

**City of Seattle
Seattle Municipal Court**

Mental Health Court

Evaluation Report

September 5, 2001

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Acknowledgements and Information About the Authors

This evaluation was conducted at the request of the Mental Health Court to help assess whether the court's new approach to handling cases involving mentally ill persons creates a positive impact in the lives of those charged, crime victims and the larger community, and effectively uses taxpayer dollars. Dr. Eric Trupin, Dr. Henry Richards and Dr. Carole Bruschi of the University of Washington conducted the evaluation, partnering with David Wertheimer of Kelly Point Partners in the instrument development, writing and non-subject research. These evaluators brought national-level expertise on mental health courts to the SMC review. Eric Trupin is Professor and Vice Chairman of the Department of Psychiatry and Behavioral Sciences and Director of the Division of Public Behavioral Health and Public Policy at the University of Washington School of Medicine. Henry Richards is Assistant Professor in the same department and division, as well as a member of the faculty of the Washington Institute for Mental Illness Research and Training. Carole Bruschi is a research scientist with a specialty in policy implications of violence prevention programs. David Wertheimer, who has worked in the mental health and criminal justice fields for the past two decades, was actively involved with the mobilization of the continuum of criminal justice and treatment services available to offenders in King County (Washington), and has worked as a consultant with numerous jurisdictions around the United States on jail diversion and court-related offender programs for persons with mental illness and chemical dependency problems. An Evaluation Advisory Committee comprised of court staff provided technical assistance and input to the evaluators.

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Seattle Municipal Court Mental Health Court 2001 Evaluation

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2001 MHC Evaluation Report

Executive Summary

The purpose of this report is to provide an evaluation of the operations of the Seattle Municipal Court (SMC) Mental Health Court (MHC). Since its inception in March of 1999, the MHC has provided services to more than 1000 individuals with serious mental illnesses who have been charged with misdemeanor criminal offenses in the city of Seattle. Highlights of the findings and recommendations detailed in the body of this report include the following:

- The MHC is serving its designated target population
- For the sample of MHC defendants studied in this evaluation, the number of new bookings decreased significantly subsequent to their MHC involvement
- Although the reincarceration rate for MHC defendants is approximately 62% in the first year, only 32% are reincarcerated for charges filed after MHC referral
- For the same sample of defendants, the average number of jail days served per booking increased if these individuals were re-booked into jail subsequent to their MHC involvement
- The MHC is effectively linking mentally ill individuals who are charged with misdemeanor offenses to needed mental health services
- MHC participation is associated with significant increases in the number of treatment episodes received after referral compared to the number received prior to MHC involvement
- For MHC defendants, participation in the MHC improves their likelihood of ongoing success with treatment, access to housing or shelter and linkages with other critical supports

For those who have not spent time observing a mental health court, when considering MHCs, it is necessary to erase the image and understanding of how more traditional courts operate. MHCs and “traditional” criminal courts are as different as, for example, a bankruptcy court and juvenile court. Mental health courts are not simply criminal courts that have been modified by grouping similar cases on a single calendar or soliciting input from a mental health professional. They are specialized “problem-solving” courts designed to serve the needs of mentally ill misdemeanor defendants

by working to *decriminalize* mental illness, while still protecting public safety and emphasizing offender accountability. They focus on how to *avoid* imposing incarceration while ensuring effective linkage to treatment.

Mental health courts are premised on the knowledge that many persons with mental illness repeatedly interact with the criminal justice system primarily because of behaviors that are manifestations of their mental illness. They operate from the belief that victims, defendants and the community at large would often benefit more from the engagement of defendants in treatment than from traditional adjudication of charges that fails to address the defendants' underlying mental illnesses.

This is achieved through a team approach in which the judge, attorneys, probation staff and mental health professionals all work collaboratively, sharing information to determine what type(s) of intervention and diversion can be most helpful to the defendant, victim and community. Assessment information is gathered at the earliest possible stage. Court hearings are not focused on legal motions and trial strategies, but rather on concrete defendant outcomes. Case managers and family members are actively involved in court proceedings. The judge does not simply rule from "on high," as it were, but actively leads the team, is familiar with each defendant's abilities and challenges, and keeps the team members working together to sustain an ongoing relationship with each defendant over many months, to promote both legal compliance and clinical stabilization. To do this, dedicated judges, prosecutors, defenders and court staff remain consistently involved with each defendant over the life of his or her involvement with the court (up to two years for SMC MHC).

These critical elements – a team approach, early intervention, assessment and information sharing, an emphasis on defendant-based (in contrast to case-based) outcomes – all have as their goal long-term problem solving for the defendant that reduces the likelihood of re-offense and re-incarceration. All of the participants in the courtroom play a role in securing for each defendant the treatment that has the potential to be most helpful and have a collective responsibility to help each defendant succeed in fulfilling court and treatment obligations.

The above elements are frequently cited as principles in the research around "problem solving courts". As these courts attempt to resolve chronic underlying causes of criminal behaviors, the role of the court itself becomes center of a debate about its involvement in moving from the traditional role into roles previously addressed by non-judicial systems, such as social services and specialized treatment. The resulting tensions scrutinize (1) the activities of the court moving from providing a process for dispute resolution to becoming a service provider intent on a specific outcome for those over whom it exercises control, (2) judges serving in non-traditional roles which

call into question the objectivity of the system (e.g., the Code of Judicial Conduct requires judges to avoid the appearance of bias and to deter *ex parte* communications), and (3) the blurring of distinctions in the separation of powers between judging, administering and case management of defendants.¹

The evaluation that follows explores both the process and organizational issues that have been critical to the creation and sustaining of the Seattle MHC, as well as outcomes for individuals who have been referred to the MHC.

Because the MHC represents a multi-system, integrated effort, one of the challenges faced by this evaluation has been assessing the impact of the larger organizational environments on the ability of the MHC to succeed. While the evaluation focused on the operations of the MHC, the evaluators recognize that the court system, criminal justice system and mental health system in which the MHC functions have the potential to diminish or dilute the MHC's effectiveness as profoundly as they can help sustain it.

It is precisely because the court represents a cross-systems integration effort that the MHC is highly susceptible to changes in other systems and to the impact of the larger fiscal and political environments. We find that even since the evaluation activities commenced in early 2001, significant changes to the key systems outside the MHC's range of immediate influence have created a potential challenge to the MHC's continuing effectiveness.

County revenue shortfalls have resulted in proposed reductions in both the criminal justice and treatment arenas for 2002. Within the publicly funded mental health system, projected reductions of more than \$42 million over the next six years in treatment provider contracts threaten the capacity of the mental health system providers to enroll and serve individuals referred to them by the MHC. Significant cuts to the jail and criminal justice budgets portend equally dramatic cuts in the services available from those stakeholder systems.

Although support for the institutionalization of the MHC is strong on the part of the City's and County's Legislative and Executive branches, support for funding, staffing and space for the MHC within the Municipal Court bench remains mixed.

The findings of this report suggest that the MHC offers a model distinct from existing practices that has the potential to reduce the demand for jail

¹ For more discussion, see "Problem-Solving Courts: A Fad or the Future". Conference of Chief Justices Conference of State Court Administrators (Aug 2000), COSCA Resolution In Support of Problem-Solving Courts.

services while promoting positive outcomes for defendants and the public. If the various systems that have facilitated the creation of the MHC fail to sustain their respective commitments, the resulting elimination of the MHC may further exacerbate the problems of jail overcrowding, recidivism of mentally ill offenders and the lack of viable options for victims and families that existed prior to its creation.

The Evaluation of the Seattle Municipal Court Mental Health Court (MHC)

Introduction

The information and recommendations presented in this evaluation are addressed to judges, policy-makers, criminal justice personnel and those interested in the development and evolution of Mental Health Courts as an alternative to current criminal justice practices involving mentally ill persons. It is our intent that this evaluation will provide a deeper understanding of the unique nature of the MHC approach and guidance in the application of those principles and practices that this research demonstrates have important effects on defendants and their families, victims and the public.

Mental Health Court Case Vignette

Mr. Jones is a developmentally disabled man in his 40's with a mental health diagnosis of Major Depression. He was referred to the MHC following charges of assault against his elderly and blind mother with whom he lives. MHC team members talked with neighbors, who reported concern for some time regarding the situation of Mr. Jones being developmentally disabled, at home all day every day, prone to angry outbursts, and providing the only assistance for his elderly mother.

Mr. Jones was remorseful about the incident, and there was no prior criminal history. There was also no history of mental health or developmental disability services for Mr. Jones. The MHC Court Monitor initiated contact with a mental health provider with experience working with clients with developmental disabilities. Mr. Jones agreed to MHC Conditions that also included anger management counseling, and was linked to specialized job training and placement services for Developmentally Disabled individuals. He was allowed to return to his mother to continue her care, as long as he complied with his MHC conditions. In addition, Mr. Jones' mother was linked with Services for the Aging.

Mr. Jones and his mother appeared at his review hearing where she, the Court Monitor and the case manager told the MHC Judge that Mr. Jones was now well connected with services and had followed through with all of his obligations. He had attended anger management sessions, began a trial of anti-depressant medications, obtained a job with the help of DD services, and regularly met with his case manager. There had been no additional incidents. The neighbors were also pleased with Mr. Jones' success. All parties agreed that the MHC intervention had addressed the underlying issues and the case was dismissed.

Over the past three years, mental health courts have emerged as a new and innovative tool for helping to address the growing crisis of persons with mental illnesses incarcerated in local jail systems in the United States. These courts use models of "therapeutic jurisprudence," a growing jurisprudential methodology that has emerged since the mid-1980's.¹ In essence, this approach to court proceedings enhances the roles of judges, lawyers and courts to produce therapeutic results for individuals involved in the legal system, rather than simply

¹ Wexler, David B.(1990). *Therapeutic Jurisprudence: The Law as a Therapeutic Agent*. Durham, NC: Carolina Academic Press.

addressing the legal aspects of the proceedings. Courts that utilize this approach are often referred to as “problem-solving” courts.²

“Problem solving courts” have common elements that distinguish them from traditional courts. The most central characteristic is the court’s use of its authority to forge new responses to chronic social, human and legal problems that have proven resistant to conventional solutions. They seek to broaden the focus of legal proceedings, from simply adjudicating past facts and legal issues to an early intervention into the behavior of litigants. And they attempt to fix broken systems, making courts (and their partners) more accountable and responsible to their primary customers – the citizens who use the courts every day, either as victims, jurors, witnesses, litigants or defendants.³

Problem solving courts originated with the Dade County (FL) drug court in an effort to address the problem of drug-addicted criminal recidivism. The results attracted national attention and provided the environment for other courts to think “outside the box” with this population; currently more than 500 drug courts exist around the country.

In addition, the drug court experience provided momentum for testing this new approach with other chronic problems. Using the problem-solving philosophy, Manhattan (NY) initiated Midtown Community Court which targeted misdemeanor “quality-of-life” crimes (e.g., prostitution, shoplifting, low-level drug dealing, etc.). The positive outcomes energized numerous jurisdictions around the country and replications popped up in large and small jurisdictions. As these courts proliferated, the models evolved, responding to specific local needs. Prime among these needs have been youth courts (Red Hook NY), abandoned property courts (Memphis TN), “community court” where court is conducted in the community at neighborhood centers (Portland OR), domestic violence courts (Brooklyn NY) and mental health courts.

As of mid-2001, there were fewer than fifteen Mental Health Courts nationwide.⁴ Seattle was among the first cities in the country to establish mental health courts.⁵ Despite the relative

² The Community Justice Exchange provides a chronology dating from 1979 when “problem solving approaches” were first promoted. The 1980’s saw the development of domestic violence courts, drug courts and community courts. In 1996, Marion County, Indiana, started the Psychiatric Assertive Identification Referral/Response (PAIR) Program in Indianapolis, which many considered to be the nation’s first mental-health court. This Indiana initiative is a comprehensive pre-trial, post-booking diversion system for mentally ill offenders. For example, see Feinblatt, John, Berman, Greg, and Sviridoff, Michelle (1998). *Neighborhood Justice: Lessons From the Midtown Community Court*. Washington, DC: National Institute of Justice. <http://www.courtinnovation.org>.

³ Berman, Greg, and Feinblatt, John. (2001) “Problem-Solving Courts: A Brief Primer”, *Law & Policy* 23.

⁴ Taylor, Nancy M. *Post-Booking Diversion: Mental Health Courts Provide a Hands-On Therapeutic Approach*. Mental Health Issues Today issue (Vol 5, No 1). Lists mental health courts in Broward Co, FL; King County, WA; San Bernardino, CA; Anchorage, AK; Toronto, Ontario; Seattle, WA; Honolulu, Hawaii; Indianapolis, IN; Brooklyn, NY; and Akron and Butler Counties, OH; in addition to a MHC initiative in Santa Clara, CA.

⁵ Two slightly different models of MHCs are currently operating within the county, one in the King County District Court and a second in the Seattle Municipal Court. Seattle Municipal Court has jurisdiction over misdemeanor crimes committed within Seattle city limits and District Court handles those offenses occurring outside the city but within the county. Misdemeanors in Washington State are crimes punishable by up to one year in jail and a \$5,000 fine.

scarcity of these courts, they have generated significant attention at the national level. Both the Executive (Department of Justice) and Legislative (Congress) branches of the federal government have begun to mobilize strategies to analyze and replicate mental health court models across the nation.⁶ Ten state legislatures had some sort of mental health court-related legislation proposed since January 2001.⁷

The Seattle Municipal Court (SMC) Mental Health Court (MHC) sought resources to conduct this evaluation, recognizing that an evaluation of its effectiveness could help not only its future operation, but could also help inform the national debate, providing policymakers and funders with some degree of empirical data on which to base their decisions. The purposes of this evaluation were 1) to set the SMC MHC in the national context of mentally ill offenders; 2) to document the evolution of the MHC and identify lessons learned; 3) to describe the MHC and evaluate its operations; 4) to create baseline data along with preliminary findings for defendant outcomes and plan for the next phase of evaluation; and 5) to discuss issues of sustainability.

Part I of this evaluation provides a contextual overview, including the societal and criminal justice issues that led to the development of the Seattle Municipal Court MHC.

Part II describes the overall environment in which this MHC functions, including the funding mechanisms, treatment systems, competency laws and structure of the local court system that are distinct from those of many other localities and which can significantly impact the operation of a “problem-solving” court.

Part III looks at the basic principles that guide the MHC, how it operates, and how it is distinct from traditional courts.

Part IV provides a summary of our findings with regard to process and organizational issues, based on court observations and extensive interviews with key stakeholders and staff from multiple systems who are interested in or directly involved with the MHC.

Part V describes defendant-related outcomes based on an analysis of jail data and mental health system data.

Part VI contains recommendations based on our findings.

We recognize that this Mental Health Court is young with barely two years of operation at the time this evaluation was undertaken. We are also aware that the assignment of resources dedicated to this MHC has changed during the two years, reflecting the increased volume of cases served by the MHC in its current operations.

⁶ In 2000, President Clinton signed S.1865, the Law Enforcement and Mental Health Project Act, which received bipartisan support in both houses of Congress. It authorized the appropriation of up to \$10 million in grants in fiscal years 2001 through 2004 to fund up to 100 mental health courts. The Department of Justice is charged with developing the process for implementing that legislation.

⁷ The National Center for State Legislatures identified that, during 2001, legislative efforts were undertaken in the following states--New Hampshire, Oklahoma, Nevada, Illinois, New Mexico, Virginia, Minnesota, Pennsylvania, Massachusetts, and Iowa.

In addition to the many interview and data questions that we were asked to explore as evaluators, there are numerous other questions which could not be addressed in this evaluation because of lack of time, lack of resources, or the infancy of the court. SMC has begun identifying areas of interest to include in “a next phase” evaluation of the MHC. Key among these areas would be a longitudinal study of individual MHC defendants, behavioral variables which impact the bookings and the lengths of jail stay post-MHC referral, the assessment of jail costs, including avoided costs, for MHC defendants and what data elements would need to be captured to address the efficacy of the mental health system treatment provided to MHC defendants.

Part I. The National Context of Mental Health Courts

Since the mid-1960's and the rise in the availability of anti-psychotic medications, local mental health systems have been expected to carry the expanded caseloads that resulted from psychiatric hospital closures and de-institutionalization of persons with mental illness. Although the goal of helping people to live in the community was laudable, the resources required to effectively meet intensive service needs of clients released from more restrictive settings were never provided to the community mental health system. Without these resources, maintaining these individuals with severe forms of illness in the community remained a highly challenging task. Because of behaviors that are labeled as criminal (even though they are the by-products of mental illness rather than sociopathy), many mentally ill people have ended up either homeless or in the custody of the criminal justice system, or at times both. In short, many advocates now argue that the vision of de-institutionalization that was created decades ago has never been realized. Rather, experience and statistics suggest that the phenomenon is more accurately identified as "trans-institutionalization" – custody responsibilities for many of the most severely disabled persons with mental illness have shifted from psychiatric hospitals to local jails.

A variety of other causative factors have added to the growing national problem of incarceration of persons with mental illnesses.⁸ In recent years, ongoing care in many community based mental health systems has become more difficult to access for persons in crisis, due to the lack of insurance parity for mental disorders, insufficient public funding and the recent trend of using managed care systems to oversee service delivery and to control costs in the public sector. Narrow criteria for involuntary commitment also contribute to jail incarceration for persons in crisis; when access to involuntary treatment is limited, the demands for restrictive settings (such as jail) in which behaviors can be controlled increase. Additionally, when police officers without specialized training and without simple and accessible alternatives to jail face the stresses of dealing with people in psychological crisis, they are more likely to use jail than the hospital, where time-consuming assessment and admission procedures discourage police involvement.

"Jail diversion" is the term used to describe a variety of strategies that seek to reduce the rate and duration of incarceration of persons with severe mental illnesses. Different types of diversions target different points in the criminal justice system process. They can be categorized in three different groups: "Pre-booking diversion," "post-booking diversion" and "post-release linkages." Mental health courts are one type of post-booking diversion strategy.

"Pre-booking diversion" seeks to prevent persons with behavioral health problems from becoming involved with the court system by creating alternatives to arrest and jail booking. Rather than being arrested and jailed, police officers and others can link individuals in crisis directly to alternatives such as crisis triage facilities. Successfully diverted individuals have

⁸ H. Lamb & L. Weinberger, "Persons with Severe Mental Illness in Jails and Prisons: A Review," *Psychiatric Services*, April 1998.

no charges filed against them and do not face criminal court proceedings related to the incident for which they were diverted.

“Post-booking diversion” seeks to promote expedited linkage to mental health services for individuals who have been arrested and/ or booked and face the potential of further court involvement. Although individuals in this diversion category may face ongoing court involvement (through, for example, a mental health court), the goal of diversion is to remove the individual from the jail setting at the earliest opportunity and provide structured linkages to community-based treatment services in lieu of further incarceration.

“Post-release linkages” are not technically diversions, but seek to link persons coming from the “back end” of the criminal justice system (i.e., jail or prison) to treatment and supportive resources designed to provide an array of services and intensive monitoring to maintain stability and reduce the risks of recidivism. These individuals have usually completed sentences for specific offenses; the treatment linkage is part of a strategy to reduce the risks of recidivism.

These various options can be used individually but are most effective when they are part of an integrated system of response. For example, a police department Crisis Intervention Team is of limited use without a 24-hour, secure drop-off point (such as a crisis triage unit) for use by law enforcement officers. Similarly, a mental health court will be less successful without a mechanism for identifying and assessing persons with mental illness who are booked into jail. A post-release linkages project serving persons with mental illness coming out of jail or prison post-sentence will produce better outcomes if it maintains an ongoing connection to housing and substance abuse treatment services. The range of options that may be deployed within each category are identified in *Table 1: Criminal Justice Diversion Continuum*.

Criminal Justice Diversion/ Linkage Continuum

Locus of Diversion	Systems or Structures that Facilitate Diversion	Activities in Seattle Diversion Continuum
<p>Pre-Booking Diversion</p> <ul style="list-style-type: none"> • Family or Community Provider • Police/Law Enforcement 	<p>Community Treatment Teams: Teams that include families and other forms of natural support can help to identify and address acute episodes that might result in arrest without professional intervention.</p> <p>Police Crisis Intervention Teams (CIT): Teams of specially trained police officers dispatched to de-escalate situations involving mental health crises.</p> <p>Mobile Crisis Response Team: Cross-system team comprised of law enforcement and mental health professionals who can be dispatched as needed to respond to crises in the community involving persons with mental illness.</p> <p>Secure Drop-Off Point/Crisis Triage Services: Secure drop-off facility staffed by mental health professionals for use by police and others seeking alternatives to charging or booking mentally ill offenders into jail.</p>	<p>Community Treatment Teams: Teams that actively involve family members are not a feature of the local mental health system.</p> <p>Police CIT: The Seattle Police Department maintains a Crisis Intervention Team program with more than 200 specially trained officers and sergeants and a MHC liaison.</p> <p>Mobile Crisis Response Team: Mobile crisis response capacity is limited to County Designated Mental Health Professionals (for civil commitment evaluations).</p> <p>Crisis Triage: The County hospital (Harborview) maintains a secure Crisis Triage Unit.</p>
<p>Post-Booking Diversion</p> <ul style="list-style-type: none"> • Jail • Courts 	<p>Jail-Based Screening and Assessment: Capacity within the jail to identify persons with significant mental health problems at time of booking or while in jail custody and provide assessments by jail-based mental health professionals.</p> <p>Real-Time Notifications: Mechanism to identify to mental health providers within 24 hours of incarceration those individuals receiving community-based mental health services who have been booked into jail.</p> <p>Mental Health Court (MHC): Capacity to divert individuals with mental health disorders who are charged with criminal offenses to an alternative that includes “therapeutic jurisprudence” as the foundation of the court process. Includes dedicated judge, prosecutor, public defender, court monitor and probation staff.</p>	<p>Jail-Based Screening: Capacity exists to identify persons with mental illness through use of jail-based Psychiatric Evaluation Service (PES) staff.</p> <p>Real-Time Notification: Mental health providers are notified electronically within 24 hours when enrolled consumers are jailed. County policies do not yet require immediate follow-up to these notifications.</p> <p>Mental Health Court: MHCs operate at the Seattle Municipal Court and King County District Court levels.</p>
<p>Post-Release Linkage</p> <ul style="list-style-type: none"> • Specialized Programming 	<p>Jail-Mental Health Linkages: Capacity to make referrals from the jail to community mental health services for individuals being released from custody who are not under the jurisdiction of a Mental Health Court.</p> <p>Specialized Probation Services: Presence of dedicated probation staff with mental health expertise to provide ongoing supervision of offenders with mental illnesses.</p> <p>Corrections-Mental Health Linkage: Opportunity to link offenders being prepared for release from state correctional custody to specialized, community-based services for mentally ill offenders (including those with co-occurring substance abuse disorders).</p>	<p>Jail-Mental Health Linkages: The capacity for Psychiatric Evaluation Service staff in the jail to make referrals to mental health providers exists in policy, but is rarely exercised in practice.</p> <p>Specialized Probation: Specialized probation counselors with mental health expertise are assigned to the two MHCs.</p> <p>Corrections-Mental Health Linkage: A pilot project serves 25 state-level offenders who have been released to the community.</p>

The emergence of Mental Health Courts reflects a growing recognition among judges, policy-makers, prosecutors, defense counsel and others who are involved in the criminal justice and mental health systems that the traditional methods of arrest, incarceration, and probation have done little to address the cycle of recidivism, especially when that incarceration does not include treatment or other intervention into the underlying causes of the behavior.

Although mental health courts are a response to these frustrations, they have not developed without major debate within a branch of government that is understandably cautious about innovation. Core judicial values -- certainty, reliability, impartiality and fairness -- have been safeguarded over generations, largely through a reliance on tradition and precedent. As a result, efforts to introduce new ways of doing justice are subjected to careful scrutiny. Critics have questioned the results of problem solving courts and their ability to preserve the individual rights of the defendant. While the academic literature continues to emerge, a number of areas of potential tension between this new brand of jurisprudence and traditional practices have been identified.⁹

While that debate is happening in the legal/ judicial community, at the same time criminal justice professionals have come to realize that incarceration alone does little to reduce the huge numbers of persons with mental illness in our nation's jails and prisons, and little to aid the families and communities who turn to the courts for help in dealing with the impacts of behaviors that are the manifestation of mental illnesses.¹⁰

Available national data reinforces this perspective. In 1960, approximately 559,000 persons were in state hospitals for the mentally ill across the United States. As of 1999, the number was fewer than 60,000. Meanwhile, national reports indicate that of the almost 850,000 homeless persons in the U.S., approximately 1/3, or about 300,000, suffer from a serious mental illness. The National Alliance for the Mentally Ill estimates that 25 to 40% of America's mentally ill will at some point come into contact with the criminal justice system. And 75% of those individuals will have had at least one prior conviction in addition to their current sentence. Similar data is repeatedly cited as the prompt for the development of a "problem solving court", in this instance mental health courts.

Recent research underscores the high incidence of mental illness and co-occurring substance abuse among jail detainees. In local jails throughout the United States, approximately 16.3%

⁹ Berman, Greg, and Feinblatt, John. Op. Cit. The authors cite the following topics of potential tension: coercion (What procedures exist to ensure a defendant's consent to participate is fairly and freely given?), zealous advocacy (Is advocacy in this court more or less zealous than in a traditional court?), structure (Do these courts give greater license to the judges to make rulings based on their own idiosyncratic worldviews rather than the law?), impartiality (As judges become better informed about specialized classes of cases, is their impartiality affected?), paternalism (Are judges in these courts imposing treatment regimes without reference to the complexity of individuals' problems?), and separation of powers (Do these courts inappropriately blur the lines among the branches of government?).

¹⁰ National Institute of Corrections (2001). *Special Topics: Mentally Ill in Corrections Settings*. http://www.ncic.org/services/special/mentally_ill. Also, The Center on Crime, Communities & Culture (1996). *Research Brief: Mental Illness in US Jails: Diverting the Non-violent, Low-Level Offender*. <http://www.soros.org>.

of detainees have some form of serious mental illness. Of these individuals, two-thirds report co-occurring alcohol or drug-use at the time of their offense.¹¹

In King County, the local jail incarcerates on average more than 250 mentally ill people on any given day, making it the equivalent of the state's second largest psychiatric institution; the average length of stay for mentally ill offenders in the King County jail is 28 days, while for non-mentally ill offenders it is 17 days.¹² Many of these individuals have been through court and jail systems multiple times over periods that range from months to years. Apart from the devastating human toll associated with this problem, the fiscal cost of these individuals to the taxpayer of Seattle includes \$139 for each jail booking and almost \$64 per person for each incarceration day.¹³

¹¹ U.S. Department of Justice (1999). *Mental Health and Treatment of Inmates and Probationers*. Bureau of Justice Statistics Special Report.

¹² Source: King County Correctional Facility Dept of Adult & Juvenile Detention Statistics 1999.

¹³ Source: City of Seattle Budget Office

Part II. The Environment in which the Seattle MHC Functions

The Local Court System

The Seattle Municipal Court Mental Health Court operates in a complex local environment, many aspects of which make the creation and ongoing operation of a multi-disciplinary, multi-system court such as the MHC particularly difficult. Washington State does not have a unified court system. Each county may have both municipal and district courts which are courts of limited jurisdiction, operating within cities and unincorporated county areas respectively, and a superior court, the felony level trial court. While the city of Seattle is the largest city in the county and in the state,¹⁴ the Seattle Municipal Court is one of 30 courts operating within the County. The Seattle Municipal Court, the King County District Court and the King County Superior Court are located within a two-block radius. The Seattle Municipal Court is funded by the City of Seattle, and adjudicates misdemeanor offenses that occur within the city. The District and Superior Courts are funded by the county and the state, adjudicating misdemeanor cases that occur in the unincorporated areas of the county or felony offenses respectively. None of these courts are linked by technology or case-sharing systems that allow for consolidation of cases when a defendant has cases in multiple courts or in multiple jurisdictions.

Local Correctional System

Most cities in Washington State do not maintain their own local jail facilities, but instead contract with the local county for the provision of jail services. The King County Department of Juvenile and Adult Detention (DJAD) operates several correctional facilities from which the City purchases jail bed capacity. The facilities housing adult offenders are the King County Correctional Facility (KCCF) in downtown Seattle (approximately 1700 inmates)¹⁵ and the Regional Justice Center (RJC) (approximately 1400 inmates) in the city of Kent, about 23 miles southeast of Seattle.

The most severely mentally ill offenders are housed in the KCCF, which is where most of the psychiatric staff is located. Jail psychiatric staff report to the Director of the KCCF, while jail health staff report to a different agency, the Seattle-King County Health Department. Jail staff in charge of decisions about transportation of mentally ill defendants to and from medical facilities and psychiatric facilities are not part of either the jail psychiatric services division or the jail health division. Each staff group maintains its own policies, practices, procedures, staffing assignments and confidentiality rules. Jail health staff provide services to offenders in all locations of the jail, while jail psychiatric staff serve primarily those offenders in the psychiatric unit.¹⁶ Offenders who are mentally ill but who do not present

¹⁴ The population of King County is approximately 1.7 million, with roughly one third of these individuals (575,000) living within the city of Seattle.

¹⁵ This includes the central KCCF as well as capacity at North Rehabilitation Facility (NRF), work release and electronic home detention.

¹⁶ Bed capacity for Jail Health Unit/Infirmary is 40. While the Jail Psychiatric Unit has a bed capacity designation of 150 beds, on a recent day its population census was 173 and other sites in the jail had been shifted to accommodate Jail Psych beds.

with easily identifiable signs of psychosis at booking or who appear not to be in immediate need of specialized psychiatric services are housed in the jail's general population units and not in the psychiatric unit, and thus are not observed directly by psychiatric staff.

Forced medications are not required for any offender if that offender chooses not to take medication, since the jail is not a licensed mental health treatment facility and has no statutory or policy authority to compel medication compliance. At present, neither drug treatment (beyond a limited methadone program for those already enrolled prior to arrest) nor mental health treatment nor discharge planning are available in or provided by the jail.

Mental Health and Substance Abuse/Chemical Dependency Treatment Systems

King County has statutory responsibility for the management of community-based mental health and substance abuse treatment services. The City receives no funding for the provision of these services nor does it have any oversight role in the provision of care. Oversight of these services is provided by the Mental Health, Chemical Abuse and Dependency Services Division (MHCADS) of the King County Department of Community and Human Services (DCHS). Funds for these services are secured largely from Federal, State and a limited number of County sources. The County's MHCADS, in turn, contracts with United Behavioral Health (UBH), a for-profit managed care organization, to manage the service contracts with a network of 17 mental health agencies that provide direct client mental health services.

The County is designated by the state as a "Regional Support Network" (RSN). Within the RSN, a "Prepaid Health Plan" (PHP) provides a range of services to individuals meeting medical necessity and financial eligibility requirements. Individuals can be authorized for different "tiers" of care that represent different intensities of service. The levels of service provided and the quality of those services are overseen by UBH. The mental health professional assigned to the MHC, known as the Court Monitor, is an employee of UBH, rather than SMC or the MHC or MHCADS, in order to have the ability and authority to access client information, ensure provider compliance with client referrals and maintain quality of service.

Psychiatric hospitalization is provided in three primary locations. At the local level, Harborview Medical Center (the County hospital), West Seattle Psychiatric Hospital and Fairfax Hospital¹⁷ provide both voluntary beds and bed capacity for individuals who are involuntarily committed under the state's civil commitment statute. Access to the involuntary beds is controlled by County Designated Mental Health Professionals (CDMHPs), employees of MHCADS, who authorize detentions for involuntary commitment evaluations. At the state level, the County has access to inpatient beds at Western State Hospital, largely limited to persons ordered to longer-term inpatient commitments or for

¹⁷ In addition to being the county hospital, Harborview Medical Center is equipped to handle difficult (e.g. violent, medically compromised, etc.) Involuntary Treatment Act (ITA) commitments. King County purchases additional inpatient capacity at West Seattle Hospital. Fairfax Hospital is licensed to provide short-term ITA services for both juveniles and adults but is not used as frequently as the other two hospitals.

evaluations/restorations to competency. [See discussion of competency and commitment issues below]

Substance abuse and chemical dependency services are also managed by the County's MHCADS, but the funding mechanisms for these services are quite different from those of the PHP. The State maintains a contract with the County for a range of categorical services, and the County in turn contracts with 30 local providers offering community-based substance abuse and chemical dependency treatment at 37 different service sites. Agencies are reimbursed on a fee-for-service basis rather than through a tier-based managed care formula. The State maintains a significantly higher degree of oversight and involvement of local substance abuse services than of local mental health services.

For individuals diagnosed with both mental health and chemical dependency needs, integrated treatment plans must be developed either by agencies that maintain dual certification and offer care for persons with co-occurring disorders, or must be negotiated and constructed across agency and system lines. The latter process is cumbersome at best, and MHCADS is currently seeking to expand integrated care for dually diagnosed individuals; the different funding and reimbursement methodologies maintained by the State mental health and substance abuse systems make this work extremely challenging. In addition, each system maintains an independent data system that prevents either system from providing comprehensive cross-system data analysis without extensive effort on the part of in-house information system specialists and without negotiation of inter-agency working agreements.

Residential chemical dependency treatment is provided in two different settings. The Cedar Hills Addictions Treatment Facility (CHAT), located 27 miles southeast of Seattle, is operated by the County and provides 208 residential treatment beds to individuals throughout Washington State. As of July 2001, 64 of these beds are for women. County policy at the present time does not allow for persons with significant mental illness to be admitted to CHAT if their mental illness has not been stabilized. Additionally, CHAT is non-secure and is not a custody facility, thus being inappropriate for some types of court referrals and offenders.

Pioneer Center North (PCN), located several counties to the north of King County in Sedro-Wooley, is the state's only facility for the provision of residential treatment services for individuals who have been committed under the auspices of the state's drug/alcohol involuntary commitment statute.¹⁸ It has 115 beds. To access these services, state statute requires that an individual must have failed treatment at least two times before being committed to PCN, even if it is a voluntary (or stipulated) commitment.

The overall bed capacity of these mental health and chemical dependency treatment facilities is extremely limited. Dedicated beds for offenders with mental illness are even scarcer. In part because of limited capacity and in part because policies restrict access to these longer-term beds, the MHC has been provided access to 20 'respite' or short-term beds for persons with mental illness. These beds and the 3.0 FTE staff who provide case management and support services for persons in the respite program are funded jointly by King County

¹⁸ See RCW 70.96A.140. Involuntary commitment of persons incapacitated by chemical dependency.

MHCADS and the Seattle Department of Human Services. The beds are located in a shelter in downtown Seattle, and are operated by the city's largest shelter provider, the Downtown Emergency Service Center (DESC). There are 14 beds for men and 6 for women. Use of these beds is shared with the County's Crisis Triage Unit (CTU)¹⁹ and the King County District Court MHC. Because the two MHCs and the CTU see a high volume of cases involving persons with both mental illness and unstable housing, the demand for these respite beds is heavy.

Competency and Civil Commitment Laws

In Washington State, modifications to competency laws for misdemeanants became effective in 1999, as a result of the same incident that precipitated the creation of the MHCs. [See Part III below.] Courts of Limited Jurisdiction such as the Seattle Municipal Court now are required to order a competency evaluation for any misdemeanant whom the judge believes may lack an understanding of the charges against him²⁰ or be unable to assist in his own defense.

If the Court finds, after an evaluation, that a defendant is incompetent, the case must be dismissed, unless the defendant has committed a violent act in the past or as part of the current charge. If the defendant meets the "violent act" criteria, then the Court must order restoration treatment, which may include forcibly administered medications, if there is no less intrusive alternative, for a period not exceeding 29 days, less the days used by the evaluation (usually 7-15 days). After the restoration period, if the Court finds the defendant remains incompetent, then the case must be dismissed.

Upon dismissal of a case because of incompetency, the Court is required, where appropriate, to order that the defendant be referred directly to a County Designated Mental Health Professional (CDMHP) or to Western State Hospital for an assessment as to whether the defendant meets the criteria for involuntary civil commitment, defined as having a mental illness and being unable to care for self or at risk of harm to self or others.

Once a CDMHP is advised that a person may be in need of commitment, the CDMHP makes the threshold determination as to whether to pursue commitment proceedings and the County prosecutor makes the final determination. The threshold for meeting the criteria is quite high, and the prosecutor must prove to a Superior Court judge or commissioner that involuntary commitment is warranted. Civil commitment proceedings are within the jurisdictional authority of the Superior Courts, where there is a different prosecutor, public defender and judge than in the criminal matter.

¹⁹ The CTU, operated by Harborview Medical Center under contract to MHCADS and UBH, provides crisis stabilization services for up to 24 hours to persons with behavioral health problems, operating 24 hours a day, 7 days a week. The CTU is designed to provide opportunities for diversion from psychiatric hospitalization as well as diversion from police arrests and bookings into the County jail. Approximately one-third of the 600+ individuals brought to the CTU each month are referred by law enforcement professionals. Upward of one-third of the individuals served by the CTU are homeless.

²⁰ For purposes of reading ease, the masculine pronoun is used in this report.

If a defendant suffers from a significant mental illness and refuses to take medications, the criminal court cannot order him to take medications unless competency is at issue, and then only for the period of time allowed by law for restoration. If the criminal court is concerned that the defendant's behavior is or could soon put him or others at risk, the court can only refer him to the CDMHP for consideration of possible civil commitment proceedings.

Information Sharing and Confidentiality

The complexity of the system described above is made even more complex by policies and statutes that limit the sharing of information across multiple systems. Separate state laws govern the release and dissemination of client-specific data about mental illness and chemical dependency treatment. Federal laws (e.g. 42 CFR, Part 2) further limit information sharing among provider agencies and across service systems. As various courts seek to develop effective offender interventions for individuals with mental illnesses and substance abuse treatment needs, it is essential that the court system respect individual privacy related to medical treatment needs and function within the constraints of statutes governing confidentiality of medical information. Yet because the MHC is so involved with sorting out offender involvement with many treatment systems (e.g. police, jail, jail psychiatric services, jail health services, mental health services, substance abuse services, the County hospital, homeless services, etc.), these legal restrictions have a severe impact on the ability of the court to gather and evaluate information about defendants in a coherent and timely fashion.

Part III. The Seattle Municipal Court Mental Health Court

Local Events that Led to the Creation of the MHC

In 1997, a mentally ill man, who had recently been released from jail after having committed a misdemeanor theft of a bicycle, stabbed and killed a retired Seattle firefighter who was leaving the local baseball stadium with his family. While the incidence of violence by many of those who are mentally ill is less than for other types of offenders,²¹ this incident prompted a wave of concern about the lack of coordinated strategies and information for mentally ill persons in the criminal justice system and the lack of effective alternatives. Because the County has local responsibility for the jail as well as the provision of mental health services, this critical incident prompted the King County Executive to convene the Mentally Ill Offender (MIO) Task Force. Comprised of criminal justice officials, leaders in the mental health community and others,²² the goal of the Task Force was to look at ways to address more effectively the treatment needs of this population.

The Task Force, in 1998, recommended three new strategies:

- 1) The creation of a ‘crisis triage unit’ (CTU) at Harborview Medical Center, the site of Seattle’s largest emergency room;
- 2) The development of a program known as HOST (Homeless Outreach and Stabilization Team) to connect homeless mentally ill persons with shelter and mental health services; and
- 3) The creation of a specialized Mental Health Court (MHC).

A work group of the MIO Task Force, including the SMC then-presiding judge who also presided over the in-custody arraignment calendar, began to research and explore a King County MHC, including a site visit to Broward County, Florida, site of the nation’s first Mental Health Court. Upon return, the SMC judge convened a similar work group as had King County to explore a SMC MHC.

In late 1998, King County adopted the Task Force recommendations and moved forward to implement each of these recommendations. The Task Force’s recommendation had been for a single MHC. While the County was ready to quickly move ahead,²³ the Seattle Municipal Court, cautious about accepting both the MIO Task Force mandate and the MHC model, continued to explore options and discuss alternatives, including the creation of its own MHC.²⁴

²¹ Bonta, J., Law, M., & Hanson, K. *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta Analysis*. 123 Psychological Bulletin 123, 139 (1998).

²² The SMC presiding judge represented the Municipal Court on this Task Force.

²³ The County Executive had convened the Task Force, endorsed the recommendations and directed his staff to move quickly to plan and implement the recommendations.

²⁴ SMC was seriously impacted by significant organizational crises during this period. An innovative and energetic court administrator experienced severe health problems and died in Nov 1999. A lengthy national search took several months to complete during which an interim administrator managed the day-to-day operations. Programs in development at this time (e.g., Revenue Recovery and Relicensing) continued but new initiatives were handicapped by the leadership transition during this time. In addition to this crisis in the court’s organization, state voters adopted I-695, a tax limiting initiative, which resulted in immediate impacts to the

As the mental health court model moved toward development in the Seattle Municipal Court, the concept received broad endorsements from the Seattle Police Department, prosecutors, public defender agencies, elected officials and social service agencies. However, despite this initial agreement on the concept, these endorsements did not include a clear consensus on the full range of principles and practices to be utilized by the court. In addition, although the District Court secured funding from a variety of sources and dedicated staff to support its mental health court development and operations, the needed funding, staff and courtroom for the Municipal Court program was not sought by SMC. Concurrently King County MHCADS shifted the funds for the existing city/ county Jail Alternative Services Program to support Court Monitor positions in the King County SMC and in SMC's yet-to-be-defined MHC.

In early 1999, the SMC judges adopted a MHC proposal on a 4-phase "pilot" basis, including adoption of the core elements seen in the Broward County model (i.e., dedicated staff, space, court, etc). The proposal offered a specific "virtual" plan for the MHC operations (such as court being convened at 11 AM daily for in-custody defendants and at 9 AM Fridays for out-of-custody defendants, the roles and activities of a MHC Probation Officer, the roles and activities of the dedicated defense and prosecutors, etc. as well as 3- and 12-month evaluations), most of which were not realized.

At this same time, a SMC judicial vacancy occurred and the arraignments court (and no-longer presiding) judge accepted a new assignment. When the MHC began operating in March of 1999, a newly appointed judge was on the bench and a newly assigned Court Monitor was in the courtroom. While SMC had adopted the MHC proposal, the necessary elements for the MHC were not in place. Although the prosecutor's office and the public defender agencies verbally supported the MHC principles, establishing specific formal operational protocols proved more challenging and, without having a dedicated defense agency, the MHC defense social worker position was non-existent.

Without new funding, the MHC judge worked with court staff and stakeholders from allied systems in collaborative efforts across multiple systems to support the development and implementation of the MHC. This included overseeing the creation of policies and procedures, development of training materials, development of automated coding for data collection and numerous other implementation activities, in addition to full time judicial responsibilities for the arraignment calendar.

Unique challenges to the mobilization of the court resulted from the fact that, as described above, unlike the County, the City did not have jurisdiction or control over the jail, the mental health treatment system or the substance abuse treatment system. Developing successful MHC operations required that extensive time be dedicated to establishing and maintaining relationships with key partners from other systems, developing new systems and processes, integrating technology and training personnel. Over the months that followed, the work of implementing a MHC, while continuing to design it and get core elements in place, continued to present a complex and challenging set of ongoing tasks.

city's budget. A staff position for a mental health probation counselor which had been previously authorized was frozen, delaying the addition of this position for 9 months.

MHC Philosophy and Structure

MHCs have two significant philosophical predicates: First, that mental illness is an organic medical condition and if individuals with mental illness are untreated, insufficiently treated or refuse treatment, behaviors that our society considers inappropriate or that are in violation of the law may be manifested by some individuals. The best way to keep this type of behavior from reoccurring is to help ensure appropriate treatment. Traditional criminal justice sanctions such as incarceration do not address the underlying cause of the problem, and in fact often exacerbate it due to lack of access to medications, interruption of case management services and possible loss of benefits and housing. MHCs work for safe diversion of misdemeanor defendants who are mentally ill, utilizing, whenever possible, a non-sanction based, treatment approach which tailors a defendant's treatment conditions to meet his individual needs and circumstances.

The second core philosophical foundation of the MHC is that courts have a larger responsibility to the public than simply processing cases as courts have done for some time. MHCs are part of a decade long movement toward making courts more accountable to the public, with an emphasis on treatment intervention, on problem solving instead of litigation, and on long term solutions instead of short term wins and losses. MHCs are based on a core belief that what is in "the best interests" of the defendant, the victims and the general public goes beyond a conviction or dismissal of the legal matter. MHCs seek to address the root causes that contribute to the involvement of the defendant in the criminal justice system in the first place. They involve the community and family in the court process, bring service providers into the courtroom and the jail to rapidly connect defendants with needed assessments and services, have staff working to help defendants succeed from the earliest point of entry and then strive to help defendants with whatever aspects of their lives pose barriers to their successful reengagement with the community.

Because of this philosophical foundation, MHCs require the development and implementation of practices and systems that are different than those still used by most courts. And since MHCs operate within a larger court environment, these differences in philosophy and approach can lead to additional challenges that come with being the proverbial "round peg in a square hole." What follows is an overview description of how Seattle's MHC has changed traditional court operations to make operational its commitment to the core MHC philosophy. The chart in the appendix to this evaluation report illustrates the caseflow process for the MHC.

To begin with, MHC defendants have every hearing in the same courtroom with the same judge, same attorneys and same courtroom staff involved with them from their point of entry into the court for as long as they participate in the MHC. The MHC by definition utilizes a team approach, involving a dedicated judge, prosecutor, defense attorney, mental health professional (called a "court monitor") and two probation staff with mental health expertise.²⁵

²⁵ Only three of these positions are actually funded and dedicated; the Mayor and City Council have provided dedicated funding for the Court Monitor and the two MHC probation staff. The other members of the team (Judge and attorneys) as well as the MHC court staff (clerks, bailiffs, marshal) currently handle the daily arraignment calendar in addition to the MHC.

To the extent possible, the players shed the traditional roles, move beyond the legal formalism of the traditional court and look for the best life outcome, rather than simply the best legal result. They work to link defendants to treatment, housing and other support systems and then monitor the defendants for adherence to treatment conditions over a period of time. All members of the MHC team, including the judge, share responsibility for a defendant's success or failure.

The MHC concentrates not only on the offense, but attempts to ascertain and address the root causes of the defendant's behavior through linkage to an intensive supervision and treatment program. The goal of the MHC is to reinforce the value of and adherence to treatment, using a range of sanctions and incentives tailored toward each defendant's needs, abilities, progress and level of risk to self or others in order to achieve twin goals of public safety and treatment compliance. The intervention is immediate and the adjudication process is comparatively non-adversarial in nature.

The MHC judge sits at the heart of the collaborative and individualized approach. The judge must be keenly aware of the court's underlying philosophy at all times – lack of consistency in approach can derail the MHC's effectiveness at virtually any stage of the court process. The approach of using a single judge consistently leads to a familiarity with each defendant and case, allowing the judge to know what approaches, tenor, demeanor, incentives and sanctions can be most effective with each defendant. In addition to the legal authority wielded by the judge, the effective MHC judge must be able to function in the roles of cheerleader, advisor, director, parent, and disciplinarian – each at the right time and to the right degree.

The MHC model also modifies the traditional role of the prosecuting attorney. Within the MHC, the prosecutor is no longer the detached enforcer who seeks the maximum conviction and maximum sentence permitted by the court. The MHC prosecutor works from an understanding that jail time without treatment intervention does not increase public safety or reduce recidivism. The effective MHC prosecutor recognizes that linking defendants with serious mental illness to treatment will ultimately reduce recidivism, increase public safety and decrease the cost of mentally ill defendants to the system. The MHC prosecutor advocates for sanctions where the defendant fails to comply, but is cognizant of the defendant's mental health diagnosis, the efforts to comply since entering the MHC and the level of risk presented by the defendant.

In a parallel fashion, the defense attorney must likewise step away from the adversarial mindset in which the best interests of the defendant is getting a case dismissed, or getting a client released without restrictions or winning a case on technicalities or appeal. In the MHC model, the defense counsel ensures that the defendant understands the nature of his legal rights, the requirements that come with participation in the MHC and the possible consequences of failure to comply with the court's order. The effective defense attorney seeks to help the defendant succeed over time, rather than simply win the particular motion before the court at a particular point in the adjudicative process. The goal for the public defender is to help the client achieve a more successful life, avoiding as much as possible any future, additional interactions with the criminal justice system.

The MHC model includes a “new player” to the courtroom proceedings, the mental health professional known as the Court Monitor. The function of this critical team member is different from the traditional roles of mental health professionals in court proceedings. In the MHC model, the court monitor is a “1st responder”, the initial point of contact for defendants. He assesses which defendants should be referred to the MHC, quickly gathers information about mental health diagnosis, treatment compliance, family interaction, and chemical dependency issues. He contacts treatment providers to promptly get them reconnected with their clients or, when no treatment connection exists, he directs the linkage to immediate treatment services. He interacts with jail psychiatric and medical staff, civil commitment personnel, state hospital staff on a daily basis, helping to share information and make seamless service connections. The Court Monitor makes recommendations to the MHC judge for release, diversion or sentence conditions, advocating his position side by side with the attorneys.

The MHC model includes a new role for probation counselors (PCs) as well. They too are participants on the team and part of the daily courtroom activity. They begin learning about the defendant at the first hearing, are there when the MHC judge tells the defendant what is expected of him and are introduced to the defendant by the judge at time of sentencing. They set his first appointment time before he leaves the courtroom.

One concern expressed by advocates for the mentally ill about the creation of MHCs is that they may unintentionally stigmatize those who participate. The MHC has sought to be respectful and thoughtful about this issue. The MHC has designed and implemented a variety of strategies to help address the issue of stigma. Because court dockets are public information, they state hearing types (as well as conditions) as “MHC,” rather than “mental health court.” The MHC team refers to the “2 P.M. calendar” or “the afternoon calendar” rather than the “mental health court,” particularly when defendants are less comfortable with the idea of MHC. Team members often say in competency hearings that “the defendant is unable to have his case go to trial,” rather than saying repeatedly “the defendant is not competent.” The judge incorporates the confidential Western State Hospital (WSH) evaluation reports into the record rather than reading that information aloud, as the hearings occur in a public forum in front of many people. The use of a pre-hearing conference is another significant way in which the MHC team has worked to reduce stigma. Team members review cases scheduled for that day prior to the court hearing. Details about a defendant’s diagnosis, difficulties and personal abilities are discussed in that conference rather than in open court where a public audience is present and a record is made. Treatment information is not kept in the MHC file, but in the files of the court monitor and probation staff. WSH evaluation reports are sealed.

Lastly, the MHC has sought to create a model that is defendant-based and oriented toward problem solving in accord with the established Trial Court Performance Standards.²⁶ The MHC consistently seeks to increase access to justice, to promote timeliness and expeditious-

²⁶ In August 1987, the National Center for State Court (NCSC) and the Bureau of Justice (BJA) of the U.S. Department of Justice initiated the Trial Court Performance Standards Project to develop a system to measure the performance of the Nation’s general jurisdiction state trial courts. There were 22 standards designed for use by trial courts to assess and improve their performance. SMC adopted the TCPS for use in 1999.

ness in case processing, to sustain public trust and confidence in the judicial process and to bring fairness to the administration of justice for persons being arrested on minor offenses who suffer from major mental disability.

The Seattle MHC Goals, Target Population and Case Processing

The goals of the Seattle MHC are to:

- Protect public safety,
- Reduce the use of jail and repeated interaction with the criminal justice system for mentally ill persons,
- Connect or re-connect mentally ill persons with needed mental health services, and
- Improve their likelihood of ongoing success with treatment, their access to housing or shelter, and linkages with other critical support.

From its inception in March of 1999 to the end of June of 2001, over 1,000 defendants were referred to the MHC.²⁷ Individuals referred may be charged with any type of Municipal Court offense, except Driving Under the Influence.²⁸

As the MHC considers each case that comes before it, the core issue is whether the alleged criminal behavior is related to or caused by the defendant's mental illness. The defendant:

- (a) may have any type of serious mental illness, be developmentally disabled, have a brain injury, or suffer from an aging disorder;
- (b) may be a first time offender or have a lengthy record;
- (c) may also be struggling with some form of substance abuse or chemical dependency; and
- (d) must volunteer to participate or "opt in" to the MHC.

Defendants who are not legally competent are automatically referred to the MHC for specific proceedings required by State law. If the defendant is later determined to be competent, he may volunteer to stay in the MHC or to have his case transferred to a regular court.

The first significant difference of the MHC process is the immediate intervention to secure information concerning defendants referred to the MHC. The MHC has developed several different methods by which defendants can be referred to the MHC within hours after booking.²⁹ As soon as possible after a defendant is booked into jail, and authorizes information to be shared, the Court Monitor, the mental health professional assigned to the

²⁷ This includes 286 defendants with MHC hearings in 1999; 464 in 2000 and 286 through June 2001.

²⁸ At the inception of the MHC, the SMC judges decided to exclude defendants charged with DUI primarily due to the statutory obligations required as part of DUI sentencing.

²⁹ In the MHC, the different ways in which cases are processed can emerge as early as the first point of contact between the defendant and the police officer responding to the reported offense. In such an instance, when a defendant is identified at arrest as possibly being mentally ill, the officer can include a recommendation on the booking report that the defendant be considered for MHC. The booking officer, in turn, forwards that information via computer to the court staff who set hearings, so that the defendant's case is automatically set in the MHC for the first appearance.

MHC, researches the defendant's history in the mental health system, and checks on the status of medication compliance, housing, family support, and language needs.

If the defendant is not enrolled in the mental health system, the enrollment process is immediately initiated by arranging an intake appointment. If the defendant is already enrolled in the mental health system, the case manager is contacted and notified of the arrest. The case manager provides information to the Court Monitor for an appropriate treatment plan to be presented to the MHC judge at the defendant's first court appearance, which will occur within 24 hours of the booking into jail. All other cases and obligations that the defendant has in SMC are quickly identified and are also addressed in the first appearance hearing.

Prior to this first hearing, the Court Monitor will have assessed whether the defendant is an appropriate candidate for the MHC. If the defendant is appropriate and agrees to participate in the MHC, the Court Monitor proposes an alternative to traditional handling of the case(s) with the primary emphasis on the underlying mental health needs. If a resolution of the case is not immediate at the first hearing, rather than setting routine bail, the MHC judge asks the Court Monitor to propose MHC conditions of release which require the defendant to comply with specific mental health treatment obligations until disposition of the case. These release conditions, monitored by the Court Monitor and/or case manager, include an appointment schedule for when to report to the mental health case manager as well as compliance with terms of the mental health treatment plan. Compliance reports and updates are provided to the court at each hearing, so the court continues to have confidence in the effectiveness of this "safety net" as the case proceeds.

If the defendant did not have housing when referred to the MHC, the Court Monitor can access short-term respite beds specifically set aside for this purpose at a near-by shelter. Additionally, case coordination with the King County Drug Court or King County District Court MHC begins and information about court obligations in other courts is gathered. Since the defendant is quickly connected or reconnected with mental health services, shelter and support, he will not spend more time in jail because of the mental illness than would other defendants. Because of the quick intervention and stabilization, allowing for pre-trial release, he will in fact often end up spending less time in jail than individuals not involved with the MHC.

If the defendant is also in need of drug or alcohol treatment, the Court Monitor makes a referral to appropriate resources with expertise in co-occurring substance abuse disorders. If in-patient treatment is needed and the defendant shows a desire to try this option, the Court Monitor is authorized to access designated, priority residential treatment beds to quickly get the defendant into specialized treatment designed to address co-occurring mental illness and substance abuse issues. [Note: The availability of these beds is, however, very limited by existing capacity in the treatment systems.]

Once a defendant "opts in" to the MHC, all future proceedings for all SMC matters are referred to the MHC. A formal protocol has been created by the MHC, working with staff from throughout SMC, to ensure that all MHC defendant matters that surface elsewhere in

the SMC, whether they are new filings, fines, infraction hearings or other obligations, are referred immediately to the MHC for the team to address with the defendant. That way a MHC defendant will not find himself arrested for failing to do something related to another, older case when he in fact is now engaged in treatment, staying out of trouble and doing precisely what the court would like to see happen. This bundling of cases also allows the MHC probation staff to assist the defendant with the myriad of obligations he may have, rather than only working with him on specific obligations ordered by one judge for one case.

The immediacy with which the MHC can function is a key to the court's success. MHC clients are seen quickly, report back frequently for reviews of treatment compliance and behavioral issues, and receive rigorous supervision and case management. For offenders under the MHC's jurisdiction, the court becomes a hub of linkage to services and monitoring of treatment.

Some defendants elect not to "opt in" to MHC when they are initially referred or may, upon receiving that initial assessment information, be determined not to have a significant mental illness or to have other issues that would limit their treatment involvement. The MHC nonetheless handles their case at that first hearing so that they will not be disadvantaged by their initial referral to the MHC. This "no wrong door" approach helps to encourage referrals from as many sources as possible. A traditional disposition, guilty plea or bail conditions are imposed, just as would occur in a non-MHC court. If a disposition or plea is entered, the MHC judge, having this early information, is then able to fashion a sentence or disposition that would be more precisely targeted to the defendant, rather than simply imposing the filing prosecutor's recommendation, made prior to any assessment. If the defendant pleads not guilty, the parties benefit by the information gathered from the Court Monitor for this initial hearing despite the case not staying in the MHC. This information can result in a more appropriate release or treatment recommendation than routinely proposed by the filing prosecutor.

The parties are also asked to note in their files the appropriateness or inappropriateness of various treatment or probationary obligations so prosecutors, defense attorneys or judges involved in future hearings can use it at time of sentencing, should there be a conviction or disposition.

Other defendants may not have evidenced symptoms of mental illness when their case began in the court system. In these instances, if the defendant is an appropriate candidate, he can choose at a later date to participate in the MHC. If a defendant is an appropriate candidate whose probation conditions were imposed by another SMC court, his "regular" probation counselor can recommend the case be transferred to the MHC for development of obligations which are more specific to the mental health needs and which include closer monitoring by the MHC Probation staff.

Whether a defendant "opts in" to the MHC at the first appearance, or after having difficulty with another case, or at the time of sentencing, he is engaged with the MHC for a period of up to two years.

The MHC also uses a different process for determining the court-ordered conditions. Upon release from custody and prior to disposition of the case, there is a set of conditions called “MHC Conditions of Release.” These include requirements of individualized treatment, medication compliance, no use of other drugs or alcohol, no weapons, staying in an appropriate respite program or housing, no harm or threats of harm, no violations of the law, no contact with victim, etc. When a defendant is not ready to enter into a disposition or it is unclear to the MHC team that he will initially be unsuccessful in complying, the MHC conditions of release allow for a shorter, immediate time period to “test” his abilities while under strict supervision of the Court. The Court Monitor proposes the conditions of release at the initial hearing, based on the assessment information and treatment linkages arranged since the defendant was booked. The defendant must comply with these until disposition of the case. At each hearing the MHC judge checks with the Court Monitor, case manager and defendant to ensure that he is following through as promised.

The “MHC Conditions of Sentence” is a similar set of obligations, entered into as part of a diversion agreement or guilty plea, with which the defendant must comply in its entirety, as long as he is working with the MHC. The obligations cannot be severed and are ongoing. Through this order, the defendant agrees to participate in the MHC and understands that he must comply with this set of obligations over the two-year period, including being monitored by the MHC probation staff.³⁰ The sentence or diversion agreement³¹ will include treatment obligations for this entire time, and MHC probation staff will intensively monitor the defendant. The monitoring begins in the MHC courtroom when the sentence is entered. The MHC judge reviews the obligations in detail with the defendant who then signs the agreement and is introduced by the judge to his MHC Probation Counselor (PC) who starts working with him in the courtroom, and continues throughout the duration of the jurisdiction.

The MHC PC already has some familiarity with the defendant since the PC participates in the initial decision for referral, and in the assessment discussion before the initial hearing. This early introduction to the defendant allows the PC to be familiar with the defendant’s diagnosis, criminal history, treatment compliance history, housing, chemical addiction, and degree of stability right from the start. Because the Court Monitor has initiated the connection to a treatment agency, the probation counselor begins coordination with the case manager right away, making for a seamless process. And since the probation staff is in the courtroom, the PC is able to review the order with the judge and, knowing the capacity of the defendant’s abilities and challenges, tailors a monitoring approach that will work best for that particular defendant.

The PC sets review hearings as often as are needed to help keep the defendant on track. The PC prepares a report for each review hearing that summarizes what the defendant has done well and/or not done, including an assessment of the cause of the success or failure. The PC

³⁰ Sample MHC Conditions of Release and Conditions of Sentence are included in the Appendix.

³¹ A diversion agreement in the context of the MHC is a variation of any of the following dispositions: dispositional continuance, stipulated order of continuance, deferred prosecution, pre-trial diversion, or guilty plea. The defendant complies with MHC Conditions of Sentence, rather than traditional court-ordered obligations, for a set period of time, in order for the charges to be dismissed.

coordinates with the case manager and/or housing provider and they join the PC at the defendant's review hearings whenever possible.

Review hearings may be for the purpose of acknowledging how well the defendant is doing, or for letting the MHC team know that he is doing well but starting to have difficulty in one area or another, or to propose a modification to better address a particular need, or to report his failing to comply. Because the purpose of the court is to divert mentally ill persons from incarceration to treatment and to prevent re-incarceration, the MHC PC and the team have to be creative, inventive and resourceful in proposing sanctions when a defendant fails to comply. It is expected that recommendations will include a mix of incentives and sanctions, with each team member understanding the abilities and nature of the defendant's mental illness, the current stability and engagement in treatment, and the progress the defendant has made since beginning his participation in the MHC.

Thus, MHC PCs do not take a passive role in the defendant's compliance but are pro-active in helping the defendant address any barriers to success. The PC's primary objective is the success of the defendant over the long-term. Understanding relapse and recovery signs and strategies, being familiar with the behavioral manifestations and side effects of medications (for instance, a defendant who takes medication with a drowsiness side effect would not do well with morning appointments) are critical areas of knowledge for the PCs as well as appreciating the limitations that the mental illness presents for each individual (such as a need to meet someone at the shelter or treatment agency rather than requiring them to meet on site at the probation office or knowing that sometimes it works better if the judge is the "enforcer" rather than the probation staff or case manager)

MHC PCs play a key role in matching treatment settings, interventions, and services to each offender's particular problems and needs. They understand that getting benefits, housing, family support and other "wrap around" services for a defendant are critical to the ability to remain engaged in treatment and avoid repeated arrest.

Collaboration and communication with community treatment providers on a frequent and regular basis about defendants is a necessary and critical component of MHC. Updates to the MHC judge on a defendant's progress may be daily if, in the discretion of the MHC probation staff, such frequent communication helps ensure the defendant's success. Communication between the MHC Court Monitor and MHC PCs and treatment providers may be daily, in person or by telephone, written memo, fax or email, in order to be as timely as possible. The MHC PCs make assessments about a defendant's ability to succeed, his need for extra support and attention, his ability to function independently, the value of frequent court interaction, the availability of familial support and other factors in making judgments about the frequency of status reports and the need for court action and intervention. Because the MHC is an individualized approach and because the MHC PCs have expertise in dealing with mentally ill persons, they continuously assess treatment and service plans for their defendants, updating the MHC judge as needed, and requesting modification of conditions as necessary to ensure that the plan meets the defendant's changing needs.

The treatment court model with intensive supervision and a hands-on role by the judge also means the probation staff prepare numerous status reports to the MHC judge, apprising her of changes in stabilization, of slippage in compliance, or other factors (e.g., in-patient treatment bed not available; defendant lost housing, etc.) which require attention and seek input or direction about how to respond.

If a MHC defendant fails to appear for a MHC hearing or fails to comply with MHC ordered conditions, a MHC warrant is issued. The MHC developed a separate warrant process, based on the knowledge that the sooner a defendant is reconnected with the court, the probation staff and treatment, the more likely it is he will remain compliant.

When a MHC warrant is issued, the defendant can have his case added onto any MHC calendar at any time to address the warrant, as soon as the next day. If a case manager, family member or the probation counselor can contact the defendant, they can counsel him to come to court on an out-of-custody basis to address the MHC warrant. A separate protocol has been established if the defendant reports to the warrant office. The warrant office sets the case only in the MHC, gives the defendant his paperwork, and notifies the MHC by fax so that the case can be heard quickly.

At the hearing, the MHC judge can hear from the case manager or family or defendant about the missed hearing. The judge, attorneys and PC at that hearing are members of the MHC team. They have attended every hearing for this defendant so they will be very familiar with him, his case and his obligations. The case proceeds with little delay and with little interruption in treatment.

If the defendant's warrant is not addressed as above, both the Seattle Police Department SPD Warrants Office and the SPD Crisis Intervention Team (CIT) unit have liaisons with the MHC who work to quickly address the warrant. They work collaboratively with MHC staff who are able to provide essential information to get warrants served. Once a defendant is booked, the MHC protocol ensures his case is set only in the MHC.

Because MHC staff, including the MHC probation counselors, are required to have in-depth expertise in working with persons with mental illness, there is greater understanding of behaviors caused by a particular mental illness that may result in non-compliance. Staff are also able to pay close attention to what may cause risk of harm to self or others, cognizant of the support or gaps in the treatment system and skills and abilities of case managers, and familiar with the involuntary commitment system. At all times, the MHC staff are encouraged to maintain an approach with defendants that is attuned with the principles and philosophy of the MHC.

Relationships to External Partners

The operation of the MHC requires high levels of coordination with a number of different community partners to be effective and successful. Although these coordinating activities are time consuming and complex for the MHC team, this work is vital to achieve the MHC's

goal of addressing the defendant's mental illness treatment needs in a fashion that does not further punish the individual because of a recognized disability.

As stated above, the Seattle Police Department (SPD) is integral to the early identification of defendants recommended for the MHC. In addition to the responding officer's recommendation for MHC included on the booking form, the SPD's Crisis Intervention Team (CIT) provides a daily "front end" read of incident reports, looking for comments and descriptors about a defendant's situation that could benefit by closer review for mental health needs. Similarly, this CIT unit provides a beneficial "back end" safety net with immediate notification when warrants on MHC defendants are issued, when coordinating information about defendants with investigations from other jurisdictions, and when keeping victims informed about court processes.

The Jail Psychiatric and Jail Health Units of the King County Correctional Facility (the jail) are also key partners to the MHC process. They play a critical role in referring defendants to the MHC and in assuring that services needed for the MHC defendants are provided during any incarceration. This includes monitoring for medication reviews, assisting case managers to obtain easier access to the jail and organizing release provisions. The MHC has worked to create partnerships with jail psychiatric and health staff, and with other units in the jail, such as the court detail unit, in order to implement processes and procedures that allow a multi-system model like the MHC to work well.

The Forensic Services Division of Western State Hospital (WSH) is also of critical importance to the MHC, since the SMC MHC has more defendants with competency proceedings than any other court in the state. The MHC has worked with WSH to develop new processes allowing for quicker evaluations, more efficient communication and more immediate transportation of defendants.

Another significant partner with the MHC across systems has been the King County Mental Health Chemical Abuse and Dependency Division. MHCADS manages the contract with United Behavioral Health, which in turn contracts for all community-based mental health services. In addition, MHCADS encompasses the units housing both the CDMHPs and the staff responsible for chemical dependency involuntary commitments.

At the direct service level, the quiet heroes of the MHC are the case managers and treatment staff of the mental health provider community. The MHC is able to function as a treatment facilitator because the mental health community has agreed to be actively and collaboratively engaged with defendants who have become involved with the criminal justice system. Because an arrest is not a planned event, case managers won't know which of their clients may be referred to the MHC on a given day. They are called upon by the MHC Court Monitor daily between 8 and 10 AM, for treatment plans and information about defendants being considered for the MHC. This response has significant impact on the nature and terms included in the MHC order at the first appearance hearing, as well as at subsequent hearings. The case managers appear at court hearings as needed and are called upon by the MHC judge to provide information that is critical for continued success of the defendant in meeting the

conditions of the ordered treatment plan and ultimately the defendant being able to remain in the community.

Lastly, a unique group of partners has emerged in the MHC's first years. The MHC hosted numerous visitors from throughout the nation who came to Seattle to observe the MHC in operation, with interest in developing a MHC in their own communities or in building strong linkages in Washington State. These visitors helped identify issues and made suggestions that assisted the MHC in becoming more effective in its efforts. The list of visitors for 2000-2001 is included in the Appendix to this report.

Part IV. Evaluation Findings about Mental Health Court Processes and Structure

Methodology

This evaluation was conducted using three methodologies:

- 1) direct observations of the MHC, including defendant assessment interviews, pre-session conference and court proceedings,
- 2) a) structured key informant interviews with individuals working closely enough with the MHC to have detailed knowledge of its operation or factors leading to its success or limiting its effectiveness, and
b) structured key stakeholder interviews with individuals from the Municipal Court, the City's Legislative and Executive branches, the County, and the community,³² and
- 3) analysis of defendant outcomes, which is covered in section V, below.

The process evaluation component of this report covers the full spectrum of MHC operations and activities. The defendant outcomes evaluation component details outcomes related to a more limited sample of individuals. The MHC holds most all of the competency proceedings for the SMC. This population was not included as part of the evaluation sample, unless individuals were found competent and opted into the MHC. Also not included were those individuals referred to the MHC who did not participate in MHC for a variety of reasons, including being inappropriate for the MHC (e.g. not being significantly mentally ill) or having no charges filed or choosing to go to trial and not requesting to be referred back to MHC at a later date.

Within the scope, timing and funding of this evaluation, we were not able to evaluate other data sources that we believe are also critically important, such as rate of hospitalization, family interactions, housing, life skills, etc. Because this evaluation is being conducted after two years of operation, it can provide valuable input while the MHC is still a new program. On the other hand, a limitation to conducting an evaluation at this early stage is that long-term, multi-year defendant outcome data is not available. We urge SMC to do one or more follow up evaluations to measure results consistently over time. However, currently there is no institutionalized process for initiating and guiding evaluation efforts. The Evaluation Advisory group for this evaluation was formed *ad hoc*. We recommend the establishment of an ongoing committee for SMC program evaluation that, in addition to independent evaluation researchers, would include among its membership criminal justice and mental health professionals, and key representatives from the County agencies that have the most impact on SMC programs.

³² The interviews were conducted under confidential circumstances; individuals were informed that their opinions or statements would not be personally attributed without an additional written consent to do so. Interviewees were asked to read the interview form in advance. Interviewees were selected by nomination from members of the MHC Evaluation Advisory Committee or by the researchers.

We also note that much data that would be useful for comparative purposes could not be found. While the MHC created specific tracking mechanisms within the court’s automated case management system to help measure its effectiveness, the same mechanisms were not identified elsewhere in the SMC. For example, we were unable to compare MHC defendant outcomes to defendants in other SMC courts who had been ordered to do treatment because SMC tracks compliance for other outcomes differently. We recommend that SMC consider development of systems similar to those developed by the MHC to allow for measurement of effectiveness on a number of different scales.³³

Key Informant and Stakeholder Interview Findings

Key informants included individuals interacting with the MHC on a regular basis, such as mental health providers, attorneys, probation counselors, mental health staff, and others in the mental health and criminal justice systems with direct and extensive knowledge of MHC operations. Key stakeholders interviewed included elected officials such as City Council members, the City Attorney, the County Executive and SMC judges, as well as key appointed officials such as the Seattle Police Chief, the Mayor’s Chief of Staff and the County Human Services Director.³⁴

Our questions for the key informant interviews focused on whether the MHC is meeting its stated goals, whether its processes and roles are clearly defined and having a positive impact, and whether its operations are consistent with its philosophical precepts. Our interviews of key stakeholders focused on the environment in which the MHC operates.³⁵ Our assumption was that in addition to the quality of the MHC operations and processes, the sustainability of the MHC rests as well with systems, policies, funding decisions and levels of support largely outside of its control.

Hundreds of hours were spent conducting and summarizing these interviews, which covered a broad range of topics. The most significant findings from these interviews are summarized below. We were asked as part of the evaluation scope of work to provide information as well about specific issues. We have included each of those areas in the findings below.

A. Is the MHC meeting its goals?

Goal #1: Protect public safety

Key informant and stakeholder interviews and defendant outcome data indicate that the MHC is meeting this goal.

- Interviewees felt that the MHC demonstrates appropriate concern for community safety, while also maintaining the goal of quickly transitioning defendants into the community.

³³ We understand that MHC Probation and program staff have been involved in the Court’s effort to define the “specs” for a new case management system with the MHC mechanisms providing a “template” for defining the needed data elements.

³⁴ A complete list of interviewees is included in the Appendix.

³⁵ The Interview Protocol is included in the Appendix.

- The MHC’s defendant-based model effectively links community treatment and supervision with the criminal justice process, and allows for the rapid revocation of conditions when needed.
- Key informant interviewees and court observations indicated that probation counselors are thorough and proactive in collecting information about defendants’ compliance and community adjustment and are flexible in arranging optimal supervision conditions (e.g., community visits, drop-in periods, etc.).

Goal #2: Connect or re-connect mentally ill persons with needed mental health services

Key informant and stakeholder interviews and defendant outcome data indicate that the MHC is highly successful in meeting this goal.

- Overwhelmingly, interviewees indicated that the linkage of defendants with mental illness to the treatment system was a major strength of the MHC, particularly for those unable to secure appropriate mental health treatment in the past.
- The period from referral by the MHC to engagement with treatment providers is rapid. The mode (value that occurs with the greatest frequency) for length of time from referral to a treatment provider was one calendar day. One-half of the defendants on MHC conditions of release or MHC conditions of sentence were seen within four (4) calendar days and 75% were seen within eight (8) calendar days.
- Defendant outcome data reflected that MHC defendants experienced a significant increase in treatment episodes over the pre- to post-period, suggesting that the MHC was successful in increasing treatment episodes.
- All key informants indicated that the MHC had significantly facilitated greater overall linkages between the criminal justice system and the mental health treatment provider system by reducing barriers and helping defendants make immediate connections.

Goal #3: Improve their likelihood of ongoing success with treatment, their access to housing or shelter, and linkages with other critical support

Key informant and stakeholder interviews and defendant outcome data indicate that the MHC has made major progress toward this goal, despite serious limitations in the availability of appropriate and adequate support services.

- The MHC has actively engaged other systems and community agencies that deal with the MHC target population. This has included the development of liaison contacts, shared efforts to problem solve (at the city, county and state level), and improved services to the defendant population through the elimination of barriers. Examples include active

collaboration with respite housing providers, developmental disability and aging services providers, inpatient chemical dependency providers, the SPD CIT liaison officer, the SPD Warrants Office liaison and the next-day-transport to Western State Hospital for defendants ordered for competency restoration.

- Several key informants and stakeholders commented that the large number of provider agencies involved with MHC clients and the rapid turnover among mental health case management staff affects the “continuity of care” for MHC participants and adversely impacts communication between the court and provider agencies.
- Interviewees indicated that these linkages as a major strength of the MHC. *“The MHC staff are always working to assist with the most needed services, like benefits or housing.”*

Goal # 4: Reduce the use of jail and repeated interaction with the criminal justice system for mentally ill persons.

The opinions of the key informant interviewees were mixed in this area. Defendant outcome data were analyzed for bookings pre- and post-MHC for a sample of 65 defendants referred to the MHC for the 1st time between February 1, 2000 and June 30, 2000, and placed on Conditions of Release/ Sentence. Data elements included overall bookings and release dates, charges, cases and court adjudication for each booking.

- Individuals involved with the MHC experienced a significant decrease in the number of bookings in comparison to their bookings prior to MHC involvement.
- When incarcerated, individuals involved with the MHC spent longer periods of time in jail by an average of 6 days.
- Defendant outcome data reflect that, although the reincarceration rate for MHC defendants is approximately 62% in the first year, 32% are reincarcerated for charges filed after MHC referral.

B. Is the MHC serving the target population?

The defendant outcome data indicates that the MHC serves the identified and prioritized target population of persons with mental illness.

- 52.0% of the sample was diagnosed with chronic psychotic disorders
- 28.0% of the sample was diagnosed with major mood disorders
- 18.0% of the sample was diagnosed with brief psychosis
- 2.0% of the sample had other diagnoses

C. Are the MHC operations consistent with the MHC philosophy?

Stakeholder and key informant interviews, evaluator observations of the court and defendant outcome data indicated that the team strongly sustains the core components of the MHC philosophy. Interviewees value the MHC's focus on "continuity of care." Involvement of the probation counselors and other MHC staff in all aspects of the case assessment, facilitation, monitoring, and disposition was cited as an integral aspect of the success of the defendant-based approach.

- Court activities are defendant-based rather than case-based.
- Mental illness is viewed as an organic medical condition that benefits more from treatment than punishment.
- Early identification and assessment information is always gathered.
- The MHC uses, whenever possible, a non-sanction based, treatment approach which tailors a defendant's treatment conditions to meet individual needs and circumstances.
- The MHC maintains a highly individualized and defendant-centered approach to assessment, disposition recommendations, and ongoing monitoring of mentally ill defendants.
- Participation of the Court Monitor and MHC probation counselors in all hearings provides a high level of knowledge about each defendant.
- Defendant outcome data confirms that MHC cases are resolved rapidly relative to other SMC cases, and there is no prejudicial impact on defendants from the increased information gathering aspect of MHC related to timeliness in case processing.
- The MHC involves family members, providers and the community in the court process in order to help defendants succeed from the earliest point of entry and successfully re-engage with the community.
- Team members share information about defendants and their treatment needs, and successful relationships are developed between team members and the defendants.

D. Does the MHC operate efficiently and effectively?

Key informant interviews and evaluator observations of the court indicated that the MHC team has a coherent and tight organizational structure, is well managed and utilizes a consistent, protocol-driven approach to court operations. Court operations are extremely clear to each member of the MHC team and others involved, including courtroom personnel.

- Consistency of staff on the MHC team is an essential component of its operation. Key informants stressed the importance of this consistency for creating the stability which mentally ill offenders need to promote recovery and re-integration into the community. The following comment was given, *“Without that team of people concentrating on the client’s need, you don’t have a mental health court, you simply have a judge hearing cases of individuals with mental health problems or mental illness.”*
- Key informants reported that a minimum tenure of at least six (6) months is necessary in order to become proficient with the operations of the court. Interviewees indicated that there was great potential benefit for MHC defendants when a consistent team is present that promotes familiarity, comfort, and trust in the court and its operations. A downside noted is that this results in fewer people working in the criminal justice/ court system being exposed to the uniqueness of the MHC approach.
- The MHC was viewed by a majority of those interviewed as MHC is judge-centered. While consistent with the MHC model, this raised concerns about whether continuity of protocols and organization could be maintained if and when a new judge operating with a different management style rotates into the court.
- Some interviewees raised the topic of the judge being involved in the daily pre-hearing informational conference. The conference meeting was created for 2 reasons: from a practical perspective, the judge and attorneys are assigned to the morning arraignment calendar and there isn’t sufficient time in the calendar day for consultation with the court monitor, probation staff and treatment providers before the calendar is called. From a sensitivity perspective, it was designed as a way to prevent detailed clinical discussion of a defendant’s diagnosis and treatment in open, public court proceedings. Although the kind of information sharing and problem solving that are facilitated in the pre-hearing conference is consistent with the MHC philosophy, some interviewees view this conference as a source of potential bias in the adjudication of the defendant’s case(s).
- A few interviewees raised objection as the conference potentially violating the rights of the defendant. While one interviewee recommended continuing the conference practice but with the judge not attending and the Court Monitor as “chair”, other interviewees stated that MHC probation staff and the Court Monitor rely on the give-and-take with the MHC judge, describing the judge as a “hands-on, treatment facilitator with each individual defendant.” These interviewees felt that the information sharing and the individualized approach were critical to the MHC process. They felt that balancing these competing concerns is an important component of preserving the MHC model.
- Numerous interviewees acknowledged the remarkable quantity and value of the work performed by the Court Monitor as well as MHC probation counselors. Operations of the court seem to be thriving with the current staff, who manifest a high level of energy, enthusiasm and passion about the court. Not surprisingly, these same interviewees raised questions about sustaining this level of commitment as turnover and rotation of staff occur.

- There has been assertive outreach to mental health providers, SMC staff, attorneys, police officers and others. Less assertive engagement with the general public was noted and was viewed by mental health provider agencies as central to increasing awareness about the parameters and functioning of the MHC, as well as the unique needs of the MHC defendants.
- Many key informants and several key stakeholders cited the clarity of the disseminated training materials (made available on-line to all court employees, from clerks to judges) which include summaries of how the MHC operates, MHC forms and protocols utilized as a strength of the MHC. In addition, the policy of regularly updating the notebooks regarding new information and policy changes was appreciated by key informants and stakeholders.
- The benefits of having the MHC become more prominent to the public (i.e., television and newspaper features about the court) was expressed by interviewees as a way of increasing support from both key stakeholders as well as citizens.

E. Has the MHC effectively developed case processing tools that differ from “regular” court processes?

Key informants felt that the MHC has been successful in developing and implementing new case processing components that expedite the goals and objectives of the court. These include:

- A variety of new mechanisms that promote collaboration across multiple systems and facilitate the identification of defendants with mental health issues for possible MHC consideration.
- Early access to clinical and treatment information, substance abuse treatment needs, and other needs without delay of initial hearings.
- Direct linkage to treatment as early in the court process as the initial hearing and pre-trial monitoring of court-ordered conditions.
- Grouping all defendant obligations together from the initial hearing each time the defendant interacts with the court.
- Individualized and defendant-centered assessments, disposition recommendations and treatment plans in court orders.
- Specialized probation policies and procedures that include close monitoring of Court-ordered conditions while retaining the focus on helping defendants succeed over the long-term.

- Procedures for the expedited processing of warrants to keep defendants engaged with the court and their treatment.

F. What are the advantages and disadvantages to the MHC sharing courtroom, staff, attorneys and judge with the arraignment calendar?

The MHC calendar is currently “tied” to the daily arraignment calendar by being co-located in the jail courtroom and utilizing the same judge, attorneys and courtroom staff. Key informant interviews and court observations indicated that this arrangement has a variety of impacts on the operations of the MHC, the activities of MHC staff and defendant access to/relationships with the MHC.

- Interviewees reported the difficulties of “changing the pace of the court” between the morning arraignments and the afternoon MHC. One interviewee commented, “*The rapid/ frenetic pace of the morning is still ‘present’ in the afternoon*”. The multiple simultaneous activities and rapid pace of the arraignment calendar is sometimes carried to the end of the day when cases not concluded in the AM are disposed of after the MHC has adjourned. The activities and pace are not conducive to interacting with MHC defendants and can result in a courtroom environment that is overly stimulating for defendants struggling with mental illnesses. This pace also can make it difficult to transition from a case-focused approach into the individualized defendant-focused approach of the MHC.
- The relationship with the arraignment calendar obscures a clear organizational identity for the MHC within the Seattle Municipal Court, raising serious issues about the institutionalization of the MHC and its continuing viability over time. Because the MHC has been tied to the arraignment calendar, there has been no mechanism to contract directly with the Public Defender’s office for MHC defense services. A by-product of this problem has been that the prosecutor has also not yet appointed a dedicated MHC prosecutor.
- An advantage of the existing structure is that the defendant’s arraignment hearing can be quickly transferred to the afternoon in MHC if deemed appropriate, since the judge can give immediate approval and transport of the defendant is not an issue. However, this also creates an extraordinary burden on court staff for quick and concise information gathering in a short (few hours) amount of time.
- A disadvantage of separating the MHC from the arraignment court could be a delay in the initial hearing if clear protocols for the identification and transfer of cases to the MHC are not developed, implemented and monitored by SMC.

G. Should the MHC court be located in the new Justice Center rather than in the jail courtroom?

The potential to move into the new Justice Center presents a unique opportunity for the MHC. Relocation of the MHC could alleviate current space concerns, but also raises important questions regarding defendant transportation.

- Unanimous feedback was given by interviewees and through evaluator observations regarding the insufficiency (e.g., too small, loud and bustling, overwhelming, adjacent to the holding tank, etc.) of the current jail courtroom setting and the need for a “consumer friendly” courtroom that takes into account the unique needs of the defendants with mental illnesses and the involvement of the many players who participate in MHC proceedings. One interviewee commented, *“It’s difficult to conduct an on-site assessment in this confined area with a defendant whose diagnosis includes hearing voices while there are multiple other conversations happening simultaneously between attorneys and other defendants, the marshal and custody officers, and others.”*
- Some disadvantages of the existing structure are the over-stimulating environment created by noise, the lack of confidentiality created by the use of the holding area for interviews, and the absence of private meeting spaces for MHC clients, MHC staff and treatment agency staff. A move to the Justice Center could address the need for confidential meeting space in or adjacent to the courtroom and the aspects of MHC proceedings that would be better served in a setting designed for that purpose.
- Should the MHC be moved from the jail into the Justice Center, key informants and stakeholders raised a number of important questions regarding the transporting of defendants from the jail to the Justice Center. Concern was expressed regarding the issues of security, disturbance to the defendant and staffing needs that such a move would generate.
- A separate courtroom would also allow the MHC to conduct contested competency hearings or other proceedings involving witnesses, which currently must be held in a different courtroom in the Public Safety Building due to insufficient space in the jail courtroom.
- A move to the Justice Center would help the SMC highlight the role and the importance of the MHC as a community court program, and would alleviate the problem areas that interviewees indicated were the result of associating the MHC with the arraignment calendar.

H. Should the MHC and the King County District Court MHC merge?

Strong positive and negative opinions were voiced by interviewees about this issue. Despite many potential benefits such as shared space, consolidation of municipal and district court management of cases, and the possibility of expanded clinical and support staff, the over-

riding sentiment of the interviewees was that the jurisdictional and operational challenges of consolidation were insurmountable without strong leadership from the Presiding Municipal and District Court judges as well as the Mayor and County Executive.

- The majority of stakeholders associated with the County (elected officials, policy staff, department managers and providers) and family advocates were consistently in favor of combining the two courts.
- Most municipal stakeholders, including judges, other elected officials and police officials viewed consolidation as unworkable. Reasons provided consistently referenced the significant need for the Municipal Court to handle a higher volume of defendants without delay, an approach that was not seen as consistent with the current practice of the District Court.
- Preference for the MHC's assertive and intensive approach in monitoring compliance with court ordered conditions was an additional driver referenced to maintain the individual identities of these courts.

I. What are the barriers that may hinder the sustainability of the MHC?

The barriers to the MHC's long-term success arise from the challenges of operating a multi-system model, having limited authority for key systems and having created new ways of doing business within a traditional court system.

- As of July 2001, the State began decreasing funding to King County by more than \$42 million over the next six years for mental health services, threatening an already overburdened system. Additionally, the County is considering the elimination or reduction of the few existing inpatient or secure treatment services for offenders with substance use disorders (e.g., North Rehabilitation Facility/ NRF) and has requested a renegotiation of the jail contracts, which may significantly impact the type of defendants utilizing the KCCF and the nature of the services provided there (e.g., restriction on booking of misdemeanor offenders).
- Experiences from around the nation with existing MHCs and other community court programs suggest that questions exist about the best way in which to mobilize and sustain MHCs. Some jurisdictions have formally established specialty courts with budget and program authority. In other settings, the arrangements are more *ad hoc* – MHCs exist without being formally called out in budget line items and court structures. The SMC's current operations are consistent with this *ad hoc* approach since the MHC is without staff positions and a structure that can be readily identified in the SMC budget or operational structure. While the existing MHC has been highly successful in meeting its goals and objectives, the long-term sustainability of the court, especially as it addresses the issue of continuity in the face of change in judge or staff and various other constraints, may become highly problematic.

- Limited access to appropriate chemical dependency /co-occurring disorder treatment were cited by almost all interviewees as continuing significant catalysts of treatment failure and recidivism. The significant number of defendants who also have substance abuse addictions and the very limited number of inpatient treatment facilities in the region for dually diagnosed individuals results in significant numbers of defendants who are successfully engaged with mental health treatment, only to fall out of compliance and recidivate due to untreated alcohol or drug addictions.
- The lack of housing options for this population is also an ongoing barrier, despite the concerted efforts of the MHC team to make linkages wherever possible. Appropriate and consistent housing for defendants, especially those with a history of substance abuse or aggression remains very limited.
- Interviewees reported a decline in consistent, quality communication and coordination with Jail Psychiatric assessment staff and Jail Health staff after the Jail eliminated an identified Jail Psychiatric Evaluation Services (PES) / MHC liaison position. In addition, the location of these two jail-based services in two different departments (PES staff are Dept. of Juvenile & Adult Detention employees while Jail Health staff are Seattle-King County Public Health Dept. employees) can hinder effective partnerships.
- Large numbers of very seriously mentally ill and often incompetent individuals are referred to the MHC. The daily interaction with this population and the limited options for those who may be resistant to medications make it challenging for MHC court personnel and the MHC team on a day in/day out basis.
- Mental health provider agency staff with backgrounds in forensic mental health service are not consistently available to work with MHC clients. Key informants identified a variety of possible reasons for this problem. Some cited the inadequacy of funding in the public mental health system. Others cited the high turnover in provider agency staff (that may be in part the result of inadequate funding). Some interviewees also identified the absence of sufficient training by agencies on forensic case management issues as well as organizational structures at the overall agency level that inhibited rather than promoted the delivery of effective forensic mental health services.
- Several key informant interviewees suggested that a tremendous obstacle to consistent medication compliance among defendants was the discontinuity between medication services from hospitalization to jail stay and then to the community and the difficulty of beginning medications for in-custody defendants who are not currently enrolled in treatment services.
- Much of the MHC model is predicated on the presence of a consistent and highly trained staff. The MHC relies on a team approach, has a unique set of players in the courtroom, adds on cases during the day, handles its own warrants, and uses specialized coding in its case entry work. It may not be possible to sustain the specialized skill levels and team consistency the MHC model requires within SMC's traditional framework.

- Support for funding, staffing and space for the MHC within the Municipal Court bench remains mixed.
- Support for the institutionalization of the MHC is strong on the part of the City's and County's Legislative and Executive branches. While key stakeholders overwhelmingly spoke of MHC being a wise use of public resources, the benefits of having the MHC become more prominent to the public (i.e., television and newspaper features about the court) was expressed as a way of increasing support from both key stakeholders as well as citizens. Several key stakeholders expressed that having other judges familiar with the model and able to articulate the benefits of the MHC model would help to increase support from the public as well as key stakeholders. One interviewee commented that *"seeing the success of this program will facilitate the consensus with (the public) population"*.

Part V. Evaluation Findings about Mental Health Court Defendant Outcomes

Data Collection

Data for bookings and related time spent in detention were collected and analyzed for a sample 65 individuals referred to the MHC and placed on MHC Conditions of Release or Sentence between February 1, 2000 and June 30, 2000. The start date for selecting subjects (Feb 1, 2000) marked the end of the early implementation phase of the court, as reflected in the addition of a probation counselor to the MHC team, which brought it to its full complement. The end date for subject selection (June 30, 2000) was chosen to allow a minimum observation period of 9 months from referral to the end of feasible detention data capture for this evaluation.

Detention data was collected for the interval of June 1, 1999 to March 30, 2001. Mental health data for the same individuals was collected for the period of January 1996 to March 30, 2001. Extending the capture of mental health data to the earlier period was planned to allow for a better comparison of the individual's involvement in treatment during pre and post referral periods. Defendant data was obtained from four regularly maintained archival sources:

1. Seattle Municipal Court Docket and Hearing Information System. These data were obtained from the Court through the assistance of Lois Smith, Program Specialist for the MHC.
2. King County Department of Juvenile and Adult Detention information system. These data were obtained from the department's automated system through the assistance of Lois Smith, Program Specialist for the MHC. Most of the data utilized for this research is information available to the public related to criminal charges and detention.
3. King County Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) information system. Access to this database received the approval of the MHCADSD Evaluation and Research Committee.
4. Court Monitor and Probation Counselor files maintained in the normal course of MHC business.

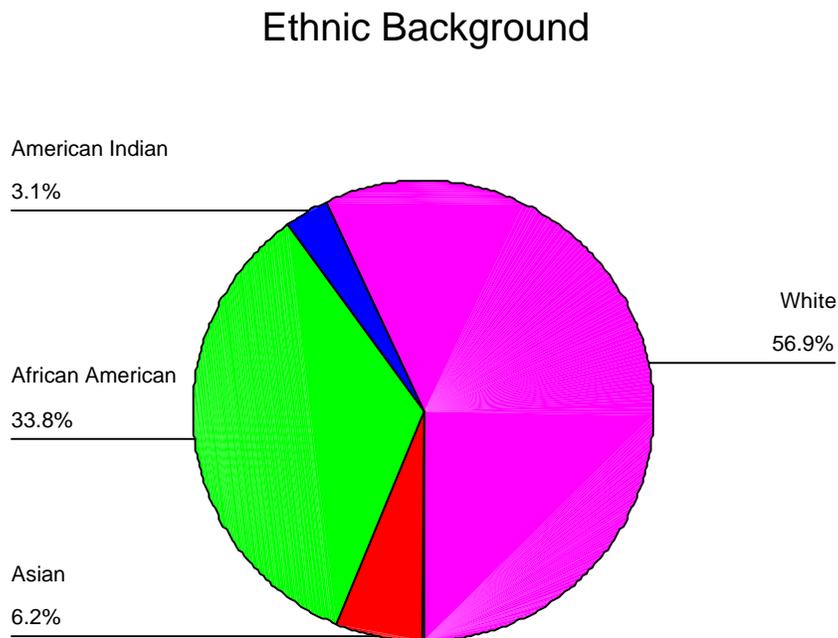
Research Design

Data was analyzed to describe the population in regard to demographics, diagnoses, treatment engagement, criminal charges, booking history and time spent in detention. We also planned comparisons between pre- and post-MHC referral periods for defendant criminal justice and treatment variables. **The sample reported here is limited to those MHC core participants, defined as individuals placed on MHC Conditions of Release or Sentence.** Comparisons of this group of MHC core participants to individuals referred but not placed on MHC Conditions of Release or Sentence, and to defendants from the King County District Court Mental Health Court are included in the Appendix.

Sample Description

The sample of 65 defendants was 74 % male and 26 % female had a mean age of 37.01 (10.58)³⁶ ranging from 18 to 59. The ethnic composition of the sample is depicted in Figure 1.

Figure 1. Ethnic Background of Participants



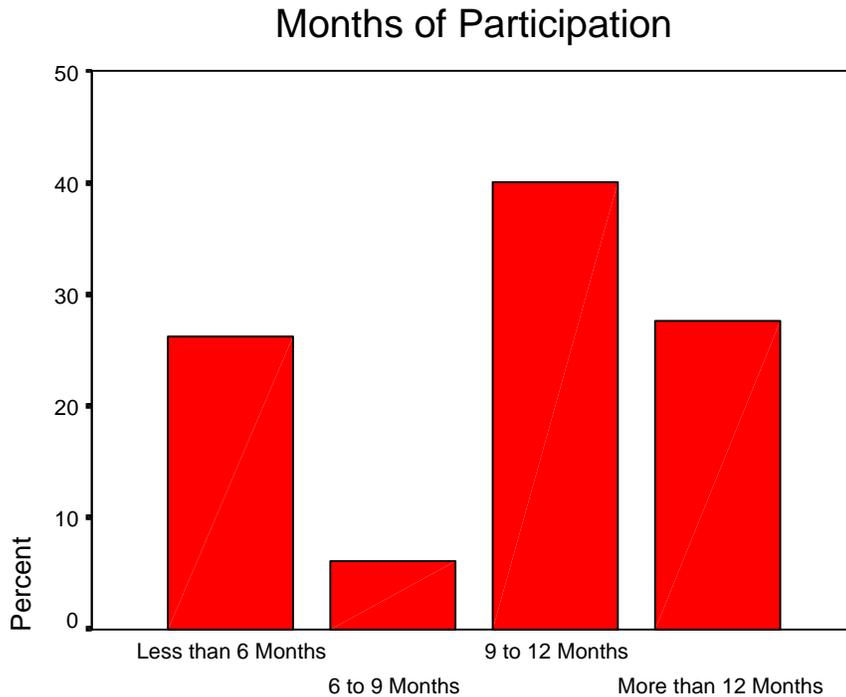
Length of Participation

Length of participation was calculated from the date of referral to the MHC to the date of removal from the MHC or the end of the period of observation (i.e., March 30, 2001), whichever came first. The mean number of days of participation was 267.32 (128.34) with a range of 4 to 424 days. 25% of participants had 140 days or less, 50% had 308 days or less, and 75% had 330 days or less.

³⁶ Throughout the text and tables of this report, measures of standard deviation are reported in parentheses following the respective mean. The standard deviation is a measure of how much variation there is in the scores which make up the average. Relative to the size of the mean, a smaller standard deviation indicates there is little variation among the averaged scores, whereas a larger standard deviation indicates there is more variation among the scores.

Figure 2 displays an abbreviated distribution of days of participation using four unequal categories: Less than 6 months, 6 to 9 months, 9 to 12 months, and more than 12 months. These categories were used as a simplified “best fit” to the distribution of this variable.

Figure 2. Length of Participation



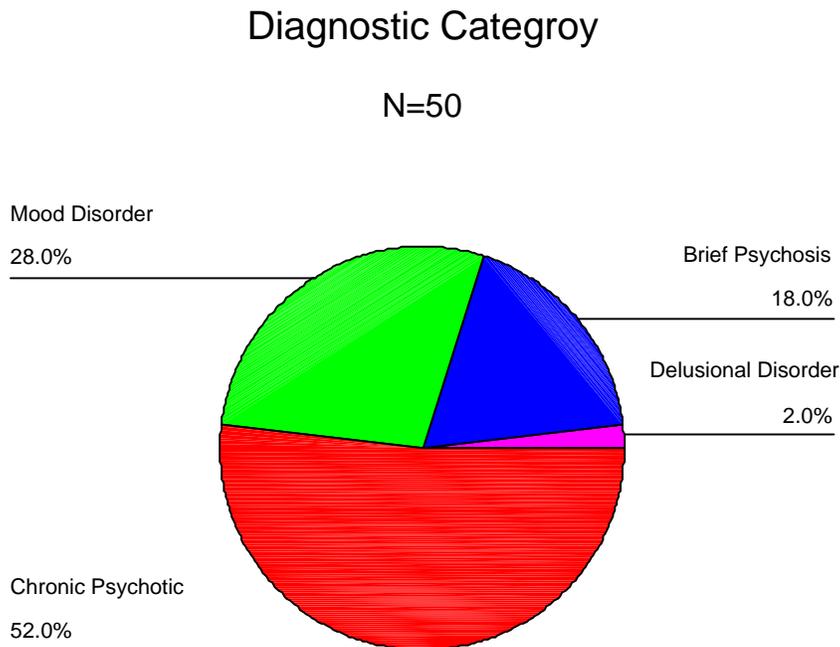
Analysis of Mental Health Data

Data for date of referral for mental health services and date of first contact with mental health services were obtained from the MHC Court Monitor’s files, which contain contemporaneous records of referral transactions. Data for first treatment contact was captured by means of a lookup from the MHCADSD Extended Client Locator System (ECLS) automated treatment records. Data for diagnosis, authorization for treatment, first treatment contact, number of treatment episodes, and amount of treatment received were downloaded from the MHCADSD system after appropriate approvals were obtained.

Diagnosis

Diagnostic data for Axis I clinical syndromes that were the primary focus of treatment were available for 50 of 65 core participants. The breakdown appears in Figure 3.

Figure 3. Diagnostic Category of the Primary Focus of Treatment



It is important to note that many participants carry several other diagnoses that are not the primary focus of treatment for the King County Mental Health care providers. For example, approximately one third of those with available mental health data had a diagnosis of a personality disorder in their record. When diagnostic variables were matched with booking and the detention data described in a separate section of this report, no impact of diagnosis was found for the core participant group.

Engagement in Treatment

Two sources of data on treatment engagement were available, the MHCADSD automated records and the MHC Court Monitor/Probation Supervision records. We did not expect these two data sources to be in complete agreement because they were designed and used for different purposes.

MHCADSD information system is used to track thousands of patients enrolled in King County reimbursed services. Not all individuals seen in the MHC would qualify for these services; some have private provider coverage, or coverage through the VA, or other providers. On the other hand, the MHC records document and track highly individualized interventions and court supervision contacts, including linkages to the VA and private providers.

The two systems also differ in the timeliness of data entry. MHCADSD information system contains data that may be entered in “batches” after a significant delay, while still accomplishing the purpose it was intended for, whereas MHC records are contemporaneous records of actions and contact.

For the MHCADSD data source, by searching the MHCADSD treatment service records, we identified the first service contact made with a MHC defendant after referral. Fourteen (14) core participants had no identifier number (KCID) for use in tracking in the MHCADSD information system. We were able to verify the first face-to-face treatment contact post-MHC referral for 92.7% of core participants with a KCID.

To establish the successfulness and speed of engagement in treatment services, we calculated from MHCADSD data the number of days from their referral to the MHC to the first recorded hour of mental health service. On average, the first service hour took place 11 days after referral, with 25% of cases seen within one day, 50% within 5 days, and 75% within 13 days. Table 1 summarizes data from this source. The most frequent length of time (mode)³⁷ from referral to a treatment provider is 1 day.

Table 1. Treatment Engagement: MHCADSD Information System Download

Documented Engagement	92.7%
Mean	11.23 (16.21)
Mode	1
25 th percentile	1
50 th percentile	5
75 th percentile	13
Minimum	1
Maximum	76

Note: N=51 core participants with a KCID.

Given the lack of completeness of this data source, we did further analysis based on data collected from the MHC Court Monitor/ Probation Counselor records, expected to be more complete. This refined the results to show that on average the first service hour took place 8 days after referral, with 25% of cases seen within 1 day, 50% seen within 3.5 days and 75% within 8 days. All 65 core participants were accounted for. Of these participants, 3 were not linked to services. Two of these individuals had refused treatment and were removed from the MHC, whereas the remaining individual had a unique condition of attending to other medical concerns at Harborview Medical Center but was not obligated to attend other treatment, according to Court Monitor records.

³⁷ The following statistical measures of distribution are included in this report: mean (which is the average of the values analyzed), mode (which is the most frequent value in the sample) and median (which is the value at the half-way point with all the values arranged in order).

Table 2 summarizes data from this source. The most frequent length of time (mode) from referral to a treatment provider is 1 day. Both data sources support high levels of successful engagement in treatment.

Table 2. Engagement in Treatment Services: Court Monitor/Probation Counselor

Documented Engagement	95.38%
Mean	6.44 (8.06)
Mode	1
25 th percentile	1
50 th percentile	3.5
75 th percentile	8
Minimum	0
Maximum	8

Note: N= 65 core participants.

Duration of Treatment Engagement

Using the MHCADSD data, we identified the first treatment episode after referral to the MHC and the most recent treatment episode in the database which had dates inclusive of January 1997 through December 2000. We calculated the days from referral to the MHC for these treatment events.

On average, participants were observed for 258.47 (44.73) days after referral. Table 3 summarizes descriptive statistics for these variables.

Table 3. Days from Referral to First and Last Treatment Episode by Observation Period

	First Pre Episode ¹	Last Pre Episode ²	First Post Episode ³	Last Post Episode ⁴
Mean	- 357.82 (147.20)	- 31.18 (70.77)	15.16 (30.34)	219.47 (61.24)
25 th percentile	- 336	- 1	0	179
50 th percentile	- 447	- 3	2	231
75 th percentile	- 495	- 15	17	272
Minimum	- 4	- 1	0	48
Maximum	- 547	- 364	153	303

1. N= 44.
2. N= 44.
3. N= 51.
4. N= 51.

On average the last treatment contact prior to MHC referral was 31 days and the first treatment contact after referral was 15 days. On average, defendants had at least 219 days of treatment engagement out of an average 258 days of possible engagement and 25% of core participants had over 272 days of treatment engagement. This reflects, on average, approximately 85% of the possible duration of engagement for the observed period.

Intensity of Treatment

We were interested in comparing the number of treatment episodes and total number of minutes of treatment received during the pre-MHC and post-MHC referral periods. Data entries in the database provided to us ended on December 15, 2000. We calculated the number of days from referral to this date for each individual. Having calculated the number of days of observation post referral, we then limited our inspection of pre-MHC referral data to an equivalent interval. On average, individuals were observed for 258.47 (44.73) days, with a median of 261 days, a mode of 167 days and range of 167 to 317 days.

Table 4 contains descriptive statistics for these variables, and the findings of appropriate tests for the difference between the Pre and Post periods.

Table 4. Treatment Episodes and Total Minutes Treatment Received, N= 52

	Pre-MHC	Post-MHC	
Treatment Episodes	67.52 (96.9)	74.54 (149.14)	$p < .03$, two-tailed. ¹
Hours of Treatment	53.05 (129.52)	48.05 (100.05)	$p = .091$ two-tailed, NS. ²

1. Wilcoxon Signed Ranks Test, $Z = -2.177$, $p < .03$.

2. Wilcoxon Signed Ranks Test, $Z = -.1689$, $p = .091$, two-tailed, NS.

Core participants experienced a significant increase in treatment episodes over the pre- to post-period; however, the number of hours of treatment received did not change significantly. These analyses suggest that the MHC was successful in increasing treatment episodes.

It is important to note that the duration of treatment engagement and the number of treatment contacts may be more important to successful community adjustment for individuals with mental illnesses than the number of treatment hours. For example, treatment minutes per episode may be high in instances where staff intervene to control or contain symptoms in an individual who has already decompensated, whereas briefer treatment contacts may be used effectively to prevent relapse to severe psychiatric symptoms.

Analysis of Detention Data

The sample of 65 persons was observed for a period of 22.27 months (from June 1999 through March 2001). On average defendants' detention history was captured for 10.39 (1.57) months prior to their referral to the MHC and for 11.88 (1.57) months after their referral to the MHC. The booking level analyses of these data are presented prior to the presentation of the analysis of data aggregated by defendant.

Booking Level Data

The 65 defendants logged 233 bookings in the King County Detention Center during the period of observation. Time spent on temporary release from jail, usually to a hospital or other treatment facility, was removed and not counted as part of jail time.

In addition to categorizing bookings and associated jail days as pre- or post-MHC referral, bookings can be categorized as related to misdemeanor offenses, felony offenses, or a combination of the two. Also, the court of jurisdiction for the booked offenses for each booking can be categorized by jurisdiction as SMC, Non-SMC and combined jurisdiction.

Descriptive statistics for booking and average jail days served by jurisdiction of origin, by felony/misdemeanor booking offense and by observation period are contained in Table 5, which also contains the appropriate statistical tests for differences between the pre-post periods.

Defendants spent an average of 23.64 (37.88) days in jail on a booking, with a median of 10 days, a mode of 2 days, and a range of 1 to 319 days.

Core participants served a total of 5509 days over the 22.27-month observation period. Jail days were served at the approximate rate of 244 days per month in the pre-MHC referral period and at the approximate rate of 251 days per month in the post-MHC referral period.

Examination of Table 5 (pg. 49) reveals a significant increase in days served per booking in the post- compared to the pre-referral period. This increase is due primarily to bookings with only SMC misdemeanor charges and with mixed misdemeanor (of SMC) and felony charges. The increase on average of almost 9 days per booking for SMC cases is particularly important because, in the post-referral period, the SMC category includes bookings during which the participant is involved with the MHC.

Aggregate Level Analysis

Booking data and associated jail days were aggregated by participant. Over the 22.27-month observation period, core participants averaged 3.58 (3.11) bookings per year and served an average of 85.11 (100.96) days in detention.

Since defendants were referred at different points in time and observed for different pre- and post-referral intervals, annualized booking rates and annualized jail day rates were calculated to provide a basis of comparison.

Annualized booking rate variables were computed for each of three observation periods: Total Period (22.27 months), Pre-MHC Referral, and Post-MHC Referral. Individuals who had no bookings or jail days in either the pre- or post-referral period were assigned a rate of 0 for that period. Forty (40 or 62%) core participants were re-booked after referral to the MHC during an average observation period of just under one year (11.67 months).

Table 6 (pg. 49) contains descriptive statistics for annualized rates with the appropriate statistical tests for the difference between the pre-post periods. Annualized bookings dropped significantly over the pre-/post-referral period. Although annualized jail day rates declined, on average, the decrease was not statistically significant.

It is possible that booking and jail day rates can drop on average for defendants while simultaneously remaining unchanged, decreasing, or even increasing for defendants that are reincarcerated. We examined this possibility.

Table 7 (pg. 49) contains the statistics for pre-MHC referral and post-MHC referral booking and jail rates limited to the 40 individuals who were reincarcerated during the observation period. Among these reincarcerated defendants, booking rates and jail day rates increased on average, but this increase was not statistically significant.

Taken together these findings indicate that the MHC had the effect overall of decreasing bookings. While the MHC appears to have caused decreased bookings overall, those defendants that are reincarcerated after referral are spending significantly more time in jail on each new booking.

Although support was found for the MHC reducing new bookings for its core participants, these analyses do not support the conclusion that the MHC significantly reduced jail days for core participants overall. Evidence was found for increased jail days for referred defendants who were later reincarcerated.

Defendants can be reincarcerated for charges filed prior to their referral to the MHC. To estimate the number of defendants booked in the post-MHC Referral period on new charges, we identified bookings with at least one charge file date that occurred after the date of referral to the MHC. Among core participants, 23 (or 35.4%) were booked on newly filed charges after their referral to the MHC, with the observation period being just under one year. Based on these analyses, we estimated the recidivism rate among MHC core participants to be approximately 35% per year, during the first year of MHC involvement.

Table 5. Days of Incarceration by Booking Category

Booking Category	N	Total Observation	N	Pre-Referral	N	Post Referral	Significance of difference
<u>Jurisdiction</u>							
SMC	131	19.53 (26.49)	76	15.82 (23.56)	55	24.66 (29.54)	
NonSMC	71	20.51 (32.47)	32	24.50 (38.43)	39	17.23 (26.71)	
SMC and NonSMC	31	48.23 (69.80)	14	39.07 (81.97)	17	55.77 (59.52)	
<u>Charge Type</u>							
Misdemeanors	163	20.87 (37.79)	93	17.98 (38.40)	70	24.71 (36.88)	
Misdemeanors and Felonies	22	37.73 (37.29)	8	22.75 (17.46)	14	46.28 (43.18)	
Felony Investigations	48	26.61 (37.56)	21	32.33 (44.93)	27	22.15 (30.80)	
Total Bookings	233	23.64 (37.88)	122	20.77 (38.76)	111	26.81 (36.80)	p < .025 ¹

1. Mann=Whitney Test, Z= -.1.147, p<. 025.

Table 6. Aggregated Annualized Booking and Jail Day Rates

	Annualized Total	Rate Pre-MHC	Rate Post MHC	t-test for Paired Means (Pre to Post)
Bookings	1.93 (1.69)	2.23 (1.67)	.95 (2.14)	t (64) = 2.348, p < .05, 2-tailed.
Jail Days	45.86 (54.40)	48.24 (80.77)	44.42 (69.11)	t (64)=.301, p= .541, 2-tailed, NS.

Note: N=65 defendants.

Table 7. Annualized Booking And Jail Day Rates For Reincarcerated Core Participants (N=40)

	Rate Pre-MHC	Rate Post-MHC	t-test for paired means (Pre to Post)
Bookings	2.66 (1.94)	2.75 (2.13)	t (39) = -.281, p = .780, 2-tailed, NS.
Jail Days	20.10 (24.72)	25.10 (19.88)	t (39)=-.1.164, p= .251, 2-tailed, NS

Charge Severity

Bookings related to FTA-only were not included in this charge severity analysis. Booked offenses were placed in one of six severity categories as described in Table 8. Investigations for felony offenses were included and rated in the most severe category.

Table 8. Charge Severity Categories

RANK*	TRAFFIC	NON TRAFFIC
6	DUI	Assault, Violate Court Order, Harassment
5	DWLS 1, Hit & run (attended)	All DV Offenses (other than Assault & violate court order), Sex Offenses (other than Vice), Reckless Endangerment
4	Reckless Driving, Hit & Run (unattended)	Theft, Weapons Violations
3	DWLS 2, DWLS (undesignated level), Negligent Driving, Other Traffic	Criminal Trespass, Malicious Mischief, Vice, Other Non-person, Other person
2	DWLS 3, Motor Vehicle Offenses	Alcohol, Drug (Marijuana, drug paraphernalia, etc.), Aggressive Begging
1	NVOL	Animal, Boating Offenses, Fish & Game, Littering, Miscellaneous Regulations

*Note: 6 = Most Serious, 1 = Least Serious

At the booking level, two measures of severity were examined: maximum severity of booked offense and the mean severity of the booked offense. These measures for pre-MHC and post-MHC referral bookings were then averaged for each subject. 32 individuals with at least one non-FTA booking in the post-MHC referral period were included in the analysis. The means and standard deviations of these subject-level variables appear in Table 9.

Table 9. Charge Severity Measures by Observation Period

Severity Variable	Pre-MHC	Post-MHC	t-test for paired means (Pre to Post)
Maximum Charge	4.81 (1.38)	4.88 (1.36)	$t(31) = -.205, p = .839, 2\text{-tailed}, NS.$
Mean Charge	4.28 (1.37)	4.17 (1.36)	$t(31) = .405, p = .688, 2\text{-tailed}, NS$

Note: Pairs are 32 for individuals who had bookings that include charges other than FTA in the post- MHC period.

Failure to Appear (FTAs)

52 bookings related to FTA-only were found for 30 core participants.

25 FTA-only bookings were filed in the pre-MHC period. An average of 10.48 (11.12) days were served per FTA-only booking in this period.

In the post-MHC period, 27 FTA-only bookings were filed, and were associated with an average of 23.07 (43.72) days of detention. The difference between observation periods in the number of days served on FTA-only bookings was not statistically significant.

Analysis of Case Processing Data

Warrants

Warrant data was collected from MCIS for the period 06-01-1999 through 02-28-2001. This resulted in 179 warrants issued for 79 MHC defendants.³⁸ Table 10 shows the frequency and percent of warrants by how they were closed.

Table 10. Warrants by Closing Category

	Frequency	Percent
Error	1	.6
Booked	143	79.9
PRed	10	5.6
Quashed	15	8.4
None	10	5.6
Total	179	100.0

Figures 4 and 5 graphically display the warrants by closing category and the number of days from issuance to type of closing category, respectively. Ten (10) warrants (5.6%) had no associated resolution code. Approximately 80% of warrants were resolved through a booking.

On average warrants were resolved in 32.60 (48.25) days. Quashed warrants were resolved most quickly with a mean of about 17 days.

³⁸ MHC and Warrants Office staff regularly review the MHC active Warrants list which is typically about 4% of the MHC caseload, contrasted with a 31% average warrant rate for intake and pre-trial hearings in the SMC non-MHC courts.

Figure 4. Warrants by Closing Category

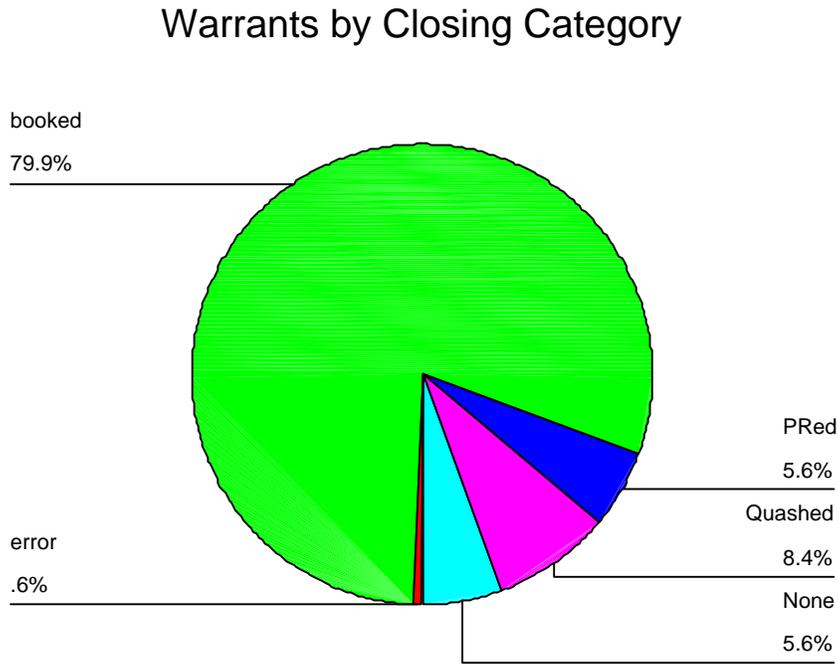


Figure 5. Days to Warrant Clearance by Type

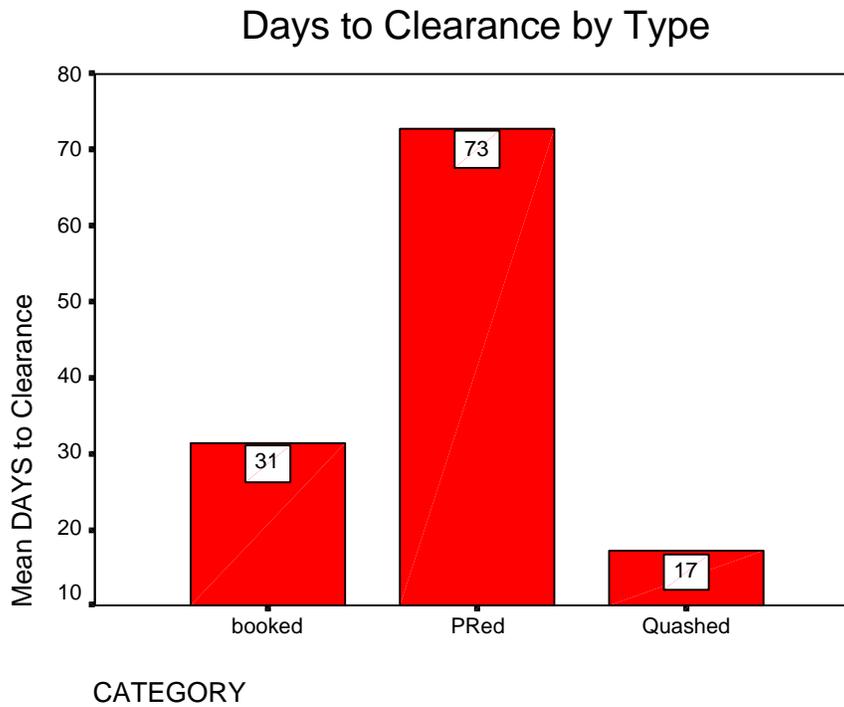


Table 11 contains means and standard deviations for days from warrant issuance to warrant resolution. The 10 unresolved warrants had an average of 341.80 (130.67) days running from their issuance to the close of the observation period on 06-14-2001.³⁹

Table 11. Mean Days to Resolution by Closing Category

Category	N	Mean
Booked	143	31.41 (45.94)
PRed	10	72.80 (84.47)
Quashed	15	17.13 (18.61)
Total	168	32.60 (48.25)

Note: Means are significantly different $F(2, 166) = 4.464, p < .015$.

Speed of Case Resolution

The MHC has, as one of its goals, the rapid resolution of cases to avoid any prejudicial impact on defendants from the increased information gathering aspect of MHC involvement. To determine if this goal were being met, data was provided by MCIS on cases filed on MHC defendants during the 5-month period of the same time period (February, 2000 through June, 2000) used for capture of MHC referrals.

Variables used in analyses included the date of filing, the defendant, the offense, the resolution type, and the date of resolution. This resulted in 301 misdemeanor and infraction cases. Table 12 displays the frequency of various case dispositions by court location (MHC/ non-MHC) and the related percent of disposition type for each location grouping.

Of the 301 misdemeanor and infraction cases filed on MHC defendants during this period, 276 cases had a recorded case resolution date. Of the 25 unresolved cases, 1 was a missing data entry value from a resolved MHC case (i.e., Dismissal without Prejudice), 2 were cases pending in Non-MHC courts, and 22 were unresolved infractions.

The number of days from the filing of the case to its disposition was calculated for the 276 resolved cases. The category for dismissal due to the defendant being not competent to stand trial is unique to the MHC and was broken out from other MHC dismissals. Infractions were also tabulated separately.

Table 13 provides the descriptive statistics for the number of days from charge filing to charge resolution for four major charge location groupings. When comparable cases (i.e., those in the Other Dispositions category) were compared between the two court locations, MHC cases were resolved in fewer days (on average just over 7 days faster) than non-MHC cases, although this difference was not statistically significant. These analyses support the conclusion that, with the exception of cases eventually found not competent to stand trial,

³⁹ This is the date of the MCIS/ Municipal Court Information System data run.

MHC cases are resolved rapidly relative to other SMC misdemeanor cases, and there is no prejudicial impact on defendants related to timeliness in case processing. It is important to note that in cases involving extended competency issues the defendant typically spends many of the days between filing and resolution in a mental health evaluation and treatment facility, rather than in jail.

Table 12. Resolution Type for Misdemeanor and Infraction Cases by MHC/ non-MHC Location

MHC Misdemeanor Cases	N	Percent	
Defendant Not Competent	35	44.9	1. Includes dispositional order of continuance, deferred sentence, suspended sentence, stipulated order, etc.
Other Dismissal	7	9	
Sentenced ¹	32	41	
Pending	0	0	2. Includes Appeal Filed, Paid, Default, FT.
No Complaint Filed	0	0	
Miscellaneous ²	4	5.1	3. All Infractions cases were located in Non-MHC courts.
Total MHC Misdemeanors	78	100	
Non-MHC Misdemeanor Cases			
Defendant Not Competent	0	0	
Other Dismissal	71	44.0	
Sentenced	45	28.0	
Pending	5	3.1	
No Complaint Filed	28	17.4	
Miscellaneous	12	7.5	
Total Non-MHC Misdemeanors	161	100	
Infraction Cases ³			
Dismissal	21	33.9	
Sentenced	33	53.2	
Pending	6	9.7	
No Complaint Filed	2	3.2	
Miscellaneous	62	100	
Total Non- MHC Infractions			
Total Cases	301		

Table 13. Descriptive Statistics for Days to Case Resolution by MHC/Non-MHC Location

Case Location	N	Days	Median	Minimum	Maximum
Total MHC	77	25.96 (31.79)	15.0	1	130
Defendant Not Competent	34	36.71 (40.37)	21.5	1	130
Other MHC Disposition	43	17.47 (19.52)	14.0	1	86
Total Non- MHC Misdemeanors	159	20.68 (36.24)	2.0	0	209
No Charge Filed	28	1.43 (2.55)	1.0		14
Other Dispositions	131	24.79 (38.76)	5.0	1	209
Infractions	40	48.55 (62.96)	16.5	3	226
Total ¹	276	26.19 (41.07)	12.5	0	226

1. Of 301 cases, 25 had no disposition date.

Part VI. Recommendations

We were asked to make recommendations based on our findings. Some of these recommendations are actions that can be taken by the SMC on its own. Others will require SMC to take a leadership role in working with other branches of government and various system partners. As we noted in the Executive Summary, while the evaluation focused on the operations of the MHC, the evaluators recognize that the court system, the criminal justice system and the mental health system in which the MHC functions have the potential to diminish or dilute the MHC's effectiveness as profoundly as they can help sustain it.

The MHC, interacting as it does with so many different systems, is highly susceptible to changes in other systems and to the impact of the larger fiscal and political environments. We find that even since the evaluation activities commenced in early 2001, significant funding changes to the key systems outside the MHC's range of immediate influence have created a potential challenge to the MHC's continuing effectiveness.

Our recommendations to SMC are as follows:

1. Formally endorse and adopt the MHC model.
2. Provide the MHC with the needed staff and facility resources to accommodate the growth of the MHC caseload, which is anticipated to be more than 500 defendants in 2001, based on number of defendants seen year-to-date.
3. Establish a clear identity for the MHC. Identify the MHC as a specialized court in SMC [e.g., create staff, judge and attorney assignment lists, contact numbers, court signage, new employee orientation materials, training of SMC personnel outside of the MHC]. Establish within the SMC budget a specific MHC program budget that includes a dedicated MHC judge, court staff, space, training, etc. In addition to enhancing the institutional commitment to continuing the MHC, this will allow the SMC to more accurately track costs associated with the MHC, enabling future allocation decisions to be based on accurate budget history.
4. Clearly separate the MHC from the arraignment calendar. This step will help achieve recommendation # 3 above, by making the MHC clearly distinguishable as a dedicated court. It will also allow members of the MHC team and support staff to concentrate on the MHC caseload, rather than continuing to handle both caseloads on a daily basis. In separating the MHC from the arraignment calendar, the SMC should take care to protect the critically important early assessment and referral function done prior to arraignment. This can best be accomplished by establishing a case referral mechanism for new filings, training arraignment court personnel, developing new protocols, and establishing ways to monitor and evaluate the effectiveness of the protocols.
5. Provide a courtroom in the new Justice Center that meets the unique needs of the specialized MHC approach. The current jail-based courtroom space impacts not only SMC's ability to use the courtroom for other in-custody proceedings, but also is not

conducive to the goals and philosophy of the MHC. The MHC courtroom should address the need for confidential meeting space in or adjacent to the courtroom and to allow for the involvement of many participants in MHC proceedings. Since the courtroom will no longer be within the jail facility, increased transportation and security needs will result. Defendants will have to be accompanied by SMC marshals from the jail to the courtroom in the Justice Center by way of the tunnel. While this is true as well for most other SMC defendants, special care will need to be taken in the design of the security and transportation process in order to meet the unique needs and challenges of this population.

6. Establish a minimum tenure in the MHC of at least 6 months, with a 1-3 years as preferred,⁴⁰ for members of the MHC team, including the judge, attorneys, court monitor, probation staff, as well as courtroom personnel. Time and staff consistency are required for all members of the MHC team to become proficient with the unique approach and processes utilized by the MHC, and to ensure that the individualized, defendant-based approach is effective with individual defendants. In addition, in order to avoid several MHC players rotating out at the same time, thereby disrupting the team approach, transition planning should be created for each position so that staff turnover can be managed in a cyclical fashion.
7. Continue the new processes, procedures and mechanisms developed and established by the MHC team. The only new procedure not universally supported by key informants and stakeholders was the pre-hearing conference. Interview data suggested that opinions on this subject are strongly held but have not been fully aired within the SMC as a policy issue. The MHC presiding judge and team should review the advisability of continuing it in its present form, once the other recommendations in this evaluation are implemented that would allow different approaches to be considered.
8. Contract with a single defense agency for MHC defense services prior to relocating MHC to the Justice Center.⁴¹ The RFP should include criteria regarding the ability of the chosen agency to work within the MHC's philosophy and practices. Awarding the arraignment contract and MHC contract to the same agency could potentially expedite the integration of referral and assessment and appropriate case transfers to the MHC prior to arraignment, thus minimizing one of the risks noted in # 4 above.
9. Work with the City Attorney to get a dedicated prosecutor appointed to the MHC to complete the dedicated team concept. While traditional rotational practices of the prosecutor's office have been modified substantially to help ensure continuity and consistency of prosecutors by using a small number who are familiar with the MHC philosophy and practices, a dedicated prosecutor and back-up prosecutor have yet to be assigned.

⁴⁰ A 2-year tenure is standard in King County Superior Courts although the Drug Court Judge Michael Trickey will have completed a 3-yr term when he is re-assigned.

⁴¹ We understand that the Court has included this in their 2001 Work Plan.

10. Establish a maximum caseload standard for the MHC probation counselors and provide probation counselors to match increases in the defendant population. The MHC model is based on providing an intensive tracking of MHC defendants with community providers. Because the complexity and intensity of probation services required for defendants with mental illness is greater than with non-mentally ill offenders, appropriate caps on caseload size for MHC probation staff are strongly indicated. The reconvened MIO Task Force (recommended below) could develop consistent standards for these probation positions or SMC could utilize national benchmarks, if these are established.
11. Convene a series of meetings of judicial, prosecutorial, legislative and executive branch officials representing the City and County in order to consider mechanisms for consolidation of MHC cases with cases that may be pending in King County District Court Mental Health Court and King County Superior Court Drug Court and to explore the feasibility of consolidating the SMC MHC and the King County District Court MHC. Despite the strong sentiments evoked by stakeholders in the interviews, the evaluators view maintaining these courts as totally separate entities without investigating potential areas for increased collaboration, if not shared resources, as an unfortunate consequence of conflicts unrelated to the teams or functioning of these specialty courts.
12. The establishment of an ongoing committee for SMC program evaluation that, in addition to independent evaluation researchers, would include among its membership criminal justice and mental health professionals, and key representatives from the County agencies that have the most impact on SMC programs.

Our recommendations to SMC with necessary leadership by the County are as follows:

13. Reinstate the liaison role provided by the Jail Psychiatric staff to the MHC. Significant negative impact resulted from the discontinuation of this position by the jail.
14. Assure that the Court Monitor remains dedicated to the tasks of early identification and treatment linkages for MHC referrals. The Court Monitor has to juggle multiple defendant assessment and treatment plans in a very narrow window of time between booking and first hearing, communicate with family members and treatment providers for defendants on MHC conditions of release, and make recommendations to the MHC team for all defendants referred to the MHC. Currently the Court Monitor also provides some discharge planning services. Discharge planning might be more effectively managed within the detention facility through Jail Health Services or Jail Psychiatric Evaluation Services, or alternatively with an additional position assigned to the MHC.
15. A clinician with prescription-writing authority should be made available to the MHC for the review and facilitation of essential medication services. The success of mentally ill offenders in the community is often dependent on timely evidenced-based assessment for treatment needs, particularly those regarding medication initiation and management. This position or function could be on contract or could reside in Jail Health, with liaison responsibility to the MHC, and responsibility for ensuring swift medication assessment,

medication continuity between the hospitals and the jail and between the jail and the community. It could also provide assistance to reduce the waiting period for a prescription that would facilitate release from jail and compliance with medications for those defendants not housed in the jail psychiatric unit, but who nonetheless are in need of medications.

16. Modify the mental health provider contracts to contract annually with one or two mental health provider agencies to work with the MHC. Because of the complexities of MHC cases and the special forensic skills required to work with MHC clients, not all agencies can provide the intensity of services with the needed expertise for dealing with this population. The County and UBH should consider following the model that the Washington State Department of Corrections (DOC) has established with the mental health system by contracting with one or two agencies to provide services to MHC clients, rather than (contracting with) all 17 current providers. The benefit of utilizing a variety of agencies has been the ability of the MHC to address the geographic, cultural and language needs of the diverse populations served by the MHC. The County should ensure that these special needs continue to be addressed.
17. Explore ways to integrate jail psychiatric staff and jail health staff to minimize operational barriers created by different policies, practices and reporting structures. Due to budget cuts, both groups of personnel have faced staffing shortages that can exacerbate these kind of operational barriers.
18. Establish and convene a cross-systems work group with the MHC, UBH and various King County governmental divisions (including but not limited to King County Department of Adult and Juvenile Detention, Department of Community and Human Services and Seattle-King County Department of Health) to minimize barriers to service and define and implement practices and procedures for services to mentally ill defendants in custody. The lack of jurisdiction with regard to the jail, the mental health system and the chemical dependency system make it particularly difficult for the MHC to address daily operational issues under the jurisdiction of these entities. Routine issues include defendant referrals, medication continuity, provider access, and transportation of defendants to and from hospitalization related to involuntary commitment and competency restoration.
19. Reconvene the Mentally Ill Offender Task Force to address ramifications of mental health, chemical dependency and jail funding cuts and continuing problems in service coordination and adequacy of service availability across systems. Sufficient time has passed since the initial MIO Task Force to review and re-assess these issues, as well as the impact of changes in laws, here and elsewhere in the country, governing competency issues and involuntary treatment. These difficult problems are best addressed in regional process that includes key stakeholder participation.

goal of addressing the defendant's mental illness treatment needs in a fashion that does not further punish the individual because of a recognized disability.

As stated above, the Seattle Police Department (SPD) is integral to the early identification of defendants recommended for the MHC. In addition to the responding officer's recommendation for MHC included on the booking form, the SPD's Crisis Intervention Team (CIT) provides a daily "front end" read of incident reports, looking for comments and descriptors about a defendant's situation that could benefit by closer review for mental health needs. Similarly, this CIT unit provides a beneficial "back end" safety net with immediate notification when warrants on MHC defendants are issued, when coordinating information about defendants with investigations from other jurisdictions, and when keeping victims informed about court processes.

The Jail Psychiatric and Jail Health Units of the King County Correctional Facility (the jail) are also key partners to the MHC process. They play a critical role in referring defendants to the MHC and in assuring that services needed for the MHC defendants are provided during any incarceration. This includes monitoring for medication reviews, assisting case managers to obtain easier access to the jail and organizing release provisions. The MHC has worked to create partnerships with jail psychiatric and health staff, and with other units in the jail, such as the court detail unit, in order to implement processes and procedures that allow a multi-system model like the MHC to work well.

The Forensic Services Division of Western State Hospital (WSH) is also of critical importance to the MHC, since the SMC MHC has more defendants with competency proceedings than any other court in the state. The MHC has worked with WSH to develop new processes allowing for quicker evaluations, more efficient communication and more immediate transportation of defendants.

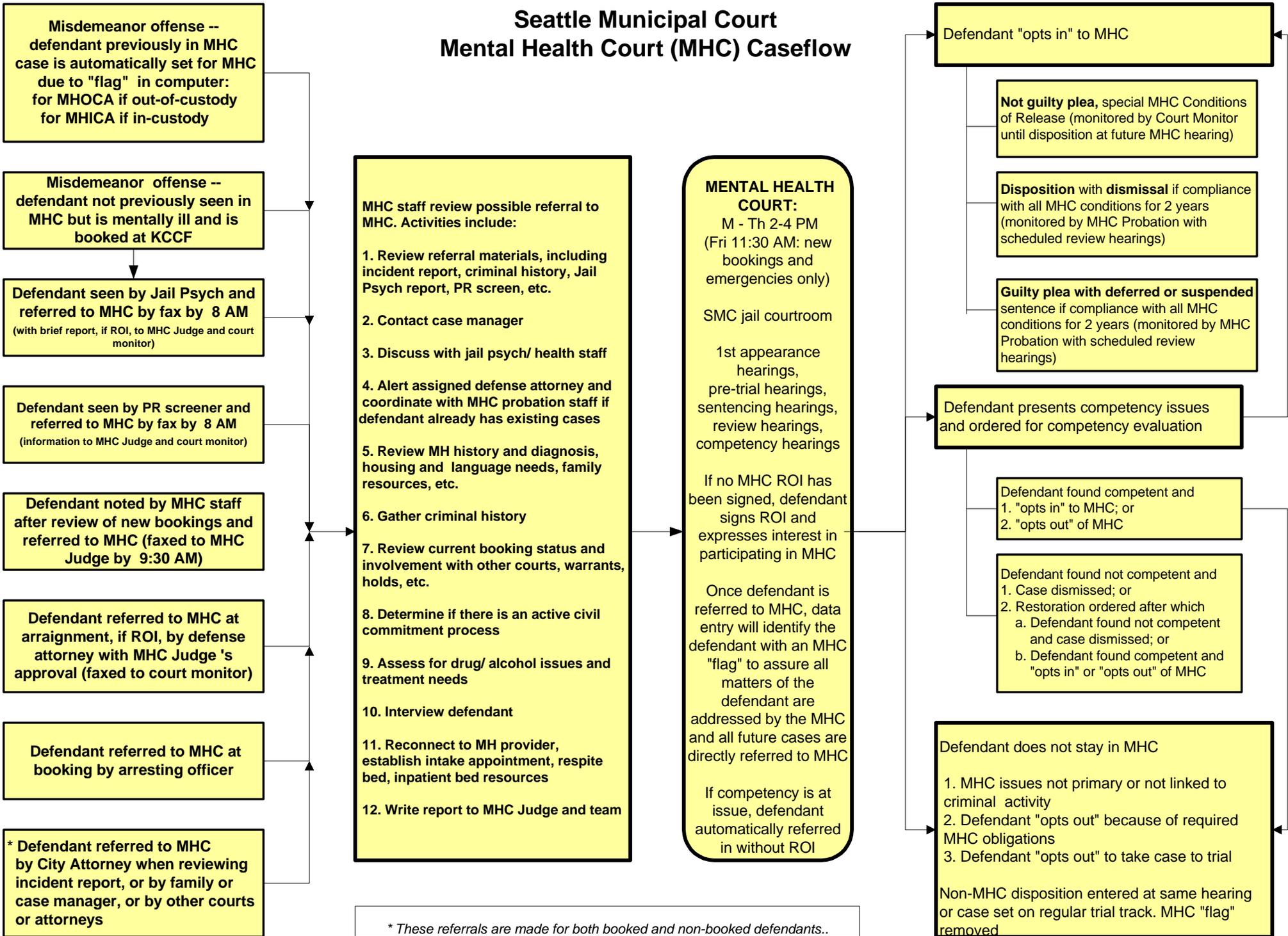
Another significant partner with the MHC across systems has been the King County Mental Health Chemical Abuse and Dependency Division. MHCADS manages the contract with United Behavioral Health, which in turn contracts for all community-based mental health services. In addition, MHCADS encompasses the units housing both the CDMHPs and the staff responsible for chemical dependency involuntary commitments.

At the direct service level, the quiet heroes of the MHC are the case managers and treatment staff of the mental health provider community. The MHC is able to function as a treatment facilitator because the mental health community has agreed to be actively and collaboratively engaged with defendants who have become involved with the criminal justice system. Because an arrest is not a planned event, case managers won't know which of their clients may be referred to the MHC on a given day. They are called upon by the MHC Court Monitor daily between 8 and 10 AM, for treatment plans and information about defendants being considered for the MHC. This response has significant impact on the nature and terms included in the MHC order at the first appearance hearing, as well as at subsequent hearings. The case managers appear at court hearings as needed and are called upon by the MHC judge to provide information that is critical for continued success of the defendant in meeting the

conditions of the ordered treatment plan and ultimately the defendant being able to remain in the community.

Lastly, a unique group of partners has emerged in the MHC's first years. The MHC hosted numerous visitors from throughout the nation who came to Seattle to observe the MHC in operation, with interest in developing a MHC in their own communities or in building strong linkages in Washington State. These visitors helped identify issues and made suggestions that assisted the MHC in becoming more effective in its efforts. The list of visitors for 2000-2001 is included in the Appendix to this report.

Seattle Municipal Court Mental Health Court (MHC) Caseflow



* These referrals are made for both booked and non-booked defendants..

Seattle Municipal Court Mental Health Court Evaluation

Key Informants Interviewed

Harborview Medical Center Crisis Triage Unit (CTU): Program Mgr Ed Dwyer-O'Connor and staff Ann Allen, Tammy Baer, Jerry Lubeck and Briggita Folz

King County Dept. of Adult & Juvenile Detention Jail Health Services Ass't Nursing Supervisor Kari Petersen and Kate Kalb

King County Dept. of Adult & Juvenile Detention Jail Psychiatric Services Administrator Larry Smith and Jail Psychiatric Services staff, Greg Powell and Mike Roleru

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADS), Cross-Systems Integration, Dept. Admin Patrick Vanzo and Program Analyst Margaret Smith

King County MHCADS County Designated Chemical Dependency Involuntary Treatment, Program Coordinator Richard (Dick) Andrews and Brenda Meyer

King County MHCADS County Designated Mental Health Professionals (CDMHPs) Supervisors Amnon Shoenfeld and Jody Schneider

Mental Health Providers: Community Psychiatric Clinic (CPC) CEO Shirley Havenga and Clinical Director Christine Hearth; Seattle Mental Health (SMH) Manager of MH and CJ Systems Programs Declan Wynne; Downtown Emergency Services Center (DESC) Exec. Director Bill Hobson and Clinical Programs Manager Graydon Andrus; and Asian Counseling & Referral Services (ACRS) Clinical Manager Connie Cheng

Mental Health Providers: Program Managers / MHC Liaisons and Case Managers for 4 agencies: CPC Program Manager Kelli Nomura and MHC liaison Kris Frederickson; SMH Coordinator of Community Reintegration Services Kate Huntley; DESC Clinical Supervisor Nicole Zacher and Case Manager Peter Snell; and ACRS Program Manager Phillip Long and Clinical Supervisor Damien Yee

Seattle City Attorneys Tamera Soukup, Cindi Williams, Laura Petregal and Case Prep Supervisor Suzanne Hatfield

Public Defenders Associated Counsel for the Accused (ACA) staff attorneys Duncan Lewis and George Eppler

Seattle Mental Health Court Court Monitor Rob Fors

Seattle Municipal Court Court Services Director Mary Lewis; Court Services Manager Bob White; MHC Court Operations staff Court Clerks Pam Brown and Julie Giovanni, Bailiffs Cathy Mayovsky and Kim Dudley, and Marshal Ron Pace

Seattle Municipal Court Mental Health Court (MHC) Judge Anne Levinson

Seattle Municipal Court Mental Health Court (MHC) Judge *pro tem* Joan Pedrick

Seattle Municipal Court Probation Services Div (PSD)/ MHC Probation Counselors Kathy Moellering and Laurie Hanowell, former MHC PC Rick Hume, MH Probation Counselor Mekka Robinson, PSD DV and MH Supervisor Joni Wilson and PSD Director Susanne White

Seattle Municipal Court Project Specialist Lois Smith

Seattle Police Dept. Crisis Intervention Team (CIT) Sgt Liz Eddy & MHC Liaison Officer Susie Parton

United Behavioral Health Program Director Tony Van Jones and Clinical Director Alan Weisser

West Seattle Psychiatric Hospital Director Clinical Care Coordinator Mickey Clary and Discharge Planner Bonnie Pendley

Western State Hospital Competency Evaluation (Forensics) Carl Redick, Ph.D. and Competency Restoration / In-patient Admissions Dai Nakashima. Ph.D.

Key Stakeholders Interviewed

Seattle City Council Public Safety Committee Chair Jim Compton

Seattle City Council Finance Committee Chair Jan Drago

Seattle City Attorney Mark Sidran

King County Executive Ron Sims

King County Councilmember Larry Gossett

King County Superior Court Drug Court Judge Michael Trickey

King County Department of Adult and Juvenile Detention Director Steve Thompson

King County Department of Community and Human Services Director Barbara Gletne

King County Executive's Public Safety Advisor Steve Nolen

Seattle Mayor's Chief of Staff Maud Smith Daudon

Seattle City Budget Office staff Doug Carey and Anne Friedlander

Seattle Municipal Court Court Administrator Yolande Williams

Seattle Municipal Court Judge Fred Bonner

Seattle Municipal Court Judge Jean Rietschel

Seattle Municipal Court Judge Judith Hightower

Seattle Municipal Court Judge Kimi Kondo

Seattle Municipal Court Judge Michael Hurtado

Seattle Municipal Court Judge Ron Mamiya

Seattle Police Department Chief Gil Kerlikowske

National Advocates for the Mentally Ill/ Washington's Advocates for the Mentally Ill (NAMI/ WAMI) Executive Director Eleanor Owen

National Alliance for the Mentally Ill/ Washington State Chapter President Tom Richardson

Neighborhood Crime Prevention Seattle Neighborhood Group Executive Director Kay Godefroy

Seattle Municipal Court Mental Health Court

KEY INFORMANT INTERVIEW QUESTIONS: General

- G1. What are the MHC's primary goals?
- G2. Please rate to what extent the court is accomplishing the stated goals (show prompt)?
- a. (Low accomplishment)
 - b. (Low to substantial accomplishment)
 - c. (Substantial to high accomplishment)
 - d. (High accomplishment in all goal areas)
 - e. (Do not know/not sure)
- G3. How would you recommend changing or modifying the MHC's primary goals?
- G4. What are two strengths of the MHC?
- G5. What are two weaknesses of the MHC?

Referral/Population

- R1. Who is the target population? Has it been consistent throughout the MHC's operation? Please explain.
- R2. How does the target population compare with the current population?
- R3. In your opinion, are the criteria for referral to the MHC too restrictive, not restrictive enough, or just right? Please explain.
- R4. Please describe your role in the referral process.
- R5. How do you think the referral process is working?
- R6. Please identify any existing barriers to the referral process.
- R7. Are there differences between defendants who opt-in to the court compared to those who opt-out? If so, can you describe these differences? [Prompt: If the informant is not comfortable with the opt-in opt-out distinction, please ask that they explain why].
- R8. What factors appear to be influential in a defendant's decision to participate in MHC?
- R9. How would you assess the rate at which defendants choose to participate in MHC?
- a. (Poor)
 - b. (Fair)
 - c. (Good)
 - d. (Excellent)
 - e. (Do not know/not sure)
- R10. How would you recommend improving the rate of participation by defendants in MHC?

Mental Health Court Approach

C1. The MHC is described as defendant-centered and highly individualized. Do you agree with this description? Describe any aspect of MHC that you view as particularly important or different from other traditional courts.

C2. What aspect(s) of the Mental Health Court approach would you recommend modifying?

C3. Please rate the court's ability to assess defendants' mental health status/needs for initial hearings:

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

Please explain:

C4. Please rate the court's ability to assess defendants' substance abuse status/needs for initial hearings:

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

Please explain:

C5. Please rate the court's ability to identify defendants' housing status/needs for initial hearings:

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

Please explain:

C6a. What should be the objectives of initial MHC hearings?

C6b. Do these objectives occur?

C7a. What changes would you recommend to improve the *quality of information* available at initial hearings?

C7b. In what other ways would you recommend changing the initial MHC hearing process and/or procedures?

C8a. What are the objectives of the MHC's review hearings?

C8b. Do these objectives occur?

C9a. What changes would you recommend to improve the *quality of information* available at review hearings?

C9b. In what other ways would you recommend changing the review hearing process and/or procedures?

C10. Compared to other traditional courts, has MHC allowed extra courtroom time for initial hearings? If yes, in your opinion, has there been an impact on case outcomes? Please explain.

C11. Compared to other traditional courts, has MHC allowed extra courtroom time to process cases (i.e., review cases)? If yes, in your opinion, has there been an impact on case outcomes? Please explain.

C12. How are issues of FTA (failure to appear), and other warrants handled differently by the MHC?

C13. Please give two strengths and two weaknesses of how the MHC handles FTA's and warrants.

C.14. How is the issue of competency handled differently in the MHC as compared to non-traditional courts?

C15. What does the MHC do to reduce jail time for defendants?

C16. How would you rate the MHC's overall performance with respect to reducing defendants' time spent in jail?

- a. (Low)
- b. (Fair)
- c. (Good)
- d. (Excellent)
- e. (Do not know/not sure)

Please explain:

C17. What obstacles exist to further reductions in defendant jail time?

C18. Could the MHC take other steps to further reduce jail time for defendants?

C19a. What preference or priority does the court appear to place on obtaining specific types of case dispositions (guilty pleas, deferred sentences, suspended sentences, deferred prosecution, dismissal etc., length of sentence)? Does this differ from other courts? How?

C19b. Are diversions used differently in the MHC than in traditional courts?

C20. We have discussed the priority given to different case dispositions within the MHC. Should these priorities be changed? (If yes, in what way?)

C21. Please rate the MHC's ability to balance transitioning defendants into the community with public safety.

- a. (Insufficient concern for community safety)
- b. (Appropriate amount of concern for community safety)
- c. (Excessive concern for community safety)
- d. (Do not know/not sure)

Please explain:

C22a. How does the MHC manage defendants' obligations from other Seattle Municipal courts? How would you recommend improvements in this area?

C22b. How does the MHC manage defendants' obligations in other non-Seattle Municipal courts? How would you recommend improvements in this area?

C23a. Describe the relationship of the MHC with the Seattle Police Department.

C23b. Describe the impact of this relationship on defendants.

C24. Describe the range of sanctions and incentives used by the MHC?

C25. Please describe the MHC's ability to balance the use of sanctions and incentives.

C26. How effective is the use of sanctions and incentives in changing the behavior of MHC participants?

- a. Not effective
- b. Somewhat effective
- c. Moderately effective
- d. Very effective
- e. Not sure

MHC Team

S1. How do the roles and responsibilities of the MHC team differ from those of other courts? (Show prompt). Please emphasize discussing your own role in your response.

S2. Do you perceive any role conflicts or inefficiencies in the MHC team roles and responsibilities?

S3. How would you recommend modifying the roles and responsibilities of MHC team members? (ask about each individually): Judge, Program Manager, Court Monitor, Court Clerk, Public Defender, Social Worker, City Attorney, Probation Counselors

S4. Please rate the extent to which there is a shared vision among the different MHC team members.

- a. (Low)
- b. (Low to Med)
- c. (Med to High)
- d. (High)
- e. (Do not know/not sure)

S5. How is collaboration and information sharing different in the MHC than in traditional courts?

S6. How could collaboration and information sharing be improved among MHC team members?

S7. Are policies, procedures, protocols, and expectations comprehensive and clear enough to cover the majority of situations encountered by you as a member of the MHC team?

S8. Please rate the level of collaboration/information sharing that takes place between the MHC team members and jail staff?

- a. (Low)
- b. (Low to Medium)
- a. (Medium to High)
- b. (High)
- c. (Do not know/not sure)

Please explain:

S9. How would you recommend improving collaboration/information sharing between MHC team members and jail staff?

S10. How are operational problems and emergent situations managed on an ongoing basis?

S11. How are the MHC's boundaries/interactions with other systems (e.g., mental health providers, civil commitment system, substance abuse system) developed, managed, and maintained?

S12. The MHC is premised on the idea that a consistent group of team members will better serve mentally ill defendants. In your opinion, has the consistency of the core team of professionals improved case processing?

S13. What is the optimal range of tenure for each role in the MHC?

S14. Has the MHC provided training for its team members? If yes, how many hours and what type? Is training needed? If yes, how much and what type?

S15. Over the course of implementation, how much has the MHC's team members improved their level of understanding in relation to mental health issues?

- a. No improvement
- b. Low level of improvement
- c. Substantial level of improvement
- d. High level of improvement
- e. Do not know/not sure

Please explain:

S16. If the levels of understanding have improved: to what extent have improved levels of mental health understanding impacted the team members' behavior/work performance?

- a. No impact
- b. Low level of impact
- c. Some impact
- d. High level of impact
- e. Do not know/not sure

Please explain:

Probation

P1. How does the role of the MHC probation counselor differ from the role of probation officers in traditional courts?

P2. How are the conditions of probation for MHC defendants different from those in a regular court?

P3. When a defendant is not following the conditions of his/her probation, what types of responses are carried out by the probation counselor to foster compliant behavior prior to recommending revocation?

P4. What are the formal and/or informal protocols guiding Probation Counselors' decisions to recommend probation revocation?

P5. How would you recommend changing the probation and court supervision process for defendants?

P6a. How do the roles of MHC probation counselors and treatment providers overlap?

P6b. What are two strengths of this overlap? Two weaknesses?

Treatment

T1. Please describe and rate the timeliness of mental health treatment services (time between initial referral for treatment and the first day of treatment).

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T2. Please describe and rate the engagement strategies used by MHC defendants' mental health treatment providers.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T3. Please describe and rate the frequency of treatment and case management interventions implemented by MHC defendants' mental health treatment providers.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T4. Please describe and rate the type and intensity of mental health treatment and case management services provided for MHC defendants.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T5. Please describe and rate the collaboration that takes place between the court core staff and the mental health treatment providers.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T6. Please describe and rate the collaboration that takes place between the jail staff and the mental health treatment providers.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T7. Please describe and rate the MHC/mental health treatment providers' ability to link defendants to medical and financial assistance.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T8. Please estimate the proportion of MHC defendants who are in need of housing upon referral to the court.

T9. Please describe and rate the MHC/mental health treatment providers' ability to link defendants in need of housing to appropriate housing.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T10. Please describe and rate the MHC/mental health treatment providers' ability to provide or link defendants to integrated mental health/substance abuse treatment services – for those in need.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T11. Please describe and rate the coordination that takes place (among court staff, jail staff, mental health treatment providers, housing providers, substance abuse treatment, medical/financial assistance, family etc.) on behalf of MHC clients.

Sufficient for:

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T12. In your opinion, what parts or elements of the MHC have had the most impact on treatment outcomes?

T13. How has the overall MHC process affected clients' treatment outcomes?

T14a. Please identify sub-populations for whom providing necessary treatment services have been especially challenging.

T14b. Specifically for clients with co-occurring disorders, please describe the availability of residential services and it's impact on defendants.

T15. How often during court review hearings and other court sessions are mental health case managers present?

- a. 0-20% of cases
- b. 21-40% of cases
- c. 41-60% of cases
- d. 61-80% of cases
- e. 81-100% of cases
- f. Do not know/not sure

T16. How are MHC mental health treatment services (including treatment monitoring) different for those defendants already enrolled in the public mental health system upon referral to the MHC court?

T17. How does the MHC monitor defendants' treatment progress?

T18. How do the roles of court monitor and treatment providers overlap?

T19. What are two strengths of this overlap? Two weaknesses?

T20. What is the role of the MHC in monitoring provider performance after referral/enrollment? What should be the MHC's role in regard to the quality of post-referral services?

T21. In general, how can mental health treatment and other necessary services be improved for MHC clients?

Overall

O1. How would you rate the adequacy of the organizational structure of the MHC?

- a. (Poor)
- b. (Fair)
- c. (Good)
- d. (Excellent)

O2. How would you modify the organizational structure of the MHC to improve its effectiveness and/or efficiency?

O3. How does the arraignment courtroom setting affect the functioning of the MHC?

O4. In your opinion, how would the functioning of the MHC be affected by moving the court from of the arraignment courtroom of the jail to the Justice Center expected to open in 2002?

O5. What might be the strengths and weaknesses of consolidating MHC with other specialty courts, for example, with the King County MHC?

O6. If consolidation of courts were proposed, how should consolidation be initiated or developed?

O7. Please describe and rate the degree to which the MHC has facilitated greater overall linkages between the criminal justice system and the mental health treatment provider system.

- a. (Low)
- b. (Low to Medium)
- c. (Medium to High)
- d. (High)
- e. (Do not know/not sure)

O8. Is there an appropriate role for coercive treatment in the MHC? Please describe.

O9. What methods/procedures/systems are currently in place for supporting ongoing evaluation of the MHC?

O10. What legislative or policy changes would you recommend in order to improve the effectiveness/efficiency of the MHC?

O11. Do you believe the MHC program in its present form represents a wise use of public resources? Why or why not?

Mental Health Treatment Provider Questions

M1. Please describe and rate the frequency of communication you have experienced with:

MHC Court Monitor	No Communication 1 2 3 4 5 Very Frequent
MHC Probation Officers	No Communication 1 2 3 4 5 Very Frequent
MHC Social Worker	No Communication 1 2 3 4 5 Very Frequent
Defense Attorney	No Communication 1 2 3 4 5 Very Frequent
Prosecuting Attorney	No Communication 1 2 3 4 5 Very Frequent
Jail Staff	No Communication 1 2 3 4 5 Very Frequent

M2. Please describe and rate the effectiveness of communication – in terms of providing coordinated services for your clients -- you have experienced with:

MHC Court Monitor	Not Effective 1 2 3 4 5 Very Effective
MHC Probation Officers	Not Effective 1 2 3 4 5 Very Effective
MHC Social Worker	Not Effective 1 2 3 4 5 Very Effective
Defense Attorney	Not Effective 1 2 3 4 5 Very Effective
Prosecuting Attorney	Not Effective 1 2 3 4 5 Very Effective
Jail Staff	Not Effective 1 2 3 4 5 Very Effective

M3. Please describe how your staff members participate in MHC clients' review hearings.

M4. How often do staff accompany clients at MHC hearings:

- Rarely
- On occasion
- Fairly Often
- Frequently
- At every hearing staff is made aware of

M5. Please describe how, if at all, MHC clients -- as a group -- are different from other clients on your caseload.

M6. What parts or elements of the MHC have had the most impact on you clients' therapeutic process? Generally speaking, how has the MHC impacted your clients' therapeutic process?

M7. What obstacles exist in meeting the treatment needs of MHC clients?

M8. How does your staff respond to issues of treatment non-compliance by MHC clients?

M8b. How does the court intervene to improve compliance?

M9. Please identify and describe what elements or strategies have proven effective in engaging and treating MHC clients and ultimately improving their stability and well being in the community.

M10. Services typically provided to MHC clients (circle all that apply)

- | | |
|--|---|
| <input type="checkbox"/> risk assessment | <input type="checkbox"/> crisis intervention |
| <input type="checkbox"/> medication management | <input type="checkbox"/> group therapy |
| <input type="checkbox"/> case management services | <input type="checkbox"/> individual therapy |
| <input type="checkbox"/> home visits | <input type="checkbox"/> day treatment |
| <input type="checkbox"/> housing assistance | <input type="checkbox"/> behavior therapy |
| <input type="checkbox"/> assistance obtaining financial assist | <input type="checkbox"/> referral for other therapy |
| <input type="checkbox"/> assistance obtaining medical assist | <input type="checkbox"/> substance abuse (outpatient) |
| <input type="checkbox"/> assistance with other benefits | <input type="checkbox"/> substance abuse (inpatient) |
| <input type="checkbox"/> referral for health issues | <input type="checkbox"/> protective payeeship |
| <input type="checkbox"/> money management | <input type="checkbox"/> family therapy |
| <input type="checkbox"/> other (specify) | |

M11. Please recommend ways to improve the MHC in general and specifically its coordination with mental health treatment providers.

M12. How many hours of cross-training (criminal justice/mental health) have you received? What areas and levels of training would you recommend mental health treatment staff serving MHC client receive in the future?

KEY STAKEHOLDER INTERVIEW QUESTIONS

1. How has the Mental Health Court been brought to your attention since its inception?
2. Has the existence of the Mental Health Court impacted the way you think about the mental health and criminal justice systems? If so, how?
3. Do you believe the MHC program in its present form represents a wise use of public resources? Why or why not?
4. What have been the strengths of the Mental Health Court?
5. From your perspective, what are the most important or valuable components of the MHC?
6. What are the most important impacts or outcomes of the MHC?
7. In what areas, if any, would you recommend the Mental Health Court improve?
8. How would you suggest Mental Health improve its support among key stakeholders and the public?
9. What legislative or policy changes, if any, would you recommend in order to improve the efficacy of the Mental Health Court?



SEATTLE MUNICIPAL COURT
MHC CONDITIONS OF RELEASE
VOID - SAMPLE

Defendant name _____ DOB _____

Case # _____ Charge(s): _____

Case # _____ Charge(s): _____

During the period of release from jail and until the next court date (listed below), the defendant agrees to comply with all the following conditions:

1. Reside at: _____
(address)

(City) (State) (zip) (Phone)

2. Follow all rules and regulations of this residence.

3. Attend all appointments with _____
(name) (agency)

(Address) (City) (State) (zip) (Phone)

Weekly _____ / Daily _____ / As scheduled by case manager _____

4. Get approval of the caseworker/ case manager (listed in # 3 above) before changing residence. Notify case worker/ case manager of any change in phone number (or contact ph number) within 24 hours of change.

5. Take all medications as prescribed.

6. Refrain from use of alcohol and non-prescribed drugs and comply with random urinalysis, if cause.

7. Refrain from acts and threats of harm to self, others, and others' property.

8. Commit no criminal law violations.

9. Possess no weapons.

10. Other: _____

11. **Appear for next hearing on _____ at 2 PM in Court # 7 (Courtroom is on the 1st floor of the jail / KCCF @ 5th and James St.). Bring proof of compliance with items above.**

Compliance with these Conditions of Release will be monitored by Rob Fors, MHC Court Monitor, 206-291-1018. Case Managers are expected to promptly advise Court Monitor of any violations.

(Defendant's signature)

(Date)



SEATTLE MUNICIPAL COURT
MHC CONDITIONS OF SENTENCE / DISPOSITION¹
VOID - SAMPLE

Defendant name _____ DOB _____ Case # _____

Charge(s) : _____ Jail Term: _____

Charge(s) : _____ Jail Term: _____

The defendant shall, for a period of (___ 90 days/ ___ 1 yr / ___ 2 yrs/ ___ other) and upon completion of his/her jail term on (date) _____, do the following:

1. Reside at: _____
(address)

(City) (State) (zip) (Phone)

2. Follow all rules and regulations of this residence.

3. Attend all appointments with _____
(name) (agency)

(Address) (City) (State) (zip) (Phone)

Weekly _____ / Daily _____ / As scheduled by case manager _____

4. Get approval of the caseworker/ case manager (listed in # 3 above) before changing residence. Notify case worker/ case manager of any change in phone number (or contact ph number) within 24 hours of change.

5. Take all medications as prescribed.

6. Refrain from use of alcohol and non-prescribed drugs and comply with random urinalysis, if cause.

7. Refrain from acts and threats of harm to self, others, and others' property.

8. Commit no criminal law violations.

9. Possess no weapons.

10. Other: _____

11. **Appear for next hearing on _____ (if no date is included here, the next hearing will be scheduled by a MHC Case Coordinator) at 2 PM in Court # 7 (this courtroom is on 1st floor of the jail @ 5th & James Sts.).**

Compliance with these Conditions will be monitored by a MHC Case Coordinator and case managers are expected to promptly advise Case Coordinator of any violations. Case Coordinator monitoring this case is [Kathy Moellering, ph 206-615-1471] or [Laurie Hanowell at ph 206-615-1961].

(Defendant's signature) (Date)

¹ Includes Stipulated Orders of Continuance, Orders on Pre-Trial Diversion, Dispositional Continuances, etc.

Appendix: Defendant Outcome Comparison Groups

Rationale and Overview of this Appendix

This appendix contains comparisons of the MHC Core Participant group with two other relevant groups. It was felt by the MHC Evaluation Advisory Committee that these analyses were of secondary importance to those centered solely on MHC core participants, which are the only individuals for whom the MHC has claimed any intended effect or for which the MHC has any responsibility in regard to community outcomes. Comparisons in this section were performed to provide a context for understanding what happens to MHC core participants relative to other misdemeanor defendants who have at some point been identified as potentially being appropriate for a mental health court. Presentation of findings and interpretations of analyses in this section closely follow the method and order of presentation in Part V. of this report, but with the inclusion of one or more comparison groups.

The first group for which comparisons are made consists of individuals referred during the same interval used to select the core participant sample (February 1, 2000 and June 30, 2000) who were never placed on Conditions of Release/Sentence. We followed the same methodology of data collection described in Part V. of this report. The second group to which comparisons are made are individuals referred to another mental health court, the King County District Mental Health Court (KCDMHC) studied previously by two of the co-authors of this report (KCDMHC) (Trupin, Richards, Lucenko, 2000).

The first set of comparisons is that of core participants to defendants with only limited involvement with the MHC. We will refer to those individuals who were referred to the MHC but did not go out on MHC Conditions of Release/Sentence as “MHC Off” participants and to those making up the group of core participants who were eventually placed on Conditions of Release/Sentence and who received specialized supervision as well as referral and linkage services as MHC On participants.

It is important for the reader to keep in mind the fact that these two contrast groups (MHC Off and MHC On) are not the same as a control and experimental group. The MHC Off group can be assumed to have different characteristics in regard to criminal severity and mental health severity than the MHC On group, since the two groups are identifiable only as the result how the MHC decisions about how to handle these individuals and their cases. Among the factors influencing these decisions were the individual’s clinical status, criminal history, and current willingness to cooperate with the MHC, and the characteristics of the current offense(s). The defendant’s decision to participate or not would, of course, be influenced by factors such as severity of the offense and previous criminal history and the quality of evidence against the defendant, all of which might affect the defendant’s judgment of regarding the risk of going to trial versus the benefit or burden of participating in the MHC.

Comparisons are also presented of the MHC core participants with fairly comparable subjects referred King County District Court-Mental Health Court (KCDMHC). Defendants referred to these two courts (MHC and KCDMHC) are incarcerated in the same detention facility and are provided mental health services through the same county managed care system, often in

the same agencies. The Court Monitors in the two courts work for the same managed care provider. Only a few city blocks geographically separate the two courts. MHC cases originate within the city limits with the Seattle police being the most typical arresting authority, whereas KCDMHC cases originate in other areas of the County, with the King County police being the typical arresting authority. We reasoned that although the contingencies leading to arrest and detention might vary in the two jurisdictions, one highly urban and the other largely suburban, common goals and processes of a mental health court process might to some extent level out these differences. The KCDMHC comparison also provided the research advantage of an identified group of individuals referred to a mental health court who did not systematically receive referral and linkage services (KCDMHC Opt-Outs) and a group of individuals who received intensive services (KCDMHC Opt-Ins). This more stark distinction among those referred allowed for using the relationship between the expected performance of the KCDMHC Opt-Out and Opt-In groups as lower and upper benchmarks, respectively, against which the experience of the MHC could be meaningfully compared. Nevertheless, the reader is again cautioned not to assume that these groups are equivalent to experimental and control groups. This caveat is important because it is possible that any differences that might be found between these two groups could be due to many factors that were not examined in this research.

Description of MHC ON MHC OFF Combined Sample

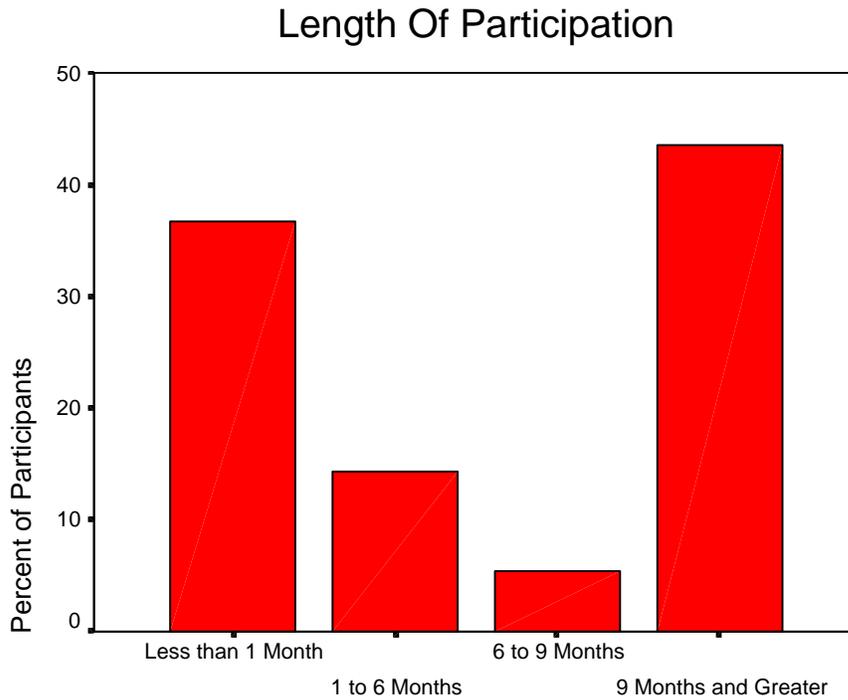
The combined sample of 147 defendants was 73 % male and 27 % female had a mean age of 38.57¹ (11.05) ranging from 18 to 74. The women were on average 4 years older than the men, a difference that was statistically significant.¹ The ethnic composition of the sample was similar to that for the MHC core participants as described in Section V of the main body of the report.

Length of Participation

Length of participation was calculated from the date of referral to the MHC to date of removal or the end of the period of observation (March 30, 2001) whichever came first. The mean number of days of participation was 176.49 (159.69) with a range of 1 to 423 days. 25% of participants had 12 days or less, 50% had 145 days or less, and 75% had 330 days or less. Figure 1 displays an abbreviated distribution of days of participation using four unequal categories: Less than 1 month, 1 to 6 months, 6 to 9 months, and 9 months and greater. These categories were used as a simplified best fit to the distribution of this variable. The large percent of referred individuals who have 9 months or more of participation with the MHC reflects the growing population that results from retention of cases on supervision for up to 2 years.

¹ Throughout the text and tables of this report standard deviations are reported in parentheses following the respective mean.

Figure A1. Distribution of Length of Participation



Engagement in Treatment

Based on MHCADSD data, although a lower percentage of MHC OFF participants were engaged in treatment following contact with the MHC than were MHC ON participants (64.9% versus 72.9%, respectively) this difference was not significant.

Comparisons of defendants based on placement on conditions revealed that the MHC ON group had a very low rate of missing records and a more rapid engagement rate.

Table A1. Engagement in Treatment Services

	Sample	MHC OFF	SMC ON
Documented Engagement	71%	59%	92.7%
Mean	18.33 (30.56)	26.74 (40.26)	11.23 (16.21)
Median	6	10	5
Mode	1	4	1
25 percentile	2	4	1
50 percentile	6	10	5
75 percentile	28	31	13
Minimum	1	4	1
Maximum	175	175	76

Note: Sample N=94, SMC OFF N=43, SMC ON N=51.

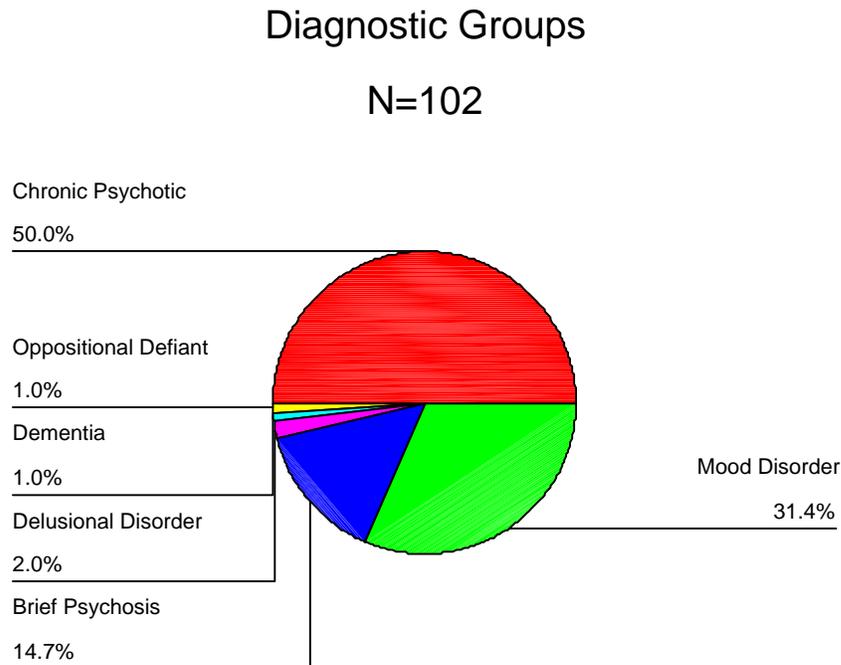
Diagnosis

Diagnostic data for Axis I clinical syndromes were available for 102 of 133 persons. The breakdown appears in the following table and chart. There were no significant diagnostic differences between MHC ON and MHC OFF groups for those with a diagnosis in the MHCADSD data base. Placement on conditions was not related to diagnostic category. Many of these clients carry several other diagnoses that are not the primary focus of treatment for the King County Mental Health care providers. For example approximately, one third of those with available mental health data had a diagnosis of a personality disorder in their record. Diagnosis was unrelated significantly to detention variables, with the exception of a two significant positive correlation of having any psychotic disorder (Category 1 or category 3) and serving days on a filing after the first release post referral to the MHC (N=94, $r = .236$, $p < .02$) and the rate of bookings after referral to the MHC (N=94, $r = .218$, $p < .02$). These correlations indicate a moderate tendency for those with psychotic disorders to be re-arrested more frequently and to serve more time related to these bookings after their contact with the MHC.

Table A2. Diagnostic Groupings for 102 Referred Defendants

	N	Percent
Chronic Psychotic Disorder	51	50.0
Major Mood Disorder	32	31.4
Brief Psychosis	15	14.7
Delusional Disorder	2	2.0
Dementia	1	1.0
Oppositional Defiant Disorder	1	1.0
Total	102	100.0

Figure A2. Diagnostic Groups



Intensity of Treatment

We were interested in comparing the number of treatment episodes and total number of minutes of treatment received during the pre and post referral periods. Data entries in the data base provided to us ended on December 15, 2000. We calculated the number of days from referral to this date for each individual. Having calculated the number of days of observation post referral, we then limited our inspection of pre referral data to an equivalent interval. On average, individuals were observed for 258.47 (44.73) days, with a median of 261 days, a mode of 167 days and range of 167 to 317 days. Both the increase in treatment episodes and the increase in treatment minutes received over the pre to post referral periods were significant using nonparametric procedures for the two groups.² These analyses suggest that the MHC was successful in increasing treatment episodes and total minutes of treatment. Analyses by group, in Table A3, indicate that for the contrast groups separately, only the MHC ON group experienced a significant increase in a treatment intensity variable, that being a significant increase in treatment episodes.

Table A3 Treatment Episodes and Total Minutes Treatment Received, N= 101.

	Pre-MHC	Post-MHC	
MHC ON N=52			
Treatment Episodes	67.52 (96.9)	74.54 (149.14)	$p < .03$, two-tailed. ¹
Hours of Treatment	53.05 (129.52)	48.05 (100.05)	$p = .091$ m two-tailed, NS. ²
MHC OFF N= 49			
Treatment Episodes	45.96 (82.50)	52.16 (82.24)	$p = .077$, two-tailed, NS ³
Hours of Treatment	37.17 (79.69)	46.08 (97.57)	$p = .057$, two-tailed, NS ⁴

1. Wilcoxon Signed Ranks Test, $Z = -2.177$, $p < .03$.
2. Wilcoxon Signed Ranks Test, $Z = -.1.689$, $p = .091$, two-tailed, NS.
3. Wilcoxon Signed Ranks Test, $Z = - 1.768$, $p = .077$, two-tailed, NS.
4. Wilcoxon Signed Ranks Test, $Z = - 1.902$, $p = .057$, two-tailed, NS.

These analyses indicate that the MHC OFF group contained a large percent of mentally ill individuals that were in many ways comparable to the MHC ON group. After referral to the MHC, these individuals were engaged in treatment to a lesser extent and experienced smaller increases in treatment intensity than MHC ON participants.

Analysis of Detention Data

The sample of 147 persons was observed for a period of 22.27 months. On average defendants detention history was captured for 10.38 (1.46) months prior to their referral to the MHC and for 11.89 (1.46) months after MHC referral. The booking level analyses of these data are presented prior to the presentation of the analysis of data aggregated at the subject and group (MHC Off and MHC On) levels.

Booking Level Data

The 147 defendants logged 451 bookings in the King County Detention Center during the period of observation. Time spent on temporary release from jail, usually to a hospital or other treatment facility, was removed and not counted as part of jail time. In addition to categorizing bookings and associated jail days as pre or post MHC referral, bookings can be categorized as related to misdemeanors, felonies, or a combination of the two. Also, the court of jurisdiction for the charged offenses for each booking can be categorized by jurisdiction as SMC, NonSMC and combined jurisdictions. Descriptive statistics for booking and average jail days served by jurisdiction of origin, felony/misdemeanor and observation period are contained in Table A4, which also contains the appropriate statistical tests for differences between the pre-post periods. Defendants spent an average of 25.58 (41.57) days in jail on a booking, with a median of 10 days, a mode of 2 days, and a range of 1 to 327 days.

A total of 11,536 days were served over the 22.27-month observation period. Jail days were served at the approximate rate of 598 days per month in the Pre-MHC Referral period and at the approximate rate of 448 days per month in the Post-MHC Referral period. Some of the savings

of 150 days per month on average in the Post-MHC Referral period may be attributable to the effects of the MHC. However, it is not possible to gage how much of the reduction in jail time is related to individuals who were never prone to recidivism, and who would have had few or no new bookings after those captured in the post MHC period. When individuals with only one booking in the Pre-MHC Referral period the rate of jail days served is 488 per month in the Pre-MHC Referral period and 443 days per month in the Post-MHC Referral period, or a savings of 45 days per month. This comparison suggests that much of the reduction in jail days in over the two periods is attributable to defendants who were not chronic offenders and high utilizes of the detention facility (i.e., those with only one booking in the Pre-MHC Referral period).

Examination of the Table A4 reveals that the significant increase in days served per booking in the post compared to pre referral period is due primarily to SMC bookings for offenses with misdemeanor charges and offenses with mixed misdemeanor and felony charges. The increase on average of almost 7 days per booking for SMC cases are particularly important because in the post referral period the SMC category includes bookings for which the MHC is responsible.

Aggregate Level Analysis

Booking data and associated jail days were aggregated at the individual and contrast group (MHC Off and MHC On) levels. Table A5 contains descriptive statistics for defendant and group level detention data for total bookings and total jail days over the 22.27-month observation period. The means suggest that the MHC On group was a higher severity group, with more bookings and more jail days.

Table A5. Average Aggregated Bookings and Jail Days Served Over 22.27 Months.

	N	Bookings	Jail Days
Sample	147	3.06 (2.85)	78.63 (98.16)
MHC Off	82	2.66 (2.58)	73.50 (96.20)
MHC On	65	3.58 (3.11)	85.11 (100.96)

Since defendants were referred at different points in time and observed for different pre and post referral intervals, annualized booking rates and annualized jail day rates were calculated to provide a basis of comparison. Annualized booking rate variables were computed for each of three observation periods: Total (22.27 months), Pre-MHC Referral, and Post-MHC Referral. Individuals who had no bookings or jail days in either the pre or post period were assigned a rate of 0 for that period. 145 individuals had bookings in the Pre-MHC Referral period, whereas 72 had new bookings in the Post-MHC referral period (a 49% reincarceration. rate over an average period of 11.7 months). In the Post-Referral Period, 44.4 % of MHC Off participants had at least one new booking, compared to 55.6% of MHC On participants, a statistically significant difference indicating a higher reincarceration rate among MHC On participants.³

Table A6 contains descriptive statistics for annualized rates with the appropriate statistical tests for the difference between the pre-post periods. Annualized bookings dropped significantly over the pre-post period for the total sample, and for both contrast groups. Although annualized jail day rates declined on average for the sample and the MHC On contrast group over the pre-post period, these decreases were not statistically significant. However, the MHC Off group did experience a statistically significant decrease in jail days served over this period. This finding parallels that of decreased bookings for MHC Off defendants, suggesting a favorable response to MHC referral for this group in regard to future detention.

It is possible that booking and jail day rates can drop on average for defendants while simultaneously remaining unchanged, decreasing, or even increasing for defendants that are reincarcerated. We examined this possibility. Table A7 contains the statistics for Pre-MHC referral and Post-MHC referral booking and jail rates limited to the 70 individuals who had one or more Pre-MHC bookings and one or more Post-MHC bookings, that is to only those who were reincarcerated during the observation period. Among these reincarcerated defendants, booking rates declined on average, but this decline was only significant for the MHC Off group. In regard to jail days served, reincarcerated defendants experienced an increase in the rate of jail days served. This difference was only significant for the MHC Off group who spent on average a jail rate of almost 11 days per year higher in the Post-MHC referral period than in the Pre-MHC Referral period.

Taken together these findings indicate that the MHC had the effect overall of decreasing bookings primarily through the impact of the referral and linkage function applied to individuals in the MHC Off contrast group. While the MHC appears to have caused decreased bookings overall, those defendants that are booked are spending more time in jail on each new booking, and that this increase is significant for those in the MHC Off group. Although the MHC Off group defendants were significantly less likely than those on MHC conditions to be reincarcerated, when they were returned to jail it was for significantly longer stays than prior to their referral to the MHC. The increase in jail days for the MHC Off group could be due to the imposition of increased sanctions for individuals who are not involved with the MHC. The decrease in jail days averaging 4 days per year for the MHC On group is not statistically significant, meaning that it is not interpretable, since it can be attributed to chance.

Although support was found for the MHC reducing new bookings for its core participants, these analyses do not support the conclusion that the MHC significantly reduced jail days for its core participants, and evidence was found for increased jail days for referred defendants who were later reincarcerated.

Comparison Of MHC Detention Data to King County MHC

We compared the core participants of the MHC (MHC On) with the core participants of another mental health court, KCDMHC Opt-In participants. KCDMHC Opt-In participants had demographic and diagnostic characteristics similar to those of the MHC On participants (Trupin, Richards, Lucenko, 2000). Table A8 contains descriptive statistics and statistical test for

comparisons of rate variables for the core participants of two mental health courts, MHC On participants and KCDMHC Opt-In participants. The means and standard deviations are similar enough in the two groups to suggest that individuals in these two groups are from the same population. Examination of tests for the difference between groups revealed that the two core participant groups were significantly different at the Pre-MHC period, such that the KCDMHC core participants had a significantly lower booking rate. Although both groups experienced a decline in bookings, the difference between groups was no longer significant in the Post-MHC period, indicating that the MHC On group had caught up from behind to the point that they were statistically equivalent to the Opt-In participants, who the historically lower average booking rate. In regard to jail day rates, the MHC On group began with a much higher jail rate than the Opt-In group in the Pre-MHC period. Because of a modest and nonsignificant decrease in jail day rates in MHC On group and a large increase in jail day rates for Opt-In defendants, the two groups were statistically equivalent in the Post-MHC period. Taken together these analyses suggest that the MHC was equally or more effective than the KCDMHC in reducing new bookings. While jail day rates increased for the core participants of the KCDMHC, the MHC contained jail rates for its core participants.

References

Trupin, E., Richards, H.J., Lucenko, B. (2000). King County District Court Mental Health Court Phase I Process Evaluation Report. King County District Court, Seattle: WA.

Table A4. Booking Variables by Category

Booking Category	N	Total Observation	N	Pre-Referral	N	Post Referral	
<u>Jurisdiction</u>							
SMC	265	19.71 (34.34)	175	17.47 (36.82)	90	24.07 (28.62)	P < .001 ²
NonSMC	124	24.89 (36.01)	62	24.56 (35.18)	62	25.21 (37.11)	NS ³
SMC and NonSMC	61	52.71 (64.87)	35	46.46 (66.93)	26	61.11 (62.28)	P = .052 ⁴
<u>Charge Type</u>							
Misdemeanors	318	21.48 (39.36)	208	18.85 (40.81)	110	26.47 (36.13)	P < .001 ⁵
Misdemeanors and Felonies	50	51.51 (56.43)	27	49.15 (53.44)	23	54.28 (60.84)	NS ⁶
Felony Investigations	82	25.82 (33.57)	37	25.92 (36.18)	45	25.74 (31.68)	NS ⁷
Total Bookings	450	25.61 (41.61)	272	22.82 (42.45)	478	29.88 (40.03)	P < .001 ⁸

² Krukis-Wallis Test, Chi-Square (df=1) = 12.397

³ Krukis-Wallis Test, Chi-Square (df=1) = .007

⁴ Krukis-Wallis Test, Chi-Square (df=1) = 3.764

⁵ Krukis-Wallis Test, Chi-Square (df=1) = 13.036

⁶ Krukis-Wallis Test, Chi-Square (df=1) = .340

⁷ Krukis-Wallis Test, Chi-Square (df=1) = .021

⁸ Mann-Whitney Z = -3.546

Table A6 Aggregated Annualized Booking and Jail Day Rates

Annualized Booking Rates					
	N	Annualized Bookings	Booking Rate Pre-MHC	Booking Rate Post-MHC	t-test for paired means (Pre to Post)
Sample	147	1.65 (1.53)	2.16 (1.70)	1.23 (1.82)	t (146) = 6.660, p <.001, 2-tailed.
MHC Off	82	1.43 (1.36)	2.10 (1.73)	.86 (1.44)	t (81) = 7.520, p <.001, 2-tailed.
MHC On	65	1.93 (1.69)	2.23 (1.67)	.95 (2.14)	t (64) = 2.348, p <.05, 2-tailed.
Annualized Jail Day Rates					
	N	Annualized Jail Days	Jail Day Rate Pre-MHC	Jail Day Rate Post-MHC	t-test for paired means (Pre to Post)
Sample	147	42.37 (52.89)	49.24 (77.26)	36.98 (64.96)	t (146)=1.587, p =. 115. 2-tailed, NS.
MHC Off	82	39.61 (51.83)	50.03 (74.84)	31.09 (61.26)	t (81)=1.988, p <.05, 2-tailed.
MHC On	65	45.86 (54.40)	48.24 (80.77)	44.42 (69.11)	t (64)=.301, p = .541, 2-tailed, NS.

Table A7. Annualized Booking And Jail Day Rates For Reincarcerated Defendants.

Annualized Booking Rates				
	N	Booking Rate ² Pre-MHC	Booking Rate Post-MHC	t-test for paired means (Pre to Post)
Reincarcerated	70	2.92 (2.06)	2.55 (1.90)	t (69) = 1.440, p = .154, 2-tailed, NS.
MHC Off	30	3.26 (2.19)	2.28 (1.55)	t (29) = 2.555, p < .025, 2-tailed.
MHC On	40	2.66 (1.94)	2.75 (2.13)	t (39) = -.281, p = .780, 2-tailed, NS.
Annualized Jail Day Rates				
	N	Jail Day Rate Pre-MHC	Jail Day Rate Post-MHC	t-test for paired means (Pre to Post)
Reincarcerated	70	19.89 (24.53)	30.79 (28.63)	t (69)= -2.831, , p = .095. 2-tailed, NS
MHC Off	30	19.60 (24.68)	38.38 (36.26)	t (29)= -2.781, p < .01, 2-tailed
MHC On	40	20.10 (24.72)	25.10 (19.88)	t (39)=-1.164, p = .251, 2-tailed, NS

Table A8. Comparison of Annualized Booking and Jail Day Rates for MHC and KCDMHC Core Participants.

Annualized Rate	Group	N	M (SD)	t-test for Difference
Total Bookings	Opt In MHC On	31 65	1.13 (.66) 1.93 (1.69)	$t(95) = -3.322, p = .00, 2\text{-tailed.}$
Bookings Pre-MHC	Opt In MHC On	31 65	1.36 (.76) 2.23 (1.67)	$t(95) = -3.5071, p < .001, 2\text{-tailed.}$
Bookings Post MHC	Opt In MHC On	31 65	.79 (1.07) .95 (2.14)	$t(95) = -.4883, p = .6267, 2\text{-tailed, NS.}$
Jail Days Total	Opt In MHC On	31 65	22.93 (26.71) 45.86 (54.40)	$t(95) = -2.2184, p < .01 2\text{-tailed.}$
Jail Days Pre-MHC	Opt In MHC On	31 65	16.69 (24.53) 48.24 (80.77)	$t(95) = -2.2184, p < .01 2\text{-tailed.}$
Jay Days Post-MHC	Opt In MHC On	31 65	37.82 (60.50) 44.42 (69.11)	$t(95) = -.4548, p = .6503. 2\text{-tailed NS.}$

Note: Significant values are in bold type.

¹ $T(145) = -2.124$, $p < .04$, two-tailed.

² Episode comparison: Wilcoxon Signed Ranks Test, $Z = -2.452$, $p < .015$. Treatment minutes comparison: Wilcoxon Signed Ranks Test, $Z = -2.758$, $p < .007$.

³ Chi-Square (1) = 7.355, $p < .01$, 2-tailed.

VISITORS TO SMC'S MHC 2000/ 2001

One of the operating practices of the Mental Health Court (MHC) is to encourage other system partners to observe MHC proceedings, offering us suggestions and recommendations, and minimizing system barriers as we build relationships. Another practice is to welcome visitors from jurisdictions around the country who ask to observe MHC as part of their exploration of innovative processes designed to better address the unique needs of mentally ill offenders.

Over the past 2 years, more than 150 visitors from a variety of local, national and international jurisdictions have asked to observe MHC proceedings and participate in a post-court Q&A (Question-and-Answer) session with the MHC team. Some of our best innovations have come from suggestions made in these sessions.

	Date	VISITORS to MHC	Count
1.	2-14-00	Seattle Neighborhood Group Executive Director Kay Godefroy	1
2.	2-23-00	Dept of Social and Health Services (DSHS) Belltown Community Service Office Administrator Margey Rubado	1
3.	2-28-00	Seattle Police Department Crisis Intervention Team (CIT) Sgt Lisbeth Eddy	1
4.	3-6-00	National Institute of Corrections (NIC) Criminal Justice Professionals Board	10
5.	3-14-00	Case Managers for Downtown Emergency Services Center and Kerner-Scott House	5
6.	3-16-00	Seattle Housing Authority Case Manager Shaun Walsh; and Seattle Municipal Court Finance Division Acting Director Mary Rabal	2
7.	3-20-00	Seattle Housing Authority Case Manager Denise Highley	1
8.	4-15-00	Case Managers for Downtown Emergency Services Center and Kerner-Scott House	5
9.	5-10-00	State of Washington Department of Corrections, Mental Health Unit, Kathy Stout and Lyn Francis	2
10.	5-16-00	Seattle Municipal Court Probation Services Division new MH Supervisor Joni Wilson and PCs Ameo Butler and Laurie Hanowell	3
11.	5-24-00	King County Superior Court Drug Court Judge Michael Trickey, Program Manager Mary Taylor, Treatment Alternatives to Street Crimes/ TASC staff Faire Lees, and 2 Drug Court public defenders	5
12.	5-31-00	Brooklyn Community Court Project Director Valerie Raine and Jayme Delano-Fitzgerald, and Center for Court Innovation Sr Planner Derek Denckla	3
13.	6-27-00	Mental Health Agency Legal Liaison Enrique Digala, CONSEJO	1
14.	6-29-00	City of Seattle Strategic Planning Office Assistant Director Bob Scales	1
15.	7-26-00	State of Washington Joint Legislative Audit & Review Committee, Principal Management Auditor, Robert Krell	1
16.	8-2-00	Washington State Senator Pat Thibadeau, 43rd District	1

17.	8-7-00	Seattle Municipal Court new staff orientation	5
18.	8-10-00	City of Seattle Strategic Planning Office staff Jen Chan	1
19.	8-16-00	Criminal Justice and Social Service System visitors from Sioux City (Woodbury County), Iowa	9
20.	8-23-00	Contributing Editor to King County Bar Bulletin Henry Wiener	1
21.	8-29-00	City of Seattle Human Services Division Planners Karen Dawson and 4 staff	5
22.	9-11-00	Criminal Justice and Social Service System visitors from Charleston, SC including Judge Irv Condon and Schelley Strasberg, Drug Court Coordinator	2
23.	9-13-00	Criminal Justice visitors from Wichita, KS Probation Division	2
24.	9-18-00	Criminal Justice and Social Service visitors from Charleston, SC and Pennsylvania	7
25.	10-16-00	Downtown Emergency Service Center Executive Director, Bill Hobson	1
26.	10-24-00	City of Seattle Councilmember Jim Compton and Deputy Mayor Tom Byers	2
27.	11-28-00	Criminal Justice and Social Service System visitors from Kansas City, Mo and NH.	12
28.	11-30-00	Case Managers from Plymouth Housing Group	5
29.	12-06-00	Washington State Representative Al O'Brien, 1 st District; House Democratic Caucus Senior Counsel House of Representatives Jane Beyer; and King County MHCADS staff Terry Mark	3
30.	1-11-01	Society of Counsel Representing Accused Persons attorneys Brad Meryhew and Ann Potter	2
31.	1-25-01	Seattle Police Department Crisis Intervention Team (CIT) Sgt. Lisbeth Eddy and MHC police liaison, Officer Suzanne Parton	2
32.	1-30-01	Criminal Justice and Social Service visitors from Springfield, Missouri; Cowlitz County, WA; and Yamhill County, Oregon	12
33.	2-1-01	WA Juvenile Rehabilitation Administration Juvenile Justice Administrator Marilyn Perry and Dan Schaub	2
34.	2-21-01	Criminal Justice and Social Service System visitors from Boulder, Colorado	6
35.	3-28-01	Criminal Justice and Social Service System visitors from British Columbia; King County Mental Health, Chemical Dependency and Abuse Division staff Margaret Smith; and Dr. Henry Richards, Washington Institute for Mental Illness Research and Training	5
36.	3-29-01	Seattle Municipal Court new staff orientation	5
37.	4-4-01	Case Managers from Community House; and Defense Agency TDA Social Worker Monaliese Earl	7
38.	4-9-01	Case Managers from Rose of Lima Housing Project; and Carole Bruschi, UW doctoral student	3
39.	5-3-01	Executive Director WAMI/ NAMI, Eleanor Owen	1
40.	5-7-01	MHC Research evaluators Drs. Eric Trupin and Henry Richards	2
41.	5-9-01	Social Service visitors Kate Hunter and Jim Hauser, People Circle Proposal	2

42.	5-10-01	Mental Health professionals from Muldova (previously Romania), guests of the United States State Department	7
43.	6-4-01	Seattle Municipal Court new staff orientation	9
44.	6-14-01	Criminal Justice and Social Service Colorado MIO Task Force Director and member Ray Slaughter and Dr Tom Barrett	2
45.	6-28-01	Captain Willie Johnson and Major Ruth Wyatt from Hinds County, Mississippi	2
46.	6-28-01	CBO Budget Analyst Anne Friedlander and intern Elise Downer	2
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