell Downey, John Roman, and Shelli B. Rossman. 2012. "Drug Court Policies and Practices: How Program Implementation Affects Offender Substance Use and Criminal Behavior Outcomes." *Drug Court Review* 8(1):43–79.

Appendix A

CENTER FOR COURT INNOVATION
Mental Health Court Policy Survey

The questions below refer to your mental health court's current policies and practices. Please answer the questions in this survey candidly and to the best of your knowledge. Although some of the court's policies may be reflected in an official policy manual or handbook, the purpose of this survey is to learn about **actual practices** as they are currently applied in your court.

Your responses will be invaluable in producing a basic understanding of your mental health court's policies and procedures as well as identifying promising practices, lessons learned, and any training and technical assistance needs. Your responses will only be shared with the researchers conducting the survey and those individuals who are directly involved in providing your court with technical assistance.

Name of Court: ____________________
Date Opened: ____________________
Your Name: ____________________
Your Position: ____________________
E-mail: ____________________

I. TARGET POPULATION

A) LEGAL ELIGIBILITY

1. Which arrest charges are potentially eligible for your mental health court? *Check all that apply, including in your answer all charges that may sometimes be legally eligible, even if they are not admitted in all cases.*
   - ☐ Violent felony
   - ☐ Nonviolent felony
   - ☐ Misdemeanor
   - ☐ Summary offense
   - ☐ Sex offender registry charges
   - ☐ Weapons charges
   - ☐ Domestic violence charges
   - ☐ Other: Please specify: ____________________

2. Please note any special charge exclusions that are not apparent from the preceding list?

   ____

3. Can defendants enroll as a direct result of a probation violation? *Check all that apply.*
   - ☐ No
   - ☐ Yes – with new arrest
   - ☐ Yes – with technical violation

4. Are defendants <u>ineligible</u> based on the following criminal history considerations? *Check all that apply.*
   - ☐ Prior violent felony conviction
   - ☐ Prior nonviolent felony conviction
   - ☐ Prior violent misdemeanor conviction
   - ☐ Prior misdemeanor conviction
   - ☐ Prior summary offense
   - ☐ Too many felony prior convictions
     If yes, how many is the maximum allowed? ______ (#)
   - ☐ Too many misdemeanor prior convictions
     If yes, how many is the maximum allowed? ______ (#)
   - ☐ Too few priors
     If yes, how many is the minimum? ______ (#)

5. Please note any special criminal history criteria that are not apparent from the preceding list?

   ____

   ____

B) LEGAL SCREENING

6. What are all common referral sources for the mental health court? *Check all that apply.*
   - ☐ Some types of cases (e.g., based on charge) are automatically referred
   - ☐ Referral by judge
   - ☐ Referral by prosecutor
   - ☐ Referral by defense attorney/defendant
   - ☐ Referral by probation
   - ☐ Referral by county jail
   - ☐ Referral by local service providers
   - ☐ Referral by pretrial service agency
   - ☐ Other: Please specify: ____

7. Answer only if some cases are automatically referred to the mental health court for further screening: Which specific types of cases are automatically referred to the mental health court?

   ____

   ____

   ____

8. How often does the prosecutor exclude an otherwise legally eligible case?
   - ☐ Never or rarely *(Skip to Question #10)*
   - ☐ Sometimes (less than one-quarter of potentially eligible cases)
   - ☐ Often (one-quarter to one-half of potentially eligible cases)
   - ☐ Very often (more than half of potentially eligible cases)

9. Why might the prosecutor exclude an otherwise legally eligible case? At what stage of case processing does the prosecutor exclude the case? *Answer only if you checked "sometimes," "often," or "very often" in the previous question.*

____

____

____

10. Other than the prosecutor, do other members of the mental health court team ever provide a recommendation to exclude an otherwise legally eligible case? Which team members might provide this recommendation, and at what stage is it conveyed?

____

____

____

C) CLINICAL ELIGIBILITY

11. Which clinical characteristics are eligible for your mental health court?

	Yes, MHC Eligible	Yes, MHC Eligible **only if co-occurring with a psychiatric diagnosis**	No, Not MHC Eligible
Schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or other psychiatric diagnosis consistent with formerly Axis I diagnosis	☐	NA	☐
Personality disorder (formerly Axis II diagnosis)	☐	☐	☐
Posttraumatic stress disorder (PTSD)	☐	☐	☐
Substance use disorder	☐	☐	☐
Intellectual disability and/or developmental disabilities	☐	☐	☐
Traumatic brain injury	☐	☐	☐
Other (please specify) ____________________	☐	☐	☐

12. Please note any special eligibility criteria or special categories of defendants who are not able to participate for clinical reasons?

____

____

13. Are exceptions to legal and/or clinical eligibility made on a case-by-case basis for unusual circumstances?
    - ☐ No
    - ☐ Yes

E) Defendant Opt-In or Refusal

14. When given the chance, about how often do defendants refuse to participate?
    - ☐ Never or rarely
    - ☐ Sometimes (less than one-quarter of eligible cases)
    - ☐ Often (one-quarter to one-half of eligible cases)
    - ☐ Very often (more than half of eligible cases)

15. What do you think is the <u>most common</u> reason why defendants refuse to participate?
    - ☐ Mental health court program is too long and intensive
    - ☐ Better legal outcome is likely by not participating
    - ☐ Unmotivated to enter treatment
    - ☐ Other: Please specify: ____

II. CLINICAL SCREENING AND ASSESSMENT

D) Risk Assessment

16. Do candidates and/or participants receive a structured assessment for risk of re-offending and/or risk of failing to comply with terms of supervision (<u>i.e.,</u> <u>criminogenic risk/needs assessment</u>)?
    - ☐ No *(Skip to Question #22)*
    - ☐ Yes

17. Who receives the risk assessment?
    - ☐ All defendants in the courthouse
    - ☐ All defendants who are referred to the mental health court
    - ☐ Only enrolled program participants
    - ☐ Other subgroup: Please specify: ____________________________________

18. At what stage is the assessment conducted? *Check all that apply.*
    - ☐ During the process of determining eligibility
    - ☐ Following eligibility determination but before formal enrollment into the mental health court
    - ☐ After enrollment into the mental health court program
    - ☐ Other (please specify): ____

19. What tool does the court use to assess participants' criminogenic risks and needs? *Check all that apply.*
 COMPAS
 LSI-R
 LS-CMI
 Other (please specify): ____

20. To the extent that you formally assess for risk of re-offense (i.e., you apply a formal risk classification scheme based on the results of a formal assessment), which of the following risk levels do you seek to enroll in your mental health court? *Check all that apply.*
 N/A (risk assessment not performed)
 Low-risk
 Moderate-risk
 High-risk

21. To the extent that you formally assess for risk of re-offense, do you vary initial program requirements based on risk level? *Check all that apply.*
 N/A (risk assessment not performed)
 No
 Yes, vary initial frequency of judicial status hearings
 Yes, vary initial frequency of case management
 Yes, vary initial treatment modality or frequency of treatment attendance

22. Do candidates and/or participants receive a structured assessment for risk of violence?
 No *(Skip to Question #26)*
 Yes

23. Who receives the assessment for risk of violence?
 All defendants in the courthouse
 All defendants who are referred to the mental health court
 Only enrolled program participants
 Other subgroup: Please specify: ____

24. At what stage is the assessment for risk of violence conducted? *Check all that apply.*
 During the process of determining eligibility
 Following eligibility determination but before enrollment into the mental health court
 After enrollment into the mental health court program
 Other (please specify): ____

25. Briefly describe the instrument or process the court uses to assess for risk of violence: _______

____

____

E) CLINICAL ASSESSMENT

26. Do potential mental health court participants receive a brief clinical screen (e.g., 10 minutes or less)?
    - ☐ No *(Skip to Question #29)*
    - ☐ Yes, Brief Jail Mental Health Screen
    - ☐ Yes, other clinical screening tool (please specify):___________________________________

27. Who receives the brief clinical screen?
    - ☐ All defendants in the courthouse
    - ☐ All defendants who are referred to the mental health court
    - ☐ Only enrolled program participants
    - ☐ Other subgroup: Please specify: ____

28. At what stage is the brief clinical screen conducted? *Check all that apply.*
    - ☐ Prior to mental health court referral (i.e., used to inform whether a referral is appropriate)
    - ☐ After a referral/prior to mental health court enrollment
    - ☐ After mental health court enrollment
    - ☐ Other timing (please specify): ____

29. Do potential mental health court participants receive a full clinical assessment before referral to the treatment?
    - ☐ No *(Skip to Question #36)*
    - ☐ Yes

30. If "Yes" to previous question, please identify or briefly describe the clinical assessment process, including any instruments used: ____

    ____

    ____

31. Do you still administer the full-length assessment if a defendant does not screen as clinically eligible based on the brief screening tool(s)?
    - ☐ Not applicable/brief screen is not used
    - ☐ Yes—assessment still administered in all instances
    - ☐ Yes—assessment still administered in at least some instances
    - ☐ No—assessment not administered if brief screen indicates defendant is ineligible

32. Who receives the full clinical assessment?
    - ☐ All defendants in the courthouse
    - ☐ All or most defendants who are referred to the mental health court
    - ☐ Only enrolled program participants
    - ☐ Other (please specify): ____

33. At what stage is the full clinical assessment conducted? *Check all that apply.*
    - ☐ Prior to mental health court referral (i.e., used to inform whether a referral is appropriate)
    - ☐ After a referral/prior to mental health court enrollment
    - ☐ After mental health court enrollment

☐ Other timing (please specify): ____

34. How do you routinely use your full-length assessment? *Check all that routinely apply.*
   ☐ Determine eligibility for the mental health court
   ☐ Determine mental health service needs and assign to mental health treatment
   ☐ Determine additional behavioral health service needs
   ☐ Determine selection of specific community-based treatment provider(s)
   ☐ Determine need for criminal thinking intervention
   ☐ Determine other ancillary service needs (education, employment, housing etc.)
   ☐ Determine frequency of judicial status hearings at outset of program participation
   ☐ Determine frequency of case management at outset of program participation
   ☐ Other: Please specify: ____

35. Does the court routinely re-administer your full-length assessment after certain periods of time?
   ☐ No
   ☐ Yes: When/how often? ____

36. Does your mental health court conduct a formal assessment for trauma?
   ☐ No
   ☐ Yes (Please list the name of the assessment tool: ______________________________)

III. DETERRENCE AND INCENTIVE STRATEGIES

A) Legal Leverage

37. At what stage is a defendant admitted as a mental health court participant? *Check all that apply in at least some cases.*
   ☐ Pre-plea *(the defendant has not yet pled guilty)*
   ☐ Post-plea/sentence deferred *(the defendant has pled guilty but sentence is not imposed)*
   ☐ Post-plea/sentenced to probation with mental health court as a condition of probation
   ☐ Post-plea/enrollment in conjunction with probation violation on an earlier case
   ☐ Other: Please specify: ____

38. At the point when a defendant becomes a mental health court participant, have the participant, judge and prosecutor agreed on what the disposition of the case will be, if the participant graduates from the court?
   ☐ Always
   ☐ Sometimes
   ☐ Rarely/Never

39. What happens to the court case at graduation? *Check all that apply in at least some cases.*
   ☐ Conviction expunged
   ☐ Probation closed at expiration
   ☐ Probation term reduced or early discharge
   ☐ Probation sentence imposed or continued/no adjustment to sentence length
   ☐ Other: Please specify: ____

40. Are participants told at enrollment <u>exactly</u> which legal outcome will result at graduation? *Please answer "no" if participant is merely told what <u>may</u> happen or is told of one or more <u>possible</u> outcomes. Please answer "no" if there is any doubt.*
   - ☐ Yes
   - ☐ No

41. *If "Yes" to previous question:* Who tells participants what will happen if they graduate? *Check all that apply, but check <u>only if the given role conveys this information routinely in all cases</u>.*
   - ☐ Specified in the mental health court contract/plea agreement
   - ☐ Judge
   - ☐ Prosecutor
   - ☐ Defense attorney
   - ☐ Court coordinator
   - ☐ Case manager
   - ☐ Probation officer
   - ☐ Treatment provider
   - ☐ Other: Please specify: ____

42. At the point that a defendant becomes a mental health court participant, have the participant, judge and prosecutor agreed on what the disposition of the case will be, if the participant is <u>terminated</u> from the court?
   - ☐ Always
   - ☐ Sometimes
   - ☐ Rarely/Never

43. Are participants told at enrollment <u>exactly</u> how much jail or prison time, if any, they will serve if they fail the program (not a possible upper limit or range, but the <u>exact terms of sentence</u>)?
   - ☐ Yes
   - ☐ No *(Skip to Question #46)*

44. *If "Yes" to previous question:* Upon failing, will participants <u>always</u> in fact receive the **exact sentence length** (e.g., same number of days/months/years) **that was specified** at the time of mental health court entry?
   - ☐ No
   - ☐ Yes (always or virtually always)

45. Who tells participants in advance of the exact legal consequences of failing? *Check all that apply, but check <u>only if the given role conveys routinely in all cases</u>.*
   - ☐ Specified in the mental health court contract/plea agreement
   - ☐ Judge
   - ☐ Prosecutor
   - ☐ Defense attorney
   - ☐ Court coordinator
   - ☐ Case manager
   - ☐ Probation officer
   - ☐ Treatment provider
   - ☐ Other: Please specify: ____

46. How often do the following events result in termination in your mental health court?

	Always	Sometimes	Rarely/Never
Any new arrest	□	□	□
New arrest for a serious offense	□	□	□
Inadequate attendance at treatment program	□	□	□
Failure or refusal to take medications	□	□	□
Violating rules of a service provider	□	□	□
Positive toxicity screen	□	□	□
Other: ___________________________________	□	□	□

47. What happens to the court case when a participant is terminated from the mental health court? *Check all that apply in at least some cases.*
□ Sentenced immediately to jail or prison
□ Sentenced immediately to probation
□ Subject to further court hearing(s) before the mental health court judge
□ Subject to further court hearing(s) before a different judge
□ Other: Please specify: ____

48. What is roughly the *most common* or *average* length of the jail or prison sentence that is actually imposed on participants who fail?

Charge Severity	Typical Jail/Prison Sentence
Misdemeanor	
Felony	

49. Prior to mental health court entry, who provides the participant with an overview of court policies and procedures? *Check all that apply.*
□ Specified in the mental health court contract
□ Specified in the participant handbook or other written information provided to participants
□ Judge
□ Prosecutor
□ Defense attorney
□ Court coordinator
□ Case manager
□ Probation officer
□ Treatment provider
□ Other: Please specify: ____

B) COURT SUPERVISION

50. On average, about how many times per month are participant required to attend judicial status hearings during the first three months of mental health court participation?
______ (#) times per month

51. On average, about how many times per month are participant required to attend judicial status hearings after at least six months of participation?
______ (#) times per month

52. During judicial status hearings, please indicate how often each of the following types of interaction take place.

	Always	**Some-times**	**Rarely/ Never**
Participant answers questions	☐	☐	☐
Participant provides answers exceeding one-sentence length	☐	☐	☐
Judge states consequences of future compliance	☐	☐	☐
Judge states consequences of future noncompliance	☐	☐	☐
Judge provides specific instructions or advice	☐	☐	☐
Judge elicits questions or concerns of the participant	☐	☐	☐

53. Are all participants assigned to a probation officer with specialized mental health training?
☐ No
If no, approximately what % of participants are assigned to a specialized Mental Health Court Probation officer? _________%
☐ Yes

54. How many specialized Mental Health Court Probation officers oversee Mental Health Court participants? _______ (#) of probation officers

55. What is the average caseload of each specialized Mental Health Court Probation officers?
______ (#) cases per FTE probation officer

56. How frequently do participants meet with specialized Mental Health Court Probation officers during the first *month* of participation?
______ (#) required meetings per month

57. Does frequency of participant meetings with specialized Mental Health Court Probation officers change over the course of program participation? *Check all that apply.*
☐ No, participants continue to meet with probation officers at the same frequency
☐ Yes, frequency of meetings varies based on participant compliance
☐ Yes, frequency of meetings varies based on clinical needs/progress
☐ Yes, frequency of meetings decreases with program progress
☐ Other: Please specify: ____

58. Who, if anyone, provides ongoing case management for the mental health court apart from and in addition to whatever case management services are incorporated into the role of probation? *Check all that apply.*
    - ☐ Court-employed case management staff
    - ☐ Probation
    - ☐ Single designated community-based treatment provider agency
      Please name: ____
    - ☐ Multiple community-based treatment provider agencies
    - ☐ Other: Please specify: ______________________________________

59. What is the average caseload per case manager?
    ______ (#) cases per FTE case manager

60. Are participants required to meet with case managers regularly?
    - ☐ Yes
    - ☐ No, case manager meetings are held on an as-needed basis *(Skip to #62)*
    - ☐ No, case manager meetings are not held *(Skip to #62)*

61. On average, about how many times per month must participants meet with a case manager over the first three months of participation?
    ______ (#) required meetings per month

62. Please briefly describe the overall case management strategy of your court:

    ____

    ____

    ____

C) INTERIM RESPONSES TO PROBLEMS AND PROGRESS

63. What interim positive responses to progress does your court commonly use? *Check all that apply.*
    - ☐ Judicial praise
    - ☐ Courtroom applause
    - ☐ Journal
    - ☐ Phase advancement recognition
    - ☐ Other token or certificate of achievement
    - ☐ Gift certificate
    - ☐ Tickets to an event (movies, sports, etc.)
    - ☐ Decrease in judicial status hearing frequency
    - ☐Other: Please specify: ______________________________________

64. Which actions commonly receive either judicial praise or a tangible positive response? *Check all that apply.*
 Compliant with Service Plan since last status hearing
 Drug-free since last status hearing
 Phase promotion
 Completed community-based treatment program
 GED or completed vocational training
 Obtained work
 Finding housing
 Obtaining benefits
 Other achievements: Please specify: ____

65. For mental health court participants who meet all program rules, about how often do they receive a tangible positive response or incentive—not including judicial praise?
 Each judicial status hearing
 Monthly
 Once every two months
 Once every three months
 Less than once every three months

66. Does the court have a formal (written) sanction schedule defining which sanctions to impose in response to different infractions or combinations of infractions?
 No *(Skip to Question #69)*
 Yes

67. If the court has a formal sanction schedule: Do participants receive a written copy of the sanction schedule at time of enrollment?
 No
 Yes

68. If the court has a formal sanction schedule: How often is the sanction schedule followed in practice?
 Never
 Rarely
 Sometimes
 Usually
 Always

69. When you receive a report of a significant problem, about how soon must participants appear in court?
 Within 1-2 days, regardless of the judicial status hearing schedule
 Within 3-7 days, regardless of the judicial status hearing schedule
 At the next scheduled judicial status hearing
 Other: Please specify: ____

70. What interim responses to problems, including clinical responses, does your mental health court use? *Check all that apply.*
 ☐ Judicial admonishment
 ☐ Formal "zero tolerance" warning (automatic consequence for next noncompliance)
 ☐ Jail (3 days or less)
 ☐ Jail (4-7 days)
 ☐ Jail (more than 7 days)
 ☐ Jury box/observe court
 ☐ Essay/letter
 ☐ Increased frequency of judicial status hearings
 ☐ Increased frequency of treatment attendance and/or upgrade of treatment modality
 ☐ Assignment to new service/treatment program
 ☐ Community service
 ☐ Increased length of participation
 ☐ Others: Please specify: ____

71. How often are tangible interim sanctions (not including judicial admonishment) imposed in response to the following infractions?

	Always	**Some-times**	**Rarely/ Never**
Missed judicial status hearing	☐	☐	☐
Late for judicial status hearing	☐	☐	☐
Missed probation appointment	☐	☐	☐
Missed case manager appt.	☐	☐	☐
Single treatment absence	☐	☐	☐
Multiple treatment absences	☐	☐	☐
Reports of noncompliance with rules at treatment or other community-based service program	☐	☐	☐
Failure to take prescribed medication	☐	☐	☐
Absconding (broke contact with treatment and court)	☐	☐	☐
New arrest (misdemeanor)	☐	☐	☐
New arrest (felony)	☐	☐	☐
Positive drug test	☐	☐	☐
Missed drug test	☐	☐	☐
Tampered drug test	☐	☐	☐
Dishonesty with court personnel			
Poor attitude in treatment	☐	☐	☐
Poor attitude in court	☐	☐	☐
Other:	☐	☐	☐

IV. TREATMENT, SERVICES, & CASE MANAGEMENT

72. What services for people with mental illnesses are available in your community? For each service, please indicate how often mental health court participants are referred to and enrolled in these services.

	Often	Sometimes	Rarely/ Never	Not Available	Don't Know
Mental health treatment	☐	☐	☐	☐	☐
Case management/care coordination	☐	☐	☐	☐	☐
Substance abuse outpatient	☐	☐	☐	☐	☐
Substance abuse residential	☐	☐	☐	☐	☐
Integrated mental health/substance abuse outpatient	☐	☐	☐	☐	☐
Integrated mental health/substance abuse residential	☐	☐	☐	☐	☐
Specialized trauma treatment	☐	☐	☐	☐	☐
Assertive community treatment (ACT)	☐	☐	☐	☐	☐
Supported housing	☐	☐	☐	☐	☐
Supported employment	☐	☐	☐	☐	☐
Family psychoeducation	☐	☐	☐	☐	☐
Illness management & recovery	☐	☐	☐	☐	☐
Cognitive behavior therapy	☐	☐	☐	☐	☐
Social skills training	☐	☐	☐	☐	☐
Other: Please specify: _________________ ____________________________________	☐	☐	☐	☐	☐

73. How often do mental health court participants receive each of these supportive services as a result of their involvement with your court? For each service, please indicate how often participants are referred or linked to these services. *(If the service is not available in your community, check the "not available" answer option.)*

	Often	Sometimes	Rarely/ Never	Not Available	Don't Know
Physical health and medical services	☐	☐	☐	☐	☐
Housing assistance (general)	☐	☐	☐	☐	☐
Vocational services (other than supported employment)	☐	☐	☐	☐	☐
Job placement services	☐	☐	☐	☐	☐
Employment readiness (resumes, job searches, interview skills)	☐	☐	☐	☐	☐
High school equivalency (GED or TASC) or adult education classes	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐
Parenting classes	☐	☐	☐	☐	☐
Anger management	☐	☐	☐	☐	☐
Specialized "young adult" treatment (up to 25 years)	☐	☐	☐	☐	☐
Specialized gender-specific treatment	☐	☐	☐	☐	☐
Other: Please specify: _________________ ____________________________________	☐	☐	☐	☐	☐

74. Does your community have adequate and appropriate housing resources for your clients' needs?
 No
 Yes

 a. *If no, p*lease describe any specific barriers or delays to housing: ______________________

____

____

75. At the outset of mental health court participation, does your mental health court provide Motivational Enhancement Therapy (e.g., Motivational Interviewing) to any participants?
 No
 Yes, administered by clinical staff at the court
 Yes, administered by clinical staff at treatment provider agencies

76. Does your mental health court link any of its participants to a cognitive-behavioral treatment that is designed to reduce criminal thinking (pro-criminal attitudes, beliefs, and behaviors)? *Check all that apply.*
 No *(Skip to Question #77)*
 Yes, Thinking for a Change (T4C)
 Yes, Moral Reconation Therapy (MRT)
 Yes, Reasoning and Rehabilitation (R&R)
 Yes, Interactive Journaling
 Yes, Some Other Treatment: What is it called? ______________________________________

If yes to the previous question:

 a. Please estimate to the best of your ability about what percentage of your participants are assigned to a criminal thinking treatment (e.g., closer to 25%, 50%, 75%, or 100%)?
 _________ (approximate percentage assigned to criminal thinking treatment)

 b. Does your court determine assignment to a criminal thinking treatment based on the results of a formal risk-needs assessment?
  No
  Yes

 c. When does assignment to a criminal thinking treatment take place?
  Outset of participation
  Following initial period of treatment only
  Depends on severity and nature of clinical needs
  Depends on when the next sequence of available treatment sessions is due to begin
  Other: Please clarify: ____

77. Does your mental health court link any of its participants to an evidence-based trauma treatment? *Check all that apply.*
 No
 Yes, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

□ Yes, Seeking Safety
□ Yes, Trauma Recovery and Empowerment Model (TREM)
□ Yes, Trauma, Addictions, Mental Health, and Recovery (TAMAR)
□ Yes, Some Other Treatment: What is it called? ______________________________________

78. Do any of your mental health participants receive Medication Assisted Treatment for an alcohol or substance use disorder? *Check all that apply.*
□ No
□ Yes, for heroin/opioid dependence
□ Yes, for alcohol dependence
□ Yes, other (specify treatment type: ____)

79. Is compliance with psychiatric medication recommended by treatment providers a requirement of the mental health court? Do you expect participants to adhere to a medication regimen prescribed by their treating psychiatrist?
□ No
□ Yes, for all participants
□ Yes, for some participants based on clinical need

80. Are any psychiatric and/or pain medications prohibited during mental health court participation (such as benzodiazepines)?
□ No
□ Yes (Which medications: ____)

81. Does the court have an understanding of the principles and practices of the treatment providers used by the mental health court?
□ No *(Skip to Question #84)*
□ Yes
□ Uncertain

82. Based on the information you have received, do <u>most</u> of the treatment programs your court uses have the following characteristics? *Please answer "not sure" if there is any doubt.*

	Yes	**No**	**Not Sure**
Coherent treatment philosophy	□	□	□
Written treatment manual created in-house	□	□	□
Written research-based treatment manual (adapted from outside, evidence-based curricular materials)	□	□	□
Extensive use of cognitive behavioral approaches	□	□	□
Availability of treatments for special populations (e.g., young adults, women, trauma victims, etc.)	□	□	□
Frequent/regularly scheduled supervision meetings between line treatment staff and clinical supervisors	□	□	□

	Yes	No	Not Sure
Clinical supervisors frequently sit in on groups that line staff facilitates—after which supervisor provides feedback in a meeting with the line staff member	☐	☐	☐
Regular formal training offered for line treatment staff	☐	☐	☐
Line treatment staff are held accountable for following a written treatment manual with fidelity	☐	☐	☐
More than half of all line treatment staff have a bachelor's degree or higher	☐	☐	☐
More than half of all line treatment staff have received advanced certification as a treatment counselor	☐	☐	☐
Group treatment sessions have a maximum of 12 participants	☐	☐	☐
Participants meet individually with a designated treatment counselor at least once per week	☐	☐	☐

83. If you would like, please feel free to offer relevant comments to explain/elaborate on your answers to the previous question.

____

____

____

84. How do treatment providers communicate to the court about participants? *Check all that apply.*
☐ Specialized court database/management information system
☐ In person (at staffing meetings or court sessions)
☐ Fax
☐ Phone
☐ E-mail
☐ Hard copy/snail-mail

85. Do you employ a standardized form for treatment provider reports?
☐ No
☐ Yes

86. About how often do you believe treatment provider reports are both complete and accurate?
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely or never

87. About how often do you believe treatment provider reports are timely (i.e., always prior to staffing meetings and court sessions, with immediate updates in cases of significant problems or unusual incidents)?
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely or never

V. STAFFING, COLLABORATION, AND FUNDING

88. Is there one judge who regularly presides over your mental health court?
☐ No *(Skip to Question #91 following explanation)*
If no, please explain:
____

□ Yes

89. Does the judge also preside over a local drug court or any other problem-solving court?
   □ No
   □ Yes

90. How long has the judge presided over your mental health court? *Please specify number in months <u>or</u> years.*
   ______ (# Months)
   ______ (# Years)

91. How many judges have presided over the mental health court since its inception? *Do not include <u>back-up judges</u> in this answer.*
   Number of judges: ______

92. In the <u>last six months</u>, how many judges have served as a <u>back-up judge</u> for your mental health court?
   Number of back-up judges: ______

93. When you have <u>back-up judges</u> in your court, have they received any training in mental health or mental health court issues?
   □ No
   □ Yes
   If yes, please list training topics:
   ____
   ____

94. Who serves the coordinator role in your court?
   Full Name: ____
   Staff Title: ____

95. What is the affiliation of the coordinator? (e.g., agency that employs the individual)?
   □ Fifth Judicial District/Court of Common Pleas
   □ Probation
   □ County behavioral health/social services agency
   □ Community-based treatment provider
   □ Other: ____

96. Does the coordinator of your mental health court perform a similar role for a local drug court or another problem-solving court?
   □ No
   □ Yes (please specify which courts: ____)

97. What advanced training or educational credentials does the program coordinator possess (e.g., JD, MSW, LSW, CASAC)? ____

98. Please indicate whether the current judge or coordinator helped to plan the mental health court.
   □ Neither

☐ Yes, judge
☐ Yes, coordinator
☐ Yes, both judge and coordinator

99. Please indicate whether the current judge or coordinator have ever attended a formal training covering each of the following topics by checking the appropriate boxes.

Training Topic	**Judge**	**Coordinator**
Fundamentals of mental illness	☐	☐
Advanced topics related to mental illness	☐	☐
Mental health treatment and services	☐	☐
Pharmacology of addiction	☐	☐
Co-occurring mental health disorders	☐	☐
Best practices in client engagement and responses to problems and progress	☐	☐
Best practices in communicating with offenders with mental illnesses	☐	☐
The "Risk-Needs-Responsivity" principles	☐	☐
Trauma assessment and/or trauma-informed therapy	☐	☐
Treatment for special populations (e.g., young adults or women with children)	☐	☐

100. Does the judge or coordinator regularly read research on evidence-based practices?
☐ Neither
☐ Yes, judge
☐ Yes, coordinator
☐ Yes, both judge and coordinator

101. Has the judge or coordinator used, or do they currently use, research to shape or revise the design of the program?
☐ Neither
☐ Yes, judge
☐ Yes, coordinator
☐ Yes, both judge and coordinator

102. Does your mental health court hold regular staffing meetings to discuss individual cases?
☐ No
☐ Yes, weekly
☐ Yes, biweekly
☐ Yes, less often than biweekly

103. Does your mental health court hold regular policy-level stakeholder meetings to discuss court policies and practices or to review quantitative performance data?
 No
 Yes, monthly or more frequent
 Yes, about quarterly
 Yes, about two or three times per year
 Yes, about annually
 Yes, less than annually

104. How often do members of the mental health court team receive training?
_______ (# of trainings annually)

105. Which members of the mental health court team typically attend these trainings? *Check all that apply.*
 N/A, no team members attend training
 Judge
 Representative(s) from District Attorney's Office
 Representative(s) from the public defender's office
 Case manager(s)
 Project Director/court coordinator/resource coordinator
 Representative(s) from a county behavioral health/social services agency
 Representative(s) from probation
 Representative(s) from law enforcement
 Representative(s) from treatment providers
 Other: Please specify: ____

106. For each position listed in the chart below, please indicate how many regularly attend staffing meetings, policy meetings, and judicial status hearings.

Position	**# at Staffing Meetings**	**# at Policy Meetings**	**# at Court Sessions**
Mental health court judge			
Representative(s) from District Attorney's Office			
Representative(s) from public defender's office			
Case manager(s)			
Project Director/court coordinator/resource coordinator			
Representative(s) from a county behavioral health/social services agency			
Representative(s) from probation			
Representative(s) from law enforcement			
Representative(s) from treatment provider			
Other:			
Other:			

107. What do you believe are the most important training needs for the staff of your court?

____

____

____

VII. ADDITIONAL POLICIES AND REQUIREMENTS

A) Participation Timeline

108. On average, about how many **days** pass between an arrest and a clinical assessment at the mental health court? *(Please convert responses to days; e.g., one week = 7 days, one month = 30 days.)*
______ (#) Days

109. On average, about how many **days** pass between a clinical assessment and officially becoming a mental health court participant? *(Please convert responses to days; e.g., one week = 7 days, one month = 30 days.)*
______ (#) Days

110. On average, about how many **days** pass between becoming a mental health court participant and having a first appointment at each of the following community-based treatment providers? *(Please convert responses to days; e.g., one week = 7 days, one month = 30 days.)*

Community-Based Treatment/Service	Average Number of Days
a. Mental Health Treatment	
b. Outpatient Substance Abuse Treatment	
c. Residential Substance Abuse Treatment	
d. Case Management	
e. Care Coordination/Enrollment in a Health Home	
f. Supported Housing	

111. What is the duration of the mental health court (average time from becoming a participant to court graduation)?

	Misdemeanor Cases	Felony Cases
Official program time defined by the court policy manual	_______ (# months) ☐ N/A, no official policy exists	_______ (# months) ☐ N/A, no official policy exists
Average time actually required to reach graduation (including extra time due to noncompliance or other reasons)	_______ (# months)	_______ (# months)

B) OTHER COURT POLICIES AND PROCEDURES

112. Does the mental health court have an official policies and procedural manual?
 - ☐ No
 - ☐ Yes

113. Do all participants receive a handbook detailing all program policies and requirements?
 - ☐ No
 - ☐ Yes

114. Does your court require any of the following before a participant can graduate?

	Always	Sometimes	Rarely/Never
Consistent attendance in behavioral health treatment	☐	☐	☐
Completion of treatment program	☐	☐	☐
Evidence of improvement in symptoms	☐	☐	☐
Evidence of improvement in functioning level	☐	☐	☐
Adherence to prescribed medication regimen	☐	☐	☐
Specified period of abstinence demonstrated through drug tests	☐	☐	☐
Stable housing	☐	☐	☐
Payment of fees	☐	☐	☐
Community service requirement	☐	☐	☐
Employed or in school	☐	☐	☐
HS degree/GED	☐	☐	☐
Graduation application	☐	☐	☐
Other graduation requirements: ______________ ____	☐	☐	☐

115. If community service is a typical graduation requirement, what is the typical number of hours required?
 ________ # of Hours Required
 ☐ N/A, community service is not a typical graduation requirement

VII. COURT DATA AND EVALUATION

116. Has a formal evaluation of your mental health court ever been conducted?
 - ☐ No
 - ☐ Yes (Please list the affiliation(s) of the evaluator(s) involved: _________________________
 ____

117. Does your mental health court use a specialized management information system/database to track participant data?
 - ☐ No
 - ☐ Yes (Please list the database name and what computer program it is in: __________________
 ____

118. Do you track the mental health court's one-year retention rate?
- ☐ No
- ☐ Yes

119. What do you believe are the greatest strengths of your mental health court program?

____

____

120. What do you believe are the greatest needs for improvement of your mental health court program?

____

____

Thank you very much for completing this survey!

Note: The questions in this survey were largely based on previous surveys developed by research staff at the Center for Court Innovation. A small number of questions are also based on domains and/or items in the Correctional Program Assessment Inventory (Gendreau, P., & Andrews, D.A. 2001. *Correctional Program Assessment Inventory (CPAI)-2000*. Saint John, NB: University of New Brunswick.)

Appendix B

Allegheny County Mental Health Court Evaluation
Courtroom Observation Form

OBSERVATION #_______ **Date:** _________________________

Appearance Start Time: ________________ **Appearance End Time:** ________________

Defendant Sex: □ Male
□ Female

Defendant Incarcerated: □ No
□ Yes
If yes, handcuffs/restraints used? _____________________________

Appearance Type: □ Pre-MHC or Plea □ MHC status hearing
□ No-show/non-appearance □ Other: ____________________________

Present in Court	Spoke?	Addressed by Judge?
□ Judge	□	
□ Defendant	□	□
□ Case manager	□	□
□ MHC Coordinator	□	□
□ DA	□	□
□ Defense Attorney	□	□
□ Community Tx Provider	□	□
□ Other: __________________________________	□	□

Judge Interaction with Defendant:
- □ Eye contact with defendant (for most of the appearance)
- □ Talked directly to defendant
- □ Asked non-probing (Y/N) questions
- □ Asked probing questions
- □ Imparted instructions or advice
- □ Explained consequences of future compliance (e.g., phase advancement, graduation, etc.)
- □ Explained consequences of future noncompliance (e.g., jail or other legal consequences)
- □ Directed comments to audience (e.g., using the current case as an example)
- □ Spoke off-record to defendant
- □ Touched or shook hands with defendant
- □ Judge raised voice
- □ Other noteworthy: ____

Defendant's overall demeanor seemed:

□ Happy/satisfied □ Forthcoming □Intimidated
□ Angry □ Confused □ Upset
□ Resentful □ Other: ____

Compliance Status: □ Good Report □ Bad Report (select if any noncompliance noted)

Achievements		Incentives	
Compliance w/court mandate	□	Judicial praise/encouragement	□
Tx compliance/attendance/participation	□	Praise from other staff (Who: ___________)	□
Drug-free days (#:__________)	□	Courtroom applause	□
Phase advancement	□	Shook hands with judge	□
Job/school event	□	Decreased court appearances	□
Eligible for graduation	□	Decreased Tx modality	□
Other:____________________________	□	Other: ______________________________	□

Infractions		Court Response	
Absences – At program – At court	□ □	None	□
Positive drug test	□	Verbal admonishment, judge	□
Re-arrest	□	Verbal admonishment, other (___________)	□
Return on warrant	□	Adjustment to Tx plan	□
Violated Tx rules	□	Jail time	□
Poor attitude	□	Failed MHC (Sentence: __________________________)	□
Other:____________________________	□	Other:____________________________	□

After Hearing:

□ Defendant put in custody
□ Defendant left courtroom
□ Defendant remained in courtroom
Where: ____

Defense counsel satisfied □ Not at all □ Somewhat □Very
Defense counsel upset □ Not at all □ Somewhat □Very

Additional notes: ____

____

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Appendix C

Appendix C. Comparison of Sample Differences, Before & After Propensity Matching (Full Variable List)

	Original Samples		p<.50?	Matched Samples [2]		Included in the propensity score model?
	Mental Health Court	Comparison Group [1]		Mental Health Court	Comparison Group	
Number of Cases	227	8,356		227	227	
Nagelkerke R-Squared			0.362***			
DEMOGRAPHICS						
Age	36.98*	35.12	✓	36.98	37.48	✓
Age categories			✓			✓
17 and under	0%	0%		-	-	
18-25 years	17%	24%		17%	17%	
26-35 years	36%	33%		36%	34%	
36-45 years	23%	20%		23%	22%	
46-65 years	25%	21%		25%	27%	
66+ years	0%	1%		-	-	
Male	69%	71%		69%	70%	✓
Race/Ethnicity [3, 4]						✓
White	63%	60%		63%	65%	
Black/African American	37%	40%		37%	35%	
Risk Score	5.08	5.05		5.08	4.96	
Risk Level [5]						✓
Low	31%	34%		31%	33%	
Medium	47%	47%		47%	50%	
High	21%	19%		21%	17%	
BEHAVIORAL HEALTH DIAGNOSIS [6]						
Diagnosis (5 Years)						
Any Adjustment Disorders	11%	8%	✓	11%	12%	✓
Any Alcohol Use Disorders	24%*	18%	✓	24%	26%	✓
Any Anxiety Disorders	26%***	13%	✓	26%	20%	✓
Any Behavioral Disorder	9%	7%	✓	9%	9%	✓
Any Impulse-Control Disorders	4%*	2%	✓	4%	5%	✓
Any Mood Disorders	88%***	46%	✓	88%	89%	✓
Any Personality Disorders	2%**	0%	✓	2%	1%	✓
Any Psychotic Disorders	39%***	8%	✓	39%	37%	✓
Any Substance Use Disorders	54%	54%		54%	57%	✓
Any Unspecified Disorders	59%***	30%	✓	59%	53%	✓
Any Other Disorder	1%	1%		1%	2%	✓
CRIMINAL HISTORY [7]						
Prior Arrests (3 Years)						
Any Prior Arrests	76%**	65%	✓	76%	79%	✓
# prior arrests	1.85**	1.44	✓	1.85	2.02	✓
Any Person Arrest	29%**	22%	✓	29%	30%	✓
# person arrests	0.43*	0.30	✓	0.43	0.46	✓
Any Property Arrest	40%**	31%	✓	40%	43%	✓
# property arrests	0.86**	0.55	✓	0.86	1.00	✓
Any Drug Arrest	16%+	21%	✓	16%	19%	✓
# drug arrests	0.24	0.30	✓	0.24	0.26	✓
Any Other Arrest [8]	25%	23%		25%	23%	✓
# other arrests	0.32	0.30		0.32	0.30	✓

Comparison of Sample Differences, Before & After Propensity Matching (Full Variable List, *Continued)*

	Original Samples			Matched Samples [2]		Included in the propensity score model?
	Mental Health Court	Comparison Group [1]	p<.50?	Mental Health Court	Comparison Group	
Number of Cases	227	8,356		227	227	
Nagelkerke R-Squared			0.362***			
Any Felony Arrest	47%***	33%	✓	47%	52%	✓
# felony arrests	0.79***	0.50	✓	0.79	0.87	✓
Any Misdemeanor Arrest	48%	49%		48%	53%	✓
# misdemeanor arrests	1.05+	0.86	✓	1.05	1.14	✓
Any Summary Arrests	1%*	5%	✓	1%	1%	✓
# summary Arrests	0.01***	0.05	✓	0.01	0.01	✓
Any Weapons Arrest	1%	3%	✓	1%	1%	✓
# weapons arrests	0.01*	0.03	✓	0.01	0.01	✓
Any Violent Felony Arrest	14%*	9%	✓	14%	17%	✓
# violent felony arrests	0.16+	0.11	✓	0.16	0.18	✓
Prior Arrests (5 Years)						
Any Prior Arrests	81%*	73%	✓	81%	85%	✓
# prior arrests	2.75**	2.02	✓	2.75	2.95	✓
Any Person Arrest	35%*	28%	✓	35%	36%	✓
# person arrests	0.59*	0.41	✓	0.59	0.60	✓
Any Property Arrest	46%**	38%	✓	46%	49%	✓
# property arrests	1.32***	0.78	✓	1.32	1.52	✓
Any Drug Arrest	22%+	27%	✓	22%	24%	✓
# drug arrests	0.36	0.42	✓	0.36	0.35	✓
Any Other Arrest [8]	32%	30%		32%	33%	✓
# other arrests	0.48	0.41		0.48	0.48	✓
Any Felony Arrest	53%***	41%	✓	53%	58%	✓
# felony arrests	1.17***	0.71	✓	1.17	1.24	✓
Any Misdemeanor Arrest	61%	57%		61%	66%	✓
# misdemeanor arrests	1.55*	1.20	✓	1.55	1.67	✓
Any Summary Arrests	3%*	6%	✓	3%	4%	✓
# summary Arrests	0.03**	0.06	✓	0.03	0.04	✓
Any Weapons Arrest	3%	4%		3%	3%	✓
# weapons arrests	0.03	0.04		0.03	0.03	✓
Any Violent Felony Arrest	18%*	12%	✓	18%	21%	✓
# violent felony arrests	0.22*	0.14	✓	0.22	0.23	✓
Prior Convictions (3 Years)						
Any Prior Conviction	45%***	25%	✓	45%	49%	✓
# prior convictions	0.71***	0.33	✓	0.71	0.80	✓
Any Person Conviction	9%**	4%	✓	9%	7%	✓
# person convictions	0.10*	0.0437	✓	0.10	0.08	✓
Any Property Convictions	25%***	10%	✓	25%	25%	✓
# property convictions	0.37***	0.13	✓	0.37	0.43	✓
Any Drug Convictions	12%**	7%	✓	12%	15%	✓
# drug convictions	0.12*	0.08	✓	0.12	0.15	✓
Any Other Convictions[8]	11%+	8%	✓	11%	14%	✓
# other convictions	0.12	0.08	✓	0.12	0.15	✓
Any Felony Convictions	27%***	14%	✓	27%	29%	✓
# felony convictions	0.37***	0.16	✓	0.37	0.40	✓
Any Misdemeanor Convictions	25%***	14%	✓	25%	30%	✓
# misdemeanor convictions	0.33***	0.16	✓	0.33	0.40	✓
Any Weapons Convictions	0%	1%	✓	0%	0%	✓
# weapons convictions	0.00	0.01	✓	0.00	0.00	✓
Any Violent Felony Convictions	5%*	2%	✓	5%	4%	✓
# violent felony convictions	0.05+	0.02	✓	0.05	0.04	✓

Comparison of Sample Differences, Before & After Propensity Matching (Full Variable List, *Continued)*

	Original Samples		p<.50?	Matched Samples [2]		Included in the propensity score model?
	Mental Health Court	Comparison Group [1]		Mental Health Court	Comparison Group	
Number of Cases	227	8,356		227	227	
Nagelkerke R-Squared			0.362***			
Prior Convictions (5 Years)						
Any Prior Conviction	57%***	39%	✓	57%	63%	✓
# prior convictions	1.08***	0.63	✓	1.08	1.23	✓
Any Person Conviction	12%*	8%	✓	12%	12%	✓
# person convictions	0.14+	0.09	✓	0.14	0.15	✓
Any Property Convictions	33%***	17%	✓	33%	35%	✓
# property convictions	0.59***	0.25	✓	0.59	0.71	✓
Any Drug Convictions	15%	12%	✓	15%	15%	✓
# drug convictions	0.16	0.15		0.16	0.16	✓
Any Other Convictions[8]	16%	13%	✓	16%	20%	✓
# other convictions	0.19	0.15	✓	0.19	0.22	✓
Any Felony Convictions	36%***	22%	✓	36%	38%	✓
# felony convictions	0.57***	0.29	✓	0.57	0.64	✓
Any Misdemeanor Convictions	35%***	24%	✓	35%	41%	✓
# misdemeanor convictions	0.50**	0.32	✓	0.50	0.56	✓
Any Weapons Convictions	2%	1%		2%	1%	✓
# weapons convictions	0.02	0.01		0.02	0.01	✓
Any Violent Felony Convictions	7%+	4%	✓	7%	7%	✓
# violent felony convictions	0.07	0.04	✓	0.07	0.07	✓
Prior Incarceration (3 Years) [9, 10]						
Any Prior Incarceration Sentences	19%***	11%	✓	19%	22%	✓
Any Prior Jail Sentence	19%***	9%	✓	19%	22%	✓
Any Prior Prison Sentence	1%	2%		1%	0%	✓
Prior Incarceration (5 Years)						
Any prior incarceration sentence	28%***	16%	✓	28%	30%	✓
Any Prior Jail Sentence	27%***	14%	✓	27%	30%	✓
Any Prior Prison Sentence	3%	2%		3%	1%	✓
Prior Probation Supervision						
Any Prior Probation Sentences (3 Years)	27%**	20%	✓	27%	30%	✓
Any Prior Probation Sentences (5 Years)	35%**	27%	✓	35%	37%	✓

Comparison of Sample Differences, Before & After Propensity Matching (Full Variable List, *Continued*)

	Original Samples		p<.50?	Matched Samples [2]		Included in the propensity score model?
	Mental Health Court	Comparison Group [1]		Mental Health Court	Comparison Group	
Number of Cases	227	8,356		227	227	
Nagelkerke R-Squared	0.362***					
INDEX EVENT						
Index Event Year	***		✓	***		
2013	36%+	43%	✓	36%*	47%	✓
2014	30%	35%	✓	30%	34%	✓
2015	27%	23%	✓	27%*	19%	
2016	7%***	0%	✓	7%***	0%	
Index Arrest Charge Type [11]						
Person top charge	37%***	20%	✓	37%	39%	✓
Property top charge	43%***	29%	✓	43%	46%	✓
Drug top charge	3%***	26%	✓	3%	1%	✓
Other top charge	16%**	26%	✓	16%	13%	✓
VFO top charge	27%***	11%	✓	27%	28%	✓
Weapon top charge	2%	2%		2%	2%	✓
Index Arrest Charge Severity						
Felony	76%***	46%	✓	76%	78%	✓
Misdemeanor	24%***	53%	✓	24%	23%	✓

+p<.10 * p<.05 ** p<.01 ***p<.001

[1] The comparison pool was limited to those persons with a mental health diagnosis in the 5 years prior to the Index Event (first arrest after 2013) and to those individuals with at least two years of recidivism data, with information on gender, race, age, proxy risk level and a proxy risk score.

[2] Three logistic models were used to match mental health court participants and comparison groups: the full model contained persons with no missing data for the variables included in the model (R^2=362, p <0.000); a second logistic model was used to match the five participants with no race information (R^2=.360, p<0.000); and a third logistic model was used to match the single participant with missing risk level information (R^2=.361, p<0.000). R^2 presented in the table heading reflects the primary model, which matched 221 Mental Health Court participants to suitable members in the comparison group.

[3] Five mental health court participants have missing/unknown race information. A separate logistic model excluding race was used to match these persons.

[4] Hispanic ethnicity data was not available.

[5] One mental health court participants participant has missing/unknown risk level information. A separate logistic model excluding risk level was used to match this participant.

[6] Persons could have more than one diagnosis in the past five years and percentages do not sum to 100%; each type of diagnosis was counted only once.

[7] Separate three year criminal history variables were included in the full PSM model (see Appendix C). Sums arrest/convictions by most serious charge, ranked in the following order: Person felony, property felony, drug felony, other felony, person misdemeanor, property misdemeanor, etc. Weapons charge and violeny felony charges only included if they were the top/most serious charge. Arrests that occurred on the same day count as a single arrest; similar logic applied to convictions.

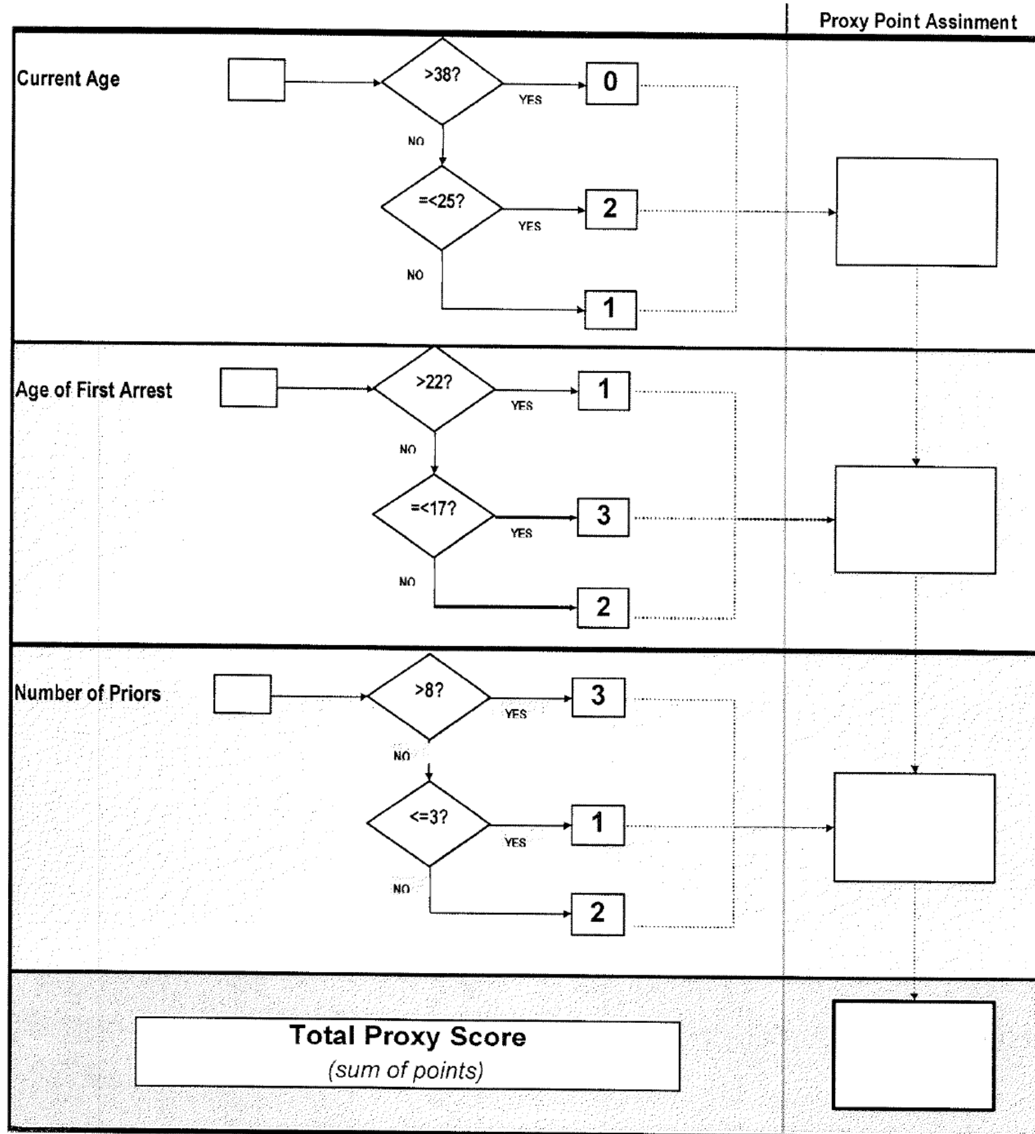
[8] Other charges includes weapons, criminal-other, DUI, public order, and motor vehicle-other.

[9] Sentencing data should be interpreted with caution. Sentence data is tracked by charge rather than by case; charge sentences were collapsed to create a single case-level variable.

[10] Based on top or most serious charge, ranked in the following order: Person felony, property felony, drug felony, other felony, person misdemeanor, property misdemeanor, etc. Person, property, durg and other charges are mutually exclusive categories. Violent felony and weapons charge only included if they were the most serious charge in the arrest.

Appendix D.

Allegheny County Proxy Risk Score Calculation Worksheet*



Risk Level Classification

Low Risk			Medium Risk		High Risk	
2	3	4	5	6	7	8

**Source:* Bogue, B. 2006. *Application of Proxy Classification Methodology to Allegheny County Probation Population*. Final Report Submitted to the Allegheny Probation Department. Boulder, CO: Justice System Assessment and Training (JSAT).