6-27-2011

A Case Study of Allegheny County, Pennsylvania's Mental Health Court: Balancing Therapeutic Jurisprudence and Public Safety

Melanie Pallone
Indiana University of Pennsylvania

A CASE STUDY OF

ALLEGHENY COUNTY, PENNSYLVANIA'S MENTAL HEALTH COURT : BALANCING THERAPEUTIC JURISPRUDENCE AND PUBLIC SAFETY

A Dissertation

Submitted to the Department of Criminology

and the School of Graduate Studies and Research

in Partial Fulfillment of the Requirements

for the Degree of Doctor of Philosophy

Melanie Pallone

Indiana University of Pennsylvania

May 2011

Indiana University of Pennsylvania
The School of Graduate Studies and Research
Department of Criminology

We hereby approve the dissertation of

Melanie Beth Pallone

Candidate for the degree of Doctor of Philosophy

February 23, 2011	Signature on File
_____	_____
	Kathleen Hanrahan, Ph.D Professor of Criminology
February 23, 2011	Signature on File
_____	_____
	Erika Frenzel, Ph.D Assistant Professor of Criminology
February 23, 2011	Signature on File
_____	_____
	John Gibbs, Ph.D Professor of Criminology
February 23, 2011	Signature on File
_____	_____
	Alida Merlo, Ph.D Professor of Criminology

ACCEPTED

_____ _____

Timothy P. Mack, Ph.D
Dean for Research
The School for Graduate Studies and Research

Title: A Case Study of Allegheny County, Pennsylvania's Mental Health Court: Balancing Therapeutic Jurisprudence and Public Safety

Author: Melanie Pallone, Esq.

Dissertation Chair: Dr. Kathleen Hanrahan

Dissertation Committee Members: Dr. Erika Frenzel
Dr. John Gibbs
Dr. Alida Merlo

ABSTRACT: When support mechanisms that keep mentally ill offenders from committing crimes break down, many of these special offenders have been incarcerated, contributing to a decline in their welfare and problems for society upon their release. Like drug courts, mental health courts arose in response to a crisis, allowing these offenders to be diverted from jail and instead directed to appropriate treatment and supports, along with intensive probationary controls. Restorative justice and therapeutic jurisprudence underpin the diversion of mentally ill offenders back into the community.

This study examined the inception of a specific large mental health court and the inner working of the courtroom workgroup formed to handle the dual duty of treatment and regulation of offenders with serious mental illness. Creation of the mental health court in Allegheny County, Pennsylvania, occurred after a formal program had already been in place to assist mentally ill offenders in treatment while diverting them from jail, and allows for longer periods of probation and monitoring of participants. The research employed in-depth qualitative inquiry of past and present stakeholders in the court process, including semi-structured interviews with court team members and participants, observation of courtroom and workgroup behavior in both public and private settings,

and document analysis, and triangulated data with various court and agency records of court characteristics and participant behavior.

Primary goals of this case study were to add to the literature on this emerging area of criminal justice research on problem-solving courts, by probing a specific local decision to implement and fund a mental health court, by delving deeply into the formation and functioning of this court's workgroup and the experiences of its participants, and by illustrating possible improvements in the case processing model that might be accomplished for this and other courts. Implications include what might be necessary and appropriate for a mental health court to be founded and to operate successfully, regarding both treatment of mentally ill offenders and regulation of their behavior for community safety. Findings may be useful to assist jurisdictions contemplating a mental health court, respecting court and agency personnel, case processing, community treatment resources, participant pools, sanctions systems, and funding.

ACKNOWLEDGEMENTS

This study was completed with the aid and support of a number of special people.

Loving thanks goes to my parents, grandparents, and surviving sibling and spouse for endorsing me, both in this educational endeavor, and the concomitant challenge of changing careers as an adult. Special thanks go to my father for his technical assistance and critiquing of my thoughts, and my mother for for encouraging me. Thanks goes to my boyfriend, for his English skills, and for unknowingly providing me a source of personal adversity to overcome. And love to my niece for being a new source of inspiration.

I am grateful for the professors and peers in the Department of Criminology at the Indiana University of Pennsylvania who believed in my ability as a non-traditional student to follow this path. Also, I am grateful for those with whom I have studied and practiced law who supported my desire to embark on a new challenge.

My appreciation goes to the staff of the Office of Behavioral Health in the Department of Human Services and to the Court Team and Participants of Allegheny County's Mental Health Court, for allowing me the insights into this special court.

My gratitude goes to all my Committee Members for their willingness to serve and to share their knowledge with me. They never cease to amaze with the levels of work and scholarship they are able to maintain.

Deepest and heartfelt thanks go to my Chair, for her graciousness in guiding a novice through this arduous process. She is a consummate editor, and an example of what it means to pursue qualitative research in earnest. Moreover, she has had infinite patience with me as few could have, and I am forever in her debt.

Here is to past and present students--they deserve recognition for showing me why life-long learning is a valuable pursuit for both teacher and student.

TABLE OF CONTENTS

CHAPTER I.

INTRODUCTION

Mentally Ill Persons in the Criminal Justice System

This dissertation examined the inception, structure, and functioning of a mental health court. The examination was done through the actions and relations of the courtroom workgroup who managed treatment and regulation of mentally ill persons charged with crimes and referred to the court for processing, and through the experiences of those mentally ill offenders within the court. The study also explored tenets of restorative justice within this court's functioning, from the vantage of those attempting to incorporate it and those who may have benefited from it. The research format was a case study of a single jurisdiction, a mental health court located in Allegheny County, Pennsylvania. It was conducted in the context of the history and effectiveness of drug courts, the development of mental health courts in the U.S., and in the needs of the jurisdiction where it sits.

The proportion of people having some kind of mental illness in our criminal justice system is much higher than in the population at large. A recent survey comparing prisoner data with pyschiatric hospital inpatient data estimated that on average, there are three times the numbers of mentally ill receiving treatment in U.S. prisons and jails as are in state psychiatric hospitals, with the worst odds in some states nearly ten to one (Torry, Kennard, Eslinger, Lamb, & Pavle, 2010, p. 8). According to the American Psychiatric Association, twenty per cent of prisoners had some form of serious mental illness

(American Psychiatric Association, 2000, Introduction, xix). The problem of large numbers of mentally ill in prison is not solely an American one, either. Reports from the United Kingdom show ever-increasing transfers of persons with mental disorders from jails to forensic hospitalization, attributing the problem in part to insufficient community care and failures of law enforcement to divert them in the first place (Rutherford & Duggan, 2008, p. 5). In a review of surveys from 12 western nations, Fazel & Danesh (2002) found that numbers of prisoners with psychosis or major depression were several times greater than in the general population (p. 548).

Furthermore, rates of recidivism for the seriously mentally ill, even when defined as return to prison (as opposed to arrest), compound the problem for corrections administrators faced with shrinking service resources. One recent look at a 5-year slice of everyone released from the Utah State Prison system showed that the median time for seriously mentally ill offenders to return to prison was about fifty per cent shorter than others (about 1 year versus about 2 years), and seriously mentally ill parolees were sent back to prison an average of 200 days earlier than others (Cloyes, Wong, Latimer, & Abarca, 2010, p. 182).

With the widespread closing of state mental institutions beginning in the 1970s, a void was left for the treatment of many of the nation's chronically mentally ill. No one has proven that the deinstitutionalization of the mentally ill from hospitals is directly responsible for the increase of that population in correctional institutions, but it has been shown to be the most plausible explanation (Lamb & Weinberger, 1998, pp. 486-7). State hospitals had sadly become known for frequent patient abuses, and the idea was to replace them with community-based mental health care. However, the social response in

the last few decades has unfortunately been functionally and financially insufficient. An assortment of community-based mental health providers have come about in the last several decades with the closing of state mental hospitals. But such services can be confusing for the mentally ill to navigate, and programs are often subject to the limitations of insufficient funding (Osher & Levine, 2005, pp. 3-4; 12).

Given the shift from public psychiatric hospitalization to community mental health treatment, and the drastic shortages to funding of both, the seriously mentally ill with "disruptive public behaviors" have become more involved in the criminal justice system. Many seriously mentally ill persons have not been connected to outpatient mental treatment care, or made good use of it. From police encounters to court cases to sentencing to re-entry, real issues exist of how best to handle and fund their cases at arrest, inside jails or prison, or upon their release pre-trial or via probation or parole. (Lurigio & Fallon, 2007, pp. 363-6). As a result, when the social support mechanisms that would keep them from committing crimes break down, many mentally ill persons have instead been institutionalized within jails and prisons.

Correctional institutions are not designed for the adequate care of the mentally ill, and attempts to provide for their care are inferior compared to community care resources. The National Association for the Mentally Ill asserted in a recent white paper that our correctional facilities are inherently incapable of providing adequate therapy for the mentally ill, as their charge is to provide social control (National Alliance on Mental Illness [NAMI], 2008, p. 3). Our criminal justice system is becoming a repository for persons with serious mental disorders. Unfortunately, affected individuals can further decompensate when exposed to the hazards of incarceration.

Mentally ill convicts report much higher levels of physical and sexual abuse prior to being admitted to jail or prison or beginning probation; further, they report higher percentages of alcohol or drug dependence. The mentally ill who are incarcerated or on probation tend to have longer criminal histories than their counterparts who have not reported prior treatment for mental illnesses. In state prisons, they serve longer sentences; they also tend to have more frequent disciplinary problems while incarcerated in either prisons or jails (Ditton, 1999, pp. 1; 3; 6-9). And the mentally ill on parole or probation face greater risks of recurring criminal problems without access to the means to cope with life's pitfalls, such as treatment, appropriate housing, and other supports (Ditton, 1999, p. 5). After a two-year investigation of the state of correctional care for the mentally ill after deinstitutionalization, Human Rights Watch published a report where they summarized conditions:

> [P]risons are dangerous and damaging places for mentally ill people. Other prisoners victimize and exploit them. Prison staff often punishes mentally ill offenders for symptoms of their illness – such as being noisy or refusing orders, or even self-mutilation and attempted suicide. Mentally ill prisoners are more likely than others to end up housed in especially harsh conditions, such as isolation, that can push them over the edge into acute psychosis. Woefully deficient mental health services in many prisons leave prisoners undertreated – or not treated at all. Across the country, prisoners cannot get appropriate care because of a shortage of qualified staff, lack of facilities, and prison rules that interfere with treatment.

(Abramsky & Fellner, 2003, Preface).

The criminal justice system may not be the best institution to address management of mentally ill offenders, but it must deal with them once they have entered the system (Osher & Levine, 2005, pp. 38-9). Incarceration is contributing to a decline in the welfare of mentally ill offenders, and greater problems for them and the rest of society upon their release. For the well-being of the mentally ill, for the protection of others in

society, and for alleviation of the burden on the court and corrections systems, different approaches were sorely in need.

Pre- and post-trial programs began to divert from jail or prison the population of the seriously mentally ill who were arrested or to be sentenced to incarceration. Mental health courts have sprung up, both to address the underlying breakdowns that led to the affected population ending up in the criminal justice system, and to relieve draining of resources from correctional facilities (Kondo, 2001, pp. 269-73; 288-89; 306-11). Drug courts arose in response to a similar crisis within the criminal justice system; when many offenders, but for the addiction, had no history of criminality, they were diverted from jail and instead directed to appropriate treatment in concert with intensive probationary controls. The call has gone out for professionals to train to work with mental health courts, just as they learned to do with drug courts (Tyuse & Linhorst, 2005, pp. 238-9). It should come as no surprise that the numbers of diversionary programs for mentally ill offenders have exploded in recent years.

Purpose for and Goals of this Case Study

While recognizing the potential shortcomings of mental health courts and lack of research documenting their effectiveness, many in the mental health community see them as worth attempting as an alternative to imprisoning the mentally ill (Harvard Mental Health Letter, 2006, pp. 4-6). The number of mental health courts has quickly grown to two hundred or more nationwide. To assist jurisdictions unfamiliar with the territory of

such courts, the Bureau of Justice Assistance (2006) and the Council of State Governments (2005) have produced technical manuals on designing and implementing mental health courts for jurisdictions contemplating start-up of one, and have sponsored research on the same (Almquist & Dodd, 2009); (Thompson, Osher, & Tomasini-Joshi, 2007).

While a portfolio of research has been done on the value of drug courts, mental health courts are relatively new and criminology lacks much study of these diversionary courts as of yet. To date, as described in Chapter II, most examinations of mental health courts have been either surveys of the components and process of mental health courts, short-term quasi-experimental evaluations of court efficacy, general attempts to demonstrate the value of therapeutic jurisprudence to the mentally ill offender, or concerns about the loss of due process rights for diversion participants.

In the decade since the majority of those courts began operating, little study has been done on specific local decisions to implement and fund mental health courts, individual examinations of the formation and functioning of their courtroom workgroups, experiences of participants, or how one might best structure these courts in particular locales within the local legislation and law enforcement conditions. The goal of this research was to thoroughly understand and analyze the workings of one particular mental health court, Allegheny County's Mental Health Court, in the context of the history and effectiveness of mental health courts in the U.S. and in the context of the jurisdiction where it sits in Pittsburgh, Pennsylvania. A review of both qualitative and quantitative data was conducted, but in the end it was fundamentally a qualitative investigation.

One objective of the instant research was to investigate the choice of a model for the court implemented in this community. The literature review entails an historical overview of drug courts to place the development of mental health courts in the context of the diversionary court model. It then reviews the nature of model mental health courts as put forth by the Bureau of Justice Assistance and by private research entities. Mental health courts around the country take different structures, to suit the goals of the government unit in which they sit, and the needs of the population they serve. There was a deliberate selection of the model used in Allegheny County, yet the court incepted here has also gone through some changes in its several years of operation. This part of the case study is a descriptive process, detail of which may help to guide other counties in the state seeking to start a court in their jurisdiction.

After description of the local court's history and construction, the next objective was to examine the court's daily operations, its strengths and weaknesses, and its utility for its given goals. This portion of the inquiry was qualitative in nature. The researcher directly interviewed the people engaged in the work of the court, especially those persons who make up the "workgroup" who perform various functions necessary to processing of cases and management of the mentally ill offenders whose cases were referred to the Court. Invested in its daily operation, the workgroup members are the best evidence of its desired function within a qualitative inquiry.

As permitted by Indiana University of PA's Institutional Review Board, the researcher also interviewed a number of mentally ill offenders who participated in the Court about their experiences, with their informed consent. Participant offenders in the Mental Health Court—both graduates and non-graduates—may be the best evidence of

its real function within a qualitative inquiry. Additionally, the researcher engaged in field observation of the processing of cases not only in open court, but observed behind-the-scenes meetings of various members of the courtroom workgroup as they made decisions on whether to accept potential participants in the court, what stipulations to impose on a defendant's probation, whether or not a participant had been compliant with the plan designed for him or her, and when to graduate a participant from the Mental Health Court. Finally in the qualitative inquiry, the researcher reviewed documentary evidence regarding the formation of the court, its evolution, and its current format.

The researcher believed it was essential to undertake at least a small descriptive quantitative evaluation of Allegheny County's Mental Health Court, especially since assistance with that type of research formed the basis of the grant of access to the Court and Department of Human Services records. The purpose of this step would have been important to the County's Department of Human Services and other agencies, intending to aid in determining if the jurisdiction of the Court might be expanded to include more serious cases or more high-risk offenders than it currently accepts. Of course, to conduct even a descriptive quantitative review, agency records must be accurate and complete. Unfortunately, there is no one who consistently enters data for the agency and no one checks on the thoroughness or validity of what data is entered. In fact, the only publicly released report the Department has undertaken itself was a recent one, reviewing strictly court graduates, for a recent 3-year period (Allegheny County Department of Human Services, Office of Behavioral Health Justice-Related Services Unit, 2009). Still, access to agency records for this researcher proved insightful regarding the backgrounds of participants and the workings of the Mental Health Court, as well as to help confirm data

gathered through qualitative investigation, but not conclusive for any snapshot of the demographics or the quantitative outcomes of the Court over time.

After undertaking this intensive examination, possible improvements in the case processing model were suggested. It is hoped that the conclusions about the interactions of the courtroom workgroup and experiences of the participants will be helpful to any jurisdiction utilizing or planning to utilize such a workgroup to accomplish the business of a mental health court. In addition, it is hoped that the results of this study might be used as a recommendation or guide for helping the Commonwealth to draft a model for mental health courts in the criminal justice system state-wide.

CHAPTER II.

REVIEW OF SPECIALTY COURTS

Introduction

With America's jails and prisons facing overflows of capacity and expenses, and corrections budgets siphoning funds from education, health, and transportation budgets, states have had to explore other means for managing admissions of offenders and trying to reduce recidivism. One of the most tapped strategies is to divert lower-level and non-violent offenders with drug addictions or mental illness into community-based corrections programs such as day reporting centers, alternative housing or electronic monitoring, or community service. There, treatment or vocational training is incentivized, and accountability for attaining goals is monitored. Diversion programs were aimed to help break the pattern of repeated arrests and incarcerations, and to increase the chances of restitution, taxes, and child support being paid. At the same time, jail and prison space is freed for violent or high-level felony offenders (Pew Center on the States and the Public Safety Performance Project, 2008, pp. 13-20).

As diversionary programs expanded, specialized courts arose to work with offenders who had identifiable problems, both for therapeutic and practical reasons. David Rottman, researcher at the National Center for State Courts, said this about their development in 2000:

> There is an affinity between the legal theory and practice of therapeutic jurisprudence on the one hand, and problem-solving courts, on the other hand. Judges striving to respond to changes in American society and the resulting implications for their caseloads created specialized courts as a vehicle for implementing changes. In that sense, specialized courts were laboratories in

> which traditional adversarial court processes could be modified, collaborations with public and private service providers forged, and judicial oversight extended to cover the life of a treatment program.

(Rottman, 2000, p. 26).

The Canadian National Judicial Institute compared traditional and transformed court processes in examining a therapeutic justice approach to judging:

Traditional Court Procedure	**Therapeutic Justice Procedure**
Dispute resolution	Problem-solving dispute avoidance
Legal outcome	Therapeutic outcome
Adversarial process	Collaborative process
Claim- or case-oriented	People-oriented
Rights-based	Interest or needs-based
Emphasis placed on adjudication	Emphasis placed on post-adjudication and alternative dispute resolution
Interpretation and application of law	Interpretation and application of social science
Judge as arbiter	Judge as coach, social worker, cheerleader, case manager or risk manager, member of treatment team, listener, translator, lead actor in courtoom drama
Backward-looking	Forward-looking
Precedent-based	Planning-based
Few participants and stakeholders	Wide range of participants and stakeholders
Individualistic	Interdependent
Legalistic	Common-sensical
Formal	Informal
Efficient	Effective
Success measured by compliance	Success measured by remediation of underlying problem

(Goldberg, 2005, p. 5, adapted from Popovic, 2003). (This has also been credited to Judge Roger K. Warren, former President of the National Center for State Courts [Personal communication, Judge John Zottola]).

Specialty, Problem-Solving, or Diversionary Courts

Specialized courts allowed for coordination of various agencies relevant to solving the problem at hand, be they legal, medical or social service in origin. They linked participating offenders to programs offering relapse prevention, mental health treatment, housing assistance, and job training. Early on, though, limits of the resources in the community and problems funding the courts themselves hampered their capacity to bring about social reforms (Tyuse & Linhorst, 2005, pp. 234-6; 233).

Mental health courts, one of which is the subject of this dissertation, are a type of "specialty court", "problem-solving court", or "diversionary court". The concept of a specialty court is not old. Nor is it completely new. Perhaps the best known of these newer, narrowly focused courts is the drug court; drug courts are certainly the most common. After two nationwide surveys conducted in 2005 and 2007, the National Drug Court Institute determined that there were 3,204 specialty or "problem-solving courts" in the U.S., 2147 of which are drug courts dealing with either adults or juveniles, as of 2007 (Huddleston, Marlowe, & Casebolt, 2008, pp. 18-20; 2-4). The National Association of Drug Court Professionals estimates that as of June 30, 2010, there were 2,559 operating drug courts in the U.S., and 1,219 other problem-solving courts including mental health courts, community courts, re-entry courts, DWI courts, and others (for a total of 3,778). (National Association of Drug Court Professionals, 2011, para. 3). Annually, 120,000 people are estimated to be served in drug courts, with over 1 million people having

graduated from drug courts since these courts were devised (National Association of Drug Court Professionals, 2010, "The Facts on Drug Courts").

Since the creation of the first drug court in Dade County (Miami), Florida, in 1989, we have seen the emergence of numerous other specialty or "problem-solving courts". One of the first to come about was a court to address the problem of domestic violence. Other specialized courts that are about as common as the domestic violence court deal with homelessness, truancy, and child support problems. Still others more recently created concentrate on guns, gambling, DWI's, parole violations, prostitution, and re-entry of convicts into the community. The formats and procedures of the various specialty courts differ somewhat, nonetheless, they all share the basic premises and standards of the drug court model (Huddleston, Marlowe, & Casebolt, 2008, pp. 18-23).

First, the drug court model was introduced, with the idea of diverting defendants from jail and instead treating the underlying factors contributing to their commission of crime. Mental health courts are much younger in their design and implementation, with about a hundred and fifty or more in existence as of one estimation three years ago (Thompson, M. , Osher , F., & Tomasini-Joshi, D., 2007, pp. vii-viii); more have come into existence since that estimate. But they are similar to drug courts in adopting the principle that if the person charged can receive treatment, counseling, and support services for their sake, along with formal supervision for the sake of public safety, they will be more likely to cope and less likely to engage in wrongdoing.

Problem-solving courts have been initiated in other countries as well. Sociologist James Nolan compared development of problem-solving courts in common-law countries such as Great Britain, Australia, and New Zealand, to those in the U.S., and made this

keen observation on their formation and nature as depending on the legal and cultural contexts in which they are established:

> In the non-U.S. cases, problem-solving courts are not typically initiated or advanced until there had been legislative approval, the establishment of an investigative working group, a long discussion among relevant parties, the establishment of a pilot scheme, and/or the reevaluation of a program based upon the results of a pilot scheme. In the U.S., problem-solving courts usually start at the local level without legislative approval or discussion. Instead of boldness, then, problem-solving courts in the other regions are characterized by caution and deliberation; caution with respect to the extent to which judges are willing to act outside of legally defined and legislatively approved limits to their actions, and deliberation about whether to start the programs and/or to expand them after they have been piloted for a specified period of time.

(Nolan, 2007, p. 10).

The Success of Drug Courts

Mental health courts are modeled primarily on drug courts. This is not surprising, given the increasing numbers and apparent success of drug courts over the past two decades. On review of four meta-analyses of research on drug courts, the National Drug Court Institute was able to conclude that drug courts reduce crime figures by an average of 7 to 14 per cent (Huddleston, Marlowe, & Casebolt, 2008, p. 6). The federal GAO analyzed 23 program evaluations of drug courts and found significant reduction in crime as well as an ultimate reduction in costs in areas where a drug court was implemented (Government Accountability Office, 2005, pp. 25-35; 44-56).

The drug court model, as identified in 1997 by the National Drug Court Institute is characterized by ten key components:

1. Integrating alcohol and other drug treatment services with justice system case processing.
2. Prosecution and defense counsel using a non-adversarial approach to promote public safety while protecting participants' due process rights.
3. Identifying eligible participants early and placing them promptly into the drug court program.
4. Providing access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Monitoring abstinence by frequent alcohol and other drug testing.
6. Governing drug court responses to participants' compliance with a coordinated strategy.
7. Keeping ongoing judicial interaction with each drug court participants as essential.
8. Measuring the achievement of program goals and gauging effectiveness with monitoring and evaluation.
9. Continuing interdisciplinary education to promote effective drug court planning, implementation, and operations.
10. Forging partnerships amongst drug courts, public agencies, and community-based organizations to generate local support and to enhance drug court program effectiveness.

(Huddleston, Marlowe, & Casebolt, 2008, p. 18; adapted from National Association of Drug Court Professionals, 1997).

As an example in practice, a drug court was incepted in Allegheny County in 1998. The Drug Court accepts defendants who are either active drug users or dually diagnosed as drug/alcohol dependent and mentally ill (with the mental health diagnosis as secondary). Referrals to this drug court may only be made by the County District Attorney's office, rather than by defense counsel, judges, counselors, family members, or others. Candidates cannot have been charged with any crime of violence in the past decade, and must be willing to plead guilty to the drug-related charges. Cases may include drug sale charges, but are screened to accept only those who are Level 3 or 4 offenders under PA's state sentencing guidelines for drug offenses (i.e., facing a state-level sentence of 2 years or more). Again, participation is voluntary, yet candidates must be willing to plead guilty to the drug-related charges. They are placed into intensive drug

treatment as an alternative to incarceration, with the objective of helping restore them to a constructive life. Over two years of restrictive intermediate punishment and six months probation, the special court conducts regular progress hearings, where participants must remain sober and attain education or employment goals.

All drug courts utilize treatment for drug and alcohol abuse in the community as the foundation of tackling criminality related to addiction. They might be residential or instead outpatient. This is both to improve the health and functioning of participants who abuse drugs or alcohol, and also to help reduce crimes committed to obtain drugs, or driving under the influence and its concomitant dangers. Treatment programs offer care of a rehabilitative nature; this could mean counseling or therapy, as well as coordination of essential health and social services (McLellan, 2008, pp. 15-19).

The co-founders of Denver's drug court, one of the first drug court systems in the country, were one of its trial judges and its district attorney. In an article asserting that drug courts are working, they cite the work of Dr. Stephen Belenko of the National Center of Addiction and Substance Abuse. Belenko reviewed 95 evaluations of drug courts in three phases from 1998 to 2001. He initially found, in reviewing 30 drug courts, that they offer closer and more thorough supervision than community supervision; engage felony drug offenders who have had sizeable drug abuse and crime records but little treatment before; span public health systems to the courts; reduce drug use, arrests, and costs; and stimulate cooperation among criminal justice agencies, public health agencies, and the courts (Meyer & Ritter, 2002, p. 179; Belenko, 1998, pp. 29-39).

Belenko then verified his conclusions in another review of 28 additional drug court evaluations. Accordingly, he found drug courts achieve results that might be

expected: Substance abuse relapse and crimes are lowered considerably during participation, and remain lower afterwards for up to a year (especially for those who graduate); and they create financial savings from reductions in jail stays, victimizations, and court costs (Belenko, 1999, p. 4; 18-29; Meyer & Ritter, 2002, p. 184). Finally, Belenko for the third time found support for the same conclusions after reviewing 37 more drug court evaluations, though conclusions for post-program impacts were not definitive (Belenko, 2001, p. 7; 19-33; Meyer & Ritter, 2002, p. 184).

Likelihood to complete or "graduate from" a drug court program appears to be dependent upon certain factors. Of importance is that those currently mired in substance abuse need to be referred immediately into treatment, calling for expedited processing or sentencing of their cases (Hartley & Phillips, 2001, pp. 115-6). Drug abusers with higher educations have shown a greater probability of graduating from drug court; similarly, there is some substantiation that education and job training assistance for participants aids in success of participation (Hartley & Phillips, 2001, pp. 117-19). One may be the type of addiction that brings the person to drug court; it has been shown that the abuse of cocaine tends to lessen the chance of graduation and that hard drug users may need different forms of intervention (Hartley & Phillips, 2001, pp.119, confirming Schiff & Terry, 1997).

Scholars who initially assessed whether drug courts "work" next began to focus on how they worked. Goldkamp argued for development of factors internal and external to a drug court that would be a typology for organization (Goldkamp, 2000, p. 957). Then in one comparative study of two courts, Goldkamp, White, & Robinson (2001) evaluated numerous elements of offender attributes and behavior, along with drug court

elements, in a theoretical model of drug courts. They found that items as diverse as changing from the focus of a single-judge model to use of multiple judges, to problems with treatment providers, can impact drug court outcomes including relapse, re-arrest, and escape, making it is hard to disentangle whether re-arrest affects, or rather is affected by, drug court treatment (Goldkamp, White, & Robinson, 2001, pp. 58-62).

Early on in the drug court movement, the Urban Institute studied a drug court in the District of Columbia for effectiveness, finding that a method of graduated sanctions demonstrated capacity to reduce re-arrests over time (Harrell, 1998, pp. 207-8). This court was geared toward felony-level offenders who mostly had prior convictions, and intervened at the pre-trial stage (rather than at adjudication). Also, its judges were actively involved on a regular basis in monitoring progress, and made use of frequent drug testing with immediate test results being provided. There were three different dockets to which defendants were randomly assigned. The control docket had no compliance hearings or case management and only twice-weekly drug tests, whereas the day treatment docket utilized several stages from stabilization to cognitive re-structuring to community leadership. The sanctions docket also used drug testing, but employed progressive sanctions for each relapse from time in court, to time in jail, to time in detoxification (Harrell, 1998, pp. 207-8).

Measuring at 100 days, 200 days, and one year from release, the author found lower rates of re-arrest for those in the sanctions program versus those on the standard docket at all points (they did not appear to measure the day treatment participants' relapse or re-arrest). Likewise, she found a statistically significant difference in the average rate of failed drug tests between those in the sanctions program versus those on the standard

docket, with the former experiencing few failed tests. Harrell (1998) also found the cost per participant for day treatment participants was much higher than the other two formats, as completion of the program took far longer than anticipated (pp. 207-8).

Some drug courts utilize a bevy of graduated sanctions, either for expeditious processing of participants, or for prevention of new crimes. One pre-eminent researcher in the study of drug courts, Marlowe, concedes the possible negative effects of sanctions. But he asserts that they are necessary for public safety and that sanctions can be constructive in reducing both substance abuse and repeat offenses when applied properly and when in concert with "adequate treatment and incentives for sobriety" (Marlowe, 2008, p. 109). Marlowe adds that sanctions should be specific, certain, immediate, and fair in the magnitude of punishment. Furthermore, he explains that they must be adapted to individual circumstances. For example, he states that sanctions might be effective if a program withholds or cancels a sanction in the event a client admits, then corrects, a mistake (2008, pp. 109-11). Finally, he stresses that sanctions should only be punitive in response for non-compliance with program requirements, such as testing positive for drugs, and not punitive for unsatisfactory advancement in treatment. In the latter instance, he suggests instead sanctions should be remedial in nature, such as amending the treatment plan to require more frequent visits, or having the physician or psychiatrist prescribe a different medication for the client (Marlowe, 2008, pp. 111-12).

Other research on evidence-based treatments in drug courts has shown that certain principles are more effective in preventing relapses: individual as well as group counseling, suitable medications (both anti-addiction medicines and those to treat co-existent mental conditions), complementary social services for medical or psychological

issues or family problems, and aftercare like 12-step programs. Thus, treatment programs that can make those items available have been shown to have better outcomes--with a cautionary note that treatment must always be adapted to the person and his or her circumstance. Lastly, drug court team monitors need to regularly confer with treatment personnel and inspect treatment sites to make certain appropriate service is being delivered (McLellan, 2008, pp. 18-20).

Finally, one of the factors associated with successful completion of the drug court program is treatment for a co-occurring mental illness. The assertion that a mental illness often exists in concert with an addiction is one made by researchers who both conducted their own drug court study and who reviewed the literature on co-occurring disorders (Gray & Saum, 2005, pp. 58-63). They found that drug court participants who reported depression in the month before entering treatment were less likely to complete drug court; yet on the other hand, those who were prescribed medication to alleviate a psychological or emotional problem once they entered a drug court program, along with other factors, were more likely to graduate (Gray & Saum, 2005, pp. 65-7).

As to the phenomenon of women in drug court programs having higher rates of mental illness, the Substance Abuse and Mental Health Services Administration has done research showing this was due to the history of women being more willing to seek treatment for mental illnesses, rather than there being fewer men with co-existent drug and mental illness problems (SAMHSA, as cited in Gray & Saum, 2005, pp. 56). Evidence of the efficacy of incorporating depression treatment with substance abuse treatment was confirmed in a meta-analysis of numerous research studies on persons with co-occurring depression and alcohol or drug problems (Nunes & Levin, 2004, p. 1893).

Development of Mental Health Courts

The "problem-solving" approach employed in drug courts was in dire need in the wake of epidemics of homelessness and addiction in the 1980s and 1990s. There were two problems often experienced by the mentally ill when they were not successfully involved in community treatment. As more state mental hospitals were closed, with inadequate community mental health facilities in place to replace them, the persistently mentally ill cycled in and out of the criminal justice system. After the drug court concept showed promise with addicts, a few test mental health courts sprung up in the late 1990s in Florida, Washington, Alaska, and California, to try to address the mentally ill who were arrested and jailed (Goldkamp & Irons-Guynn, 2000, pp. vii; ix; xiv-xvi; 4-7; 59-61).

In response to the problem of the seriously and persistent mentally ill being incarcerated in large numbers, mental health courts have been established in at least 35 states at the local criminal justice system level (Redlich, Steadman, Monahan, Robbins, Petrila, 2006, pp. 352-3). These specialty courts are designed to divert certain mentally ill defendants from traditional criminal processing and, if possible, from incarceration, while instead attending to the needs of their underlying mental illnesses. Similar to drug courts, with special dockets, candidates are identified through an assessment of their mental health and according to screening of acceptable charges. In cases where a defendant agrees to participate voluntarily, a plan for his treatment and intensive supervision is developed, along with conditions to be imposed, by a team of court staff

and mental health professionals. Status hearings are conducted at regular intervals, at which time progress is judicially evaluated, and rewarded or sanctioned.

In the Bazelon Center of Mental Health Law evaluation of functioning of the early generation mental health courts (2004) referenced in Ch. III, the authors found that a majority of courts require a plea of guilt or *nolo contendre*, or conviction after a trial, in order to participate in a mental health court program (pp. 8-9). That many mental health courts follow a post-adjudication model was confirmed more recently by the Mental Health Consensus Project of the Council of State Governments (Almquist & Dodd, 2009, pp. 12-3). Other courts may follow a pre-adjudication model and hold the charge(s) in abeyance until the program is successfully completed, but many defendants do not fully undergo treatment or otherwise fail to complete the program. While a good number of mental health courts the Bazelon Center surveyed may have promised to dismiss the charges on completion of treatment or other stipulations of probation, in the Bazelon Center report, most of the courts did not do so automatically. Furthermore, dismissal is no guarantee that a record of conviction will be expunged, a separate procedure that often requires the services of an attorney (Bazelon Center of Mental Health Law, 2004, pp. 13-4).

There are several major differences between mental health courts and drug courts, though, as distinguished by The Justice Center of the Council of State Governments recently (2008). Aside from accepting a variety of charges as opposed to merely drug charges, mental health courts have not developed means to monitor compliance with treatment terms or other stipulations as straightforward as drug testing is for drug courts. On the other hand, mental health courts allow for more individualized rather than

routinized treatment plans than do drug courts. Likewise, they tend to adjust those plans for non-adherence and rely on jail far less often as a sanction for non-adherence. While drug courts often use internally established treatment programs, for which they sometimes charge participants, mental health courts typically contract with community providers, and normally offer those resources to participants for free. Last, in most cases, drug courts frequently condition total abstinence and require employment or job training of their participants, whereas expectations for mental health court participants rarely impose such demands. Recognizing that their participants may not be capable of working or even functioning without multiple forms of assistance, advocates who stress that absolute requirements of the mentally ill might interfere with recovery are the ones who run mental health courts in many occasions. Drug courts typically are far less affected by community advocacy (Council of State Governments Justice Center, 2008, p. 10).

At last written estimate, there were around 175 mental health courts operating in the United States (Council of State Governments Justice Center, 2008, pp. 1; 21); or 184 courts by another count (Raines & Laws, 2008, pp. 1-2). One more current estimate of self-reporting mental health courts garnered from a policy analyst at the Criminal Justice/Mental Health Consensus Project is that we have rapidly expanded to 250 to 300 courts nationwide (Fader-Towe, Hallie, Policy Analyst, Criminal Justice/Mental Health Consensus Project, Council of State Governments and the Bureau of Justice Assistance, Personal communication, January 28, 2011). Some were able to be implemented with no update to law, court jurisdiction, policy, or funding. Others required selection of a principal agency to oversee the proceedings, changes to the legal code, endorsement of

court administration, the supervising judge or special budgets (Council of State Governments, 2005, p. 24).

A body of research has been devoted to examining the structure and function of drug courts, yet less study has been done on mental health diversionary courts, as they have only existed for a little over a decade. Nonetheless, in that time, the number of mental health courts has quickly grown, evidencing a need. While the Bureau of Justice has produced technical manuals on designing and implementing mental health courts like those described above, little study has been done on specific local decisions to implement and fund mental health courts, the formation of their courtroom workgroups, or how best to structure these courts in a particular locale within the local legislation and law enforcement climate. And little, if any research has been done on the activities and decisionmaking of the courtroom workgroups around mental health courts, or the experiences of participants in these problem-solving courts.

Descriptions of Mental Health Courts

For the Consensus Project, a collaborative project of the Council of State Governments and the Bureau of Justice Assistance, researchers Thompson, Osher, & Tomasini-Joshi (2007) determined that most every mental health court employs these four features:

> (A) A specialized court docket, which employs a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses;

> (B) Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement;
>
> (C) Regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation; and
>
> (D) Criteria defining a participant's completion of (sometimes called graduation from) the program.

(Thompson, Osher, & Tomasini-Joshi, 2007, p. vii).

They also lay out what they consider to be the ten essential elements of any mental health court:

> (1) Planning and administration
>
> (2) Target population
>
> (3) Timely participant identification and linkage to services
>
> (4) Terms of participation
>
> (5) Informed choices
>
> (6) Treatment supports and services
>
> (7) Confidentiality
>
> (8) Court team
>
> (9) Monitoring adherence to court requirements
>
> (10) Sustainability

(Thompson, Osher, & Tomasini-Joshi, 2007, pp. vii; 1-10).

As for the court team assembled to handle cases in a mental health court, Thompson, Osher, & Tomasini-Joshi (2007) stated: "The mental health court team works collaboratively to help participants achieve treatment goals by bringing together staff from the agencies with a direct role in the participants' entrance into, and progress through, the court program." (p.8). And they added, "Mental health court planners should carefully select team members who are willing to adapt to a nontraditional setting

and rethink core aspects of their professional training . … Mental health professionals must familiarize themselves with legal terminology and the workings of the criminal justice system, just as criminal justice personnel must learn about treatment practices and protocols." (Thompson, Osher, & Tomasini-Joshi, 2007, p. 8).

Research on the key components of drug courts has shown that drug court case processing can benefit from the inclusion of workgroup members not normally included in the traditional courtroom workgroup, even though their inclusion changes the dynamic and adds to the workload. Some mental health courts include a psychologist or psychiatrist on staff, or add treatment providers to the workgroup staff. Adding probation officers, for example, will add perspective and better inform case monitoring, as Olson, Lurigio, & Albertson *(*2001) said:

> Probation staff who served the dual role of case supervision and substance abuse treatment liaison were readily accepted by the drug court team because these officers were already recognized as "part of the system" and used commonly understood terminology.

(pp. 183-4). Mental health courts can draw on the experience of drug courts in forming their courtroom workgroups as well.

Example Of A Mental Health Court Design Process

One mental health court that has been touted as a successful model is the court in Brooklyn, NY. When the planning group for Brooklyn's Mental Health Court considered the parameters for their jurisdiction, they acknowledged that many communities would be

uncomfortable with a court that dealt with felony offenses, considering a mental health court's dual function of improving both public safety and offender stability. Several other problem-solving courts in Brooklyn already existed, and two of them took felonies along with misdemeanors. Many of the group members had experience with these other courts, including their treatment (drug) court. As explained by the head of the Center for Court Innovation, one of the stakeholder groups involved, felony offenders may be more likely to succeed than misdemeanants. First, they have more incentive to comply with court orders because they are typically facing longer jail sentences; second, a longer treatment period tends to produce better results with substance abusers (Fisler, 2005, pp. 590-2).

Ultimately, the Brooklyn Court's planning group decided to concentrate on non-violent felonies, while accepting some misdemeanors and some violent felonies. Certain stakeholders (including mental health consumers) insisted that jail sentences for failing to comply with treatment mandates be long enough to motivate participants (at least a year). But defense attorneys involved in the plan insisted that the longest sentence a participant would face for failing the program should not be longer than the sentence they could have received in traditional court. And the Brooklyn District Attorney's Office agreed, so long as a guilty plea was required for felony offenders to participate in mental health court. The motivation for defendants was that misdemeanants and first time non-violent felony offenders who successfully completed their treatment mandates would have their charges dismissed (and thus able to be expunged); felony offenders with records would have their charges reduced to misdemeanors. The Brooklyn D. A.'s Office agreed to accept

certain violent felonies (robberies, assaults, and burglaries) on a case-by-case basis, so long as they retained veto power over case acceptance (Fisler, 2005, pp. 593-4).

All potential participants in the Brooklyn Mental Health Court are evaluated by both a psychiatrist trained in forensic psychiatry, and a social worker with experience in community mental health treatment. These professionals assess whether a mental disorder exists and contributed to the commission of the crime charged, as well as whether the mentally ill offender might be too much at risk of violence for the program. They also prepare an individualized treatment plan to help stabilize the offenders and prevent their commission of future crimes. The clinical staff shares reports equally with the judge, prosecutor, and defense attorneys, remaining neutral as opposed to being an advocate for one side or the other, which has helped to engender the confidence of the various team members (Fisler, 2005, pp. 594-6; 600).

The rewards and sanctions for participants in Brooklyn's court are set by the judge with the advice of the court's clinical staff; while graduated or incremental in form, they are far more individualized than many problem-solving courts such as drug courts would provide. Yet the clinical staff , in communication with treatment providers, "strive for consistency in their responses" when a participant violates the program rules (Fisler, 2005, pp. 597-8; 600). The judge's willingness to work with participants and "adjust services" they received rather than "to impose a punitive sanction" when they were experiencing problems may help participants in the end to graduate (Fisler, 2005, p. 598). According to Fisler, the judge's firmness showed the district attorney that he was not willing to risk the whole program for a wayward participant; in turn, the judge's

flexibility has encouraged defense attorneys to make referrals, knowing their mentally ill clients will be given the help they need (Fisler, 2005, pp. 597-9; 600).

Consequently, referrals grew in the first several years of the Court's operation (Fisler, 2005, p. 600). Still, the referrals received by Allegheny County's Mental Health Court in one year are equivalent to that of the Brooklyn Court's total in those years Fisler discussed. Key to the Brooklyn Court's measured development was its agreement to undergo an evaluation by the non-profit Center for Court Innovation, done within several years of its founding (O'Keefe, 2006, pp. 8; 13).

Monitoring Those Diverted From Incarceration

Just as the police, prosecutors, defense counsel, judges, and jail personnel were not equipped for the tests of dealing with the seriously mentally ill, nor were probation agencies. Probation officers are given the responsibility not only of monitoring this population, but often of attempting to place them into services needed either for treatment or to maintain living supports. Thus, the probation officers assigned to mentally ill offenders would benefit from training and from smaller, exclusive caseloads where they have the ability to manage these challenges. Specialty mental health probation agencies have sprung up with the growth of jail diversion programs. Their officers must integrate resources within and without the agency (Skeem, Emke-Francis, & Eno Loudon, 2006, pp. 59-60).

That could entail anything from placement into inpatient mental health or drug treatment, or outpatient counseling or support groups; finding various types of supervised housing or supportive personal care homes; transportation to doctors' appointments; applying for medical or Social Security benefits; family or parenting assistance; job training or placement; or even arranging for legal advocacy. In spite of the fact that such assistance is often (and typically) performed by a caseworker, in regions where caseworker services are overloaded, or are not available, the task falls upon a specialized probation officer. Like any other members of the workgroup representing a stakeholder agency, probation staff might be asked to do too much, nevertheless. One group of researchers on drug court workgroups, for instance, cautioned that probation officers of those special dockets:

> were often overwhelmed by their wide range of roles and responsibilities: overseeing probationer supervision, conducting urinalysis, verifying employment, doing arrest checks, preparing for and attending status hearings, and being in contact with treatment providers on a daily basis to monitor participant attendance and progress.

(Olson, Lurigio, & Albertson, 2001, p. 184). The same applies to mental health courts.

A national survey was conducted of agency supervisors of both specialty and traditional probation offices, to assess their differences in structure and case management, and to understand strategies for how they get probationers to carry out treatment mandates. From the responses, they found that specialty agencies used "an active, problem-solving approach" to address treatment non-compliance by the seriously mentally ill, affording "procedural justice" to the probationers to avoid the perception of coercion; specialty supervisors believed they were more likely to decrease the risk of violations, in the short-term (Skeem, Emke-Francis, & Eno Loudon, 2006, pp. 173; 181).

Where specialty agencies handled mixed caseloads, or assigned more than 44 probationers per agent, however they tended to function more like traditional agencies (Skeem, Emke-Francis, & Eno Loudon, 2006, pp. 171; 178-80).

Following up on that survey, a second survey was conducted to look at the policies and practices of departments with specialty caseloads, in terms of number of contacts with mental health providers monthly, methods to address noncompliance and violations, and time allotted to activities such as field work. Violations typical to the seriously mentally ill were listed as "missing a probation appointment; missing a treatment appointment; failing to take medications; drinking alcohol to excess; possessing, using, or selling drugs; hitting someone or fighting; and committing a new offense" (Eno Loudon, Skeem, Camp, & Christensen, 2008, pp. 835-7).

Surprisingly, there were few differences in their time allotments, with the exception of time specialty agents spent attending treatment team meetings. Likewise, there was little difference in their behaviors, with the exception of more in-person contacts with both probationers and treatment providers by specialty agents. Neither model of agency had formal policies setting the nature of their management of the persistently mentally ill. Finally, while both traditional agents and specialty agents used graduated sanctions for violations, the former tended toward enforcement of stipulations and the latter tended toward encouragement via problem-solving. Of course, problem-solving is not only more time-intensive and requires more training, but it involves the probationer in "generating solutions and alternative behaviors to use when they face problems" (Eno Loudon, Skeem, Camp, & Christensen, 2008, pp. 842-5).

One viable intensive option for the chronically mentally ill offender being diverted or released from incarceration is Assertive Community Treatment, or ACT. An ACT program "employs a multi-disciplinary team approach to provide intense, comprehensive, coordinated, and integrated services (psychiatric, rehabilitative, and social support) . . . to persons with chronic mental illness, limited insight, severe functional impairments, substance abuse and dependency disorders, limited financial disorders, and housing instability." (Lurigio & Fallon, 2007, p. 375). Lurigio, a psychologist and criminologist, worked with Fallon, an ACT program director, to look at the handling of the mentally ill in the criminal justice system.

They described the plight of a long-term homeless schizophrenic, a middle-aged man hospitalized 27 times and arrested 140 times before being placed into an ACT program. This man's days in jail or hospitals dropped from a range of 20-220 per year to an average of only one arrest per year (Lurigio & Fallon, 2007, p. 374). Granted, with 24-7 services provided, some assessing ACT programs would expect nothing less of an outcome for them, and criticize them as costly. The key difference is that these mental health, medical, employment, housing, family, and advocacy services are being provided to people in the community instead of while incarcerated or institutionalized (Assertive Community Treatment Association, 2009, "Principles of ACT").

Empirical Research To Date

Of the studies to date, there have been some promising results on the effectiveness of mental health courts. Review of the research that has been done previously in this area shows that many of those examinations have been either surveys of the components and process of mental health courts, short-term quasi-experimental evaluations of court efficacy, general attempts to demonstrate the value of therapeutic jurisprudence to the mentally ill offender, or arguments against the compromise of defendants' due process rights in the diversionary court model. Much of the research to date concludes with invocations of the need to do further research.

In a testament to the rapidity of the growth of mental health courts, a very recent review of 18 quantitative studies was conducted, a majority of which were, again, quasi-experimental. Admittedly, this meta-analysis was without statistical controls for differences between mental health court participants and comparison groups, as the latter "were often comprised of individuals who opted out of participation" and thus there was a possible "bias favoring the MHC condition" (Sarteschi, Vaughn, & Kim, 2011, p.19). Nevertheless, the authors declared the mental health court intervention was effectual on both reducing recidivism rates and improving clinical outcomes:

> Evidence of the effectiveness of MHCs has important clinical implications for incarcerated individuals with serious mental illness as well as for society. Within the context of MHCs, the participants are viewed not as criminals but as individuals afflicted with an illness that impairs their psychological capacity to refrain from behaviors considered crimes and thus punishable by law. Perhaps most importantly, MHCs are focused on rehabilitation and giving individuals the chance to rebuild their lives.

(Sarteschi, Vaughn, & Kim, 2011, p.11).

Gurrera (2007) found diminished rates of arrest for those who completed a mental health court program, and no statistical difference in arrest rates between non-completers and the control group. Yet, she also found that severity of charges upon re-arrest was similar for both completers and non-completers in MHC, over similarly matched control group defendants, allowing her to state that participation alone made for "a significant impact" on the "severity of arrest" (pp. 193-4). The author did acknowledge selection bias into the control group, however. Selection was made by the chief district court judge of defendants with whom he was familiar in the system "who would have been slated for the MHC had it been in existence at the time", which may have resulted in choice of those with more serious criminal histories or more severe mental illnesses than MHC participants (Gurrera, 2007, p. 220).

McNeil & Binder (2007) found that San Francisco County mental health court participants fared better than those going through traditional courts on new and also on violent charges, regardless of whether they completed the program; moreover, they continued to have reduced recidivism if they graduated. Their court team also included psychiatrists and therapists and, while most of the participants were charged with felony offenses there, the court was small in size, so participants may have had a good deal of individualized attention. In a review of the Clark County, WA, Mental Health Court, Herinckx, Swart, Ama, Dolezal, & King (2005) found significant reductions in probation violations during participation, and re-arrests of participants one year post-enrollment were four times less than the year prior to coming into the court.

One judge who operates his state's first felony mental health court cited to descriptive statistics of his court's first 30 months: 41 per cent of participants "were not

rearrested after coming into the program" (Goss, 2008, pp. 410-11). Though located in rural southwest Georgia, where "high maintenance cases stretch already thin budgets", the court is an example of success "with planning, identification, and coordination of existing resources and treatment options" (Goss, 2008, p. 405). This court is one of the Bureau of Justice Assistance Mental Health Courts Program's five Learning Sites Initiative courts, combining both a pre-adjudication component (jail diversion) and case management of post-adjudication cases (coming into mental health court after entering a plea). The judge advises stakeholders to assess the level of support and funding the community will put forth, as well as the treatment options available, in planning the type of mental health court for one's jurisdiction (Goss, 2008, pp. 406; 407-8).

On the other hand, in a study of the oldest mental health courts in the country, Christy, Poythress, Boothroyd, Petrila, & Mehra (2005) found that the court may have reduced days spent in jail by participants, but it did not shorten the time until their re-arrest, and it did not necessarily increase their mental stability. And findings from a six-year review of the mental health court in Melbourne, Australia, show varied results based on the demographics of those given community mental health services. The latter researchers were able to document continuity of care and access to services, however, they found the likelihood of a jail sentence was higher for married persons, substance abusers, the unemployed, and those referred from within the court system as opposed to from inpatient psychiatric units. Further bias seemed to be displayed based on gender: males were less likely to have their cases dismissed, and females were more likely to be subjected to longer-term monitoring (Sly, Sharples, Lewin, & Bench, 2009).

A multi-site study examined seven fairly large mental health courts' referral and processing decisions, where the public defender's office was the largest or second-largest source of referrals (Steadman, Redlich, Griffiin, Petrila, & Monahan, 2005). They discovered that women, especially older white women, were most likely to be referred to mental health courts, though not necessarily accepted into the courts. The researchers could not ascertain if this resulted from the methods by which referrals were processed, however, they did determine that persons with more severe mental illness tended to be accepted more readily.

This same group of researchers, Redlich, Steadman, Monahan, Petrila, & Griffiin (2005), took another look at what they called the "second generation" of mental health courts a year later. From a sample of seven newer courts, they discerned four important patterns that the "first generation" of courts (the eight they first reviewed in 2005) did not utilize at inception. The first pattern, accepting felony charges rather than just misdemeanors, was something all of the newer courts they examined did, and half of the original eight courts now did as well. Second, while at first only four employed a pre-adjudication rather than a post-adjudication model, seven of the original eight examined had adopted a pre-adjudication model. Likewise, all but one of the newer cohort employed a pre-adjudication model. According to the researchers, the pre-adjudication model signals an attempt to refer potential participants earlier after arrest, in keeping with the goal of therapeutic jurisprudence. Third, they stated that all 15 of the courts reported using jail as a sanction, though in differing amounts and frequencies. The second-generation courts used the jail sanction more regularly, perhaps because they handled

more felony offenders, but they did so with discretion and flexibility according to the offender's situation (Redlich, Steadman, Monahan, Petrila, & Griffiin, 2005).

Finally, the first-generation courts were divided as to who monitored for compliance with stipulations. Half of the older courts relied on supervision of clients by professionals internal to the criminal justice system (i.e., probation officers or court personnel), instead of external monitors such as community treatment providers or some combination of the two. On the other hand, most of the younger courts tended to rely mostly on supervision of clients by internal criminal justice professionals; again, this could be due to the fact they accepted more felony offenders (Redlich, Steadman, Monahan, Petrila, & Griffiin, 2005).

The first mental health court in the country, that in Broward County, Florida, was evaluated over a period of 6 years by researchers at the Florida Mental Health Institute. They compared the county's Mental Health Court clients to a sample of similarly situated defendants in a county which has no mental health court. Differences in re-arrest were insignificant, as were self-reported "aggressive" acts, but the Broward County clients did report fewer "violent" acts than "aggressive" acts (the only difference in definition being that "violent" acts resulted in injury and "aggressive" acts did not). The groups were non-equivalent in the number of arrests they had prior to the study's start, however. The researchers noted that the incidence of previous arrests is a factor which could affect future criminal acts (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005).

In a quasi-experiment, Moore & Hiday (2006) compared recidivism of mentally ill offenders participating in a mental health court with similar defendants in a traditional criminal court setting. The district attorney of the county studied selected participants for

the mental health court, and the researchers compiled a sample of similar offenders in the county from the year prior to establishment of the mental health court. For ethical reasons, the researchers explained, random assignment was not possible, so as not to deny eligible candidates the chance to participate. They defined recidivism in terms of numbers of re-arrests and the severity of the crimes for which a defendant was re-arrested. Findings were that mental health court defendants had about half the re-arrest rate of traditional defendants. Furthermore, they found that a "full dose" of mental health treatment had the greatest effect of reducing the incidence and level of recidivism, although they postulated the opposite effect could be at play, that is, re-arrest might lead to non-completion of the mental health court program (Moore & Hiday, 2006).

Recent evaluators of mental health courts and research on the courts have put forth valid concerns about the reliability of studies to date. Wolff & Pogorzelski (2005) said there may be selection bias based on the discretion of district attorneys and judges in accepting some defendants over others. [Note that McNeil and Binder (2007) recognized that, since randomized assignment cannot ethically be employed to select participants into mental health courts, and so used a methodology called propensity weighting to help reduce the effects of such a bias in looking at a mental health court.] Also, Wolff & Pogorzelski (2005) pointed out that comparing different sites is difficult, given the differences in components of various mental health courts (charges accepted, sanctions employed, and or pre-adjudication versus post-adjudication model).

Criticisms Of Mental Health Courts

A staff attorney from the Judge David Bazelon Center for Mental Health Law in Washington, D.C., wrote a blistering critique of mental health courts and criminal justice and mental health systems, some of which bears repeating in its entirety:

> Mental health courts fail to address the root causes of the overrepresentation of people with serious mental illnesses in the criminal justice system, and considering the state of the public mental health system, are inherently coercive. Communities would be better served by undertaking broad reform of the community mental health system to replicate successful models and develop a comprehensive strategy to break the cycle of poor treatment, worsening mental illness, escalating criminal behavior, and increasing arrest and incarceration. Court-based diversion, although necessary, is not a panacea for people with mental illnesses who come into contact with the criminal justice system . . . it is important to build any reforms in such a way as not to bypass the mental health and other systems or to allow them to shirk their responsibilities.

(Selzer, 2005, pp. 585-6).

In a poignant debate, one of the originators of the concept of therapeutic jurisprudence, Bruce Winick, asserts the merit of mental health courts for the seriously mentally ill. Though he agrees that many of the mentally ill who are arrested do not belong in the criminal justice system, he says their appearance in it is a sign instead of the failure of the mental health and social service systems. He fears, as did his counterpart, Susan Stephan, that preventive outpatient commitment is coercive and might "widen the social net" of arrests for the mentally ill who do not fit within criteria to be civilly committed. Mental health courts may not be the most desirable way to get them to accept treatment and services, nonetheless, he states mental health courts are preferable to jail, which is more stressful for them, and better attends to their needs (Stefan & Winick, 2005, p. 520). And in the cases where the persistently mentally ill are arrested for serious

crimes that anyone would likely be arrested for if they behaved similarly, the choice of diversion over trial and punishment is one they have been flocking to. He cites to examples such as the court in Broward County, FL, as providing high levels of "procedural justice", where "judges and defense counsel . .. ensure that defendants receive dignity and respect, are given a sense of voice and validation, and are treated with fairness and good faith" (Stefan & Winick, 2005, p. 516, citing Wexler & Winick, 1996).

Winick's ideas are contested by Stefan, a mental health disability lawyer, who makes a number of persuasive points. She asserts "the prejudice of communities that call on police to rid them of people they find uncomfortable" allows for the criminalization of the mentally ill (Stefan & Winick, 2005, p. 516). Stefan considers the need to create a whole separate justice system to handle people with psychiatric disabilities an indictment of the public criminal justice system: "The courtroom is no place for a therapeutic alliance" between judge, lawyers, and treatment teams to be formed, she declared; she questions whether the decision by a jailed mentally ill person to accept diversion in exchange for giving up rights they would have in a traditional court is truly voluntary, particularly where their competency is at issue (Stefan & Winick, 2005, pp. 524-5).

Stephan would end such separate but unequal justice, where the mentally ill are marginalized and receive fewer procedural protections; she notes that mentally ill with financial resources have always been able to negotiate to get their charges dismissed by agreeing to attend counseling. If mental health courts truly wanted to help the seriously disabled, she argued, they would accept all crimes for diversion. She prefers to better train police not to arrest the mentally ill at all, especially not for nuisance crimes for

which others might not be arrested, and to find more appropriate ways to compel the mentally ill to accept treatment (Stefan & Winick, 2005, pp. 512-15).

Other outstanding issues should really be dealt with, say commentators, in forming key components of mental health courts. One of Stefan's suggestions as to the segregation of the mentally ill in special courts was addressed more fully in the context of equal protections for all defendants. Wolff (2002) advised giving all courts information about offenders' psychological backgrounds, rather than handling the seriously mentally ill in a separate court or docket. The judge would remain a neutral arbiter, but then would weigh therapeutic options for sentencing if an offender's mental illness contributed to the crime charged, she suggests. Seriously mentally ill offenders would be given an advocate trained in mental health therapy and law to follow them through all steps of the court process (Wolff, 2002).

In the alternative, not everyone would advocate that all mentally ill persons caught in the criminal justice system be admitted into a mental health court, either. In fact, most mental health courts do limit participants in some fashion, such as requiring an Axis I diagnosis, a severe and persistent mental illness, or a combination of mental illness and substance addiction, per a national survey done (National Alliance on Mental Illness NAMI, et al., 2005). Another relevant screening factor used is to limit acceptance to cases wherein the mental illness directly contributed to the charges at hand; unfortunately, this refining parameter was only required by eight per cent of mental health courts to limit participation (NAMI, et al., 2005). One set of commentators went further to suggest that initial assessments for mental health courts might determine those who "need treatment more than punishment" by including a screening tool for

criminality, to "eliminate those with significant criminogenic needs from mental health court participation" (Miller & Perelman, 2009, pp. 122-23).

Some criticism has been levied upon drug courts, too, for the deviations in operations nationwide, such as "who is eligible, how they are selected, what treatments are available, and very importantly, how court practices affect the outcome" (Harrell, 2003, p. 211). Harrell urged more study of concerns like "legal pressure implied by the consequence for failure, the drug treatment provided (quality, appropriateness, duration), the motivating effects of the personal interest of the judge, the consistence and perceived fairness of sanctions for non-compliance" (Harrell, 2003, p. 211). These concerns are all applicable to the operation of mental health courts, and likewise demand research examining their effects on the value and success of the newer form of specialized court. Nonetheless, the drug court model has been touted by some commentators as worthy of repetition both for other problem-solving courts and for court administration practices, for everything from incorporating employment services for participants, to use of graduated (incremental) sanctions (Sanford & Arrigo, 2005).

Program completion in a mental health court might be fairly direct, assuming steps to completion have been set up in advance and are measurable. Consider this difference from drug courts, though: Failure to comply with stipulations or treatment mandates once admitted into a mental health court is a much thornier issue, one that has yet to be adequately defined by researchers. That is perhaps because these newer courts themselves, even if they employ graduated sanctions, often do not want to impose sanctions on any timetable or triggered by a scale. Ultimately, the underlying question for the mental health court faced with a participant's treatment relapse, probation

violation, or new charge is: "Should mentally ill probationers who commit a crime because of break-through symptoms or failed medication be prosecuted and sentenced to incarceration or placed in a hospital for stabilization, treatment, and return to probation?" (Lurigio & Snowden, 2009, pp. 213-14). From the literature, it seems the answer to that question is often malleable.

Evolution of the Present Mental Health Court

Allegheny County is the second largest county in Pennsylvania. Its Court of Common Pleas is in the Fifth Judicial District of Pennsylvania and has county-wide trial-level jurisdiction of all felony and upper-level (first and second-degree) misdemeanor crimes committed in the county. The Criminal Division currently has 15 sitting judges, two of whom are senior status. Its courthouse is located in the county seat of Pittsburgh, the center of a large metropolitan area.

Overwhelmed with the mentally ill needing social services after their arrests in Allegheny County, the county's Department of Human Services and other agencies sought a way to divert these arrestees from the county Jail's burgeoning numbers. The County maintains mental health base service coordination units, which divide the county into geographic sections for the delivery of publicly funded mental health care. These sub-agencies, as well as their privately run community counterparts, were left to deal with the same issues that confronted this portion of the mentally ill population once they were released from jail. The County Jail was basically ill-equipped to handle health

issues experienced by the mentally ill. There was little doubt that for them, arrest and incarceration complicated their lives even more than those who do not suffer with mental problems.

Over time, efforts to tackle the issue of mentally ill offenders led to an array of programs at several points in the criminal justice system. These programs, some of which overlap somewhat, are run under what is now called the "Justice-Related Services" division within the County's Office of Behavioral Health, Department of Human Services. What follows is a listing and brief description of each of the major forensic programs developed by Allegheny County to deal with its mentally ill offenders.

Two decades ago, the Office of Behavioral Health first created a general forensic diversion program to assist persons with mental illness and substance use disorders at the "front door" of encounters with the criminal justice system. Staff coordinated services for persons likely to be released from the Allegheny County Jail prior to or at the preliminary hearing stage of misdemeanor or felony cases. Referrals are typically made for cases where the facts would allow for the bargaining away of higher charges in exchange for treatment, or possible dismissal of an entire case pending hospitalization of the defendant. The primary goal was to tailor a service plan for services both inside and outside of the County Jail, which may have included housing, counseling services, and linkage with community case management. The plan is presented to the magistrate in District Court (minor judiciary) at the preliminary hearing stage of a case, in hopes of diverting persons with mental illness from incarceration and hopefully decreasing their rate of return to the system. Staff is able to coordinate care for approximately 3 months, via this "Diversion" unit for cases that remain at the lower court (magistrate level).

Then came an intervention for people at the "back door" of an experience in the criminal justice system. Soon, a Justice-Related Services "Support" unit was created for those persons whose cases have already proceeded beyond the preliminary arraignment or preliminary hearing stage. Persons with mental illnesses could be referred for assistance and diversion from incarceration at any point from formal arraignment, to cases that were bound over to the Common Pleas Court for trial (judge level), to sentencing in court, with the same diversion and treatment concept. In addition to doing a service plan like that done by pre- and post-booking Diversion staff, Support staff assist the person for 60 to 90 days by coordinating services in the community for their case. This includes setting up behavioral health therapy, housing support, and otherwise providing for their successful reassimilation into the community. The Support staff can also handle persons with probation or parole violations or those whose state sentences have expired and are being released, so long as an agreement for a service plan can be negotiated with the assistant district attorney on the case, and accepted by the judge hearing the case.

The experience of the "Forensics" units would prove that many clients would soon be needing their assistance again—at more expense for the County, and hampering progress for the client. Mentally ill offenders with serious enough charges were often being assigned and handled just like any other serious criminal case in the general docket of Common Pleas Court. If their cases were serious enough to make it past the preliminary hearing stage, they were assigned randomly to one of the County's criminal court judges. The outcome of the case, that is, whether diversion from jail and an ensuing service plan for probation would be accepted, or instead a jail or intermediate

punishment term would be handed down, depended upon the viewpoint of whichever judge and/or assistant district attorney was assigned to the case. Of course, differing sentence results occurred, depending on the judge hearing the case. In some instances, probation was given with no plan to assist and monitor the mentally ill offender—which could have equally distrastrous results for a mentally ill person in crisis.

Allegheny County was subject to a federal lawsuit in the 1970s to relieve abhorrent treatment of inmates (especially mentally ill inmates) in its jail, medieval conditions, and excessive overcrowding; the suit ultimately resulted in a new jail being built to replace the century-old jail (Krakoff, *Pittsburgh Post-Gazette*, 1998). Shortly after the new jail was finally opened in 1995, it was filled to more than planned capacity (Pro, *Pittsburgh Post-Gazette*, 1998). In response to the continued overcrowding and levels of recidivism at the county jail in the 1990s, the Allegheny County Jail Collaborative was formed in 2000 by the County Jail's warden and the director of the Department of Human Services and of Health. The Collaborative's goals are to improve safety to the public and to decrease the number of repeat offenders returning to the Jail, along with providing access to inpatient or outpatient mental health and addiction treatment, job training, family services, housing and hunger and other supports (Allegheny County Department of Human Services, 2007, "Services and supports offered"). It now includes representatives of various government agencies, court administration, service providers, faith-based organizations, and members of the community.

This was an opportune time to address the problems of mentally ill offenders being managed at the Allegheny County Jail. At the insistence of one particularly

energetic caseworker hired to assist this population, a former prison guard herself , the county explored adding a mental health court as an integrated means to target cases of the persistently mentally ill at the Common Pleas level in 1999. The goal was to implement a centralized court for the processing of these cases, with staff dedicated to its function so they would be able to focus on its tasks. As the County already had a small staff of caseworkers who advocated for the mentally ill in both civil and criminal court, it would not be too great a reach to add this facet, instead, it became a funding issue for the Department of Human Services and other county agencies. The Offices of the District Attorney and the Public Defender would each need to dedicate an assistant attorney to a specialized mental health court; the Court of Common Pleas would need to dedicate one of its fifteen criminal division judges willing to concentrate on these cases; and the Office of Probation and Parole would need to dedicate and train a core of probation officers to handle a specialized caseload.

Referrals to the Allegheny County Mental Health Court were to be post-arrest, and at any time up to sentencing. Similar social support services would be offered, but for a longer period of time; likewise, monitoring by the Probation Office would be more intensive, with more stringent conditions imposed via the service plan. A mental health court was formulated in Allegheny County Common Pleas Court sometime in 2000, implemented, and took its first case in 2001. It has functioned continuously in its current format since then, with a few changes in the types of cases accepted and the manner of terminating cases, with funding taking various forms.

An “out the door” arm of support services was designed for former offenders with mental illness who have served their maximum state sentences. Sometimes released with

simply a set of clothes and a box of personal effects, an offender with mental illness may only have a short-term supply of medications last prescribed to them inside the prison, and may need medical aftercare as well. If no resources or family contacts are in place, a person with mental illness is at greater risk of re-arrest upon release into the community. While Allegheny County's State "Max-Out" program began in 1999 with the goal of developing immediate discharge plans to aid mentally ill offenders, its secondary goal was to avoid persons unfairly being kept beyond their maximum sentences, thereby helping to lower prison populations. The process, now called "State Support", links them to resources to live as independently as possible, while receiving the services necessary to manage their illness and to remain offense-free. Participation is voluntary, and the courts usually have no jurisdiction over these former offenders unless they were paroled and receive a state parole violation. But a participant must agree to a service plan and to accept the short-term services offered, such as: busing, food, medicine, rent, housing placement, inpatient or outpatient mental health or drug and alcohol treatment, securing of benefits; transportation to early round appointments, job training, and locating family.

Around the same time, Allegheny County created a sentencing diversion program for persons dually diagnosed, who have both persistent mental illness and histories of chronic offending (Community Reintegration of Offenders with Mental Illness and Substance Abuse, or "CHROMISA"). As noted, the county's Drug Court began in 1998, but accepts participants who are primarily drug-addicted and at a particular level of criminal justice offending. The CHROMISA program, begun in 2000, is also voluntary, but individuals are referred to this reintegration program through county, state, or federal courts to be evaluated and treated as a condition of their probation or parole. Within a

residential therapeutic community, they are closely supervised, receiving recovery-oriented services for behavioral health, drug and alcohol abuse, life and family skills training, and education and job skills training (White Stack, *Pittsburgh Post-Gazette*, 2000). Offenders are initially sentenced to CHROMISA either from jail, after the resolution of a probation or parole violation, or if released, directly. The program is 6 to 9 months, sometimes followed by placement in a community residential recovery house. The referring court receives regular reports on residents' progress, and probation or parole can be revoked for failure to comply with the terms of their service plan.

Then in 2006, the County implemented a criterion known as the Sequential Intercept Model (SIM) for services pertaining to persons with mental illness or dual disorders engaged in the criminal justice system. Now all Justice-Related Services addressing that population, including the Mental Health Court, employ the SIM objectives: trying to avert their involvement in the criminal justice system at the outset; once engaged, reducing their entrance into jail; engaging them in treatment as rapidly as possible; aiming to cut the total time they spend in the system; connecting them to therapy both in jail and once released from jail; and trying to diminish the number of times they revert to the system. The SIM model is one based in therapeutic jurisprudence (Munetz & Griffin, 2006).

From its initial diversion program, Justice-Related Services (the division with the Office of Behavioral Health, Department of Human Services, charged with coordinating services for the mentally ill who are arrested) grew to develop a continuum of services and supports at each stage of the criminal justice process and beyond, based on the SIM paradigm. An even earlier stage of diversion, Pre-Booking Diversion, was added in

2006. Their staff are stationed at the County Jail to present an appropriate service plan to the night arraignment court prior to the person's booking into criminal justice records databases. (Pre-Booking Diversion is much the same as the original post-booking program diversion described above, but was started some years later with the assistance of grant funding). At either diversion stage, staff can authorize emergency psychiatric hospital commitments for distressed persons if needed.

In the past several years, the County added a crisis intervention team for police and emergency responders (CIT), where training is to recognize mental disorders, understand psychotropic medications, and to de-escalate potential crisis in the community for the safety of all concerned. CIT intervention is pre-arrest, before the "front door" is entered--and persons in distress are aided in obtaining behavioral health services. The first CIT training took place in 2007 and training for interested officers or police departments in the County have been conducted twice yearly since then, with great response from the local law enforcement community.

The most recent additions are that of a Veteran's Court in 2009, and a brand new jail-based re-entry program in 2010. The Veterans' Court is really a new "track" docket for veterans dealing with issues handled in the other specialty courts (drug, mental health, domestic violence, or DWI), where a veteran might be uncomfortable having his or her case heard in one of those courts; they are assigned a veteran mentor who assists them with the process and with obtaining services from the V.A. and elsewhere. The Re-entry Program will be headed by none other than the same woman who founded the County's first diversionary program. Funded by a new federal grant, its purpose is coordinate reintegration services for those completing sentences upon release into the community.

Formation of This Mental Health Court

Tracing the formation and evolution of Allegheny County, Pennsylvania's Mental Health Court is a focus of this dissertation. What follows here is a broad outline of the structure of the court. As stated, in Allegheny County, the county containing the City of Pittsburgh and surrounding suburbs, a formal mental health court has been in existence since 2001. The Court is a cooperative effort of the County's Department of Human Services' Office of Behavioral Health (through Justice-Related Services, formerly Forensic Services); the Court of Common Pleas; the Office of the Public Defender; the Office of the District Attorney; and the Department of Probation and Parole. Each of these offices has at least one representative on the Mental Health Court (MHC) team.

Historically, the Mental Health Court's jurisdiction has been limited to certain misdemeanor and felony cases as a general guideline, with discretion given to the District Attorney's Office to reject specific cases based on injury to a victim or the criminal history of the defendant., non-violent misdemeanor and felony charges were eligible, excluding drug sales, DUI, sex offenses, and probation offenses. As for eligible charges, the literature which is publicly distributed on this MHC states that "aggravated assault, arson, burglary, robbery, and VUFA offenses may be reviewed on a case by case basis" (Allegheny County Mental Health Court, 2005, Brochure, p. 3). Some of those charges to be evaluated on their facts are by definition crimes of violence under the Pennsylvania criminal statutes. Here, the District Attorney's Office will consider such felonies where the violence was self-inflicted, or in the process of arrest, with victim or police consent as

obtained by the assistant district attorney, or the burglary was of a non-occupied structure. More recently, though, the Court briefly experimented with taking first-time DUI or sex offenders whose sentences would otherwise be limited to probation by the sentencing guidelines for their case and criminal history. Also, cases are sometimes referred post-conviction by judges of other courts in the county's criminal division, thus, those cases do not go through the eligibility screening process, but they are the exception.

Defendants with a previously documented diagnosis of mental illness or disability under Axis I of the American Psychiatric Association's Diagnostic and Statistical Manual, or a dual diagnosis of mental illness and substance abuse, can at any point up to trial, be referred by any interested party (including a self-referral). Thus, most of the participants suffer from schizophrenia, bipolar disorder, or persistent major depression. Through grants, the Department of Human Services funded a qualified Mental Health Court Monitor to psychologically assess each candidate's diagnosis and case needs, and designated Liaisons from the Probation Office ("Probation Liaisons") to oversee their placement with support services from community-based mental care and correctional services. The Mental Health Court accepts defendants who are dually diagnosed as seriously mentally ill and drug/alcohol dependent, when the mental health diagnosis is primary. The MHC Assistant Public Defender, MHC Assistant District Attorney, and the MHC Monitor review the referral information, including pending charges, to determine eligibility and to grant or deny acceptance to MHC. Then the individual and/or defense counsel are informed of the acceptance or denial decision.

The Mental Health Court Monitor, (now called the Mental Health Court Director), is to oversee the crafting of a service plan with designated treatment and housing, with

input from probation officers as to terms of probation. If the Judge accepts the service plan formed by the Court team, then the defendant can be released from jail under the stipulations of the plan. Those with longer criminal histories will be placed in alternative housing rather than individual housing, for additional supervision. Those who have had histories of violence might be asked to go through anger management counseling. A dedicated probation officer is assigned to oversee the defendant's activities more intensively than the average convict would receive, and reinforcement hearings are set up with the Court at 30, 60, or 90-day intervals, depending on the progress of the defendant with his service plan. On its website, Department of Human Services of Allegheny County, PA, gives a fuller process description on the steps that take place after referral and acceptance (Allegheny County, PA, Department of Human Services, 2009). This can be viewed as Appendix H of this dissertation. See also the Flow Chart at Appendix I.

About 55-60 persons graduated in the last three years from Allegheny County's Mental Health Court, with about 450 to 600 being referred yearly, and 350-400 persons being processed through the Court annually; these numbers are increased since the first years of the Court's operation, as will be discussed in Ch. V. When participants do not complete the program, it is due to them rejecting the program after being accepted, death during their probation, or their not complying with their service plan (Allegheny County Department of Human Services, Office of Behavioral Health Justice-Related Services Unit, 2009). Sometimes the MHC Judge "closes interest" in a case, that is, terminates the person's participation for repeated non-compliance with probation terms (see Ch. V). Non-compliance could entail anything from failing to report to one's probation officer, to leaving a treatment program against medical advice, to re-arrest. The "closing interest"

feature is contrasted to termination components of other mental health courts, where non-compliant participants might have their cases transferred back to the general docket for regular processing, or have their probations revoked for re-sentencing, etc.

On the nationwide Criminal Justice/Mental Health Information Network website, Allegheny County states the court and service components of its Mental Health Court are funded by state mental health funds (that is, Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse funds, some of which are received by the state from the federal government for mental illness service to the public) (Criminal Justice/Mental Health Information Network, 2009). To begin with, the Court received a grant for operating funds from the PA Office of Mental Health and Substance Abuse, and private contributions from several area foundations to fund both an assistant district attorney and an assistant public defender being assigned to work on the specialized court docket court alone (Fraser, 2004). The court has been shown to provide some cost savings to the county, not necessarily on the front end, but probably on the back end. A recent Rand Corporation report found the court saved money in terms of the expense of keeping someone with mental illness incarcerated in the county's jail, versus treating them in the community through county-provided resources. (Ridgely, Engberg, & Greenberg, 2007). For this reason, the Mental Health Court is likely to remain in place as one of the diversionary courts in Allegheny County.

In the following chapter, some background on the theory of therapeutic jurisprudence and restorative justice will be provided in a review of the literature, and their relation to the foundations of problem-solving courts. In addition, literature on

courtroom workgroup formation and behavior, especially that pertaining to sentencing and legal reform will be examined, and its relation to mental health courts will be made

CHAPTER III.

THEORETICAL FRAMEWORK

A Therapeutic Jurisprudence Model

Slobogin defined therapeutic jurisprudence as the "use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people if affects" (1995, p. 96). Birgden said much later: "While therapeutic jurisprudence initially developed out of analysis of mental-health law, three decades later, therapeutic jurisprudence analysis has moved well beyond mental-health law to utilize psychology, sociology, anthropology, political science, and economics to examine the law … ." (Birgden, 2009, p. 95).

Therapeutic jurisprudence asks that "lawyers and judges be sensitive to the fact that their actions and decisions can have therapeutic or anti-therapeutic consequences" (Casey & Rottman, 2000, p. 448). It does not take precedence over other key justice concerns and is not "reflexively paternalistic"; nor should it render due process invalid or back up the courts (Casey & Rottman, 2000, p. 447).

In a point-counterpoint about the merits of therapeutic jurisprudence, psychologist Astrid Birgden's promotion of the theory for offender rehabilitation is challenged by Andrews and Dowden (Birgden, 2004, pp. 283-5; Birgden, 2009, pp. 97; 107; Andrews & Dowden, 2009, pp. 119-21). Birgden praised the recent movement in corrections policy from a punishment model to a rehabilitation model, but was concerned the latter model employs psychological theory only to address offender characteristics (internal), without also addressing the characteristics of correctional personnel and environments

(external). She posited therapeutic jurisprudence as a legal theory complementing the use of psychological approaches to motivate offenders by "harnessing correctional staff as . . . potential therapeutic agents" in a new "cognitive-behavioral model of organizational culture change" (Birgden, 2004, pp. 283-5).

Andrews & Dowden proposed "crime prevention jurisprudence" as an alternative to therapeutic jurisprudence—one not necessarily retributive or punitive, but which is not focused on offender welfare, either. Their concept, though using the psychological model of "risk-needs-responsivity" to build offenders' skills, concentrates on reducing recidivism above all else (Andrews & Dowden, 2009, pp. 119-21). Birgden relies on the originators of therapeutic jurisprudence Wexler and Winick in her retort. She states rehabilitation should balance offender with victim rights to increase community protection, and in doing that, therapeutic jurisprudence provides a framework that the crime prevention jurisprudence model does not (Birgden, 2009, pp. 95; 107-9).

One of the reasons therapeutic jurisprudence has resonated with proactive judges who are "tired of merely processing people according to law" is that therapeutic outcomes tend to be more effective than punitive ones (Carson, 2003, p. 126). This is because restorative justice achieves efficiency "by concentrating upon process", using measures shown scientifically to be more efficient for policing, trials, and corrections (Carson, 2003, p. 126). Thus, judges who wish to make a difference can take up the concept of restorative justice and still remain apolitical (Rottman, 2000).

Judges who work in U.S. problem-solving courts can be key to the adoption of such courts in their jurisdictions and, Nolan (2007) asserts, commonly see themselves as advancing a revolution of the judicial system. By promoting systemic reforms, they

believe they are able to accomplish goals that traditional court models cannot. These jurists enthusiastically embrace the practicality of trying to reduce costs through treatment. At the same time, they enjoy the discretion to try to therapeutically alter the behavior of defendants who come before them with mandatory treatment, even if some would view the process used as coercive (Nolan, 2007).

Restorative Justice Theory

The theory of restorative justice posits a new way of responding to criminal behavior. It has been defined in various ways. Latimer, Dowden, & Muise (2005) operationalized the concept as: "a voluntary, community-based response to criminal behavior that attempts to bring together the victim, the offender and the community, in an effort to address the harm caused" (p. 131). They explain the idea as this: those most concerned should be given the chance to collectively negotiate a solution. Though restitution or community service could be included, those components alone do not make for restoration, and are not necessarily voluntary (Latimer, Dowden, & Muise, 2005). Sanford and Arrigo (2005) referred to restorative justice as "major paradigm shift in the criminal justice arena" (p. 225) in examining the implication of drug courts on justice policy. They paraphrased other writers' investigation of restorative justice within published literature about problem-solving courts as "an informal approach to criminal law that attempts to repair the harm inflicted by an offense and rebuild relationships within a community" (Sanford & Arrigo, 2005, p. 254, citing Levrant, Cullen, Fulton, &

Wozniak, 1999), one recognizing “that purely retributive of punitive responses by the state must be replaced by processes that promote healing the relationship between the victim and offender. . . , healing of the community, and accountability and healing for the offender" (Sanford & Arrigo, 2005, p. 254, citing Sullivan & Tifft, 2001). Rather than extending sentences and restricting judicial discretion like the "get-tough" policies of determinate sentencing and three-strikes legislation did, the drug court policies they compared allowed for judicial latitude and flexibility of court treatment team responses in developing solutions for repeat offenders, for these courts to be effective (Sanford & Arrigo, 2005).

In the late 1980s, Australian criminologist John Braithwaite developed the restorative justice theory of reintegrative shaming as a wiser method for social control, a philosophical alternate to the more retributive “get-tough” movement (*Braithwaite*, 1989). Early examinations of Braithwaite’s theory were not necessarily convinced of its effectiveness for the purpose intended (Levrant, Cullen, Fulton, & Wozniak, 1999; Miethe, Lu, & Reese, 2000). Although they supported the concepts of restoring the community, offender, and victims in a justice paradigm, the researchers Levrant, Cullen, Fulton, & Wozniak (1999) argued that the goals of restorative justice systems touted by progressives may in fact backfire. The probationary requirements and sanctions of reparative programs are potentially more coercive and intrusive than the adversarial system, they stated, and through increased surveillance and net-widening, may heighten the chances for failure of defendants, especially offenders without the resources to afford treatment or reparations. They did suggest that a restorative justice theory of criminal justice moves toward making offenders accountable for their behavior in order to regain

social respect and trust from the community, a model of social exchange. This they believed is an improvement over the weakness of a purely rehabilitative justice model first put forth by liberals, one seemingly concerned only with entitlement of the offender to restoration (Levrant, Cullen, Fulton, & Wozniak, 1999).

Miethe, Lu, & Reese (2000) analyzed Braithwaites's assertion that efforts to impose social control in the rise of diversion programs nationwide may produce not only conformity, but deviance. They inspected the drug court sanction/reward component of publicly shaming and praising offenders in the courtroom in one well-established drug court in Las Vegas. Proponents of diversionary programs such as drug courts claim the communitarian goal of continued respect for offenders while disapproving of their deviant behavior deflects addicts from the "revolving door" of re-arrest and reintegrates them into society. Directly comparing randomly selected drug court and non-drug court participants who came into court charged with similar crimes over a one-year period, the researchers found drug court participants in most instances to have higher levels of repeat offending (with recidivism defined as arrest, prosecution, or conviction). Their explanation of these unexpected results were that shaming only works if (1) someone respected by offenders, not necessarily the judge, is shaming them; (2) shaming is focused on offenders' behavior and not on them; and (3) shaming takes place in the context of still accepting offenders and providing them with second chances (Miethe, Lu, & Reese, 2000, p. 538).

One researcher has questioned the theoretical clarity of restorative justice, and argues for a clearer model specification of restorative programs so that they can be tested (Lemley, 2001). Lemley recognizes that before the victims' rights movement, the use of

informal dispute resolution, or the advent of community-oriented policing, communities or victims had no real operative role in the criminal justice system. Restorative justice, she describes through the work of Braithwaite and other theorists, is born of theoretical traditions that are non-retributive. Rather than offsetting the prior harm done by the offender with current harm to the offender, which renders the offender passive and further alienates him or her from the community, restorative justice actively engages the offender in repairing consequences for the community and the victim and in making the future better for all parties (offender included). Lemley mentions the reparative sentencing practice used in Vermont for non-violent offenders: They meet with a citizen board to form a plan to understand and rectify harm to victims and to learn ways to avoid offending. But she points out that empirical verification of any of these processes is lacking at the time of her article's writing, and that restorative justice will not be relevant to policymakers until such questions are answered (Lemley, 2001).

Other studies have found that participants in a restorative justice model are no more likely to re-offend than those involved in traditional models of justice (Maxwell & Morris, 2002). Maxwell and Morris hypothesized that levels of re-arrest can even be lowered in a comprehensive scheme that addresses the needs of both society and the offender. For its theoretical basis, the current study integrates concepts of restorative justice and social change in a community-based correctional model. Meaningful rehabilitation of convicts, in terms of recognizing the additional hazards the mentally ill face and addressing those hazards, forms part of the restorative social change model. Attempting to provide for the needs of mentally ill offenders is intrinsically therapeutic. Imposing necessary structure and constraints upon the mentally ill offender, short of

incarceration if possible, and thereby providing greater protection for the people such offenders encounter, forms another part. Incorporating community correctional and mental health care, so that mental illness is acknowledged and collectively managed by the community rather than simply criminalized and hidden behind bars, is the third prong of a restorative social change model (White, 2004). Finally, such a model can reduce financial costs from those an incarceration model imposes, as discussed in the Rand Corporation report referenced in Ch. II (Ridgely, Engberg, & Greenberg, 2007).

Restorative justice has been utilized with some regularity in countries of the British crown, especially with youthful offenders. It usefulness for adult criminal behavior was recently examined by British researchers Shapland et al. (2006). Integral to any form of restorative justice, they explain, is that an offender acknowledges the harm he or she has caused and apologizes for that behavior in the practice of "reintegrative shaming", though a victim may not be able to accept such apology, immediately or ever, in the process of healing from victimization. Reparation is often offered to the victim, yet it does not always take the form of financial or physical restitution. Sometimes the assurance that offender is to be rehabilitated is viewed as "symbolic reparation" by a victim, such as a "confirmation of apologies" by the offender, and "expression of potential reparative change" (Shapland et al., 2006, pp. 515; 518) with hope for future reductions in crime. Although the rights of the offender via the state are not viewed as paramount as would be within a traditional criminal justice system, nonetheless, one of the keys to a restorative justice framework is that offenders can gain "social capital" through the support offered for them to rebuild their lives and through reinforcement of their micro-communities for the future (Shapland et al., 2006, pp. 519-21).

These researchers were concerned that roles of the players within a restorative justice scheme—offenders, victims, their respective supporters, and facilitators--were informed by their existing views of the powers within the criminal justice system. They also noted limits of their own knowledge about rehabilitation opportunities for offenders. Despite the constraints of these normative assumptions and knowledge about rehabilitation as being restricted to professionals, the researchers found that a restorative model offers the opportunity for procedural justice that the traditional model does not permit (such as information-sharing and communication input). They also found that a restorative model can be transformative in the sense that generalized and punitive court-dispensed sentences are replaced by democratic, individualized remedies, whose outcomes are fashioned according to the mutual efforts of participants in the case (Shapland et al., 2006).

In their meta-analysis of studies on the effectiveness of restorative justice practices, Latimer, Dowden, & Muise (2005) sought to test the utility of restorative justice programs. They selected programs which considered outcomes for at least one of the following elements of restoration: victim satisfaction, offender satisfaction, recidivism (defined as new charge, new conviction, pre- or post-test offending), or restitution compliance, and which had a randomly assigned control group of cases handled with traditional criminal justice approaches. Measuring effect sizes for each study, controlling for potential moderating effects on the outcomes, and using methods to ensure reliability, they found restorative justice-based programs to be significantly more effective at achieving each of the four desired outcomes than incarceration, court-ordered restitution, or other non-restorative methods. Their only reservations had to do with the

self-selection bias of participation in some restorative justice programs, and the fact that participation may not always be truly voluntary for offenders (Latimer, Dowden, & Muise, 2005).

Application To Problem-Solving Courts

A specialized court is more likely to use therapeutic jurisprudence principles, as judges and staff see the same individual and system issues repeated throughout their dockets. Interaction of judges with community treatment professionals engenders mutual cooperation, allows the court to coordinate care among providers in the community, and possibly even makes for reductions in costs. Judges and attorneys involved in specialty courts can share ideas to facilitate restorative case processing and therapeutic results (Casey & Rottman, 2000).

The drug court concept, while not formally initiated under a restorative justice paradigm, has been described as grounded in many of the tenets of the theory. Drug courts are retributive in the sense they require the defendant to admit wrongdoing (drug abuse) and harm to society (thefts, assaults, or DWI's) in court, and pay restitution to those they may have victimized. Yet, the program utilizes reintegrative shaming by allowing defendants to remain in the community during the program, by applauding their success when they have completed treatment, and by publicly accepting them back into that community when they have graduated (Fulkerson, 2009). Fulkerson finds restorative standards as well as therapeutic ones in the goals of drug courts: "to interrupt

the recurring pattern of addiction and criminal behavior, restore the person to a life without drugs and crime, help the addict to accept responsibility for her actions, restore drug addicts to their families, make society safer, and repair the harm caused by drug addiction" (Fulkerson, 2009, p. 264).

A different justice paradigm entails different roles for the players in the criminal justice system within problem-solving courts. Fulkerson detailed these roles for the drug court workgroup. The drug court judge, as "team leader", must acknowledge the chronic nature of addiction, exercising patience at a series of court reviews. Drug court participants are expected to relapse; on the other hand, they are monitored more intensely than when on traditional probation and thus more likely to be brought into court for potential violations. The judge is called upon to both encourage progress and critique setbacks as part of the treatment team. The prosecutor in drug court must view the process as rehabilitative rather than adversarial. He or she needs to focus on prevention of future crimes and relapses instead of on convicting and punishing the defendant for the instant crime. A defense attorney in drug court must set aside usual strategies in a several ways: first, by taking part in the screening of a defendant for eligibility; second, by having the client be open about relapses and criminal activity to the court rather than trying to suppress such information; and third, to move the client towards program completion rather than to seek acquittal. Also key to the team is the involvement of treatment providers. They are not only called upon for input as they might in a pre-sentence report to traditional court judges, but also to be present at court hearings. The information they give the court about treatment developments is used both for rewards and sanctions for drug court participants (Fulkerson, 2009, pp. 256-56).

Although diversionary courts such as drug courts were not specifically founded on a restorative justice model, Sanford and Arrigo nonetheless found parallels of drug courts to the greater concept, such as rehabilitation and counseling for the offender, and use of community resources to deliver those goals within a non-adversarial format. However, to implement a restorative justice paradigm, they emphasized that fundamental policy or legislative changes in the diversionary court model might be required (Sanford and Arrigo, 2005).

Restorative justice historically directly involves victims and other community members. Most restorative justice formats do include some form of victim meeting or contact with the offender in a mediation setting. Lemley looked at victim-offender mediation (VOM), where a restitution agreement is worked out and signed by all parties and filed with the court. She also reviewed the family group conference process that is used in juvenile justice cases in Australia and New Zealand, which stresses the position of family and community in dealing with crime, and involves everyone from victims to police in resolving responsibility and restitution for the crime, preventing additional offenses, and promoting healing for all concerned. Though she concluded that these methods of restorative justice had not been proven to reduce recidivism, Lemley does note that such programs are supported by victims and offenders due to perceptions that the process is fair (Lemley, 2001). Still, indirect negotiation between offender and victim, where information is shuttled between the parties by a mediator, is considered as restoration rather than punishment for defendant participants, and reparation for the community (Shapland et al., 2006).

Wemmers, a researcher who has done much writing on victim rights, suggested that the therapeutic participation of victims in the criminal justice system requires empathy for them from first responders, respect for them when testifying (that is, not treating them as suspects upon cross-examination), refraint from excessive delays and inconvenience, provision of information and reassurance to them, recognition of their concerns (possibly even with their own attorney to communicate the same), and giving them support which empowers them (2008, pp. 172-85). "When victim participation means respect and recognition, . . . it does not put victims at increased risk of exposure and confrontation", Wemmers says (2008, p. 188). Thus, direct mediation with an offender, even one who may not have been able to form the mental capacity to harm, might not be amenable to some victims.

Where mentally ill offenders are concerned, the community interest may be more directly represented by the mental health practitioners who will treat the released offender as an inpatient or outpatient in the community, and by the probation officers who will try to monitor their behavior on a regular schedule. These parties make up some of the stakeholders in the mental health court diversion process; they aid in the management of offenders' mental illnesses and report on progress to the court about offenders in their care. As mentally ill offenders heal, they can take part in their own recovery and once again carry on as members of the community. The resultant process is meant to be both therapeutic, and restorative. Still, the absence of the victim is obvious.

Some considerations for specialty courts with therapeutic jurisprudence exist: caseloads must not be too broad or too narrow to accomplish their goals; judges may be reluctant to take on these unglamorous, frequently difficult cases; and courts can be

swayed by the outlook of outside professionals on whom they must rely for opinions about treatment progress (Casey & Rottman, 2000). Problem-solving courts must incorporate lessons from social science into practice, though the questions posed by their caseloads are not resolved in simple fashion by the social sciences; and the judges applying social science methods may misinterpret them or find them unhelpful in many instances. Thus, Casey and Rottman (2000) advise that making use of therapeutic jurisprudence principles "will require thoughtful discourse and experimentation," not conceived arbitrarily or hastily imposed (p. 455).

Limitations Of The Model

With mental health specialty courts, it is particularly important that criminal justice processes augment, rather than detract from, the rights of mentally ill offenders, for restorative justice to be meaningful. The Bazelon Center for Mental Health Law reviewed 32 mental health courts after several years of early courts' operation, and pronounced cautions to be taken regarding risks to civil liberties of mentally ill offenders (2004). Some of their concerns were: that mental health courts not be coercive in offering jail diversion in exchange for treatment; that candidates be fully informed of the right to withdraw, especially given the stresses of deciding to participate while jailed and possibly going untreated; that defense counsel knowledgeable about mental healthcare be appointed as soon as candidates are identified, to make certain they are fully informed on decisions to waive rights to trial and enter a plea with all the ramifications of

conviction; that mental health courts not maintain jurisdiction beyond that period which could be imposed for the underlying charges; and that stipulations be manageable for those with serious mental illness, as well as sanctions for not complying be specified and foreseeable (Bazelon Center for Mental Health Law, 2004).

These authors feared that the mentally ill would be "needlessly arrested for nuisance crimes" unless police were trained to intervene appropriately when encountering them; also, they pointed out the irony of community mental health providers denying service to "the very individuals who are most likely to benefit from their intervention and who are least appropriate for prosecution" (Bazelon Center for Mental Health Law, 2004, p. 14). They warn that "court-based diversion, whether through specialty mental health courts or through regular criminal courts, is not a panacea for addressing the needs of the growing number of people with mental illnesses who come in contact with the criminal justice system" (Bazelon Center for Mental Health Law, 2004, p. 15), and indicated that diversion programs have simply shifted the cost of caring for the population of mentally ill who are hardest to serve from public mental health systems to state corrections departments. Finally, they suggest that mental health courts be given the power to "hold mental health providers accountable" for "delivering appropriate services to defendants", including possibly controlling funds designated for diversion programs (Bazelon Center for Mental Health Law, 2004, p. 13). But at least the restoration of offenders' rights is being addressed within these courts.

So far, the "therapy" in therapeutic jurisprudence has mostly only been extended to offenders, and possibly to their families (such as programs to help children of incarcerated parents). Carson describes how injustices in the adversarial system have

sometimes been reformed in a therapeutic manner. For example, allowing victims of child sexual abuse to testify on closed circuit television or in chambers fairly balances the defendant's right to confront accusers with offsetting the anti-therapeutic effects of trauma on the child witness (Carson, 2003). He points out that in Anglo-American jurisprudence, we have required police and social workers begin to use cognitive interviewing of child abuse victims (because it enhances memory, if not for the fact it is kinder toward the interviewee). As yet, though, we have not extended those protections to other victims or witnesses in trials—we do not require lawyers and judges to follow the same practice toward them, even though cross-examination and trials have been shown to be unscientific in their pursuit of accuracy. Despite that the goal of a trial is ostensibly to seek the truth, we also enforce verdicts, even though judges and juries might believe evidence that appeals to emotions rather than logic (Carson, 2003).

Nonetheless, we accept the traditional process with its flaws because we have decided the rights of the accused are sacrosanct. Thus, by not espousing other reforms in the "procedures and processes that are as rational and consistent with current quality research as we can currently maintain," (p. 127) Carson (2003) says that therapeutic jurisprudence and restorative justice have taken a *de facto* political stance of maintaining the status quo respecting most victims and witnesses. That is, considering how victims and witnesses are treated in the existing system, their participation is often anti-therapeutic and they have little incentive to participate in it (Carson, 2003).

The level of participation of victims in problem-solving courts is very much dependent on the format of the court. Sanford and Arrigo cautioned that drug courts lack necessary components of a restorative justice model, and that "implementation . . . within

a drug court requires adaption of existing processes and, arguably, foundational change within the basic drug court model" (Sanford & Arrigo, 2005, p. 255). Fulkerson suggested a way to make drug courts more restorative by involving primary victims of drug crimes, as well as secondary victims like family members, friends, and employers, into the treatment programs, i.e., to incorporate the defendant's "community" into the process (Fulkerson, 2009). To date, victims have very little involvement in mental health courts, and they rarely appear at court meetings. At best, the prosecutor secures agreement of victims for a mentally ill offender to be referred to mental health court for processing, or their cooperation in dropping charges if the court offers that to successful participant offenders. In other instances, victim interest is represented by the probation officer or prosecutor, such as insisting that reparation or restitution be made in order for a mentally ill defendant to be accepted into mental health court.

Adaption To Mentally Ill Offenders

The principles of therapeutic jurisprudence are generally implicit in diversionary courts such as mental health courts. The reforms being promoted by judges and other members of problem-solving courtroom workgroups are in part based on the theory of restorative justice as well. Most tenets of the definitions given above will be useful to this study as a theoretical framework and a guide to how data will be interpreted in this study.

As discussed in the introduction, the numbers of persons with a mental disorder or co-occurring mental illness and substance abuse disorder active in the criminal justice system has dramatically increased in the last several decades, and jails and prisons are housing those persons at alarmingly high rates. As traditional mental institutions continue to close, when individuals with mental illnesses encounter the criminal justice system—either as victims or persons committing crimes--they may often be arrested for lack of adequate community options for their care. Pennsylvania's correctional institutions and many of its county jails are attempting to provide programming to address offender's needs while housed within, however, they are not necessarily best equipped to handle the multitude of problems such offenders face.

Mental health courts have drawn lessons from the management of drug courts. In spite of the many reasons for addiction, the best evidence an addiction has been managed is still in abstinence from substance-abusing behavior. Managing mental illness, outside or inside the courts, is potentially far more complicated. A myriad of mental illnesses exist, and symptoms of mental illness can be manifested in a myriad of ways. When mental illness manifests itself in criminal behavior, the questions of whether and how to punish the mentally ill offender can be answered in a variety of ways, as covered in Chapter II.

Mental illness is a quality much like youth—not of one's choosing. Though arguably the *symptoms* of mental illness are within a person's ability to control, some mentally ill persons lack the insight to understand their illness. A state of untreated mental illness can be compared to a youthful brain that is not developed enough to make rational adult decisions. Lessons might be taken from the management of youthful

offenders in the juvenile court system and the issue of lessened culpability wrangled with there.

In trying to answer the question of whether to transfer juveniles to adult courts, Aaron Kupchik studied a specialized "youth part" court in New York City with jurisdiction over 14 and 15-year olds charged with serious felonies and 13-year olds charged with murder. By law, these juveniles are precluded from case processing in juvenile court, and are processed as adults despite their tender age. Therefore, this court "straddles the boundary between juvenile and criminal justice" (Kupchik, 2004, p. 151), and judges in the court face the dilemnas of "judging the level of culpability of adolescents for their criminal offenses, and deciding how to balance the competing objectives of allowing youth second chances while punishing offenders for their crimes" (Kupchik, 2004, p. 150).

Judges in this special court have the alternative to grant "youthful offender" status to those juveniles whom they deem too young to incarcerate, and thus depart from sentencing guidelines even where the prosecutor or the probation officer disagrees. They grant more lenient sentences, either non-custodial or with short prison terms, yet to satisfy the delicate balance, they have developed a practice of severely admonishing juveniles as a kind of "informal sentence enhancement" for these "salvageable" cases (Kupchik, 2004, pp. 167-68). Kupchik likens the admonishment to Braithwaite's reintegrative shaming ritual (see previous section on restorative justice), describing it as a dramatic, ceremonial act, where the judge lectures the juvenile in open court, possibly threatening to imprison him or her for any additional offenses (p. 164). This occurs with encouragement from defense counsel and without objection of program advocates

appearing on the juvenile's behalf, who know it is usually to their client's benefit. In so doing, proportionality is achieved with limited sentencing options. Kupchik describes it:

> Admonishment has a functional role . . . the judge can express the hostility of a community against criminal offenders, attempt to deter the defendants from further crime … . It communicates the defendants' responsibility and denounces them for the harm they have caused, but it allows them second chances by sparing them from lengthy prison terms.

(Kupchik, 2004, p. 169).

There will always be apprehension that the release of offenders with mental illness into the community could be dangerous to themselves or to others. There are limits that forensic assessment can accomplish regarding the mentally ill, as one article asserts. Knowing what parameters a forensic assessment does entail is helpful, to all concerned, yet mental health professionals simply cannot completely predict criminality for court outcomes, especially when reviewing past actions (Grisso & Vincent, 2005).

And criminal justice professionals, too, must learn to adapt their expectations and behaviors in order to carry out the work of any specialty court, probably nowhere as much as with a mental health specialty court. The present judge who sits on the Allegheny County Mental Health Court, Judge John Zottola, had this to say in a recent Public Broadcasting System documentary on the mentally ill being released from incarceration:

> Supervising Mental Health Court was unlike any judging that I've ever done before. And I'm sure, for any other judge that's in a specialty court, ... we're used to a system that is a vertical system, where the judge is making that decision after hearing arguments by both parties. Mental Health Court is really a horizontal system, where a judge gives up a lot of the authority that that person has in recognizing that other members of this team may be in a better position to make decisions or to make suggestions regarding how we can affect someone that is in Mental Health Court. ... I do my best to be as thoughtful as I can, but ultimately I make the decision. I hope I make the right decision.

(Zottola, 2009, Interview with Frontline: *"The Released",* para. 3, 7).

Mental health service providers have begun to overlap with criminal justice practitioners to establish successful alternatives where both the community and persons with mental illness or dual disorders are protected. This is a form of restorative justice, although it tends to focus more on reintegration of offenders with mental illness into a life in the community and with restoration of the community as a whole, rather than with reparation to or healing of specific victims, as described above.

The Courtroom Workgroup Model

In our criminal justice system, trial judges have the final say on the disposal of cases. Yet many factors go into the formulation of plea bargains, the rendering of verdicts, and the calculation of sentences, beyond the judge herself looking at the facts of the case, a defendant's prior record, or offender demographics. For example, the judge relies on evidence obtained and testimony given by law enforcement on the charges; input from the prosecution and defense presented at trial or in a plea bargain outweighs anything the judge can personally observe from the defendant in court; and information gathered by the probation agency for the pre-sentence report can and does influence sentencing decisions. Certain tasks performed in the court process prior to trial and long before the point of sentence ultimately affect verdicts and pronouncements of sentence, and the enforcement of sentence. And a good deal of those tasks is conducted by administrative court staff, probation officers, defense attorneys, prosecutors, and police

officers. Various groupings of these players have been referred to in studies of court behavior as the "courtroom workgroup". There is long-standing recognition that courtrooms spawn informal workgroups and that the workgroups "do justice" at the local level.

Legislation is often introduced requiring certain matters be accomplished by courts or other arms of government, without necessarily determining how those tasks will be carried out. Courtroom workgroups often are the agents who by default must carry out those tasks. Much research has been done on effects players in court room workgroups have in carrying out those tasks. Less study has been done on their interactions. For purposes of this study, this author will review research looking at courtroom workgroup actions and reactions in carrying out reforms.

Older studies on case disposition set the tone, considering characteristics of offenders, cases, and traditional courtroom workgroups (judge, prosecutor, and defense attorney) (Eisenstein & Jacob, 1977; Eisenstein, Flemming, & Nardulli, 1988; Flemming, Nardulli, & Eisenstein, 1992; Nardulli, Eisenstein, & Flemming, 1992). Ulmer & Kramer (1998) summed up the seminal conclusions of this work nicely: "[T]the context of local 'court communities' and the formal and informal case processing norms of courtroom workgroups are at least as important as formal laws and state-level policies in influencing important phases of the criminal legal process, such as court case processing and sentencing." (Ulmer & Kramer, 1998, p. 248).

The bulk of later research on courtroom workgroups or court communities concerns effects either on sentencing outcomes, or on implementation of legislation or regulatory changes. Review of the literature on courtroom workgroups demonstrates that

larger-scale research must inherently involve analysis of secondary data, in the search for overarching behavioral themes. A look at the qualitative or multi-method studies uncovers a less common research strategy of interviews with open-ended questions of key workgroup members, supplemented by observations in the courtroom and in other meetings of the workgroup.

Sentencing Outcome Research

Sentencing outcome research is plentiful, though it is fair to say the majority of it centers on disparity in sentencing and attempts to discern why it occurs. Much of the research of the past two decades concerns the effects of widespread determinate sentencing reforms, and reviews large data compilations. Sentencing reform laws were passed both to "get tough" and to try to remove arbitrariness from sentencing. While such reforms have had effects on sentencing decisions of judges, some of the goals of those laws are thwarted in other ways. One of the primary ways has been in the charging decisions, which are solely in the discretion of the district attorney. Another key way is in the plea-bargaining function, where the prosecutor controls offers made to defense counsel so to avoid a trial. While a judge might be able to exert pressure on a prosecutor by refusing to accept certain plea-bargains, ultimately, the D.A. decides whether to drop charges or otherwise lessen charges in a manner favorable to the accused.

One key finding of sentencing outcome studies, for example, regards the power of prosecutors over the plea bargaining process to try to secure convictions or lighten

dockets. It is tempered when the typical "concessions" model, where unpredictability reigns, is replaced by a "consensus model", where greater certainty ensues. In a concessions model, defendants are persuaded to plead guilty with the offer of dropping counts, a method that allows factors unrelated to the case to come into play. Workgroup members in a concessions model implicitly agree that defendants charged with similar crimes in similar scenarios should receive similar sentences, and group expectations for outcomes work to limit prosecutorial discretion (Nardulli, Eisenstein, & Flemming, 1992). Testing a modified version of this model, Ball used statistical analysis of 2,500 guilty pleas to find that offender characteristics do not affect plea bargaining over the number of counts charged with any significance. Yet there might still remain disparate results for certain offenders. The prosecutor could initially "overcharge" people based on factors that should remain legally irrelevant (race, gender, age, ethnicity, or employment status) or refuse to offer anything but a straight plea (a plea to all charges, with no agreement as to punishment, thus the judge controls the sentence) (Ball, 2006). These interactions are much harder to measure than sentencing outcomes, however. The latter are clearly recorded by the court system; the former, if recorded at all, are statistics not easily obtained.

Expanding on studies on sentencing guidelines and outcomes, Engen and Steen (2000) tried to fill a vacuum left by most prior research, that is, specifically exploring whether prosecutors will react to sentence reforms by shifting the exercise of discretion to earlier stages in the process—charging and plea-bargaining decisions. They evaluated several changes to Washington State's drug laws of two decades ago. One legislative change eliminating reduced sentences for first-time heroin or cocaine sales (thus making

prison sentences mandatory for all deliveries of those drugs); another legislative change increased minimum sentences for all deliveries, as well as for enhancements on guns and protected zones sales. A third initiated by court appeal worked in opposition, allowing non-prison sentences for offenders charged with "anticipatory" offenses of conspiracy, attempt, or solicitation, regardless of the number of counts charged. Three possible theories framed the mandatory sentencing reforms: formal legality, where laws are adhered to; substantive rationality, where the workgroup takes action to achieve criteria its norms say are fair (typically suppressing change); and organizational efficiency, where attempts to maintain case processing expedience take priority over formal rules (though fairness may be evoked if not impeding efficiency). They reviewed over 15,000 cases in their statistical analysis (Engen & Steen, 2000).

In the end, these researchers found charges were manipulated, so that while likelihood of imprisonment and sentence length increased as per reforms, they did not do so drastically. Most obvious was that severity of charges, use of enhancement penalties, and overall sentence length were all well-correlated to the type of conviction, such that those who pleaded guilty almost always received lesser sanctions than those who went to trial. Judges, in great part, were found to have followed the laws, though they mitigated reform effects somewhat by eliminating prison sentences in about every eleventh delivery case. Reforms made it less desirable for the defendant to take a plea for delivery cases and most possession cases, because no option without prison was available.

Still, prosecutors were able to find a way to exercise discretion by dropping charges or not asserting facts needed to charge sentence enhancements, or amending charges to conspiracy to reward those who pleaded with the least possible incarceration.

This adaption and shifting of discretion, was consistent with the organizational efficiency theory described (Engen & Steen, 2000). The authors discussed an earlier qualitative study by Engen and Steiger which seemed to have confirmed that conclusion. There, defense counsel revealed in interviews cases which could have been charged as deliveries but which were instead plea-bargained as conspiracy charges, showing not changes in offending patterns, but changes in charging practices (Engen & Steiger, 1997). The authors warned further research would be necessary to determine whether the reforms "may have resulted in less uniform sentencing for similar offenders than existed prior to the reforms", particularly if charging decisions were tied to "status characteristics such as sex, race, or ethnicity" of offenders (Engen & Steen, 2000, p. 1387).

In a contemporary review of mandatory minimum sentencing reforms, Merritt (2007) discussed how the foreseen impacts of heavy-handed reforms were often lessened when carried out. She examined how prosecutorial discretion interacts with workgroup characteristics to enhance or detract from the implementation, and found discrepancies in case selection, processing and disposition. Variations were based on distinctions in the workgroups themselves, or entailed differences in policies used to carry out the reforms. These policies were primarily controlled by the district attorney in her conclusion (Merritt, 2007). For instance, Pennsylvania allows enhancement penalties for use of a gun or commission of a crime in a school zone, which compel mandatory additions of jail time. Such penalties, again, are the prosecutor's discretion to charge, and the only influence that could be exerted to remove that penalty, once invoked by the district attorney, might be a defense counsel's complaint to the judge regarding fairness of the plea bargain offered. Making this kind of request is tenuous and may provoke the

prosecutor's ire, and should only be put forth with some knowledge of the judge's propensity in similar cases.

Differences in makeup of workgroups have been shown to influence the outcome of sentences in a recent study across the federal court system by Ward, Farrell, and Rousseau (2007). They hypothesized disparate severity of punishment based on race of judges and prosecutors as workgroup members, and the size of minority population they serve. Acknowledging that numerous elements and circumstances could make for variances in case processing, they looked at these variables in the context of arrest data, workload, case processing times, and other factors within 90 federal judicial districts. In their statistical review, using the workgroup as the unit of analysis, findings were that the proportion of black judges in a district did affect the chance of incarceration, as did the proportion of black judges and black prosecutors combined (though the proportion of black prosecutors alone did not affect likelihood of imprisonment or sentence length). Given their results, the researchers believed that diverse courtroom workgroups helped to produce less biased decisions. Thus they proposed that strict sentencing guidelines be modified to maintain some degree of judicial discretion (Ward, Farrell, & Rousseau, 2007).

A major recent study evaluating courtroom workgroup effects on sentencing was published this year, after the bulk of research was completed for the instant study. Haynes, Ruback, and Cusick (2010) followed the methodology of older studies by Eistenstein and colleagues. Again, they limited the workgroup studied to judges and prosecutors only. They found, as did the others, that the weight of the charges and the defendant's prior record had the most to do with sentences imposed. Although they

found factors like rates of poverty and crime did not significantly affect sentencing in their recent study, characteristics of the workgroup did (Haynes, Ruback, & Cusick, 2010).

This research team conducted their study of the decade 1990 to 2000, for all 67 counties in Pennsylvania, in the context of a 1995 statutory change in the state requiring that restitution be imposed whenever a victim suffered physical or financial loss, whether or not the offender was able to pay it. They first examined similarity of workgroup members on demographic information, and second looked at "proximal" data about members like whether their offices were located in the same building, what their political party affiliation was, and where they attended college and law school. Third, they investigated stability of relationships over time. The statistical analysis was done both with and without Philadelphia and Allegheny counties, the two largest urban counties containing Philadelphia and Pittsburgh. Their study looked at sentencing regarding decisions to incarcerate (separating jail from prison sentences), set fines, and order restitution; they did not include sentences imposed for second or greater offenses in any year. With the exception of the two large counties (whose groups had lengthy stability), judges and district attorneys were very similar in race, gender, region, and schooling (white, male, local, having attended PA colleges and law schools); the only differences were in age (median for prosecutors 41 versus judges' median 51) and political affiliation (judges mostly Democratic, district attorneys mostly Republican) (Haynes, Ruback, & Cusick, 2010).

Decisions to incarcerate were significantly influenced by workgroup variables; the more similar workgroup members were on all points except college attended, the less

likely offenders would be imprisoned (similarity of college attended had the opposite effect). Decisions to impose fines were more likely with similar college alma maters and proximate offices of workgroup members, but less likely if the group had worked together longer (more stable). Decisions to order restitution were most impacted by greater similarity in workgroup law school attendance, where there was less likelihood of a restitution order. Likewise, restitution orders decreased for each year of stability the group sustained; there was no significant difference anywhere after the year of the statutory change, however.

Outcomes were consistent for all counties (except that fines were more likely in rural counties), overcoming any differences in gender, race or political party by county type. Group factors mattered least for serious crimes, where it was reasoned anyone in the group would tend to want to sentence more heavily. The researchers thought that punitiveness as to imprisonment was born of stronger state ties making for less diversity of opinion (overcoming any liberalness that might have come from attending certain colleges). Still, they reasoned that "more similar workgroups may have been less likely to incarcerate offenders because members are more likely to agree about possible alternatives … " (Haynes, Ruback, & Cusick, 2010, p. 156). They felt that compromises born of proximity made for exchanges of incarceration for financial penalties; they also felt that if a workgroup was more stable, it was also probably more experienced, and so members would realize that offenders could not pay economic sanctions (Haynes, Ruback, & Cusick, 2010).

As mentioned above in some of the sentence reform research on court communities, danger exists that workgroups will behave to constrain defendants based

upon legally irrelevant characteristics (race, ethnicity, gender, age, sexual orientation, marital or employment status). On the contrary, courtroom workgroups might utilize those same characteristics in order to assist mentally ill defendants with the special problems they face. Presence of a serious mental illness could in fact be relevant to the commission of the crime and, as mentioned above, might be pertinent to culpability; likewise, the fact the defendant suffers from the disease can be relevant to choosing the correctional options available to him or her.

Legislative And Policy Reform Research

Research on legislative or policy reform abounds as with that on sentencing reforms. For purposes of the instant study, this researcher will limit discussion to works pondering the interaction of court communities as they attempt to carry out reforms foisted upon them by legislatures, executive agencies, or administrators. Ulmer and Kramer (1998) detailed the court community framework research by Eistenstein, Flemming, and peers as concentrating on social psychological factors including: "1) membership stability, 2) local party politics, 3) interrorganization relations and balances, 4) dominant sentencing ideologies and goals, 5) organization type and leadership style of prosecutor's offices, and 6) the strength and nature of locally defined 'going rates', or informal sentencing norms" (Ulmer & Kramer, 1998, p. 253).

Reviewing a major federal legislative reform, the Adoption Assistance and Child Welfare Act of 1980, as it was implemented by the states, researchers found that reforms

were not effected as designated. The research looked at workgroups statewide in a state that had implemented the legislation. Surveys were sent to six key decisionmakers of the workgroup surrounding child placement in all counties: juvenile district court judges who handled dependency hearings; circuit court judges who handled terminations of parental rights; the court clerks who administrated both courts; chairs of foster care review boards; guardians *ad litem* for abused or neglected kids; and court-appointed advocates for dependent kids. Surveys were followed up by interviews with open-ended questions of other key members at 5 sites varied by locale, structure, and size: prosecutors, law enforcement officials, parents' attorneys, and caseworkers (Knepper & Barton, 1997).

The researchers concluded that, aside from the problem of little federal guidance about how to implement the law, the obstacles to implementation had more to do with the impacts the law would have on informal daily decsionmaking and routines of the courtroom workgroups. Judges, despite their leading roles, were dependent on caseworkers for information to resolve cases with certainty, and on clerks for technical compliance with the law. Likewise, caseworkers' lack of preparation or insistence on a course of action that slowed overloaded dockets or created work for others would result in their censure within the workgroup. The researchers declared that, regardless of the clarity of the law about its objectives, "real change depends on the extent to which [the workgroup] can adapt their informal rules and expectations to coincide with those expressed" in the law. They suggest future training to improve "role clarification, shared expectations, improved working relationships, and collaboration across professions …" (Knepper & Barton, 1997, pp. 305-6).

In a similar sort of study, sociologists looked at the implementation of a major policy reform in juvenile law, the effort to reduce juvenile detention by using a new screening tool to assess recidivism risks when misdemeanor juvenile offenders were released. The researchers anticipated finding higher levels of cooperation among juvenile court workgroups, due to the juvenile court philosophy of acting in the best interests of the child. Here, the reform was piloted in four counties, where a prior quantitative study had shown lack of acquiescence in using the screening tool. So these researchers followed up with semi-structured phone interviews of a sample of justice professionals from several counties, where they employed open-ended questions. They triangulated information with observation of workgroup interaction and quantitative data from detention cases. Despite stated agreement on the value of reducing detention, the tool was not widely used by those interviewed. Again, the issue of dissuading increased workloads arose from those workgroup members who were most affected; probation officers tried to thwart the instrument if they were unable to find placement for a child, displacing the apparent power of the judges who had the discretion to use it or not. Perceptions of the value of the tool for the purpose designed was also tied to the amount of confidence and trust justice professionals had in other members of the group. For example, sometimes a police officer believed detention was necessary for a juvenile, and did not believe the judge would detain the child, so subverted use of the tool by trumping up charges to assure placement. The researchers suggested contemplating the impact of legislative reform on workloads and on the interaction of established workgroups (Gebo, Stracuzzi, & Hurst, 2006).

In study of a courtroom workgroup which investigated legislative reform pertaining specifically to sentencing reform, Harris & Jesilow (2000) found dysfunction among the workgroup. These researchers also used open-ended questions, but this study used a questionnaire of senior officials in each of six counties--the elected district attorney, senior public defender, presiding judge of the court, and senior court administrators. First, the workgroup was dealing with a cumbersome law, California's "three strikes" legislation, designed to limit workgroup discretion involved in plea bargains. They found the statute "significantly disrupted the efficiency of the courtroom workgroup and has made the prediction of case outcomes difficult" (Harris & Jesilow, 2000, p. 202), and results varied widely by county, depending on which charges the district attorney employed to meet the law's definition. Members of the group engaged in tactics to nullify the law for a number of reasons, including settling cases where they felt the result would be onerous for a defendant, to reduce workloads, or for political reasons. Judges retained the power to strike prior felonies "in the interest of justice" Harris & Jesilow, 2000, pp.186-7), and sometimes conflicted with more harsh district attorneys in doing so. Defenders bore the brunt of increased workloads and stress "due to their uncertainty as to what facts may cause a prosecutor or judge to ignore a prior allegation in any particular case" (Harris & Jesilow, 2000, pp. 198-99). They had to communicate uncertainty or prosecute intransigence to their clients and so would try to get a jury to nullify a conviction where one of the charges did not warrant a lengthy sentence.

These tensions meant the workgroup did not develop norms for case negotiation to aid in their tasks. Such behavior not only undermines duties of the workgroup, the researchers discovered, but in upsetting the group's dynamics, it can also affect members'

fulfillment with the court process and the results. Even prosecutors were unable to predict outcomes, and as a result, proposed that the law's use be limited to "individuals whose current offense involves a serious or violent felony" (Harris & Jesilow, 2000, pp. 201-2).

In workgroups, interaction behaviors are aimed at accomplishing the tasks of the group. Notably, none of the sentencing outcome studies reviewed directly examined actual behavior of the workgroups; most purely analyzed data on characteristics and contexts of workgroups. Some of the legislative reform studies reviewed for this subsection, in the alternative, were conducted through qualitative interview designs which attempted to get at the interactions between members in carrying out tasks and accomplishing objectives expected of them. But we can also look to other fields like organizational theory, where workgroups abound for descriptions of workgroup relations and their effects on the work conducted.

Economists Milton & Westphal's research (2005), done on workgroups in the business world, is particularly relevant to the dynamics of workgroups covered in this study. Their research was grounded in social psychology, much like the progeny of research done by Eisenstein and colleagues referenced earlier in this chapter. Individuals have self-identities; consistency in how one defines oneself and how others define that person makes for positive social relations. Workgroup members seek to lessen the cognitive dissonance that would come from others defining them in ways contrary to their own self-identity. Thus, individuals will tend to work with group members who confirm their self-identities more than those who do not. In particular, they say, those who hold structurally equivalent positions in the workgroup will probably cooperate with

each other. Taking this a step further, Milton and Westphal explain that cooperation between pairs of individuals is in turn affected by the identity confirmation other group members extend to them. They refer to this as "social network theory", where features of networks can affect workgroup performance beyond social category memberships or even friendship (Milton & Westphal, 2005).

Other group members confirm individuals' self-identities by assigning them tasks for the workgroup that are consistent with those identities. Positive interactions in the workgroup like identity confirmation can then induce more cooperation, such as sharing information. There may even be an implied moral obligation to engage in confirmation and to otherwise assist one's peers in achieving goals. As a result, those who do not reciprocate may experience others in the group ceasing to cooperate with them or conversely, to compete with them (*Milton & Westphal*, 2005). One can see the alternating concepts of cooperation and coercion implied in this phenomenon, and how social networks can advance or sabotage work of the group. Human behavior may be predictable to an extent for any workgroup, thus, those creating obligations for a workgroup should be cognizant of the nature of interpersonal relations, and personal beliefs, and their impact on tasks members of the group will or will not carry out. It would be wise to try to plan for workgroup members to work cooperatively without subverting the goals and objectives they are assigned.

Application To Mental Health Courts

In researching the organizational contexts of decision-making in Pennsylvania courts, Ulmer and Kramer (1998) explained that PA's sentencing guidelines are looser than many other states' structures in allowing judges to make written justification for departing from set calculations of offense severity and offender prior convictions. They assert that the Pennsylvania Commission on Sentencing "was well aware" of the risk of displacing sentencing power to prosecutors by restricting judicial sentencing discretion and "wanted the responsibility and accountability of sentencing to remain with the judge" (Ulmer & Kramer, 1998, pp. 250-1). They also claim the PA Sentencing Commission was trying to avoid "mechanical sentencing" which failed to consider "any special circumstance and needs of individual offenders or particular communities", and which respected the great variance in our 65 counties' "court and correctional resources and the diversity and seriousness of offenders" (Ulmer & Kramer, 1998, p. 251).

Mental health courts may not impose sentences more severe than those they could have received in traditional courts. Sentencing departures are appealable to a limited degree, so judges in Pennsylvania attempt not to issue them repeatedly for fear of being overturned, or scrutinized. In light of Pennsylvania's sentencing structure, on the other hand, judges in diversionary courts have the capacity to issue alternative sentences. Ordering intensive probationary controls on mentally ill offenders, and effectuation of correctional programs and support services to address their mental illnesses, can provide justification needed for circumventing guidelines that would otherwise warrant

incarceration. The basis is therapeutic for seriously mentally ill offenders, and fits within a restorative justice scheme in trying to prevent their further criminal activity.

One can imagine the balance that must be achieved to maintain equilibrium among members of a courtroom workgroup charged with the dual duty of treatment and public safety, as are those belonging to a mental health court workgroup. In a study more on point to the research proposed (in substance, if not in method), Mary Lee Luskin examined how referral decisions were made to divert defendants into mental health treatment monitored by a court. She notes two key differences of mental health diversion decisions from drug court decisions that make the former decisions more complex: a wider range of possible eligible charges, and the reliance of legal decisionmakers on the diagnoses of mental health providers (Luskin, 2001, pp. 219-21).

Using a model from the data kept on screening of referrals by one court, she found certain results she did not expect. The interaction of age and gender worked in the opposite for males and females. Older males were viewed as less dangerous and so more likely to be diverted, whereas older females were thought to know better, and so less likely to be diverted. And though having a record of felony convictions or being charged with a crime against a person generally decreased the likelihood of being diverted, these factors did not have nearly the significance as the factors about who the defendants were (Luskin, 2001, pp. 225-29). As for the workgroup roundtable who made decisions about whom to refer, only the prosecutor could actually divert a case. But the presence of defense counsel and treatment personnel, Luskin found, meant they could lobby for inclusion of persons normally excluded, or exercise *de facto* veto power over referral

decisions. She suggests that beliefs about mental illness are invoked in choosing, and workgroups should take care in their selection process (Luskin, 2001, pp. 220; 225).

Another issue which may not even be considered in planning for mental health court workgroups is the extent to which outsiders may influence the process. One study even implies that non-legal professionals outside the traditional courtroom workgroup and the dynamic of powers within it may be the ones really exercising ultimate discretion in diversionary programs, suggesting that actors like caseworkers from outside nonprofit agencies have been given an influential decision-making role in some court contexts without the same checks that may be imposed on workgroup members (Castellano, 2009).

It is crucial to comprehend how the workgroup sees its duties and interacts with one another. For example, in the absence of standardization of the court processes, personal inclinations or biases can fill the voids. Likewise, those processes will remain open to political influence or co-opting. On the other hand, taking a logical approach to the workgroup could aid in the tasks assigned. For instance, when the Brooklyn Mental Health Court was first established, the judge worked with a forensic psychiatrist to learn about Axis I diagnoses, risk assessment of offenders, benefits of community versus institutional placement for various clients, and projection of emotions of workgroup members onto clients who exhibited certain behaviors. Relevant knowledge helped him to carry out appropriate decisions and to avoid contention with other group members (Needell & D'Emic, 2005).

The courtroom workgroup model will be relevant in this study to show how the local court community makes decisions about referrals, treatment plans, compliance or

non-compliance, sanctions and rewards, and graduation. It will also be important to understanding how the workgroup interacts, cooperates, views its purpose, holds itself accountable, and serves as a model for court reform.

CHAPTER IV.

METHODS

Overview of the Project

This research project was a multi-method study examining the inception, structure, and functioning of the Mental Health Court in Allegheny County, PA. Through immersed examination of this court and its stakeholders, the researcher studied the decision to establish the court in Allegheny County, selection of the model used, how it has evolved in its several years of operation, and how it functions in the present. Little study has been done to date on specific local decisions to implement and fund mental health courts, individual examinations of the formation and functioning of their courtroom workgroups, or how one might best structure these courts in particular locales within the local legislation and law enforcement conditions.

In particular, the study sought to examine the behavior and perspectives of those involved in a large mental health court. A primary focus of the dissertation was on the interaction of the courtroom workgroup, criminal justice professionals and treatment professionals who formed to carry out the dual duty of the Court in treating and regulating offenders with serious mental illness. A secondary focus was on experiences and perspectives of the mentally ill participants referred to the court for diversion from jail and treatment. The study explored the tenets of restorative justice from the vantage points of those attempting to incorporate them into the functioning of the Mental Health Court and those who might be affected by them. One of the ancillary goals of this study was to help inform guidelines for mental health court structure and functioning standards,

specifically what might be sufficient, and appropriate, for a Mental Health Court to be founded, and what might be necessary to operate successfully in terms of both treatment of mentally ill offenders, and regulation of their behavior for community safety. Another ancillary goal was to add to the theory on therapeutic jurisprudence attempted by diversionary or special courts within the justice system.

This multi-method case study primarily relied on qualitative research methods. The data sources were gathered from observation of courtroom activity and workgroup behavior (public and private), and from open-ended, semi-structured interviews. In addition, the study includes review of internal documents from the agencies involved in the court. The researcher also reviewed case file data kept by county and state agencies, to confirm the qualitative findings, and in hopes of including a minimal quantitative descriptive analysis of agency records based on one year of records from the court.

Selection and Background of the Case

The jurisdiction was selected by the researcher in part based on her familiarity with Allegheny County's criminal justice system, where this Mental Health Court is situated, and from experiences as a prosecutor and defense attorney in the County. Yet the choice of the project was fortuitous. As an attorney handling a criminal case in the Allegheny County Courthouse, this researcher occasioned to meet a young man whom she had briefly mentored while in law school. Now an assistant public defender for the County, he was working with one of the diversionary courts, the Mental Health Court,

and was very excited about its prospects. He suggested a visit to the court and to consider studying it and this researcher did both. At that time, the Court was headed by a senior judge who had long been district attorney of the County prior to becoming a judge. When the researcher expressed further interest, the Assistant P.D. provided the name of the woman in Allegheny County's Department of Human Services who directed the (then) Forensics unit of the county's Office of Behavioral Health. Now called Justice-Related Services, this unit is responsible for aiding mentally ill persons arrested in the County. She helped to form the Mental Health Court a decade before. After meeting with her and looking at what little information had been gathered on the Court's initial years, the researcher volunteered to assist her department in updating their case files so as to study it and thereby possibly facilitate obtaining grants.

At first, this entailed helping the director of the Mental Health Court on the researcher's lunch hours. Paper records had been kept by the County since before 2000, albeit in somewhat sporadic fashion; computerization of the records began in 2001 or so, but they were subject to major data entry gaps. Pertinent to the MHC was the County "eCAPS" database (Electronic Client Assessment Program), designed to compile histories of assistance requested of Justice-Related Services, as well as a litany of services rendered by various County staff and within the mental health base service coordination units county-wide. The MHC Director serving at that time had also created a "Mental Health Court Database" in Microsoft Access used by him and his staff, where he compiled referral and demographic information on persons referred to MHC in the hope of keeping better track of referrals than in years before. The researcher took a couple days off work to help when they needed to quickly gather case information for an

article *U.S. News and World Report* planned to do on this specialty court. After another few months of volunteering, in exchange for which this researcher would be granted access to their databases, the County agreed to fund the researcher as a department intern for the Court to help maintain court records for study and grant purposes. The County-wide database of mental health services, eCAPS, was the only place where recidivism of Mental Health Court participants could be maintained and easily accessed. The mutual goal was to compare the Court's participants to similarly situated clients who were not eligible for the Court but who were serviced by short-term assistance from another Forensics program (the Support program), with an eye toward possible expansion of the Court's jurisdiction to include more serious cases or offenders, as well as to capture data sufficient to satisfy grant funders.

Permission to conduct the study and access to records was negotiated by this researcher with the county's Department of Human Services and its Information Technology Division[1]. The Office of Behavioral Health understood and supported the nature of the study. In turn, they granted permission to use agency case file data records and databases kept by the county's Department of Human Services through its Information Technology Division to the researcher. They also granted access for the non-public component portions of the case study, insofar as they were able to grant it, that is: observational field work of the workgroup activity involving their staff, confidential interviews, review of internal documents and reports on the court, and existing summaries of internal case file data which may have existed. The researcher

[1] A paper copy of the confidentiality agreement that the researcher executed with the county to view and analyze data is on file with her.

also discussed the study with the Deputy Public Defender and Deputy District Attorney responsible for the Court and they agreed to cooperate with her.

From volunteering, the researcher learned that "eCAPS", the County-wide database logging use of mental health services (where diagnoses and much MHC progress information was to be housed), frequently contained duplicated or erroneous demographic information on clients, so that finding a client's full Forensics history was sometimes confused or incomplete. Paper files on a client could have been created in one of four Justice-Related Services programs where mentally ill offenders received services beginning in the late 1990s. And the Mental Health Court Director's Access database of MHC referrals was not supported by the County's Information Technology Division; it created a new case file each time a person was referred to Mental Health Court, even if a second referral came in for charges already referred. So for the numerous clients referred to Mental Health Court, many of whom had also been serviced by other JRS programs, the researcher undertook to accomplish entry or correction of data to allow for the study contemplated, as little staff time existed for anyone to do so. There was often difficulty getting the MHC Director and Justice-Related Services Forensic Probation Liaisons to keep case records current; outcomes of Mental Health Court review hearings (supposed to be entered weekly) were often incomplete or inaccurate; and recidivism by persons accepted into Mental Health Court clients was rarely recorded, much less acted upon.

For a year and a half, the researcher tried to get the records of current Court clients in enough order that they eventually be properly assessed. Though all files on any one client were supposed to be merged to give caseworkers full client history, and to avoid duplication of services, merger was often overlooked, even when cases were

closed. Clients serviced more than once by Justice-Related Services program due to multiple arrests often had several files, open and closed, floating around JRS, at times confounding or delaying efforts to process or service them. When the Department moved locations in 2008, paper records were to be purged after digital scanning. Since this meant crucial data about mentally ill clients, including MHC records, risked being permanently lost or confused if files were not first consolidated, the researcher took on merging the files for any hope of accuracy in the records about recidivism or services. In addition, during the first several months of employment, she was asked to work on other projects for the Office of Behavioral Health, partly for a grant that funded her wages. These tasks put working on Mental Health Court on the backburner in the interim, although they did allow insights into clients and casework that the researcher could not have gathered on her own.

All in all, given that many MHC participants were sentenced up to four years probation, this was far too much to accomplish for a court that contained 350 or so clients at any one time and continually accepted new people. With the additional numbers of clients referred but not accepted by MHC, keeping up with recordkeeping was daunting. It seemed a thorough case study on a mental health court specifically including an in-depth look at a court workgroup or participants, was wanting. Here was a large mental health court, existing fairly early in the history of such courts, with other evidence more readily obtainable. The head of Justice-Related Services agreed the qualitative inquiry might be a more appropriate study, but also permitted the review of a limited quantitative description of court and participant characteristics for a one-year period to confirm what the researcher learned in the case study. The Information Technology Department ran a

list of referrals for the years 2007 and 2008, so that the researcher could cull data from records of court participation.

Use of a Multi-method Case Study

The review of the literature for the proposal of this research revealed that there were few descriptive case studies on mental health courts, and most court to court research struggled to draw adequate comparisons of courts that were different in many ways. This researcher already had access to persons who could inform her about the history and context of Allegheny County's Mental Health Court, or direct her to helpful sources. She further proposed studying the large courtroom workgroup that meets to process the cases in the MHC, which had not been published for a mental health court as of the time the proposal for this research was formulated, as well as to look at the experiences of the participants involved in MHC themselves, which had not been done in any depth for a mental health court, either. Since that time, the researcher has learned of a recent evaluation study of a mental health court involving quantitative and qualitative data, including evaluation of how case decisions were made, which was conducted in the interim. Its focus was on use of services improving defendants' lives, the operation of judicial power and court processes on compliance, and the effects of participation on re-offending (Gurrera, 2007, Abstract).

The main concern for this project was that the information researched here would be of benefit to the field in general, and to other courts or potential courts in particular.

Maxwell makes the point that generalizability "plays a different role in qualitative research, . . . because qualitative studies are usually not designed to allow systematic generalizations to some wider population" (Maxwell, 2002, p. 52). Instead, generalizability for qualitative researchers "is best thought of as a matter of the 'fit' between the situation studied and others to which one might be interested in applying the concepts and conclusions of that study" (Schofield, 2002, p. 198). As for transferability of a case study, Lincoln and Guba suggest it is "the extent to which the case study facilitates the drawing of inferences by the reader that may have applicability in his or her own context or situation" (2002, p. 211).

The qualitative method allows both direct observation and systematic interviewing, and can focus on contemporaneous events. Eisenhardt defined the case study method as a “research strategy which focuses on understanding the dynamics present within single settings”. She stresses that case study can be used for theory-building, especially for producing novel theory where existing theory may not suffice, and that theory can be tested with the very constructs which were measured throughout the theory-building process (Eisenhardt, 2002). The case study, Robert Yin tells us, is useful for the social sciences, for it does not separate a phenomenon from its context, nor does it require control over behavior, as an experiment does. A case study can start from either a deductive or an inductive premise. It can answer “how” and “why”, as opposed to simply “who” or what”, as with a survey (Yin, 2004). Finally, Patton suggests, as applicable for this project: "If individuals or groups are the primary unit of analysis, then case studies of people or groups may be the focus for case studies" (2002, p. 439).

Validity can be increased in qualitative research by using several tactics for gathering data, or triangulating from two or more points (Flick, 2004). As noted, this research encompassed multiple sources of data, primarily qualitative observation of courtroom and workgroup behavior, and in-depth qualitative inquiry of past and present stakeholders in the court process. Components of the qualitative phase of this project included: (1) observations of the MHC process both inside and outside of the courtroom, including case negotiation, defendant behavior, compliance estimations, and sentencing decisions; (2) interviews with key personnel in the court process, including past and present staff; (3) interviews with participants and (where possible) their family members; and (4) analysis of documentary information such as news coverage of the court, any documents accompanying its founding, and any additional information that various agencies in the county could provide. These methods were supplemented by a review of documents related to the court and records of court participation, the fifth method planned to be utilized.

Research Questions

When this researcher first learned of the Allegheny County Mental Health Court, she took an interest in the non-adversarial, restorative justice approach being attempted for handling cases of certain seriously mentally ill offenders charged with misdemeanors and felonies. She had had personal experience prosecuting offenders who claimed to be

mentally ill, as well as drafting criminal cases opinions while serving as a judge's trial clerk in another local county. The researcher was keenly aware of the tension between fairly handling a case for a mentally ill defendant, and protecting victims from unsupervised mentally ill offenders in the community. Here was a new concept that had promise to help resolve this tension, and yet it seemed in many ways untested. The issue of how best for court actors to process these cases resonated clearly with the researcher; it did not take long to see that here was a courtroom workgroup where the judge, prosecutor, and defense attorney were doing things differently and that they were not the only ones involved in the tasks of the court. When the concept for the study was honed, it became clear that hearing directly from participants as to their experiences, rather than just what they said in open court, would round out the case study.

The research proposed to examine how the professionals in the courtroom workgroup for the county's mental health court actually worked together to accomplish the processing of these cases given this expanded framework, and what the participants involved thought about that process. It also proposed to look at a slice of cases to determine who was being served and the nature of the cases being handled. Research questions for this study were suggested by a review of literature on the formation and function of mental health courts, evaluations of their predecessor drug courts, restorative justice theory, research on courtroom workgroup behavior, and the researcher's background in the practice of criminal law. But they were also informed by what the researcher had learned about the court by sitting in on sessions and initially learning about the court from the Assistant Public Defender and the Director of Justice-Related Services. Here are the questions forming the rubric for the research:

1. Why was the Allegheny County Mental Health Court founded?
   What purposes was it meant to serve?
2. Who are the court's clients and how are their needs identified and met?
3. How does the courtroom workgroup interact and make decisions?
4. How do court activities reflect the tenets of restorative justice?
5. How has the court evolved since its founding in purpose or philosophy?
6. How well does the court meet its objectives?
   What do the court participants think about the court's functioning?
7. In what manners might the court operate differently?
8. To what extent could the court serve a model for other counties wishing to develop a mental health court?

Connection Of Research Questions With Methods

Denzin said, "A deconstructive reading of a phenomenon includes a critical analysis of how the phenomenon has been studied and how it is presented and analyzed in the existing research and theoretical literature" (2002). The thematic content analysis of both interviews and field observation notes, as described, along with integration of analysis of the content of documents, formed the crux of the research plan for explaining how Allegheny County's Mental Health Court evolved in the context of the social and political climate at that time. An examination of founding documents, and interviews of the Director of Justice-Related Services and other key stakeholders who helped to form of the Court, assisted in clarifying purposes the Mental Health Court is meant to serve. The in-depth interviews of workgroup members past and present, along with field

observation of the inner and outer workings of the Court processes, and in some part the document analysis, aided in determining how well the Court was meeting those objectives. A period of quantitative data was attempted to be descriptively analyzed; likewise, that method, though not summarized statistically as initially intended, still helped point toward manners in which the Court and its agencies might operate differently. Lastly, an overall integration of the information developed from all of the methods proposed helped to clarify how this particular court might be a model for other courts in the state. See the related chart in Appendix A for a visualization of how the methods used were proposed to be connected to the research questions.

Selection of Subjects

The numbers of persons observed in open court numbered in the hundreds. As described, there are several hundred persons accepted to participate in the Mental Health Court at any one time, although only a portion of them are scheduled to come to court on any given weekly session. There were also many persons working in some capacity in various operations of the Court who may have been present at any weekly court session. All persons observed in Court, as well as those interviewed for this study, whether workgroup member or participant, were adults.

There were two respondent groups for the interview portion of this study, the main group consisting of key "Criminal Justice personnel" (professionals in the courtroom workgroup described) who worked in the Mental Health Court by appointment

of their office or by choice. Along with the Criminal Justice personnel were several "Treatment personnel" who serviced court participants in the community by arrangement (such as mental health counselors from community treatment facilities, or administrators of group or halfway homes in which the clients were housed).

Designation of a traditional mental health courtroom workgroup is by definition. It includes the judge who sits on the court, and assistants from the office of the district attorney and of the public defender or court-appointed counsel assigned to work with a court. For purposes of this research, the workgroup was expanded to include others who played a key role in case processing and without whom this Court could not operate. That entailed: the Director of the Mental Health Court (who assessed persons referred to the Court and tracked referrals) and other Justice-Related Services staff such as MHC Support Specialists (case managers who support the clients in obtaining treatment, housing, and other services) and the MHC Probation Liaisons (who manage the cases once participants are stabilized, and are the link between treatment and monitoring); the JRS Director, head of that County department, who helped incept the court and who initially reviewed all referrals to the court, and the specialized Probation Officers to whom the defendants report regularly and who monitor them intensely.

The emphasis of the interviews was on the Court and its processes, insights about its services, interactions among the Court team, and perceptions of its effectiveness, and any suggestions or observations about how mental health courts could improve services. Though this researcher contemplated interviewing other persons relevant to the operation of the Court, such as court administrative staff or deputy sheriffs who transport mentally ill offenders to court, their roles were more limited, and they could only have answered

some of the questions posed in the interviews. Thus, interviews only took place with those who both interacted with Court participants in more than just open court interactions, and who either were directly involved in case processing or made decisions about treatment.

As for interviews with Criminal Justice personnel in the court process, the researcher solicited everyone who held relevant positions in the decade of the Court's operation of whom she was aware, for depth of the information that might be gained. The researcher was able to locate most of the former staff who had held key positions within the Mental Health Court team prior to the current staff. No one involved in the courtroom workgroup at any point in the court's ten-year history was excluded, however, the researcher was unable to definitively locate two former members of the courtroom workgroup, and three more declined to participate (one current, two past). The researcher was also fortunate enough to be able to speak with several members of an intensive community treatment team whose clients were frequently involved in the Court. It was hoped that 15 to 20 members of the courtroom workgroup or treatment personnel could be interviewed for these confidential and voluntary interviews. That goal was met; the researcher was able to interview 27 current or former Criminal Justice or Treatment professionals. Most were members of the expanded workgroup; one was in a more administrative court position. Persons in this group were of both genders (though all judges assigned to the Court in its history have only been male); 14 women and 13 men agreed to grant an interview.

The second group interviewed were Court program participants (mentally ill offenders) processed by the Mental Health Court. It was thought this piece of the

research would be valuable to understanding of the functioning of the MHC process. Indeed, the Court exists for many reasons, but one of the most important is the well-being of the participants; hearing from them could only help the Court to function. Interviews with participants were derived from an availability sample, based first on suggestions from courtroom personnel or treatment staff. The researcher asked Mental Health Court caseworkers, MHC Probation Liaisons, and the Assistant Public Defender to provide names of program participants who had the capacity to be interviewed, i.e., those who were stabilized and who had no recent arrests.

In addition, for about two months, the researcher made invitations in open court sessions to Court participants while they awaited the start of review hearings. A copy of the invitation to be interviewed is attached as Appendix D. With the permission of the MHC judge, she both read the text, and circulated paper copies of the invitation, which contained her contact information, lest an interested participant not feel free to approach her in court. The researcher stressed that interviews would be both confidential and voluntary and that neither granting an interview nor declining to be interviewed would affect their case. Since many participants in the Mental Health Court had peer relationships with other participants, should a Participant have recommended a peer, the researcher would have also interviewed the latter, subject to checking on the latter's competency with his or her caseworker. No interviews were ulimately derived from "snowball sampling" (Maxfield & Babbie, 2005), though.

Invitations to be interviewed were offered to Mental Health Court participants whether they were thought to be "successful" at the court process, or not, so long as a participant had been involved in the court long enough to have experienced several court

hearing sessions and be familiar with the procedures and activities of MHC. Graduates or soon-to-be graduates, being most familiar, were of course sought as well. It was hoped that at least ten Mental Health Court participants, and possibly their family members, could be directly interviewed. That goal was doubled with Court participants alone; a total of 22 Participants agreed to an interview, 11 men and women each. Family members who appeared in support of Court participants during Court sessions were invited to be interviewed, but none chose to be interviewed. Anyone of either gender and any age who otherwise met eligibility criteria for participation in the Mental Health Court could be interviewed if willing, and if competent.

Qualitative Research Methods

Field Observation of Courtroom Proceedings and Workgroup Behavior

The qualitative portion of the study entailed observations of the Mental Health Court process from both inside and outside of the courtroom, that is, public and non-public sessions, respectively. The site of the research was Pittsburgh, the county seat of Allegheny County, Pennsylvania, the county where this Mental Health Court is situated. Observation took place inside the County Courthouse and in other locations in the County where courtroom workgroup members performed other court-related tasks, such as at the County's Human Services Building, or the County Jail.

The interview question design was preceded by field observation of the Court team and participants in open court. Taking this step served two purposes: to be able to give a descriptive account of the court process, and to be able to craft a body of questions that would apply to all interviewees. Implementation of interviews took place after observation began of various private facets of the workgroup in other procedures. This aided in the researcher being able to report on the court's functioning and how it serves participants and the public, and an understanding of how the courtroom workgroup interacts and makes decisions prior to engaging in questions of the persons involved.

Patton (2002) organized several variations of field work and the dimensions they entail. While this researcher might have been viewed as what Patton calls an "insider" by some members of the courtroom workgroup, those who knew the researcher in her professional role, or even by JRS staff who saw her working with their files each week, the researcher stressed that her role for the research was as a student researcher. Therefore, she had to straddle the "insider" and "outsider" perspectives. As Patton describes, an "onlooker" at first may eventually be viewed as a participant as the field work goes on (pp. 267-77). This may have worked to the researcher's advantage or disadvantage, depending on the setting for observation. For purposes of this research, she pursued full disclosure of her role both before performing observation and to interviewees, so as not to engage in "covert" observation for ethical reasons (Maxfield & Babbie, 2005; Patton, 2002). In disclosing her role, yet remaining a quiet observer, those observed were more likely to behave naturally.

Babbie adds that the mere immersion or presence of a field researcher can make for greater validity in measurement than survey or experimental measurements (Babbie,

2001). This researcher was able to fully immerse in the workings of the Court, and behaviors of its workgroup and participants, for purposes of this study. What follows is a brief description of the many facets of the Court's processes observed. Further elaboration will be provided in the chapter on findings.

The earliest step in this Court's process was the making of a referral. Since referrals were by agreement processed by the County's Justice-Related Services (JRS, formerly Forensics), the researcher had a chance to see how incoming referrals were actually handled by a full-time intake person, as well as the initial screening of cases referred by JRS supervisors, almost on a daily basis. Persons referred to the Court were screened for appropriate diagnoses and potentially appropriate charges. If both criteria were met in the opinion of the JRS Supervisor or the Mental Health Court Director (also JRS staff person), the case was put on the list for discussion at the next referral meeting.

Prior to referral meetings, though, persons referred are to be assessed to evaluate the following: their mental health history, what family supports were in place, hospitalizations and rehabilitation stints, what medications they were taking, what criminal history and current probation status they had, which social services have been utilized, what services might be needed, and whether they wished to participate in the Mental Health Court. At the Court's inception, the MHC Monitor (now called MHC Director) was a mental health professional who conducted the assessments. Assessments were done either in the County Jail if the potential referral had been arrested, or in the Human Services Building or a placement facility if they were not incarcerated, with those in jail having priority.

When time permitted, the researcher was able to join the most recent Mental Health Court Director when he did assessments. Visiting the Jail meant getting a Jail clearance, and going through the required steps to visit a prisoner within the County Jail. At no time did this researcher conduct assessments, so as not to blur the line between researcher and subject. However, completed assessment forms were used to input information about accepted participants into the County's eCAPS database. Information gathered during assessment was used by a JRS caseworker to draft a treatment plan which stated which social services would be sought for the client, and what stipulations for behavior would be expected of him or her in order to participate in Mental Health Court. At times, the researcher viewed the actions and decisions of caseworkers in securing services for clients, both in the office over the phone, and in the field when they visited treatment facilities with clients.

Decisions on which cases will be accepted into the MHC ("acceptance") take place at administrative meetings held between the Assistant District Attorney and the Assistant Public Defender assigned to the Court, and the Mental Health Court Director. The D.A.'s office first reviews the facts of each case, and speaks to the arresting officer, and to any victims in the case, to see if they will agree to the person' s being handled by the Mental Health Court, as well as to ascertain whether restitution was at issue. The D.A.'s office also researches the criminal history of the person referred to make certain it is not too lengthy or serious as to be objectionable. When at first working with the Office of Behavioral Health, this researcher was invited by the Assistant Public Defender for MHC to sit in on these meetings. The researcher did sit in on several such meetings as time permitted, and even took notes, without opposition from any of the parties present.

During this period, the third MHC Director to serve the Court and the third and fourth A.D.A.'s to serve the Court were in place. When the fifth A.D.A was assigned to serve the Court by her office, there was an objection lodged, and the researcher no longer attended any of these meetings.

Early on, and then throughout this study, for a total period of two and a half years, the researcher sat in on open MHC sessions. Once or twice a month, pleas into MHC were taken, or the occasional trial was held (persons referred were permitted to opt for a trial and conviction before participating). For the most part, Court sessions consisted of court review hearings for cases already adjudicated. There, Court proceedings included matters like:

-progress reviews given by JRS caseworkers or JRS probation liaisons;
-testimony offered by mental health providers and treatment facility staff;
-defendants' statements made explaining behavior or making requests;
-counsels' arguments made for leniency or punishment, or case negotiation;
-questioning of participants, family members, or providers by the judge;
-discussion of changes to facility placement or to medications;
-sentencing decisions made where sanctions were meted out, including jail;
-praise or rewards (like gift cards) given, to clapping by audience; and
-graduation ceremonies conducted, where participants made final statements.

Mentally ill offenders who pleaded into MHC, or who were sentenced after trial before the MHC Judge, were initially to be scheduled for review 30 days later. Later, reviews would be scheduled 60 days out, then 90 days out as they had more and more positive review hearings, and neared anticipated completion of probation and graduation. The goal was not to follow any particular defendant, since some defendants were given up to four years probation, rather, to follow the process. In fact, this researcher still

visited the Court on review hearing days up through the conclusion of the research, if time permitted.

Another form of field observation was ride-a-longs with JRS caseworkers or the MHC Director while they attended to MHC participants getting housing placement, meeting with treatment providers, filing for Social Security disability, or driving them to appointments. Prior to the researcher joining them, the caseworker would inform the client and make certain they were comfortable with her attending. On several instances, the researcher was able to visit particular facilities that housed numerous JRS clients. There, she was able to speak with staff or administrators about the services they provided and their philosophy for service provision.

One of the most crucial methods for field observation was this researcher's presence in the in-chambers case processing meetings of the court team. Each date when MHC had scheduled court reviews, and sometimes on plea/trial dates, the courtroom workgroup met to evaluate status of cases prior to open Court session. Of course, discussions went on during the week among members of the workgroup, by email or phone; on occasion, the researcher was privy to these conversations when in the JRS office. But the primary airing of key issues was done in chambers, so that anyone in the workgroup could offer input. Any issue regarding these matters was discussed: progress with mental health or addiction, compliance with the participant's treatment plan, new charges or probation violations, adjustments to medication, placement in particular facilities, breaking facility rules, warrants and bond matters, readiness for graduation, motions to remove from MHC, and Participant or family member concerns. Consensus was sought as to whether the person would be given a positive, negative, or neutral

review for that hearing date. Plea arrangements were typically worked on privately between the Assistant P.D. and the Assistant D.A. On occasion, however, talk of a plea negotiation would arise in chambers or at referral meetings if counsel believed other members of the workgroup would have a concern about terms of the plea.

Depending on the Court list for the day, the MHC Judge would call the workgroup to meet in chambers at 8:30 or 9:00. The group did not break until each case on the list for review or plea that date had been discussed, if only briefly. Program participants (mentally ill offenders referred to the court for processing) were not present at these non-public meetings of the courtroom workgroup. Participants were only to be present in open court, or at individual meetings with their service providers in the hallway; on review hearing days, most Participants were scheduled to appear at 9:00 A.M., and could leave after their case was called. If the list were especially long, some cases were scheduled for after lunch. The researcher sat in on these chambers meetings for approximately two months prior to beginning interviews, and thereafter, when she did not have an interview scheduled for that morning, for another several months.

Another of the most effective methods of field observation for this study was attendance at the quarterly court team meetings of the courtroom workgroup. At these meetings, issues of concern to the group were hashed out and changes in policies were considered. Agenda issues entailed, but were not limited to: reviews, probation terms, bond, drug testing, referrals, electronic monitoring, facility breaches, scheduling cases, early disposition, revocation of probation, re-sentencing, rewards, caseloads, extending probation, subpoenas and other procedural matters, sanctions, graduations, sentence length, restitution, probation transfers from other courts, house arrest, victim concerns,

changes to agency job descriptions, expediting plea dates, HIPAA and privacy matters, press coverage, and accepting different charges into MHC.

Always present at these meetings was the JRS Director., the MHC Director, and the two JRS Probation Liaisons (all staffers of JRS); the MHC Judge; the Supervisor of the specialized probation officers and all of the individual Special Services Probation Officers (unless they had to be in the field); the Assistant D.A and Paralegal from the D.A.'s office assigned to MHC; and the Assistant P.D assigned to MHC. When the Assistant P.D was assigned a Paralegal to assist him from the P.D.'s Office, she began to attend the meetings as well; so did the JRS interns who did assessments for the MHC Director. Initially, JRS MHC Support Specialists were invited to attend, but as their ranks grew, it took too many of them away from casework. They were replaced by the head of JRS's Support division. The researcher was invited to be present at these meetings by the JRS Director since the time the Director first agreed to the researcher's conducting a study of the Court; she has attended a dozen of these meetings. Although the researcher's role was as a nonpartisan observer, she was permitted to discuss issues with the group.

Although this researcher had hoped to ride along with probation officers as they conducted field visits of participant for intensive monitoring, time did not permit this type of observation. Because she conducted most interviews of the Special Services Probation Officers for MHC at each of their field offices, however, she was on occasion able to witness mentally ill offenders (not necessarily Court participants) showing up for weekly or monthly report-ins.

In-Depth Interviews

Observation began several months before interviews, and continued throughout the interview process, so as to better inform the qualitative responses. The period following the end of the researcher's paid internship was actually a good time to be able to conduct the interviews for the study. Scheduling, traveling, and conducting interviews would not have been possible if she was still working with the Office of Behavioral Health records to get them done. Still, the researcher had a desk and phone from which to schedule the interviews, and access to the Human Services Building interview rooms if needed. Interviews ran from late August 2009 through April of 2010. Saturation was being achieved when the researcher was getting repetitive answers to the questions asked.

Babbie declares that a "qualitative interview is an interaction between an interviewer and a respondent in which the interviewer has a general plan of inquiry but not a specific set of questions that must be asked with particular words and in a particular order." (Babbie, 2001, p. 291). In this way, it differs from a survey; nonetheless, the qualitative interviewer should still be quite versed in the questions to be posed, so the interview flows comfortably and the desired information is obtained.

There were two distinct groups of potential subjects to be interviewed as part of this study. But the methods to be used were nearly identical. The interviews were semi-structured, using open-ended, exploratory questions. Two separate interview guides were used to conduct them one for members of the courtroom workgroup, and one for court participants or family members. They are attached as Appendices F and G. It was

anticipated that as the research generated more knowledge, additional themes might emerge. Since this is the strength of a qualitative design, emergent themes could also be explored if they were deduced.

Interviews of workgroup members sometimes took place in other County office buildings where they worked, or at nearby restaurants or coffee shops, as was convenient for interviewees. For the JRS staff, most of the interviews were done over the lunch hour, so as not to take up part of their precious days. The researcher was interested in visiting the probation field offices, and as it turned out, those were the locations most convenient for all but one of the Probation Officers to be interviewed. The few treatment providers who were willing to talk with her were interviewed at their treatment facilities, per their request. Finally, the researcher was able to employ the County's Arbitration Hearing Office rooms, which sat in another hallway of the County Courthouse. When an arbitration hearing room was free, this researcher secured permission to conduct interviews in a private room, and was able to interview treatment providers in the Courthouse for Mental Health Court who were too busy to meet at a separate time.

Interviews of Court participants also took place wherever was most convenient for them. Sometimes they took place at their treatment facilities, such as when they were inpatient and only permitted to leave to attend court sessions or doctors' appointments or the like. Other times it was mutually convenient to meet with them in the interview rooms of the Human Service Building, such as when they already had to meet with their JRS caseworker in town. For those interviews, the interviewer ensured that the locations were away from caseworker offices, so that these Participants were assured of comfort and confidentiality when talking during an interview. For graduates or those whose

probation stipulations were stepped down after participating successfully for a year or more, the researcher would agree to meet with them at their apartments or at restaurants. In a few of those instances, the person failed to appear at the appointed time and place, even after phone calls were made to the number given to reach them.

Sometimes, participants were interviewed over the lunch break during court sessions. In part, this was for mutual convenience, but at times, it was because a participant agreed to be interviewed after hearing the researcher's solicitation in open court. If a participant approached this researcher about willingness to be interviewed and were available that day, she would not forego the opportunity. The researcher would first check with his or her MHC caseworker or Probation Liaison to make sure no competency concerns existed. Also, at the time of executing consent and conducting questioning, she heeded an interviewee's state of mind, to assure s/he was cognizant when giving consent. And before the interview began, she made assurances of voluntary participation and confidentiality clear. Human subject protections will be explained in depth later in the chapter.

When the number of participants willing to be interviewed seemed to be dwindling, the JRS Director suggested the researcher forego sitting in on private workgroup meetings in Court chambers. During workgroup chambers meetings, participants scheduled for A.M. court reviews waited in the courtroom, sometimes for as much as two hours. This was time that the researcher could be conducting an interview, if they were amenable. Since she had been sitting in on chamber meetings for a couple months by then, the committee chair agreed that this would be more productive. Indeed, the researcher was able to secure several more participant interviews through this

technique. Again, the interview could then be conducted in a free arbitration hearing room if available. On two occasions, when the Arbitration Hearing Office was locked for lunch, interviewer and interviewee were able to move to a bench in a quieter area of the Courthouse to conduct the interview in a place relatively private, removed from the eyes and ears of others involved with the Court. Should a willing interviewee not have enough time to stay and be interviewed that day, this researcher was able to schedule a few more participant interviews for other locations and times. Ultimately, she obtained nearly as many interviews (22) with Court participants as with court or treatment professionals, a result the researcher did not foresee.

Open-ended question design. A set of interview questions, open-ended and exploratory in form, was employed to allow the respondent freedom to contemplate and offer their answers. The questions, asked in a semi-structured interview format, permitted the researcher to deduce information through the respondent's relating of experience and perception. Contrary to what some may believe, semi-structured interviews are not easier than fully structured interviews, states one commenter:

> They are semi-structured, but they must be fully planned and prepared. Improvisation requires more training and mental preparation before each interview than simply delivering lines prepared and rote-learned in advance . . . Given an equivalent amount of time and money, you can 'do' (prepare, do, and analyze) *far fewer* semi-structured interviews than you can do fully structured ones. They may yield much more than fully structured ones can, under the right conditions. Under the wrong conditions, they may yield nothing at all.

(Wengraf, 2001, p. 5).

Questions of the courtroom workgroup members focused on elements of the court process and their importance to restorative justice, like:

- Whether the target population for the Court was being identified;
- Whether treatment and support services were appropriate and available;
- Whether monitoring and enforcement of the service plans were being accomplished;
- Whether adherence to the service plans was occurring;
- Whether community safety was ensured; and
- What suggestions could be offered to improve the program model.

Other interview questions for this group were designed to elicit knowledge of the court and their roles in the court and courtroom workgroup structure. They sought to cover the following topics:

- Belief as to why the Court may have been needed in Allegheny County;
- Involvement in establishing the Court and the form it would take;
- Understanding of the purposes of the Court and knowledge about similar courts in the nation;
- Decisions as to their enlistment in the Court team;
- Description of their responsibilities within the Court team;
- Perception as to how they differed from their predecessors or other team members in how they carry out their role; and
- Relationships with defendants or "clients" in the Court.

Interviews with participants and their family members were designed to elicit individual concepts crucial to restorative justice, as well as court components. They sought to cover the following topics:

-What kinds of diagnoses they had;
-How much time they spent in jail prior to participation;
-What kinds of support services they received;
- Whether they were re-arrested after their initial decision to participate in the Court;
- How sentencing and probation violation decisions were made for their cases;
- How long they remained in the program;
- How their success was impacted for better or worse by these processes; and
- Whether trust or respect was restored to them from participating in the Court.

A full list of the interview guides for workgroup members and for Court participants are attached as Appendices F and G.

Conducting Interviews

Merriam remarks, "In qualitative research, ethical dilemnas are likely to emerge with regard to the collection of data and the dissemination of findings. Overlaying both . . . is the researcher-participant relationship." (Merriam, 2002a, p. 29). Wengraf summarizes obstacles to listening first detailed by McKay, Davis, & Fanning in 1983, including simply being too focused on taking notes to pay attention. They are: comparing or identifying what the speaker says to your own experiences; trying to read the other person's mind; rehearsing your next question instead of listening; listening for topics you think relevant or filtering those you think irrelevant out; judging the person and reacting to the judgment; daydreaming; sparring to correct the speaker, or insisting on being right; advising to help the speaker instead of just documenting their answer;

placating or agreeing with the speaker to get them to like you instead of focusing on what they are saying (McKay, Davis & Fanning, 1983, pp. 202-3, as cited in Wengraf, 2001).

The open-ended question interview format allowed for secondary questions. In spite of that opportunity, only a few additional common questions arose during most interviews. (That is not to say certain interviews did not delve into more depth with pointed questions to derive information from those interviewees.) Fortunately, the additional general questions emerged within the first or second interview conducted, and so could be asked of all subsequent interviewees. The only additional question shared of both groups was whether the Court should compel offenders in taking of medications. For the participant interviews, several more common questions arose. One was already being asked of the court team on the original interview guide, that is, how court process might be improved. The other ones additional to participants were:

-What was your original charge or charges referred to MHC (if recalled);

-Did you undergo any inpatient or outpatient programs prior to MHC; and

-Compare your experience in other courts to that if MHC (if any).

Interviews were to be taped to ensure that responses were reflected without bias on the part of the interviewer. Allowing for the possibility of equipment malfunction, this researcher always took copious notes during the interviews. Of the total court team interviews, four interviews could not be taped, either due to their location during interview, or to personal request; in those instances, interviewees were sometimes asked to repeat their answers. While this researcher stressed to interviewees that they need not answer any particular question with which they were uncomfortable, very rarely did an

interviewee choose not to answer a question. More often, interviewees elaborated on matters that were not asked of them, such as what brought a participant into the Court. The researcher did not expect to gain as full an answer to each question from each interviewee and in fact length and depth of answers differed widely, based on everything from personality to length of time involved with the Court. Interview times ranged from 45 minutes to over 2 hours.

Analyzing Information Obtained

Qualitative interview data was to be coded and summarized as to a logical scheme, based on the questions asked and the answers received. Originally, the researcher thought that the interview data would lend itself more fully to inductive analysis, which involves "discovering patterns, themes, and categories in one's data . . . through the analyst's interactions with the data" (Patton, 2002, p. 453). This researcher was somewhat familiar with the Court and some of the issues facing the workgroup and participants from having visited it and volunteered to help the department early on in this process. So the "grounding of the theory" and inductive "deriving of concepts" (Patton, 2002, p. 454, citing Strauss and Corbin, 1998) began prior to in-depth observation behind the scenes, and prior to formulating questions for the semi-structured interviews. Thus, it entailed deductions as well, or "hypothesizing about the relationships between concepts" (Patton, 2002, p. 454, citing Strauss and Corbin, 1998). As this was a multi-method case study, the researcher was able to begin the process of sitting in on discussions in the

Judge's chambers and certain workgroup meetings, along with frequent Court sessions, before securing interview candidates and actually conducting any of the interviews. The induction that typically occurs in the early phases of qualitative research occurred at first for the researcher with those observations.

Eisenhardt noted that research questions and constructs in theory-building of a case study may change as the research unfolds, so early identification of them may not be possible (Eisenhardt, 2002). When it came time to look at the data from interviews, ultimately it made the most sense to look at the answers more deductively, "where the data are analyzed according to an existing framework" (Patton, 2002, p. 453). Also, fewer additional common questions than anticipated grew out of the conducting of the interviews, as described. So it seemed most logical to categorize the responses according to the framework of the questions asked. Though further induction occurred in the patterns of answers that appeared, the patterns were more obvious in participant answers than with those of the court team. Schmidt suggests the categories utilized inherently depend on the nature of the material collected (2004).

Reviewing Documentary Information

A number of newspaper articles have been written about Allegheny County's Mental Health Court since its founding. Many of them have been in the local press, some of which have given positive accountings of the purpose and functioning of the Court, but which have more critically detailed the handling of specific cases where the monitoring

of mentally ill offenders proved inadequate. There have also been a couple of articles published in nationally distributed periodicals such as *U.S. News & World Report* (Schwartz, 2008), and an accolade in a special edition of *The American Prospect* (Abramsky, 2008). Also, a television documentary was done on the Court, an examination of mentally ill offenders who ended up in Pittsburgh (Frontline*: "The Released",* 2009). In addition, this researcher reviewed internal reports prepared by county information technology personnel for grant-reporting or bureaucratic purposes; administrative reports prepared for the county's website, press releases, or general dissemination; and an external report analyzing the cost-benefit of Court diversion versus incarceration. Documents were reviewed generally for opinions of the workgroup, court officials, participants, or the community on the value of the Court.

Quantitative Research Methods

For the quantitative component of the study, this researcher attempted to extract a recent year-long sample by combining data from county and state computerized databases and from the paper files which were maintained by the Office of Behavioral Health and the Common Pleas Court. The plan was to gather whatever information could be culled from the case files kept by the Department of Human Services Mental Health Court and Forensic Diversion Unit for either the year 2007 or 2008, each of which had referrals to the Court numbering 350 to 400 persons. As described in the section

regarding the selection of the case, gathering records thorough and accurate enough for any kind of rigorous study failed.

The Data Analyst for the Office of Behavioral Health discussed hiring a clerk for entering JRS case data, but funding did not exist. Eventually college interns were hired part-time to assist the Mental Health Court Director in conducting screening assessments at the Jail and other tasks. The Director then sought this researcher's help in completing entry of some of the case information in his files, for this was overwhelming given his other duties, including managing his own client caseload. The Director's "Mental Health Court Database" was really only for his purposes in processing referrals, tracking assignment to caseworkers, and keeping demographics; as explained, eCAPS, the County-wide database of mental health services, was the only place where recidivism of MHC participants was maintained and easily accessed. Eventually, an undergraduate intern was the only person entering initial case data upon a person's acceptance into Mental Health Court in either database. For consistency, the researcher asked to train this intern to look up criminal history from state and county records, and to input that, along with data on diagnoses and mental health history from the assessments, into the eCAPS database. Nonetheless, the intern rarely entered re-offense data, and it is unclear if she or other MHC interns who took her place were ever instructed to do so as part of their jobs. Furthermore, only the MHC Director or the MHC Probation Liaisons entered weekly outcomes of Court review hearings into the database; as might be expected, consistency and precision fluctuated when their caseloads approached 50 and 100 clients, respectively.

All data entry by any agency involved with the Court was unmonitored and sporadic. If the Court learned of a new offense by a Mental Health Court Participant after his or her acceptance into the program, it was almost always through one of two means. First, as the County's Probation Office is automatically alerted of arrests of current probationers, specialized Probation Officers raised the issue to the workgroup when the client's progress was at issue. Second, the Assistant Public Defender would move to have the Mental Health Court Judge release a Court Participant from jail after he or she had been arrested either on a new offense or probation violation, or on a warrant from an outstanding offense that was not divulged by the client when s/he first came into Mental Health Court. When the workgroup was made aware of additional offense(s), typically the result was for the new offense(s) to be accepted into Court, unless the charge was out of county or a felony too serious to be acceptable to the D.A's Office.

Collection Of Descriptive Data On Participants

As mentioned above in the section on the background of the case, it was originally hoped to gather information culled from records of court participation and on criminal history, to flesh out the case study and to confirm concepts or issues learned in the observation and interview phases. Data available consisted of the specialty court's client demographics, criminal charges and sentence details, compliance reviews, and times of referrals for, acceptance into, sentencing by, and graduation from, the MHC. In addition, there were sometimes entries for fields regarding health issues such as inpatient

or outpatient rehabilitation, hospitalizations, or social supports utilized. The researcher had negotiated access to the County's primary database for social services provision by agreeing to assist with data entry completion of the records. Information on post-sentencing arrests and probation violations, or mental health or substance abuse relapses was not necessarily collected by the County's Department of Human Services' Office of Behavioral Health, however.

Criminal history information could come from other sources, such as the County's Clerk of Courts Office and the Commonwealth Uniform Judicial records (state database on criminal record information), both of which were primarily public record, and the County Jail Records, which were not. For that reason, this researcher also negotiated access to the database detailing entries to the Allegheny County Jail. Information on arrests and release, along with certain demographic and court details, was maintained by the Jail dating back to the mid-1970s, albeit not always accurately. In the statewide criminal history database, there is public access to any Pennsylvania case that did not result in total acquittal (thus not subject to expungement). The PA records give dates of arrest, court appearances, verdicts, sentences, and violations of probation and parole. Both the county and state criminal history databases are fairly reliable, but do not include all details desired for the instant study; for example, there were many instances where Common Pleas Court records did not reflect charges being handled in the Mental Health Court. On occasion, this researcher was able to garner information which was not public record from the Offices of the Allegheny County Public Defender (on case processing) or the County Jail's Correctional Health Services (on jail psychiatrist diagnoses or arrests).

As explained, the researcher tried very hard to organize and complete portions of the DHS file data in the hopes that more complete data would aid the agency for future evaluation and for seeking funding. Though she expected this data to be a relatively small part of the research project, the hope was to use whatever quantitative data set she was able to construct from the available sources for a limited quantitative description of court and participant characteristics. In the end, such a report would not come to fruition, as completing data collection on prior and accumulating matters was a never-ending task. Nevertheless, review of these files benefitted the study in the researcher's gaining familiarity with the process entrusted to the Court workgroup, and with the nature of Justice-Related Services' provision of assistance to Court participants, and later allowed for cross-checking of responses given in participant interviews against other sources.

Human Subjects Protections

Approval from the Institutional Review Board of the Indiana University of PA was granted for this study's observation and interviews for a one-year period during which much of the observation and all of the interviews for the study were conducted. Continuing approval from the IRB was granted for a second year, during which review of court documents continued.

Interviews

The majority of persons subject to this study were not considered as vulnerable. Members of the court workgroup and other persons to be interviewed were initially apprised in advance of the confidentiality (or possible lack of confidentiality) of their responses in the written research product, and to whom the data might be made available This was in the form of an Informational Handout on the Case Study (see Appendix D), prior to the signing of a specific individual informed consent form.

Most of the members presently making up the courtroom workgroup were County employees or employees of County-funded agencies or contractors; these persons were asked to talk to the researcher in their official capacities. Despite potential willingness to talk, they might have had concerns about the procedure or goals of the research. Each member of the courtroom workgroup was separately informed of the procedures for maintaining their confidentiality. As detailed in the court team consent form (see Appendix B), each courtroom workgroup member was told at the start of his or her interview that s/he was free not to answer any question with which s/he was uncomfortable. In addition, due to the researcher's concern some workgroup members might be reticent to answer candidly, she tried always to conduct the sessions in a confidential, impartial setting rather than in their work settings. The purpose of interviewing them elsewhere was to engender comfort, if work schedules permitted. Accomplishing the interviews in that way added to the cost and time of the study somewhat; most meetings with courtroom workgroup members outside the office were

over lunch at restaurants. Some Criminal Justice professionals still preferred to be interviewed at their offices, in the interest of saving time.

Participants in this Mental Health Court—that is, offenders processed by the Court—usually had an Axis I diagnosis under the APA's Diagnostic and Statistical Manual, serious mental illnesses such as schizophrenia, bipolar disorder, or major persistent depression. Those Mental Health Court participants interviewed might be considered a vulnerable population if their condition had not been stabilized or if they had recently experienced a relapse of their symptoms at some point during their enrollment in the Mental Health Court.

Thus, the researcher took precautions to make certain participants had sufficient mental stability and cognition to be able to understand the process of giving informed consent, and to engage in questioning during an interview. As detailed above in the section on subject selection, the researcher relied on treatment staffs' assessments of program participants prior to scheduling any interviews. Likewise, this researcher relied on her experiences as a practicing attorney in criminal court, as well as experiences as a journalist, to determine if program participants who were willing to be interviewed were able to engage in a reliable question and answer process when it came time to conduct interviews. The researcher made clear to Mental Health Court participants that they could decline to answer any question if they did agree to be interviewed, and that they could discontinue the interview at any time. Since the interview process took at least 45 minutes, the researcher also made certain to give an interviewee a break if the situation called for it. The only compensation offered for court participants was a cup of coffee or dessert, in the event an interview was conducted in a setting where no eavesdropping

could take place. For example, certain Participants preferred not to be interviewed within the Courthouse complex, or at the facility where they were housed, so the researcher took them to a restaurant. Most preferred to talk either at home, or while awaiting their review hearings, however. No other compensation, in-kind or otherwise, was offered, and that fact was reiterated both in court and in person to participants.

Specific legal consent waivers were obtained from participants who agreed to be interviewed, both for University and County approval. Every participant to be interviewed was given the choice of where to interview, was separately informed of the procedures for maintaining their confidentiality, and was given time to read an informed consent form that spelled out the terms of the confidentiality agreement for the research before signing it. A separate voluntary consent form was used for participants willing to be interviewed (see Appendix C). The researcher emphasized to participants, both verbally and on the written consent form, that there was no pressure to engage in an interview. Extra precaution was taken to ensure that mentally ill offenders participating in interviews fully understood the confidentiality agreement and their consent to be interviewed, and that declining to talk would have no effect on their participation in, or graduation from, the Mental Health Court.

The potential risks to subjects in both groups in the study were limited. As explained above, conventional steps were taken to ensure their confidentiality. Workgroup members were offered to talk to the researcher in a confidential, impartial setting rather than in their work settings or outside the courtroom, in order to able to speak freely. The only risk envisioned to workgroup members was possible censorship by supervisors at work or embarrassment with peers, should a critical opinion or

statement be attributed to them in particular within the finished report. However, as professionals, these persons could decide for themselves what answers they gave to interview questions, especially if they believed some form of liability may be invoked by giving a certain answer. Since the research product was to refer to official positions in general terms only, with no other personally identifying information, the risk of attributing a particular statement or opinion to a particular member of the courtroom workgroup would have been slim.

Nor were there substantial risks to participants who agreed to be interviewed. None of the questions for participant interviews was directed at the personal health status of the participants or designed to elicit sensitive information about the participants. As with the workgroup interviews, the emphasis of these interviews was on the Court and its processes and services, and perceptions of its effectiveness. (See interview guides attached as Appendices F and G). Note, too, that participants in the Mental Health Court had already signed legal consent waivers agreeing to release or obtaining of confidential information in order to be involved with forensic services from the Court; their consent form was supposed to be renewed annually. (A copy of a blank County MHC consent form is attached here as Appendix E following the informed consent forms). Mental health records are subject to legal protections in Pennsylvania, even from patients themselves, and can only be obtained with confidentiality waivers and the cooperation of the service provider (where applicable). A MHC participant's consent must be given, however, to allow members of the courtroom workgroup the ability to obtain or release

information necessary to process and manage the participant's court case, or to authorize treatment or other services[2].

Field Observation

The researcher received IRB waiver of obtaining written consent from those observed prior to observation of non-public meetings of the Mental Health Court process, as it was not practical. Nevertheless, full disclosure of the purpose of the research was made prior to conducting interviews and before engaging in observation, especially since so many of workgroup members were already familiar with the reseacher either as an attorney or from the Office of Behavioral Health. Moreover, this researcher prepared a brief information sheet describing the observation phase of the study, as mentioned above, which was handed out to this finite population just prior to beginning the formal observation phase of the study (attached as Appendix D). She also explained to workgroup members that any reports on observations were to be summarized into comments generalizing "Criminal Justice personnel" or "Treatment personnel", so that individual speakers were not identified.

There might have been times when the Judge would have declined a researcher from viewing meetings in chambers. Had that have occurred, this researcher would have excused herself from observation at that time, but this did not occur. Surprisingly, it was

[2] Note that a caseworker who suggested a potential participant was not made aware of the participant's decision to be (or not to be) interviewed unless the participant told the researcher to inform the caseworker—-consent to be interviewed was a matter directly between the researcher and the interviewee.

not unusual for observers interested in the Mental Health Court who were not members of the workgroup to sit in on the progress review meetings that take place in court chambers prior to the public Mental Health Court review hearings. Thus, it was unlikely that members of the workgroup would object to the researcher's presence at a particular meeting, and for the great part, they did not; in fact, this researcher was invited in most instances to be present. There was only one circumstance where it did occur. The researcher was eventually asked not to observe the administrative referral meetings by the A.D.A. who currently serves in MHC, for reasons that were never made fully articulated.

As for information sharing, the researcher executed a confidentiality agreement with the county's Information Technology department, granting access to records as may be given by the various departments on an as-needed basis. The researcher did not grant the County the power to deny publication of this dissertation, however, as a courtesy, she did agree for DHS review of the manuscript prior to its release if requested. Also, she informed any workgroup members or court participants who inquired that a copy of the dissertation would eventually be placed on file with an abstracting service.

Other Methods

The methods described above were be supplemented by review and analysis of documentary information about the Mental Health Court and news reports about the Court. If internal documents regarding founding of the Court, or any more current information on the Court, such as memos and procedure manuals, were made available

by the program director or by various agencies in the county, they were reviewed. External or publicly available documents included pamphlets about the Court or reports posted about it on relevant websites, or review of several print or broadcast articles done about the Court.

The qualitative portion was also supplemented and verified by one other method, descriptive data culled from agency records on client demographics, criminal charges and sentence details, compliance reviews, and times of referrals for, acceptance into, sentencing by, and graduation from, Mental Health Court. These additional methods were used to confirm or triangulate information gathered in the qualitative portion of the research. Should the nature of a participants' diagnoses or crimes be established, it was solely with the goal of discerning whether certain types of mentally ill offenders were more successful in the Mental Health Court than others (such as graduating, or not being re-arrested). Any quantitative data extracted from the case files either had personal identifiers removed and replaced with an anonymous number, or was aggregated with no reference to individuals.

As explained in detail above, the researcher worked part time with the County's Department of Human Services (DHS) for over a year, with much of that time used to fill in data missing from individual Mental Health Court case files. This researcher was in no way involved in providing services to participants; rather, she helped Mental Health Court program staff to see areas needing to be improved in data collection for better management of case processing, and in order to help secure future funding for Mental Health Court operations. More recently, the researcher worked to create a one-year dataset for this study, using several databases. That was for the purpose of describing

Court functioning and verification of data gathered through the qualitative methods, but of course could also have assisted for the Department of Human Services, which did not have the staff to keep up with its own records. Unfortunately, it was not possible for gather a year's worth of decent data due to numerous problems with incomplete and inaccurate data in a sample of nearly 600 persons. Copies of any data compiled, along with tapes and transcriptions of interviews, and field notes, will be kept by the researcher in a private, secure location for three years.

Limitations on Analysis of Data

The obvious drawback of this type of qualitative information gathering is that it is an arduous and demanding method. A second risk is researcher bias. Schmidt (2004) urges unbiased note-taking and justifies repeated reading of transcripts, so as not to imbue the material with "one's own theoretical assumptions by reducing the analysis to a search for locations in the text that are suitable as proof or illustration of these assumptions" (p. 255). Quantifying surveys of the material, she justifies, can be useful to qualitative inquiry, by pointing to associations and relations in the analytic categories. (Schmidt, 2004).

Needless to say, there are many ways in which the collection, coding, or analyzing of data could go wrong. And there are some concerns about the validity or truthfulness of interviewee responses, or the reliability of agency data. On the other hand, data collection and start of analysis were conducted at the same time. This is one

of the strengths of qualitative research method. Also, with multiple data sources, triangulation can occur. Verification interviews could be conducted where discrepancies in facts seem to exist. Likewise, the researcher was able to rely to some degree on the small data set she gathered for confirmation, as can the Department of Human Services (see the paragraphs to follow). The researcher believed it was essential to undertake at least a small quantitative evaluation, as explained above, especially since this agreement formed the basis of the grant of access to the court records. The value of any analysis that could have been conducted was highly dependent on the quality of data collected by County staff for the years at issue (Steadman, 2005), as will be discussed in Ch. VI.

Potential Gaps In Findings

The invitation to Mental Health Court Participants that they were free to decline interviews without penalty or to talk without reward may in fact have discouraged some Participants, such as those who were facing sanctions, from agreeing to be interviewed. As mentioned in the methods sections, there were several times MHC Participants promised an interview, even confirmed the interview, but then failed to show and were unreachable by phone. Though defined as vulnerable subjects, Participants to be interviewed would of course have been excluded if, at the time of explanation of the consent form or conducting of the interview, the symptoms of their disease rendered them unable to comprehend the nature of granting consent or to answer questions coherently.

Most of the Participants who agreed to be interviewed did not have terribly serious records, although some may have had one major incident or serious charge for which they were referred to MHC. Others who had longer records tended to have less serious charges. These may have been self-selection or bias issues. Another point that cannot be explained is that only two of those interviewed were identified as having schizophrenia; the bulk of them seemed to have Bipolar disorder as their primary diagnosis. (No references to personal identifiers were made for these findings.) As the Participant interviews were transcribed, the researcher was able to check database records to determine the accuracy of statements they made about diagnoses, criminal charges, and probation violations. This was useful if their memories had faded about events, or if they seemed to be glossing over certain facts. Indeed, there were times when their self-reports were not accurate. For the most part, though, they were honest, to the best of their memories at the time.

Only two clients presented a competence issue. One male relapsed and also was charged on a new offense, which resulted in his being re-arrested, and rendered him unable to make the initial interview appointment. Thereafter, he was in an undetermined location and was not able to be re-contacted by phone. When he did renew contact with this researcher, she informed his MHC Probation Liaison of his new phone number and ostensible whereabouts, and asked the Liaison to determine whether his competency was sufficient to be interviewed. He did eventually have an interview, but the Probation Liaison was not informed of whether or not the interview took place (as was the case with any participant, per promise of confidentiality). Likewise, another Participant who seemed eager to talk relapsed, and checked herself into an out-of-county facility the day

before the scheduled interview. Her only communication thereafter was through her Probation Liaison, and the researcher was never able to reschedule her, as this Participant did not come back to Court for some time thereafter.

On the other hand, the researcher learned that the Office of Behavioral Health had at some point contracted with a private psychologist consultant to interview mentally ill offenders across all JRS programs. The extent of that program is unknown to this researcher; however, a couple of Participants expressed that they had 'already talked to someone'. They might have been speaking of the consultant, but they could also have been speaking of a journalist; the local newspaper ran a story on severely mentally ill persons who were receiving services from the County around the time interviews were beginning for this research. So there might have been persons who were willing be interviewed for this research, but who had already been interviewed for another purpose, or who assumed these interviews were for the same purpose. Since the researcher believes to have achieved saturation of participant responses after conducting 22 interviews of MHC Participants and Graduates, she does not believe the instant research suffered in any way for participant information.

With Court team members, all in all, at least one person in each key subcategory of Criminal Justice professionals and Treatment professionals, and in most instances, several in each category, were interviewed. The researcher was only able to locate or interview two of the Court's four MHC Director/Monitors; one former MHC Director who had served for several years was reluctant to cooperate. Likewise, she was only able to locate and interview one of the two Assistant Public Defenders who have served through the Court's existence, but was able to supplement that with interviews of

Conflicts Counsel, who were also appointed to represent mentally ill offenders in the Court. The Deputy Chief D. A. would not cooperate in either allowing the researcher to interview the current Assistant D.A. or another Assistant D.A. who was still employed in the Office but no longer assigned to MHC, or to continue to attend referral meetings. Thankfully, all of the several former Assistant D.A.'s involved with the Court at prior times agreed to be interviewed, with their service spanning most of the years the Court had been in operation, and this researcher believes she obtained a full spectrum of their management of the prosecution side of MHC. Because she was able to sit in on referral meetings when prior Assistant D.A.'s were assigned to MHC, before cooperation ceased, this researcher was able to gather plenty of information on their role and actions. The relevance to this study is that the researcher cannot comment on how interactions in these meetings may have differed after changes in the workgroup took place.[3].

Though the official information-gathering portion of this study spanned over a year, the interview phase was limited to about seven months. The researcher is fully confident she achieved saturation of information regarding each role comprising Court team members. She was able to gain a good sense of the issues confronted by all Court team members who conducted them, as will be discussed in the findings chapter.

One of the goals of this case study was to add to the literature on mental health courts and in doing that, to provide some guidance to other counties wanting to form a

[3] When the researcher was asked by current Assistant D.A not to observe referral meetings, despite other interns being permitted to continue to sit in on these meetings, she honored the handout she had given to the Court team stating they could object to her presence as an observer. She was from that point unable to gather information about how that process may have evolved over time, or how different personalities might have made a difference in how duties were carried out, short of what was related to her by workgroup members.

mental health court, as well to propose research that may be called for on this and other mental health courts. In the next chapter, the development of mental health courts will be examined in the context of problem-solving courts, as modeled on drug courts, and the history and progression of this Court

CHAPTER V.

FINDINGS

Overview

"Reliability is problematic in the social sciences simply because human behavior is never static . . . . Replication of a qualitative study will not reveal the same results, but this does not discredit the results of any particular study . . .. The more important question for qualitative researchers is whether the results are consistent with the data collected." (Merriam, 2002a, p. 27). This case study involved extensive observation of human behavior, both general and specific, concerning the existence and operation of one large mental health court, through the hundreds of people involved in it. Triangulation was achieved through field observation of private and public court functions and staff meetings, thorough interviews of court team members, treatment providers, and defendant participants, and review of documentary evidence.

In the interest of providing cohesive answers to the eight research questions that shaped this study, data from all sources are presented in combination and organized by question. Some of the findings addressed more than one question, but were included in the section to which they were most pertinent. The discussion that follows focuses on findings; conclusions and implications are discussed in more depth in the final chapter. To reiterate, these questions form the rubric for the research:

1. *Why was the Allegheny County Mental Health Court founded? What purposes was it meant to serve?*
2. *Who are the court's clients and how are their needs identified and met?*
3. *How does the courtroom workgroup interact and make decisions?*
4. *How do court activities reflect the tenets of restorative justice?*
5. *How has the court evolved since its founding in purpose or philosophy?*

6. *How well does the court meet its objectives?*
   What do the court participants think about the court's functioning?
7. *In what manners might the court operate differently?*
8. *To what extent could the court serve a model for other counties wishing to develop a mental health court?*

Founding and Purposes of the Court

An assembly of court and treatment professionals concerned about the criminalization of the mentally ill formed in the late 1990s, calling itself the Allegheny County Forensic Providers Collaboration. They were overwhelmed with the number of mentally ill being arrested and housed in the County Jail, the backlog of magistrate and trial court cases of mentally ill offenders, and problems resulting from inadequate identification of the mentally ill in jail and their release to the community without appropriate aid. Buoyed by the promise of Allegheny County's Mental Health Forensic Program at diverting and treating mentally ill offenders, they created a task force to establish a mental health court to "accelerate the adjudication process for offenders with mental illness and safeguard public safety by providing comprehensive community services and supervision" (Valentine, 2000, *Allegheny County Mental Health Court Project*, p. 2) Task Force representatives came from a wide range of County agencies and private provider groups: the Office of Behavioral Health's Forensics Program (now Justice-Related Services) and Drug & Alcohol Division, the Bail Agency, County Adult Probation Office, the Jail Psychiatric Service, County Base Service Mental Health Units, the Court Behavior Clinic, the four largest Community Mental Health providers, as well

as from Mayview State Hospital, three regional Community Mental Health Advocacy Associations, and two area District Magistrates. This is their mission statement:

> The Allegheny County Mental Health Court's mission is to advocate for increased public safety and reduced recidivism rates of mentally ill offenders by the establishment of a specialized division of the criminal court system. This specialized court is fully committed to focusing its staff, resources, and expertise on the unique needs of the mentally ill offender thereby ensuring just process of law, as well as promoting public safety and improved quality of life for offenders by incorporating comprehensive community based treatment and services as mandatory sentencing requirements.

(Valentine, 2000, *Allegheny County Mental Health Court Project*, p. 3).

The task force identified the following key staff positions: dedicated Judge, Assistant D.A., and Assistant P.D, Mental Health Court Monitor (now MHC Director), Forensic Case Managers (now JRS Support Specialists), and Special Services Liaison Probation Officers (role now expanded and split into JRS Probation Liaisons along with Specialized Probation Officers). [See the Flow Chart at Appendix I.] In addition, it was determined that those filling the positions would undergo specialized training such as that already given to the Forensics Program (now Justice-Related Services, or JRS).

It was decided the Court would take only non-violent and misdemeanor cases, and that the cases would be identified from those receiving County mental health services and from a variety of other sources. Referrals were anticipated from community mental health caseworkers, family members, judges, mental health professionals, the Behavior Clinic, attorneys, state hospital forensic units, police agencies, and probation officers. The Assistant D.A. and the Mental Health Court Monitor (now MHC Director) were to meet twice weekly to review flagged cases. The idea was for the Court to fully adjudicate each case within 30 days of arrest, to prevent mentally ill offenders from

losing housing, medical assistance, and other supports on which they depended. Unique needs of the offender would be addressed through the same court staff and community providers throughout the process.

Within their formalized "Mental Health Service Plan", mentally ill defendants would be sentenced to court-ordered treatment rather than standard sentencing, or a combination of the two. Special Services Probation Officers would be assigned to them, with a "reduced caseload … ensuring an intensive level of supervision" (Valentine, 2000, *Allegheny County Mental Health Court Project*, p. 4). Community treatment and support services were to be coordinated by the Mental Health Court Monitor (now MHC Director) and progress followed by the Forensic Case Managers (now MHC Support Specialists, or JRS Support Specialists), and monitored by Special Services Liaison Probation Officers, who were to report to the Court (duties actually performed by the JRS Probation Liaisons instead). Court was to be held daily for reinforcement hearings "to track progress, compliance, and response to the service plan"; upon any non-compliance, the Judge and MHC Team were to "reconvene immediately to problem solve and implement appropriate interventions, including incarceration should the public be at risk". (Valentine, 2000, *Allegheny County Mental Health Court Project*, p. 4).

Funding for a pilot project was sought to compensate both an assistant district attorney and an assistant public defender being assigned to work on the specialized court docket court alone. As described in Ch. II, the Court started with operating funds grants from the PA Department of Public Welfare's Office of Mental Health and Substance Abuse (OMHSAS, some of which are federal Medical Assistance funds received by the state), and Allegheny County's Court of Common Pleas along with other County funds.

The funding application was supported by the Administrative Judge of the Criminal Division of Allegheny County's Court of Common Pleas, Gerard M. Bigley, in the hope of a finding a better way of handling mentally ill offenders charged with misdemeanors than existed (Allegheny County Mental Health Court Project, October 31, 2000). Also supporting the project was the Director of the County's Department of Human Services, whose department houses the Behavioral Health Division. The Task Force Chair was the Administrative Case Manager for the Western Psychiatric Institute and Clinc, and its co-chairs, a lead probation officer in the County's Special Services Unit of Probation, and the director of Forensic Support Services in DHS Behavioral Health.

For the first two years' initial operating expenses, OMHSAS provided $180,000 in public funds; over three times that amount in private contributions was sought and received from several area foundations, the Staughton Farm Foundation, the Pittsburgh Foundation, and the Jewish Healthcare Foundation (Fraser, 2004). The Staughton Farm Foundation solely makes grants "improving the lives of people who live with mental illness and/or substance use disorders" and "works to enhance behavioral health treatment and support by advancing best practices" (Staughton Farm Foundation, 2010, "Our Mission") and the Jewish Healthcare Foundation's funding includes "efforts to improve … healthcare quality" and to "respond to the health-related needs of … indigent and under-served persons throughout Western PA" (Jewish Healthcare Foundation, 2010, "What We Fund"). Public concern over the County's mental health care systems peaked after two notorious racially and ethnically motivated killing sprees by seriously mentally ill men in Allegheny County occurred within one month of each other in early 2000 (Ronald Taylor and Richard Bauhammers). These two Foundations had as a result been

involved in trying to improve the delivery of public and private mental health care in the County, including care of mentally ill offenders who were jailed (Fraser, 2004).

The Mental Health Court Task Force testified the next year before the PA Legislature, on behalf of "citizens, health care providers, politicians, court and law enforcement personnel" in support of enacting a bill to amend the state's court system and judicial procedure to allow and provide for a mental health court division. They provided data on brain disorders and the magnitude of the crisis of mentally ill offenders in the County, the state, and the nation (Allegheny County Mental Health Court Task Force, 2001). Their first brochure on Allegheny County's Mental Health Court (undated, but likely distributed in 2000) states that it became the first mental health court in PA on May 1, 2001; one of the goals stated was "to maintain effective communication between the criminal justice and mental health systems" (Allegheny County Mental Health Court, undated, Brochure, p. 3).

The second Mental Health Court brochure, intended "For Attorneys and Court Personnel" states similar goals as the original brochure, but is more specific about Court procedures. It specifies a "documented diagnosis" of mental illness, disability, or dual diagnosis in conjunction for eligibility and steps for referral (Allegheny County Mental Health Court, 2005, Brochure, p. 3). There is still dispute among the founders of Allegheny County's Mental Health Court about whether they intended a person's mental illness to have contributed to their committing the crime in question to be eligible. Some mental health courts require this. For example, if a schizophrenic were not taking medication, became psychotic, and broke into a business thinking it was his home, the crime is presumed related to the illness; alternately, if a person with Bipolar disorder

were not having a manic episode and planned a burglary, arguably, the crime was not related to the illness, unless perhaps he were dually diagnosed with heroin dependence, not taking prescription medications, and self-medicating at the time of the break-in.

These are fine distinctions, best left to a psychologist or psychiatrist capable of discerning illness versus general criminality. Two of the first Mental Health Court Directors (staff of Justice-Related Services, formerly called MHC Monitors) were both licensed counselors, one a social worker, one a psychologist, each of whom often made diagnoses after conducting their intake assessments. And the chair of the Task Force advocating for and implementing the Court was a psychiatric nurse who administrated case management for the area's largest psychiatric clinic and private forensic hospital.

Typically Participants plead guilty to enter into MHC. No jury trials are permitted in MHC, though bench trials may occur. Terms of the service plan and resulting probation are based on the facts of the case, and the person's criminal and mental health history. What happens to a case after acceptance is detailed in the second Mental Health Court brochure, for example, the mentally ill offender is to receive a subpoena for the first "Reinforcement Hearing" date, and reinforcement hearings at 30, 60, and 90 day intervals "depending upon the defendant/consumer's progress" (Allegheny County Mental Health Court, 2005, Brochure, p. 6). It explains that reinforcement hearings are "scheduled if the defendant/consumer violates probation or fails to follow their service plan" and sanctions include "jail for an afternoon … or months depending on the situation … Electronic Monitoring . . . curfews,"; and though the brochure says the Court proffers early graduation "if doing well and stabilized", it also warns of revocation and removal from the program "if failing to comply and show amenable to treatment"

(Allegheny County Mental Health Court, 2005, Brochure, p. 6). The Flow Chart at Appendix I help to illustrate the process as envisioned by the MHC Task Force.

An important step at the reinforcement hearing is the awarding of a positive or negative review to each Participant assessing their progress or decline. In a document drafted more recently by the Court team on MHC Review guidelines, criteria for graduation are described as (1) a minimum of one-half the period of supervision has been successfully completed; (2) at least two-thirds of all MHC reviews are positive; and (3) a defendant's last two reviews must be positive (Allegheny County Mental Health Court, 2007, *Mental Health Court Review Guidelines*). When the County's Electronic Client and Provider Information System (eCAPS) was designed in 2001, its purpose was to provide "accurate and timely client and service provider information, including information for more effective client referrals, client service delivery, and provider management" (Allegheny County Department of Human Services, 2010, " Electronic Client and Provider Information System"). Essential data about MHC cases such as demographics, assessment, treatment, and criminal case history was to be kept there by JRS through the MHC Director and JRS Probation Liaisons. If reinforcement hearing data is being promptly and properly kept there, a Participant's record of review grades in eCAPS would provide a ready source of his or her timeline during probation and assist the Court team in determining whether the Participant is ready to graduate from MHC.

All referrals were to be reviewed for appropriateness of charges and diagnoses. Normally, certification of diagnosis would either be found in eCAPS (the County's electronic social service database, including input from one of nine base service coordination units county-wide), or from the Allegheny Correctional Health Services

(mental health treatment provider service in the County Jail); if a private doctor or the Veterans' Administration evaluated the person, their diagnosis would not be listed there. When competency was in question, a diagnosis might come from the County's Behavior Clinic (the evaluation entity of the Criminal Courts) or from one of the state forensic hospitals, if a court ordered evaluation or involuntary commitment there. Pennsylvania's statute on mental health procedures defines competency:

> Whenever a person who has been charged with a crime is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense, he shall be deemed incompetent to be tried, convicted, or sentenced so long as such incapacity continues.

(50 P.S. § 7402). In some instances, if a mentally ill offender referred to MHC remained for more than several months committed to Mayview or Torrance State Hospital, the charges against that person may be dropped altogether, but not automatically. When the Court had a smaller caseload, the MHC Monitor (now MHC Director) or forensic (now Justice-Related Services) Support Specialist would visit them at the state hospital when the charges were still pending; more recently, the MHC Director does not make those visits. With serious charges, the Behavior Clinic psychiatrist had to find them not likely to become competent at a competency hearing before the charges would be dropped.

Identification and Meeting of Clients' Needs

Unpublished semi-annual reports on the Court were also done for the first several years of its existence by the Department of Human Services' Office of Behavioral Health. In the period the reports were done (2002-2005), there was a "steady growth in the use of the MH Court services" (Kroll, 2005b, p. 2); annual referrals averaged about 335 per year, with a large percentage of denials (about 45-55%) and refusals (about 10%). Most referrals were of persons with mood disorders (major depression, bi-polar disorder), followed by persons with psychotic disorders (schizophrenia, schizo-affective disorder), and about half self-reported drug or alcohol usage, appearing to have reached the target population. The average probation length reported was 18 months, but no MHC participant received more than 5 years' probation; positive reviews were 2 to 1 over negative reviews; 11-12 per cent of participants were arrested on new charges; and 6-8 per cent were re-incarcerated on probation or parole violations (Kroll, 2002-05). Concerns ranged from insufficient housing for those with a double stigma of mental illness and criminal charges (Kroll, 2002, p. 2; 2005b, p.4), to changes in the staff, such as the re-assignment of the original A.D.A. designated for the MHC (Kroll, 2003, p. 2).

The only evaluation study done on the Court was for the second and third years of its existence, 2002 and 2003, and contained in a brief unpublished report by the Department of Human Service's Office of Information Management. Descriptively, the report found concentrations of white consumers with bi-polar disorders and black consumers with a schizophrenic disorder; that men spent 2 months longer in the program than women on average, given 661 means days for all participants; and that nearly half

the participants were referred for a property crime, but that there was no connection between diagnosis and offense (Petrusic-Cooper, 2006).

One of the most apparent facts about this Mental Health Court is how quickly it has grown in numbers of persons served. From statistics he culled from his personal MHC database of referrals, the former MHC Director showed that the Court expanded from handling 5 or 6 cases per month at its outset to 70 per month in 2008. There were, for example, nearly 500 cases referred in 2007 and over 600 by 2008, with more than half of those becoming active cases yearly. Some of the Treatment and Criminal Justice professionals believed increasing the Court's numbers could only be a positive sign, and that this meant the referral process was working. Others expressed concerns that Mental Health Court was not meant for all mentally ill offenders, and that the Court team's capacity to adequately process, assist, or monitor the large numbers of mentally ill offenders coming through it was affected by not following guidelines for limited acceptance. As one treatment professional, Court Team Member #17, expressed:

> As long as you have the numbers, and you have tons of people coming through the program, it's all good. … it's OK for the Court get too big—but … You gotta add people to work with the clients. It's like more clients, and not enough staff. Everything, from Probation, the D.A., to the whole MHC, and I guess the thing about it is, is who is benefitting from that, and who is not? Is the client, the 305th client that's coming into MHC, are they going to get the services they need? I don't know. Maybe. Maybe not … Don't they see that the majority of people we're working with are sick and they're going to mess up, so we're going to start back from square one?

Participants who had opinions on this matter were of opposing beliefs; either they actually knew someone who could have benefitted from being in the Court, or they had observed someone in Court who did not appear to be an appropriate candidate.

Whichever is true, a few changes have taken place to try to make certain the Court was effectually reaching its target mentally ill population.

In 2005, Allegheny County's Office of Behavioral Health (OBH) revised its criteria for acceptable diagnostic categories of mentally ill persons referred after arrest to any of its Forensic services programs (these programs were described in Ch. II in detail). The Office of Behavioral Health continued to accept Schizophrenia, Major depression, Bipolar disorder, Post-traumatic stress disorder, Obsessive-compulsive disorder, Panic disorder, Psychotic disorder, Anxiety disorder, Dysthymic disorder, and Eating disorder. They no longer accepted Adjustment disorder, Impulse control disorder, Attention deficit hyperactivity disorder, Drug & alcohol disorder without any mental illness diagnosis, and Sexual deviance or Pedophilia without any major mental illness diagnosis. And they reviewed referrals for Dissociative disorder or Depression NOS (Not Otherwise Specified) on a case-by-case basis.

The Forensic services programs (now called Justice-Related Services, JRS) is the division of Behavioral Health which was agreed upon by the agencies involved with the Mental Health Court task force to process all referrals to the Court at first instance. Forensic services programs were in essence excluding some common mental illnesses as not fitting the definition of "major mental health diagnoses". By excluding these more manageable illnesses, JRS was honing in on diagnoses of serious persistent illness, and probably trying to curtail unwarranted referrals. It was explained by staff of Justice-Related Services that if a diagnosis of Depression NOS (not otherwise stated) was made for the first time upon an offender's visit to the County Jail, with no prior history of mental illness, the referral would not be accepted. That exclusion was due to frequent

referrals they get from the Jail for Depression NOS. Notwithstanding, a psychiatric evaluation can be concurrent with the crime(s) referred, if from the Court's Behavior Clinic or the Correctional Health Services at the Jail.

Several years after the initiation of MHC, Justice-Related Services now has staff working overnight at the County Jail in their Pre-Booking Diversion Unit; they notify the MHC Director of any cases that likely will not be resolved at the magistrate level and which may in turn be appropriate for Mental Health Court. The reason arrestees have priority at the MHC assessment phase is because they are both in jail and not yet accepted by the Court; so they are supposed to be assessed prior to release. Assessments may be delayed if the defendant is not in jail, is employed, or is a remote location like Torrance State Hospital. Originally, it was contemplated by the MHC Task Force that jailed mentally ill offenders would be in Court for their first MHC appearance within 3 weeks, so as not to lose any benefits they were receiving (which occurs after 30 days in jail). That time frame is rarely accomplished now, with the numbers of referrals MHC receives. Both Court team and various Participants were keenly aware of how long it was taking to get from referral to plead-in dates.

As described in Ch. IV regarding competency hearings, where a person's competency had been regained but charges against them were too serious to dismiss, the case against them would proceed to the next stage in the criminal justice stage (usually trial). The person is then returned to the County Jail, if they were detained when their competency evaluation was ordered. Justice-Related Services tried to intervene at that juncture, but if the MHC Director was not notified in time, the person was released from the Jail (typically on a bond) before JRS could meet with them about MHC or other

programs. Note that in their original job description, the JRS Probation Liaisons were supposed to "track the defendant while at Mayview [State Hospital], and schedule all hearings ASAP when the defendant returns to the Allegheny County Jail" (Human Services Administration Organization, 2001, Duties and Responsibilities, para. K).

So Justice-Related Services would have to close such a case referral, and the mentally ill offender would be left without supervised treatment or support in the community. What is more, JRS almost always later received a duplicate referral for the same charges for that defendant when they reached the next criminal justice stage, meaning additional processing and effort that could have been unnecessary. Considering that persons who have been at recent points incompetent are probably most in need of aid and monitoring, this glitch between the mental health and criminal justice agencies should be addressed system-wide. This issue is one that might be attended to by the Allegheny County Jail Collaborative, a multi-agency task force that addresses both public safety and recidivism, and treatment and re-integration of offenders into the community (Allegheny County Department of Human Services, 2010, "Community Re-integration Program is the foundation"), and will be discussed in the conclusions and implications chapter.

Where items were missing from referral forms, in particular the requisite diagnosis information, more recently the Mental Health Court Director stepped in to obtain the necessary documents, or encouraged the referring party to obtain a diagnosis if he could not obtain the information himself. Proclivity to take incomplete referrals rather than to turn them down, even with charges likely to be denied by the D.A.'s office, might be construed as net-widening. Instead, it could be just aiming wider for the target

audience. Eventually, an administrative assistant took over referral processing for the entire Justice-Related Service Department and all of its programs. There are far too many referrals for her to try to obtain missing documents or send a referral through with ineligible charges; she now simply informs whomever made the referral about the missing requisite criteria. Refusing incomplete referrals may slow down the numbers of cases handled, or it may just compel the referring sources to take more care prior to sending a referral. A few participants discussed experiencing a delay in being released from jail because their referral was not immediately accepted; however, in observations of this researcher, delays more often occurred in the acceptance process, described below.

Where a referral is complete and potentially appropriate, the Mental Health Court Director contacts the candidate in the community or meets with him or her at the County Jail to explain MHC and to determine his or her interest in participating. A candidate willing to participate is asked to sign release forms, and an assessment is conducted. The MHC Director puts the case on the referral list to be discussed at the next referral meeting, and sets up a time for an assessment of the candidate. When a person is already in MHC and a new charge for them is referred, the referral will not necessarily be rejected by the D.A.'s Office. So the MHC Director will add that referral to the list unless it is obviously too serious for acceptance, especially where the case was initially docketed for the MHC Judge's courtroom (note that the MHC Judge also has a docket of non-MHC cases). If their charges or record precludes them from qualifying for MHC, the case is routinely referred to the another JRS program, the shorter-term Support program described in Chapter II, for which most mentally ill offenders would still likely be eligible if they desired assistance.

Sometimes, though, a potentially acceptable candidate declines to participate in MHC. They might believe in their innocence, or that they would get a better deal through the expedited plea program, just as any other defendant might. Or they may refuse out of fear or misunderstanding, not believing they are mentally ill, even if they could benefit from MHC, so they might not respond to calls from the MHC Director to join the Court. As Participant #6, an especially thoughtful interviewee, conveyed, "The decisions that we make determine our destiny", yet some people " because of their mental condition … they don't have the ability to make healthy choices". Another explanation came from Participant #1, who suggested to me he was "sure there's people with mental illness issues who have rejected MHC because of the process or programs they have to go through". Refusals were especially hard for Justice-Related Services staff to understand; they had faith in what they were trying to do for mentally ill offenders. It was Justice-Related Services policy to then refer potentially acceptable participants who refused MHC to another JRS program, the Support program, in hopes they would at least agree to shorter-term support services as part of their probation.

This internal agency policy was clearly aiming for the target population without net-widening. The only MHC report that mentioned numbers of refusals addressed the first 3 years of MHC history, but it estimated ten per cent of those who were acceptable refused participation—a significant amount (Fraser, 2004). The researcher did interview one Participant who had initially refused services but who later agreed to come into MHC after persuasion from the MHC Director. This person, Participant #5, was an especially difficult case who claimed to have gone through "up to fifteen" different rehabilitation facilities or treatment programs, viewing them as punishment, and absconding from many

of them. She spent at least five, possibly six total years in the Court. After graduation, she came back to visit Court to tell the Court team and Participants she knew that she was doing well and living on her own, with no mental health or substance abuse relapses.

Given that many mental health courts require a plea of guilt or a conviction in order to participate, it is crucial that mentally ill offenders be represented by counsel who adequately inform them of their due process rights and their right to decline to participate, and that these offenders be competent to engage with counsel about ramifications of conviction. Without dismissal of charges or eventual expungement of record, the conviction from a guilty plea can make life more difficult for mentally ill offenders already struggling to cope with life. A criminal record may preclude one from serving in the military or obtaining a government loan or position; in some states, it results in the loss of voting rights or capacity to serve as a juror. In the immediate sense, there could be consequences affecting personal or family life from a conviction: possible barring from federally funded housing or student financial aid, potential barring of receipt of state welfare benefits; and denial of many types of employment. For serious crimes, conviction might culminate in loss of parental visitation or even termination of parental rights (Bernstein & Seltzer, 2003).

Allegheny County's Mental Health Court allows for a potential participant to have a trial prior to entering the program; but in the absence of a mentally ill offender making that choice, they must plead guilty to come into this Court. In many instances, referrals were made by the Assistant Public Defender assigned to MHC (or other Assistant P.D.'s in his office), and so the A.P.D. made early contact with potential participants to explain the MHC program and their rights to them. From Participants interviewed who were

represented by the Public Defender's Office, in most cases, they felt they were informed of their options either by the A.P.D. or by the MHC Director. When referrals were made by private defense counsel or even by some family members, it was less clear that decisions were made for the mentally ill offender's overall welfare and treatment, instead of merely seeking to divert them from incarceration.

Candidates to be assessed are asked to sign release forms to allow JRS and the Court to obtain necessary medical and treatment information from current or past healthcare providers, as well as to be able to provide it to others in the MHC process (Appendix E). The release forms could also include names of family or friends with whom the courtroom workgroup could correspond regarding the person's progress while involved (or in the alternative, persons whom they did not want to receive information about them). In the assessment, current information about mental state, decompensation, medications, and drug and alcohol abuse is solicited, along with the information history described in Ch. II. In a "mental health court, the limits of confidentiality are often stretched so that communication can take place between the criminal justice system and the mental health system; and severely mentally ill people in particular may have difficulty recognizing the consequences of disclosing personal information to treatment and case management staff that are aligned with the court" (Wyatt, 2003, pp. 132-33). From this researcher's observations of the assessment procedure, at least those conducted by the MHC Director, care was taken to only request that information which was needed for monitoring of participant progress, and Participant requests not to share particular personal information was respected, so long as such requests did not inherently interfere with the Court's ability to carry out its functions.

The terms of their forensic service plan are to be read into the record on the date of the plea into MHC, though the Court has taken to simply asking them if they accept the plan. Each plan should have some requirement for mental health treatment. Normally, this is not hospitalization, as a person should be mentally competent on the day of entering MHC. Participants with more severe mental illnesses or who are not fully stabilized might need intensive case managers, community treatment teams who as explained follow them where they are, or even locked facilities with 24/7 monitoring (called Long-Term Structured Residence, highly structured therapeutic residential mental health treatment facilities). Treatment can also be in the form of inpatient care for those with dual drug or alcohol problems, whether inpatient rehabilitation, residential rehab, or step-down programs; it can also be in the form of outpatient counseling, support groups, or parenting classes. The County's Department of Human Services coordinates payments or reimburses for many of these services for Participants. Those with longer criminal histories or several cases pending will usually need alternative housing (somewhere other than the home), or possibly electronic monitoring (which can be imposed for house arrest if a support system is in place). They may have to stipulate to such terms in order to be released pre-trial, sometime even before formally coming into MHC. Where there is an assault charge or a history of violence, the Assistant D.A. will often request anger management; where substance abuse is indicated, a drug and alcohol evaluation might be ordered. If a weapon is involved (uncommon in MHC), it is to be forfeited. No contact with a neighborhood location or victims in a case is a common stipulation of probation, which may benefit the defendant as well.

The next step in the MHC procedure is the reinforcement hearing. Progress is evaluated in terms of advancing participant mental health and lack of service plan violations. From the Probation Liaison's report, and input from other members of the Court team at each reinforcement hearing, Participants learn in open Court what sort of review they received. The MHC Judge also listens to Participants about their own assessments of their condition, as well as their needs or worries. Where their health is in order and they have substantially complied with service plan stipulations, such as appearing for probation visits, following rules at their placement facility, and refraining from contact with the people or drugs that cause them harm, the review for that day's hearing is to be listed as positive. When they have relapsed mentally or engaged in substance abuse, the review is to be listed as negative; likewise, if they have committed a new offense or walked away from a treatment facility, the review is negative. Here, the Judge may admonish a Participant, particularly after hearing from Probation Officers about violations or from Support Specialist or intensive case managers about non-cooperation. Participants' opinions are considered in treatment or placement decisions as much as possible, unless someone in the workgroup or a treatment provider working with them strongly believes those desires work against what is needed for mental health or overall welfare.

Should a negative review be anticipated, the Probation Liaison or MHC Director often alerted the Participant before his case was called, especially when the situation required an immediate change in placement or treatment to which he may object. Sometimes the decision on grading the review was made based on a urine test that the Probation Officer administered the morning of that reinforcement hearing to that

Participant; this occurred where there was evidence presented in chambers that the mentally ill offender was recently using illicit drugs. Participants may ask to offer information or are quizzed by the Judge or other team members about breaks of their service plan or probation violations and disagreements with the Court team about them.

Although those explanations have spared many a participant further incarceration, for those Participants who have been less forthcoming with the judge or other team members, Participant reactions may seal their own fate. The researcher observed in chambers meetings or in Court sessions that cases of those Participants who were honest about facing relapse and who were quick to reach out for help from the Court team were handled differently than those who went MIA (missing in action) or who tried to hide their violations. This was true, with the exception of egregious offenders, even where some Participants had repeated transgressions. It was confirmed to this researcher in interviews as what is referred to as "surrendering" to the illness to find recovery:

> Hey, if you want to leave the treatment center--you can go. Just know that there's going to be consequences for your action, that there is probably going to be a warrant. I put the ball in their court, that's kind of like how I've adapted to this job … --I'm not going to fight you on you staying because this isn't about me getting my recovery, it's about you getting your recovery. I let them make those decisions.

(Court Team Member #17).

If the JRS Probation Liaison (or anyone else on the Court team) is made aware of a crisis with a participant, an emergency hearing could be called for the next upcoming Court session, or even when Court is not in session. The job description for the Probation Liaison describes, "If the defendant is in the community and not following the specified Service Plan, this person [Probation Liaison] will help schedule immediate technical violation hearings." (Human Services Administration Organization, 2001, Duties and

Responsibilities, para. Q). Should there be a mental breakdown, drug relapse, new crime committed, or some other risk, what usually happened instead in recent years was for the Participant's regularly scheduled reinforcement hearing to be moved up to the current week's Court session, so that his or her situation could be re-assessed sooner at an emergency hearing. Where substantial non-compliance had taken place, like commission of a serious crime, attempts to deceive caseworkers, Probation Officers, or the Judge about transgressions, absconding from placement without notice or reason to Court team members, or repeated dirty urines, the MHC Judge might order the Participant be taken to the Jail holding pen. The Judge might then pull the Participant back after lunch to speak with her and gauge if the situation warranted further incarceration. But he might allow the Participant to remain jailed until the next week's court session to allow for further investigation, or just to attempt behavior modification for the wayward Participant.

Of course, breakdowns happen in this system, most notably when a Participant encounters problems and requires help, but does not reach out, and the Probation Liaison does not learn of such problems in time. In the past few years, the Probation Liaisons each have 90 to 100 cases for which they are responsible at any one time. One can foresee that close communication with 100 people, some of whom are really needy, cannot always occur smoothly, no matter how devoted the attempts. Furthermore, for those who had relapsed, violated, or just needed more help after their initial work-up and stabilization with the Support Specialist, current procedure is that their case is handled by one of the two Probation Liasions rather than by the Support Specialist, overwhelming the Liaisons even more. This could mean a new placement or other re-working of the service plan. Some Participants interviewed thought of Support Specialists and Probation

Liaisons in the same way: as caseworkers, and basically, as Court Team members explained, they were, but the latter had added responsibilities of monitoring, interacting with other Court team members, keeping records, and reporting to the Court.

A number of Participants simply objected to transferring caseworkers once they had relied on a particular professional or come to trust them. Other Participants interviewed seemed to understand the difference in staff functions. Some expressed very clearly that, despite the care or efforts of the Probation Liaisons, they did not have enough contact with them, especially when matters were rocky for the Participants. Said Participant #17: they had ""too many cases . . . they can't get close to each individual as they should". Still, no more Probation Liaisons have been added, though the issue has been raised at quarterly team meetings that caseloads are not at levels contemplated with the founding of the Court. The JRS Supervisor explained that, with the addition of more Support Specialists to her staff, the Probation Liaisons and the MHC Director would be freed to be in the field managing assessing and clients, as they were intended to do. That policy change to transfer clients within JRS did not, however, relieve them of their many casework duties throughout the remainder of participants' probationary periods.

Some Participants who are stabilized but who desire or would benefit from more contact with the Court can be scheduled to appear more frequently. Given that the Court meets weekly (except holidays and summer vacation), more of the Court's precious time might be taken up with this practice. It may be more likely to leave a void for these Participants once they graduate, too. But it seems to have aided these Participants in gaining the structure they needed for their lives. Granting such requests are judgment calls, usually left up to the MHC Judge, with input from the Assistant P.D. or Assistant

D.A. For other Participants, too frequent contact or excessive monitoring might be a hindrance, given their diagnosis or mental state; they could tend to fall into violations if the process invoked anxiety or paranoia. Members of the Court team who have more direct interaction with Participants (Support Specialist caseworkers, Probation Liaisons, Special Services Probation Officers) are in a better position to determine their reactions, and the Judge would rely upon these workgroup members to evaluate the situation.

As part of field observation, this researcher was able to view assessments conducted by the MHC Director at the County Jail, at a mental illness/substance abuse (MISA) inpatient facility, and at a halfway house for substance abusers with secondary mental illness. She was also able to observe in-person assistance provided to clients by forensic Support Specialists at various facilities, such as registering a client for community mental health treatment; applying for Social Security disability or medical assistance benefits; negotiating accommodation problems at a personal care home that dispenses medications to mentally ill residents; and obtaining a medical evaluation and psychiatric diagnosis from a community physician.

The JRS staff acted with the utmost concern for their clients' medical and legal needs. One, Court Team Member #19, described their roles as "helping them [Participants] to stay out of Jail", doing anything to "help them get their lives back", and return to the community, above all else, which would be an advocate role. This Treatment professional spoke of their duty as that of "education", both for their clients about options available to them, as well as for other parties on whose opinions and actions the clients rely. The professional described having to "sell the consumer" (Participant or client) to placement facilities who may be dubious of a mentally ill

offender due to criminal activity or simply behavior patterns. Other Court or Treatment professionals focused on a "mentor" type role, helping them to stay clean, get their housing and finances in order, or to regain interaction with their families. On other levels, they may also contact the police involved, or probation officers or judges assigned to Participants in non-MHC cases, family members, or even employers, to seek their cooperation in forming a service plan that invoked treatment rather than incarceration for the mentally ill offender.

Interviews of treatment providers or Court Participants the researcher conducted on facility sites were instructive, especially one where severely ill clients were managed. She was able to visit and speak with several professionals within an intensive, 24/7 treatment model called a "community treatment team", or CTT. In particular, they were very willing to provide the researcher with an explanation of the nature of their program and their philosophy towards helping their unique patients. The CTT component was first added to MHC through a grant from the Bureau of Justice Assistance in 2003 "to significantly improve outcomes for individuals with complex histories and multiple needs" (Kroll, 2004, p. 2). A CTT professional might do everything from arrange counseling for a client and then go to their home to administer medication to them, to teaching them how to shop and keep a budget, to speaking on their behalf in Court. CTT's in the County facilitated release from the state hospital of many of the persons who were not necessarily low-functioning, but who needed more help after being "labeled" or "institutionalized".

As a result, their staff would advocate for the least restrictive alternative for their clients in most situations, and not view them as being non-compliant when others in the

Court team surely would have, such as when they missed more than one counseling session or did not want to work with their psychiatrist on medication management. On the other hand, working with a client for years, CTT staff get to see all of the dynamics of clients' lives and thus gain an understanding of them than others cannot. When CTT was servicing a client in MHC or the Support program, Justice-Related Services staff would defer to them for case management of the mentally ill offender, so as not to duplicate or contrast services, and also for reporting on their progress to the Court, due to CTT's level of involvement in coordinating the Participant's care.

Certain cases are excluded from MHC where other specialty courts or procedures in Allegheny County were set up to handle them (DUI Court, Drug Court, Domestic Violence Court), as well as probation violations with no new charges attached. But shared caseloads presented some challenges in establishing eligibility. For instance, charges of Possession with Intent to Deliver (drug sales) were to be rejected, unless the Assistant D.A. originally assigned to the case agreed to drop the drug sale charge for a simple drug possession charge. Persons who merely have drug addiction problems were not to be accepted into MHC. If they self-medicated with street drugs, they needed to be diagnosed and assessed for a primary dual mental illness/substance abuse problem to qualify; drug-induced psychosis is not a valid diagnosis. Otherwise, they have the option to apply to Drug Court.

Unfortunately, if they are a level 3 or 4 drug offender in PA (i.e., with charges for sale of cocaine or heroin over a small amount, or a prior record likely to result in a sentence long enough to send them to state prison), or have committed a crime of violence or a gun charge, they are not eligible for Drug Court, based on federal grant

criteria for drug courts. Hence, persons with any history of mental illness and a non-qualifying drug offense might try to get into MHC by feigning mental illness. They may have accounted for some of the inappropriate referrals mentioned in the unofficial reports on the Court, or those Participants opined by some members of the MHC workgroup to be trying to "play" the Court, as will be discussed in the findings sections on *Satisfaction of Court Objectives* and *Evolution of Court Purpose and Philosophy*. On the other hand, Court Team Member #17 casts a different light on the condition of the dually diagnosed:

> …[A] lot of the people that are in MHC are dually diagnosed, whether it's mental health diagnosis above, or D&A diagnosis above, I don't know. Because once they're clean, you can see that they're not thinking correctly, so well, what's going on now? … Are they just not used to the drug, or is this truly a mental illness that they've just masked for so many years? … Bipolar disorder sort of mimics cocaine use, where people are up—like cocaine, you use, you go up, and then you crash down."

Sadly, there were six MHC participants who died, mainly from drug overdoses, in 2008. These deaths were spoken of as suicides, yet not necessarily by official ruling of the County Medical Examiner. Some looked more broadly at the numbers of psychiatric hospitalizations waning since the closure of Mayview State Hospital began in 2007 as a possible contributing factor. With the closure of the University of Pittsburgh Medical Center's Braddock Hospital in 2010, the only large forensic hospitals in the area which remain are Torrance State Hospital, and the University of Pittsburgh Medical Center's Western Psychiatric Institute and Clinic (WPIC). And WPIC was temporarily suspended by the state Department of Public Welfare in 2008 from taking new patients after some very public cases of neglect of mental health patients in their care (Fahy, *Pittsburgh Post-Gazette*, 2008).

For obligations of MHC, still, there was concern over inadequate monitoring of dually diagnosed participants who had recently relapsed (mentally or with substance abuse) or who failed to show for Court hearings. The Probation Office pressed for weekend jail stays for violators in this category, if only to protect them from themselves. There is no formal suicide prevention task force in Allegheny County, to the researcher's knowledge. Yet a group was already organized in Allegheny County to examine the epidemic of overdoses in recent years, to review various cases County-wide, and to address solutions, which meetings the JRS Director started to attend in 2009. Representatives from hospitals, rehabilitation facilities, physicians, pharmacists, prevention groups, the police medical examiner, and the County Bureau of Drug and Alcohol convened to increase knowledge on drug intervention and treatment for public and providers alike, and to increase cooperation between agencies and organizations with a stake in prevention or care (Allegheny County Overdose Initiative, February 2009).

Workgroup Interaction and Decision-making

To carry out the considerable operations of the Mental Health Court, the courtroom workgroup must interact and make decisions at many points. These points include typical phases in the criminal justice system, such as negotiating a plea bargain and presenting it in court. They also include atypical points necessitated by the specialized case processing entailed in a mental health court, and in particular, the steps

designed for operation of this Mental Health Court. Aside from the makeup of the courtroom workgroup, the structure and tenor of any diversionary court is next defined by who its defendants are. Two of the key preliminary decision-making functions of this Mental Health Court process are referrals to the Court, and acceptance into it. Key intermediate decisionmaking functions are reinforcement hearings, service plan changes, and violations of service plans or probation. Finally, two of the key posterior decision-making functions are graduations and revocations or terminations. Note that this section of the dissertation includes much discussion of MHC procedures that may be relevant to answering the other research questions posed in this study; this is necessary to provide the context in which workgroup decisions and interactions were carried out.

For many mental health courts, as with this Court, a key part of the preliminary procedures are the guidelines kept on charges and criminal histories permitted by Court. Members of the workgroup perform a gatekeeping function when they control these procedures. In Allegheny County, MHC case acceptance was evaluated at "referral meetings" of the MHC Director, Assistant P.D., and Assistant P.D. Referral meetings were intended to take place twice weekly when the Court was created. As the court grew, they moved to once weekly, then bi-weekly. As of 2009, meetings may have been scheduled every three weeks, yet ended up being held just once monthly. In part, delay was attributable to the volumes of other work for which the attendees were responsible weekly. But it may have been due to competing organizational or philosophical views and the resulting contentiousness into which meetings sometimes devolved.

The Director of Justice-Related Services had final say on whether a MHC referral would go forward to the workgroup referral meetings, and she frequently communicated

to defense counsel or others who might be pushing for acceptance as to why a referral would not ultimately be acceptable and thus not passed on. In a few instances, when there was no Axis I diagnosis by a licensed psychiatrist or psychologist documented, somehow, the referral somehow passed muster. Once a referral was sent forward by Justice-Related Services, the MHC Director always advocated for a client to be accepted into MHC on behalf of his office, regardless of circumstance. Moreover, the Assistant P.D. resorted to a more traditional role for this function of MHC on behalf of his office; he similarly advocated, especially when the MHC Judge or another judge had made the referral. Naturally, with some candidate's records or charges, the Assistant D.A. was going to take issue with certain referrals on behalf of her office. As a consequence, the list of pending cases awaiting acceptance decisions continued to accumulate. Tension ebbed and flowed as different relationships were forged among the team and as different personnel came and went.

Despite the concessionary nature of the referral meetings held between the Assistant D.A., Assistant P.D., and Mental Health Court Director, it was the District Attorney's Office that asserted veto power over acceptance. This fact was later confirmed by interviews of persons involved in the founding of the Court and reflects the early negotiations to establish the Court. Key to the D.A.'s Office initial agreement to be part of the Court was to retain decisions over those felony charges only acceptable on a case-by-case basis (aggravated assaults, burglaries, robberies, false imprisonment, terroristic threats, firearm violations). One Criminal Justice professional, Court Team Member #9, insisted the D.A.'s decisions were "discretionary", and that borderline cases were to be approved by a supervisor "for political reasons". In fact, there were disputes between the

Assistant D.A. and the Assistant P.D. or the MHC Director on those borderline cases—as might be expected.

The MHC courtroom workgroup routinely interacts with staff in other special courts in the County, as mentioned in the section on *Identification and Meeting of Clients' Needs*. When persons referred for an eligible charge got a DUI (DWI) shortly before or after pleading into MHC, the Court did not then deny or exclude them from being accepted, though. As might be expected, that boundary was squeezed and private defense counsel tried to refer persons with more than one DUI. Aside from the dangers of someone with a psychotic disorder driving when intoxicated--the problem presented was that sentences in PA for second or more DUI cases are not only complicated, but call for mandatory jail time--defeating the purpose of diversion. Nevertheless, at a MHC quarterly meeting, the JRS Director and the Assistant P.D. asked to try a test case and the MHC Judge agreed to see how it would work. The test case ended up with a major probation violation and other compliance problems; eventually the person just pleaded guilty to the charges and served the traditional DUI sentence. As for chronic domestic violence offenders or those who had indirect criminal contempt violations of Protection From Abuse (PFA) orders, a history of violence is a basis for rejection from MHC. Though other Justice-Related Services programs have taken such cases, MHC almost never does; there is too much risk of repeated violence with these offenders, and exceptions have been tragically regrettable.

The Public Defender's Office would prefer to have had inconsistent decisions from the prosecutor than to have all cases with certain charges denied, however. According to pieces of official literature of the Mental Health Court publicly

disseminated during the Court's tenure, certain serious charges were not eligible for the Court: assault or robbery with a weapon, assault while a prisoner, sexual offenses other than open lewdness, arson or gun offenses (where suicide was not attempted), burglary of a residence, theft by extortion with threats of violence, homicide offenses, kidnapping, drug trafficking, protection from abuse order violations, and escapes[4].

When interviewed, certain Criminal Justice professionals and Treatment professionals expressed their desire that there no longer be limits to the types of charges or records accepted into MHC; they thought that more serious offenders need to be monitored more closely than offenders who commit only 'nuisance' crimes when acting out[5]. Translated, this philosophy meant a good deal of pushing and pulling between offices about case referrals and acceptances. Ironically, some MHC Participants had just the opposite feeling. Having met some mentally ill offenders they considered dangerous while in jail, some were uncomfortable with the notion of flexible admission standards for MHC, particularly where a serious mental illness existed. A perceptive interviewee witnessed a paradox in jail, however, saying that "more violent criminals who are really sick, and need help, cannot get in, when some petty criminals who don't want help just use MHC to avoid prison or jail" (Participant #7).

Informal referrals that sidestep the normal MHC process also took place. In some cases where the Assistant P.D. or the MHC Director were pushing for a person to be accepted into MHC, but that person was not deemed acceptable by the D.A.'s office, the

[4] A probation violation on a previous case in another courtroom cannot be handled by MHC, either.
[5] Of course, serious offenders can surely be monitored while incarcerated, so these interviewees were presuming that all serious offenders could qualify for parole under PA's sentencing guidelines, when in fact they might not have.

JRS Director would ask the Deputy D.A. who oversaw MHC to reconsider the case. If that did not change the decision of the D.A.'s office to reject, the MHC Judge might be approached by the Assistant P.D. or by private defense counsel to 'accept' the case, that is, to take jurisdiction of the case over the D.A.'s objection. And in other instances, the MHC Judge might make a referral himself by asking the Assistant P.D. to fill out a referral form for someone he deemed appropriate for MHC. Though the MHC Director would be informed of these referrals, essentially the process was sidestepped, because no one would challenge the judge's desire. It is not clear whether anyone ever confirms the defendants' diagnoses or charges meet the guidelines in such cases, or whether anyone even fills out a referral form for similar cases where other judges in the criminal division wish a defendant to be referred into MHC .

Some Treatment professionals perceived the MHC Judge as having input on whether to accept a referral into MHC when acceptance was debated, and that the Judge usually advocated to "let them in". A couple of the Participants directly related to the researcher that an appeal to the Judge allowed for their serious charges to be admitted into MHC. A particularly avid professional, Court Team Member #24, spoke of hoping MHC would take "anyone" in, and described looking for Criminal Justice professionals members in the Court team on whom they could depend to get their clients out of jail, those with whom there was less conflict because they "got it", rather than those with whom it was a "struggle" getting them to understand the client's needs.

One group that does not participate directly in the referral meetings is the specialized probation officer contingent, though their office was represented at MHC quarterly meetings and lodged objections to violent or sex charges being accepted into

MHC. At the least, the Special Services Probation Officers would like to review the list of "acceptable" referrals (those screened and classified as acceptable at referral meetings) to have some input prior to their formal acceptance into MHC. The Probation Officers expressed concern as a group because they had experience with certain mentally ill offenders already in the criminal justice system, particularly those with personality disorders, whom they believed would not be amenable to treatment or to the structure of MHC. Another member of the workgroup confirmed that there had been instances where the Probation Officers knew a client and objected to that person's entering the Court, but the Judge basically said "We're taking the case."

In fact, some of the Participants who had continuing trouble complying with Service Plans or who seemed to 'play' the Court until they were finally ejected, were those the Probation Officers had warned others in the Court team about. After time to experience these Participants' behaviors, general agreement of the workgroup was that the primary diagnoses for these unsuccessful or unwilling Participants may really have been an Axis II diagnosis, such as Adjustment Disorder or Anti-Social Personality Disorder, rather than a serious mental illness categorized under Axis I of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders[6].

Once a mentally ill offender has been accepted into Mental Health Court, he or she was to be scheduled for a plea or trial date. If a higher charge stood in the way of acceptance to MHC to begin with, it had been the decision of the Assistant D.A. assigned to the case whether or not to drop that charge to make the case acceptable. Even with an amended indictment, plea negotiations can and do take place. At this juncture, the

[6] Axis I diagnoses are clinical disorders, including major mental disorders, while Axis II diagnoses are personality disorders.

primary interaction in the Court team is between the Assistant D.A. assigned to MHC and the MHC Assistant P.D. or private counsel. Here, decisions about charges and sentences in a negotiated plea are similar to what they would be if the case went through traditional court. The Assistant D.A. draws up descriptions of plea agreements negotiated prior to plea dates and they are still presented to the Judge in MHC, who can deny them as any other trial judge can. But the A. D.A. might push for the most probation time possible to monitor a defendant, particularly if a felony charge was dropped. Several Treatment and Criminal Justice professionals took issue with what they perceived as a trend; one, Court Team Member #24, felt that MHC sentences were getting longer and longer with the D.A.'s Office insistence on them. And several more wished that prosecution and probation would become more "recovery-focused" in their outlook on the cases, believing attitudes of the law enforcement contingent impacted their decision-making.

The service plan is set forth at the plea or trial by the Support Specialist. A participant's first reinforcement hearing date is set up 30 days thereafter, for it is anticipated that all supports such as housing and treatment are in place by that time. The long-serving Assistant P.D. has taken it upon himself to schedule all the Court's reinforcement hearings, keep the MHC docket, and distribute it to the team; he also prepares new subpoenas for upcoming reinforcement hearings and delivers them to various Participants in Court for signature. Thereafter, they will be put on the docket for reinforcement hearings at 30 day intervals until the team agrees they are stable enough to drop back to 60 or 90 days out[7]. These are additional tasks that do not exist in traditional

[7] There have been cases where the mentally ill offender has not actually pleaded into MHC, and yet they have been scheduled for review dates (which they attended), and were even logged into the state's criminal court database as being in Mental Health Court. PA

court, but they are necessary to MHC; someone has to perform them. Tasks like these are normally performed by the Court Administrator's office or the minute clerks of the courtrooms. So the Assistant P.D. has taken on an administrative role that would not be performed by his co-workers in the P.D.'s Office in other courtrooms.

Probation Liaisons and Probation Officers relate what has transpired since the last reinforcement hearing and often are asked to assess the Participant's situation. If the JRS Support Specialist has been active in assisting the Participant with an issue, they will be asked to attend the hearing and relate that, too. At times, announcement of a review status at the hearings was contentious, when conflicts existed about whether it was the right outcome between team members, or between the Participant and the Court. With challenging cases, the Judge may ask outside counselors or other placement facility staff to appear and inform the Court of what problems have been occurring with the Participant. This information assists the MHC Director or Probation Liaisons in forming adjustments to treatment with Treatment professionals, or Probation Officers or in amending the service plan stipulations, which suggestions the Judge often accepts.

These decisions and opinions are integral to the functioning of MHC. Court team members are aware that not only what is said, but how the message is delivered, has impact on what a mentally ill offender may do in the period until their next reinforcement hearing. They are careful to stick to the facts when lodging criticism; they offer praise when Participants take steps toward compliance, or incentive when they see a need. But the Judge is the final arbiter for orders from the MHC. If he decides to forego the advice

---

does not discipline the performance of its courts, and there is no oversight of its diversionary or problem-solving courts to audit issues like these.

of providers or other workgroup members in making a ruling, like just about all the professionals interviewed stated, those are "his calls".

The Judge almost always gives Participants a chance to explain special circumstances that may have led to probation violations, and many of the Participants interviewed evaluated him as very fair. Good at remembering each Participant's case, he frequently offers words of encouragement, or comments on improvement in their health or appearance. This buoys Participants and gives those in the audience hope to do better. As time goes on, Participants will bring good news to the Court, like telling the Judge about their "clean date" from alcohol or substance abuse, or that they have found a job, enrolled in school, or regained connection with a family member.

Persons already in MHC who fail to appear for a scheduled reinforcement hearing with no explanation and who also fail to make contact in the near future with their JRS or Probation Liaison or Support Specialist, their Probation Officer, the Assistant P.D., or even an intensive case manager from the community who is in touch with the Court, are considered missing in action (MIA). Normally, the MHC Judge gives the Participant until the following week before issuing a warrant, to allow for miscommunications to be cleared up. The Probation Officers and the Assistant D.A. have learned not to ask for a warrant until the next Court session, unless it is an extreme violation or a dangerous situation. In those cases where the Judge intended to send a non-compliant Participant to the Jail holding pen or a weekend stay in the Jail as a sanction, the MHC Director or the Assistant P.D. might take issue, if they believed being in jail would be damaging to the Participant's psyche, or extenuating circumstances kept a Participant from appearing.

On the other hand, a special Probation Officer or the Assistant D.A. might lobby for temporary incarceration, either to protect the Participant or others. On occasions when a special Probation Officer has had reason to believe the Participant is using drugs or has had a mental breakdown, they have asked the Judge to issue a warrant immediately. After losing several Participants to drug overdoses or suicides in the past two years, the Judge is more inclined to issue the warrant, in the hopes that apprehending and jailing the fugitive will protect that Participant from a worse fate.

Graduation from MHC is supposed to be based on the Participant's meeting the formula described in the *Founding and Purposes of the Court* section, that is, at least one-half the period of supervision has been successfully completed, with at least two-thirds of all MHC reviews being positive, and the last two reviews being positive. Though this might be a fairly straightforward assessment if eCAPS data were accurate and current, it really was not, confounded more recently by the addition of "neutral" reviews. The Court team relied upon the Assistant P.D., who kept his own fairly meticulous records, to tally successful reviews. He typically made an email request of the rest of the Court team when he believed a Participant was ready to graduate from MHC, and solicited input from team members of their opinions on the Participant's readiness to graduate.

If graduation looked promising, the MHC Director would alert the Participant to make sure to be present in Court, and would prepare a certificate of graduation in the person's name. At the next scheduled reinforcement hearing, the Participant's graduation request would be debated in chambers and a final decision made. If general consensus existed, the Assistant P.D. made a motion to the Court for the Participant's graduation. In

a few instances, the MHC Judge would grant the motion over the objection of a Court team member who reminded the team of a non-compliance issue that might merit keeping the mentally ill offender in MHC a little longer for his own sake or that of the public. This was a judgment call based on an overall feeling that the Participant had recovered and would be unlikely to re-offend.

All of these factors were discussed privately in Court chambers, for each Participant on the docket. The Court team assembled on each reinforcement hearing date or plea date, prior to the start of open Court. Everyone in the workgroup was able to offer evidence or opinions about progress or the lack thereof. As with any group, personalities dictated who was more assertive about offering input, versus who had to be called upon to speak despite having information crucial to the decision. They negotiated an agreement as best they could about the grading of the review and what actions need be taken for each Participant's hearing. Often they scripted how the review would be communicated in open Court, with a team member who advocated for or against a certain action indicating what they would say about the Participant, what options the Judge would offer to a Participant who was out of compliance, or what motions the prosecution or defense would make in reliance on the Court's decisions, to remove the element of surprise between members and in presentation to the Participant.

Sometimes outside treatment providers sat in on chambers discussion when they had a client review. This researcher had the benefit of interviewing several providers who had worked both as Criminal Justice professionals and as Treatment professionals; in fact, this shift back or forth between the positions is becoming fairly common in the forensic mental health field in Allegheny County. Court Team Member #19 described

the "intimacy" of working within the Court team, and being relied upon for their opinions from the MHC Judge. That was visible; it was satisfying to see the team interact as they did, in agreement or even dispute, with a level of interaction that is not commonly seen in government or in business. Fair and honest discussion was the only way to find the best solution for cases, and so the workgroup took the time to carry out the work needed to get through what was often a lengthy docket for the day, even if they did not come out to start reinforcement hearings until 11:30 A.M. after going into chambers at 9:00.

Perhaps this was because most everyone on the team wanted to be there—they had either volunteered to work with MHC or chosen the spot directly by applying for the positions they held. A telling quote from a Criminal Justice professional, Court Team Member #12, summed it up:

> We have a really good group of people—I think we all have a heart for this … I feel like we fight …sometimes we lose sight of that … we all have the ultimate goal of helping the person first, as well as protecting the community … everybody needs to get out of their comfort zone, that sometimes jail is necessary, as well as 'let's give this person another shot' is necessary … but it's less of a fight than in other courtrooms … because they don't have the same goal, and I think that we do.

Bickering was not uncommon, though, and at times the Judge would foreclose debate if it seemed there was unresolvable disagreement over a difficult case or if he had decided one way or the other after weighing it. In this circumstance, some Criminal Justice professionals interviewed spoke of their dismay with certain other team members, both Treatment professionals and Criminal Justice professionals alike, who never wavered from what they termed "blind advocacy". That is to say, they felt that those team members behaved as if they preferred to hide violations of wayward offenders, rather than to come forth and permit the team to find a solution. Their actions may have

been sacrificing the trust of the team in order to preserve the trust of a Participant whose secret they may know; or instead it could have been that team member believed they could manage the Participant's problem without getting them in trouble with the Court.

In the alternative, a few Criminal Justice professionals and Treatment professionals told me that they wished other team members who took an opposing stance would come to better understand the trauma of serious mental illness and be more forgiving of, or less harsh on, Participants. Several professionals reminded me that MHC Participants are scrutinized more than they would be in the Support program (where they go through traditional court processing and a short-term service plan). They pointed out that MHC Participants were being followed by more persons than just a probation officer as they would be with a typical sentence, in addition to being monitored intensively throughout their probation period. For that reason, these professionals believed public safety was better ensured with MHC, where Participants were monitored throughout the sentence, than with the Support program, where their cases were closed after several months when supports and assistance were in place. As Court Team Member #17 put it, " if they do commit a charge and they go to jail, we're putting them back into certain types of programs".

Other research has demonstrated concern for the "border straddling" that takes place most often with forensic caseworkers and probation liaisons who must both treat participants and act as their advocates, along with surveiling and sanctioning them (Wyatt, 2003). Wyatt explains that the role is "a crucial variable to ensure collaboration and communication between the criminal justice system and the mental health system, and to assist participants in meeting the goals of each …" (p. 129). These group

members often have "tremendous discretion and power in determining sanctions for non-compliance", but their dual accountability can make for "conflicting allegiances" (p. 133); where they are aligned with or influenced by program administrators or others in the team who use coercive means to get defendants to comply rather than incentivizing good behavior, their participant clients may be more at risk of program failure through cumulative probation breaches. Wyatt cautioned: "[M]ental health court is, by design, vulnerable to the use of sanctions that may have unclear justifications, particularly if sanctions are related to contract violations rather than new offenses" (2003, p. 127).

In Allegheny County's Mental Health Court, the MHC or Support Specialist forensic caseworkers and MHC Probation Liaisons tended to lean toward advocacy more than surveillance. Perhaps this is because this Court's designated workgroup was replete with just about every possible team member described in the literature, short of outside treatment professionals; and team members were likely able to stick more to their stated job descriptions than in smaller courts where workgroup members may have had to 'straddle' and serve multiple roles. This Court's caseworkers and liaisons were probably then more comfortable with the special Probation Officers doing most of the monitoring and allowing the P.O.'s and D.A.'s to suggest sanctions; but in the end, that may have contributed to greater tensions between the Treatment professionals and Criminal Justice professionals.

An interesting twist here is that some Criminal Justice professionals described the ease of being able to work better with a particular Court team member who always advocated for the client's welfare, and yet who tried to be forthcoming about non-compliance matters that arose with them. From this researcher's own interview with this

particular Treatment professional, it is her opinion that this team member ascribed to that dual philosophy and carried it out thoughtfully, with attention to the individual circumstances of each Participant, care that was noted by the Participants served by this person. The idea taken from these descriptions is that this team member was adapting his advocacy role from that expected in traditional court to one useful to a diversionary court like MHC, where therapeutic jurisprudence and restorative justice were valued. It is the researcher's opinion that the longer a team member serves in MHC, the more they adapt their roles and try to bridge the gap between what is asked of them in the criminal justice system and what is asked of them in the mental health treatment field. If they are uncomfortable with having to do so, then they tend to leave their positions; some have even taken on new roles, as mentioned above, moving in either direction.

Either way, when accusations of unprofessional behavior cropped up from actions in chambers or during the week in group email communication, the MHC Judge saw to it that more civil exchanges take place. At several MHC Quarterly Team meetings, the agenda included the topic of trust. He addressed the matter of differing duties and philosophies being brought to the table and how those differences might cause team members not to trust one another. But he stressed more open lines of communication. And as time went on, from this researcher's observations in chambers as well as during the work week, a calmer atmosphere where team members tried to focus on accomplishing the demanding work of the Court, occurred.

Reflection of Restorative Justice Tenets

More clearly than any other finding in this study is the agreement among Criminal Justice professionals, Treatment professionals, and Participants alike, that the MHC operates with concern for the restoration of the mentally ill offender's stability, recovery, and trust. In the words of one Criminal Justice professional, Court Team Member #12,:

> It should be the mission statement of what we do: make them take ownership, but yet provide more of a treatment, because if they're legitimately ill while they're doing these offenses, it's not fair to punish them at the same level of somebody who knew what they were doing.

Several Participants stressed that recovery was theirs alone to credit; that "if you take it seriously, it works; if you don't, it's not going to work"; or that trust in them was only theirs to give up. Most, however, fully agreed that they would not have recovered, or regained respect of others, without having undergone the MHC process or without the aid and concern of the MHC team. One graduate, Participant #6, who was in the Court several more years after a new spate of charges, made it clear:

> They would help me with treatment … give me the benefit of the doubt … and see how I would react to that … I like how they come together . … the teamwork--forensics workers, probation officers … I picked up a little bit of something from each one of the people that tried to help me … it did make a difference …maybe if I would not have met those people … or had their support … or their understanding to my situation… it might not have happened for me.

And this is the sort of thankfulness others expressed about being in the Court:

> MHC allowed me to see . .. somebody in system is willing to help you, not treat you like a criminal just because of past mistakes, they get to see that it's a mental thing … just getting into trouble because I don't know how to cope with emotions and feelings, I act out. (Participant #9)

> MHC helped me to have that support and that unconditional love from people that get paid to be on your side but are there for you … I like that they praise

> people and are willing to go that extra step to help, and if you're not doing that good, they're willing [to get you help]. (Participant #14)
>
> They join together to help somebody …you don't have that in other courtrooms; it's, 'OK, you did this, and this is what we're going to do to you' … there's no, 'maybe if we put this person in treatment instead of sending him off to prison' … . (Participant #6)

There was less agreement about restoring mentally ill offender's accountability, though surprisingly, it was not from the Participants themselves, but rather, among Treatment professionals. Most Participants believed not only that they had gained or regained accountability and responsibility in their lives, but that it was their duty to do so, when the Court team had done so much to help them. Several Participants especially cited the MHC Judge's faith in them when they were out of compliance as helping to guide them back. These are typical Participant descriptions of the Judge :

> He is compassionate … you can see in his demeanor that he actually cares … when you screw up, he's not mean about it, just says, 'this is what has to be done'. (Participant #22)
>
> He takes more time out … to try to figure out what needs to be done with somebody … to let you know how good you're doing … he encourages you to keep pushing forward. (Participant #6)

Despite assertions from some interviewees that the law enforcement side of MHC needed to be more focused on giving chances to mentally ill offenders, the researcher found evidence that indeed there were sincere endeavors by Criminal Justice professionals to do just that. In adapting their traditional roles, they sometimes helped in ways others on the Court team could not. For instance, in a sort of role switch with the Public Defender's Office, the D.A.'s Paralegal in MHC often went to other judge's courtrooms to advocate for transfer of probation on outstanding cases to MHC, for a potential participant whose referral to MHC was accepted. This professional likely

received cooperation from the other judges which might only have been given to the D.A., or maybe the MHC Judge.

Another instance the researcher observed was a MHC Probation Officer who took the side of a dually-diagnosed Participant who continually engaged in low-level, but self-destructive crimes. This professional, Court Team Member #23, took it upon herself to contact the Participant after news of an arrest, and to try to find the Participant new treatment or placement opportunities, seemingly never giving up hope when others on the team thought the Participant a lost cause. She told me she benefitted from mental health training engaged in both on the job and off, to gain an appreciation of the difficulty recovery might have been for this Participant.

When opinions about ensuring community protection were offered, again, it was Participants who were most convinced that society was safer with the Court's existence than without it. A few Participants spoke of persons they knew, before or after arrest, who were mentally ill, and in need of assistance and who could have used the Court's supervision. Participant #6 even said of himself, during the times he had to sit in Jail throughout his MHC tenure, he realized "the courts were backed up … because of the caseloads", but that his incarceration "also has to do with the choices I made … I had to have some kind of consequences of my behaviors and my actions".

Most Criminal Justice professionals concurred, and yet were more resigned to the fact that not every criminal act can be stopped by the criminal justice system, even with an extraordinary measure like MHC. Some Treatment professionals were somewhat non-chalant about the community safety question; they might be the Court team members others referred to as "blind advocates" for their mentally ill clients. Almost everyone

interviewed felt the community was generally better off with the Court, though a couple Treatment professionals expressed uneasiness that the mentally ill who offend might receive more attention and care than the mentally ill who never offend.

As for victims of crimes committed by mentally ill offenders, only Criminal Justice professionals charged with law enforcement even mentioned restoration for them as part of the MHC process. The D.A.'s Office manages all interaction with victims, if any victims exist. Victims do get a letter from the District Attorney's Office notifying them the defendant on their case was referred to Mental Health Court. Though it allows for objections to case acceptance, the D.A. does not affirmatively check with the victim unless a violent or invasive crime was involved. As part of the Victims' Bill of Rights in PA, victims may make oral or written statements in court, though they rarely do in MHC. And they are often told not to expect restitution be made to them (despite requirements of law for specific crimes that it be), based on the circumstances of mentally ill offenders.

The Probation Office is charged with collecting victim restitution as part of the sentence, and they will not sign off on probation stipulations which ignore repayment for victim loss. However, restitution was said to be a last priority for an earlier MHC judge, so the victim's understanding of the likelihood of being compensated is important to the D.A.'s office when obtaining victim cooperation. Nonetheless, several Participants spoke proudly of making regular restitution payments or having fully paid restitution.

What may have been most invaluable to this researcher was the opportunity to be present at quarterly Court team meetings. She was able to view the inner workings of the workgroup, condensed, and evolving. The agenda was set by the JRS Director, and confirmed by the MHC Judge, with input from each agency represented. It was the only

time the role of the researcher was in flux. The researcher was viewed as a nonpartisan observer, who was able to bring forth the view of an "outsider" when debates got too fierce. But permission to speak at these meetings made her somewhat like an "insider" to the workgroup. The benefit was in permitting immersion, and in allowing the researcher to refine her understanding of statements made by members on issues.

More was accomplished in these meetings than at any time team members were working with one another on individual cases. They were the crux of the Court team resolving disputes and continuing to work together well. This working relationship also allowed the Court team to design individualized responses to each Participant's needs, as opposed to fixed sanctions. Truly, they were able to accomplish restorative justice and partake in therapeutic jurisprudence, at least for Participants, by their willingness to get together and reconcile differences by consensus. Though it might be hard to explain, this Criminal Justice professional, Court Team Member #12, did so eloquently:

> You can just see it click with somebody, where they're like, 'this has saved me life'—and they mean it … when you have too much treatment, or too little treatment, or treatment when the person doesn't even need treatment because they need to be in Drug Court, then it doesn't work … but when you have the serious mentally ill getting the right amount of treatment and having that insight, and realizing that they don't have to live that life on the street anymore, and they're finally safe and have support, that's a day … with the right offender, that is when it clicks.

Graduation is the ultimate positive reward for the Participant, a public declaration that s/he has successfully completed the intensive probation. At the presentation of the embossed graduation certificate by the MHC Director, the successful Participant is lauded with clapping and kudos from the Judge and various Court team members about their history with the Court. He or she is offered the chance to make a statement to the

Court, which most of them take advantage of; some even prepare a written statement if they know the occasion is coming. It is a rewarding moment for the Court as a whole, and a chance to inspire current Participants about the opportunities they have, so they may continue to work toward recovery.

Evolution of Court Purpose and Philosophy

In the ten years since this mental health court was started, many of the basic structures of the Mental Health Court remain similar to what they were when in the first year of receiving cases. A few pivotal changes have occurred, and many less critical ones. There are both apparent changes and those more discreet. The list includes what types of referrals are accepted, what qualifies as a referral, whether political influence is exercised, what happens when service plans are altered, changes in designation of reviews given in Court, how probation violations are handled, and which cases result in revocations and terminations.

With each year of the Court's operation, as referenced in the section on *Identification and Meeting of Clients' Needs* and elsewhere above, the number of referrals grew, and along with it the caseload. At the formation of this Court, 400 referrals were anticipated annually (Valentine, 2000, *Allegheny County Mental Health Court Project*, p. 4). The most recent official report released regarding the Court shows that referrals steadily increased from 493 in 2005 to 616 in 2008, and a 34% increase in referrals took

place from 2006 to 2008 (Allegheny County Department of Human Services Office of Behavioral Health Justice-Related Services Unit , 2009). While statistics on the number of acceptances were not included, an earlier report indicated a 30 per cent acceptance rate (Fraser, 2004). But the number of MHC clients Justice-Related Service serves monthly is an indicator of both the growth of acceptance rates and of caseloads. With that average increasing from 190 to 255 in the period 2006 to 2008, the recent report added: "Since clients are supported by Justice-Related Services MHC staff until they graduate or their case is closed, which may take months or potentially years, these numbers are duplicative." (Allegheny County Department of Human Services Office of Behavioral Health Justice-Related Services Unit , 2009, p. 2). Numbers serviced refers to clients accepted and initially serviced by JRS; the point is that it does not include additional services provided by JRS throughout the length of the probationary period while they remain on caseloads of caseworkers, liaisons, and probation officers. The ability to deliver services and the level of service received could be compromised by multiple tasks affecting clients' care, as could the ability to monitor their activity. Time management pressure to handle this volume of cases has affected just about everything in the Court.

So do bureaucratic decisions affect total cases managed. Should more than one case be referred at a time for a new candidate, all cases must be acceptable for the candidate to be admitted. In spite of that, once someone is already in the MHC program, additional charges are not necessarily a basis for rejection, especially if the new case is for the same kind of charge already accepted. Earlier in the Court's history, however, there was an informal rule of reviewing three new (additional) case referrals before the D.A.'s office made a motion to expel the person. Such motions are rarely filed in recent

years; some participants have accumulated as many as ten new cases, yet remain in MHC, by the researcher's examination of hundreds of Participant case records and files. A possible reason is that such motions may be denied by the MHC Judge until a Participant has neared the expiration of their original probation, so that the current Assistant D.A. prefers to let the Judge take the lead.

An unusual referral is for someone who has already graduated from MHC, but it has happened occasionally over the years. The Rand report which evaluated the cost-benefit of the MHC made this guess as to referrals of MHC graduates, "Perhaps the mental health treatment system did not sufficiently engage these individuals after their probation ended or perhaps they are people who need the structure of periodic reinforcement hearings to keep them 'on the straight and narrow." (Ridgely, Engberg, & Greenberg, 2007, p. 35). Should graduates re-offend, if they truly gained from the process the first time around, they may prefer to come back to the Court rather than to face traditional processing. It is the nature of seriously mentally ill persons that their recovery may take some time to achieve, and that it may not be final in all situations. With that understanding in mind, being a graduate does not preclude a new referral and acceptance by the workgroup unless they have been through the Court twice.

Given the burgeoning numbers, sometimes probation periods were cut in half earlier than pledged to a Participant if they neared the half-way point of their probation, and had simply not received a negative review recently, even if they had received several of them in the recent past year. On the other hand, for those mentally ill offenders with a long record or a serious charge, the D.A.'s Office was often negotiating for longer periods of probation than the P.D.'s Office saw fit. Though the original goal of the Mental Health

Court was primarily to handle certain misdemeanors and lower-level felonies, it was also designed to be able to work with a mentally ill offender for a long enough period of time to see marked improvement in symptoms, life circumstance, and likelihood of re-offending. Participants could not initially be sentenced more than in traditional court, yet they might legally have served more time overall if they received probation violations, just as someone who violates probation in traditional court. It is important to note that in regular court, shortening a probation sentence would require a motion for modification of sentence be filed and granted; essentially, the informal making of a motion to graduate a MHC Participant prior to the expiration of the full probation sentence has taken the place of that process without any concurrent legislative change in the sentencing statutes.

Exclusions of certain charges, especially regarding violence, indirect criminal contempt of Protection from Abuse orders, weapons cases, or arson charges, seem to have been overlooked where enough pressure was exerted on the D.A.'s Office or the MHC Judge, either by the MHC Director or the Assistant P.D., or by private defense counsel. A robbery with bodily injury was initially deemed ineligible, but sometimes later accepted where the victim is a family member or friend who is not opposed; similarly, some gun or assault cases were pushed into court over the D.A.'s objections, without the mentally ill offender's trying to harm themselves (the stated reason for not banning those kinds of crimes entirely when the Court began). The informal referral process described in the section called *Identification and Meeting of Clients' Needs* above obviously leaves a good deal up to the judgment of the agency actors involved. Whether that allowance was intended or fair, and more importantly, whether it is even beneficial, are questions still unanswered by this research.

Opinions of those involved differed. Surprisingly, one Court Team Member, #17, a Treatment professional, had this to say:

> No, I think that the truly sick are going to struggle in MHC—the ones that are very sick—the ones that … don't understand that "If I leave a program, I could have consequences behind it." And what are we going to do? If they leave, you can't just let 'em go and be out there, cause if something happens -- usually, the only thing you can do it put in the warrant, and put 'em back in the County [Jail].

On the other hand, a Criminal Justice professional whom some others viewed as strict added: "People who are ill do commit serious crimes… it's great that we're starting to open up to more felonies because I really think those are the sickest people" (Court Team Member #12).

In a couple unfortunate instances for this MHC, particularly domestic violence cases, a Participant went on to badly injure or kill a girlfriend or to commit other serious assaults. There was also concern after two high-profile murders (one of a stranger) in 2008 by severely mentally ill persons on court-ordered JRS Support program service plans. Fingers initially pointed at the closing of Mayview State Hospital, then focused on lax oversight of patients at the University of Pittsburgh Medical Center's Western Psychiatric Institute and Clinic (Sherman, *Pittsburgh Post-Gazette*, 2008). Neither person accused of these homicides had been a participant in Mental Health Court where they could have been monitored more intensively and for a longer period, nevertheless, the ripple effect of the shock these cases created seemingly resulted in a more careful look at crimes of violence coming into the Court.

A few minor misdemeanor sex crimes have been permitted into the Court over the years, such as indecent exposure or even an indecent assault where the victim is not a child, or the facts were too weak to prosecute the offender on a more serious charge.

Luring a victim may be accepted with no prior record, but with any history of dangerous behavior, the charge is usually rejected. However, when one mentally ill offender with a record of child molestation was permitted to come into MHC on a non-sex charge and later arrested on a child luring case, the MHC team renewed consensus on strictly limiting sex offenses from Court. As much as some members of the Court team might like to expand the Court's jurisdiction to accept more serious charges, everyone on the team is keenly aware of what damage a high-profile case could do to the good will of the Court. And the Rand Report, though commissioned to analyze the costs of jail versus treatment in MHC, discerned that "the lack of graduated sanctions in the current program model" was important in relation to staffing shortages and taking on more felons into the program (Ridgely, Engberg, & Greenberg, 2007, p. 35).

Some referrals without an Axis I dual diagnosis for mental illness and drug dependence who did not meet Drug Court eligibility requirements might still push to be admitted to MHC despite inappropriateness for the stated purposes of MHC. These may have been those diagnosed with Axis II disorders (such as personality disorders) who so often seemed to fail at structured directives and continued to use street drugs and to miss scheduled mental health treatment, drug tests, or reports to Probation Officers. Complaints by Criminal Justice professionals that this type of mentally ill offender was not intended for Mental Health Court were substantiated in a couple of cases where the Participant indeed had only Anti-Social Personality Disorder, Impulse-Control Disorder, or an adjustment disorder, none of which is categorized as Axis I mental illnesses, but who had still been accepted into the Court.

Cases which circumvented the referral and acceptance process altogether were dubbed "back door" cases by the D.A. and JRS staff. First of all, without a formal referral, the person is not checked for whether his or her diagnosis, charges, or criminal history is appropriate for MHC. Even if one assumes the criteria were met, sometimes an assessment would never be done on the person, or he or she would never be scheduled for a court reinforcement hearing. Thus they would be suspended in regular probation, where no one was intensively supervising them or reviewing them in Court, nor was a treatment plan formed for them or services and supports put into place. Another problem that should be foreseeable to the Court team prior to an already sentenced transferee coming into MHC becomes patently unclear after a new offense occurs: Which court should handle the probation violation? That is, does this defendant belong to the MHC, or is he under the jurisdiction of the original judge's court?

Here is an example of where a "back door" case made for a public safety problem and a glaring jurisdictional dispute for the Mental Health Court: a man with several assault cases was sentenced on 5 cases by another judge. He had a diagnosis that would have been acceptable to MHC, but a lengthy record that probably would not have been acceptable to the D.A.'s office. The judge assigned to his cases supposedly transferred this man's probation into MHC. This decision was either not communicated to the MHC workgroup, or was communicated to one of the workgroup members but not shared with the others or followed up as expected. In any event, this defendant's case went unnoticed and he remained unprocessed by MHC. Several months later, he was involved in a retail theft where he was apprehended by a police officer performing a security function in the department store where the theft occurred. The defendant managed to take the officer's

handcuffs during the attempted arrest, and in a fit of rage, he struck several blows to the officer's head with the cuffs, knocking him down and injuring him.

Transfer of this man's probation might technically have occurred, but the offender was never formally listed in the state criminal records database as being in MHC. The original judge ended up handling both the probation violation and the new charges, perhaps due to the MHC Judge's insistence in this one case. This may have been a fortuitous outcome for MHC, given the bad press the case received. But it does not answer the question of how to handle other cases that come into MHC through the "back door".

Where a case is transferred from another court pre-sentence, it could procedurally be sent back to the original courtroom, but the criminal bench would frown on sending the case back after having asked the original judge to give up jurisdiction on the case. (Administratively, the Allegheny County Common Pleas Court only permits transfers between courtrooms when a plea is to be entered in the receiving courtroom, to prevent "judge-shopping", though that would not be occurring with a revocation). Furthermore, where "back door" cases were transferred into MHC from other courtrooms post-sentencing, probation violations are technically a breach of another judge's sentence, and so must be acted upon by that judge—something the MHC Judge does not want to ask them to do to ensure their cooperation in referring cases to the Court.

Other original directives have been overlooked or excepted for certain persons. For example, unlike some mental health courts, participating in this Court was to be a permanent part of the criminal record. What participants gained in exchange was diversion from incarceration, needed supervision, and assistance finding and paying for

treatment, housing, transportation, and other supports. Although one can come into this MHC either upon pleading guilty or upon having been found guilty after a bench trial, they were not to be able to receive ARD (Accelerated Rehabilitative Disposition) while in MHC because in Allegheny County, successful completion of ARD results in an automatic expungement of the criminal conviction. However, a few MHC participants, one of whom is an attorney, were admitted into ARD for the case referred to MHC. While the rest of the MHC Participants may not be aware of these exceptions, nonetheless, it is unfair to them, as they were not given the choice to clear their records after participating.

Service plans, a vital purpose of the MHC arrangement, are not being managed as set forth early in the MHC process. They were intended to be a contract with the mentally ill offender diverted from jail. A service plan told the mentally ill offender what was expected of him or her during probation and what would be provided for in return. Thus, it was in writing and the defendant was required to sign it, acknowledging its receipt, when it was presented at his or her plea or trial date. The JRS caseworker (from whichever program prepared it), along with the Special Services Probation Officer and the MHC Director, received a copy to maintain for monitoring purposes. The importance was that the mentally ill offender had it to refer to, so as to not be caught unaware as his or her mental state possibly changed. Unspoken was that it protected the Court and agencies involved in the event a major violation occurred. When major terms to the service plan were adjusted, it was supposed to be re-written and the amended copy re-signed--a logical procedure for the Court. Early in the Court's chronology, this occurred

regularly. As the caseload grew, filling out the amendments seemed to fall by the wayside, just as reading the service plan terms into the record in open Court did.

Another change regarding cases existing in Mental Health Court was brought up in the section on *Workgroup Interaction and Decisionmaking*. Since 2007, a "neutral" review began to be used as a compromise when the non-compliance was not substantial, or facts about a violation were in dispute. The neutral review has been used effectively, when a Participant who was not taking prescribed medications advises the Court that his attempts to tell counselors or physicians about side effects experienced were overlooked. Rather than sanction a Participant in that situation, the Judge might direct the Probation Liaison to facilitate communication between the Participant and counselors and call the Participant back to Court in a week or two to re-evaluate the developments. For more difficult cases, the Judge has called the physician into Court to explain the history of prescriptions and prognosis before compelling a Participant to go against his own wishes for treatment. Less clear are those cases where a Participant has in fact been non-compliant, such as providing a dirty urine screen, but the Judge enters a neutral review with the promise that it be converted to a positive review should the Participant provide a clean drug screen the next week. This may be an effective incentive for Participant cooperation, but it confounds accurate evaluation of progress based on case history.

Once in MHC, very rarely does a non-compliant defendant voluntarily remove him or herself from MHC and choose to deal with traditional processing on his or her own. Participants who violate probation too many times, and do not respond to chances at treatment or progressive sanctions, may be expelled from MHC. The procedure if persons are to be expelled is to have their probation revoked and then be re-sentenced on

the original charges. They can then be sentenced for whatever period they could have received at the outset (minus credit for any jail time served), as well as supplemental time on any probation violations they incurred. The revocation procedure was followed in the past, either upon the motion of the D.A.'s Office, or the Probation Office, particularly with the second MHC Judge, who was the County's prosecutor for two decades prior to becoming a trial judge. It almost never happens in recent years, however. Though one Participant who had only been in court a few months warned, "Don't mistake the Judge's kindness for weakness", insinuating defendants who do will be jailed or kicked out (Participant #19), a Participant who spent five years or more before graduating declared, "… very rarely have I seen him [the Judge] revoke somebody unless they really did something . . . that their probation needed to be revoked." (Participant #6).

Changes, too, have taken place in the handling of those cases which are indeed terminated. Allegheny County lists facts about its Mental Health Court on the Criminal Justice/Mental Health Information Network website. There, for the component called "Case disposition upon unsuccessful program completion", it states: "Participants are returned to the court of original jurisdiction for case processing" (Allegheny County Mental Health Court, 2009, Program Listing, Mental Health Consensus Project, " Case disposition upon unsuccessful program completion"). In fact, this rarely if ever happens in Allegheny County's MHC. Instead, the Court will do what the Court team refers to as "closing interest" in the case of a difficult (non-compliant) participant. The current MHC Judge has undertaken the act of "closing a case" for an incorrigible participant, in essence closing out his or her probation prior to its natural expiration. In effect, the court ends its own jurisdiction over the offender's probation *sua sponte*, effectively terminating that

participant's involvement in the court, but taking no action to revoke their probation or to transfer the case back to the general docket. Nor is the fact of "interest" being "closed" in a case recorded anywhere on the state's computerized docket sheets for Common Pleas Court cases, however. Therefore, a public search of a case may show an offender as being officially on probation when in fact the Court is not exercising any control over that defendant. Or it may lead one to believe the offender successfully completed MHC.

The reasoning given for this action is that, by the time the Judge agrees a participant no longer belongs in MHC, the participant has served most of his original probation sentence. This philosophy does not take into account jail time such Participants might have received on additional charges accepted into MHC after their original referral, had they committed those offenses while on probation in traditional court; nor does it account for the probation violation time they might have received had their cases been revoked. Underlying the reasoning for this philosophy could be an expectation that any person who repeats offenses while within the confines of MHC is sure to commit other crimes and to be arrested again when out of MHC anyhow. However, if they do so, they will not have a probation violation hanging over their head, since the MHC Judge has now closed out their MHC probation. "Closing the case" does make room for someone else to join the Court, but so would revocation. It merely lets unsuccessful participants fade out quietly, which invoking revocation would not.

Satisfaction of Court Objectives

One can confidently say that Allegheny County's Mental Health Court has tried to encompass all of the ten "essential elements" of a mental health court as defined by the Mental Health Consensus Project of the Council of State Governments and the Bureau of Justice Assistance. The elements were put forth in Ch. II: planning and administration; target population; timely participant identification and linkage to services; terms of participation; informed choices; treatment supports and services; confidentiality; court team; monitoring adherence to court requirements; and sustainability (Thompson, Osher, & Tomasini-Joshi, 2007). To what degree these elements have been accomplished or satisfied has been the subject of much of this dissertation.

Several matters to be resolved by the Mental Health Court were listed in the first two years of those unpublished semi-annual reports on the Court from 2002 to 2005 (described in the section on *Identification and Meeting of Clients' Needs*): that MHC clients were not being released from jail in 30 days as desired; that the stigma of mental illness and a criminal background was making access to public housing difficult; that criminal justice staff and forensic mental health staff needed to become more educated about each other's fields; that funding was needed for an additional MHC Probation Liaison, and that inappropriate referrals were being made "by various sources as a 'last ditch effort' to avoid jail or to try to assist individuals who have no other option" (Kroll, 2005b, p.4). As those reports progressed, important notes were that charge information was not entered for about one-third of persons referred, and that "[f]or several reporting

periods, the data available from the electronic information system eCAPS did not correspond to pen and ink data kept by staff" (Kroll, 2005b, p.5).

Findings from a limited evaluation study of years 2002-3 also referenced above indicated that "a significant number of referrals had to be eliminated from the sample due to the absence of an MH Diagnosis and Offense" (Petrusic-Cooper*,* 2006, p. 5). It also stated that referring parties needed more training to make appropriate referrals. The study was requested by the County's Office of Information Management to measure program success of the Mental Health Court and to discern whether or not eCAPS data was capturing outcomes on recidivism, cost, and diversion of low-level offenders from jail. But the author declared that "Success (graduation) cannot truly be determined as the data collected in eCAPS alone does not fully capture the outcomes of the program", recommending that "data entry is a program issue that needs to be addressed internally" and that "[m]ore complete data will ensure a better representation of referrals into the program." (*Petrusic-Cooper,* 2006, p. 7). The only concrete conclusions that could be made about the Court's effectiveness were that being white, in jail at the outset, and having more positive reviews at hearings increased the likelihood of graduation.

To address some of these problems, the Mental Health Court program received about $300,000.00 in additional funding for services from the Bureau of Justice Assistance, Office of Justice Programs in 2003 for the two-year period June 2003 through May 31, 2005. In the semi-annual reports, the grant was obtained to "build additional components to significantly affect recidivism and register lasting changes in the lives of individuals with mental illnesses in the criminal justice system", including the "addition of a Community Treatment Team (CTT) component … for individuals with complex

histories and multiple needs", and "training to enhance appropriate referrals" since "various sources" were making referrals "as a 'last ditch effort' to avoid jail or to try to assist individuals who have no other options" (Kroll, 2004, p.3). It was reported that Justice-Related Services forensic staff made presentations to community stakeholders and mental health advocacy groups for their cooperation in educating judges, magistrates, probation officers, public defenders, and district attorneys about the Court's services; and staff developed a new brochure "directed to attorneys and court personnel with the goals of facilitating appropriate referrals to MHC as well as assisting the MH Court to the legal profession in Allegheny County" (Kroll, 2005a, p.2).

Whether Court objectives were being met generally or specifically depended a great deal on whom the researcher talked to about the various objectives posed of the Court at its inception, and the fact that objectives seemed to be changing over time. The mission of the Mental Health Court was stated earlier in this chapter in the section on *Founding and Purposes of the Court.* In the present section, findings are arranged according to the premises of the mission statement. To reiterate, the statement was that this specialized criminal court was to advocate for increased public safety and reduced recidivism rates of mentally ill offenders, by focusing staff, resources, and expertise on the unique needs of these offenders, and by incorporating comprehensive community-based treatment and services as mandatory sentencing requirements, thereby ensuring just process of law, promoting public safety, and improving quality of life for offenders.

To the agreement of most interviewees, community-based treatment and services were being provided fairly comprehensively under the Mental Health Service Plans to make for "improved quality of life for offenders", and the satisfaction of other parties

concerned, like family members and even law enforcement officials who once had to deal with these offenders when symptomatic. On reflection, the greater weight of monies spent to achieve the Court's mission quickly drifted to the treatment end of Court functions. As referrals to community treatment providers grew, along with County or state payments or reimbursements for that care, the numbers of providers and ranks of their staff have seemed to grow. (This trend has occurred County-wide; Allegheny County no longer handles direct provision of social services to any population, with the exception of primary casework services to neglected and abused children.) But the Mental Health Court still needed improvements for Participant care earlier in the process.

As per the Court's mission, for the most part, Court team staff was obtaining specialized training and using those skills to focus on and address the unique needs of mentally ill offender. Still, the numbers of staff processing the cases and monitoring the sentenced offenders has grown, too, but not nearly in proportion to that of providers. That gap has had a number of ramifications, as expressed by both Court team members and Participants interviewed. One example was that "Forensic Case Managers" assigned to a mentally ill offender's case could not always be maintained throughout the probation, as originally intended. Staff members either turned over (typically Support Specialists), or were cases were re-assigned to handle caseload overflow (to Probation Liaisons).

As originally conceived, persons referred to MHC were assigned a "Forensic Case Manager" (later called "MHC Specialist", now "Support Specialist") to work with them on forming a Mental Health Service Plan for their treatment and release, and to attend hearings with them. Because the caseworker may not have been assigned until after their referral was approved months later, the service plan might not be developed soon enough

to address their needs. For example, if they were released from jail prior to acceptance into MHC, supports such as housing or medication might not be in place; or if they remained in jail awaiting acceptance until their first appearance in MHC, the service plan might not be formalized in time for their release at their plea date. When the goal of adjudicating MHC cases within 3 weeks of referral was no longer reasonably attainable, Justice-Related Services amended their procedures for assigning caseworkers to clients.

As of 2010, JRS now assigns a Forensic Case Manager to each person referred to them after their referral is processed. All JRS caseworkers are now called "Support Specialists", because their function in providing supports to a client is pretty much the same, whether the person makes it into MHC (with longer-term case assistance and monitoring) or not. And each Support Specialist now handles both Support Program (with short-term case assistance and monitoring) and MHC cases. Either way, the caseworker now drafts a Mental Health Service Plan for clients as soon possible. Should the case be accepted into MHC, that Support Specialist will present the initial service plan to the Court, just like the "Forensic Case Manager"/"MHC Specialist" used to do. With burgeoning numbers of cases in its Support program as well, JRS has nearly doubled the number of forensic caseworkers on staff in the past couple years to try to accomplish this goal. For MHC candidates, then, they now are to get a caseworker right after the assessment is conducted, more in keeping with the original MHC goal of early intervention. This addresses the clients' needs early in the process, even before acceptance into MHC, and through the first reinforcement hearing if they are accepted.

Another result of limited workgroup staffing: manpower to monitor the additional stipulations of MHC sentences is affected. The Special Services (forensic)

Probation Officers in Allegheny County Adult Probation who monitor cases after sentencing worked hard to guarantee that intensive level of supervision. They do receive continued training on behavioral health and management, and they do actively try to integrate probation functions with mental health resources for their probationers, as suggested best practices for Specialized Probation units focusing on probationers with mental illness (Center for Behavioral Health Services & Criminal Justice Research, 2010). Yet they were not allotted the "reduced caseload" foreseen, as described in the section on *Founding and Purposes of the Court* above, to always allow them the personal supervision time with participants necessary to maintaining intensive supervision. These officers might not have the same paperwork responsibilities with their MHC probationers as they would with traditional probationers, processing probation violation petitions and attending violation hearings. But they have additional duties for them such as weekly MHC court appearances, more frequent office and home visits with their charges in the field, more frequent drug testing, and investigation of treatment options for mentally ill probationers who encounter troubles with current placement or circumstances. The better these special Probation Officers were at their jobs as a group, the more cases seemed to be assigned to their division. Each of the six specially trained P.O.'s in Allegheny County MHC carry forensic caseloads atop their MHC forensic caseload. In all, they reported carrying from 100 to 120 mentally ill probationers apiece.

After a MHC Participant is stabilized with all supports in place, their case is still passed to one of two MHC Probation Liaisons (also on Justice-Related Services staff) for weekly monitoring of progress or lack thereof, to report to the Court at reinforcement hearings. Should treatment or other supports need to be adjusted thereafter during their

sentence, though, the task is now left to the Probation Liaison to address, not the Support Specialist caseworker any longer—even if a complete re-working of the service plan was in order. And of course, the JRS Probation Liaisons had ever-increasing numbers of MHC Participants on their rosters, too, allowing them less time with each Participant for whom they had to report on at reinforcement hearings[8], and less time for recordkeeping regarding the nature of Participants' review hearings. When the Probation Liaisons, Justice-Related Services employees, took on these casework duties in additional to monitoring and reporting, their burden was compounded.

In mid-2010, the JRS Director, who had been sheparding the forensics department of Human Service for two decades, took a new post within the Allegheny County Jail and many of her duties, such as reviewing referrals and supervising all caseworkers, were taken on by the former JRS Support Supervisor. Late in 2009, the administrative duties of the exiting MHC Director, such as attending referral and Court team meetings and keeping acceptance records, were assumed by the existing JRS Drug Court Director. Neither position was replaced within JRS. (Assessments continued to be conducted by an intern for MHC, who was not a Treatment professional or a Criminal Justice professional.) Those funds were made available to hire several of the forensic Support Specialists mentioned above. The trade-off was that no longer is one person in JRS dedicated to full-time oversight of MHC, or available for crisis management for the problems that so often arise with MHC participants. Nor has an additional MHC Probation Liaison been added to JRS staff as was planned several years earlier. Thus,

[8] Recall that the role of reporting to the Court was initially meant to be performed by Special Services Liaison Probation Officers, as explained in the *Identification and Meeting of Clients' Needs* section.

each of the two Probation Liaisons still carries a caseload of about 100 MHC participants each—far too many mentally ill offenders to guide, even if all of them were stabilized.

The just process of law might be ensured or not, depending upon where in the Mental Health Court process a mentally ill offender finds herself—referral, acceptance, reinforcement hearing, sanction, graduation or termination. As discussed in the section on *Identification and Meeting of Clients' Needs*, though more referrals were coming from some of the sources originally anticipated than others, there is no question the numbers of referrals to the Court have grown drastically in each year of the Court's existence. The most recent MHC Director explained that, according to database he kept, nearly a third of referrals were pending at any one time while the acceptance process moved along. The one-month time period for adjudicating MHC cases contemplated by the Mental Health Court Task Force to reduce the amount of time mentally ill offenders spend in jail and to assure mentally ill offenders kept supports in place was most often not being satisfied, as verified by Court Team Members #20 and #21, who had dealt with frustrated referrals waiting in Jail. This was a reason for concern for most everyone interviewed.

Generally, the D.A.'s Office would only consider a case for acceptability at the formal arraignment stage, since a case might be resolved at the preliminary hearing stage. And systematic deadlines had to be followed for cases at a later point in the criminal justice system, or else they may lose track of the case (i.e., waiting until a trial date was set in another judge's courtroom before transferring a case to MHC). Steps taken by the D.A.'s Office are several, but necessary: a full review of the person's criminal record and any outstanding charges; a calculation of the sentence(s) range that PA's sentencing guidelines would require, for plea negotiation as well as for MHC sentencing; and

contacting the officer on the case, and victims, if any. Each step takes time, especially when the list of persons referred was voluminous. Regrettably, those arrested might languish in jail for weeks or months in the meantime, a fact that was foremost to many Treatment professionals and some Criminal Justice professionals interviewed. The MHC Judge can order that placement be expedited when the person might be in danger of debilitation in jail. Eventually, a Paralegal from the D.A.'s office was dedicated to aid in performing some of these essential administrative functions, but the time it took to proceed from referral to acceptance was still very often several months.

The Mental Health Court Monitor (now MHC Director) used to try to locate released persons who were potentially acceptable but who did not respond to an offer to participate, by mail or visits to the last known address. Currently, with its caseload, the Court has a wait list, and time no longer permits that effort. Now the Assistant P.D. sends out notice to sign a subpoena for an initial MHC appearance once a potential candidate is accepted. If a candidate was deemed acceptable but did not appear at the pre-trial conference date to sign a subpoena, he or she would not be removed from the list of acceptable cases until their original trial date, notwithstanding absence; the latter date is a back-up, in the case of failure to attend the initial MHC appearance. The Assistant P.D. checks to see if some outstanding issue exists, such as a detainer or a warrant in another case which landed them in jail, or being committed to a psychiatric hospital. (Such tasks could also be performed by Probation or by the JRS Probation Liaisons, but are not.) Clearing detainers or warrants by the A.P. D. also takes time; those persons will be moved to the back of the pending list. If the candidate cannot make the bond set, sometimes a bail reduction hearing would be scheduled, otherwise, the candidate must

agree to wait for the initial MHC plead-in date to have the MHC Judge reconsider bail. Several Participants expressed dismay that it took so long to get started in MHC and a desire to improve this system for future Participants.

In many instances, Justice-Related Services would receive duplicate and triplicate referrals on the same charges for that person in the interim while the candidate awaited acceptance. Each referral had to be processed, and if the original referral file folder could not be located, much time was wasted with staff repeating efforts and candidates or families making inquiries. If the person was still under consideration at the time for the pre-trial conference, the case would be postponed to allow the MHC process to take place, with the delay counting again the D.A.'s Office. Once the pre-trial conference was scheduled, the D.A. could request that the defendant sign a waiver of his speedy trial rights so that the delay would count against him/her instead, particularly if the defendant had other pending cases in the system to resolve. Thus, an acceptable referral could be salvaged, but not without some pains to the MHC candidate who may have gone without support or monitoring, and inconvenience to staff responsible for processing their case.

The Mental Health Court was meant only for those with persistent and severe mental disorders. Given that the JRS Support program has existed for nearly two decades, and the census population of Allegheny County has continually declined throughout those two decades, barring some strange increase in the number of seriously mentally ill in the County, the fast growth of the MHC in the decade of its existence can only reasonably be attributable to two main factors: publicity/word of mouth, and relaxing of acceptance guidelines. Statistics pulled from the eCAPS (Electronic Client and Provider Information System) database by the data analyst for the Office of

Behavioral Health showed that in the period 2006 to 2008, very few referrals to MHC were denied, excluded, or refused, perhaps ten per cent of those together at best, and once accepted, even fewer cases were removed from Court in that period for violations (Allegheny County Department of Human Services, Office of Behavioral Health Justice-Related Services Unit, 2009).

Several Participants, despite wanting to expand the Court to reach others, felt it was "likely people manipulate a way in who don't belong"; that "some might just seek it to avoid jail"; or there were "some people that shouldn't be there" (Participants #5, #22, and #9, respectively). Participant #17 believed that "The community is at risk . . . on hearsay of MHC . . . people just walk on from the street and get into court", regardless of actual illness. One of the preceding sections touches upon referrals being passed on for potential acceptance without a major mental health diagnosis by a qualified professional. When the MHC Director was a licensed psychologist or social worker, Justice-Related Services was added as a service coordination unit in the County's eCAPS database. Thus, the MHC Director gained authority to input a diagnosis into the County's public mental health registry, although there was no equivalent assurance that this position be held by someone who could legally make a psychiatric diagnosis. But substantiation of the diagnosis was left up to Justice-Related Services (Department of Human Services) by the other agencies involved in the MHC, so no one audited this Court function. Similarly, the "back door" referrals alluded to above were not subjected to any scrutiny about diagnosis. A question of fairness arises here, for the Court's resources were sometimes being used for those who should not have qualified, while others who may be properly eligible were put on a wait list.

Often, on the other hand, there is no good explanation for why a supposedly seriously mentally ill offender has not been referred to MHC at some point earlier in the criminal justice process than post-sentencing, such as the "back door" cases described above. If the original judge assigned to the case is convinced that a defendant is seriously mentally ill, it would have been simple enough for that judge to ask the defense attorney to fill out a referral form, and to postpone sentencing until learning whether the referral was accepted. Delay in referral only harms the mentally ill offender needing assistance. Nonetheless, it has been problematic to get some of the other judges on the criminal court bench in the County to follow the protocol for referral or acceptance into MHC. It is possible this is really a problem of defense counsel knowing his or her client would be otherwise unacceptable for MHC and making the suggestion so late in the process that no one wants to hold up sentencing, or simply a judge agreeing to transfer to get a case off his or her docket by passing it off to MHC. Absent a directive from the administrative judge to the other criminal court judges, there does not seem to be a solution to this problem. The fear is that a directive might reduce cooperation by other judges in lifting detainers on MHC participants who have charges in those same judges' courtrooms to allow participation in MHC. Naturally, any judge wants to exercise control of his or her own docket, and that is why the MHC Judge has not sought such an order. In any event, after ten years in existence, the MHC protocol should be well enough known to stakeholders in Allegheny County to follow it.

The goals of advocating for "increased public safety and reduced recidivism rates of mentally ill offenders" was generally agreed upon as being met, but specifics of these goals were debated among those interviewed. Reinforcement hearings were being

regularly held for Participants once accepted into MHC, that is, so long as mentally ill offenders were not MIA or otherwise in violation of reporting or communication requirements. Even if a warrant was issued for a delinquent defendant, they had to be located to be brought into Court. Finding MHC Participants who are MIA did not seem to be a priority of local police forces; MIA Participants were generally not placed on fugitive lists, and were more likely to be re-arrested when a new crime was committed. As ranks of its Participants swelled, the Court did not "reconvene immediately to problem solve and implement appropriate interventions" for "any non-compliance", as initially envisioned by the Task Force; there were now too many cases to allow for that. But emergency hearings were scheduled for the next upcoming Court date for Participants arrested on a warrant or new charge, absconded from placement, or relapsed mentally or with substances. And when the list of scheduled reinforcement hearings would be too great to cover along with pleas each week, the Court started to schedule bi-monthly dates just to hear pleas. Of course, an additional Court day meant less time for casework, fieldwork, or paperwork.

A few Court team interviewees pointed to reluctance to including the sanction of incarceration for non-compliance to preclude the public being at risk, and yet felt the Court made the community a safer place. Some emphasized that with the Court straying from its early plan to limit jurisdiction to "non-violent and misdemeanor cases", public safety was jeopardized, while others felt casting a wider net boosted safety by the increased supervision provided by Mental Health Court. Likewise, Court Participants had conflicting beliefs about community safety: although they almost universally appreciated being diverted from jail themselves, sometimes they believed other

Participants needed to be incarcerated when repeatedly non-compliant, to protect themselves and others.

And a question remains, too, as to whether the persistently mentally ill who have committed serious crimes or who have lengthy criminal records belong in this MHC under its current format. Certain other mental health courts do accept felonies; some, such as a division of Brooklyn's Mental Health Court, are designed to accept only felony charges, however, these courts have highly structured graduated sanctions. Graduated sanctions are designed to check violations of probation stipulations with increasing penalties up to re-incarceration and revocation that are triggered at specified types or numbers of breaches (Fisler, 2005, pp. 597-9; 600). Once again, the Rand report, though not a procedural evaluation, said this in its conclusions about the shift in the Court's design from one for low-level offenders to one accepting felons or those with serious criminal records: "… perhaps it is time to evaluate whether the supervision staffing is sufficient for the program to handle larger numbers of serious offenders." (Ridgely, Engberg, & Greenberg, 2007, p. 35).

An interviewee familiar with mental health courts related to the researcher the structured sanction and supervision level of the Cook County, IL, mental health courts: In its first phase, the offender is kept in place for the first month with more reporting requirements; if they get into treatment and are taking medications, they move to the next level with less reporting and more privileges. Still, this Criminal Justice professional, Court Team Member #12, felt implementing such a format in this MHC:

> would be a major overhaul … we tried to do sanctions, like if they relapsed once, they would have to do this . … to make it very standard, but it is so difficult .. the range of illnesses and people … that we're working with, they

> don't correlate with each other sometimes … you have high-functioning, low-functioning, and you can't do the same things for each person … .

Satisfying the objective of reducing recidivism rates was not as clear a result as touted by the Court. At first, there was to be a limit on the number of new offenses that would be accepted into MHC, and unofficially it was three, as mentioned earlier. Yet this guideline was seemingly abandoned over the years, and no agency involved with the Court took it upon itself to monitor participant recidivism. It could be that in seeking to cooperate with each other, Court team members just find it easier to continue to give chances to non-compliant participants than to expel them or revoke their probation. As one Treatment professional, Court Team Member #19, revealed: "You hate to see people getting kicked out of the court; I wonder, 'Did we fail?' 'Did we do all we could do to make this person successful?', rather than just wondering what the client did wrong".

This person stressed there are those one would expect would never do well in Mental Health Court, and yet end up doing well, therefore, the workgroup ought to keep trying alternatives "until they found the right combination". The interviewee pointed to the example of someone that was ready to be terminated from Court, until the Court team met with his family. (This author interviewed that very Participant, a schizophrenic, who confirmed that some of the workgroup were ready to give up on him, but who eventually graduated). Getting the family's perspective on him "made them realize he was being genuine; he was a real person. He just needed more help." (Court Team Member #19). Whereas, this interviewee admitted, there are clients for whom Mental Health Court just does not work; in those cases, she thought there might be too much structure from coming to Court frequently to go through the scrutiny of reviews, which they cannot handle.

Not giving up on those mentally ill offenders or others after repeated non-compliance may aid a participant struggling to comply, but on the other hand, it may be a disincentive to other participants observing the Court's response to their non-compliance. Moreover, the numbers of violation hearings dropped off significantly when the current MHC judge took over the Court in 2006, as did the numbers of participants returned to jail for violations or new charges. It is notable that a trend of more positive reviews at reinforcement hearings has slowly grown in recent years as per eCAPS statistics, too. This trend could be explained simplistically by saying more participants are meeting their probation and service plan conditions. On the other hand, it might be explained more realistically by that new incentive explained in the section *Evolution of Court Purpose and Philosophy*, the "neutral" review, employed to get participants having trouble complying to change their ways, or by broader changes in what is viewed or handled as non-compliant behavior.

As explained in the section above on *Founding and Purposes of the Court*, essential data about MHC cases was to be kept in the County's Electronic Client and Provider Information System (eCAPS) database. Reviews given at reinforcement hearings were to be recorded there so that individual case history could be tracked for coordination of care, and systematic information on Court effectiveness could be evaluated for better decisionmaking. Reasons for negative reviews were to be logged, such as new charges, adjustments to treatment, substance abuse. They were with some regularity until the MHC Director and Probation Liaisons were overwhelmed with casework. And there is, in addition, no place for recording "neutral" reviews in eCAPS, so neutral reviews might be entered there improperly as positive or negative, or not

entered at all. Somehow, the Office of Behavioral Health recently issued a report that purported to give actual percentages for positive and negative "Reinforcement Hearings" (meaning reviews given at those hearings) and made conclusions about Court graduates being successfully identified and diverted (*Allegheny County Department of Human Services*, 2009)[9]. In earlier chapters, it was reported that those entries sometimes had to be completed or corrected by this researcher, so she is not reporting those numbers, because from observations of entry patterns, they may be inaccurate.

Quantitative studies of other mental health courts where more distinct records have been kept were able to find statistically significant differences in populations. For example, Gurrera concluded of the North Carolina mental health court she evaluated that "non-completers had a consistent pattern of failure to engage in and remain treatment compliant which the MHC team interpreted as unwillingness to work with the court to change their lives and resulted in termination … ", since both completers and non-completers were arrested during mental health court participation, and re-arrest did not immediately result in termination from that program (Gurrera, 2007, p.214). Without better records, I am not certain that the instant Mental Health Court could conclude, for example, as Gurrera did, that reduced arrests for completers and decreased arrest severity for both completers and non-completers is evidence of effectiveness in screening referrals for those who can be safely diverted from jail into treatment.

Earlier in MHC history, the most common problem might have been a transfer to or from Mayview or Torrance State Hospitals. Currently, many of those on the calendar

[9]At times the researcher entered missing review outcomes, or corrected entries that differed from what was stated on the record in Court; and there is no place where neutral review data, which was included in the report, was kept to her knowledge.

for Mental Health Court show problems that should have rendered them unacceptable or gotten them expelled: warrants for being a fugitive; new arrests putting them in jail; other probation violations; new cases on the pending list; transfers to, or detainers in, other counties for charges there. It is not necessarily unanticipated that some mentally ill offenders would face new charges and detainers while under the jurisdiction of the Court. But the idea of the Court is that wayward behavior will wane, or else progressive sanctions, up to termination, be applied. Participants in MHC are almost never revoked for probation violations and removed from the program anymore unless the new charges will definitely result in time in state prison, even if the D.A.'s Office does not agree to the new charges being accepted into MHC. The only possible way to remove people from MHC, it seems, other than their own decision to quit, is for trying the Court team's collective patience one too many times. This is an observation shared by many Participants, as related above.

And, though persons on detainers for state or other county's charges, or fugitives on warrants have never been eligible to come into MHC, when they committed crimes resulting in such detainers or warrants after already having been admitted into the Court, the question of what to do with their cases arose. In the past, cases might simply be closed if a detainer or sentence elsewhere would prevent them from attending MHC for any length of time, or the matter was certain to result in an unavoidable sentence outside the County. Instead now, Justice-Related Services typically advocates on their behalf in the external jurisdiction for their release based on participation in Allegheny County MHC, and their MHC case is now held in abeyance awaiting their person's return. While

this result may ultimately be better for the non-compliant Participant, it means their case is one more on the roster while others await processing or aid.

Given probation terms spanning 1 to 4 years at initial MHC sentencing, with the kinds of referral and acceptance rates mentioned, the expansion of the Court could not help but be exponential. Thus, it is no surprise that pressure began to be exerted to close cases as soon as possible, a fact acknowledged by supervisors of two key agencies involved in MHC. Without a concomitant increase in staff on the Court team, logically, something had to give. Whether Participants are graduating too early for the sake of the community or themselves is not clear. In some cases, one or more of the requirements set out for graduation, particularly one that at least two-thirds of all MHC reviews be positive, were being overlooked[10].

Suggestions for Reforming Court Operations

Although the Mental Health Court is managing a large volume of cases annually with a dedicated staff, there are issues of concern to be addressed. They include expediting preliminary procedures, refining key workgroup tasks for consistency and fairness, relieving workgroup overload to better service and monitor Participants,

[10] And that is, with the assumption the information that has been entered into the eCAPS (Electronic Client and Provider Information System) database on reviews is reliable; just as the researcher has witnessed no one regularly entering data on repeat offenses by MHC participants during probation into eCAPS, so, too, has she experienced outcomes of reinforcement hearings either not being entered on the MHC follow-up pages, or being entered incorrectly.

avoiding Participant misunderstandings about program standards or components, respecting Participant confidentiality and time demands, and improving auditing and recordkeeping.

Contingent on where a mentally ill offender is in the criminal justice process, time from referral to acceptance could be from one to six months. For those defendants with minor charges who have some timed served in jail, they may have already chosen to plead or go to trial on the charges referred to MHC while awaiting acceptance, even should they have desired to come into the Court. Their referrals are then closed by JRS. Without curtailing admissions to the Court, the only ways to redress other delays in referrals being accepted would be to dedicate more staff to the preliminary tasks of reviewing referrals and of accepting admissions. Steps the D.A.'s Office performs to check candidate backgrounds prior to acceptance cannot be side-stepped, as detailed in the preceding *Satisfaction of Court Objectives* section. Justice-Related Services has centralized their referrals processing; but they are unable to automate referral decisions via computer, given the scrutiny required to review applications.

One Treatment professional with criminal justice experience suggested a method to speed up the intake process, that is, having more people doing assessments after referrals, such as the JRS Probation Liaisons or Support Specialist caseworkers. This person thought having a psychologist doing assessments "would bring a different dynamic" to the referral process (Court Team Member #19). At first with MHC, the assessments were handled only by the Mental Health Court Monitor, who, as described in the earlier sections of this chapter, was to be a mental health professional (i.e., a licensed psychologist or someone with a master's in social work counseling), and in fact the

position was held by such persons for the first six or seven years of the court's existence. In some cases, caseworkers from other JRS divisions (typically with social work degrees) had conducted the initial assessments, if a mentally ill offender was first referred to their division, and they in turn referred the person to Mental Health Court. As time progressed, the now-called MHC Director position was held by persons who had a master's degree but were not mental health professionals by training; and on occasion, some of the MHC caseworkers were even asked to conduct assessments for the Director, but this was frowned upon by the JRS Supervisor. Yet standards were relaxed even further in the past several years, as student interns with no mental health experience at all began to conduct assessments.

So the interviewee's suggestion for assessments is a plausible solution to expedite referrals being forwarded for acceptance at referral meetings, but only if the people permitted to do assessments were at the very least trained in the use of assessment protocol, and only after confirmation of diagnosis by a mental health professional. One cogent suggestion is for MHC to employ a standardized tool for all Participant diagnoses and assessments. Instead of random diagnoses and assessments conducted by various community treatment providers and caseworkers being collected for each referral, a diagnosis for MHC purposes could be conducted at time of JRS assessment, preferably by a staff psychologist, but as a baseline, by a few staff with licensed mental health training who were educated on use of the tool. Such a procedure would ensure an appropriate diagnosis, the most frequent cause of delay in processing referrals to this Court, as well as to make for even-handedness in diagnosis. Should only one person do

all diagnoses for the Court, though, a mental health professional, consistency in standards and screening of applicants could more easily be maintained.

As the Court continued to swell in numbers, everyone in the Court workgroup was affected, including MHC caseworkers in Justice-Related Services. Any time there was a staff change, or a problem case, MHC cases were added to the MHC Director's own caseload (at one point the most recent MHC Director carried 50 cases) and challenged his administrative duties. Eventually, as explained, the MHC Specialist caseworkers were re-named Support Specialists and placed under the supervision of JRS's Support Director, who now directs all JRS caseworkers. The current MHC Director doubles as the Drug Court Director, but at least she does not carry a caseload any more. There seem to be sufficient Support Specialists for both MHC and the Support program now, yet still not sufficient MHC Probation Liaisons. The caseload for the two Probation Liaisons has continued to grow as well, and everyone aware of the problem seems to agree that adding a third Probation Liaison would help to relieve their situation.

The funding shift alluded to in the section on *Identification and Meeting of Clients' Needs* has allowed JRS, unlike other agencies essential to the Court, to grow with the expansion in caseloads of MHC and its other forensics programs. After the expiration of MHC start-up grants, the other agencies must rely on continued funding either from the Court of Common Pleas budget, or their own agency's operating budgets. The Assistant D.A. and Assistant P.D. each now have a Paralegal helping them at least part-time, but there is still only one Assistant D.A. and one Assistant P.D, dedicated to the Court, and a solitary MHC Judge.

Caseloads of the mental health (Special Services) Probation Officers far exceeded the "meaningfully reduced caseloads" they should ideally carry "in hopes that specialized training would assist probation officers in facilitating linkages with treatment services" (Center for Behavioral Health Services & Criminal Justice Research, 2010, "Specialized Probation Units"). With the numbers of mentally ill probationers they are currently assigned, Allegheny County's special Probation Officers would be responsible for the monitoring of and reporting on about five to six probationers' cases per day, assuming they only see each probationer once per month—whereas special P.O.'s normally must see mentally ill offenders bi-weekly, weekly, or twice weekly, depending on status. Whether they were handling cases where probationers report to their office or alternately, where the officer visits a probationer in the field, the multiple visits needed for MHC Participants would make it difficult to "ensure an intensive level of supervision" as planned at the Court's founding. Ranks of special Probation Officers grew to six in the past decade since the Court's beginning, but not nearly concomitant with the increases in their caseloads, and each of the special P.O.'s carries mentally ill probationers outside of MHC ranks.

There have been more and more private defense counsel referring clients to MHC over the years, akin to the number of referrals coming from County jail psychiatric staff and social workers. This development is in lieu of a wider spectrum of people originally envisioned as making referrals (community mental health caseworkers, family members, judges, mental health professionals, Behavior Clinic, state hospital forensic units, as well as police and probation officers). And the Assistant P.D. assigned to MHC handles most every case after the plead-in date to Court, even if the defendant had a private defense

attorney or court-appointed counsel refer him or her to the MHC or handle the plea negotiation. For many years, also, the Assistant P.D has scheduled the entire MHC docket (something a Judge's minute clerk would normally do with direction from the Court Administrator's office), issued subpoenas, tracked warrants, and kept graduation records, in addition to all typical duties of a defense attorney. Why the Mental Health Court has allowed one person's responsibilities to be expanded to this degree is unclear. Until a Paralegal was assigned to help in 2009, the Assistant P.D had no aid with these tasks. But this attorney is only the second Assistant P.D. assigned to the Court, serving there for two-thirds of the time the MHC has been in existence, competently and with great concern, as well as proving to be the best record keeper. The hazard to the Court, structurally, is that it will be hard to replace an attorney who performs key administrative tasks in additional to carrying out major courtroom work.

Given how the Court currently functions, then, there seems little incentive for a mentally ill offender to spend funds on private counsel to represent him or her in MHC, so long as the eligibility criteria are met. The only plausible reason to do so is if there is some question that the person would not be accepted into MHC for reasons of their charge(s) or their criminal history. Situationally, some in the private defense bar may be manipulating the MHC referral process by trying to exercise influence to bend its intended purpose, as a means of keeping clients out of jail, regardless of whether their client is sufficiently mentally ill, and regardless of whether the community is jeopardized. Again, the Court risks allegations of selective prosecution by possibly allowing those with influence to be admitted into Mental Health Court where others would not be. The Court was not designed to aid any defendant with any mental problem or drug problem,

nor could it possibly handle all of their cases. It was meant for those with demonstrated serious mental illness or dual diagnosis mental illness and substance abuse. As was stated by several Court team interviewees, "I'd be depressed if I was in jail !"

Regarding those persons for whom the Court was originally intended, there are some proposals the Court could consider to help them with the demand of the MCH process: first, to help potential candidates understand what Mental Health Court entails and how it could benefit them; second, to protect Participant confidentiality along the way, and respect their time demands in attending numerous Court sessions.

Recounted in several places in this chapter are examples where standards or components of the MHC program were misunderstood or misapplied. Closed referrals occurred where candidates refused participation in MHC. Participant #4 believed "Many mentally ill haven't been diagnosed, especially those who have been in and out of jail", so she advised the Court, "Don't just put people in jail!", but rather to steer them toward treatment. Candidates might be in denial about having a mental illness which requires treatment, and so prefer traditional probation, with fewer reporting requirements or other structure that could get them hit with a violation. The only solution, if their illness is real, is better education about how they could be helped by participating. A few MHC Participants revealed that they would like to become "peer specialists" based on their personal experiences, helping to educate candidates about what to expect in MHC so they would not refuse participation. Mentoring could be extended to newly admitted Participants, too, to help them to understand and follow service plan obligations. For stable graduates, this is a fantastic idea that would endorse their own recovery status.

For seriously ill Participants with repeated non-compliant acts facing program failure, a last resort might be administering injectable medications to them. Court Team Member #22, a Treatment professional, had an insightful comment about compelling medication: that sometimes, life makes you sad or anxious; just prescribing medication is not necessarily the answer. This professional had clients who complained that they were not benefitting from group therapy, that their mental issues would be better addressed in individual needs, but their insurance only covers group therapy. Allegheny County Mental Health Court's current judge, Judge John Zottola, said this in a piece that aired on public television about the trade-offs of mental health diversion and recovery:

> Often, the mentally ill population will start to feel better, and they'll be on their medication for a while, and they'll think that they're doing OK. They'll then try and get a job, and they'll start to place the job and the importance of that job ahead of their own health. And we have to sometimes rein those individuals in and reinforce with them: 'Look, it's great that you're working, but you have to go through treatment. You have to take your medication, or else you'll fall back into a situation where you'll commit another crime and maybe be placed in jail again.

(Zottola, 2009, Interview with Frontline: *"The Released"*, para. 12). On the issue of voluntariness of participation in a mental health court, the Judge made this clarification about one of the subjects of the documentary, a certain MHC participant suffering from schizophrenia who had been in and out of the criminal justice system for most of his adult life and who went in and out of treatment:

> That's a fine line. He's volunteered to be part of the program, and in volunteering to be part of the program, he signed off on a service plan. A service plan is part of the condition of his probation. So under probation, he would be required to take his medication. So his failure to take his medication could be considered a probation violation, and we could then be able to, if he doesn't take his medication, take some proactive steps toward getting him to take the medication. But there are a lot of steps in between that we can deal with before we have to say: "You're in violation of your probation. You have to take this medication."

(Zottola, 2009, Interview with Frontline*: "The Released",* para. 34).

Compelling medication was a subject of some dispute not only among different members of the Court team, but also among professionals nationwide, in terms of restricting civil liberties of diversion participants. Notwithstanding those concerns, one of the Treatment professionals interviewed, Court Team Member #8, found compelling medications to be alright, after seeing the harm to some clients' lives when they are off their medications, and exclaimed, "If I have that leverage to try to help them get on it", even with injections, "I'm going to use it". She perceived that clients can misunderstand what the side effects of medications prescribed might be, ascribing negative effects to them that might be caused by something else, and then stopping them or refusing to take them altogether. Her very ill clients need someone other than their treatment team to tell them they need to take their meds, she thought, since they decompensate quickly without them. She believed that mental health disorders may not be curable, but are manageable illnesses like high blood pressure, diabetes, or cancer which be treated. Pennsylvania has no law requiring the seriously mentally ill to take medications such as what she suggested "Kendra's Law" in New York did (Mental Hygiene Law, 1999), so this interviewee would prefer to have more clients refusing medications come into MHC and be compelled by incentives and sanctions.

Upon passing Kendra's Law, New York State is joining the great majority of other states in allowing courts to compel the mentally ill to comply with treatment. It was passed after a schizophrenic off his anti-psychotic medication threw a woman in front of an oncoming subway train. The statute was challenged by mental health advocacy

groups because it does not, as in some states, require a legal declaration of mental incapacity prior to forcing treatment or detention. Kendra's Law was confirmed in New York's Supreme Court because a family member, physician, or caseworker seeking an order for outpatient treatment must establish certain criterion at a hearing before a mentally ill patient can be compelled to receive treatment, and because the law expedited needed care that waiting for an incapacity ruling might delay (Santora, *The New York Times*, 2004). Note that a report from the New York Governor and the Office of Mental Health on Kendra's Law declared: " . . . Kendra's Law does not authorize courts to make independent determinations concerning the issue of whether a patient meets involuntary inpatient criteria . . . ", and discussed standards of state court rulings compelling treatment (New York Office of Mental Health, 2005, p. 51). The report insisted, "Mental Hygiene Law § 9.60, however, neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered AOT." (New York Office of Mental Health, 2005, p. 57).

Despite the apparent good intentions of the Court team, the confidentiality of Court Participants is not always being insured by their practices. True, participation in MHC is to be noted in Pennsylvania's state criminal court database—but the details of their case and mental condition are not necessarily public. Whether and when files on Participants were kept locked as required under HIPAA regulations to ensure privacy depended on the agency keeping the records and the staff person handling the records. As stated in Chapter IV, observers often sat in on the progress review meetings in Court chambers prior to start of the Mental Health Court reinforcement hearings done in open court each week. (Discussion of plea negotiations, too, sometimes occurred during the

in-chambers meetings or in referral meetings, when some term of the plea bargain might have been objectionable to one of the other members of the workgroup and the issue needed to be aired to the Court team.)

Sometimes observers were visiting from other PA counties looking to start their own mental health court and there to observe the entire docket of discussions; they sat in on meetings in chambers with at most an admonishment about confidentiality of participant diagnosis or treatment. Other times, defense counsel or treatment providers were there for a particular Participant's case discussion. Notably, these professionals were often allowed to sit in for the entire docket in chambers, or at least until the case of interest to them was discussed. To the researcher's knowledge, none of the observers except for herself and the other JRS interns had signed confidentiality agreements. There was never a formal policy in place to prevent any of the interns from other agencies who were permitted to attend referral meetings from disseminating what they learned in these meetings or in chambers to the press, or to anywhere else, even after this issue was brought to the attention of those concerned. Similarly, interns from other school programs were invited by the MHC Judge to observe the Court, and they sat in on private meetings in Court chambers, with no apparent confidentiality agreements in place.

Perhaps overlooked as a concern is that of the time Participants must contribute to MHC. Having to attend numerous reinforcement hearings, counseling sessions, regular reports to probation offices, and meetings with caseworkers, are time-consuming requirements, few of which probationers in traditional court have to endure. Yes, those offered the opportunity to participate in MHC receive diversion in exchange for their efforts, yet a lot is asked of them and Participants rarely complained. One solution,

suggested by Participants, was that they be able to check in for their reinforcement hearing and then leave the courtroom until it was time for open Court session to be conducted. Most of the hearings were scheduled for 9:00 A.M., but Participants had to wait in court until the meeting in chambers had concluded, even until 11:30 A.M. some days—often after a lengthy bus ride or other transportation to court weekly, monthly, or quarterly to Court. In any event, this would surely have relieved some stress for them.

Finally, issues of recordkeeping pervade in the effective operation of any court, much less a diversionary court where traditional procedures are set aside and new procedures are being tested. With this MHC, failure to keep complete records seems to allow circumvention of intended Court procedures. As described in Ch. IV, though cumulative charges for existing Participants were originally intended to be capped, new charges for those already in MHC were usually accepted, unless crimes were committed outside the jurisdiction. Sometimes in recent years, the MHC Probation Liaisons would even intervene on behalf of clients for release from the external county. Recently, the only time new charges tended to not be routinely accepted was where client had escaped from a locked facility while on probation or had committed arson, making it hard to find future mental health placement in a community facility. For a current Participant, where a new charge was so serious as to be objectionable to the D.A.'s Office, the outlying case or probation violation was still handled for the client by a caseworker from the Support program within Justice-Related Services (with the exception of homicide cases), and the MHC Participant was permitted to remain in MHC for probation on prior charges. For certain Participants, additional offenses could number anywhere from one up to ten.

In some cases where Participants recidivated, recordkeeping by Court agencies did not always keep up. Maintaining track of all the case numbers on the Court petition paperwork became difficult for the Assistant D.A. or Probation Officers. Accumulation of numerous additional charges contributed to Justice-Related Services abandoning updates to service plans even when a major change in treatment or placement took place; this created confusion and difficulty in enforcing violations for Participants with multiple cases. Also, when a Participant absconded from placement, all cases in the county or state records were to be noted for the defendant's fugitive status, but the Court minute clerk might only have entered warrant information on one case out of several, even when defendants had many new charges. This was likely due to time constraints; the minute clerk for MHC got no help with the additional burden of entering multiple reinforcement hearings, charges, probation violations, or warrants into the criminal records database.

The County's eCAPS Electronic Client and Provider Information System, designed in 2001 and launched in 2002, has some major glitches to be resolved, such as the duplication of entries for the same client. The records kept in it for MHC cases sorely need to be completed for current and past Participants, with everything from changes to placement, reinforcement hearings, or additional charges. Likewise, the state's criminal records database has a place for information on mental health courts, but case data on the MHC there was frequently incomplete, especially where a defendant had multiple cases. When *U.S. News & World Report* did a story on the Mental Health Court, and the reporter wanted statistics on recidivism, the Assistant P.D. was tapped to use his records. JRS did not keep them adequately; nor did the other agencies or the Court itself. This void was not in keeping with the stated plan for project evaluation of the Mental Health

Court, of which the founding Task Force declared: "Collection of all three types of outcomes—process, intermediate and long-term, will allow a formative evaluation of the project to pinpoint how the project is doing and how it can be implemented." (Valentine, 2000, *Allegheny County Mental Health Court Project*, pp. 5-6). The Task Force had planned to track and analyze everything from staff trainings to numbers of psychiatric hospitalizations, including service plan compliance, time period from referral to plead-in, days spent in jail, and arrests, with data to be kept by the MHC Director, the Probation Liaisons, the Special Services Probation Officers, and others. Job descriptions for the relevant positions state these professionals will "help with the collection of data for conducting in-depth progam analysis, evaluation, and outcome studies" (Human Services Administration Organization, 2002, Duties and Responsibilities, para. C; Human Services Administration Organization, 2001, Duties and Responsibilities, para. D).

Such information on outcomes was kept and detailed for several years in the 2002-5 unpublished semi-annual reports on the Court referred to in the sections on *Identification and Meeting of Clients' Needs* and *Satisfaction of Court Objectives*, yet those reports described missing data, particularly, large gaps in recording of criminal charges, and discrepancies in dispositions between staff records and eCAPS records. In the last several years that a full-time MHC Director was on the JRS staff, records of referrals, acceptances, pending acceptances, exclusions, denials, and refusals were kept in fairly complete form, for those were components of MHC processing for which JRS was either primarily or jointly responsible. Reinforcement hearing information to be kept by the JRS Probation Liaisons was not always thorough or correct, however. Graduation data was kept by the Assistant P.D., for his own office records. It is not clear who kept

information on pleas, trials, jail releases, violation hearings, new charges, treatment data, or psychiatric and medical hospitalizations, or who was responsible for keeping any of that data (short of the limited data to be entered into the state or county criminal records databases). If the Office of Probation and Parole, the Office of the District Attorney, or the Common Pleas Court did keep any comprehensive or detailed records, the data was not automatically shared with other agencies in the MHC.

Until a universal system—that is, agency-wide—is put into place and records kept adequately within it, any sort of quantitative or statistical evaluation of this Mental Health Court's outcomes, or comparison to other mental health courts, will never be realistic or accurate. It would help, for example, if the system were simpler and faster to use than eCAPS has been for JRS, though considering the time and funds already expended to create and maintain the database as it is, improvement in data collection is unlikely to happen anytime in the near future. According to the JRS Supervisor, the Rand Corporation was investigating better computerization of databases for the agency, but to date nothing has happened. The other agencies in MHC might be utilized to help keep these records as well, in keeping with their other responsibilities. For example, Probation or the D.A. might keep regular re-arrest, probation violation, and victim records; the Common Pleas Court might keep comprehensive plea, trial, and warrant data; the P.D. might keep updated information on jail releases and program terminations; JRS might keep standardized psychiatric and medical hospitalization information. Accomplishing recordkeeping for analysis will require the hiring of a staff person for data entry or dedication of a portion of current staff's time to that task, or both. If it were too burdensome for these agencies to keep records themselves, one person could be hired,

possibly through the Court Administrator's Office, to keep all records for the Court. As a practical matter, this type of information, along with intake and acceptance figures, is necessary to document the need for increased court operating budgets, and for future grantwriting purposes.

Basis for a Model State Mental Health Court

There are other models for mental health courts. Some jurisdictions accept participants at the preliminary hearing stage instead of waiting until the case is forwarded to the trial stage. Such a pre-adjudication model would be expedient for smaller counties which could not afford to implement intervention at each stage of criminal processing, as Allegheny County has been doing. Other jurisdictions have special disposition style mental health courts, where misdemeanants or first-time offenders are offered dismissal of charges and felons offered reductions in charges after successful completion of a treatment program without re-offending (Redlich, Steadman, Monahan, Petrila, & Griffiin, 2006).

Similarly, some courts offer expungement of a guilty verdict after successful completion of the probation term, such as Brooklyn's mental health court. A dismissal or expungement model provides a major incentive for mentally ill offenders to participate, which may or may not be needed, considering that diversion from jail is already being offered (Fisler, 2005, pp. 593-4). But for those fearing the added structure of treatment

services or the heavier monitoring of intensive probation, it could be the needed push. A jurisdiction's prosecutor and judiciary would have to be on board with exchanging leniency for the promise of reduced recidivism and recovery for participants. Allegheny County's MHC has not followed this type of model, though its founding task force allowed for that possibility. This is very likely due to prior public outcry encountered with the discretionary dismissal/expungement ARD program (accelerated rehabilitative disposition for first-time non-violent offenders, where charges are dropped after the completion of the probation period, allowing for expungement). In the past, entry to the program had at times been arbitrarily granted for persons with political influence, and now this County's D.A.'s office has a stricter policy of eligibility based on specific charge and prior record. Thus, if a county setting up a new mental health court hoped to employ a dismissal or expungement model, they would be wise to formulate structured guidelines for what must take place prior to granting dismissal and expungement, to avoid claims of selective prosecution.

The Allegheny County MHC was not founded to save the County money. However, it was one of the subjects of a 2007 Rand Corporation study commissioned by the Council of State Governments after the PA General Assembly adopted a 2004 resolution to analyze service utilization and costs for mental health court participants compared to costs they would have incurred under traditional case processing. Indeed, the report found costs of increased mental health treatment in the first year of participation with Allegheny County's MHC was offset by the decrease in County Jail expenses, and in the second year, were more than offset as mental health treatment costs dropped off, especially for those with the most severe psychiatric problems and more

serious charges (Ridgely, Engberg, & Greenberg, 2007). One reviewer of this Mental Health Court's policy and practice commented, however:

> …[I]t is too early to declare that mental health courts produce cost savings, particularly because the Allegheny County (Pa.) study is the first to study this issue. One concern is whether mental health courts save resources or simply shift costs to other levels of government. For example, although counties typically pay for court and jail costs, the expensive services that mental health court participants receive are often paid for by the state and federal government (if participants are eligible for Medicaid benefits, as many are). Costs could also be shifted locally, with corrections costs being replaced by the costs associated with mental health treatment (e.g., salaries for court case managers).

(Almquist & Dodd, 2009, p. 26). Even the Rand report added this qualification:

> Prospective tracking of participants in the MHC program could help to quantify both the long-term outcomes and cost implications for the program. Such tracking might also help to refine the entry criteria for the program, by clarifying the types of criminal offense and mental health problems that are most effectively addressed through mental health court-supervised care.

(Ridgely, Engberg, & Greenberg, 2007, p. xii).

After the startup grants, Allegheny County's Mental Health Court was being reviewed as a possible "learning site" for the Bureau of Justice Assistance and Council of State Government's Mental Health Court Consensus Project, which would have meant the Court team had to provide training and assistance to other jurisdictions trying to start mental health courts. This Court was not chosen, possibly because its sanctions criteria are not specified as clearly as could be. Through the efforts of the Justice-Related Services Director, however, several PA counties planning to start a mental health court have sent contingents to observe Allegheny County's MHC process in recent years.

The Court did receive funding from the U.S. Department of Justice in 2005 for a two-year period. One of the goals of that grant was to add Probation Liaisons to JRS staff beyond two, which has not happened to date. Since then, the County has continued

to fund the Court indirectly in a couple of ways. First, the agencies involved (Office of Behavioral Health, Common Pleas Court, Offices of the Court Administrator, Public Defender, and District Attorney) have dedicated staff out of their budgets to work in the MHC. Second, the Department of Human Services has sought state and federal funding to help pay for treatment and support of the serious mentally ill in the County. After ten years and the moving on of most of those involved in its founding, the Court has taken on a life of its own that should assure its continued existence. Presently, the MHC Judge is also working with the PA Commission on Crime and Delinquency on a grant to fund a full-time position in the Court Administrator's Office overseeing all specialty courts in the County. Such a position could be useful to this Court if the specialty court administrator would lift some of the administrative burdens from the Court team and other Court staff.

And this Court has received considerable attention about its efforts. In reviewing of documents and media coverage, the researcher found that Allegheny County's Mental Health Court was highlighted several times. A number of newspaper articles have been written about Allegheny County's Mental Health Court since its founding. Many of them have been in the local press, which has given positive accountings of the purpose and functioning of the Court. National attention centered on this Mental Health Court in 2007 about a year after the Allegheny County Department of Human Services co-sponsored a nationwide conference in Pittsburgh on using the Sequential Intercept Model for decriminalizing mental illness, featuring developers of the model, Dr. Patricia Griffin and Dr. Mark Munetz (Which Way Out? *The Sequential Intercept Model: A Framework for Decriminalizing Mental Illness,* 2007).

There have also been a couple of longer articles published in nationally distributed periodicals which take a favorable approach. In the first, a journalist from *U.S. News & World Report* (2008) visited the Court to watch the proceedings and speak with Participants. The focus of the article was on untreated mental illness and addiction ravaging Participants' lives, and Judge Zottola's alternating use of incentives and warnings to incarcerate them to get them to stay in treatment, in order to keep these mentally ill offenders out of jail where their conditions worsened (*U. S. News & World Report*, 2008). The author wanted statistics to support the Court's claim of drastically reduced recidivism, but the Court had only unofficial records for the first several years of its existence to support that claim[11].

Several months later, in a special edition of The American Prospect entitled, "The Politics of Mental Illness" (2008), Abramsky looked at mental health courts nationwide, with a focus on those in Pennsylvania. Speaking with then Justice-Related Services Supervisor Amy Kroll, he touted Allegheny County's Court as a model for having adopted the Sequential Intercept Model, and for working with necessary public and private stakeholders. He cites Kroll as saying Allegheny County has achieved a forty per cent reduction in the numbers of offenders with mental disabilities sent to state prison (which would be with sentences for felony offenses), and remarks that Pennsylvania's mental health courts take only low-level offenders "deemed harmless to the community" (Abramsky, 2008, p. A9), though no elucidation of those charges is made. He also cites

[11] At the time the article was being written, this researcher was volunteering with the Office of Behavioral Health, and she assisted the MHC Director and others as they scrambled to assemble some documentation on re-arrest of MHC participants from the files the Assistant Public Defender kept for his own purposes, as they were the best evidence of recidivism available on the Court.

Karen Blackburn, Pennsylvania's problem-solving courts coordinator, as saying Allegheny County's recidivism numbers are up to forty-five per cent lower than the statewide rate (Abramsky, 2008), though no explanation is given for this estimate.

A television documentary on the Court aired on April 28, 2009, the second in a series on examination of mentally ill offenders, some from Ohio, who ended up in Pittsburgh. The producers returned to follow the case of one schizophrenic who was particularly difficult to treat, but who had found recovery with the help of the Court. They extensively interviewed the current Mental Health Court Judge, John Zottola, on matters such as the revolving door of arrests for the seriously mentally ill, the unlikely alliances formed in workgroup, how the Judge's role changes when he must function as part of the team and in chambers, reactions of the public and the police to the Court's efforts, the difficulty of deciding when to give an errant participant another chance and when to remove them from the Court, and so on (Frontline*: "The Released*", 2009). All of this attention on the Court, coupled with the public relations efforts of the Office of Behavioral Health through its former Justice-Related Services Supervisor, has sparked the interest of other Pennsylvania counties in starting a mental health court.

From a phone interview with Pennsylvania's Problem-solving Courts Coordinator in 2009, this researcher was informed that Pennsylvania now had thirteen adult mental health courts in one form or another: Allegheny, Berks, Chester, Delaware, Erie, Fayette, Lackawanna, Luzerne, Lycoming, Montgomery, Northumberland, Washington, York; and that Philadelphia County also has a problem-solving court for dually-diagnosed mentally ill offenders, but which is designed to divert those coming out of jail on probation or parole (Blackburn, Karen, Problem-solving Courts Coordinator for the

Administrative Office of Pennsylvania Courts, Personal communication, October 16, 2009). A map prepared by the Administrative Office of the PA Courts, dated March 2010, shows the addition of an adult MHC in Lancaster County, and planned adult MHC's in the following counties: Armstrong, Blair, Dauphin, Northampton, and Westmoreland (Pennsylvania Commission on Crime and Delinquency, 2010).

Some of these courts are post-plea programs and others are pre-plea, but according to Blackburn, they all follow a similar court structure: definition of which population they serve; agreement of prosecution, defense, court administration, judiciary, and treatment providers as to a course of action; a treatment plan supervised by probation or parole; a single point of contact for treatment to be reported to the team; an established duration of the plan; regular status hearings by the court team; specifying which incentives and sanctions will be used; and the length of each phase in a structured program (recall that Allegheny County's Court does not employ a structured program and has given limited specification of sanctions). Courts should have a policy and procedures manual in place to assure the criteria is made known and followed, she affirmed. Yet there is some room for flexibility in the model, she explained; some jurisdictions actually have two teams, one to handle oversight of the treatment plan, and a second to conduct the status hearings (Blackburn, Personal communication, October 16, 2009).

With its conclusions, the final chapter of this study will discuss workgroup member interactions as they take on new roles in the context of therapeutic jurisprudence. It will also discuss Participant responses to the restorative justice incentives and sanctions imposed by this Mental Health Court. Its policy implications will include a discussion of elements important when contemplating start-up of a mental health court from this

Court's experience, and research that might be conducted in the future when Court records are fully integrated.

CHAPTER VI.

DISCUSSION AND IMPLICATIONS

Preface

We learn a good deal about ourselves in the process of conducting qualitative research, for "the researcher is the primary instrument of data collection" (Merriam, 2002b, p. 5). Merriam urges "critical self-reflection by the researcher regarding assumptions, worldview, biases, theoretical orientation, and relationship to the study that may affect the investigation" (Merriam, 2002a, p. 31). Patton refers to this as "reflexivity" about oneself, those studied, and the audience for the research. It is this researcher's goal that she has been contemplative about what she has observed and earnest in what she has reported in this study. It is her hope that the research and conclusions here are not merely viewed as criticism, but part of the platform from whence the Court can move forward constructively, and a guide on which future courts can rely.

There is hopefully a framework provided for what new mental health courts might anticipate in the fruition of this case study. Stakeholders interested in forming a mental health court can benefit by learning about the nature of key workgroup roles, and in addition, potential workgroup conflicts, prior to setting up a diversionary court. Equally relevant is to understand the collaborative nature of good workgroup decision-making and to that end, some lessons about workgroup team building are examined in this chapter. Next, the importance of participant input and cooperation to mental health courts is examined. Political and financial matters are crucial for the functioning and

sustaining of a mental health court; these, too, should be considered by stakeholders who contemplate starting a mental health court and are discussed in depth. Societal consequences of not properly treating serious mental illness are deliberated in the section on restorative justice, and therapeutic jurisprudence is offered as an alternative for mentally ill offenders in the community. Suggestions for better screening and monitoring, and more rigorous auditing and recordkeeping, are included in the final section regarding potential research on this Mental Health Court and others like it.

Key Workgroup Roles

The restorative justice underpinnings of mental health courts and other diversionary courts require that traditional courtroom workgroup roles be recast. Those who have worked in traditional, adversarial court settings may have to contradict the philosophies they have been trained to adopt and or what they have experienced in their working lives. Role conflict may take place when defense counsel are asked to share information, when prosecutors have to forego seeking convictions, or when treatment professionals must recognize risks presented by their clients' actions. Even the daily tasks some in the workgroup are used to performing will have to be changed.

Within the framework of a mental health court, it is difficult to say the court could not operate without any one individual. Each team member has a necessary role, and the manner he or she fills it either contributes to the success of the court, or draws away from

that success. The workgroup roles are less clear-cut than in a traditional setting; the known boundaries of roles may be adapted as group members in a problem-solving court. take on tasks or duties that would normally be ascribed to other members.

The most pivotal role in any mental health court, as probably in any diversionary court, would be the judge. True, a mental health court judge has the benefit of input from the other facets of the group: defense counsel, prosecution, treatment, probation, and defendant or family. In spite of that, the judge must integrate everything put forth to him or her. The judge is a team player in chambers, when the team discusses each person's case circumstance. But s/he can give credence to any one team member's opinion over another's, and the judge's say is last, for s/he is the one elected to render judgment and issue rulings in PA. This is especially important in the Court studied here, as jury trials are not permitted; the trial judge is the only public factfinder in Allegheny County's Mental Health Court if a defendant chooses a trial prior to entering Court.

So, too, it is the judge who must communicate with participants about the outcome in open court. Having to interact directly with mentally ill participants week in and week out for their period of probation, as opposed to a brief trial and sentence as in regular court, cannot be an easy task. Not only must s/he recall basic prior history of each participant's case, but s/he must act on it, sometimes quickly, with an eye toward evolving facts. A diversionary court judge's temperament must be especially balanced and patient to accomplish this. Facing participants over and over, not necessarily with final pronouncements like sentencing, may give the perception that a problem-solving judge is less harsh than judges in traditional court. On the other hand, as the Judge in this Mental Health Court was described by many of its Participants, it is his willingness to

"work with" each defendant gently or firmly, as the situation calls for, that led so many of the Participants to describe him as an eminently fair judge. "[H]e puts things on a scale and weighs things out . . . and he listens to you . . . he's really tuned in." (Participant #4).

As mentioned in Ch. II, American judges tend to like the options that therapeutic jurisprudence gives them, allowing choices for sentencing and the ability to help, not just punish, defendants. A survey of problem-solving practices done with professionals who would be found in a typical workgroup (judge, defense counsel, prosecutor) was recently done in two counties in Washington state. The author found that judges were more approving of problem-solving practices than were public defenders and prosecutors, though the latter two groups were willing to consider using problem-solving methods in certain docket assignments (Cox, 2010, pp. 37-42). Resistance to adoption was explained in the greatest percentages for the lack of support staff or services to accomplish the work of such courts, and also the need for additional knowledge or skills, yet the next largest percentages of perceived obstacles to use of problem-solving methods regarded concern for compromising the court's neutrality, and concern for whether cases currently assigned to respondents would be appropriate for such disposition or not (Cox, 2010, pp. 44-47).

When it comes to the prosecutor and the defense attorney, the other key positions in a traditional courtroom workgroup, the change in their roles from traditional court to a problem-solving court might not be so smooth. For the public defender or other defense counsel in mental health courts, the biggest change is learning to give up the zealous advocate rule. No longer can they look only to the best defense for their clients, they must think of the best means to their client's not re-offending; this is almost a role reversal for them. They might have to break confidentiality in some measure—sacrilege

for a defense attorney--if it would mean a better outcome for the client. Note that Court-Appointed Conflicts Counsel sometimes handled cases in Allegheny County Mental Health Court where the Public Defender's Office could not take the case; they too, have been ardent representatives for their clients. Similar to the Assistant P. D., the Court-Appointed Conflicts Counsel (defense attorneys) must straddle protecting clients' rights while pursuing their rehabilitation. They are not as engaged in the Court's processes, though, not being involved in the referral meetings, the quarterly team meetings, or any other administrative procedures as the A.P.D. for this Court is.

Greater opportunities exist for defense counsel or treatment advocates to look for "breaks" for mentally ill offenders than in the traditional courtroom, as alluded to in Ch. V. Pressuring a mental health court to take a referral for a client who is not amenable to treatment could backfire. Perhaps the person is unable to follow the structure of intensive probation in the state of their disease, resulting in their incarceration for probation violations they might not have faced under standard probation. Or worse, if serious illness coupled with criminality is so profound as to warrant greater constraint, failure to provide that supervision might culminate in violent or tragic events, like that which happened in recent cases in Pittsburgh where mentally ill offenders were diverted but not adequately supervised (Fahy, *Pittsburgh Post-Gazette,* 1998). Advocates might argue that these particular offenders were not being monitored within the MHC, and might not have committed their offenses had they been so. Still, advocates for mentally ill offenders should take care to adapt their roles to seeking what is the most therapeutic for their clients, and ultimately safest for the community, when they are representing these

clients as counsel, caseworkers, or treatment providers, in diversionary courts. Elsewise they may face scrutiny from law enforcement, the public, and victims' rights advocates.

In taking on a more non-adversarial role, the prosecutor's metamorphosis might be a little less rigorous; the rules of ethics already call for a prosecutor to seek justice, not just convictions. Realistically, though, many prosecutors chase convictions, if not out of satisfaction, then of out of expedience, at least in urban jurisdictions where they are saddled with large caseloads. In Allegheny County Mental Health Court, the Assistant D.A. must still research a defendant's record, pay heed to the facts of the crime alleged, and maybe placate an officer who is tired of dealing with the defendant's behavior. What is different here is that a prosecutor in any mental health court can look to other methods for protecting the community and stopping crime that do not simply entail locking the mentally ill offenders away. Though they might not offer restoration to the victim in the case at hand, the prosecutor might be sparing future potential victims of mental health court participants, if the court overseeing these offenders can find a reasonable treatment plan. And prosecutors might be able to take a different kind of satisfaction with a softer role that lets them join in the rehabilitation of the defendant.

The rest of the Court team are behind the scenes fact-finders upon which this Court depends, and just as crucial to the cases as other traditional workgroup members are. Allegheny County's Mental Health Court is especially dependent upon the two Court team players whose roles require the most direct interaction with Participants—the Justice-Related Services forensics staff (Specialist caseworkers and Probation Liaisons), and the Special Services Probation Officers. They are in theory opposite sides of the spectrum. While special probation officers are found in most mental health courts, in

other mental health courts, the roles of JRS caseworkers could be held by external caseworkers or community treatment providers. In some mental health courts, a court employee might serve a joint role of coordinating care (what JRS caseworkers do), assessing progress to the court (part of what JRS Probation Liaisons do), or monitoring, as Special Services Probation Officers do (along with the Probation Liaisons). As touched upon in the Ch. II subsection *Example of a Mental Health Court Design Process*, who provides services to Participants, who monitors them, and who interfaces with the court to report on them, are decisions the stakeholders forming a mental health court will have to decide, based on staffing, funding, and political concerns in that jurisdiction.

In Allegheny County's MHC, Justice-Related Services staff are social service agents for their clients' ostensible needs. Moreover, they are tireless advocates for mentally ill offenders, and never seem to give up on their clients. As the JRS Director used to insist (and related to this researcher as well), "You never know when that light bulb is going to go off." Translated, one has to keep believing in the mentally ill offenders, and they will come around to recovery. It is a great battle cry, one that has served many a client in dire need. Caseworkers and treatment providers in such a role may be tested by the persistence their position demands, but more than anyone else in the workgroup, they are most likely to see the immediate rewards of a client's treatment. For this reason, social workers who receive training in mental health issues, along with persons trained as counselors, are often sought to fill these positions in mental health courts, whereas criminal justice professionals are just as likely to fill a liaison or reporting role as a treatment professional might (Council of State Governments, 2005).

Which backgrounds are the best fit for each position will depend on the particular responsibilities set out for them within the mental health court plan at issue.

Probation traditionally serves a dual role of control and rehabilitation, but specially trained probation officers in mental health courts fall closer to the rehabilitative side of the continuum than their counterparts in traditional courts. Recall that ideally, the former obtain specialized mental health training so that they, too, may facilitate treatment service coordination like caseworkers do. In Allegheny County's Mental Health Court, officers of the community-based Special Services Probation Division frequently got involved in the attempt to find appropriate placement for their charges, and all took great interest in their welfare. Those Participants who had forged a bond with their assigned Probation Officer made sure to tell the researcher of the aid they got from their P.O. (just as they told her if it was the opposite and they felt their P.O. was too distrusting of them). Probation officer positions are usually filled by criminal justice professionals, yet in mental health courts, these spots could just as easily be filled by treatment professionals who instead obtain criminal justice training, and in fact in this Court sometimes they were.

At times, each Probation Officer in Allegheny County's Mental Health Court may have taken a hard line regarding certain of their probationers whom they found to be disregarding probation stipulations. This may have been to the chagrin of defense counsel, their caseworkers or treatment providers, or even the Judge. When MHC Participants in this Court took issue with the manner of enforcement of probation terms, it was typically with the special Probation Officers rather than with the prosecutor or the Judge; they may have felt their P.O. was more assailable. Other than the Justice-Related

Services Probation Liaisons, the Special Service Probation Officers had the greatest weekly involvement with the MHC Participants after the initial service plan was in place; and they were more likely to be the ones calling for sanctions, instead of simply raising concerns about compliance, to the Court. In other courts, if position responsibilities are structured differently, it might be the prosecutor or other court official such as a pre-trial services officer who requests sanctions on mentally ill offenders for violation of probation stipulations; in this Court, the prosecutor tended most often to request sanctions after learning of a violation from a victim or arresting police officer in the case, with whom they had the most direct contact.

Behind the scenes in this Court are the community mental health treatment professionals. It was their diagnoses and opinions on which JRS and Probation (and by proxy, the other team members), relied. They supplied the day-to-day counseling, life skills coping, medication management, and behavior modification tools necessitated by the MHC Participants. Judgment of these professionals was not absolute, but it was trusted on its face, unless and until a Participant should furnish a sound reason to dispute it to the team or in court.

In Allegheny County's Mental Health Court, there are no longer any licensed mental health treatment professionals directly employed by any of the agencies involved in operating the Court. There were, however, numerous Treatment professionals from community healthcare agencies, mostly intensive case managers and on occasion licensed therapists, who came into the Court at reinforcement hearings to speak of the progress of their clients. They could also be called into court by the MHC Judge when a Participant was floundering or disputed placement or medication decisions, and it was better for the

Court to hear from the provider as well as the Participant about the situation. Sometimes these Treatment professionals were the Participant's greatest advocates, backing up a defendant who was in contention with prosecution or probation. At other times, they may have been the thorn in the side of a recalcitrant Participant who was not ready to take the necessary steps towards recovery. One Treatment professional interviewed expressed wanting to have more input on sentencing for her clients, given how well she knew them.

In some mental health courts, a treatment provider is part of the workaday court team, conducting intake assessments, or testifying regularly in court about behavior prognosis for all defendants involved. A word of caution to caseworkers, treatment providers, or defense counsel who are called upon in their positions to advocate for mentally ill offenders rather than monitor or report on them: clients whose offending or drug use persists despite all exertions others make for them can be difficult to represent. When clients are dangerous or manipulative, or belligerent in their opposition to treatment terms, remaining steadfast in their advocacy or defense may be unrealistic, or worse, or come at the expense of the people around them. For this reason, some members of the workgroup in the Court studied were dubbed as relentless by those in the Court team who believed in the value of cognitive re-ordering and who would like the former to give in earlier to the utility of negative sanctions. The researcher described in Ch. V how a certain workgroup member who was more forthcoming about clients' downfalls was valued by his team members; though he might never have condoned sanctions being imposed, he sought a better balance between incentives and punishment by doing all he could to aid his clients, but not standing in the way of sanctions when the majority of the group felt sanctions were needed.

With mental health courts and other diversion programs, mental health service providers have begun to overlap with criminal justice practitioners to establish successful alternatives where both the community and persons with mental illness or dual disorders are protected. Inherently, this warrants both fields learning about the other's duties and taking on mixed responsibilities. Doing so might call for professional development and skills training for all parties. Advising workgroup members in advance of the sorts of debates and role conflicts they might encounter would be helpful. When drafting position descriptions, allowing for internal administrative changes as roles evolve would be wise, too, considering the fluidity of roles in a specialty court like a mental health court.

Importance of Court Team Collaboration

Moving to a less adversarial, more cooperative interaction style is a necessity in a mental health court. Much can be learned by the workgroup openly communicating with each other. When planning to start a mental health court, stakeholders or potential courtroom workgroup members should make a resolution to respect and communicate with each other, if nothing else. In Allegheny County's Mental Health Court, this interaction has come about, gradually, through painstaking group effort. As the MHC Judge said several times at MHC quarterly team meetings, the Court team members had to learn to trust each other and not to fear sharing information with each other. These

objectives are necessary if the Court team is to perform their tasks well and in turn the Court is to function smoothly.

Forging that trust among apparently competing interests was not always the simplest thing in Allegheny County's Mental Health Court. For example, though the Probation Officers may have had good reason to take a stand for sanctioning a Participant, their sometimes obstinate behavior lost them credence at times with others on the Court team who may then have disregarded the Probation Officers' suggestions for placement on subsequent cases. This researcher has witnessed that kind of reaction numerous times in discussions in Court chambers and the ensuing handling of cases in open court. There was haggling during the quarterly team meetings when the Assistant P.D. or the JRS Director were pushing for acceptance of more serious offenses, and the Probation Supervisor in turn stressed that it was the Probation Office on the line should a MHC Participant commit a major offense while on probation. This sentiment was loudly echoed by prior Assistant D.A.'s, who sided with the Probation Office, though the D.A.'s office seemed to view their responsibility more on the front end of the process, at time of the charging function they control, and the Probation office viewed it more on the back end, when they take up monitoring the defendant.

The Mental Health Court judges tended to portray the risk-taking as shared among the agencies, such that all parties would be questioned in the event of a high-profile case gone awry. After the recent overdoses by several MHC Participants, as well as some egregious violations by dually diagnosed offenders, those who doubted the special Probation Officers' motivations for stressing swift intervention realized they might have been wrong and the P.O.'s had been right. A climate of trust began to be forged, with the

Judge's encouragement. The apparent opposite sides seem to be working better together than ever before, as observed by this researcher. The lesson for those contemplating start of a mental health court is that if responsibility for monitoring mentally ill offenders and assisting with their recovery is shared, then the risks the workgroup members take by putting faith in the process will be perceived as shared, too.

The findings of this study were somewhat similar to those of one of the only theses on drug court workgroups, wherein a researcher looked at inter-institutional dynamics and how information sharing in a drug court workgroup facilitated social control (Colyer, 2004). The author pointed out that the drug court literature prior to his study entailed only "coverage of history, theory, and guiding principles" or "empirical analysis of program efficacy and outcomes" (Colyer, 2004, pp. 195). He claimed those studies imply that the carrot-stick approach of coercing defendants to engage in treatment must be what is effective in drug courts, instead of "case management or a continuum of care" (Colyer, 2004, pp. 198). The bulk of drug court literature focuses on participant outcomes or judicial methods of social control, he asserted, while the "personnel who make decisions about treatment, conduct the supervisory work, and actually facilitate the treatment protocols are every bit as important" in trying to get at the "blackbox" of why drug courts work (Colyer, 2004, pp. 194-5). Workgroup members who represent various agencies form what he called "institutional coalitions" to "observe the broadest range of behavior possible" Colyer, 2004, pp. 138). Because each different member of the workgroup has access to information the others do not, "ranging from human observation to computerized database query systems", they can cross-check facts across sources,

thereby "maximizing their surveillance capacity with minimal costs" (Colyer, 2004, p. 146).

Certainly in this Mental Health Court, various workgroup members made decisions about treatment placement (though not treatment itself), supervised Participants' actions, and facilitated protocols for them. Furthermore, the ability to cross-check facts exists among this workgroup's members; whether and when they shared what they learned about Participants with each other was the subject of some disagreement, as related in the findings chapter. Still, as they came to trust each other over time, they expanded what they were willing to share in a common goal.

A conclusion from observing reviews in chambers for those contemplating the start of a mental health court was this: Openness and truthfulness was the best policy to make court team interactions work. Perhaps this capacity was enabled in the Allegheny County Mental Health Court due to the continuity of some of its members. If not for the length of time most of the Court team had been working together, they might not have been able to achieve trust and openness. It would thus be beneficial for jurisdictions starting a mental health court to try to achieve overlap in service among key positions on the team, to allow them to educate one another and maintain policies or procedures that have worked well. There will always be turnover in any court community, as there has been with this court team. So it is critical to foster truth and openness in communications and decision-making for its own sake, in order to carry out essential tasks of the group in the best way possible.

When this Court worked best, Court team members would not need to see eye-to-eye on everything, but they would, as one Criminal Justice professional declared to me,

realize they all want "the same thing". That "thing" was to help a Participant to find recovery, stop their wayward behavior, hopefully make amends, and regain their lives. The majority of Criminal Justice professionals and Treatment professionals interviewed proclaimed in some fashion how all their efforts were worth it to one day see it "click" for a Participant who had once been struggling. Finding the right incentive or sanction for that Participant might have been easier for one team member than the other if that member found more empathy for that Participant's predicament. Or, a Participant might form a bond with a certain team member simply because humans instinctively form affinities. That does not mean anyone abandons their job description in carrying out their duties—it just means they give each other a little latitude, or a little more discretion, to take on that mentally ill offender's case.

One has to credit this Court team for paying attention to the symptoms and the evidence presented by non-compliant Participants and trying to make the best decisions for the Participants' welfare (and that of the community), from changing counselors or placement, agreeing to consult treatment providers about different medication, or even suggesting they be jailed briefly. Every case differed, and most every case took turns for better or worse at different points throughout the probation. What is most special about this Court team is that they were willing to look at each case individually and adjust incentives and sanctions as needed. They definitely focused "on the unique needs of the mentally ill offender", satisfying part of their mission as stated by the MHC Task Force. Surely, this is a good deal more work for the team. Imposing structured, graduated sanctions could be a lot simpler, if grounded in identifiable criterion.

On the surface, structured sanctions appear more fair. For it might seem arbitrary to some Participants as they watched in the audience when another Participant got a pass for the same behavior that sent them to jail the month before. So looking at sanctions for each case individually was a tenous strategy for the Court team. Quite commonly, Participants objected to what the Court asked of them or decided for them; frequently, Participants complained that their Probation Officer or the Assistant D.A. was coming down on them too hard. Few Participants had complained, either in open court or in an interview, that they were handled unfairly as compared to others. One can conclude that each case was being taken for what it was worth, individually. That may be the one fact that makes this Court work, by the estimation of both the Court team and the Participants.

Yet this same fact cuts both ways, and working without structured sanctions risks a mental health court's not "ensuring just process of law" or "promoting public safety", Task Force goals. Awarding graduation for this Mental Health Court seems, like many functions of the Court, to have become more a product of the agreement of the Court team than of the adherence to guidelines. One might try to compare a diversionary court like this mental health court against one which has little flexibility in admission standards, or which follows stated incremental sanctions for violation of probation stipulations, or which only awards graduation following a set formula. Drawbacks will exist with either format. Without more concrete statistics to evaluate, it is hard to say decisively if this Court's operation or any other consensus-based decision-making in a mental health court is more effective than following specific criteria to reach particular milestones.

Ideas for workgroup cohesion have been discussed in research on key components of drug courts. Success for a courtroom workgroup is "usually achieved when the group adopts common objectives, becomes aware of one another's roles and responsibilities, interacts on a continuing basis, and perceives that they are part of a cohesive group." (Olson, Lurigio, & Albertson, 2001, pp. 182, citing Carroll & Tosi). Clearly, from repeated observation of this Court team's interactions, they seem to have evolved to find a common goal, evidenced by their regular communications and by improved empathies for each others' duties and perspectives. If this Court is accomplishing what it set out to achieve, which this researcher concludes its workgroup is endeavoring to do, at least in spirit if not in letter, the teamwork and communication, trust and cooperation of this courtroom workgroup are the only "blackbox" factors that she can deduce for it.

Participant Responsivity

From her observation of hundreds of Participants in court over the three years this researcher worked with this Mental Health Court as a volunteer, then employee, then researcher, she made two stark deductions about its participants. Many suffered from a lack of family support. The great majority of Participants were not financially well-endowed. They likely did not have the advantage of early treatment or the capacity to conceal mental illness that wealthier people have. From information in their assessments, psychiatric analyses, and police reports, having conversations with caseworkers, or just

listening to them speak in Court, she deduced that there came a point when their supports collapsed. For most, it appeared to be in their twenties or thirties when familial bonds were broken, perhaps when they had burned bridges with their families, or their families exhausted all help they could render to their adult child with persistent mental illness. Family members who did appear in Court to support or speak for Participants sometimes appeared more fatigued than their loved ones.

This study does not attempt to determine any relation of demographics to the makeup or decisions of the Mental Health Court; nor has in-depth research been done on those factors in this Court. Some researchers have concluded that key matters in life which might impose social control on an individual, such as marriage or employment, may be less likely for those with serious mental illness; on the other hand, mental relapses or hospitalizations would tend to interfere with the stability that might lead to or sustain long-term relationships and economic security (Fisher, Silver, & Wolff, 2006). After experiencing social or economic deprivation, one can understand how a vicious circle of circumstances leading to being untreated or arrested might occur. The only confirmation of these deductions was in witnessing the excitement Participants showed when they reconnected with family or obtained a job after experiencing recovery.

Being able to witness Participants in MHC, as they appeared before the Judge for their regular hearings, weekly or occasionally, was instructional. The goal in the instant study was not to follow any particular mentally ill offender. Even if a random sample of Court Participants were chosen to follow, it would have been impossible to follow them all from plea to graduation, since some defendants were given up to four years probation, and some sentences extended past the original time slated if they got new charges or

probation violations. Over time, this researcher did become familiar with numerous mentally ill offenders as their reviews came up. The difficult cases--severely ill persons, or those with desperate addictions--stuck out the most. As they improved, or declined, their progress or lack thereof was the most obvious. The Judge often said things to them like, "We can tell you're doing better today", or "You look great, keep it up".

Sadly, when any particular person was not feeling well, it might be due to any number of things: mental breakdown, inappropriate dosage or type of medication, loss of job, death of a family member, addiction relapse, change of living arrangement. If their symptoms resulted in non-compliance, their actions in Court varied greatly. Some just reacted out fear of what would face them there and went blank; others got combative. Some lied to try to manipulate their sanction. Still others would own up to their actions and beg for sympathy from the Court. When Participants had a dispute with their placement or with a Treatment provider, it could have been out of denial of their symptoms, but it could just as easily have been that they truly were not being aided in recovery by their counseling method, their medication, or their living circumstance, and were not being belligerent at all.

None of this is simple to read; often the Mental Health Court team got it right, but sometimes they read it wrong. One of the most common (and only) criticisms of this Court by Participants interviewed was that, in spite of fairness, the Court gave some people too many chances; at some point, they believed, a defendant not following the service plan had to have some consequences. And though most Participants thought the referral process reached the right subjects for a mental health court, a couple of them felt that referrals were too lax, or in the opposite, did not cast a wide enough net. They either

thought that some Participants were not really sick and only came to the Mental Health Court to avoid incarceration, or that some really sick people they knew should have been offered the Mental Health Court diversion.

For one Participant, #9, who refused to report to a number of special Probation Officers and who continued to give dirty drug screens during much of his probation, it was the MHC Judge not putting him in jail and stating his faith in the Participant that allowed him to turn the corner on his disease. For another Participant, #22, it was her forensic Support Specialist's willingness to search for and provide her help with any immediate need that allowed the Participant to see she could recover from her illness without resorting to the negative behavior that got her arrested. What the Mental Health Court graduates who finally achieved success in recovery seem to agree about is two-fold: they had to want to get there for their own sake; and they could not have done it without the tireless care and support they received from the Court team. Participant #12 said: "Everyone is different, but there's only so many chances", and some "burn them up"; there is "so much desperation … but if you don't have that desire to change your life, it will never happen". But Participant #13 declared: "MHC saved my life—I didn't know where else to turn".

From the courtroom workgroup's perspective, Court Team Member #17 stated eloquently what it meant to encourage the Participants:

> You know, growth and progress for some is different between each person … And then you work off that, and you can either beat the person down to the point they have no self-esteem, or work with them on why they did relapse, and get them to relapse prevention groups, and get 'em to realize why did they do that … you got to look back on what history these people had, and the trauma they've had. Letting somebody know when they've done well is so important, because a lot of these people have never been told anything that they've done well their whole lives … for them to finally hear that, that

> they're doing well, and someone to actually back 'em up—not only us, but the other clients that are involved, that is huge. … And they might not be like that forever, but at least they know where they could get to.

General and specific incentives were a big part of Participant responsivity in Allegheny County's Mental Health Court. For those who received a positive review at their reinforcement hearing, their names were put into a box that day and they had a 1-in-5 chance of winning a $25.00 grocery store gift card. (Winners were usually thankful and said they could really use the reward.) An unwritten incentive was the opportunity each Participant had when their hearing was held to have an interchange with the Judge. Possibilities ranged from a basic "Thank you" to a five-minute diatribe of why the Participant was right and everyone else misunderstood the situation. They might give their "clean" date (the days, months, or years since they last used alcohol or drugs); they might sing the praises of their sympathetic boss, or a friend who had faith in them. The Judge almost always let the Participant speak their peace, pleasant or unpleasant, endorsing compliance or explaining non-compliance away. Family members who cared for Participants were permitted to speak in defense or praise of them as well. The judge who now sits on this Mental Health Court summed it up succinctly:

> I think we're attempting to change the stereotypical feeling that people have when they walk into a courtroom. ... It's OK to admit that you've used drugs, because we're going to attempt to deal with that problem as opposed to throwing you automatically in jail. And the word gets out. ...

(Zottola, 2009, Interview with Frontline: *"The Released",* para. 21).

Every graduate received a certificate of completion, embossed with his/her name, and a gift card. More important was the recognition, received upon being told in open court of having graduated, from the Court team and the audience. And the jewel in the

crown was that a graduate got to give a speech about his or her experience in Mental Health Court. Some comments were truly touching, and probably inspired the other Participants in the audience listening. Though some graduates were glad to be done and wanted never to have to come back to the Court again, a few Participants, especially those whose passage to completion may have been torturous, even returned from time to time to let the Court know they were still doing well.

It would be especially useful for any mental health court to learn from its participants what it is about its program that helped them or made them want to comply. Participant opinion cannot run a mental health court. Understanding and including participant concerns, though, is an invaluable way to improve a court's operations and to increase participant responsivity. One mental health court displayed amazing inter-agency cooperation and courage in surveying court litigants as to satisfaction with how they were treated by court staff (Minnesota Judicial Branch, Fourth Judicial Branch Research Division, 2005). When planning a mental health court, stakeholders might go further and consider a routine way to confidentially seek input of participants once stabilized. Sharing information might not benefit any one individual involved in a court, nevertheless, it could provide benefits for the whole, just as Allegheny County's Mental Health Court benefitted from hearing concerns of all workgroup members at their quarterly team meetings.

Policy Implications

When starting a mental health court, it is vital to have collaboration of each agency which should have a stake in a diversionary process, as well as cooperation of the other courts within the county unit. Naturally, that includes agents from the traditional courtroom workgroup such as the local judiciary, district attorney's office, and public defender's or court-appointment counsel's office, and the wider net of the probation and parole office. To be workable, it must invite human services agencies (governmental and non-profit), community mental health providers, and hospital representatives to take part. Finally, to be accepted in the community, a mental health court needs mental health or substance abuse consumer advocacy groups, victims' rights groups, and neighborhood associations to partake in planning it.

Moving forward without political support would be ineffective. Public safety concerns cannot be ignored, nor can the opinions of those primarily responsible for preserving it. Proponents might thus consider inviting skeptical stakeholders to learn more about mental health courts in place and functioning in similar jurisdictions. Anything from providing literature, to drawing up a comparison of processing differences and cost projections between traditional court and a diversionary program, to arranging a visit to a mental health court would be helpful. Securing the attention and confidence of the local media is always beneficial. Though not the easiest stories to tackle, covering the plight of the mentally ill and their families, and how they recover from illness, makes for powerful human interest. As made plain in Ch. II, it would wise for U.S. jurisdictions

to establish a pilot scheme and re-evaluate whether to start the program and/or to expand it based upon the results, as is done in non-U.S. courts.

Allegheny County is an urban/suburban county with socio-economic complications: an aging population, a struggling economy, and a shrinking pool of labor-age citizens; despite its charms, the region is mired in the vestiges of industrial pollution, blighted properties, segregation, and gender discrimination. For a jurisdiction facing these kinds of issues, there will not be a shortage of mental health problems. Nevertheless, it is doubtful the founders of the Allegheny County Mental Health Court expected the numbers of referrals to the Court or its steady rise to current parameters. Increased publicity alone, or even attempts to get out of jail by the marginally ill, cannot fully explain the numbers of referral numbers to this Court. Other explanations which could affect rates must be explored, such as police policies of arresting mentally ill offenders instead of using discretion to release them, either to avoid potential liability or to force mentally ill offenders to get care.

As discussed extensively in Ch. V, acceptance admissions have increased both through side-stepping the referral process, and informally loosening the acceptance guidelines. Though some Treatment professionals mentioned wanting to generally relax acceptance standards without otherwise curtailing admissions, a couple Criminal Justice professionals clarified that felony offenders with serious mental illnesses should be admitted, while restricting admission for anyone with less pervasive or temporary illness. Utilizing that reform might help to curtail swelling admissions, but it might not be in keeping with the planned mission of this Court. Otherwise, considering current referral and enrollment levels, this Mental Health Court may have to retreat to some of the

original procedural objectives it seems to have abandoned, or face burnout of staff and expiration of resources.

Likewise, a jurisdiction wishing to start a mental health court should survey its population for what kind of need exists, what its probable sources for referrals will be, and what levels of referrals it can anticipate. In addition, once standards are set, at the very least, the Court should be using a standardized assessment tool for screening candidates, for which assessors receive training. A better idea still would be to have licensed professionals conducting the assessments. These suggestions apply as well to any mental health court in the formation stage, and should be seriously considered in terms of anticipating staff levels and budgets.

All in all, for those jurisdictions contemplating a new mental health court, it would be wise to specify who they intend to serve, and how they intend to maintain those specifications, or at least how resources will be augmented if they do not. Furthermore, when designing a court's operating framework, it is prudent to anticipate structural changes to the Court itself. Stakeholders in the planning stages should contemplate how a court's administration will attend to changes that may be needed. A simple example in Allegheny County: The Mental Health Court had to add special plea dates to its docket when the court was overwhelmed with regularly scheduled reinforcment hearings and emergency reviews, and too busy to handle pleas during regular court sessions. Changes may be necessitated for more complicated matters, such as the way in which Justice-Related Services expedited its course of assigning caseworkers to mentally ill offenders regardless of program. Additional changes might be altering how tasks are allotted if court team roles shift, or adding staff when a workgroup member is being overburdened.

Another issue sure to affect both how the court operates is the structure of sanctions and criteria for successful completion from a mental health court program. The manner of implementing sanctions is a point of contention for Allegheny County's Mental Health Court, as mentioned in the findings chapter. This Court team wrangled with whether to implement graduated sanctions, and ultimately decided such a structure would be too difficult for them to administer, given the variety in levels of functioning and diagnoses of mentally ill offenders they served. In reality, an underlying reluctance to impose jail time may exist, given that "return to jail is generally accepted as a measure of program failure", and "success rates of the program as reflected in evaluations will drop" with return to jail (Wyatt, 2004, p. 96). Interestingly, as referenced in Ch. V, the Rand Report indicated the lack of graduated sanctions in this Court's model in the context of its expanding jurisdiction and understaffing (Ridgely, Engberg, & Greenberg, 2007). It is ironic that this Court has not moved toward structured sanctions as it moves toward relaxed eligibility standards, if only to relieve the pressure to manage caseloads, let alone in reaction to the increased risks of accepting felons.

Jurisdictions pondering how to set up their court structure will need to be honest about what options they have for mentally ill offenders who cannot comprehend or follow rules, and what they are willing to do to sanction them. Decisions to confer graduation are behind the scenes, but they are dependent upon how incentives and sanctions are administered. And the dispensing of incentives and sanctions is done in open court. Likewise, discussions of whether to issue positive or negative reviews are done in chambers, but participant progress is announced in open court. Alongside pleas, sentencing, and graduations, these court functions are the public face of a mental health

court and affect how the court is viewed by persons within and without. Therefore, it is critical that stakeholders in the planning and administration of future mental health courts give serious thought on how to lay out these functions in their court structure in a manner that respects the public and its right to be aware of court rulings while yet protecting the HIPAA rights of participants.

Also, court functions need to be audited to make certain they are being impartially carried out in keeping with the mission and standards of the court as intended, for fairness and proper use of court and public resources. Another researcher warned of the potential for discrimination with judicial discretion and that a MHC team be cognizant of that potential when considering how to handle defendants in chambers (Gurrera, 2007, p. 217). A new court would be wise to incorporate a thorough evaluation study into its objectives, to be carried out within the first several years of its running, as was done with the Brooklyn Mental Health Court in New York (O'Keefe, 2006) and the Hennepin County Mental Health Court for the Fourth Judicial District Court of Minnesota (Minnesota Judicial Branch, Fourth Judicial Branch Research Division, 2006). The Center for Court Innovation, in concert with the Bureau of Justice Assistance's Community-Based Problem-Solving Criminal Justice Initiative, offers a guide for evaluating problem-solving courts. They encourage justice officials involved in a court to engage in evaluation, particularly by independent parties, to allow them to "Answer planning questions … Establish performance measures … Document implementation … Monitor ongoing performance … Measure their project's impact" (Center for Court Innovation, 2011, p. 1). Such reports permit the agencies involved, their funders, and the taxpaying public to determine if the planned court is functioning with regard to

implementation and operational goals, like improving clinical outcomes and reducing recidivism. It also proposes areas where adjustments or improvements may be needed administratively or substantively.

Whether or not strict guidelines are employed and followed by a mental health court, trust and cooperation of its workgroup will be essential to its continued operation, as stressed earlier in this chapter. Jurisdictions are strongly urged to weigh the formation of a mental health court. Both new and existing courts are encouraged to build regular team meetings into their operating arrangement. Moreover, communication and teamwork can be improved by providing mental health skills and criminal justice training for workgroup members, in order that they gain better understanding of the challenges faced by mental health court participants, and greater appreciation of the public safety concerns of their criminal justice team members.

Also critical to a treatment-type court like mental health court is that sufficient social service resources are existent in the surrounding community, so that the court will have tools at its disposal to where it can divert mentally ill offenders from jail. "[W]ithout access to a range of mental health and supportive services, mental health courts have limited impact on the people most in need of help." (Tyuse & Linhorst, 2005, p. 237). Treatment failure, for instance, has been shown where courts have "limited treatment slots for participants", or mentally ill offenders compete for slots and are sanctioned for failures that might have been avoided (Wyatt, 2004, pp. 141-8).

The stakeholders contemplating a court should assess the levels and quality of mental health and substance abuse care available in the community. Futhermore, some elements likely needed are: short-term financial assistance for food, sundries, medicine,

busing, or rent; mental health treatment with case management follow-up; setting up drug or alcohol treatment on an inpatient or outpatient basis; transportation to early round medical, court-related, or benefits appointments; housing placement for various skilled levels of care; discharge transportation after placements; assistance securing SSI, SSDI, medical assistance, or welfare benefits; and aid with individual needs like leads/training for jobs, locating family, and legal advocacy.

Without attending to funding overall, a mental health court project might not be worth attempting. Despite their importance to all the issues delineated above, funding matters were little-discussed among the courtroom workgroup in this study and tended to be addressed at higher levels of agency bureaucracy. For example, Ch. V discussed the changes in the transfer of Participants from Support Specialist caseworkers to Probation Liaisons after stabilization, and also alluded to a shift to a fee-for-services model for casework within Justice-Related Services. JRS primarily was able to make this shift because the Support Specialist caseworkers work on a reimbursement model (billing a quasi-government agency for their services, which in turn gets state and federal funds), whereas the former MHC Specialist and current Probation Liaison position salaries were paid for directly by the County Department of Human Services. As a result, JRS added ranks to its Support Specialists, without increasing the numbers of Probation Liaisons, when the latter are much in need of additional staff help to carry out Court functions, too. Fee-for-services provision is a double-edged sword, of course, as related to the researcher by Court Team Members #11 and #17; it can fund a program, yet it forces the service providers to focus on those activities which provide reimbursement..

That switch was not without debate among some of the Court team professionals interviewed. If the primary task of the Probation Liaisons was to follow Participants' progress and report that to the Court, then there should be no problem with allowing them to pass a Participant's case back to the Support Specialist caseworker to formulate Mental Health Service Plan adjustments when that Participant is having difficulty complying. It would not relieve the Liaison of monitoring duties or make them any less familiar with a Participant's problems; and it would put adjustment efforts back in the hands of the caseworker who drafted the original plan and who would probably still be familiar with that Participant's problems and needs. The argument for changing the original casework structure was for better continuity of care, i.e., the case remains with the Probation Liaisons for the balance of their probation after the service plan is formed.

But with no change in the current structure of duties for Probation Liaisons and current enrollment levels of the Court, the Probation Liaisons will have difficulty maintaining regular contact with Participants assigned to them, notwithstanding being able to re-work Participant treatment plans and monitor compliance. Unless and until another Liaison is added to share their caseload, this policy risks putting continuity of care above basic delivery of care and following up with it--undoubtedly not the goal of the founders of MHC. Consideration of the role and job responsibilities of the probation liaison position should be made according to the tasks assigned to other Court team members for this Court and others which use a similar structure. Similarly, whether the reporting role be housed within social services or within probation should be considered, according to the framework and history of a jurisdiction's agencies.

Ideally, funding would also be provided for staff to perform the additional administrative procedures of the planned mental health court that do not exist in a traditional court. In discussions with the person in the Court Administrator's office who deals with Allegheny County's MHC, hiring a specialty court administrator to coordinate all problem-solving courts in the County was mentioned as a goal. Without some outside funding at the outset, it is highly unlikely the County would expend funds for such a position. To that end, the current MHC Judge has been pursuing a grant to help fund a specialty court coordinator's job. Such a position would be invaluable to any jurisdiction with more than one problem-solving court. That person might relieve workgroup members of some of the administrative tasks they are avoiding for lack of time.

Funding is critical to both start-up and maintenance of a mental health court. Even with the dedication of staff or court time from the government agencies, those agencies must replace staff assigned to the specialized tasks with other staff; the transfer is not necessarily one-to-one, and there will be a learning curve for both. In time, if the new diversionary court is working, it might pay for itself as costs shift from incarceration costs to treatment and service costs. Still, the county or other jurisdiction may not have extra funds to devote at the outset. Funds should definitely be budgeted by all stakeholders for specialized training to deal with the problems of the mentally ill. Private and government funding is growing for specialized courts, so the time is ripe for a prospective jurisdiction to seek a pilot project.

Restorative Justice Implications

The population of offenders with serious mental illness in U.S. jails and prisons has exploded in the past 30 years. With the continued closing of state hospitals that once housed this population, many of the persistently mentally ill in the nation were left to fend for themselves when community treatment facilities that were to replace the hospitals did not keep pace in capacity or funding. Like the development of drug courts as an alternative to incarcerating addicts caught up in the war on drugs, mental health courts in a therapeutic model were designed to treat and support mentally ill offenders caught up in life's pitfalls. Along the lines of other problem-solving or diversionary courts, a restorative justice approach imbues the handling of cases of seriously mentally ill offenders charged with misdemeanors and felonies referred to mental health courts. Their underlying problems are addressed, so that the criminal justice system might divert them from incarceration in facilities not equipped for them, and allow them to be treated and to make amends within society instead.

Starting a mental health court or other diversion program might be motivated by the desire to help some of the most vulnerable people in our society to heal, to protect them from others who would harm them, or to shield the community from the harm they can cause when they are sick and unable to stop themselves from acting out. This motivation is just one piece of the puzzle; other components are essential to a lasting solution. Yes, we are responsible for care of our children, but what of the parent who has done everything in his or her power to heal a mentally ill son or daughter, and can no longer control them as an adult—should the burden of care be entirely theirs for life?

And yes, each person should be responsible for their own actions, but what if a person is so sick that they do not even realize that they need help? Of course, citizens need to protect themselves in their communities, but do we not have a right to expect that truly sick persons are receiving needed care and are not a threat to everyone else? In theory, at least, our medical system is duty-bound to aid and heal those with grave physical illness. When it comes to mental illness, neither the assurance or the assistance is so clear. If we hope to restore mentally ill offenders to the community, improve their quality of life, and ensure just process of law for them and others, we actually need to deal better with mental illness in the first place.

As a society, we must begin to give mental illnesses the same attention and effort we give physical ailments—both treatments, and cures. When we do not yet have cures, we must do what we can to provide relief from suffering for all concerned. To do so, we will have to look beyond the criminal justice system, to the behavioral health system, the medical community, the hospital industry, and the manner we administrate health insurance. Not diagnosing and treating a serious mental illness would be like letting diabetics go without insulin and making special diets unavailable (or at best making them pay the costs of treatment themselves), and then punishing them for the consequences when they either do not or cannot seek treatment or instead commit crimes to pay for treatment. It would be preferable for our communities and our citizens if we started to find the cures, or at least offered effective treatments, for mental illnesses before the criminal justice system has to get involved.

According to a 2009 report from Allegheny Health Choices, Inc., during the period of Mayview State Hospital's closing (2006-8), all the former residents took up

living in the community. Though four of every five of them went to facilities with 24-hour staff supervision, which might be as expensive as residing in the state hospital, they reported in those same numbers more satisfaction with their lives in their new circumstances (Allegheny Health Choices, Inc., 2009, pp. 5-6). Of course, this is positive news, and just the kind of publicity that those supporting the hospital's closure wanted to see happen, as well as evidence for diversion champions that the mentally ill are better off in the community than anywhere else. But there is more to the picture for successful community life when it comes to the seriously mentally ill than just where one lives.

It is important to note that minimal numbers of former Mayview residents were tracked as being in jail during and after their first 3 months in the community. Despite that welcome news, their psychiatric hospitalizations and other critical incidents began to rise after those first 3 months (Allegheny Health Choices, Inc., 2009, pp. 17-20). Along with the loss of Mayview and the closing by the University of Pittsburgh Medical Center of two other large private hospitals with psychiatric units in Allegheny County in the past decade, this increase in needed urgent care has put stress on hospitals in the five-county area nearest the former state hospital (which includes Allegheny County). Smaller area hospitals are reporting surges of demand for inpatient psychiatric beds; caseworkers are reporting extra man hours seeking a bed and patients having to wait days for admission. Since psychiatric admissions are reimbursed at one-half to one-third the rates of medical or surgical patient care, these hospitals will not be increasing space for psychiatric inpatients (Mamula, *Pittsburgh Business Times*, November 4, 2010).

Lack of critical care for critical incidents is likely to result in crises for the mentally ill and their families. Crisis can breed crime. There is no evidence that the

mentally ill commit more crimes than the rest of the population when they are receiving appropriate care and monitoring. Still, many pitfalls confront the mentally ill who have no support system in place or who may have lost the supports they once had. The Treatment Advocacy Center found "a very strong correlation between those states that have more mentally ill persons in jails and prisons and those states that are spending less money on mental health services" (Torry, Kennard, Eslinger, Lamb, & Pavle, 2010, p. 8). Our mental health care system does not always pick up where families burn out or resources dry up. Often unable to cope with the tribulations of daily life, then, the seriously mentally ill without adequate supports can be arrested on everything from nuisance crimes to major felonies. They are typically detained for longer periods than persons without mental illness, and frequently suffer greater deterioration and abuses during incarceration, as related in Ch. I.

Interviews of treatment providers or Court Participants conducted on site at treatment facilities were instructive to this researcher about the need for a diversion measure like a mental health court, especially where severely ill clients were managed. In particular, some members of one intensive community treatment team were very willing to explain the nature of their program and their philosophy towards helping their unique patients. As for success of Allegheny County's Mental Health Court, one Treatment professional (Court Team Member #8) cited confidence that lots of her seriously ill clients had benefitted from MHC, having had fewer options before the Court existed. There were persons in her care who were psychotic when not on medication, but fine when on their meds; such persons had to be monitored daily until they were back on track. The difficulty for her was keeping them from going off the medications, and

knowing when that was likely to happen. She cited a client whose behavior was risky and erratic and was tasered by police. As his therapist, she came to know that when he withdrew and got paranoid, he had stopped taking his meds. Her experience with the client could not have been replaced by a Criminal Justice professional or even a professional who received mental health training working at the jail. But she alone could not monitor that client's behavior.

In Ch. V, the researcher alluded to a loss of referrals after potential MHC participants were committed to forensic hospitals, transferred back to Jail, and then released before the MHC Director could act upon their case. Two problems ensued: the mentally ill offender was not being aided or supervised in the community, often complicating their problems with relapses or additional crimes; and unless the charges were dropped altogether, the closed referral would simply be referred again for the same charges sometime later in criminal justice timeline—meaning duplicated processing and other efforts. To help relieve this problem, the Allegheny County Jail Collaborative, mentioned in Ch. II as a forerunner to the MHC Task Force, should be tapped.

The Collaborative is an association of "government agencies, court officials, service providers, ex-offenders, faith-based community organizations, families and the community at large" (Allegheny County Department of Human Services, 2010, "Offender Re-integration Program /Jail Collaborative"). They adopted a Community Re-integration Program in 2001. Their idea was to provide screening, treatment, and case management for inmates and to develop service plans for them while housed in the Jail and planning for aftercare upon discharge, with the aid of their families whenever possible. One of the key elements of the Re-integration Program was to deliberately

track and evaluate "service usage, provider performance outcomes, recidivism among service participants/inmates, length of time between screening, referral, service provision, and release", with the information collected "… shared with the County's Department of Human Services through the Electronic Client and Provider System (eCAPS) system". (Allegheny County Department of Human Services, 2010, "The State of the Jail in 2000"). The longtime Supervisor of Justice-Related Services, who has been involved in the Jail Collaborative and was involved in founding the Mental Health Court (as detailed in Ch. II), recently went to work for the Community Re-Integration Program of the Jail Collaborative after their procurement of federal re-integration funding in 2010 (Allegheny County Department of Human Services, 2010, "The Collaborative: Innovation Spurs Funding"). Recalling her extensive background with mentally ill offenders, it is hoped that the coordination between the criminal justice system, the forensics programs, and the mental healthcare delivery system can be strengthened and improved. Other counties would gain from a similar government/community interaction.

Additionally, it would be beneficial for those directly involved in the operation of a mental health court to collaborate with consumer advocacy groups such as the National Alliance of the Mentally Ill (NAMI) who lobbied for this MHC 's existence. NAMI or other advocacy groups could speak for participants' interests and, as one researcher expressed, help to lessen the dual stigma and psychological difficulties of having both a mental illness and acquiring a criminal record (*Wyatt,* 2003, pp. 55; 63; 76-7). Consumer groups could also aid relevant agencies and providers in helping ensure sufficient resources for participants' re-integration back into the community, which might be overlooked after the court no longer has jurisdiction over them.

Diversion programs are safety nets for those mentally ill offenders who might not have offended had they had a support system and adequate health care in place. If the programs work well, mental health courts help mentally ill offenders to be healed, help to safeguard the community in which they live from symptoms left untreated, and ultimately help to restore the welfare of offender and community. To work as well as intended, a mental health court requires more than the endorsement of the community, it needs engagement of partners in the steps to make it function.

Ideas for Future Research

For diversionary courts anywhere, there is a demand for routinized data collection to allow for formative evaluation or other research to guide fine-tuning or overhauling social service programs or court processes. The need for agencies to collaborate on recordkeeping and data collection for a court program like mental health court cannot be overstated. In the evaluation of Hennepin County, MN mental health court, its Research Division staff stated:

> We realize that filling out forms for research purposes often takes time and effort during the course of a busy day; still, they provided us with the data we needed and helped us fix problems as they were identified.

(Minnesota Judicial Branch, Fourth Judicial Branch Research Division, 2006, p. 3). It would be great to have a uniform model for data gathering, so that different courts might be compared, yet defining such a model will prove difficult with the variations found in existing mental health courts.

Determining general effectiveness of mental health courts is an even harder goal. The few experimental or quasi-experimental studies on mental health courts that have been done to this point compare different courts. Mental health courts are difficult to compare due to differences in legal systems, social settings, court structures, and mental health services available for the courts evaluated (Center for Behavioral Health Services & Criminal Justice Research, 2009). The long-time director of the Center for Mental Health Services & Criminal Justice Research, Nancy Wolff, earlier investigated ways to evaluate mental health courts with Wendy Pogorzelski. They sum it up succinctly, finding, "research challenges associated with studying the effectiveness of an intervention that is nonstandardized by nature and highly dependent on macro and local influences within the environment as well as personal preferences and relationship dynamics within the intervention itself" make for that difficulty (Wolff & Pogorzelski, 2005, p. 1).

Still, the clearer guidelines for mental health court functions are, the easier they will be to study. For example, guidelines for formulating acceptance in this Mental Health Court, discussed at length in Ch. V, are too vague to be predictable for the workgroup or fair for participants, let alone to be capably researched. To remain true to this Court's original mission, those guidelines should be tightened and defined more clearly. If the Court team is uncomfortable with being too rigid about adopting a set of guidelines, research could be conducted prior to drafting them. The study could track compliance and completion rates for various charges or length of records; these could be compared based on diagnosis or drug dependence type to evaluate amenability to treatment, incentive, or sanction. Furthermore, evidence of mental health or substance abuse relapse could be tracked and correlated with criminal justice data. Results might

be used to adapt the MHC toward procedures and policies that proved the most useful or promising, to better focus the Court's resources, time, and efforts, in the sense suggested in the Rand report (Ridgely, Engberg, & Greenberg, 2007, p. xii).

In Allegheny County, summaries of case file data integrate both criminal justice and mental health information on MHC Participants. First, there is the county-wide database registering those who have received any publicly funded mental health assistance (the eCAPS database described several times in this manuscript); anyone referred for participation in Mental Health Court should be recorded there from date of referral throughout their participation until graduation or termination. In addition to a diagnosis history section, there is a three-part MHC section in eCAPS where information on Participants is to be logged, one part for all information from the MHC assessment; another for procedural history in the Court, including charges at various criminal justice stages; and a final part for reinforcement hearing outcomes information, including positive or negative reviews and reasons therefore, placement changes, and the basis for graduation or termination.

Second, the Department of Human Services keeps an electronic version of individual case-level information for any client who has sought forensic services from Justice-Related Service after an arrest. That data is (or should be) input in one of several places: the now-digitized case files for all JRS units, scanned per each referral; the program database on referrals kept (or supposed to be kept) by the supervisor of each JRS unit; and the eCAPS database for diagnosis history and the information described above for any mentally ill offender served by JRS and other public health entities (including MHC Participants and other JRS program clients). Third, the County's Jail has its own

database of detention and release information with related arrest and probation violation entries; despite not always being accurate, it sometimes contains criminal record and arrest data that is housed nowhere else. Fourth, the state of PA has a fully computerized website with case data at both the magistrate and trial levels on arrests, aliases, warrants, bail, motions, convictions, and sentences, much of which is publicly accessible.

As discussed in Chapter IV, Justice-Related Services client files, especially those with lengthy case histories, were sometimes in disarray, and often incomplete or inaccurate. JRS receives thousands of referrals for aid yearly from mentally ill offenders; their staff is deluged in files. The one data piece they did track with relative thoroughness was referrals, because figures on cases served is a key component in the formula for agency funding from the state and federal government. In fairness, the greater concern for the Support Supervisor, MHC Director, caseworkers, and probation liaisons (all JRS staff) was in delivering services, and their loose oversight of process or outcomes recordkeeping is understandable, especially given the high numbers of clients they had to handle monthly. It is patently clear, then, that if the Department of Human Services is to be the recordkeeping agency for mentally ill offenders in the County, which they have chosen to do, they need to hire a full-time staff person to keep data, at least for Mental Health Court process and outcomes.

Upon the transfer of a misdemeanor or felony from the District Justice (magistrate) to the Common Pleas Court, certain docket and case history information is to be listed in Pennsylvania's Unified Judicial Records. PA Court of Common Pleas records rely on the diligence of each courtroom's minute clerk to record actions affecting cases, including pleas/trials, sentence orders, probation violations for re-arrest or technical violations, bail

matters, and warrants issued. For MHC, added entries for reinforcement hearings are to be made there, too. Described above is the fact that these records were sometimes incomplete for MHC participants, especially regarding probation violations, and often no connection was made to a defendant's MHC involvement within a case record for a new criminal offense committed after initial acceptance into the Court. Unfortunately, no one monitors this recordkeeping for the state. Likewise, there is no formal requirement from the state office on problem-solving courts for records to be kept for any mental health court, much less uniform records for comparison across counties for mental health courts. (Drug Courts have stricter guidelines, due to federal grants for their operations.)

The only formal tracking of repeat offenses on Participants of this Mental Health Court has been for one of two specific studies. The first was a private Rand Corporation study mentioned in earlier chapters, done for the County to evaluate the costs of diverting mentally ill offenders to jailing them (Ridgely, Engberg, & Greenberg, 2007), and the second was within a 2009 study solely of recent MHC graduates, done for a presentation at a Gains Center Conference (Allegheny County Department of Human Services, Office of Behavioral Health Justice-Related Services, 2009). Each of these studies was conducted after the fact, for particular purposes, with the benefit of paid staff perusing external databases of criminal offenses kept independently of MHC, such as those of the Administrative Office of Pennsylvania Courts or the Allegheny County Jail, and inputting data for the period of time being studied. The first focused on cost, not recidivism; the second did not consider re-offenses by non-completers or refusers of MHC.

In the one meta-analysis of mental health courts that this researcher could find, the author did not include Allegheny County's Mental Health Court in her examination

because it was one of those where for studies of a court, "There were not enough quantitative data within the studies to produce an effect size" (Sarteschi, 2009, p. 64). In fact, the instant Mental Health Court does not itself systematically track re-arrest, relapse, hospitalization, service plan changes, graduation, or termination/revocation of its Participants through any of the agencies involved in its operation—at least not at the juncture this study was conducted. As stated earlier, the MHC Director kept his own database on referrals and the Assistant P.D. kept his own records on graduation. No one entered information on recidivism into databases on a regular basis within Justice-Related Services, or any of the agencies involved in this Mental Health Court, except this researcher for the period in which she was involved in volunteering for, working with, or researching the Court. Given the lack of formal policy on records between agencies, it is no surprise that the records left to the busiest agency in the Court were incomplete.

When the policy of amending MHC service plans to include new charges ceased, the practice of keeping track of charges became pretty fluid with this Court. An instance of re-arrest made known to a workgroup member may have been shared with the others by email or verbally reported in chambers, but it may have been hidden as related in the section *Workgroup Interaction and Decisionmaking*. If the new charge was bound over for trial and was later referred to MHC (occasionally it was not for various reasons), a new case referral file was to be processed by the Justice-Related Services intern for MHC; the file was supposed to be merged with the mentally ill offender's existing JRS client folder, which sometimes did not happen. New charge information supposed to be entered into eCAPS by JRS through the MHC Director (a task later delegated to the MHC intern) was frequently left to another day or not done at all. If the new referral was

accepted for MHC, an additional Common Pleas court number was simply added to the docket listing the Assistant P.D. kept for scheduling purposes, and sometimes add-on case numbers were left missing. Missing cases made further confusion upon a Participant's graduation or termination from MHC. Special Service Probation officers already had difficulty with their own case files where fines or restitution were unpaid, for even if the MHC Judge graduated a Participant or "closed" a case despite those matters being outstanding, the P.O.'s were not permitted to close their own agency files on a defendant until the matters were resolved[12].

If a new case was transferred to MHC from another courtroom instead, even those basic steps may not have been followed, as explained in the findings section regarding "backdoor" referrals. If a new case with serious charges was rejected by the D.A.'s office, as explained earlier, rarely was the Participant ever expelled from MHC; so JRS would then have 2 open files on the mentally ill offender, one for MHC, and a second for the Support program; in that event, no one in the Support program entered the new charge information regarding the MHC Participant into eCAPs. On occasion, the new case was simply handled in another courtroom with a plea before another judge; it is unclear if this omission was an attempt to evade revocation by a MHC participant who failed to inform counsel of prior MHC participation; counsel's naïvely fearing the client's revocation and not referring the new case to MHC; a caseworker's decision to handle the matter on their own without informing the workgroup; the Probation Office not picking up on the new arrest; the D.A.'s Office not connecting the new case with MHC; or the

[12] Of course, the question remains of how the Probation Office can legally collect fines or restitution from a defendant once that person's probation is closed by the court.

other judge's unwillingness to transfer the case to MHC. Whatever the reason be, even rudimentary MHC recordkeeping was usually not performed for those new cases.

Directives to maintain records need be issued from above for the present MHC, possibly from the Court Administrator's Office or the County Executive's Office, and funding allotted for the agencies involved to keep records. It appears that the problem of tracking new cases into MHC could be solved by JRS sharing MHC referral information with the Court Administrator's Office and the Court Administrator keeping the MHC docket. Though it would not keep track of new arrests disposed of at the Magistrate level, at least then, Common Pleas Court case numbers could be followed throughout the trial phase, whether a referral was refused, denied, accepted, or transferred into MHC. In the last chapter, the possibility of a specialty court administrator overseeing all county problem-solving courts was mentioned as possibly helping to lift some of the administrative burdens from the Mental Health Court team and certain Common Pleas Court staff; but whether such an administrator could exercise sufficient control over the Mental Health Court processes when this Court has been in existence for ten years will depend a great deal on the willingness of the courtroom workgroup to cooperate with that administration process.

Regarding outcome data, the Probation Office could be designated to keep statistics on recidivism as part of their role with MHC, particularly because they already get regular reports of re-arrest, at least within state. That was the original plan of the MHC Task Force. Given that the JRS Probation Liasion positions ended up being housed within Human Services, rather than within the Probation Office as originally envisioned, the Liasions were performing more casework functions than monitoring and gathering

outcome data to report to the Court, as discussed in the findings section. Thus, Probation could still fill the reporting role, updating service plans and tracking reinforcement hearing review data, since they already monitor the Participants' compliance. Doing so would add an administrative task to the already crowded schedules of the Probation Officers, and cut into their field time. What that means is that the Office of Probation, instead of the Department of Human Services, might ultimately be the agency to hire someone to keep treatment compliance and recidivism records for the Court, rather than Justice-Related Services.

Recordkeeping problems will hamper researchers in accumulating data to potentially conduct studies on recidivism or treatment outcomes for a large diversionary court like Allegheny County's Mental Health Court that handles 350 plus persons annually, with referrals of five to six hundred people annually. Were the records in Allegheny County described above to be kept properly, as intended, there is a wealth of information that could be used to design evaluation or quantitative studies relevant to the mentally ill offender. The County's Information Technology Division could search and de-identify lists for research. County-wide behavioral health information and managed care (insurance) data is kept by two other quasi-governmental agencies, and a psychiatric tracking system maintains admissions and commitments to community hospitals, including transfers to state hospitals. An invaluable study could be done intersecting behavioral health, hospitalization, treatment histories, and substance abuse records with diagnoses, arrests, types of crimes, and demographics.

Flexibility has no doubt accounted for the rapid proliferation of mental health courts across the country, but the great variation in courts has sometimes made for

diluting of recommended court components or procedures (Erickson, Campbell, & Lamberti, 2006). Researchers have found that the intersection of the criminal justice and mental health systems and the many possible variations of those systems among jurisdictions made "isolating the independent effects associated with mental health courts" difficult (Wolff & Pogorzelski, 2005, p. 541). Like a recent survey of MHC's asserted, though, "Future research that tracks individuals in jail diversion programs and compares to a control group of non-diverted individuals is desperately needed in the literature." (Raines & Laws, 2008, p. 11). Where it would be unethical to deny treatment and diversion to a group of mentally ill offenders just to study them, however, comparison of similarly situated defendants in different diversion programs might be conducted to try to isolate the effects of mental health court. Like the study first contemplated by this researcher, for example, a significant comparison of Allegheny County's short-term Support program for diversion of mentally ill offenders to Participants in its longer-term Mental Health Court could be conducted—if court compliance and social support data is better kept in the future.

Other mental health courts would do well to adopt guidelines making it easier for them to work within a structure and to pursue evaluation. That way they might adapt procedures according to those most beneficial to their courts' missions as time progresses. Pennsylvania would be aided by a state-wide evaluation of its problem-solving courts and some real guidelines about how best to structure those courts within the state's legal framework. Existing and future courts could also use technical and financial assistance in keeping paper and computer records from the state's court administration agency, the Administrative Office of Pennsylvania Courts. Even within the behavioral health field,

the argument is made that mentally ill offenders are inherently different than the majority of the mentally ill who are never arrested. Thus, it is especially important not to simply analyze data that is incomplete when it comes to mentally ill offenders.

The value of studies such as those just described could be to better determine populations on which to focus intervention, to examine which supports offered in diversion programs are most beneficial to mentally ill offenders, or to amend sanctions according to what is most effective for both recovery and compliance. In a like manner, jurisdictions which keep detailed records on mental health and criminal justice can look forward to doing comparative studies to evaluate court functioning and service provision. They can use that information to adjust budgets, staffing, and even priorities for their courts and agencies. Statistical evaluations can be supplemented by qualitative evaluations of courtroom personnel, treatment providers, and mentally ill offenders, as well as of the public, to round out their understanding of systems and operations. Finally, mental health courts keeping a watch on their actual performance and reforming programs accordingly will be more likely to receive continued grants or appropriations.

Conclusion

Mental health courts are still youthful in the dual spectrum of criminal justice and mental health; so too, is the literature recent, yet rapidly expanding like the growth in these courts. This study relied on a variety of data sources to provide a rich description

of the mental health court process in the county of its case study. Information was gathered first from extensive field observation of various modes of courtroom activity and workgroup behavior, both public and private; second, from a number or voluntary, confidential, semi-structured interviews, which questions were formed after immersion in observation; third, from review of plenteous documentary evidence regarding the formation of the court and its evolution to its current format; and fourth, from considerable examination of court and agency records on participants.

Goals of this case study were to add to the literature on this emerging area of criminal justice research, by probing a specific local decision to implement and fund a mental health court, by delving deeply into the formation and functioning of this diversionary court's workgroup, and by illustrating possible improvements in the case processing and treatment model that might be accomplished for this and other courts. Secondary goals were to provide some guidance to other counties in the throes of instituting a court in their region as to structuring a mental health court in a particular locale within the local legislation, law enforcement, and political conditions, and to offer suggestions for future research on this and other mental health courts. Findings of the project may be useful to assist jurisdictions contemplating a mental health court, respecting court and agency personnel, case processing, community treatment resources, participant pools, sanctions systems, and funding.

By its nature, this intensive case study research project was limited to one court in one county. To compare Allegheny County's Mental Health Court to another court within Pennsylvania's court structure might be illustrative, particularly if the latter were a more structured program than this one. Allegheny County's MHC appears to be the

largest and longest-running court dealing solely with mental health in the state. Philadelphia's Co-occurring Treatment Court, the other large and long-running diversion program in PA, deals with mentally ill offenders post-sentence. Aside from that key difference, it does not appear to deal with offenders who are mentally ill without a concomitant substance abuse problem. But it is hard to say for certain; that court does not have a link on the Philadephia County Courts website, nor does the program listing under the Criminal Justice/Mental Health Consensus Project website for the Philadelphia court give any information about it. Therefore, comparisons of Allegheny County's MHC might better be made with similar larger mental health courts in other states where court program information is more readily available, if access could be garnered.

The most obvious limitation of the research herein is that it involved only one researcher. With a shared protocol, another pair of eyes and ears would have made for more field observation, after which each researcher's notes could be discussed or challenged. Moreover, a second researcher could have sat in on the interviews or read through transcripts to validate findings. Still, one of the strengths of this project was its capacity for full immersion of the solo researcher in all functions of the Court process. The couple of studies of mental health courts which have included an examination of workgroups did not seem to have that kind of immersion, behind the scenes and in the field, and did not focus on the interaction between workgroup members or consider anything but the in-court expressions of participants.

To date, limited research has been devoted to participant experience in any problem-solving court, much less mental health courts. Perhaps it is obvious that this researcher found participant responses especially compelling. What was learned from

workgroup interviews fleshed out themes observed by the researcher in the field; what she heard from participants brought the themes to life. Participants offered insights that workgroup members might get to hear when working with these mentally ill offenders, but which insights the researcher could not have gathered by only talking to workgroup members.

Having a mission is a starting point; Allegheny County had a great mission for its Court, and with forethought, its its Task Force suggested a structure in the founding documents. Mental health courts were a very recent innovation then, and forethought did not anticipate some of the issues that would arise in this Court. Policies created for the Mental Health Court as it proceeded, too, tended to be constructed in reaction to a problem in the system, rather than proactively to help avoid problems. In the recent past, delegations from several counties in PA wishing to set up a mental health court have visited Allegheny County's MHC, still, ten years later, there is no policy manual, either for the state as a whole, or even for Allegheny County, to which they can look for guidance or structure. Pennsylvania could benefit from something like the Mental Health Court Learning Sites project, where 5 courts across country were selected to host other jurisdictions seeking assistance on starting or operating a mental health court. Run by the Bureau of Justice Assistance Mental Health Courts Program (2006), the Learning Sites project chose these courts in great part due to their fidelity to the essential elements of a mental health court (laid out in the *Description of Mental Health Courts* section) and their collaboration between the criminal justice and mental health communities.

Allegheny County's MHC would surely benefit from having a procedures and guidelines manual specific to the state; so, too, would counties who have or seek to have

their own mental health court. The only information the Administrative Office of PA Courts provides relative to mental health courts on its website is a one-page fact sheet on problem-solving courts in general; no contact information appears to be available for the Judicial Programs Department of the AOPC, which states it assists with problem-solving courts (Administrative Office of PA Courts, 2011). Nor is there basic information listed about mental health courts on the Pennsylvania Commission on Crime and Delinquency website, only a map of counties having an adult mental health court in PA. The PCCD website has a link for "program or performance measures" for mental health courts, but it contains no specifics on any court, much less any measure, only a link to the PA Mental Health & Justice Center of Excellence for research and planning on dually-diagnosed offenders' programs (Pennsylvania Commission on Crime and Delinquency, 2010). More forethought is called for now in Pennsylvania's courts; it was the researcher's hope that this project would provide insight toward the drafting of a policy manual that could be adopted by current or future mental health courts in the state of Pennsylvania.

Maybe more important than any other consideration in these lean times is the need to guarantee funding to start and run an anticipated mental health court. Without processing staff, monitoring ability, and community care and corrections resources, a court might flounder or dissolve. There was little recognition of the funding sources for this Mental Health Court, excepting by the JRS Supervisor or the MHC Judge. Even those close enough to funding sources to be aware, or those whose jobs may have depended on that funding, were not aware of it; maybe they felt funding was beyond their scope; more likely they just had too much else to worry about. If this Court or any mental health court is to maintain its original substantive objectives, whether improving

the lives of mentally ill offenders, ensuring just process of law, or promoting public safety, dedicated or continued funding must be sought. The researcher wished to contribute to the literature by illustrating the many facets of day to day administration of a problem-solving court, all of which take planning, and yes, parameters, to remain functional and solvent, in order to keep to its mission.

Patton's notion that "qualitative findings are judged by their substantive significance" (Patton, 2002, p. 467) is encouraging for a qualitative research project, yet daunting for the researcher is his elaboration that readers must judge the value of the findings and conclusions, such as the extent to which they are useful, for "contributing to theory, informing policy, summative or formative evaluation, or problem solving in action research" (Patton, 2002, p. 467). Using qualitative methods for this case study allowed for intensive perception of the activities and human interactions involved in this Court in ways that could not have been done without them. A multi-method approach made for a comprehensive understanding of the various components integral to the workings of the Court—communication, deliberation, assistance, decisionmaking, support, paperwork, praise, questioning, punishment, record keeping, empathy, responding, collaboration. As Merriam suggested she should (2002c), the researcher brought a genuine interest to the subject at hand. It is one thing to sit in on an open session of a problem-solving court. It is another to immerse oneself in all aspects, from the details to the broad philosophical concepts at play. Hopefully, the researcher has been able to articulate the inner workings of a complicated mental health court and reflect on how to inform other such courts.

ENDNOTES

[1] A paper copy of the confidentiality agreements and access letters that the researcher executed with the county to view and analyze data is on file with her.

[2]Note that a caseworker who suggested a potential participant was not made aware of the participant's decision to be (or not to be) interviewed unless the participant told the researcher to inform the caseworker—-consent to be interviewed was a matter directly between the researcher and the interviewee.

[3] When the researcher was asked by current Assistant D.A not to observe referral meetings, despite other interns being permitted to continue to sit in on these meetings, she honored the handout she had given to the Court team stating they could object to her presence as an observer. She was from that point unable to gather information about how that process may have evolved over time, or how different personalities might have made a difference in how duties were carried out, short of what was related to her by workgroup members.

[4] A probation violation on a previous case in another courtroom cannot be handled by MHC, either.

[5] Of course, serious offenders can surely be monitored while incarcerated, so these interviewees were presuming that all serious offenders could qualify for parole under PA's sentencing guidelines, when in fact they might not have.

[6] Axis I diagnoses are clinical disorders, including major mental disorders, while Axis II diagnoses are personality disorders.

[7] There have been cases where the mentally ill offender has not actually pleaded into MHC, and yet they have been scheduled for review dates (which they attended), and were even logged into the state's criminal court database as being in Mental Health Court. PA does not discipline the performance of its courts, and there is no oversight of its diversionary or problem-solving courts to audit issues like these.

[8] Recall that the role of reporting to the Court was initially meant to be performed by Special Services Liaison Probation Officers, as explained in the *Identification and Meeting of Clients' Needs* section.

[9] At times the researcher entered missing review outcomes, or corrected entries that differed from what was stated on the record in Court; and there is no place where neutral review data, which was included in the report, was kept to her knowledge.

[10] And that is, with the assumption the information that has been entered into the eCAPS (Electronic Client and Provider Information System) database on reviews is reliable; just as the researcher has witnessed no one regularly entering data on repeat offenses by MHC participants during probation into eCAPS, so, too, has she experienced outcomes of reinforcement hearings either not being entered on the MHC follow-up pages, or being entered incorrectly.

[11]At the time the article was being written, the researcher was volunteering with the Office of Behavioral Health, and she assisted the MHC Director and others as they scrambled to assemble some documentation on re-arrest of MHC participants from the files the Assistant Public Defender kept for his own purposes.

[12]Of course, the question remains of how the Probation Office can legally collect fines or restitution from a defendant once that person's probation is closed by the court.

REFERENCES

Abramsky, S. (2008). The politics of mental illness: A worthy diversion. [Special Report: The Politics of Mental Illness.] *The American Prospect*, July/August 2008, A9 - 11.

Abramsky, S. & Fellner, J. (2003). Ill-equipped: *U.S. prisons and offenders with mental illness* (ISBN: 1564322904). New York, NY: Human Rights Watch. Retrieved January 31, 2010, from: http://www.hrw.org/en/reports/2003/10/21/ill-equipped-0

Administrative Office of PA Courts (2011). *Judicial Programs Department*. Retrieved April 4, 2011, from http://www.aopc.org/T/AOPC/JudicialPrograms.htm

Allegheny County Department of Human Services (2010). *Electronic Client and Provider Information System (eCAPS)*. Retrieved December 27, 2010 from: http://www.alleghenycounty.us/dhs/ecaps.aspx

Allegheny County Department of Human Services (2009). *Forensic Mental Health Court after Referral* process description. Retrieved April 28, 2009, from http://www.county.allegheny.pa.us/dhs/mhcourt.aspx

Allegheny County Department of Human Services (2007). *Services and supports offered as part of the Allegheny County Jail Collaborative*. Retrieved April 25, 2009, from: http://www.alleghenycounty.us/uploadedFiles/DHS/Individual_and_Community_Health/Justice_Related_Services/JailCollaborativeServices.pdf

Allegheny County Department of Human Services (2010). *Offender Re-integration Program /Jail Collaborative*. Retrieved November 24, 2010 at: http://www.alleghenycounty.us/dhs/jail.aspx

Allegheny County Department of Human Services, Office of Behavioral Health Justice-Related Services Unit (2009). *Mental Health Court Report 2009*. Retrieved December 29, 2010 from: http://www.alleghenycounty.us/dhs/mhcourt.aspx

Allegheny County Mental Health Court (undated). *Mental Health Court* [Brochure]. Pittsburgh, PA: Mental Health Assocation of Allegheny County.

Allegheny County Mental Health Court (2005). *Allegheny County Mental Health Court* [Brochure]. Pittsburgh, PA: The Office of the District Attorney, The Office of the Public Defender, Allegheny County Court of Common Pleas, Allegheny County Department of Human Services Office of Behavioral Health.

Allegheny County Mental Health Court (2007). *Mental Health Court Review Guidelines*. Pittsburgh, PA: Document adopted by the Allegheny County Mental Health Court Team.

Allegheny County Mental Health Court (2009). *Program Listing, Mental Health Consensus Project.* New York, NY: The Justice Center of the Council of State Governments. Retrieved June 2, 2009, from: http://consensusproject.org/program_exam ples/allegheny_county_mental_health_court

Allegheny County Mental Health Court Task Force (2001). *Informational Packet for Support of the Enactment of Senate Bill 917* [Session of 2001, amending Title 42 Judiciary and Judicial Procedure of the PA Consolidated Statutes, providing for a mental health court division, November, 2001].

Allegheny County Overdose Initiative (February 2009). *Every Life is Worth Saving: Strategic plan to address overdose and overdose deaths within Allegheny County*. Retrieved January 2, 2011, from: http://www.peru.pitt.edu/overdose/materials/Every%20Life%20is%20Worth%20Savin g%20Strategic%20Plan_2-27-09.pdf

Allegheny Health Choices, Inc. (2009). *Reports on Persons Discharged from Mayview State Hospital for the Quality Improvement/Outcomes Committee and Steering Committee*, January, 2009. Retrieved December 20, 2010 at: http://www.ahci.org/Reports/QualityFocusReports/MRSAP%20Report%2020090202.p df

Almquist, L. & Dodd, E. (2009). *Mental health courts: A guide to research-informed policy and practice*. New York, NY: Council of State Governments Justice Center and the MacArthur Foundation.

American Psychiatric Association (2000). *Psychiatric services in jails and prisons* (*2nd Ed.*) . Washington, D.C.: APA.

Andrews, D.A., & Dowden, C. (2009). Keeping a respectful eye on crime prevention: A response to Birgden. *Canadian Journal of Criminology and Criminal Justice*, 51 (1): 119-122.

Assertive Community Treatment Association (2009). *ACT Model*. Retrieved September 20, 2010 from: http://www.actassociation.org/actModel/

Babbie, E. R. (2001). *The practice of social research*, 9th Ed. Belmont, CA: Wadsworth Thompson Learning.

Ball, J.D. (2006). Is it a prosecutor's world? Determinants of count bargaining decisions. *Journal of Contemporary Criminal Justice*, *22*(3), 241-60.

Bazelon Center for Mental Health Law (2004). *The role of mental health courts in system reform*. Retrieved January 30, 2011, from: http://www.bazelon.org/LinkClick.aspx?fileticket=xQf5_1grKcI%3d&tabid=104

Belenko, S. (1998). *Research on drug courts: A critical review*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University. Reprinted from *National Drug Court Institute Review*, *1*, 1-42.

Belenko, S. (1999). *Research on drug courts: A critical review: 1999 update*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University. Reprinted from *National Drug Court Institute Review*, *2*(2), 1-58

Belenko, S. (2001). *Research on drug courts: A critical review*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University.

Bernstein, R. & Seltzer, T. (2003). Criminalization of people with mental illnesses: The role of mental health courts in system reform. *The University of the District of Columbia Law Review*, *7*, 143-62.

Birgden, A. (2009). Crime prevention jurisprudence? A response to Andrews and Dowden. *Canadian Journal of Criminology and Criminal Justice*, *51*(1), 93-117.

Birgden, A. (2004). Therapeutic jurisprudence and responsivity: Finding the will and the way in offender rehabilitation. *Psychology, Crime, & Law*, *10*(3), 283- 95.

Braithwaite, J. (1989). *Crime, shame, and reintegration*. Cambridge, UK: Cambridge University Press.

Carroll, S. J & Tosi, H.L. (1977). *Organizational behavior*. Chicago: St. Clair Press.

Carson, D. (2003). Therapeutic jurisprudence and adversarial injustice: Questioning limits. *Western Criminology Review*, *4*(2), 124-33.

Casey, P. & Rottman, D.B. (2000). Therapeutic jurisprudence in the courts. *Behavioral Sciences and the Law*, *18*, 445-47.

Castellano, U. (2009). Beyond the courtroom workgroup: Caseworkers as the new satellite social control. *Law & Policy*, *31*(4), 429–62.

Center for Behavioral Health Services & Criminal Justice Research, Rutgers University (2010). *Policy Brief: Mental Health Courts*. Retreived November 28, 2010 from: www.cbhs-cjr.rutgers.edu/pdfs/Policy_Brief _Oct_2010.pdf

Center for Behavioral Health Services & Criminal Justice Research, Rutgers University (2009). *Intervention Fact Sheet: Mental Health Courts*. Retrieved May 12, 2009, from: http://www.cbhs-cjr.rutgers.edu/pdfs/MentalHealthCourts.pdf

Center for Court Innovation (2011). *Evaluating Your Program: Problem-Solving Justice* Factsheet. Retrieved January 28, 2011 from: http://www.courtinnovation.org/_uploads/documents/Evaluating_Your_Program[1].pdf

Christy, A., Poythress, N. G., Boothroyd, R. A., Petrila, J. & Mehra, S. (2005). Evaluating the efficiency of the Broward County mental health court. *Behavioral Sciences and the Law*, *23*, 227-43.

Cloyes, K.G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior*, *37(*2), 175-187.

Colyer, C. J. (2004). Sentencing the cure: Treatment facilitation and crime control management in a drug court workgroup. Syracuse University: *Dissertation Abstracts International*, Publication No. AAT No. 3132684.

Council of State Governments Justice Center (2008). *Mental health courts: A primer for policymakers and practitioners*. Report prepared for the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. New York, NY: Council of State Governments.

Council of State Governments (2005). *A guide to mental health court design and implementation: 2nd ed., draft.* New York, NY: Council of State Governments.

Council of State Government (2005). *The essentials of a mental health court: Feedback from an online pol*l. New York, NY: Council of State Governments.

Cox, L. (2010). *Problem-solving in Seattle and King County Courts: A survey of judges, prosecutors, and public defenders*. Institute for Court Management, Court Executive Development Program, 2009-2010 Phase III Project (May 2010). Seattle, WA: Institute for Court Management.

Criminal Justice/Mental Health Information Network (2009). *Project of the Justice Center of the Council of State Governments*, New York, NY. Retrieved April 28, 2009 from:
http://www.cjmh-infonet.org/main/show/2536
[Accessible at http://consensusproject.org/programs_start]

Denzin, N.K. (2002). The interpretive process. In A.M. Huberman & M.B. Miles (Eds.) *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage.

Ditton, Paula M. (1999). Bureau of Justice Statistics Special report: *Mental health and treatment of inmates and probationers*. Washington, D. C.: U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Eisenhardt, K.M. (2002). Building theories from case study research. In A.M. Huberman & M.B. Miles (Eds.) *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage.

Eisenstein, J., & Jacob, H. (1977). *Felony justice: An organizational analysis of criminal courts*. Boston, MA: Little, Brown.

Eisenstein, J., Flemming, R.B., & Nardulli, P.F. (1988). *The contours of justice: Communities and their courts.* Boston, MA: Little, Brown.

Engen, R.L., and Steen, S. (2000). The power to punish: Discretion and sentencing reform in the war on drugs. *American Journal of Sociology*, 1*05*(5), 1357-95.

Engen, R.L., and Steiger, J. (1997). *Trading time for treatment:: Preliminiary evaluation of the drug offender sentencing alternative*. Olympia, WA: State of Washington Sentencing Guidelines Commission.

Eno Loudon, J., Skeem, J.L., Camp, J. & Christensen, E. (2008). Supervising probationers with mental disorders: How do agencies respond to violations? *Criminal Justice and Behavior*, *35*(7), 832-847.

Erickson, S.K., Campbell, A., & Lamberti, J.S. (2006). Variations in mental health courts: Challenges, opportunities, and a call for caution. *Community Mental Health Journal, 42*(4), 335-344.

Fahy, J. (1998, July 24). Referrals to Western Psych halted: State intervenes after rash of incidents involving outpatients. *Pittsburgh Post-Gazette*. Retrieved July 25, 2008, from:
http://www.post-gazette.com/pg/08206/899182-455.stm

Fahy, J. (2008, August 1). Probe focuses on outpatient referrals to Western Psych. *Pittsburgh Post-Gazette*. Retrieved July 25, 2008 from: http://www.post-gazette.com/pg/08214/901053-114.stm

Fazel. S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359*, 545-50.

Fisher, W.H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration & Policy in Mental Health & Mental Health Services Research*, *33*, 554-557.

Fisler, C. (2005). Building trust and managing risk: A look at a felony mental health court. *Psychology, Public Policy, and Law*, *11*(4), 587-604.

Flemming, R.B., Nardulli, P.F., & Eisenstein, J. (1992). *The craft of justice: Work and politics in criminal court communities*. Philadelphia: University of Pennsylvania Press.

Flick, U. (2004), Triangulation in qualitative research. In U. Flick, E. von Kardoff & I. Steinke (Eds.) *A companion to qualitative research*. Thousand Oaks, CA: Sage Publications.

Fraser, J. (2004). *Mental health court: Final report (9-03-04*). Report prepared on the Allegheny County Mental Health Court by the Mental Health Association of Allegheny County. Pittsburgh, PA: Mental Health America.

Frontline*:* "*The Released"* (2009). Retrieved April 29, 2009 from: http://www.pbs.org/wgbh/pages/frontline/released/inside/

Fulkerson, A. (2009). The drug treatment court as a form of restorative justice. *Contemporary Justice Review*, *12*(3), 253-67.

Gebo, E., Stracuzzi, N.F., & Hurst, V. (2006). Juvenile justice reform and the courtroom workgroup: Issues of perception and workload. *Journal of Criminal Justice*, *34*(4), 425-33.

Gurrera, M.M. (2007). An evaluation of a mental health court: Process, procedure, and outcome. North Carolina State University: *Dissertation Abstracts International*, *68*(06), Publication No. AAT No. 3269390.

Glassberg, H. & Dodd, E. (2008). *A guide to the role of crime victims in mental health courts*. Report to the Council of State Governments Justice Center. New York, NY: Council of State Governments.

Goldberg, S. (2005). *Judging for the 21st Century: A Problem-solving Approach*. Report for the National Judicial Institute. Ottawa, ON, Canada: National Judicial Institute. Adapted from: Popovic, J. (2003, Dec.). "Judicial Officers: Complementing Conventional Law and Changing the Culture of the Judiciary." *Law in Context: Therapeutic Jurisprudence* [special issue] *20*(2), 121-136.

Goldkamp, J. S. (2000). The drug court response: issues and implications for justice change. *Albany Law Review*, *63(*3), 923-61

Goldkamp J.S., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal case load: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.* Report prepared for the Crime and Justice Research Institute, Bureau of Justice Assistance, Office of Justice Programs. Washington, D.C.: Office of Justice Programs.

Goldkamp, J.S., White, M.D., & Robinson, J. R., (2001) Do drug courts work? Getting inside the drug court black box. *Journal of Drug Issues*, *31*(1), 27-72.

Goss, S.S. (2008). Mental health court programs in rural and non-affluent jurisdictions. *Criminal Justice Review, 33*(3), 405-13.

Government Accountability Office (Februrary 2005). *Adult drug courts: Evidence indicates recidivism reductions and mixed outcomes for other outcomes; Report to Congressional communities*. Washington, D.C.: U. S. Government Accountability Office.

Gray, A. R., & Saum, C. A. (2005). Mental health, gender, and drug court completion. *American Journal of Criminal Justice. 30*(1), 55-71.

Grisso, T. & Vincent, G. M. (2005). The empirical limits of forensic mental health assessement. *Law & Human Behavior, 29*(1), 1-5.

Harrell, A. (1998). Drug courts and the role of graduated sanctions. *Alternatives to Incarceration*, *4*(6), 26-7.

Harrell, A. (2003). Judging drug courts: Balancing the evidence. *Criminology and Public Policy*, *2*(2), 207-12.

Harris, J. C. & Jesilow, P. (2000). It's not the old ball game: Three strikes and the courtroom workgroup. *Justice Quarterly*, *17*(1), 185-2004.

Hartley, R. E. & Phillips, R. C. (2001). Who graduates from drug courts? Correlates of client success. *American Journal of Criminal Justice, 26*(1), 107-120.

Harvard Mental Health Letter (2006). Mental health courts. Cambridge, MA: Harvard Health Publications, August 1, 2006.

Haynes, S.H., Ruback, B., & Cusick, G.R. (2010). Courtroom workgroups and sentencing: The effects of similarity, proximity, and stability. *Crime & Delinquency*, *56*(1), 126-61.

Herinckx, H.A., Swart, S.C., Ama, S.M., Dolezal, C.D., & King, S. (2005). Rearrest and linkage to mental health services among clients of the Clark County mental health court program. *Psychiatric Services*, *56,* 563-57.

Huddleston, C.J. III, Marlowe, D. B., & Casebolt, R. (2008). *Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States* (Vol. II, No. 1, May 2008). Alexandria, VA: National Drug Court Institute, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.

Human Services Administration Organization (2001). *Forensic MH Court Probation Liaison* [job description contract], June 22, 2001.

Human Services Administration Organization (2002). *Forensic MH Court Monitor* [job description contract], December 1, 2002.

Jewish Healthcare Foundation (2010). Retrieved December 20, 2010 from: http://www.jhf.org/

Knepper, P.E., & Barton, S.M. (1997). The effect of courtroom dynamics on child maltreatment proceedings. *Social Service Review*, *71*(2), 288-308.

Kondo, L. (2001). Advocacy of the establishment of mental health specialty courts in the provision of therapeutic justice for mentally ill offenders. *American Journal of Criminal Law*, *28*(3), 255-337.

Krakoff, J. (1998, August 30). "Cruel and Unusual Punishment: In 1977, many inmates in the old Allegheny County Jail endured horrifying conditions". *Pittsburgh Post-Gazette*. Retrieved April 24, 2009 from: http://www.post-gazette.com/magazine/19980830jail1.asp

Kroll, A. (2002). *Semi-Annual Reports, Allegheny County Mental Health Court* (May 15, 2002 Report). Pittsburgh, PA. Unpublished reports to Allegheny County Department of Human Services Office of Behavioral Health.

Kroll, A. (2003). *Semi-Annual Reports, Allegheny County Mental Health Court* (April 1, 2003 Report). Pittsburgh, PA. Unpublished reports to Allegheny County Department of Human Services Office of Behavioral Health.

Kroll, A. (2004). *Semi-Annual Reports, Allegheny County Mental Health Court* (Sept. 4, 2004 Report). Pittsburgh, PA. Unpublished reports to Allegheny County Department of Human Services Office of Behavioral Health.

Kroll, A. (2005a). *Semi-Annual Report, Allegheny County Mental Health Court* (Mar. 7, 2005 Report). Pittsburgh, PA. Unpublished reports to Allegheny County Department of Human Services Office of Behavioral Health.

Kroll, A. (2005b). *Semi-Annual Report, Allegheny County Mental Health Court* (June 7, 2005 Report). Pittsburgh, PA. Unpublished reports to Allegheny County Department of Human Services Office of Behavioral Health.

Kupchik, A. (2004). Youthfulness, responsibility, and punishment. *Punishment & Society*, *6*(2), 149-73.

Lamb, H.R. & Weinberger, L.E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services*, *49*, 483-92.

Latimer, J., Dowden, C., & Muise, D. (2005). The effectiveness of restorative justice practices: A meta-analysis. *The Prison Journal*, *85*(2), 127-44.

Lemley, E. (2001). Designing restorative justice policy: An analytical perspective. *Criminal Justice Policy Review*. *12*(1), 43-65.

Levrant, S., Cullen, F.T., Fulton, B., & Wozniak, J.F. (1999). Reconsidering restorative justice: The corruption of benevolence revisited? *Crime and Delinquency*, *45*(1), 3-27.

Lincoln, Y.S., & and Guba, E.G. (2002). Judging the quality of case study reports. In A.M. Huberman & M.B. Miles (Eds.) *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage.

Lurigio, A.J. & Fallon, J. (2007). Individuals with serious mental illness in the criminal justice system; The case of Richard P. *Clinical Case Studies*, *6*(4), 362-78.

Lurigio, A.J. & Snowden, J. (2009). Putting therapeutic jurisprudence into practice: The growth, operations, and effectiveness of mental health court. *Justice System Journal*, *30*(2), 196-218.

Luskin, M.L. (2001). Who is diverted? Case selection for court-monitored mental health treatment. *Law & Policy*, *23*(2), 217-236.

Mamula, K. B. (2010, November 4). "Psych admissions on the rise as number of beds reaches a low point". *Pittsburgh Business Times*. Retrieved November 20, 2010 from: http://bizjournals.com/pittsburgh/print-edition/2010/11/05/psych-admissions-on-the-rise.html

Marlowe, D. B. (2008). *Application of sanctions,* in *Quality improvement for drug courts* (Monograph Series 9), in Hardin, C. & Kushner, J.N, Eds. Alexandria, VA: National Drug Court Institute, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.

Maxfield, M.G., & Babbie, E. (2005). *Research methods for criminal justice and criminology*. Belmont, CA: Wadsworth Thomson Learning.

Maxwell, G., & Morris, A. (2002). Restorative justice and reconviction. *Contemporary Justice Review: Issues in Criminal Social and Restorative Justice*, *5*(2), 133-146.

Maxwell, J.A. (2002). Understanding and validity in qualitative research. In A.M. Huberman & M.B. Miles (Eds.) *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage.

McKay, M., Davis, M., & Fanning, P. (1983). Messages: The communication skills book. Oakland: New Harbinger. Cited in Wengraf, T. (2001). *Qualitative research*

interviewing: Biographic narrative and semi-structureed methods. Thousand Oaks, CA: Sage Publications.

McLellan, A. T. (2008). Evaluating the effectiveness of addiction treatments, in *Quality improvement for drug courts: Evidence-based practices* (Monograph Series 9), in Hardin, C. & Kushner, J.N, Eds. Alexandria, VA: National Drug Court Institute, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.

McNeil, D.E. & Binder, R. L. (2007). Effectiveness of a mental health court in reducgin criminal recidivism and violence. *American Journal of Psychiatry*, *164*, 1395-1402.

Mental Hygiene Law, Title B. Mental Health Act, Article 9. Hospitalization of the Mentally Ill, NY CLS Men Hyg § 9.60 [Kendra's Law"] (1999).

Merriam, S.B., (2002a). "Asessing and evaluating qualitative research", in Merriam, S.B. & Associates, Eds., *Qualitative Research in Practice: Examples for Discussion and Analysis*. San Francisco, CA: Jossey-Bass.

Merriam, S.B., (2002b). "Introduction to qualitative research", in Merriam, S.B. & Associates, Eds., *Qualitative Research in Practice: Examples for Discussion and Analysis*. San Francisco, CA: Jossey-Bass.

Merriam, S.B., (2002b). "Reflections on doing qualitative research", in Merriam, S.B. & Associates, Eds., *Qualitative Research in Practice: Examples for Discussion and Analysis*. San Francisco, CA: Jossey-Bass.

Merritt, N. (2007, Nov.). *Sentencing Reform and the Influence of Courtroom Communities*. Presentation to the Annual Meeting of The American Society Of Criminology, Atlanta, GA.

Meyer, W. G., & Ritter, A. W. (2001-2002). Drug courts work. *Federal Sentencing Reporter*, *14*(3-4), 179-85. Nov. 2001-Feb. 2002

Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recdivism risk in drug court: Explanations for some unexpected findings. *Crime and Delinquency*, *46*(4), 522-41.

Miller, S. L. & Perelman, A. M. (2009). Mental health courts: An overview and redefinition of tasks and goals. *Law & Psychology Review*, *33*, 113-124.

Milton, L. P., & Westphal, J. D. (2005). Identity confirmation networks and cooperation in work groups. *Academy of Management Journal*, *48*, 2.

Minnesota Judicial Branch, Fourth Judicial Branch Research Division (2006*).* *Evaluation of the Hennepin County Mental Health Court* (May 2006). Retrieved

January 2, 2011 from:
www.mncourts.gov/documents/4/Public/Research/MHC_eval.doc

Minnesota Judicial Branch, Fourth Judicial Branch Research Division (2005). *Probate/Mental Health Court Fairness Study* (October 2005).
Retrieved January 2, 2011 from:: http://www.mncourts.gov/district/4/?page=1741

Moore, M. E. & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court partipans. *Law & Human Behavior, 30*, 659-674.

Munetz, M. R..& . Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services 57*, 544-549.

Nardulli, P.F., Eisenstein, J., & Flemming, R.B. (1992). *The tenor of justice*. Urbana: University of Illinois Press.

National Association for the Mentally Ill (2008). *Decriminalizing mental illness: Background and recommendations: A white paper prepared by the Forensic Taskforce of the NAMI Board of Directors*. Arlington, VA: NAMI.

National Association for the Mentally Ill, TAPA Center, National Gains Center for People with Co-Occurring Disorders in the Justice System, and the Mental Health Consensus Project (2005). *Survey of mental health courts*. National Council of State Governments. Arlington, VA: NAMI.

National Association of Drug Court Professionals (2011). Retrieved January 31, 2011 from: http://www.nadcp.org/learn/about-nadcp

National Association of Drug Court Professionals (2010). Fact sheet: The Facts on Drug Courts. Retrieved December 30, 2010 from:
http://www.nadcp.org/sites/default/files/nadcp/Facts%20on%20Drug%20Courts_0.pdf

National Association of Drug Court Professionals Drug Court Standards Committee (1997). Defininig Drug Courts: The Key Components. Washington, D. C.: U. S. Department of Justice, Office of Justice Programs, Drug Courts Progarm Office. Retrieved March 31, 2011 from:
http://www.ndci.org/sites/default/files/ndci/KeyComponents.pdf

Needell, N.J. & D'Emic, M. (2005). The Brooklyn Mental Health Court-A collaborative effort. *Psychiatric Times*, *22*(6), 14-15.

New York State Office of Mental Health (2005). Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. Retrieved April 1, 2011, from:

http://www.nami.org/Content/Microsites86/NAMI_Albuquerque/Home82/Current_Activities/NAMIWalks6/AOTFinal2005-Kendra's_Law.pdf

Nolan, J. L. (2007, August 11). *Problem-solving in criminal courts: A comparative analysis of legal transplantation*. Presentation to the annual meeting of the American Sociological Association, New York, NY. Retrieved March 4, 2009 from: http://www.allacademic.com/meta/p185314_index.html

Nunes, E. V. & Levin, F. R. (2004). Treatment of depression in patients with alcohol or other drug dependence: A meta-analysis. *Journal of the American Medical Association*, 291: 1887-1896.

O'Keefe, K. (2006). *The Brooklyn Mental Health Court evaluation: Planning, implementation, courtroom dynamics, and participant outcomes*. Report to to the New York State Office of Mental Health: Center for Court Innovation and the New York State Unified Court System. New York, NY: Center for Court Innovation.

Olson D.E., Lurigio, A. J., & Albertson, S. (2001). Implementing the key components of drug courts : Practice and policy considerations. *Law & Policy*, *23*(2), 171-196.

Osher, F. C., & Levine, I. S. (2005). *Navigating the mental health maze: A guide for practitioners*. New York, NY: Council of State Governments; Washington, D. C.: U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*: 3rd Ed. Thousand Oaks, CA: Sage.

Pennsylvania Commission on Crime and Delinquency (2010). Mental Health Courts. Retrieved January 13, 2011, from:
http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5281&&PageID=494082&level=3&css=L3&mode=2

Petrusic-Cooper, T. (2006). *Allegheny County Mental Health Court Evaluation* (January 2006). Pittsburgh, PA: Allegheny County Department of Human Services Office of Information Management.

Pew Center on the States and the Public Safety Performance Project (2008). *One in 100: Behind bars in America* (2008). Washington, D.C.: Pew Charitable Trusts.

Pro, J. A. (1998, December 4). "Jail crowding ahead of its time". *Pittsburgh Post-Gazette*. Retrieved April 24, 2009 from: http://www.post-gazette.com/regionstate/19981204prison4.asp

Raines, J., & Laws, G. (2008). *Mental health court survey*. Social Science Research Network. Retrieved April 1, 2011 from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1121050

Redlich, A.R., Steadman, H.J., Monahan, J., Robbins, P.C., Petrila, J. (2006). Patterns of practice in mental health courts: A national survery. *Law & Human Behavior*, *30*, 347-62.

Redlich, A. R., Steadman, H.J., Monahan, J., Petrila, J., & Griffiin, P.G. (2005). The second generation of mental health courts. *Psychology, Public Policy, and Law*, *11*(4), 527-38.

Ridgely, M.S., Engberg, J. & Greenberg, M.D., RAND Technical Report (2007). *Justice, treatment, and cost: An evaluation of the fiscal impact of Allegheny County Mental Health Court.* Pittsburgh, PA: Rand Corporation. Retrieved June 1, 2007, from: http: //www.rand.org/pubs/technical_reports/TR439/

Rottman, D. B. (2000). Does effective therapeutic jurisprudence require specialized courts (and do specialized courts imply specialist judges)? *Court Review*, *37*(1), 22-7. Retrieved April 26, 2009, from http://www.lexisnexis.com

Rutherford & Duggan (2008). Forensic mental health services: Facts and figures on current provision. *The British Journal of Forensic Practice*, *10* (4), 4-7.

Sanford, J.S., & Arrigo, B.A. (2005). Lifting the cover on drug courts: Evaluation findings and policy concerns. *International Journal of Offender Therapy and Comparative Criminology*, *49*(3), 239-59.

Santora, M. (2004, February 18). "Court Upholds Law for Forced Treatment". *The New York Times*, Section B, Metropolitan Desk, p. 4.

Sarteschi, C.M. (2009). *Assessing the effectiveness of mental health courts: A meta-analysis of clinical and recidivism outcomes*. (Doctoral dissertation, University of Pittsburgh, Pennsylvania). Dissertations & Theses, Full Text (Publication No. AAT 3384946). Retrieved December 18, 2011 from: http://proquest.umi.com/pqdlink?did=1922955941&Fmt=7&clientId=79356&RQT=309&VName=PQD

Sarteschi, C. M., Vaughn, M. G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice, 39*, 12-20.

Schiff, M. & Terry, W. C., III. (1997). Predicting graduation from Broward County's dedicated drug treatment court. *Justice System Journal*, *19*, 291-310.

Schmidt, C. (2004), "The analysis of semi-structured interviews", in Flick, U., von Kardoff, E., & & Steinke, I, Eds. *A companion to qualitative research*. Thousand Oaks, CA: Sage.

Schofield, J.W. (2002). Increasing the generalizability of qualitative research. In A.M. Huberman & M.B. Miles (Eds.) *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage.

Selzer, T. (2005). Mental health courts: A misguided attempt to address the criminal justice system's unfair treatment of people with mental illnesses. *Psychology, Public Policy, & Law*, *11*(4), 570-86.

Shapland, J. Atkinson, A., Atkinson, H., Colledge, E., Dignan, J., Howes, M., Johnstone, J., Robinson, G., & Sorsby, A. (2006). Situation restorative justice within criminal justice. *Theoretical Criminology*, *10*(4), 505-32.

Sherman, J. (2008, October 29). "19 crimes tied to mental health patients". *Pittsburgh Post-Gazette*. Retrieved July 25, 2008 from: http://www.post-gazette.com/pg/08303/923614=85.stm

Skeem, J.L., Emke-Francis, P., & Eno Loudon, J. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior*, *33*(2), 158-84.

Slobogin, C. (1995). Therapeutic jurisprudence: Five dilemnas to ponder. *Psychology, Public Policy, & Law*, I(1), 193-219.

Sly, K.A., Sharples, J., Lewin, T.J., & Bench, C.J. (2009). Court outcomes for clients referred to a community mental health court liason service. *International Journal of Law and Psychiatry*, *32*, 92-100.

Staughton Farm Foundation (2010). Retrieved December 20, 2010 from: http://stauntonfarm.org.

Steadman, H. J. (2005). *A guide to collecting mental health court outcome data*. New York: Council of State Governments.

Steadman, H.J., Redlich, A. D., Griffiin, P.G., Petrila, J. & Monahan, J. (2005). From referral to disposition: Case processing in seven mental health courts. *Behavioral Sciences and the Law*, *23*, 215-226.

Stefan, S. & Winick, B. L. (2005). A dialogue on mental health courts. *Psychology, Public Policy, and Law*, *11*(4), 507-526.

Substance Abuse and Mental Health Services Administration (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Washington, D.C.: U.S. Department of Health and Human Services.

Torry, E.F., Kennard, A. D., Eslinger, D., Lamb, R. & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Arlington, VA: Treatment Advocacy Center. Retrieved March 10, 2011 from:

http://www.treatmentadvocacycenter.org/storage/tac/documents/final_jails_v_hospitals_study.pdf

Thompson, M., Osher , F., & Tomasini-Joshi, D. (2007). *Improving responses to people with mental ilnesses: The essential elements of a mental health court*. New York, NY: Council of State Governments Justice Center.

Tyuse, S.W. & Linhorst, D.M. (2005). Drug courts and mental health courts: Implications for social work. *Health & Social Work*, *30*(3), 233-40.

Ulmer, J.T., & Kramer, J.H. (1998). The use and transformation of formal decision-making criteria: Sentencing guidelines, organizational contexts, and case processing strategies. *Social Problems*, *45*(2), 248-67.

Schwartz, E. (2008). Mental health courts: How special courts can serve justice and help mentally ill offenders. *U.S. News & World Report*. Retrieved May 4, 2009, from http://www.usnews.com/articles/news/national/2008/02/07/mental-health-courts

Valentine, P. L. (October 31, 2000). *Allegheny County Mental Health Court Project*. Pittsburgh, PA: Allegheny County Mental Health Court Task Force.

Ward, G., Farrell, A. & Rousseau, D. (2007, Nov.) . *The contextual significance of federal courtroom workgroup racial diversity on sentencing outcomes.* Presentation to the Annual Meeting of The American Society Of Criminology, Atlanta, GA.

Wemmers, J. (2008). Victim participation and therapeutic jurisprudence. *Victims and Offenders*, *3*, 165-91.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structureed methods*. Thousand Oaks, CA: Sage.

Which Way Out? *The Sequential Intercept Model: A Framework for Decriminalizing Mental Illness* (2007, November 14-16). Conference sponsored by Allegheny County Department of Human Services, the University of Pittsburgh Center on Race & Social Problems, the University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences, & the Ash Institute at Harvard University, Pittsburgh, PA.

White, R. (2004). Community corrections and restorative justice. *Current Issues in Criminal Justice: Journal of the Institute of Criminology*, *16*(1), 42-56.

White Stack, B. (2000, July 18). Released mentally ill addicts to get help. *Pittsburgh Post-Gazette*. Retrieved June 2, 2009 from: http://www.post-gazette.com/regionstate/20000718grant1.asp

Wolff, N. (2002). ‘ New’ public management of mentally disordered offenders: Part I. A cautionary tale. *International Journal of Law and Psychiatry*, *25*, 15-28.

Wolff, N., & Pogorzelski, W. (2005). Measuring the effectiveness of mental health courts: Challenges and recommendations. *Psychology, Public Policy, and Law*, *11*(4), 539-569.

Wyatt, S. (2003). Sentenced to treatment: California's mentally ill offender crime reduction grant and the mental health court. The Wright Institute: *Dissertation Abstracts International*, Publication No. AAT No. 3084502.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Beverly Hills, CA: Sage.

Zottola, J. A. (2008, July 3). Frontline: "*The Released"*. [Transcript of interview]. Retrieved April 29, 2009 from: http://www.pbs.org/wgbh/pages/frontline/released/inside/zottola.html

APPENDIX A

CONNECTION OF RESEARCH QUESTIONS WITH METHODS

Research Questions	Interviews w/MHC Professionals	Interviews w/MHC participants	Observation of court and workgroups	Documentary information	Quantitative Data
Foundation and purposes	X			X	
Clients, needs ID, satisfaction	X	X	X		X
Workgroup interaction and decisions	X	X	X		
Restorative justice tenets	X	X	X	X	
Evolution of purpose, philosophy	X		X	X	X
Court objectives, participant perspectives	X	X	X	X	X
Possible manner for different operation	X	X	X		X
Model protocol for other courts	X	X	X	X	

APPENDIX B

VOLUNTARY CONSENT FORM

PERSONAL INTERVIEW – Mental Health Court Team

This is an invitation to participate in a research study. The study is to be conducted by doctoral candidate Melanie Pallone, under the direction of Dr. Kathleen Hanrahan of the Department of Criminology at the Indiana University of Pennsylvania.

The researcher plans to examine the formation of the Mental Health Court located in Pittsburgh, Allegheny County, Pennsylvania. She will study the workings of the courtroom team formed to handle the treatment and regulation of offenders with serious mental illness, and the perspectives of staff and participants of the Court about the value of the Court for the purposes it was intended.

The study will use several different research methods, such as courtroom observation and interviews of Court staff and participants, along with review of documents from agencies involved in the Court, analysis of agency records, and news reports, to confirm her findings. The study's goal is to add to research on special problem-solving courts, about what might be necessary, sufficient, and appropriate for a Mental Health Court to be founded and to operate for the benefit both of treatment of mentally ill offenders, and safety of the community.

The information below is provided to help you to make an informed decision whether or not to participate in this study. If you have any questions, please do not hesitate to ask the researcher. You are eligible to take part in this study because you are employed by the County of Allegheny or you or your employer contract with the County of Allegheny, and you work in some capacity with the County's Mental Health Court.

Taking part in this study is completely voluntary. There are no financial benefits to talking to the interviewer. There are no other benefits, except that your thoughts and opinions about the Mental Health Court will be heard and considered for the study's results. On the other hand, there are no repercussions for not taking part in the study. The interview will take about an hour, over lunch or at another time of your convenience.

You are free to decide to take part in this study or not. Also, you can decline to answer any particular question(s). You are also free to withdraw from the study at any time without adversely affecting your employment or your participation in the Court. Your decision will not result in any loss of benefits to which you are otherwise entitled. If you choose to participate, you may withdraw at any time by notifying the researcher conducting the interview with you. Should you request to withdraw, all information pertaining to you and your interview will be destroyed, if that is your wish.

If you choose to take part in this study, all information about you will be held in strict confidence. Your agreement to take part will have no affect on your employment, or on your participation in the Court. The interview with you and any other observations about you and others involved in the Court is anonymous.

Should I need additional information or clarification from you as the study progresses, I may contact you for a follow-up interview. Any such follow-up interview will also be completely voluntary and confidential, and I will ask you to sign a new consent form prior to the start of a second interview. Note that in order to seek your consent to conduct a follow-up interview, I will need to be able to contact you in the near future with a current phone number.

No risk is anticipated for Court participants who take part in interviews. Persons interviewed will be referred to as "criminal justice professionals" or "treatment professionals", so that readers of the study cannot attribute an opinion or statement to you in particular. Please note that the information you provide will be considered only in combination with that of other Court participants or other Court team staff. The information obtained in the study may be published in social science journals or presented at scientific meetings, but your identity will be kept confidential by the researcher.

However, if a statement you made in the interview is specifically worth quoting word-for-word, and your role in the court is important to understand the context for your words, the researcher may return to you for specific written permission to identify your role. However, efforts will be made not to link such a quote to any other statement you might have made, to maintain your confidentiality. If you do not wish your quote to be attributed in this manner, it will not be; the quote will be paraphrased so as to protect your confidentiality.

If you are willing to take part in this study, please sign and date this statement on the next page, and return it to the researcher administering the survey. You will be provided with a copy of this consent form once it is signed and dated. After answering the interview questions, you may receive the results of the study by contacting the researcher.

Project Director: Melanie Pallone, Doctoral Candidate
Faculty Sponsor: Dr. Kate Hanrahan, Professor of Criminology
Department of Criminology
Indiana University of Pennsylvania (IUP)
105 Wilson Hall
Indiana, PA 15705
Phone: 724/357-3927

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730).

Informed Consent Form (continued)

VOLUNTARY CONSENT FORM:

I have read and understand the information on the form and I consent to volunteer to be a person interviewed for this study.
I understand that my responses are completely confidential and that I have the right to withdraw at any time.
I have received an unsigned copy of this informed Consent Form to keep in my possession.

In the event I am willing to volunteer for a follow-up interview, should I be invited, I can be contacted at the phone number and times listed below.

Name (PLEASE PRINT) _____

Signature _____

Date _____

Phone number where you can best be reached _____

Best days and times to reach you _____

I certify that I have explained to the above-named individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, that I have answered any questions that have been raised, and that I have witnessed the above signature.

_____ _____

Date **Researcher's Signature**

APPENDIX C

VOLUNTARY CONSENT FORM

PERSONAL INTERVIEW – Court Participant

You have received this invitation to participate in a research study. You are eligible to take part in this study because you participate in the Mental Health Court or because you graduated from the Court. The study will be done by Melanie Pallone, a doctoral student at the Indiana University of Pennsylvania. She is being supervised by Dr. Kathleen Hanrahan of the Department of Criminology there.

I plan to look at how the Mental Health Court located in Pittsburgh, Allegheny County, Pennsylvania, was formed. The goal of this research is to study special problem-solving courts, and what might be needed to start and operate a Mental Health Court for the treatment of mentally ill offenders, and for the safety of the community.

The study will use several different methods for the research. First, I will observe court cases. For this, I will study the team in the courtroom who handle cases of defendants who have mental illness and the participants who appear in Court. Next, I will interview court staff, and participants of the Court about the value of the Court for the purposes it was meant. Third, I will review documents written about the Court from various agencies, and news reports written about the Court. Finally, I will analyze case file records to confirm my findings.

The information listed below is to help you to decide whether or not to participate in this study. If you have any questions, please do not hesitate to ask me. If you agree to talk to me, I will interview you about your experiences in the Court and your opinions about it. The interview will take about a half hour.

You are completely free to decide to take part in this study or not. You will not gain any new benefits by agreeing to talk to me, and you will not be paid to talk to me. However, your thoughts and opinions about the Mental Health Court will be heard and considered for the study's results. On the other hand, nothing will change if you decide not to take part in the study. Your participation in the Court will not be affected either way.

During the interview, if there is particular question are not comfortable answering, you can tell me you do not want to answer it. You are also completely free to stop the interview at any time even if you chose to be involved. All you have to do to stop the interview is to tell me when we are talking. If you stop the interview, it will not affect your participation in the Court in any way. Your decision to stop will not mean that you lose any benefits that you were already receiving. If you ask to stop the interview, any information about you and your interview will be erased, if that is what you wish me to do.

The interview with you and any other observations about you and others involved in the Court is anonymous or secret. If you decide to take part in this study, all information about you will be completely kept confidential.

If I need additional information from you in the near future, I may contact you for a follow-up interview. Again, you will be completely free to talk to me or not to talk to me. A follow-up interview will also be voluntary and confidential. Likewise, I will ask you to sign a new consent form before starting a follow-up interview. Please note that I will need to be able to contact you with a current phone number if you are willing to conduct a follow-up interview with me.

I do not believe that there is a risk to you if you decide to take part in an interview with me. I will not ask you about sensitive topics. I will only ask questions about the way the Mental Health Court works and about your experiences in it or in other courts. No information to identify you personally will be written into the study.

Please note that the answers you give to my questions will only be considered in combination with those of other Court participants. Readers of the results of the study will not be able to tell what you may have said to me. The information I gather in the study may be published in educational journals or presented at scientific meetings, but your identity will always be kept confidential and secret by me.

If you are willing to take part in this study by being interviewed, please sign and date this form on the next page. Then please return the consent form to me. I will give you a copy of this consent form once it is signed and dated. After answering the interview questions, you can get the results of the study by leaving a message for me at the phone number that is listed here:

Project Director: Melanie Pallone, Doctoral Candidate
Faculty Sponsor: Dr. Kate Hanrahan, Professor of Criminology
Department of Criminology
Indiana University of Pennsylvania (IUP)
105 Wilson Hall
Indiana, PA 15705
Phone: 724/357-3927

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730).

Informed Consent Form (continued)

VOLUNTARY CONSENT FORM:

I have read and understand the information on the form and I consent to volunteer to be a person interviewed for this study.
I understand that my responses are completely confidential and that I have the right to withdraw at any time.
I have received an unsigned copy of this informed Consent Form to keep in my possession.

In the event I am willing to volunteer for a follow-up interview, should I be invited, I can be contacted at the phone number and times listed below.

Name (PLEASE PRINT) _____

Signature _____

Date _____

Phone number where you can best be reached _____

Best days and times to reach you _____

I certify that I have explained to the above-named individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, that I have answered any questions that have been raised, and that I have witnessed the above signature.

_____ _____

Date **Researcher's Signature**

APPENDIX D

INFORMATION ON CASE STUDY OF THE MENTAL HEALTH COURT

I have been given permission to conduct a case study on the formation and evolution of the Mental Health Court in Allegheny County Pennsylvania as part of my doctoral program at I.U.P. The focus of my dissertation is the decision to establish this court, how it has evolved, and how it currently functions. The study will examine the court's case processes, the behavior and perspectives of those involved in mental health courts, primarily, the courtroom workgroup made up of criminal justice professionals and treatment professionals, and secondarily, the mentally ill participants referred to the court. This case study will use several research methods, including interviews of professionals and participants, observation of public and non-public case processing, review of internal documents from the agencies involved in the court, and a minimal analysis of agency records (to confirm the findings made in the other methods).

This initial phase of the project is observation of the court processes. As you know, it is not unusual for observers interested in Allegheny County's Mental Health Court to sit in on the progress review meetings that take place in court chambers prior to public Mental Health Court sessions. Observations for the current study will entail the researcher's presence in public courtroom sessions, in other non-public meetings of the mental health court team, and possibly during delivery of services to court participants. I will not be involved in decision-making at any meeting observed. The observations will allow me to describe the court functions, and will help inform the questions for the interview phase of the project.

Persons to be interviewed later in the study will receive an informed consent form them asking them whether they wish to be interviewed. However, it would not be practicable for the normal operation of mental health court team meetings for the researcher to obtain written consent from everyone involved in each meeting observed. Instead, I am giving all participants a copy of this project description. While it is unlikely that any information to be discussed would be of such a sensitive nature that the researcher cannot hear it, should that be the case at a particular meeting, I will excuse myself from observation.

Please note that my notes on statements made during observation will be summarized as statements by "criminal justice personnel" or by "treatment personnel", so that individual speakers are not identified. Since the research will refer to official positions in general terms only, with no other personal identifying information, the risk of someone attributing a particular statement to a particular member of the courtroom workgroup is very slim.

Thus, I ask your cooperation as I conduct the observation phase of this study in the next few months. I look forward to interviewing you in the near future as the study progresses.

Thank you,
Melanie Pallone
Principal Researcher
412-350-XXXX

Dr. Kate Hanrahan
IUP Faculty Supervisor
724-357-XXXX

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730).

APPENDIX E

JUSTICE RELATED SERVICES
CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

I, _____, DOB: _____ SS# _____
do hereby consent to and authorize Allegheny County Justice Related Services, Human Services Building, One Smithfield Street, Suite 300, Pittsburgh, PA 15222 to:

☐ **RELEASE INFORMATION** ☐ **OBTAIN INFORMATION**

as indicated below:

Service Coordination Units (SCU's):

☐ Allegheny East Mental Health/Mental Retardation Center, Inc.
☐ Chartiers Mental Health/Mental Retardation Center, Inc.
☐ Family Services of Western Pennsylvania, Inc.
☐ Mercy Behavioral Health
☐ Mon Yough Community Services
☐ Staunton Clinic, Sewickley Valley
☐ Turtle Creek Valley Mental Health/Mental Retardation, Inc.
☐ Western Psychiatric Institute and Clinic

Probation/Parole Office:

☐ McKeesport Community Based Center
☐ North Side Community Based Center
☐ Central Community Based Center
☐ South Hills Community Based Center
☐ Wilkinsburg Community Based Center
☐ Intensive Drug Unit (IDU)
☐ Electronic Monitoring (EM)
☐ Other(specify)_____

Court of Common Pleas

☐ Pretrial Services ☐ District Attorney ☐ Public Defender ☐ Behavior Clinic
☐ Judge ☐ Other (specify) _____

Other

☐ *Other (specify)* _____
☐ *Other (specify)* _____

The following information pertaining to myself from: _____through_____.
This information is being requested and released/obtained to coordinate and authorize treatment services.

Whether the client is or is not in treatment
Client progress
Prognosis
Client diagnosis
Records or referral follow-up
Psychiatric Evaluation (Most Recent)
Whether or not the client has relapsed
Client's Service Plan
Consent forms for the release of client information
Records of the release of any client information and copies of any client related correspondence
Other (specify)
Other (specify)

The information is needed for the following purpose:

Referral to targeted management
Coordination of services
Other (specify)

PLEASE FORWARD INFORMATION TO THE

ATTENTION OF:_____

Office of Behavioral Health Justice Related Services
Human Services Building, One Smithfield St., 3rd Floor
Pittsburgh, PA 15222

This information has been disclosed to you (the information recipient) from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you (the information recipient) from making any further disclosure of this information unless otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

I may revoke this consent to release/obtain information at any time in writing or verbally, except to the extent that action has been taken in reliance of it.

_____ I have been offered a copy of this document and I have: ( ) Accepted ( ) Refused
(initial)

_____ _____
Signature of client / Date Signature of witness / Date

_____ Specify date upon which release will expire. ***Revised-9-29-08***

APPENDIX F

INTERVIEW GUIDE FOR COURT TEAM

Q1. Belief as to why the court may have been needed in Allegheny County

[Involvement in establishing the court and the form it would take]

Q2. Understanding of the stated purposes of the court

Q3. Knowledge about similar courts in the nation and similarities or differences

Q4. Understanding of the concepts of restorative justice and non-adversarial processes

Q5. Description of the organization and roles of workgroup (i.e. team, business, government)

Q6. Recollection of decision as to their enlistment in the court team (how and why)

Q7. Perception of importance of their title to their function or role within the team

Q8. Description of workgroup member's job description responsibilities within court team

Q9. Interpretation of their true role as they see it, if it differs

Q10. Thoughts as to how they may differ from other team members in performing functions;

Q11. Conception as to how they may differ from their predecessors in carrying out their role

Q12. Elaboration on workgroup members with whom they have a good working relation;

Q13. Elaboration on workgroup members with whom they have a poor working relation

Q14. Explanation of which member(s) make the ultimate decisions about criminal charges

Q15. Explanation of which member(s) make the ultimate decisions about accepting referrals

Q16. Elaboration on how a non-adversarial process may create difficulty for them in their role

Q17. Description of relationships with defendants or "clients" in the court;

Q18. Belief as to whether the target population for the court is being identified and served

Q19. Suggestions for how the court referral process might be altered

Q20. Opinions on how the court acceptance process might be altered

Q21. Belief as to whether treatment and support services are appropriate and available

Q22. Definitions of what entails non-compliance in the court and how it is handled

Q23. Belief as to whether adherence to the service plans is occurring

Q24. Ideas about how to craft or implement sanctions for non-compliance

Q25. Concerns about the appropriate stipulation terms and length of probationary sentences

Q26. Understanding of who funds the court and future funding sources for the court

Q27. Opinion as to who within the team is accountable for public safety

Q28. Belief as to whether the community safety is ensured by the court

Q29. Opinions as to the successes or failures of the court

Q30. Ideas about how the court process or program model might be improved

ADDITIONAL Q31: Should Court compel taking of medication

APPENDIX G

INTERVIEW GUIDE FOR PARTICIPANTS AND FAMILY MEMBERS

Q1. Understanding of mental health diagnosis or diagnoses

Q2. Recollection of doctor(s) or psychologist(s) who diagnosed their illness

Q3. Recollection of how much time they spent in jail prior to participation (if any)

Q4. Appreciation of the kinds of support services they received while in jail

Q5. Appreciation of the kinds of support services they received once in court

Q6. Perceptions of how sentencing decisions were made for their cases

Q7. Counts for re-arrest after their initial decision to participate in the Court (if any)

Q8. Definitions of what entails non-compliance in the court and how it is handled

Q9. Perceptions of how probation violation decisions were made for their cases (if any)

Q10. Ideas about how to craft or implement sanctions for non-compliance

Q11. Recollection of how long they remained in the program

Q12. Recollection of whether they were a prior graduate of the mental health court

Q13. Belief as to whether the community safety is ensured by the court

Q14. Suggestions for how the court referral process might be altered /Target audience

Q15. Perceptions of how their success was impacted for better or worse by court processes

Q16. Perceptions of how their success was impacted for better or worse by court personnel

Q17. Belief as to experiencing recovery from mental illness by participating in the court

Q18. Belief as to whether they gained personal accountability from participating in the court

Q19. Belief as to whether trust or respect was restored to them from participating in the court

ADDITIONAL Q20: Should Court compel taking of medication

ADDITIONAL Q21: How court process might be improved

ADDITIONAL Q22: Original charge referred to MHC

ADDITIONAL Q23: Compare experience in other courts to that if MHC (if any)

ADDITIONAL Q24: Any inpatient or outpatient programs prior to MHC

APPENDIX H

MENTAL HEALTH COURT PROCESS DESCRIPTION

- The MHC PD will provide a list of accepted cases to the clerk assigned to the MHC judge.

- The individual is assigned a Justice Related Support Specialist from the Office of Behavioral Health.

- The MHC Justice Related Support Specialist works with the individual to develop a service (treatment) plan which will be presented to the court.

-At completion of the service plan and, if necessary, a bond modification hearing is held.

-Upon acceptance by the judge, the service plan will become a condition of the new bond and the individual will be released from the Allegheny County Jail, contingent upon compliance with the service plan.

-Mental Health Court personnel meet every Tuesday with accepted defendants to select trial dates and address subpoenas.

-If the individual desires a trial, cases must be scheduled far enough in advance so that the Commonwealth can subpoena witnesses.

-If a plea bargain has not been previously arranged, the trial is conducted.

-Unless a case is dismissed at trial, the plea bargained and post-conviction sentences will include probation with a condition for continued compliance with the service plan.

-Individuals are assigned a Special Services Adult Probation Officer from the Court and a Mental Health Court Probation Liaison from the Office of Behavioral Health. A subpoena for the first follow-up Reinforcement Hearing is issued during the sentencing.

-MHC Reinforcement Hearings are conducted at intervals of thirty (30), sixty (60) , or ninety (90) days, depending upon the individual's progress.

-Negative Reinforcement Hearings are scheduled if the individual violates probation or fails to follow his or her service plan.

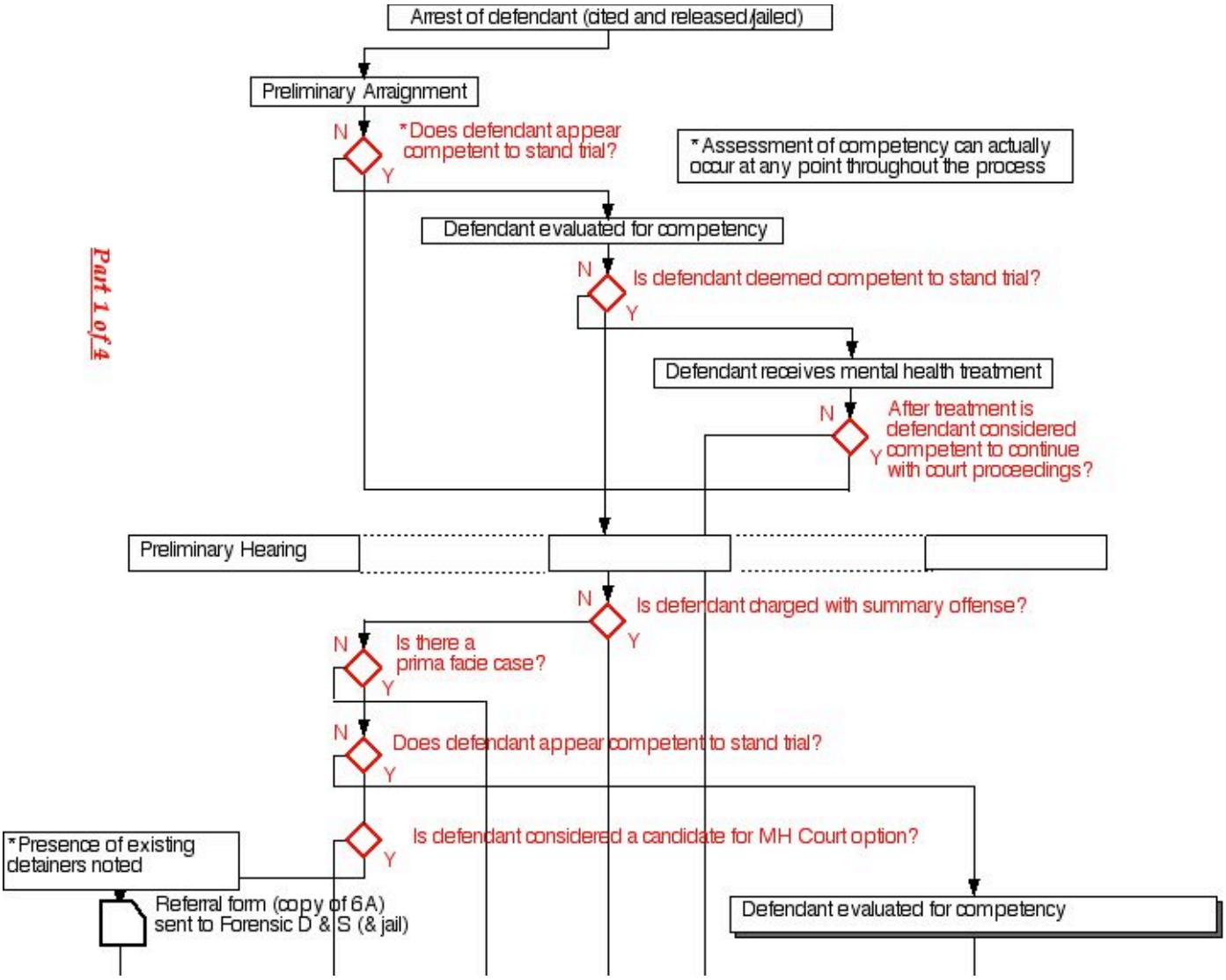
-Individuals will be monitored closely by the Special Services Probation Officer and the MHC Probation Liaison, who will also provide on-going support for compliance with the service plan, until the probation expires.

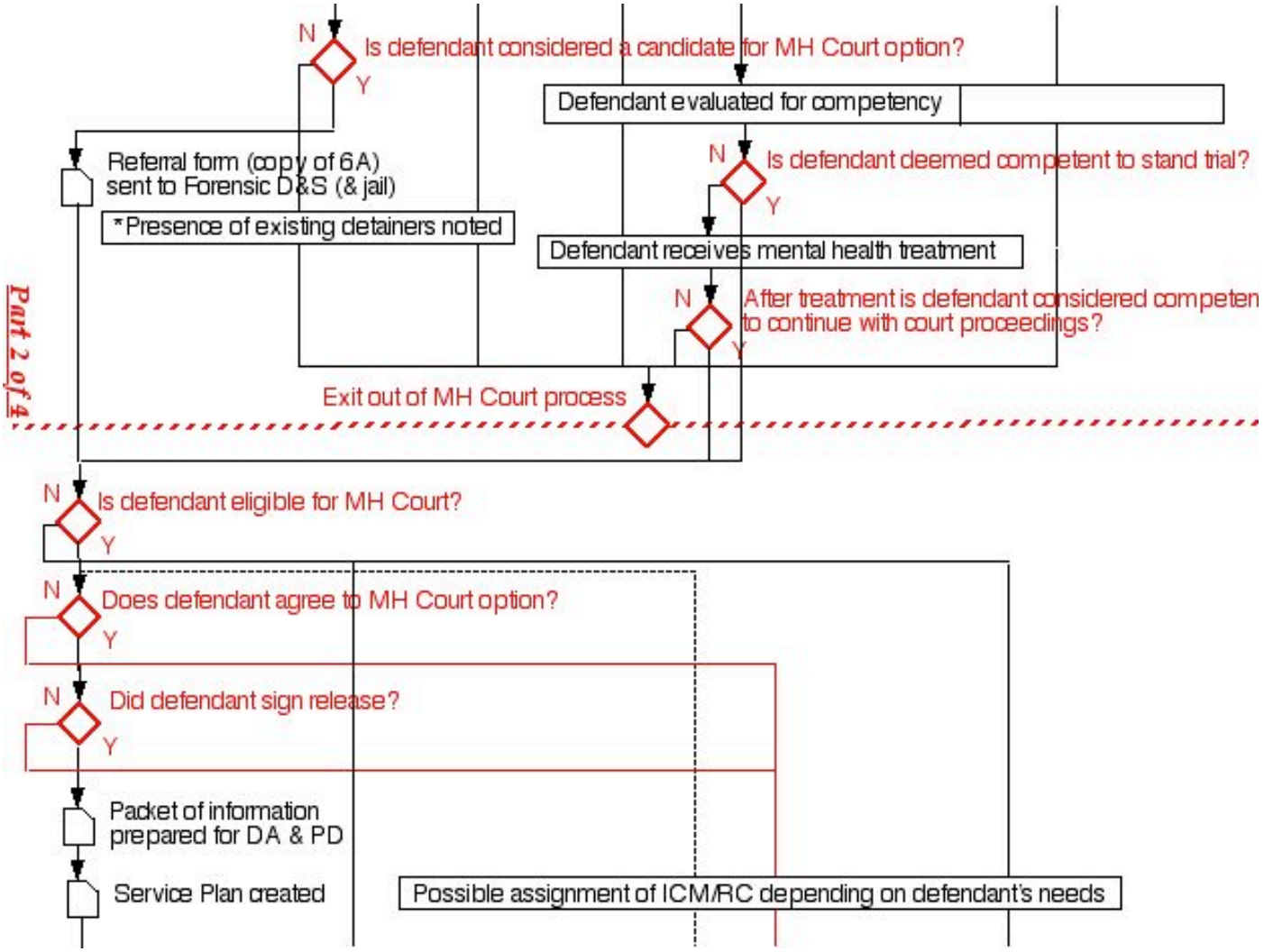
[From the Allegheny County, PA, Department of Human Services website (2009).]

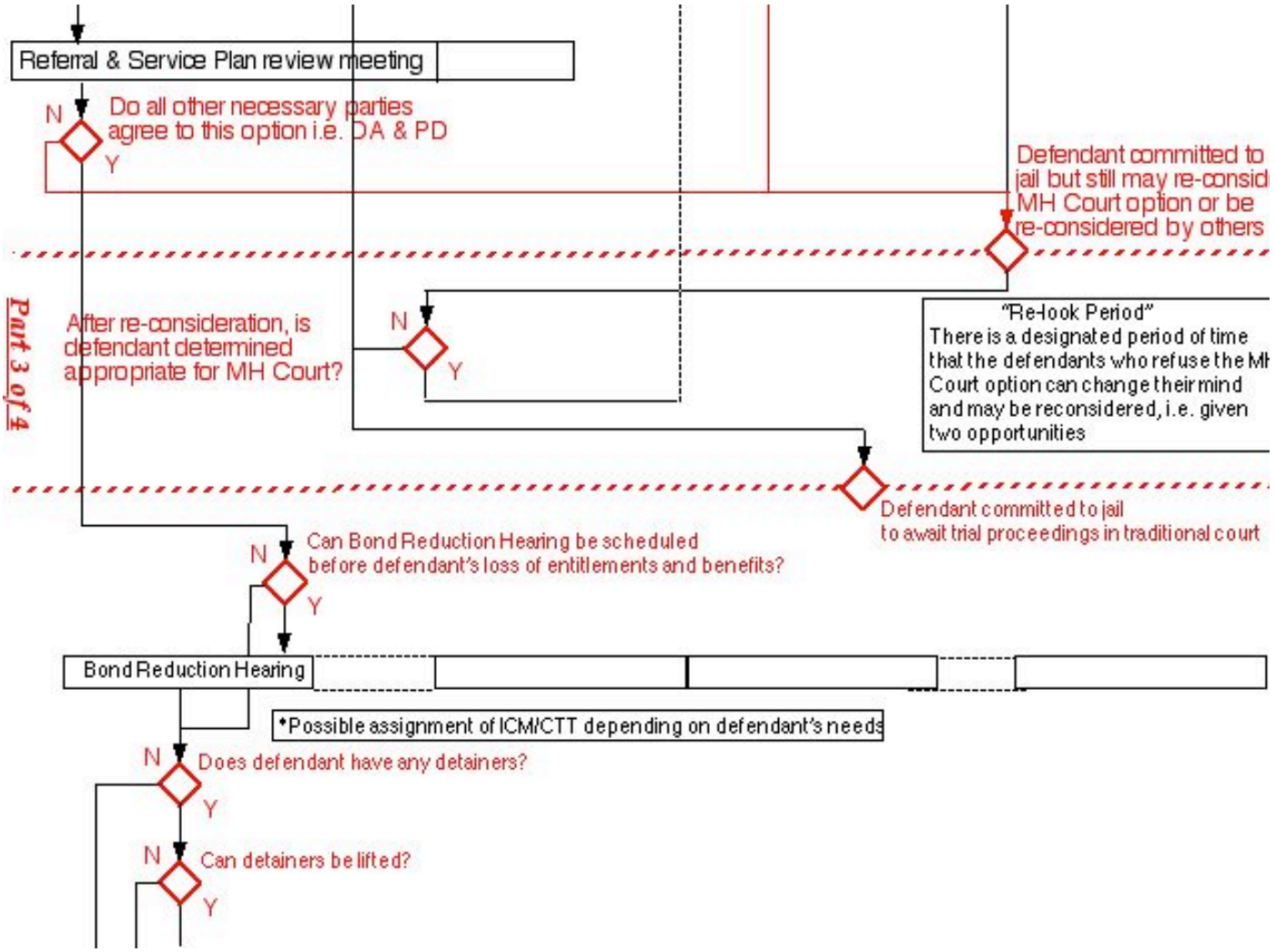
APPENDIX I

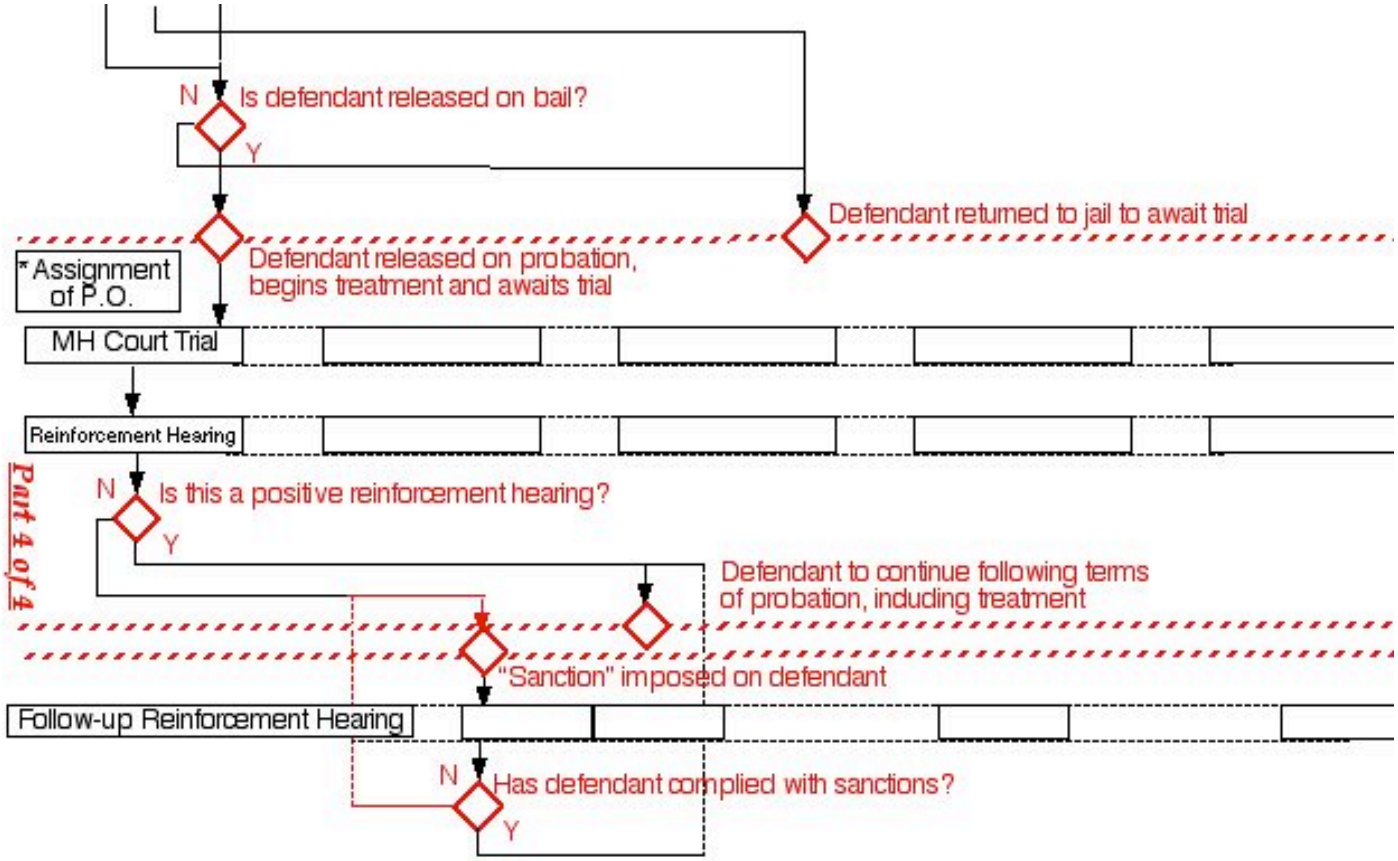
MHC FLOW CHART PARTS 1,2,3,4

Allegheny County Mental Health Court Task Force


Part 1 of 4
Arrest of defendant (cited and released/jailed)
Preliminary Arraignment
N
*Does defendant appear competent to stand trial?
Y
*Assessment of competency can actually occur at any point throughout the process
Defendant evaluated for competency
N
Is defendant deemed competent to stand trial?
Y
Defendant receives mental health treatment
N
After treatment is defendant considered competent to continue with court proceedings?
Y
Preliminary Hearing
N
Is defendant charged with summary offense?
Y
N
Is there a prima facie case?
Y
N
Does defendant appear competent to stand trial?
Y
Y
Is defendant considered a candidate for MH Court option?
*Presence of existing detainers noted
Referral form (copy of 6A) sent to Forensic D & S (& jail)
Defendant evaluated for competency


N
Is defendant considered a candidate for MH Court option?
Y
Defendant evaluated for competency
N
Is defendant deemed competent to stand trial?
Y
Referral form (copy of 6A)
sent to Forensic D&S (& jail)
*Presence of existing detainers noted
Defendant receives mental health treatment
N
After treatment is defendant considered competen
to continue with court proceedings?
Y
Part 2 of 4
Exit out of MH Court process
N
Is defendant eligible for MH Court?
Y
N
Does defendant agree to MH Court option?
Y
N
Did defendant sign release?
Y
Packet of information
prepared for DA & PD
Service Plan created
Possible assignment of ICM/RC depending on defendant's needs


Referral & Service Plan review meeting
N
Do all other necessary parties agree to this option i.e. DA & PD
Y
Defendant committed to jail but still may re-consid MH Court option or be re-considered by others
Part 3 of 4
After re-consideration, is defendant determined appropriate for MH Court?
N
Y
"Re-look Period"
There is a designated period of time that the defendants who refuse the MH Court option can change their mind and may be reconsidered, i.e. given two opportunities
Defendant committed to jail to await trial proceedings in traditional court
N
Can Bond Reduction Hearing be scheduled before defendant's loss of entitlements and benefits?
Y
Bond Reduction Hearing
*Possible assignment of ICM/CTT depending on defendant's needs
N
Does defendant have any detainers?
Y
N
Can detainers be lifted?
Y



Specialized Probation Officer	MH Forensic Case Manager	Probation Liaison	MH Court Director	Public Defender	District Attorney	District Justic City Court Night Court
Defendant	Behavior Clinic	Bail Agency	County Jail	SCU	Police & Victim	MH Cour Judge