Adult Mental Health Treatment Courts in North Carolina: A Process Evaluation Report for Orange, Mecklenburg, and Buncombe Counties

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Executive Summary

PURPOSE
This process evaluation has several purposes. First, it aims to describe the implementation thus far of Mental Health Treatment Courts (MHTCs) in three North Carolina counties: Orange (serving clients since 2000), Mecklenburg (running a pilot program since April 2004) and Buncombe (unable to implement a MHTC). Second, it compares the implementation of the Orange County CRC (the MHTC) with its proposed target population, administrative goals, and operations. Third, information from each of the three counties is used to generate conclusions and recommendations related to the questions raised by the state legislature. These questions are bulleted below:

- What is the need for MHTCs?
- What are the benefits of implementing a MHTC?
- What are the challenges to implementation?
- What financial and community service resources are available to treat this population?

METHOD
In order to answer the questions from the legislature, a combination of qualitative, quantitative, and observational data is used. For the courts in Mecklenburg and Buncombe Counties, interviews were conducted with key personnel. Additionally, data from a previous evaluation was reviewed for Mecklenburg County. For the Orange County Community Resource Court (CRC), which was the original Mental Health Treatment Court in North Carolina and the primary focus of this evaluation, data collection included the following: observations of court and Team meetings, analysis of archival anonymized client data, interviews with key personnel and current participants, consumer satisfaction questionnaires with current participants, and documents and articles written about the court.

FINDINGS
The Orange County CRC, a collaborative effort between the criminal justice and mental health systems, functions as an exceptional unit. The Team is stable, respectful and cooperative, and the program is highly rated by its current participants. However, mental health reform and related changes in funding threaten to destabilize the Team. Additionally, the Team is overworked, and the program has reached its stated capacity. Given this reality, several recommendations were made to the Team to more efficiently utilize the limited available resources.

CONCLUSIONS
Corresponding to the questions from the legislature listed above, the following conclusions are made:

- MHTCs serve dually diagnosed and repeat offenders with severe mental illness.
- MHTCs yield three primary benefits. First, preliminary evidence suggests that recidivism among the target population is reduced. Second, MHTCs result in the less frequent use of incarceration, which potentially leaves open space for those offenders who pose more of a danger to public safety. Third, MHTCs improve communication and cooperation between the criminal justice and mental health systems.
- The principal challenges to implementation include a shortage of funding, mental health care reform, and a lack of housing services and resources.
- The availability of resources varies by county and geography (urban vs. rural). As state changes in mental health care delivery begin to take form, this availability may change and could potentially worsen in the short-term.

Orange, Buncombe, and Mecklenburg Counties
Process Evaluation Report

Introduction

2004 Mental Health Treatment Court Pilot Appropriation Act

The 2004 Mental Health Treatment Court Pilot Appropriations Act (herein referred to as MHTC Appropriations Act) allotted funds for the establishment (or enhancement) of pilot mental health treatment courts in districts 15B (Orange and Chatham Counties), 26 (Mecklenburg County), and 28 (Buncombe County). In setting up these pilot programs, the Act stated two purposes. First, these pilot courts should divert repeat adult offenders with mental health and/or substance abuse needs to appropriate mental health treatments. Second, these courts should facilitate contact and cooperation between the judicial system and mental health providers and agencies in the interest of treating the target group successfully and appropriately. Although targeting a different group of offenders than Drug Treatment Courts (DTCs), these courts were envisioned as adding a mental health component to already existing DTCs. Similar to adult DTCs, the ultimate goal of the adult Mental Health Treatment Courts is to improve participants' functioning, to reduce recidivism, and to promote the effective interaction and use of resources among criminal justice and mental health personnel, as well as other community and governmental agencies, as needed.

In addition to funding these pilot Mental Health Treatment Court programs, the legislature set aside money for the evaluation of these courts. This evaluation is to provide information necessary to evaluate the feasibility and desirability of expanding these pilot courts into a statewide therapeutic court program.

Purpose of Evaluation

This process evaluation has several purposes. First, it aims to describe the implementation thus far of Mental Health Treatment Courts (MHTCs) in three North Carolina counties. Second, it compares the implementation of the existing Orange County MHTC with its proposed target population, administrative goals and operations. Third, information from each of the three counties will be used to generate conclusions and recommendations related to the following questions:

- What is the need for MHTCs?
- What are the benefits of implementing a MHTC?
- What are the challenges to implementation?
- What financial and community service resources are available to treat this population?
- What resources are unavailable but needed for implementation?

History of Mental Health Treatment Courts in Orange, Mecklenburg, and Buncombe Counties

Orange County Community Resource Court (CRC)

In response to the advocacy and initiative of the local chapter of the National Alliance for the Mentally Ill (NAMI), Judge Joseph Buckner organized and founded a mental health treatment court to address the needs of mentally ill citizens in his local court system. This court, called the Community Resource Court (CRC), involved a collaboration of several different agencies. The Orange-Person-Chatham Area Mental Health Program (OPC), Judicial District 15B, and the local probation offices each donated personnel time in the interest of setting up this court.

The court began accepting referrals in April 2000. Judge Buckner presided over the cases; Jeffrey DeMagistris, from OPC, evaluated the referrals for appropriateness; and Marie Lamoureaux, from the Orange County District Court, provided court administrative assistance. In addition to the principal partners of OPC and District 15B, the operation of the CRC included participation from the following agencies: Community Corrections Office, Chapel Hill Police Department's Crisis Unit, District Attorney's Office, Local Criminal Defense Bar, Pre-Trial Services, and the Public Defender's Office.

The CRC was designed as a voluntary program offering diversion from jail to mental health services for misdemeanants and low-risk felons. Although the CRC proposed in its federal Bureau of Justice Assistance (BJA) grant to prioritize referrals and services for those individuals with Severe and Persistent Mental Illnesses (SPMI), the CRC also stated that the Court would accept referrals for offenders with other primary mental health diagnoses, developmental disabilities, or a history of mental health treatment.

Initially, the CRC operated without formal funding. However, through the efforts of several key team members (Marie Lamoureaux and Jeffrey DeMagistris) and with help from others, the CRC secured funding from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the form of a state block grant, which provided monies for a dedicated Court Case Manager in January 2001. When the CRC obtained additional federal funding (from BJA) in 2003, a clinical social worker was added to the Team. More monies became available to district 15B in 2004 with the state MHTC Appropriations Act. These additional funds have been earmarked for expansion of Mental Health Treatment Court services into Chatham County.

Mecklenburg County

The idea for a Mecklenburg County Mental Health Treatment Court predated the MHTC Appropriations Act. It occurred in response to the "extreme number" of mentally ill offenders who had been repeatedly circulating through the criminal justice system. Concern about this problem prompted the formation of an interdisciplinary planning committee to find a means of addressing this challenge through the combined resources of the mental health and criminal justice systems. The group began reviewing the Mental Health Treatment Court literature and identifying best practice models with the goal of setting up a MHTC. After reviewing the literature and visiting existing MHTCs, the committee designed a rough outline of the court structure and applied for grant funding.

Grant funding was not forthcoming. However, when money became available through the MHTC Appropriations Act, the plan for a pilot program became more feasible.

The Mecklenburg MHTC accepted its first referral in April of 2004. As a result of delayed access to the funds appropriated by the General Assembly, the court treatment Team has only accepted referrals for offenders who automatically qualify for state-funded mental health services because of the nature of their disability. To date, the pilot program is serving four participants. The court will begin official operations on February 25, 2005, the first scheduled court date.

Buncombe County

The 2004 MHTC Appropriations Act allotted funds for the establishment of a pilot Mental Health Treatment Court program in Buncombe County. The Act provided that a mental health component be added to an already existing drug treatment court in the county's district court. However, Buncombe County's DTC is housed in Superior Court. Given the difficulties of linking a district-level court with a superior-level court, a mental health treatment court has not been implemented.

Orange County CRC: Process Evaluation

Methods and Procedures

Planning and Orientation

Prior to data collection, an initial orientation meeting was convened to introduce the purpose and procedures of the process evaluation to the key court staff. Janis Kupersmidt, President of Innovation Research and Training (IRT) and Project Director for the Process Evaluation, and Jacqueline Hansen, AOC Evaluation Specialist / Research Coordinator, conducted this initial meeting. Marie Lamoureaux attended the meeting as the CRC representative.

The meeting opened with introductions and a discussion of the process evaluation's purpose and importance. Following the introduction of Team members and their roles in the evaluation, IRT and the AOC presented an outline that detailed the court materials needed for the evaluation, the timeline for data collection, and the necessary tasks to be performed by each court's administrator or director. The AOC and IRT emphasized the strict timeline for data collection, analysis, summary, synthesis, and report writing, and it was made clear that materials received after the stated deadline might not be included in the report.

Data Collection and Analysis

This process evaluation assessed treatment court functioning from a variety of perspectives, including CRC staff, participants, and impartial observers. Data collection included quantitative, qualitative and observational methods. Historical documents related to the court history and function were also obtained and reviewed. All information was collected according to methods approved by IRT's Institutional Review Board and Orange-Person-Chatham's Research review board.

Quantitative data: Quantitative data were collected from both administrative records and directly from consumers. This data provided both program-level and consumer-level information.

Marie Lamoureaux, the CRC Administrator, provided yearly summary statistics for the court from 2001-2003. These data included overall demographic information and the percentage of cases terminated and graduated in each year. In addition, Marie Lamoureaux and Jeffrey DeMagistris, the CRC Coordinators, linked individual-level demographic data with mental health diagnoses and mental health services received through the CRC for those participants served in 2004. These data did not contain information that would allow identification of the individual participants. Although not available for all CRC participants, Client Outcomes Inventory (COI) forms provided additional data about client employment, global assessment of functioning (GAF), and housing arrangements. COI forms were administered at intake or soon afterwards, then later at an unspecified point (or points) in treatment, and finally at discharge. Jeffrey DeMagistris arranged for client identifiers to be removed from these forms, and these data were provided to IRT.

Quantitative data methods were also used to describe participants' levels of satisfaction with their treatment court experience. The Consumer Satisfaction Survey asked participants to provide demographic and background information such as gender, race, ethnicity, employment status, marital status and family composition. In addition, the survey asked participants to report on different aspects of their treatment court experience, such as length of time spent in court, primary drug of choice (when relevant), criminal charges that led to Mental Health Treatment Court sentencing, and criminal and treatment history. Participants then rated (on a four-point Likert scale) their level of satisfaction with various aspects of the Mental Health Treatment Court program, including treatment services, sanctions and incentives, drug testing, community service activities, and court sessions. Finally, using the same type of scale, participants rated the level of difficulty of complying with various program requirements, such as attending scheduled appointments, cooperating with treatment programs and services, paying court fines and fees, and staying clean, sober, and drug-free (when applicable). Analyses were conducted to describe mean-level differences and similarities between participants in terms of age, race, ethnicity, and gender. Twenty-five current participants completed the survey.

Qualitative data: Semi-structured interviews provided qualitative data about participants' treatment experiences and also staff perceptions of court functioning. Trained project staff members from IRT conducted all of the participant interviews. Although separate interviews were created for the different groups of participants, all of the interviews covered topics including the most and least helpful aspects of the CRC, barriers to participation, feedback about sanctions and incentives, and how the treatment court has impacted the lives of its participants. Prior to beginning the interview, the interviewer reviewed the informed consent form with the participant and answered any questions. The interviewer then followed the protocol outlined in the interview guide to complete the interview. The consent process and interviews were taped.

Participants were randomly selected from three populations: 1) current, 2) 2004 graduated, and 3) 2004 terminated participants. The random selection procedure used stratification to select individuals representative of the different race, gender, and age group (less than 30 years old vs. 30 years old or older) combinations. When possible, at least one representative from each group was randomly selected. As a result, nine graduated, ten terminated, and 24 current participants were identified, and alternates for each stratum were identified when possible. In accordance with the OPC Research

Committee, contact information was acquired from the court. Marie Lamoureaux provided all of the information available, which consisted of names and addresses but not phone numbers.

An IRT research assistant attempted to obtain phone numbers through web-based directories, but this was successful for only a small subset of the participants. Correct phone numbers were identified for one graduated, one terminated, and seven current participants. When contacted, the participant identified as a graduate stated that she had never participated in the program. The terminated participant asserted that he had quickly opted out of the CRC program and therefore had no opinion about it. He declined to be interviewed.

Although three focus groups of eight participants were originally planned, too few of the selected current participants could be reached and scheduled. As a result, current participants were interviewed over the phone using questions from the focus group's Moderator's Guide. For this report, three current participants were interviewed; the other participants were called repeatedly. Although those participants agreed to be interviewed, they were not home or were not available to talk at the times they asked to be called. Subsequent efforts were made to obtain interviews, but these were not successful.

Team interviews covered a greater range of topics. These interviews asked questions about program history, program goals, barriers to implementation, the most and least helpful aspects of the program, as well as perceptions about the respective roles of Team members, sanctions and incentives, and the ways in which the court has impacted participants' lives. These Team interviews were conducted in person by a trained member of the IRT research team. Ten members of the overall Team participated in these individual interviews. These ten included Marie Lamoureaux, Jeffrey DeMagistris and eight other individuals identified as core members of the Team by Marie Lamoureaux. They all agreed to be interviewed. These Team members represented the various perspectives of the court and included the Judge, assistant DA, private attorney, the CRC Coordinator, CRC Administrator, case manager, two treatment providers, a police officer, and a probation officer. Prior to beginning the interview, the interviewer reviewed the informed consent form with the Team member and answered any questions. Then, the interviewer followed the protocol outlined in the interview guide to complete each interview.

All interviews were audiotaped and responses to each question were transcribed and recorded into a database. This facilitated the comparison of answers across participants and Team members. If all respondents agreed on a particular response, it was reported as such. When disagreement across respondents occurred, the differences of opinion were noted and described in the text.

Observational data: Court functioning was assessed with observations (one formal and one informal) of the pre-court staff meeting and one observation of the Chapel Hill court session. This provided information about staff communication and disposition of court cases.

IRT developed an observational form for evaluating the pre-court staffing. A formal observation of the Hillsborough pre-court staffing was conducted on January 19, 2005. For the pre-court staff meetings, trained IRT staff observed and noted such factors as the types of issues discussed and the amount of time spent on each issue, the decision-making process, the interaction among Team members, and the respective roles of each of the Team members.

Observations in court were recorded on a modified version of Satel's Court Observation Form. Two trained IRT staff members observed the court and independently recorded observations about each case discussed and then overall impressions of the court functioning.

Historical Documents: Documents pertaining to the history, implementation, modification and funding of the court were also analyzed for this process evaluation. The CRC materials reviewed for this evaluation included a description of the eligibility criteria, the Bureau of Justice Assistance grant proposal, CRC meeting minutes, documented policies and procedures, a draft of the MOU (Memorandum of Understanding), newspaper articles written about the court, an in-press publication describing 2003 participants, staff resumes, and archival data, which is detailed in the next section. Information from these documents was incorporated where appropriate.

Characteristics of CRC Participants

The CRC made three types of participant data available to IRT: court administrative records (2001-2003) with summary demographic and outcomes data; diagnostic and mental health services data; and Client Outcomes Inventory (COI) forms that were collected on a subset of participants. (See Appendix A for information about DSM-IV-TR diagnoses and the determination of Severe and Persistent Mental Illness (SPMI) and Dual Diagnosis.)

Inferential statistics were not computed for this report. All reported findings are based on visual inspection of the data tables and graphs.

When possible, the CRC findings were compared with the adult mental health target population definitions specified by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). These target populations include adults with SPMI (Severe and Persistent Mental Illness), adults with SMI (Severe Mental Illness), adults who are homeless, and adults who are deaf or hard-of-hearing. The COI data allowed a determination of SPMI, SMI, and homelessness but was only available for a subset of 2003 CRC participants. Diagnostic data, which were only available for the 2004 participants, were not sufficient to determine SPMI or SMI status. However, diagnoses that are typically disabling and persistent were categorized as "SPMI likely"; for details on the methodology, see the following section. The SMI-likely group seemed more difficult to categorize based on diagnosis alone, so this category was not created.

Overall Court Statistics (2001-2003)

The available demographic and outcome summaries for participants differed in format and content from year to year, thus limiting the comparisons that could be made. However, some basic comparisons could be made across years in terms of race, gender, and percent graduated. Criminal offense information was only available for 2003.

The ratio of males to females admitted to the program remained relatively constant between 2001 and 2003, with 67-70% of participants being male and the rest female. Unlike gender, the racial/ethnic balance varied more noticeably from year to year. Substantially more White than Black participants made up referrals in 2001 (62% White vs. 35% Black) and 2003 (56% White vs. 39% Black); the

percentages were more similar in 2002 (45% White vs. 48% Black). Very few Hispanics (less than 2%) were admitted in any of these years.

Across these three years, the percentage of participants who graduated ranged from 49% (2002) to 54% (2003). The remaining participants either chose to opt out of the program or were returned by the CRC to regular court for intractable non-compliance.

The available statistics for 2003 were the most specific. These statistics contained information about the length of time spent in the program, and also detailed the criminal charges of the participants. In 2003, 42 (46%) of the 92 cases processed did not graduate. Fifteen (36%) of non-graduates opted out of the CRC, and the rest (64%) of the non-graduates were non-compliant. Most participants (60%) spent between 7 and 12 months engaged in treatment through the court, and the average length of stay was 7.45 months. On average, offenders had between two and three charges (mean=2.27), and most of these were misdemeanors (88.6%). Theft appeared to be the most common charge with alcohol and drug violations comprising the second largest category. Drug-related offenses[1] made up 17% of the charges. A few participants had a violent charge, as defined by the FBI and SBI criteria. However, the number was a small percentage (2.4%) of the charges in the group as a whole, and the percentage was approximately half of the overall rate of violent offenses (4.7%) in North Carolina.[2]

COI forms were available for a subset of participants who entered the program prior to 2003. These 51 participants are not necessarily representative of the entire participant population. At intake, 20% percent were homeless and most (61%) were unemployed. The average GAF score (see Appendix A for explanation) was 40 (standard deviation=10). A score falling at or below 50, which is one standard deviation above the mean in this data set, indicates that the individual is not functioning well and may be experiencing significant difficulties (if not impairments) in at least one area of importance. This might encompass serious relationship problems, an inability to function adequately at school or work, and/or indicate impaired cognitive, emotional, or social functioning.

According to the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), one of the criteria for establishing SPMI status is a GAF score of 40 or less. Forty-five percent of these CRC participants scored 40 or less. Severe Mental Illness (SMI) is another group targeted for mental health services by the state DMH/DD/SAS. The criteria for establishing SMI includes having a GAF score of 50 or less. Using that criteria, 90% of this group could have been determined SMI.

Active[3] CRC Participants: Demographics, Characteristics and Services Received

Demographics: On 12/31/04, 85 offenders were considered active participants in the CRC program. Most participants were male (76%), and the predominant race was White (64%), with 35% Black and one percent "Other".

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[1] Drug related offenses included Drug Paraphernalia, DWI, Intoxication and Disruption, Possession of Marijuana, Under-age Alcohol, & Cocaine.

[2] Hiday, V.A., Gurrera, M., Lamoureaux, M., & DeMagistris, J. (in press). North Carolina's mental health court. *Popular Government.*

[3] Active as of 12/31/04. This group of participants includes only those individuals who were considered compliant with treatment or who were admitted too recently to have an established pattern of non-compliance by 12/31/04.

Methods for Diagnostic Summary: Diagnostic data were provided to IRT for each of the participants who were active as of 12/31/04 and for the 2004 graduated and terminated participants. These diagnoses were those on record at OPC, and all data were provided without client identifiers.

In order to facilitate a comparison of participant mental health problems with the stated admission criteria for the CRC and the state, the diagnoses were categorized into larger diagnostic groups (see Appendix A for more information). Each participant was placed into only one category.

The first diagnostic groups created were SPMI-Likely (a group prioritized by the CRC), Dual Disorder (a group of individuals with a severe mental health disorder and substance use disorder), and Mental Retardation. Any individual falling into one of these categories would automatically (or nearly always) qualify for state-funded mental health services in North Carolina. A participant was placed into one of these categories if his or her diagnoses seemed consistent with criteria for that group (see Appendix A).

The "SPMI likely" category represents those diagnoses that are typically disabling and persistent. A disorder was labeled as "SPMI likely" if it indicated probable disability or fell into a diagnostic category typical of persons with SPMI. A participant was placed in the "SPMI likely" group when the diagnosis listed is considered for SPMI designation (see Appendix A for more information) and/or if the disorder typically involves severe dysfunction or disruption in daily living and is persistent. For this evaluation, Bipolar, Severe and Recurrent Major Depression, Schizophrenia, Schizoaffective Disorder, Panic Disorder With Agoraphobia, Autism, Post-Traumatic Stress Disorder (PTSD) if combined with another diagnosis, and Psychotic Disorder, Not Otherwise Specified were all termed "SPMI likely".

The "Dual Diagnosis (SPMI + SA)" group refers to a specific classification that involves those with a severe and persistent mental illness and a co-occurring substance abuse or dependence disorder. For this study, only those individuals categorized as "SPMI Likely" disorder and who had a co-occurring substance use disorder were placed in the Dual Diagnosis group. In other words, everyone in this group likely has SPMI and also has a substance use disorder. To facilitate better linkage to the service use information, those in the Dual Diagnosis group were not included in the "SPMI Likely" group.

All participants placed in the Mental Retardation category had a diagnosis of MR (mild, moderate, or severe). None of these individuals had co-occurring severe, persistent mental health disorders or a Dual Diagnosis, as defined in the preceding paragraph. However, one participant categorized as MR also had a substance use disorder (SUD). This participant was <u>only</u> placed in the MR group because this diagnostic category is more specific and indicates that the individual qualified for state-funded developmental disability and mental health services.

After placing individuals into these categories, more than half of the active participants remained uncategorized. In order to better describe this remaining group of mixed diagnoses, several more categories were created. These were "Unknown", "Personality Disorder Only", and "Substance Use Disorder (SUD)".

The "Unknown" diagnostic category included only those participants whose diagnosis was listed as "unknown" in the records received. The "Personality Disorder Only" group included individuals who had only an Axis II diagnosis with no accompanying Axis I or Mental Retardation diagnosis.

The "SUD (no co-morbid SPMI)" group included those individuals who had one or more substance abuse and/or substance dependence disorders. Of those categorized as having SUD, 22 of 34 had no co-morbid mental health problems. The remaining 12 (35% of the group) had a co-morbid mental health diagnosis. These diagnoses included but were not limited to adjustment disorder, personality disorder, and major depression not listed as severe and recurrent. The co-morbid disorders in this group did not include those mental health disorders categorized as severe and persistent (i.e. "SPMI likely") for this study.

The remaining uncategorized participants had a range of problems and diagnoses which precluded useful categorization. As a result, these individuals were placed in the "Other" category. For a list of all diagnoses for actives, including both graduates and non-graduates, see Appendix B.

<u>Characteristics and Diagnoses:</u> Table 1 presents the diagnostic and service data for all of the active participants. Approximately half (48%) of the participants had only one diagnosis, and the rest had between two and four diagnoses. Based on these data, six individuals (7%) did not have a known mental health diagnosis[4]. However, two of these six were still in the assessment phase. One participant had only a personality disorder-- Borderline Personality Disorder. Those who would likely be diagnosed with SPMI or a Dual Diagnosis comprised 27% of the active group. Excluding those with an unknown diagnosis or only a personality disorder diagnosis, more than 90% of the active CRC participants had a major mental health or substance use disorder.

<u>Services:</u> Among those diagnosed with a mental health problem, everyone received at least one service, and many participated in several different services. The diagnostic data, which is archival, may not be the most up-to-date or complete representation of a participant's problems. As a result, judgments about the appropriateness of services cannot be accurately determined. However, these services are descriptive of the treatments available, and this report indicates that each group received a range of services, most or all of which seem appropriate for the problems common to that group. Individuals within a diagnostic category may be receiving more than one service, and the count of services reflects this. Most individuals received services within Orange County; however, two of the 36 individuals receiving individual therapy received this service out-of-county.

Of note, three of the active participants with unknown diagnoses received services. These services included individual therapy and medication. The fourth participant who passed through the assessment phase without a diagnosis never engaged in services; the CRC issued an order for his arrest. (As footnoted previously, some of these participants may have received a diagnosis after information was entered into the data base made available to the evaluator.)

[4] Information received immediately prior to the deadline for this report indicated that one of these participants was later diagnosed with Schizoaffective Disorder.

Table 1: Diagnoses and Services Received by Active Participants in the CRC as of 12/31/04

Diagnostic Summary	**Number (%) of Participants**	**Services Received[a] (number of participants receiving service)**
Unknown	6 (7%)	IT (3), Meds (1)
Personality disorder only	1 (1%)	IT (1), Meds (1)
SUD (no co-morbid SPMI)	34 (40%)	IT (13), Meds (6), CM (4), SAX group (4), IOP (4), AA/NA (3), PTA (2), residential SAX (1), ACT X (1), DWI classes (1), ACT (1), Day Treatment (1), DD/CM (1)
Mental Retardation	5 (5%)	DD/CM (4), Meds (3), IT (1), ACT (1), ACT X (1)
SPMI Likely	13 (15%)	Meds (8), ACT (5), STEP (2), CM (2), TEACCH (1), Carramore (1), Group Home (1), Day Treatment (1), IT (1), AA (1)
Dual diagnosis (SPMI + SA)	10 (12%)	IT (7), Meds (6), ACT (3), CM (2), STEP (1), SAX group (1), GT (1), IOP (1)
Other	16 (19%)	IT (10), Meds (3), ACT (1), GT (2), Day Treatment (1), CM (1), CHANGE (1), Group Home (1),

[a] *Services key: IT=individual therapy, Meds= psychotropic medication, GT=group therapy, CM=case management, SAX=substance abuse treatment, PTA= local SAX program for first-time offenders, IOP=intensive outpatient SAX, STEP=intensive treatment program for schizophrenia, CHANGE=domestic violence program, ACT=Assertive Community Treatment (ACT) Team, ACT X=Cross-disability ACT Team, DD/CM=Developmental Disability Case Management, Carramore=vocational program, AA/NA=Twelve-step program, TEACCH=intensive treatment program for autism.*

Diagnostic Composition of Participant Groups (Actives, Graduates, and Non-graduates)

In comparison to the active group, which was 76% male, both the graduate and non-graduate groups had a smaller percentage of males (approximately 60%). The non-graduates differed from the actives and graduates in that proportionally fewer were white; therefore, proportionally more of this group was black or Hispanic. Without further study, it is unclear whether these differences represent a statistical or meaningful difference.

The active and graduate groups, as opposed to the non-graduate group, represent the more compliant participants, and these groups have similar proportions of participants with a substance-related diagnosis (SUD or Dual Diagnosis) and participants who are “SPMI Likely”. The non-graduate group differs in composition from the active and graduate groups. It has greater percentages of participants

with a substance-related problem and also of those with only a personality disorder diagnosis. In addition, the non-graduate group has a noticeably smaller percentage of participants with "SPMI Likely".

Table 2: Comparison of diagnostic groups: Actives vs. Graduates vs. Non-graduates

Demographics	**Number (%) of Active Participants**	**Number (%) of Graduates**	**Number (%) of Non-graduates[a]**	**Total Number of Participants**
Gender				
Female	20 (24%)	18 (39%)	24 (40%)	62 (32%)
Male	65 (76%)	28 (61%)	36 (60%)	129 (68%)
Race				
Black	30 (35%)	17 (37%)	26 (43%)	73 (38%)
White	54 (64%)	29 (63%)	31 (52%)	114 (60%)
Hispanic	0 (0%)	0 (0%)	2 (3%)	2 (1%)
Other	1 (1%)	0 (0%)	1 (2%)	2 (1%)
Diagnostic Summary				
Unknown	6 (7%)	5 (11%)	8 (13%)	19 (10%)
Personality disorder only	1 (1%)	0 (0%)	3 (5%)	4 (2%)
SUD (no co-morbid SPMI)	34 (40%)	17 (37%)	27 (45%)	66 (35%)
Mental Retardation	5 (5%)	0 (0%)	2 (3%)	4 (2%)
SPMI Likely	13 (15%)	7 (15%)	2 (3%)	22 (11%)
Dual Diagnosis (SPMI + SA)	10 (12%)	8 (17%)	15 (25%)	33 (17%)
Other	16 (19%)	9 (20%)	3 (5%)	43 (23%)
Total	85 (100%)	46 (100%)	60 (100%)	191 (100%)

[a] *Non-graduate group includes those deceased (2), those who opted out (9), those later deemed ineligible based on legal or clinical criteria (6), and those who left the program AWOL (2).*

Seventy percent of the non-graduate group (as opposed to 52% of actives and 54% of graduates) has a substance-related diagnosis.[5] This suggests that participants with a substance abuse diagnosis may have more difficulty complying with and/or completing the CRC program. In addition to having the largest overall proportion of substance use disorders (SUD and Dual Diagnosis combined), the non-

[5] These percentages combine the N in the SUD and Dual Diagnosis groups.

graduate group also has the largest percentage of those categorized as Dual Diagnosis. The percentage of those with a Dual Diagnosis is a much larger percentage of the non-graduate group (25% vs. 12% and 17%, respectively). These groupings suggest that those participants with a substance use disorder are generally more difficult to engage and that the Dual Diagnosis subgroup is particularly difficult to engage in treatment.

In addition to the differences detailed above, the non-graduate group also has a disproportionate number of individuals having only a personality disorder diagnosis. However, this number is a very small percentage (5%) of the overall group. Of the three diagnosed with only a personality disorder, one had Narcissistic Personality Disorder, and the other two had Personality Disorder, Not Otherwise Specified. One opted out of the program.

The "SPMI likely" group comprises a surprisingly small percentage of the non-graduate group. The participants in this category, who by definition do not have a SUD, comprise only 3% of the non-graduate group. This contrasts with the more compliant active and graduate groups which each have 15% who are "SPMI likely" (i.e. SPMI without a substance use disorder). This difference in group proportions suggests that the CRC is particularly successful in engaging participants who have severe and persistent mental health problems with no SUD. The services to which these participants are connected may be particularly good at encouraging and reinforcing compliance. The disorders categorized as "SPMI likely" frequently respond well to compliance with medication and ACT services, which is an evidence-based approach to treating those with severe and persistent mental illnesses. Table 1 indicates that many of the actives with "SPMI Likely" are receiving at least one of these services.

Another means of "testing" the association of psychiatric disorders to outcome is to group participants by disorder and then assess, by disorder, which percent graduate and which do not. (This perspective differs from that taken in the preceding paragraphs in that the preceding approach determined the proportion of diagnoses within the non-graduate, graduate and active groups and then compared these proportions.) By examining the proportion of each diagnostic group that graduates versus those who do not graduate, we can understand the prospective relationship between diagnosis and outcome.

By examining Table 2, all of those with a "personality disorder only" and all of those with "MR" failed to complete the program. However, several of those with "MR" were still considered active in the program and may later have successfully completed the program. Firm conclusions cannot be drawn given the small number of participants with these disorders.

Table 3 presents the percentages of those categorized as "SUD", "SPMI-Likely", and "Dual Diagnosis" who successfully completed (graduated from) the program and those who did not complete the program successfully (the non-graduates). Consistent with the tentative conclusions stated previously, those participants with a SUD or Dual Diagnosis were more likely to have a non-successful program outcome, whereas the "SPMI Likely" group was more likely to graduate than not.

Table 3 Prospective Relationship of Diagnostic Groups to Outcomes

	Participant Outcome Group		
Diagnostic Summary	**Graduates (%)**	**Non-graduates (%)**	**Total Participants**
SUD	17 (39%)	27 (61%)	44
SPMI Likely	7 (78%)	2 (22%)	9
Dual Diagnosis	8 (35%)	15 (65%)	23

Summary and Recommendations

1. Based on the diagnostic data and COI forms, it seems that a sizable proportion of the cases served by the CRC are populations targeted for mental health services by the NC DMH/DD/SAS. In addition, approximately 90% of those participating in the CRC program seem to meet either the mental health or substance-abuse criteria outlined in the state MHTC Appropriations Act.
2. The groupings of graduates and non-graduates suggest that CRC services may be particularly effective for the SPMI group.
3. CRC services may be less effective for the Dually Diagnosed group. The CRC might want to explore the effectiveness of the available services for this group and/or consider the time in treatment needed to be successful with this group and the SUD group overall.
4. Approximately 10% of those graduated or served in 2004 did not have a diagnosis. Although seemingly high, this is considerably lower than the average for Mental Health Treatment Courts studied nationally to date. According to Steadman, et al, the average percentage of participants with an unknown diagnosis was 20% for five of the seven courts studied.[6]
5. The graduation and non-graduation rates are not identical for Black and White participants. The court should explore whether there are any factors contributing to this difference. Without further study, it is unclear whether or what factors, if any, are associated with this demographic difference in outcome.

<u>CRC Staffing</u>

Team Composition

Representatives from the Orange County District Court, the District Attorney's office, the Public Defender's Office, Community Corrections, OPC, the Chapel Hill Police Department, the District Court Administration, and a number of private attorneys staff the Community Resource Court. There are 16 official members of the CRC, but a smaller core Team consisting of approximately ten members. Members of the core Team attend every, or nearly, every pre-court staffing and court session, and they represent all of the affiliated CRC organizations. The remaining Team members attend meetings and court only when their clients are discussed.

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[6] Steadman, H.J., Redlich, A.D., Griffin, P.A., Petrila, A., & Monahan, J. (in press). From referral to disposition: Case processing in seven mental health courts. *Behavioral Sciences and the Law*.

Core Team: Roles, Education, and Training

Judge Joseph Buckner is the presiding judge, and his primary role is to motivate and monitor the participants and to administer awards and sanctions as the Team advises. Judge Buckner has been a District Court Judge in District 15B since 1994 and was appointed as Chief District Court Judge in the same county in 1996. He is involved with the Orange County Drug Treatment Court and has attended Bureau of Justice Assistance (BJA) trainings for that court. Although the MHTC differs from the DTC, Judge Buckner indicated that knowledge of the DTC helped the CRC Team develop the MHTC implementation. He has since attended the 2004 MHTC training sponsored by the BJA and said it was informative. He clearly has used information gained there to inform decisions made in the CRC. Judge Buckner has been involved with the CRC since its inception, and most of the core Team members joined the court as a result of his invitation.

Beverly Scarlett, an assistant district attorney, has the primary roles of identifying eligible candidates for the CRC program and making decisions regarding termination. ADA Scarlett has worked at the District Attorney's Office since 1998 and has assisted in the design and implementation of the DTC as well as the CRC. Her DTC training and familiarity with the DTC court program has helped her develop her role in the MHTC.

A public defender or an appointed private attorney fulfills the primary role of protecting the legal rights of his or her clients, facilitating an orientation to the court and explaining the legal ramifications of participation. Lauren Dickerson and Karen Murphy are both private attorneys who provide representation for CRC participants. Ms. Murphy was interviewed for this evaluation. Judge Buckner appointed Ms. Murphy to be a member of the core Team, and she has participated in the CRC since the planning phase of the program. She has experience in mental health law and has attended Continuing Law Education programs on the subject.

Vickie Fornville, a probation officer from Community Corrections, has the primary role of providing supervised probation and progress reports on the participant. She works in tandem with the counselors from OPC. Ms. Fornville has a degree in Criminal Justice and has worked at the Department of Corrections since 1998, working with some mental health offenders. Ms. Fornville was assigned to the court by the Department of Corrections and has been a member of the core Team since the inception of the court.

Jeffery DeMagistris is the Lead Case Manager from OPC and the Project Coordinator for CRC. He is a licensed clinical social worker (LCSW-P), and he has worked for OPC for approximately nine years. Prior to working with the CRC, he acted as a coordinator and case manager for a state-wide initiative in Chatham County that served mentally ill and substance abusing populations. His position on the CRC Team involves engaging the participants, encouraging program compliance, and working with Marie Lamoureaux to maintain funding for the program. Mr. DeMagistris attended the BJA MHTC training last year and also attended the New York State Mental Health Professionals Conference. He has been with the court since the planning stages and helps maintain the grants and funding for the court as well as lead the strategic planning efforts.

Michael Norton is the Team leader for the ACT Team, providing therapeutic and psychological counseling. His primary role is to report on the compliance and progress of the participant under his

care and to make recommendations to the Judge about what course of action to take. He holds a Masters in Pastoral Counseling and has worked with OPC as the SPMI Community Services Coordinator since 1993. He joined the CRC Team one year ago but was involved in grant writing for the court in 2000-2001.

Senga Carroll and David Rhyne are service providers and also core members of the Team; they provide or arrange for the interventions received by participants of the court. Prior to working as the CRC's clinical social worker, Senga Carroll was employed by TASC (Treatment Accountability for Safer Communities), which delivers treatment and case management services to substance abusing individuals. Ms. Carroll joined the core CRC Team in October of 2003. She received specialized training at the BJA Mental Health Treatment Court trainings in Ohio and Florida. She screens referred offenders to establish their eligibility for the CRC program, and for a subset of those admitted, she provides case management or direct mental health services, i.e. psychotherapy. Ms. Carroll recently accepted another job with the OPC/LME (Local Management Entity). Currently, she is working part-time for the court until a replacement can be hired.

David Rhyne is a case manager for the CRC and has worked with CRC since February, 2001. He screens and orients potential participants to the CRC and then manages the participant's case or monitors the services he or she receives through the court. He is currently working towards a Masters in Social Work. However, he is also concerned about funding changes in the state block grant structure, which now requires that a certain percentage of his salary be earned through billable services. Not all services provided through case management are billable, so the feasibility of maintaining a full-time position with the state block grant is no longer certain. Ultimately, this might mean that the CRC loses these case management services.

Matthew Sullivan acts as the Chapel Hill Police Department liaison. His primary role is to assist the district attorney in identifying eligible candidates for the program and to encourage participant compliance. Mr. Sullivan holds a Masters in Social Work and is currently working towards a law degree. He has been a police crisis counselor since 1999 and has worked as a coordinator for a substance abuse program. He was a counselor in the DTC and was also involved in the planning and implementation of the CRC at Judge Buckner's request.

Marie Lamoureaux, the CRC administrator, coordinates all elements of the court and is involved in maintaining funding for the court. She is also responsible for the staffing, planning, and maintenance of all aspects of the CRC. She holds a Masters in Psychology and has worked as a Project Coordinator for District Court 15B since 1999. She also attended the BJA-sponsored MHTC training.

Most core members of the CRC Team have been involved with the court since its inception, and everyone has demonstrated a commitment to learning more about treatment courts and mental health problems and treatment. Most have educational or work backgrounds related to mental health, and for those who do not, trainings in mental illnesses and treatments given by CRC clinical staff have been conducted. Everyone interviewed who mentioned this training emphasized its relevance and helpfulness.

Legal and court representatives have provided cross-training in criminal justice issues for the benefit of clinical Team members, and nearly every Team member has specialized knowledge of treatment courts gained through participation in BJA-sponsored trainings.

Team Stability

The staffing of the Core Team has been remarkably stable with most members having been involved with the CRC since the planning phase or the first months of its implementation. Of the ten members interviewed, eight have been involved with the court since its inception. The two remaining members have been part of the Team for at least one year. The stability of this staff is now under threat due to concerns about loss of funding for the case manager and clinical social worker positions. Mental health reform has added further complications in terms of a lack of clarity related to reimbursement for mental health services.

Orientation of New Members

Given the low turnover rate in Team members, new additions to the Team have been infrequent. As a result, more experienced Team members have generally informally oriented the new members. For instance, when new clinical personnel were added to the Team, Jeffrey DeMagistris would take responsibility for orienting that individual to the functioning of the court and his or her role in it: Marie Lamoureaux would likewise take responsibility for orienting new legal or court-related personnel.

With more Team turnover anticipated and the planned expansion to Chatham County, a more formal orientation procedure was recently approved. Now, each new member of the Team will receive a CRC Orientation Packet that includes the CRC policies and procedures, a fact sheet, a Team roster, the court schedule, a defendant information sheet and a confidentiality form. Prior to participation in Team meetings, these new members will need to meet with at least one member of the legal team and one member of the treatment team to help prepare for the next pre-court staffing. Finally, the new Team member will be required to sign the Confidentiality Agreement in order to participate in the CRC pre-court staffing.

<u>Description of Current Program</u>

Program Goals

The CRC recently drafted a Memorandum of Understanding (MOU), and it proposes four goals for its program: 1) to expedite case processing; 2) to develop greater linkages between the criminal justice and mental health systems; 3) to reduce jail time and improve access for treatment of mentally ill offenders; and 4) to increase or maintain public safety.[7] Everyone interviewed from the CRC Team endorsed these goals and emphasized the need to reduce the inappropriate use of incarceration and to improve access to mental health care for those who need it.

[7] *Memorandum of Agreement*. Orange County Community Resource Court. November 5, 2004.

Referral/Eligibility/Admission

As proposed in the BJA Grant, client eligibility for CRC requires a person to have committed a criminal offense and to have a mental health diagnosis, developmental disability or a mental health treatment history. These criteria include the presence of a substance abuse or dependence disorder. On the rare occasion when the court is near capacity, priority is given to defendants with SPMI (severe and persistent mental illness) and to those who are appropriate for long-term case management services. In addition, eligibility is awarded only to defendants who do not pose a public safety concern, as determined by the Office of the District Attorney. In order to make this determination, the District Attorney uses the following criteria: criminal history, nature of the offense, public safety and prior involvement in the mental health system. Even though CRC targets low to moderate-risk offenders, it is important to note that while most Mental Health Treatment Courts only accept defendants charged with misdemeanors, the CRC sometimes accepts defendants charged with felonies and violent offenses. Finally, since the program is voluntary, eligibility demands that defendants agree to abide by the recommended mental health and court treatment program, which lasts a minimum of six months.

Before eligibility is considered, a defendant must first be referred to CRC. The BJA Grant states that most referrals come from court officials, such as the District Attorney, Public Defender, law enforcement, judges and pre-trial services, but some referrals also come from social workers, treatment providers and family members. In order to determine if a referred defendant is eligible for CRC, the District Attorney conducts a mandatory legal screening. Once the screening has been completed and a defendant is ruled eligible to enter the CRC, the case is set for the following CRC court date. The CRC court meets monthly in each location (Chapel Hill and Hillsborough), so the time between referral and eligibility determination always occurs within 30 days.

At the defendant's first CRC session, the CRC case manager or clinical social worker conducts a clinical needs assessment. If the defendant decides to withdraw at any time during the referral process or determination of eligibility, then the case is returned to regular District Court. If the defendant agrees to participate, however, then the defendant is referred to the appropriate treatment provider, which is sometimes the clinical social worker on the CRC Team. If services are provided within the county, the case is monitored and supervised by the case manager or clinical social worker. If a defendant moves out of the county, the defendant's lawyer must monitor his or her compliance. Once admitted into the program, failure to comply with the court recommendations can result in the case returning to regular District Court for trial and/or sentencing.

While the BJA Grant plainly describes the eligibility criteria, the Team interviews revealed some differences in their understanding and opinion of these criteria. Most notably, Team members differ in their discernment of which type of client is and should be targeted by the CRC. The Team consistently agrees with the priority assigned to SPMI clients, but several Team members believe that, in order to improve the efficiency and effectiveness of the program, the eligibility criteria should be narrowed to exclude certain types of offenders and diagnoses, including sex offenders, those with borderline and antisocial personality disorder and those unlikely to be helped and those with a primary substance abuse issue. By better utilizing the limited human and organizational resources of CRC, the supporters of stricter eligibility criteria believe that a reformed policy will help avoid program overcapacity, improve service delivery, and aid those clients most likely to benefit from the program.

On the other hand, several Team members championed the current flexible eligibility policy as a means to inclusively serve more individuals who might benefit from the program. For example, CRC accepts some dual-diagnosis, i.e. mental health and substance abuse clients who, because of a co-occurring mental health issue, are inappropriate for DTC. While these clients cannot qualify for DTC because of its stricter eligibility criteria, CRC offers a beneficial and fitting resource for the judicial system.

Decision-Making and Staff Relationships

For an hour and a half prior to each court session, the CRC Team meets to discuss each case on the docket. The Team includes the Judge, Assistant District Attorney, Assistant Public Defender, court-designated private attorneys, case manager, probation officer, treatment providers (as needed) and program coordinator. As each case is addressed, discussion centers on the progress made (or lack thereof), behavioral changes, treatment compliance and needed modifications. In addition, Team members advise the Judge on how to address each client in court, either with words of encouragement or reprimand.

Based on observations of two pre-court sessions, one formal and one informal, it was clear that all Team members have an equal opportunity to provide input on any case. In the observed sessions, the Judge took the role of session facilitator, as he introduced each case on the docket and asked for an update from the appropriate Team member(s). The discussion of each participant typically began with a report on his or her mental health status, diagnosis, and treatment compliance. The treatment providers and/or case managers led this discussion because they generally had the most information about these aspects of the case. The clinician also updated the Team on any changes, either external or internal, which may have been affecting compliance.

Whereas, the clinicians had the most input related to the mental health aspects of the case, the Assistant District Attorney provided the most input from the legal side. At least one Team member stated that although opportunity for input is equal, the input from the legal side, particularly the ADA, receives more weight. As the principal legal discussant on the Team, the ADA represents the interests of the general public. This means that the ADA is focused on the public safety concerns associated with each client and case. The public defender and private attorneys also participated, and on behalf of their clients, presented the Team with updates on legal compliance and relevant changes in the participant's legal, social, or occupational situation. The Judge tried to prioritize the information presented and to focus the discussion on outcomes: incentives, sanctions, termination, and/or graduation. In most cases, the Judge asked for advice on how to verbally address the client in court, i.e. whether to encourage or reprimand.

In the observed pre-court sessions, the Team members treated each other with a high level of professional respect and courtesy. This observation was supported by interviews with Team members, as they unanimously described staff relationships and communication as exceptionally positive.

Several Team members reported that discussions sometimes became tense and that decisions were sometimes made without full agreement or notification. However, no strong disagreement occurred during either of the two observed sessions, and the consensus opinion decided each case. In a related

comment, two Team members reported that occasional communication breakdowns occur following Team meetings. In the cases described, the Team discussed a case and agreed on a certain outcome, but this outcome was reconsidered during court based on new information obtained. This change in plan was not communicated in a timely fashion to the clinical Team member, who was out of the room performing a needs assessment. The clinical assessment of eligibility occurs during court, and as a result, the case manager, clinical social worker, and coordinator are not always present for the entire court session. This can result in missed information among Team members.

Despite what is described as an occasional breakdown in communication, the observations and interviews indicate that Team members generally communicate well with each other. Overall, the Team appears to be achieving its goal of good collaboration between the mental health and judicial systems, with both sides relying on and deferring to the expertise of the other.

Court and Mental Health Collaboration

The CRC requires the participation of both the mental health and legal systems in order to function at the most basic level. Those who are accepted in to the court generally do so as part of a pre-sentence agreement, deferred prosecution, or as a condition of supervised probation. The core legal team members monitor the participants to ensure compliance with both the terms of their agreement with the District Attorney's Office and to ensure compliance with the recommendation for treatment in order to reduce recidivism. The treatment team monitors the participants to ensure that they are participating in the mental health services that they need. The legal team depends on the treatment team for assessment and treatment recommendations and the treatment team depends on the legal team for enforcement of those recommendations. Collaboration between these two systems is the essence of the Community Resource Court.

There was no structured Memorandum of Understanding agreed to by all the members of the CRC at the planning stage. There was, however, an informal understanding among all participating bodies. As the CRC developed procedurally and structurally, the core Team began to develop a formal Memorandum of Understanding. An MOU has been drafted and is in the final stages of implementation with the primary goals of expediting case processing, developing greater linkages between the mental health system and the legal system, reducing jail time and improving access for treatment of mentally ill offenders, and to increase public safety.

Outside Agency Collaboration

Jeffery DeMagistris, Senga Carroll, and David C. Rhyne act as the core clinical components of the Team. They screen defendants for eligibility, orient participants to the court and mental health services, and they act as a conduit through which participants access services. Each member of the core treatment team provides general case management and/or direct clinical services. When participants need specialized services, such as treatment for SPMI, the clinical team members refer their clients to local programs. These programs include but are not limited to ACT, CARAMORE, and the UNC STEP Clinic. Other community programs are used as needed and available.

ACT is a local Assertive Community Treatment (ACT) program that involves a multi-disciplinary team in the treatment of individuals with serious mental illness or functional impairments. The

program provides individualized psychiatric, rehabilitative, and support services. ACT is considered an evidenced-based practice with research support for its effectiveness. Michael Norton manages the local ACT program and is now a core member of the CRC Team.

CARAMORE provides training in employment and independent living skills for severely mentally ill adults in North Carolina. Its main goal is to help clients achieve a higher quality of life through productive employment and independent living in a positive environment.

The UNC STEP (Schizophrenia Treatment and Evaluation Program) Clinic is organized and staffed by the UNC Department of Psychiatry. The Clinic offers comprehensive care for individuals with chronic mental illness, especially psychotic disorders. As part of its care, the Clinic develops a comprehensive treatment plan that attempts to address both the immediate needs of each patient as well as long-term treatment needs.

These programs are commonly used by the CRC for participants with SPMI; however, other mental health resources exist and are used both for the severely mentally ill and those with other mental health problems. Many of the outside service providers are not signatories to the Memorandum of Understanding, and a few members of the core Team reported difficulty in accessing these services. Long waitlists are common for individual psychotherapy and specialized group therapy. In addition, a participant's lack of medical insurance can interfere with accessing certain psychiatric services and medication. Reportedly, a participant's criminal charge can disqualify them from receiving some outside services such as securing employment or finding stable housing. Although rare, some participants are actually residents of another county. When this occurs, arranging services for these participants has been more problematic unless the participant can afford private psychiatric or psychotherapeutic care.

Implementation Barriers

Team members noted numerous impediments that they have faced in the implementation of their program. These impediments include the following: lack of a data management system, funding issues, the quantity and quality of mental health resources and services, lack of a clear eligibility standard, overcapacity in the court, lack of personnel and their need for more training, issues with collaboration between the two systems, and a lack of communication between the legislature and the courts.

Implementation of the CRC occurred before trainings specific to Mental Health Treatment Courts were available. Although understandable, this lack of knowledge was originally a barrier to conceptualizing the court. However, every member of the Team had educational or work experience to qualify them for their positions. The core Team members read the literature about Mental Health Treatment Courts, used their knowledge of treatment courts from their DTC experience, and worked with each other to understand the "other" system. In other words, the clinical team members provided training in mental health assessment and treatment to the legal and court team members, and the court and legal personnel described court and legal procedures to the clinical staff. When the Bureau of Justice Assistance (BJA) organized a training meeting for MHTCs in 2004, several team members attended. However, by that time, most of the core Team members had extensive, first-hand knowledge of

MHTCs. The BJA has since certified the CRC program as an example of "best practice" among MHTCs nationally.

Another barrier to implementation and functioning is the lack of a data management system. Three Team members emphasized that the court needs a data management system and someone who can manage the data and report findings and information to the Team. Having a data management system would facilitate a more efficient sharing of information between the court and mental health system. It would also provide information for monitoring the program and its participants. Until recently, the CRC Team understood that it would have to pay for a data management systems. The AOC reported that it will provide the data management system at no cost to the CRC. At this time, the CRC has agreed to explore the use of one of the AOC MIS systems.

Some members of the Team reported that the CRC initially suffered from some gaps in treatment services related to the inherent complexity of providing treatment to historically non-compliant, inconsistent, and unmotivated clients. Some area service providers were initially reluctant to work with this population, so CRC team members invited these service providers to court sessions and provided education and training to them. This allowed the CRC Team to establish linkages with the providers and to bridge this gap in services.

Current Strengths, Barriers and Needs

Nearly every member of the core Team expressed concern about funding for the court. Team members reported that the uncertain funding hindered planning for the future and threatened court operations. Already, operations have been affected. Due to changes in the state block grant funding for the case manager position, the future of the position is unclear. In addition, the BJA-funded position is only guaranteed funding for one more year. With Senga Carroll's departure, Jeffrey DeMagistris is planning to take over this position, but the court may be forced to operate with fewer clinical Team members in the near future. Currently, the CRC is seeking out other possible funding sources. One Team member hoped to see state funding for mental health services expanded to different diagnostic groups. This would help the CRC serve some of its clients who for now do not have other sources of reimbursement for services.

Almost every Team member reported a lack of adequate mental health resources. If a client is not seen by the Team social worker, who can now no longer take new CRC clients, he or she will frequently have to wait one to two months for the start of individual and/or group therapy. In addition, paying for those services can be an impediment because many clients are not eligible for benefits through community or state funding for the mentally ill. Also, finding resources and services for clients who live outside of the county is difficult and has not worked well for the court.

Another ongoing concern relates to the court's capacity. The Team has a set limit of 100 participants. However, this has not allowed the Team to take all referrals. Three to four times since its inception, the Team has had to refuse referrals for as long as one month's time. Some Team members seem inclined to expand the court services to meet this need. One suggestion has been to add another case manager to handle these extra cases. Recent scheduling problems have also led some to discuss creating another court session to give each case more consideration and more legal personnel to facilitate expansion of the program. Currently, there is no funding to pay for these expanded services.

Although the CRC currently has approximately 100 participants, Team members seem overextended in serving this number. The pre-court staff meeting does not allow enough time to discuss every participant in detail. In addition, scheduling issues have arisen because the court has had difficulty processing the total number of defendants on the docket each month.

In contrast to the Team members who propose expanding services, other Team members believe that the eligibility requirements should be narrowed to reduce the number of eligible participants. Each Team member discussed certain diagnostic groups that could potentially be excluded, but there was not a consensus of which groups to exclude. However, all agree that some participants do not improve through the CRC and identifying those participants early could potentially lessen the workload.

Sanctions and Incentives

No formal policy regarding sanctions and incentives, either in form or application, exists for the CRC. While the Team agrees on the most commonly used sanctions and incentives, they acknowledge that the determination and usage of sanctions and incentives is made on a case-by-case basis. This case-by-case decision-making is necessitated by the absence of any official policy that links behavior with a set of consequences. All agree that the incentives and sanctions should be linked to compliant and non-compliant behavior, respectively. The determination of how much non-compliant behavior warrants which type of sanction, however, is left unclear. Despite this uncertainty, all of the Team members interviewed said they believed that the delivery of sanctions and incentives was appropriate.

The CRC commonly uses the Judge's verbal reprimand as a sanction, and to a much lesser extent, the court uses incarceration or ultimately termination as punishment for non-compliance. As one Team member asserted,

> We have very few sanctions. This is a much more benign court than say even Drug Court….a lot of these people … have nothing, it is hard to punish people like that. If you have no home, and you have no money, and you have no connection, taking away something is not possible and putting them in jail is not finding relief. The reward-based system on the other hand is really effective… I think praise [works]. I know so, and how much does that cost?

Sanctions are delivered when a participant has been non-compliant with the program. Missing therapy sessions, court appointments, or committing new criminal offenses are typical examples of non-compliance that warrant a sanction. Usually, the severity of non-compliant behavior correlates with the severity of sanction, but there is no official relationship. Instead, through discussion, the Team determines the consequence on an individual basis. While several Team members believe that sanctions should be employed more frequently, other Team members see little need for sanctions because of generally good compliance and the limited impact of sanctions for a majority of the client population. In the observed sessions, about 15% of clients received a sanction. Of these sanctions, all came in the form of a stern verbal reprimand and warning from the Judge. In addition to expressing disappointment in and frustration with the participant's behavior, the Judge occasionally warned that continued non-compliance would result in incarceration and/or a return to regular District Court.

Everyone on the Team seemed to agree that incentives have the potential to be more effective than sanctions, and the court places emphasis on this. However, as with the sanctions, there are limited

options for incentives. There are three basic incentives used by this court: positive social reinforcement, excused absence from a court session and graduation. The social reinforcement takes three forms: encouragement, praise, and applause. Based on court observations, the Judge verbally praised participants in roughly 80% of the cases—a demonstration of the court's preference for rewarding compliance, acknowledging sincere effort, and encouraging motivation in a public setting.

In their interviews, Team members consistently cited the positive words of the Judge as an effective incentive, and client responses supported this claim. Of the 25 participants who responded to the consumer satisfaction questionnaire, 23 (92%) expressed satisfaction with their interactions with the Judge. In addition, the current participants who were interviewed by phone also reported that the Judge's praise and positive regard were important and helpful. The Judge uses encouraging words to provide immediate (or intermediate) reinforcement for good compliance. Graduation and the opportunity to address the gallery are considered the ultimate reinforcements for improvement. In the observed court session, both graduating clients seemed very pleased with the opportunity to give a speech about their success, and they thanked the Judge and their case managers, and they encouraged other clients to strive toward graduation.

Termination and Graduation

Similar to sanctions and incentives, termination and graduation decisions are determined by participant behavior, i.e., compliance and non-compliance. Both decisions are made, usually by consensus, in the pre-court session discussions.

In interviews, staff consistently defined termination as resulting from repeated non-compliant behavior. There exists, however, no formal criteria for determining the extent of non-compliance that should justify termination. Team members seem to agree that missing a therapy session, a court appointment or appearance, or committing new criminal offense are typical examples of non-compliant behavior. However, there is no consensus on the number of appointments that need to be missed or types of new crimes committed to justify termination. Often, termination is simply reserved for those clients who are subjectively determined to be making no progress. These decisions are determined by Team consensus and, as such, are not subject to the preferences of any one staff member. However, the need to discuss each case at length and on numerous occasions before choosing termination results in a tremendous drain on resources. In addition, these resources are being utilized for those participants who are likely not benefiting from the program. None of the staff members expressed dissatisfaction with the termination policy, but at least one Team member feared that clients may be kept in the program longer than is necessary, deserved, or effective. Based on pre-court session observations, Team members introduced the issue of termination for two clients, both because no mental health diagnosis existed, but ultimately allowed these clients to remain in the program at least until the cases could be discussed at greater length. The current policy states that even clients who are terminated are eligible to re-enter the CRC at another time.

The requirement for graduation is more clearly defined than that of termination. Graduation is achieved at the conclusion of six consecutive months of compliance. Several clinical members of the Team indicated that many clients are non-compliant for the first few months before they establish a good record of treatment attendance and as a result may participate in the program for longer than six months. If a client engages in non-compliant behavior during the first six months, the CRC Team can

recommend continued participation in the program, and in fact, many participants remain in the program longer than the minimum of six months. Even with the objective six-month criteria, the decision regarding graduation remains somewhat subjective because 100% compliance is rarely, if ever, achieved. However, the Team seems to have little difficulty deciding who is ready to graduate based on its criteria.

At graduation, a client receives a certificate of completion and, more importantly, has his or her case resolved in a positive manner, either through dismissal or the successful termination of probation. In general, staff members feel comfortable with the current graduation policy. Two Team members, however, stated that six months is too short and instead recommended a minimum program length of nine to twelve months.

Overall Program Impact

<u>Outcome Data</u>

Based on the preliminary, unpublished findings of Marlee Gurrera, a doctoral candidate at North Carolina State University, participants in the CRC are less likely to be re-arrested than are defendants in regular court. Even more encouraging, Gurrerra finds that the rate of re-arrest declines further for clients who actually graduate from the program. Another encouraging finding is that the severity of offense does not increase for CRC clients, but the severity does increase for those in regular court.[8] While the findings are still preliminary, they suggest that, as compared to regular court, CRC is successfully meeting its goal of reducing recidivism.

<u>Consumer Satisfaction</u>

The consumer satisfaction questionnaire was completed by 25 active CRC clients prior to a court session in Chapel Hill. (See Appendix C for response results). The respondent sample consisted entirely of those willing and able to complete the questionnaire. Because of this self-selection, the sample is not necessarily representative of the total CRC population. However, the gender and race distribution in this sample is very similar to the overall participant demographics. In this particular sample, 76% of the respondents are male; 52% are White; and the average is age 34.

In addition to collecting relevant demographic information, the CRC consumer satisfaction survey includes questions that probe client opinions and perceptions of two principal areas: 1) satisfaction with various parts of the program, and 2) ease or difficulty in completing program requirements. In understanding the survey findings, it is important to reiterate that all responses are self-reported.

For the first programmatic area, which primarily relates to organization and operation and includes 13 questions, survey responses reveal that active CRC clients are overwhelmingly satisfied with the program. In fact, 21 of 23 (91%) applicable respondents indicate satisfaction with the overall CRC program, and a majority of applicable respondents express satisfaction with each aspect of the program targeted by the survey. For the following services: substance abuse treatment, mental health treatment,

[8] Johnston, Cheryl (August 28, 2004). Graduation is the goal in Resource Court: Program helps keep mentally ill offenders out of jail. *The Chapel Hill News*.

and community service activities, all respondents who participated in these services reported being satisfied or very satisfied with those services and that aspect of the CRC program.

Some aspects of the court were satisfactory to fewer of the respondents. Three of the ten respondents who received court sanctions reported being dissatisfied with the sanctions received, though no information was gathered about the sanctions actually received by these defendants. However, the remaining 70% of those who received sanctions reported satisfaction with this aspect of CRC.

For the second programmatic area, which primarily relates to the specific treatment recommendations and includes 18 questions, respondents indicate that they find it easy to follow the program requirements. For nearly every requirement, the majority of respondents for whom the question was applicable answered that the particular requirement was easy or very easy to follow. The one exception related to the payment of court fees and fines. For the respondents who had had to pay a court fee or fine, most found this requirement somewhat hard, difficult, or very difficult.

Conclusions

Strengths

- The CRC Team has very qualified and experienced personnel, and it has been remarkably stable for the past four years. Team members communicate well with each other, and through the group decision-making process, they avoid undue subjectivity.
- The CRC benefits from local agency support. The police department and local mental health agency have been particularly helpful.
- Consumer satisfaction and participant perceptions of the program are very positive.
- The Judge and Team are perceived as being very effective by participants and other court personnel.
- Incarceration is used judiciously and rarely.
- The program relies primarily on incentives rather than sanctions to encourage compliance.
- The program does not expect initial compliance and works to engage clients over time.
- Termination not used until a clear and extended pattern of non-compliance develops.
- Graduation policy is clear and provides ample and appreciated rewards to participants.
- Preliminary, unpublished outcome data suggests that the CRC does reduce recidivism, but the data does not address the differential outcomes of different diagnostic groups.

Weaknesses

- The CRC Team does not have a clear definition of how much non-compliant behavior should result in termination. Termination decisions continue to be made as a result of time-consuming Team discussion. Some non-compliant participants remain in the system long after non-compliant behavior is established because these participants are difficult to track.
- There are very few intermediate incentives used by the court. The court relies on encouragement and praise and sometimes the reward of skipping a court session. These are received positively, but could be enhanced with more variety.

- The court seems to be operating over capacity with Team time stretched thin. Most court decisions are accomplished through Team discussion of each case. This requires inordinate time for decisions of eligibility and termination.
- The screening procedure occurs during court, which means that occasionally the Team case manager and/or social worker cannot be present when a client presents to the Judge. This has occasionally resulted in different court outcomes that are not communicated in a timely fashion.
- Everyone on the Team agrees that certain diagnostic groups benefit less or not at all from the program. As a result, all Team members have considered narrowing the eligibility criteria. However, the Team members differ on which groups should be excluded.
- Lack of guaranteed long-term funding inhibits long-term planning of the court.
- Changes in the state system for delivery of mental health care and possible funding changes may impact this program and its current implementation and outcomes.
- Lack of a data management system has inhibited program monitoring and evaluation.

Summary and Recommendations

- At least 90% of the participants served by the CRC Team have a mental health and/or substance abuse diagnosis. Although the CRC began operating prior to the MHTC Appropriations Act, it is serving a population very similar to the target population described in the MHTC Appropriations Act.
- The CRC has good face validity and pre-publication data from a NCSU study suggesting that recidivism is comparatively low for those served by the CRC. However, given the diversity of those served by the court and the high rate of non-compliance, a formal outcome study would be a useful means of obtaining information about which diagnostic groups are compliant, which groups benefit and to what extent they benefit. This information could help inform the CRC in decisions of eligibility and termination. Ultimately, setting more firm criteria for these decisions could lessen the considerable workload of Team members.
- The CRC is already serving the maximum (or more than the maximum) number of participants possible. With changes in clinical staffing, the potential loss of one clinical position, and changes in mental health service delivery in the state, the Team will likely need to become more efficient in serving its participants and/or reduce the number of participants served. The Team could better utilize its limited resources by narrowing the eligibility criteria and developing a more standardized termination policy. In addition, using a needs-assessment screening questionnaire to help assess eligibility might allow clinical staff more time to participate actively in court.
- Acquiring a data information system could improve information-sharing between systems, to minimize communication breakdowns and to facilitate the monitoring of program outcomes.
- With the state changes in mental health care delivery, the CRC could benefit from having the mental health Local Management Entity (LME) establish or reestablish connections with area mental health care providers.
- Using more intermediate incentives might help improve compliance among the previously non-compliant group.

Mecklenburg Mental Health Treatment Court

Methods and Procedures

Data collection involved interviews with two key administrators: Janeanne Tourtellott, the DTC and MHTC Program Director and Tim Holland, a representative from the Area Mental Health Authority (AMHA). Both participated in the interdisciplinary planning committee and as a result have knowledge of the history, goals, and implementation of Mecklenburg's pilot MHTC. Both signed informed consents and responded to questions over the phone. The interviews were audio-taped, and copies of these tapes were archived and stored in a locked cabinet. Court information was also obtained through a review of agendas and minutes from planning committee meetings as well as a grant proposal for MHTC funding.

In addition to these interviews, information about the Mecklenburg County's jail population was obtained. Janeanne Tourtellott provided data about criminal charges and mental health treatment for a 30-day sample (12/6/03-1/7/04) of jailed offenders.

Information about the potential referral population for the Mecklenburg MHTC was available in the preliminary results of a university-approved study. Under the supervision of Dr. Jim Cook, researchers Christi Davis and Jerry Gambrell, II collected mental health and criminal history data from 14 consenting clients in the Public Defender's Office (Charlotte, North Carolina).[9] The researchers collected both archival data (mental health and criminal history information) and also administered a questionnaire. The questionnaire screened participants for the presence of mental illness, a substance use disorder, and a developmental disability.

Characteristics of Referral Population

In the month between December 3, 2003 and January 7, 2004, 113 offenders from Mecklenburg County were admitted to jail with a criminal charge. Most of the offenders fell between 30 and 50 years old, and most (58%) had misdemeanor charges. Of these 113 cases, 14 (12%) were receiving mental health services at the time of arrest. All of these offenders had a either a major mental illness or borderline intellectual functioning. The diagnoses in this group were psychotic disorder NOS (1), major depression (1), schizoaffective disorder (3), schizophrenia (8) and borderline intellectual functioning (1). Although this data indicates that at least 12% of offenders have mental health problems, the degree of treatment compliance and presence of a criminal history is unknown.

Of the 13 participants in the study of Public Defender clients, seven (54%) had an identifiable history of mental health assessment or treatment ("MH Group") as opposed to six (46%) ("non-MH Group") who did not. These groups differed on criminal and mental health dimensions.

On average, the MH Group had more re-arrests (5.86 vs. 2.83) than the non-MH Group, and all of those in the MH Group were charged with a felony, versus 66% of those in the non-MH Group. Drug violations were common in both groups but more so in the MH Group (100% vs. 67%).

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[9] Davis, C. & J. Gambrell, II. (in preparation). Impact of Mental Health Courts on the legal system.

Examination of mental health records indicated that most of those in the MH Group (71%) had a substance abuse diagnosis only. The screening instrument results corroborated this such that the MH Group scored significantly higher (3.00 vs. 1.83) on the Need for Alcohol or Drug Addiction Services scale. The results suggested that the screening instrument may effectively differentiate between the needs of those in the MH Group versus those in the non-MH Group.

Given the small number of participants and the use of a convenience sample, the results in this study are not necessarily representative of the Mecklenburg County offender population. However, this study does suggest that many clients served by the Charlotte Public Defender's Office are repeat offenders with a mental health history. It also suggests that many of these offenders have primarily a need for substance abuse treatment.

Program Goals and Implementation

Several years ago, an interdisciplinary Planning Committee was formed to design and implement a MHTC to facilitate better utilization of jail resources and more appropriate care for offenders with mental health problems. Several members of the committee were familiar with the DTC format and with other MHTCs, but many members of the committee expressed concerns that these court formats might not suit the needs and resources of Mecklenburg County. As a result, the committee sought to include broad representation from the agencies and organizations that might be interested in and affected by a Mecklenburg MHTC. The committee included representatives from the local DTC, the Sheriff's Department, the Division of Community Corrections, the police department, the Area Mental Health Authority, the public defender's office, private attorneys, the Criminal Magistrate, superior and district court judges, the Court Clerk's office, the Department of Criminal Justice at UNC-Charlotte, a Trial Court Administrator, Victim Assistance, and a victim advocacy group. Initially, the primary systems involved (criminal justice and mental health) had little knowledge of the workings of the other, so cross-trainings were conducted, and these were perceived as being helpful.

After gathering information, visiting courts, and discussing implementation options, the group is now in the process of finalizing these decisions. The group has developed clear eligibility criteria, admissions and graduation policies, and has established a court treatment team. The group is still discussing the types and timing of sanctions and incentives, the specifics of the MOU, and the termination policy.

Although a court team has been formed and is currently serving several mentally ill offenders, the MHTC has not yet formally met. The first court date is scheduled for February 25, 2005. The court anticipates being able to serve seven more offenders with its current funding commitment.

Referral/Eligibility/Admission

The MHTC Team will consider referrals from any source, but the Team primarily expects to receive referrals from the District Attorney, Public Defender, jail, and representatives from the mental health system. The eligibility criteria include residential, legal, and clinical requirements. In order to be eligible, the offender must live in Mecklenburg County, be legally competent, and have a misdemeanor

or non-violent felony charge[10]. In addition, the offender must have an Axis I diagnosis (see Appendix A for definition) as the primary problem and be willing to participate in treatment. Axis I diagnoses include a broad range of problems and levels of functioning. Although this criterion leaves open the possibility of treating an offender for an adjustment disorder, the program expects to target individuals with more seriously disabling mental health problems, such as schizophrenia, bipolar disorder, and major depression. The Team expects to make exceptions on occasion, but the District Attorney would be the final "decision-maker" and public safety would be considered primary.

Team Composition

The Team has already begun to meet informally and currently meets weekly to discuss the MHTC cases. The Team includes a dedicated Judge, Public Defender, ADA, and Case Manager. In addition, the DTC Counselor is participating.

Depending on the specifics of the Unified Case Plan (UCP), the Team plans to meet weekly or bimonthly with the participant to discuss the individual's progress and needs. These meetings generally include the core treatment staff but not always the Judge.

These meetings are described as having a "team atmosphere" in which everyone has the opportunity for input. Court and mental health information is shared at the Team meeting because there is no information system to allow access to both. For now, the MHTC is using the DTC's MIS system, and the case managers are entering treatment and compliance information into a separate mental health data management system.

Service Provision

The Planning Committee has solicited support from the community to provide necessary services. Even so, interviewees expressed some concern about the availability of both mental health and housing services. Already, the team has noted a lack of therapy groups for those diagnosed with both severe mental health and substance abuse disorders (Dual Diagnosis). With state-initiated changes in mental health service delivery, the availability of even existing services could change. Ideally, the MHTC would like to hire a dedicated treatment provider, but it currently lacks sufficient funds for this.

Court Decisions

The length of the program has not yet been set, and two options have been discussed. One option is to establish a fixed program length, i.e. 12-18 months, and the other is to graduate participants once they become psychologically stable, following at least six months of compliance.

Unlike the DTC, the Mecklenburg MHTC plans to individualize its sanctions and incentives based on the specific needs and resources of each participant. The Team anticipates using the Unified Case Plan as the guideline for treatment and sanction and incentive decisions. The Judge would follow recommendations made by the Team and formally administer the sanctions or incentives at the next court date.

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[10] Weapons charges, a pattern of violent activities, a history of sexual violence, DWI, Drug Trafficking, and domestic violence charges automatically rule out an offender.

The Planning Committee and court team has not yet decided how to define the extent of non-compliance that justifies termination. However, the team anticipates establishing guidelines for this soon. It is also in the process of establishing graduation procedures and rewards.

Conclusions

Strengths

- The Planning Committee for the Mecklenburg MHTC researched MHTCs and the implementations that are considered best practice. Based on this information and local agency input, it has carefully planned its court's operations. It has also anticipated and attempted to resolve potential implementation barriers.
- Although the court has not officially started, through the MHTC Planning Committee, the court has already established community support and relationships with supporting agencies.

Weaknesses

- Given changes in the state's delivery of mental health services, which might affect service access, the court believes it needs a dedicated service provider on the Team. Currently, it does not have the resources to pay for this position.
- Specialized mental health services, especially for the Dually Diagnosed are lacking.

Recommendations

- The MHTC might benefit from using a mental health screening instrument to speed and standardize the process of eligibility determination. The instrument used in the Davis and Gambrell study, detailed previously, might be considered.
- Establish a stable, long-term source of funding for the court to allow for long-term strategic planning.

Buncombe County

Methods and Procedures

Data collection involved interviews with two local judges (Judge Ronald Payne and Judge Gary Cash), a review of the Buncombe Alternatives grant proposal for a Mental Health Treatment Court, and letters of support from local mental health social service organizations. Interviews were conducted over the phone with Judge Ronald Payne, who presides over the Superior Court DTC and Judge Gary Cash, the Chief District Court Judge. Buncombe Alternatives, Inc. provides alternative sentencing for intermediate punishments, and it is the organization that initiated the grant. The interviews, grant proposal, and letters of support provided information about the perceived need for and feasibility of implementing a mental health treatment court.

Mental Health Treatment Court: Perceived Needs and Implementation Difficulties

The Judges cited several logistical reasons for not yet implementing a mental health treatment court. First, they do not believe that establishing a Mental Health Treatment Court in Buncombe County is feasible until a decision is made about where to house that program within the Buncombe Court system. Second, they reported having inadequate staff resources to set up another treatment court. By necessity, the priorities have been to attain permanent funding for the Superior Drug Treatment Court, which currently receives no state funding for its operations, and to set up the District Family Court, funding for which was provided in the 2004 Short Session of the General Assembly, prior to implementing another treatment court.

Both Judges agreed that a mental health treatment court could be helpful, especially for the dually diagnosed and homeless mentally ill. However, one expressed concern over whether a Mental Health Treatment Court in Buncombe, a rural county with a changing mental health care structure, would provide a good match between benefit and cost and needs and resources. As a result, they suggested that an evaluation of the needs and available community resources would be a useful first step. This could provide information about the feasibility of and/or structure for a mental health treatment court.

The alternative sentencing and local social service agencies seemed convinced about the need and potential success of a mental health treatment court. Service providers in Buncombe County were very supportive of the possibility of establishing a Mental Health Treatment Court in the county, and most identified recidivism and lack of adequate treatment for offenders with mental illnesses as problematic. The Buncombe Alternatives agency attempted to secure funding through a grant proposal and matching County Commissioner funds; however, the grant did not receive approval and therefore the matching funds were lost as well. Although all of these agencies see a clear need, they also perceive inadequacies in the changing mental health care system.

Overall Conclusions and Recommendations

This process evaluation sought to provide the information that would permit at least preliminary answers to the following questions. These answers are based on interviews and other data gathered from the Orange County CRC, and Mecklenburg County court, and Buncombe County.

1. **What is the need for MHTCs in North Carolina?**

   Everyone interviewed asserted that mentally ill offenders cycle through the system repeatedly and use jail and criminal justice resources at a rate that is disproportionate to the public threat caused. In addition, this group does not receive the mental health services it needs. By connecting the criminal justice and mental health systems, resources can be more appropriately utilized. Without a MHTC, the court system is unable to address the needs of offenders who do not meet criteria for the DTC but who have mental health or substance abuse problems to address. Also those with a dual disorder (severe mental health and substance use disorders) are not well served by the current system.

2. **What are the benefits of implementing a MHTC?**

   Collecting outcome data was beyond the scope of this evaluation; however, correlational data suggests that MHTCs can establish good compliance and stability with the SPMI (severely and persistently mentally ill) group. The use of jail is reduced, which leaves this resource more available for those

offenders who pose a true danger to public safety. In addition, the criminal justice system may benefit from reduced recidivism.

MHTCs improve communication between the criminal justice and mental health systems. Ultimately, this can facilitate the more appropriate use of resources. Furthermore, these courts provide the potential for more mentally ill offenders to receive needed mental health and substance abuse services.

The findings of this study suggest that the CRC is a well-implemented program, highly praised by both consumers and Team members. However, an outcome study is recommended as a means of exploring the effects of MHTCs on individual outcomes and system outcomes (cost and resource management).

3. What are the challenges to implementation?

Several factors challenge the implementation of these courts. The lack of stable funding inhibits planning and can interfere with the provision of court and/or mental health services. State changes in mental health care delivery makes unclear what mental health services will be available and by what means they will be accessed. There are large numbers of offenders with mental health problems, and it is unclear which groups can best be served by MHTCs. Should mental health treatment courts include all repeat offenders with a mental health or substance problem, or should certain groups be prioritized? Conducting an outcome study could be helpful in providing information to answer this question.

4. What financial and community service resources are available to treat this population?

Many, and perhaps most, of the participants served by MHTCs are individuals with mental health problems targeted for services by the NC DMH/DD/SAS. However, this does not guarantee that appropriate mental services can be accessed easily or quickly. Although some of the needed mental health services may be funded, the availability of these services and of other community services is frequently inadequate and can vary by county. Although counties do vary in the social service and financial resources that are available to a MHTC, all counties seem to suffer from inadequate housing and inadequate access to evidence-based and specialized services for certain mental health and substance abusing populations.

Availability may also vary by setting, i.e. urban versus rural. Plans to start MHTCs in more rural counties might benefit from a feasibility study in such settings. It cannot be assumed that MHTC implementation serving a densely populated, service-rich area will be identical to that which works best in a sparsely populated area with fewer available resources. The Orange County CRC offers the most experienced and knowledgeable staff in the state. As this court plans to extend services to a more rural county – Chatham – it may need to implement its program differently. Conducting an implementation study of this court might provide information about the changes necessary for successful implementation in a rural setting.

Appendices

Multi-axial Diagnostic Assessment

A complete diagnostic assessment results in five types of information. This information is recorded on Axes I–V. The first two Axes pertain to different types of mental health and substance use disorders. Axis III lists general medical conditions that might affect a client's emotional or cognitive health, behavior, and/or overall functioning. Axis IV lists psychosocial and environmental problems that affect or relate to the primary focus of treatment, and Axis V represents an assessment of the client's overall level of functioning. For this evaluation, only information from Axis I, Axis II, and Axis V were available.

Axis I includes most mental health and all substance use disorders. Unless otherwise specified, the first disorder listed on Axis I is the primary focus of clinical attention, i.e. treatment. Axis I disorders include both those that primarily affect infants, children, or adolescents and those that are typically diagnosed in adulthood. Delirium, Dementia, Mental Disorders due to a General Medical Condition, Substance-related Disorders, Schizophrenia and other psychotic, mood and anxiety disorders are examples of disorders that would be listed under Axis I. Personality disorders and Mental Retardation are not recorded on Axis I.

Axis II diagnoses include all Personality Disorders and the diagnosis of Mental Retardation. These disorders are classified on Axis II to ensure that appropriate attention is given to these disorders when present. They may or may not be the primary focus of treatment. Maladaptive personality "features" may also be included on this Axis.

The overall level of client functioning is recorded on the Global Assessment of Functioning (GAF) scale on Axis V. The range of the GAF is 1 to 100, with 100 representing the optimal level of functioning. A client with a GAF score of between 91 and 100 would have no psychiatric symptoms and would likely exhibit "superior functioning in a wide range of activities"[1]. At the other end of the scale, an individual with a GAF score of between 1 and 10 would be in "persistent danger of severely hurting [himself or herself] or others (e.g. recurrent violence) OR [show a] persistent inability to maintain minimal personal hygiene OR [have committed a] serious suicidal act with clear expectation of death"[11].

Definition of Severe and Persistent Mental Illness (SPMI)

Severe and Persistent Mental Illness (SPMI) is not a specific diagnosis but rather a category of diagnoses and problems. No standardized criteria exist for defining SPMI; however, experts agree that it involves a combination of diagnostic severity, degree of disability, and duration of problems.

States vary in how they define the specific criteria necessary for SPMI determination. North Carolina uses the following definition without reference to specific diagnoses:

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[11] Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision (DSM-IV-TR). American Psychiatric Association: Washington, DC, 2000.

> Adults with severe and persistent mental illness are individuals, age 18 or older, who as a result of a mental disorder, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services, of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation.

In the determination of SPMI status, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services relies primarily on the assessment of overall functioning as defined by having (or having had) a GAF score of 40 or less.

Other states, such as Alabama, do reference specific diagnoses. Having a severe mental health diagnosis (only certain ones qualify) combined with an inability to perform basic daily tasks related to everyday living (such as cooking and grooming) and/or demonstrated dysfunction in social relationships and/or employment qualifies a person for SPMI status in Alabama. The disorders considered "severe" by that state's criteria include Schizophrenia (or another psychotic disorder), a major mood disorder (including Bipolar and Major Depression), and/or a severe anxiety disorder, such as Panic Disorder with Agoraphobia or Obsessive-Compulsive Disorder.

<u>Definition of Dual Diagnosis</u>

"Dual diagnosis" is a term typically used to describe the co-occurrence of a severe mental illness and a substance abuse disorder. The co-occurrence of these disorders can be very difficult to treat, and the term is frequently used in the mental health services literature to describe this very specific population and highlight their dual treatment needs.

Race	Gender	Diag1	Desc1	Diag2	Desc2	Diag3	Desc3	Diag4	Desc4	DiagSum
W	M	304.3	SA (cannabis)	295.3	schizophrenia	296.21	major dep			Dual Dx
B	M	296.32	major dep	305.2	SA (cannabis)					SA +
B	M	298.9	psychotic NOS	304.2	SA (cocaine)					Dual Dx
W	M	301.6	pers d/o	298.9	psychotic NOS					Severe
B	M	295.9	schizophrenia	304.8	SA (poly)					Dual Dx
B	M	301.7	pers d/o	295.7	schizoaffective					Severe
W	M	301.9	pers d/o	303.9	SA (Alcohol)					SA +
W	F	296.9	mood d/o NOS	305	SA (Alcohol)					SA +
W	M	317	MR (mild)	301.83	pers d/o	303.9	SA (Alcohol)			MR
B	F	309.24	adj d/o	296.32	major dep					Other
W	F	296.7	bipolar	303.9	SA (Alcohol)					Dual Dx
W	M	296.7	bipolar	296.4	bipolar					Severe
B	M	304.2	SA (cocaine)	305	SA (Alcohol)					SA only
B	M	318	MR (mod)	311	dep NOS	312.34	explosive d/o			MR
B	M	317	MR (mild)	301	pers d/o					MR
B	M	303.9	SA (Alcohol)	305.2	SA (cannabis)	304.2	SA (cocaine)			SA only
W	M	312.82	Conduct d/o	314.01	ADHD					Other
B	M	313.8	ODD vs. Identity	296.2	major dep					Other
W	M	314	ADHD	304.9	SA (other)	296.3	major dep			SA +
W	M	305	SA (Alcohol)	296.9	mood d/o NOS	295.3	schizophrenia			Dual Dx
W	M	303.9	SA (Alcohol)	304.2	SA (cocaine)					SA only
B	M	305.6	SA (cocaine)	304.8	SA (poly)	305.2	SA (cannabis)			SA only
W	M	311	dep NOS	313.8	ODD vs. Identity	309.81	PTSD			Other
W	M	303.9	SA (Alcohol)	304.2	SA (cocaine)	296.22	major dep			SA +
B	F	296.32	major dep	304.2	SA (cocaine)					SA +
W	F	304.8	SA (poly)	295.7	schizoaffective	303.9	SA (Alcohol)			Dual Dx
W	F	300	missing data	303.9	SA (Alcohol)					SA +
W	M	309.3	adj d/o	318	MR (mod)	317	MR (mild)			MR
W	M	295.7	schizoaffective	304.2	SA (cocaine)	305.19	SA (nicotine)	305.16	SA (nicotine)	Dual Dx
B	F	300.21	agoraphobia	296.3	major dep	305.6	SA (cocaine)			SA +
W	M	301.7	pers d/o	304.8	SA (poly)	303.9	SA (Alcohol)			SA +
B	M	303.9	SA (Alcohol)	304.2	SA (cocaine)	304.3	SA (cannabis)			SA only
W	M	296.6	bipolar	305	SA (Alcohol)					Dual Dx
B	M	295.3	schizophrenia	301.7	pers d/o	305.9	SA (other)			SA +
W	M	314.01	ADHD	317	MR (mild)	296.3	major dep	309.28	adj d/o	MR
W	M	295.7	schizoaffective	298.9	psychotic NOS					Severe
W	M	296.31	major dep	303.9	SA (Alcohol)	300	anxiety NOS			SA +
W	M	296.2	major dep	301.83	pers d/o					Other
W	F	298.9	psychotic NOS	303.9	SA (Alcohol)	296.32	major dep			Dual Dx
W	M	295.7	schizoaffective	305.9	SA (other)	304.2	SA (cocaine)			Dual Dx
B	M	303.9	SA (Alcohol)	304.2	SA (cocaine)					SA only
W	M	304.3	SA (cannabis)	309	adj d/o					SA +
B	F	Unknown	Unknown							unknown
B	M	295.32, 295.30	schizophrenia							severe
B	M	304.3	SA (cannabis)							SA only

W	M	303.9	SA (Alcohol)							SA only
B	M	304.3	SA (cannabis)							SA only
B	M	303.9	SA (Alcohol)							SA only
W	F	301.83	pers d/o							Borderline PD
B	M	303.9	SA (alcohol)	305.2	SA (cannabis)					SA only
W	M	305	SA (Alcohol)							SA only
W	M	799.9	pers d/o (rule out)	303.9	SA (Alcohol)					SA only
W	M	300.4	dysthymia							Other
W	F	305.2	SA (cannabis)							SA only
B	F	Unknown	Unknown							unknown
W	M	296.3	major dep							Other
B	M	295.7	schizoaffective							severe
W	M	299	autism							severe
W	F	303.9	SA (Alcohol)							SA only
W	F	295.3	schizophrenia							severe
B	F	295.9	schizophrenia							severe
B	M	305	SA (Alcohol)							SA only
B	M	Unknown	Unknown							unknown
W	M	Unknown	Unknown							unknown
W	M	305	SA (Alcohol)							SA only
B	F	296.32	major dep							Other
W	M	Unknown	Unknown							unknown
W	M	304.3	SA (cannabis)							SA only
B	M	314.01	ADHD							Other
W	M	295.3	schizophrenia							severe
W	M	302.4	exhibitionism							Other
W	M	V62.81	ational problem NOS							Other
W	M	304.8	SA (poly)							SA only
W	F	296.32	major dep							Other
B	F	303.9	SA (Alcohol)							SA only
W	M	309.4	adj d/o							Other
W	F	296.23	major dep							Other
W	M	Unknown	Unknown							unknown
U	M	295.9	schizophrenia							severe
W	M	304.8	SA (poly)							SA only
W	M	309.4	adj d/o							Other
W	M	295.3	schizophrenia							severe
W	M	303.9	SA (Alcohol)							SA only
W	M	309.28	adj d/o							Other
W	F	296.7	bipolar							severe

Table_Satisfaction with Aspects of Orange County Community Resource Court

COMPONENT		STATISTICS		RESPONSE FREQUENCY			
	n	Mean	Standard Deviation	Very Unsatisfied	Unsatisfied	Satisfied	Very Satisfied
1. Frequency of court appearances	25	3.36	0.757	4%	4%	44%	48%
2. Interactions with the judge	25	3.40	0.645	0%	8%	44%	48%
3. Interactions with the drug court team	16	3.13	0.885	6%	12.5%	43.8%	37.5%
4. Cooperation of agencies with each other	24	3.38	0.770	0%	16.7%	29.2%	54.2%
5. Substance abuse treatment services	14	3.50	0.519	0%	0%	50%	50%
6. Mental health treatment services	21	3.52	0.512	0%	0%	47.6%	52.4%
7. Vocational treatment services	12	3.33	0.888	8.3%	0%	41.7%	50.0%
8. Other services received	15	3.53	0.516	0%	0%	46.7%	53.3%
9. Drug testing	9	3.33	0.707	0%	11.1%	44.4%	44.4%
10. Sanctions received	10	3.00	0.816	0%	30%	40%	30%
11. Community service activities	11	3.36	0.504	0%	0%	63.6%	36.4%
12. Pro-social court-organized activities	13	3.31	0.855	7.7%	0%	46.2%	46.2%
13. MHC program overall	23	3.43	0.788	4.3%	4.3%	34.8%	56.5%
				Not at all	Somewhat	Very	Completely
14. Protection of overall rights	23			4.3%	26.1%	34.8%	34.8%

Table_Ease or Difficulty in Completing Requirements of Orange County Community Resource Court

REQUIREMENT		STATISTICS		RESPONSE FREQUENCY				
	n	Mean	Standard Deviation	Very Difficult	Difficult	Somewhat Hard	Easy	Very Easy
1. Making it to court appearances	25	1.92	1.038	4%	0%	24%	28%	44%
2. Attending CRC treatment program	21	2.19	1.167	4.80%	9.50%	19%	33.30%	33.30%
3. Cooperating with CRC program	23	1.83	1.072	4.30%	4.30%	8.70%	34.80%	47.80%
4. Taking medication regularly	12	1.42	0.515	0%	0%	0%	41.70%	58.30%
5. Attending SA treatment services	15	1.73	0.704	0%	0%	13.30%	46.70%	40%
6. Cooperating w/ SA treatment services	16	2.06	1.181	6.30%	6.30%	12.50%	37.50%	37.50%
7. Attending other services	17	2.24	1.437	17.60%	0%	5.90%	41.20%	35.30%
8. Going to drug testing	8	2.63	1.598	25%	0%	12.50%	37.50%	25%
9. Cooperating with drug testing	8	2.38	1.302	12.50%	0%	25%	37.50%	25%
10. Attending meetings w/ prob. officer	10	1.80	1.033	0%	10%	10%	30%	50%
11. Attending meetings w/ case manager	17	1.94	1.144	5.90%	5.90%	5.90%	41.20%	41.20%
12. Attending AA/NA meetings	11	2.64	1.804	27.30%	9.10%	9.10%	9.10%	45.50%
13. Participating in AA/NA meetings	9	2.22	1.481	11.10%	11.10%	11.10%	22.20%	44.40%
14. Paying court fees	10	3.40	1.647	40%	10%	20%	10%	20%
15. Paying court fines	12	3.58	1.564	41.70%	16.70%	16.70%	8.30%	16.70%
16. Staying away from bad influences	20	1.90	1.119	5%	5%	10%	35%	45%
17. Staying clean and sober	21	2.14	1.195	9.50%	0%	19%	38.10%	33.30%
18. Staying crime-free	23	1.65	1.027	4.30%	0%	13%	21.70%	60.90%