
Pergamon

International Journal of Law and Psychiatry
26 (2003) 33–53

INTERNATIONAL JOURNAL OF
LAW AND
PSYCHIATRY

Seattle's mental health courts: early indicators of effectiveness

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1. Introduction

Courts specializing in the adjudication of mentally ill defendants are relatively new to the United States. Steadman, Davidson, and Brown (2001) proposed a four-part functional definition of a mental health court (MHC): (1) all identified mentally ill defendants are handled on a single court docket, (2) the use of a collaborative team which includes a clinical specialist who recommends and make linkages to treatment, (3) assurance of availability of appropriate clinical placement prior to the judge making a ruling, and (4) specialized court monitoring with possible sanctions for noncompliance. Other authors have stressed the view that MHCs are primarily vehicles for the practice of therapeutic jurisprudence, defined as the process of fostering therapeutic outcomes by legal means, or at least considering the therapeutic or antitherapeutic outcomes resulting from the legal process (Casey & Rottman, 2000; Wexler & Winick, 1996).

Publications on MHCs have been primarily limited to descriptions of MHCs and their implications from legal, health, and social policy perspectives. There remains a virtual absence of empirical data elements in published accounts, with the exception of basic program statistics, such as number of defendants screened, adjudicated, and supervised. Although a major evaluation of the Broward County Mental Health Court is underway, and a description of the evaluation's methods, measures, and challenges is available (McGaha, Boothroyd, Poythress, Petrila, & Ort, 2002), empirical reports from that research are only beginning to emerge (see Boothroyd et al., this issue; Poythress, Petrilla, McGaha, & Boothroyd, 2002), and analyses for many facets of that study are still in preparation. Heretofore, empirical evidence of the effectiveness of MHCs has been very limited and benchmarks from which different court

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PII: S0160-2527(02)00202-9

models or courts working within the same model can be compared have not been established. Generalizing from the few available observational accounts may be particularly misleading because many important contextual factors, such as the characteristics of the legal and mental health systems in which they operate, vary markedly from court to court. Commonalities and differences among MHCs, such as those outlined in descriptive reviews (Goldkamp & Irons-Guynn's, 2000; Watson, Hanrahan, Luchins, & Lurigio, 2001), may be more related to contextual contingencies rather than to the court models per se. Clarifying how contextual factors impact the implementation of empirically validated treatment models is increasingly understood as central to expanding the application of such models (Brickman, 2002; Henggeler, Lee, & Burns, 2002). Applying the same principle to MHCs even if effectiveness were to be demonstrated for a few individual courts, we would still be wanting for the kind of understanding of the impact contextual factors that could inform implementation of program models in divergent environments. Nonetheless, local initiatives and Federal legislation (Public Law 106-515, American's Law Enforcement and Mental Health Project) are providing momentum and financial support for the expansion of MHCs across the United States.

This paper is intended to advance the state of knowledge concerning MHCs in two ways. Firstly, we summarize findings from separate acceptability and effectiveness evaluations conducted at the request of the respective governing bodies of two MHCs in Seattle, WA. These evaluations combined process evaluation methods, such as interviews and surveys of key informants and surveys of stakeholders, with quantitative analyses of early data related to reincarceration, time spent in detention, and linkage/engagement with mental health services as a result of MHC participation. Secondly, by comparing and contrasting evaluations from two courts sharing a fairly uniform set of contextual factors, we hope to further set the stage for future research into the effect of such factors on MHC acceptability, organizational structure, functioning, and effectiveness. We see this focus on contextual factors as a natural extension of the concept of ecological jurisprudence (Slobogin & Fondacaro, 2000), in which the context and situation in which the individual interacts is considered with along with such factors as inherent mental disorder or impairment. Family setting, neighborhood, and access to resources are among the factors that are considered from the ecological jurisprudence perspective. Applying the notion of ecological jurisprudence to evaluation would involve developing understandings of how institutional and systemic factors influence courts and, in turn, how courts impact the interaction of individuals in their environment.

Seattle, WA's MHCs are organized at different levels of government (municipal vs. county) and have different geographical defendant pools (urban vs. suburban/exurban). Nonetheless, these courts share many contextual factors that might be reasonably believed to shape differences between MHCs and to impact effectiveness of such courts. The two MHCs are geographically located within blocks of each other, are limited in jurisdiction to misdemeanors, use the same detention facility, and make treatment referrals to the same community agencies. Defendants may have criminal charges in both courts simultaneously. Given the relative comparability of contextual factors, we hypothesized that differences between the practices and impacts of these courts are more attributable to differences in decisions, values, and preferences embodied in their models and personnel, as opposed to contingencies of the immediate environmental context, than might be the case if comparisons were made between

courts in different cities or states. Nevertheless, we acknowledge that the assumption of shared contextual factors among MHCs fostered by the same city may be no more accurate than, for example, the assumption of shared experiences of parenting practices and attachment experiences for different siblings in a household.

2. Origins of Seattle's MHCs

Seattle's MHCs trace their origins to the political and judicial response to public outcry after the stabbing death of retired fire department captain Stanley Stevenson by a mentally ill misdemeanant in August of 1997. The attacker had been recently released from the county jail, after being found incompetent to stand trial for bicycle theft charges and, despite hospital reports indicating his dangerousness, not civilly committed. In the aftermath of this tragic incident, the County Executive, Ron Sims, convened a Mentally Ill Offender Task Force, designed to have broad participation from influential stakeholders. Former State Supreme Court Justice Robert Utter chaired the Task Force, which issued recommendations only 3 months after Capt. Stevenson's death. Among other innovations, the task force spearheaded revision of the state's criminal competency laws, called for writing legislation expanding circumstances for ordering involuntary treatment, and recommended the establishment of a county MHC. The cultural context of these innovations included a longstanding tradition in Western Washington of public sympathy with civil libertarian concerns regarding the need for caution in the use of involuntary commitment, and in instituting laws or practices that might infringe on rights of mentally ill persons, or which might result in their being further stigmatized for their illness.

Two Seattle judges who observed Judge Wren's Broward County MHC as part of their task force participation later presided over MHCs at the county and municipal levels. The King County District Mental Health Court (KCMHC) was formally instituted and dedicated to the memory of the slain fire department captain in a public ceremony in February 1999. By April of the same year, the Seattle Municipal Court began operating a mental health court (SMMHC), but without being formally identified in either the municipal code or municipal court structure.

3. Mental health system

Public mental health services for King County, including those for the city of Seattle, shifted from a fee-for-service to a managed care service system in 1995. The system shifted again in 1999 to a risk-based contract in which the county assumed financial responsibility for both inpatient and outpatient services. Formally, separate addiction and mental health services were combined by under a single administrative umbrella.

Not only were residents in the jurisdictions of both MHCs covered by the same managed care firm, there was a substantial overlap among agencies providing the bulk of treatment services to individuals participating in the two courts, making the distinction between the

courts somewhat ambiguous in the perception of many individual providers, with the larger SMMHC having the more prominent profile. Although the SMMHC shared this system with the KCMHC, the county managed the contract, arguably resulting in more direct influence for the county court, KCMHC. Both MHC teams included a clinical social worker employed directly by the managed care firm. Referred to as court monitors, these clinicians provided front-line screening and assessment services and made client-specific referrals for mental health services. Although both court monitors generally filled the role described by Steadman (1992) as criminal justice/mental health system boundary spanners, they differed to the extent that they were able to serve as treatment brokers, in that the KCMHC clients were officially given priority access to services, whereas priority access or other forms of special attention to the needs of mentally ill misdemeanants in the SMMHC was effected by more informal mechanisms. Restricted resources for needed mental health and substance abuse treatment services was another shared contextual factor for these MHCs, which experienced actual or threatened resource reductions periodically during the MHCs founding period and during the period of the evaluations described here. Notably, appropriate housing for MHC participants and integrated substance abuse services for the mentally ill were ubiquitously described as unavailable by the court monitors.

A centralized assessment unit conducted trial competency evaluations for both jurisdictions. Evaluations were conducted either in the jail or at the hospital, 45 miles south of Seattle. Also, determining the need for involuntary detention pending civil commitment proceedings was the responsibility of the same pool of County Designated Mental Health Professionals, who conducted most MHC-associated evaluations in the county detention facility.

4. Adult detention

The King County Department of Adult and Juvenile Detention managed jail services for the jurisdictions of both courts, with county and city police departments booking defendants into the jail in downtown Seattle and county police booking defendants at smaller regional detention centers. Whereas the most common site of arrest for SMMHC defendants was downtown Seattle, Seattle–Tacoma International Airport was one of the most common arrest sites for KCMHC defendants. Both courts developed mechanisms of identification, referral, and progress reporting with jail mental health personnel. Treating psychiatrists and nurses in the jail were county health department employees. Staff involved in screening, assessment, and crisis/custodial management issues were for the most part trained in psychology or counseling as a core discipline, and worked directly for the jail.

5. Goals and organization

A review of written materials provided by these MHCs revealed that they had substantially the same stated goals focused on improving adjudication of mentally ill misdemeanor defendants (MIMDs). Both courts explicitly held the view that persistent and debilitating

mental illnesses are organic disorders requiring treatment, and that jails are not preferred treatment sites. Both courts shared the goal of reducing jail time by using the optimal community placement strategy consistent with public safety, and included linkage to treatment and fostering of success in treatment as integral aspects of the court's rationale. Although treatment with psychiatric medication was the focus of most linkage activity, referrals to psychosocial programs, substance abuse treatment services, housing, and other services were also deemed essential. These courts also shared the goal of improving linkages and understanding between otherwise separate parts of the criminal justice and mental health systems.

Both courts were structured for voluntary participation of defendants along the lines of drug courts and consistent with plea-bargaining of reductions in jail sentences in exchange for treatment engagement and community supervision of a longer period than that typical for most misdemeanants. Both courts received referrals from defense attorneys and other courts in the same jurisdiction. The KCMHC received most of its referrals from jail health or psychiatric evaluation staff, whereas the SMMHC, which was situated in the arrangement court, identified a large number of referrals during the arrangement process in addition to receiving referrals from jail staff. For both courts, referred defendants were approached by the court monitor, who would describe the nature of the MHC and the requirements and benefits of participation. Defendants who expressed interest in considering participation were scheduled for an initial hearing, wherein the judge would evaluate the basis for their eligibility and confirm the defendant's understanding of the MHC, particularly the fact that participation was voluntary. At some point, defendants were asked to decide on participating (opt-in) or declining participation and going on to trial in a regular court (opt-out). Under Washington State law, the MHCs maintained jurisdiction over misdemeanant cases while the defendant was involved in competency evaluation or restoration of competency. The SMMHC described itself as open to considering re-referral after an initial voluntary decision to opt-out and to taking responsibility for supervision of mentally ill probationers referred by other municipal courts. Typically, individuals who opted for trial in the KCMHC were not reaccepted on the same charge, but could be considered for eligibility on a different charge.

6. The court teams

On one level, describing the composition and roles of the MHC team is roughly equivalent to describing the court model. Both courts utilized a dedicated team approach, wherein, as far as operationally possible, throughout their adjudication experience, MIMDs would relate to the same group of court professionals. Both courts were defined as judge-centered teams, which included a clinical social worker (referred to as the court monitor), prosecuting attorney, probation counselors, defense attorney supported by a part-time social worker, and a program manager/coordinator. The court monitors assessed clinical status, treatment needs, and program suitability, and worked for the mental health managed care provider. Information collected by the court monitor was communicated to the court if the defendant signed a release of information. It was assumed that the court monitors' clinical astuteness, and not infrequent

personal knowledge of both MIMDs and local program characteristics and personnel, would enable them to make optimal referrals, thereby increasing the chance of defendant engagement in treatment and treatment effectiveness. To some extent, court monitor role involved aspects of informal clinical risk assessment, in that risk management recommendations were provided to the courts. Both courts utilized public defender offices that employed social workers that were expected to provide corresponding clinical support to the defense in team planning and in formal hearings.

Although the two courts developed similar in-court methods such as longer hearings, early hearings to determine eligibility/suitability, and later "opt-in or out" hearings for defendants to make the participation decision, a significant structural aspect separated the two courts. The SMMHC shared its judge, courtroom, and prosecutor with the general arraignment court. In contrast, the KCMHC judge was allocated several full days per week for this role and the KCMHC had its own courtroom. Although providing an opportunity for early identification and referral of mentally ill defendants, this arrangement of the SMMHC, when contrasted to the KCMHC, reduced the availability of time in-court, preparatory time for key members, such as the judge, and limited time for meetings of the entire team. Although both courts used a small amount of grant money to get started, the bulk of resources consisted of internal reallocations within their respective court systems. Notwithstanding these resource constraints, the KCMHC enjoyed formal recognition as a separate entity by the County Executive, County Council, and the Presiding Judge of the District Court, whereas the SMMHC had a less formal existence within the Seattle Municipal Court structure.

7. Evaluation methods

Since the purpose of this paper is to summarize and combine selected findings across two previously performed evaluations, the methods, procedures, analyses, and results are described here in less detail than in the original evaluation reports. The original evaluation reports contain a fuller description of methods and procedures, as well as lists of individuals interviewed, tables of descriptive statistics and related tests of statistical significance, and some findings in addition to those described here. These reports (Trupin, Richards, Lucenko, & Wood, 2000; Trupin, Richards, & Werthiemer, 2001) are available online, or can be obtained from either the MHCs studied, or from the authors.

We completed a process evaluation with preliminary outcome data for the KCMHC in the fall of 2000 and a year later performed a similar evaluation of the SMMHC. The evaluations were performed at the request of the King County District Court and the Seattle Municipal Court, respectively. The evaluations were spurred on in part because of the need to justify resource allocations to courts in general, and because of their reduced caseloads, specialty courts were under particular budgetary scrutiny. Both MHCs formed evaluation committees to interact with the evaluators regarding the structure and scope of the evaluation effort, and, as the evaluations progressed, to assist in understanding the emerging information from multiple informed perspectives. The final reports of these preliminary evaluations were delivered to the larger court bodies in which each MHC operated, and findings and

recommendations were presented in open session to the legislative bodies of the respective jurisdictions.

Three methods were used in the quantitative, process component of the evaluations. Direct observation of the court and reading of relevant court-generated descriptive documents by the evaluators was followed by the administration of structured and semistructured interviews with key informants and key stakeholders. For the KCMHC only, an anonymous survey of opinions about the court was administered to a subset of key informants who worked in agencies supporting court functions (i.e., jail staff and mental health agency staff). The quantitative component of the evaluation consisted of the collection and analysis of archival mental health, detention, and court system data relevant to MHC outcomes and impacts.

8. Qualitative methods

Interview questions and empirical data elements were sufficiently similar to allow for comparisons between the MHCs and there was substantial overlap in key informants. An 11-page structured interview form containing open-ended questions and items with Likert scale and multiple-choice response formats was administered to key informants. We defined a key informant as an individual identified as likely to have substantial and detailed knowledge of an MHC, its clients, social, political, and institutional contexts, or of impacts/outcomes that might be attributable to court participation or nonparticipation. We used a one-page semistructured interview format with key stakeholders defined as individuals identified as having a specific investment in, or responsibility for, one or more factors affecting an MHC or its clients, but with less direct or detailed knowledge than a key informant. In addition to relying on our own knowledge of the local and regional environment, members of the evaluation committee for each respective MHC suggested names for the list of interviewees. Those interviewed included members of the MHC teams, administrators from several levels of city, county, and state governmental agencies, the heads of patient advocacy groups, judges, attorneys from both sides of the bar, and a few elected officials other than judges. Some interviews were conducted in small groups. For example, case managers from a single mental health agency and persons from the city or county budget office were interviewed together.

Interviews were audio taped whenever this was agreeable to the interviewees. Otherwise, close to verbatim responses were recorded for responses to open-ended questions. These notes were later coded twice for themes, first using ad hoc categories developed by each interviewer based on emergent themes, and again later, after the evaluation team had gained consensus on prominent themes. Although informant's agreed to have their names listed as evaluation participants in final reports, they signed consent forms promising strict confidentiality of the content of their responses and comments. Informants were made aware that they would not be quoted in any written report without a separate written consent to do so, and that they could request that specific responses or comments be recorded verbatim. Informants were offered the opportunity to read the interviewers' transcriptions or notes of their own responses in order to comment on their accuracy, but they were not allowed access to anyone else's responses or comments. The questions were made available to interviewees prior to the scheduled inter-

views. A few informants chose to provide the researchers with audio taped or written responses to interview questions, which allowed for a more informal follow up interview. A few individuals were contacted after their initial interview for clarification of their responses or comments, but for the most part this was unnecessary due to the availability of audiotape, verbatim or close to verbatim notes, and multiple interviewers being present during the original interviews.

For the KCMHC, 22 key informants and 12 key stakeholders were interviewed, and 18 agency staff were administered an anonymous survey, making some overlap with the survey and interviews possible. For the SMMHC, 54 key informants and 22 key stakeholders were interviewed. Although most interviews were conducted with pairs of informants, four groups of five or more were also used. Understandably, due to the shared environments of the courts, some overlap of key informant and key stakeholder list occurred between the two MHC evaluations.

For the qualitative component of the evaluations, program effectiveness indicators were developed for the following domains: public safety, decriminalization, program gate-keeping, program integrity/continuity, organizational structure, case processing, system linkage, clinical focus, treatment, civil liberty/rights focus, and information management.

9. Quantitative methods

9.1. Participant pools and data elements

Data was collected for new referrals to both courts during specific periods of observation. For the KCMHC, data was collected on the 246 individuals referred during a 13-month from the official start of the court on February 18, 1999 through March 16, 2000. For the SMMHC, we collected data on the 158 individuals referred during a 5-month interval between February 1, 2000 and June 30, 2000. The start of this interval was the date at which the full SMMHC team contingency with two probation officers was in place. For both MHCs, the end dates for determining the participant pool was set to allow for a minimum of 9 months of observation post MHC referral. We collected data related to demographics, diagnosis, charge type, and decision to participate in the MHC for all participants referred during these intervals. More complete mental health, charge characteristics, and jail related data were collected for a subset of participants for each court. Some participants were referred to these courts on more than one occasion, for different charges. During the observed periods, approximately 19 unduplicated individuals were referred to the KCMHC each month, whereas the SMMHC received almost 32 unduplicated referrals, reflecting the fact that the SMMHC, which serves densely populated, urban Seattle, was a higher volume court than the KCMHC.

The courts provided data related to defendant demographics, the date and outcome of the defendant's decision regarding MHC participation, and criminal case information for cases under the jurisdiction of the MHC. Mental health data was captured from King County's automated system. Mental health data elements included primary diagnosis, personality disorder diagnosis, substance abuse history and readiness to engage in substance abuse

treatment, mental health system enrollment status and history, and number and duration of treatment episodes. Detention and charge data were collected from automated systems maintained by the courts and the detention facility. Jail system data included bookings, length of detention per booking, and time spent outside of jail in other, usually mental health facility, and confinement.

9.2. Approach to data analysis

We used both a pre–post and group comparison approach to investigate the impact of MHC participation. For the pre–post comparisons, we compared charge, detention, and mental health data for participants prior to their MHC contact to their own data for the period observed after MHC contact. These analyses were performed after mean or aggregate scores were adjusted for months of observation in the pre and posts periods. Our primary interest was in participants who had volunteered to participate in the MHC process and were subsequently placed, or remained, in the community at risk for new charges, eligible for community-based treatment services, and under MHC supervision. These participants, referred to as opt-ins, were compared to various groups comprised of individuals referred to the same court. We also compared outcomes between the two courts for a few important variables.

For the SMMHC evaluation, most analyses were conducted on 65 opt-in participants and 82 opt-out referrals. For the KCMHC, most analyses were conducted on 31 opt-in participants and 46 opt-out referrals. The number of subjects in the analyses related to specific findings varied due to missing data. All participants were facing misdemeanor charges at the time of referral and had a confirmed diagnosis of mental illness. Although examination of participant characteristics revealed that the opt-in and opt-out participants for both MHCs had similar demographic and primary diagnostic characteristics, opt-outs tended to have less severe index charges and, therefore, may have been facing less severe sanctions if convicted after a trial. Our interviewees had also alerted us to the possibility that referrals that eventually became opt-outs often had more severe substance abuse and dependency problems, and less severe mental health problems than referrals that eventually became opt-in participants. We adopted a quasi-experimental approach in comparing and contrasting relevant groups of similar individuals, who nonetheless had some known relevant dissimilarities such as severity of the index offense.

10. Results

10.1. Participant characteristics

Approximately 75% of those referred were male and the decision to volunteer for the court was not related to gender. The average age of participants was 38.57 (11.05) for the SMMHC and 37.6 (10.95) for the KCMHC. Approximately 60% of participants from both courts self-identified as White, the SMMHC had almost double the proportion of African American and Asian participants (33.8% and 6.2%, respectively) as did the KCMHC (15.4% and 2.4%, respectively). The reverse was the case for the relative proportion of Native Americans

Table 1
Process/qualitative domains and assessed indicators

	Seattle Municipal MHC	King County MHC	Comments
Public safety			
Protection of public safety	High	High	Minority view: overstated concern for MIMD offending in both MHCs
Rapid response to violations/deterioration clinical status	High	Moderate to high	
Priority exercise of MHC Bench Warrants upon request	High	Moderate	SMMHC "MHC Warrant" expedited by police
Decriminalization			
Diversion prior to arraignment	Low	Low	Most participants enter guilty plea in both MHCs
Possibility of avoiding criminal record	Moderate	Low to moderate	
Reduced jail days	Low to moderate	Low to moderate	Assessment and search for best community placement may increase jail time in some cases
Reduced bookings	Moderate	Moderate	Perception that revolving door was slowing down for MIMDs
Sanctions/revocation decisions informed by clinical status	Moderate to high	Moderate to high	Motivation and reasons for failures to comply were carefully assessed
Program gate keeping			
Reaching target population	High	High	
Clear and well-discriminated edibility criteria for participation	Moderate to high	Moderate to high	Concern about overlap with primary drug using population and appropriateness of organically impaired defendants
Early identification by police	Moderate	Low to moderate	Geographically difficult for KCMHC, which services different localities
Identification at arraignment	High	Moderate	SMMHC doubles as arraignment court
Adequate identification/ referral in jail and other courts	Moderate	Moderate	Some judges not referring appropriate cases to Seattle MHC. Loss of a jail psychiatric liaison worker impacted both MHCs
Program integrity/continuity			
Written orientation materials	High	Low to moderate	SMMHC very well documented
Operation consistent with philosophy	High	High	

Table 1 (*continued*)

	Seattle Municipal MHC	King County MHC	Comments
Program integrity/continuity			
Shared mission and philosophy	High	Moderate	Expectation of availability of complete diversion by public defender in KCMHC
Shared goals and problem-solving focus	High	Moderate	Defense not consistently invested in problem-solving focus in KCMHC
Written role/job descriptions	High	Low to moderate	Defense social worker had very limited involvement and impact on in-court process for both MHCs
Adversarial process does not impede collaboration	High	Low to moderate	Information sharing cumbersome and often limited in KCMHC
Organizational structure			
Formal legal status	Low	Moderate to high	
Formal status in court administrative structure	Low to moderate	Moderate to high	
Formal identification in budget	Low	Low	
Dedicated staffing for key roles	Low to moderate	Moderate to high	Judge time and attention shared with arraignment process in SMMHC
Case processing			
Expedited case processing	High	Moderate to high	Very high priority in the SMMHC
Defendant focused case consolidation	Moderate	Moderate	
Specialized court hearings	Moderate to high	Moderate to high	
System impact			
Increased linkages/ communication between systems	Moderate to high	Moderate to high	
Engagement of key community stakeholders	Moderate	Moderate	Absence of advisory or community boards for either MHCs
Adds to resources for MIMDs	Low	Moderate	Additional funds attached to MIMDs in KCMHC
Clinical focus			
Specialized clinical probation monitoring	High	High	Clinical social workers were probation supervisors in both MHCs
Access/use of standardized assessment instruments	Low	None	

(continued on next page)

Table 1 (*continued*)

	Seattle Municipal MHC	King County MHC	Comments
Clinical focus			
Monitoring/intervention regarding treatment effectiveness	Low to moderate	Low	Appropriateness and effectiveness of treatment not addressed by either MHCs
Monitors treatment compliance	Moderate	Moderate	For both MHCs, routine probation supervisor contact with case managers was supplemented by telephone reports prior to review hearings
Allows sufficient time for hearings	High	High	
Courtroom environment/ atmosphere appropriate for MIMDs	Low	Moderate	SMMHC crowed, fast paced, and in the jail environment
Requires/strongly encourages clinician testimony/reports	Low to moderate	Low to moderate	Few written reports in KCMHC. Both MHCs tried to conserve use of clinician time for appearances or written reports
Treatment referral/engagement			
Priority or dedicated access to services	Low	Moderate to high	KCMHC had priority for services with some additional compensation for providers
Increased engagement beyond referral	Moderate to high	Moderate to high	
Referral/linkage to mental health services	High	High	
Linkage/referral to substance abuse treatment services	Low to moderate	Low to moderate	Limited access to intensive outpatient substance abuse treatment services for mentally ill persons
Linkage/referral to housing	Low	Low	Housing very limited, especially for individuals with drug, alcohol, or violence problems in their history
Civil liberty/rights focus			
Appropriate concern for defendant's right to liberty and choices	Low to moderate	Moderate to high	Some informants viewed SMMHC as overly coercive and as preempting some defendant rights
No negative impact due to identification and referral	Moderate	Moderate	
No negative impact for requesting trial	Moderate	Moderate to high	Minority view that SMMHC opt-out offers from prosecution constituted an increase in typical sanctions

Table 1 (*continued*)

	Seattle Municipal MHC	King County MHC	Comments
Civil liberty/rights focus			
No unresolved due process concerns	Moderate	High	Minority view that SMMHC prehearing meeting without the defendant present was an important due process concern
Confidentiality maintained by defendant	Moderate to high	High	Minority view that court monitor role had resulted in some breaches of confidentiality in KCMHC. Open discussion of closed competency/commitment process raised for the SMMHC
Early termination of supervision possible	Moderate	Moderate	
Information management			
Adequate information available at hearings	Moderate to high	Low to moderate	
Retrievable data: diagnostic and clinical engagement	Moderate	Low to moderate	Very little written documentation in the KCMHC
Retrievable data: demographic and case history	Moderate	Moderate	Case file systems
Retrievable outcomes: revocations and sanctions	Moderate to high	Moderate to high	Automated online systems
Retrievable data: new bookings and charges	High	High	Automated online systems

Ratings are on a dimension of low to high appropriateness or accomplishment, five anchors: low, low to moderate, moderate, moderate to high, high, not applicable (NA).

between the courts, with the SMMHC (3.1%) proportion being under a third of that for the KCMHC (11.1%). The decision to participate in these courts did not vary significantly with ethnicity. Most participants were diagnosed as having psychotic or major mood disorders as the primary focus of mental health intervention, with the SMMHC having a significantly higher proportion of individuals diagnosed with a psychotic disorder when compared to the KCMHC (64.7% vs. 45.1%, respectively).

10.2. Qualitative indicators of MHC effectiveness

Table 1 contains results for each court on indicators for the 11 domains of effectiveness, which were qualitatively assessed. These domains are public safety, decriminalization, program gate keeping, program integrity/continuity, organizational structure, case processing, system impact, clinical focus, treatment referral/engagement, civil liberty/rights focus, and information management. The rating for each indicator reflects the general consensus of interviewees along the dimension of appropriateness/achievement with the following categor-

Table 2
Quantitative evidence for MHC effectiveness

Indicator S	MHC-specific findings				Findings generalized
	Seattle MHC evidence type		King County MHC evidence type		
	Opt-in pre–post	Comparison groups	Opt-in pre–post	Comparison groups	
Criminalization/recidivism					
Booking rate	Decreased; $P<.05$, $d=0.587$, $r=.282$	Group of all referred individuals. Deceased bookings significantly pre–post; $P<.001$, $d=0.528$, $r=.255$ For Opt Out only, those with any new reincarceration after MHC had reduced bookings after MHC contact; $P<.025$, $d=0.517$, $r=.250$	$P<.025$, $d=0.617$, $r=.295$	NS	Decreased reincarceration medium effect
Mean charge severity	NS	NS	NS	Increased for opt-out, but not for opt-in; $P<.05$, $d=0.501$, $r=.243$	Prevention medium effect[a]
Jail LOS per booking	Increased; $P<.025$, $d=0.351$, $r=.173$	Increase for sample as a whole; $P<.01$, $d=0.200$, $r=.010$	NS	Increased for sample as a whole; $P<.05$, $d=0.562$, $r=.270$	Increased sanction medium effect

Annualized jail LOS	Decreased; $P<.01$, $d=0.779$, $r=.363$	Opt-out decreased significantly; $P<.05$, $d=0.442$, $r=.216$	NS	Opt Outs only increased jail days; $P<.03$, $d=-0.766$, $r=-.356$	Decreased jail days for participants medium to large effect
Annualized jail LOS pre–post following new booking	NS	Increased for opt-out only; $P<.01$, $d=-0.606$, $r=.290$	Trend toward increase; $P=.069$	Increased for sample as a whole; $P<.001$, $d=0.840$, $r=.387$	Increased sanction after reincarceration large effect
Treatment referral, engagement, impact					
Treatment referral	95.4% linkage	NA	84% enrollment	Opt-in higher than opt-out, 84% vs. 54%, $P<.01$	Increased linkage large effect
Monthly treatment hours	NS	Trend toward increase in opt-outs; $P=.057$, two-tailed	Increased; $P<.001$, $d=0.349$, $r=.172$	NS	Increased treatment hours medium effect
Global assessment of functioning ratings	NA	NA	Increased; $P<.05$, $d=0.257$, $r=.128$	Decreased in opt-out group; $P<.001$, $d=-0.612$, $r=-.293$	Improved functioning small effect Prevention of deterioration medium effect[a]

NS = not significant; NA = not assessed.

[a] More tentative conclusion based primarily on considering differences between findings for Opt-Out and Opt-In participants.

ies: none to low, low to moderate, moderate, moderate to high, high, and not assessed. Although a similar scale was used for some indicators in the original evaluations, the ratings in this table are derived from the evaluator's synthesis of all available qualitative information, and therefore are both somewhat subjective and do not have the strength of a complete listing of known exceptions and minority viewpoints. The comments column for each MHC is used to provide some of this level of detail and divergent, rather than convergent, information.

10.3. Quantitative indicators of MHC effectiveness

Indicators for each quantitative domain were evaluated for each court separately by means of one or both of two methods. The first method used to assess the indicators was that of pre–post analyses comparing data on each opt-in participant prior to referral to their own data after MHC referral. The second method utilized data for one or more comparison groups of referred individuals who did not chose to participate in a MHC, the opt-out participants. A pre–post design was followed in this method as well, and these analyses also incorporated opt-out data.

In the original evaluation reports, results were reported as either differences between means or correlations with associated statistics and probability levels. For purposes of this article, results from original analyses were converted to one of two effect size measures, Cohen's *d* (Cohen, 1988) and the effect size *r*. Cohen's *d* and can range from 0 to 2. Although the meaningfulness of an effect size depends on comparing it to those found in similar studies in the same field, Cohen generally described effect sizes of $d = 0.2$ as small, $d = 0.5$ as medium, and $d = 0.8$ as large. The effect size *r* is closely related to the more familiar Pearson correlation coefficient and measures the relationship between an indicator (dependent variable) and group membership (i.e., treated or untreated). The square of *r* is the percent of variance accounted for in indicator scores by group membership status. An *r*-value of .6 means that group membership accounts for .36, or 36% of the variance in respective indicator scores, whereas an *r*-value of 1 means that group membership accounts for 100% of the variance in indicator scores. Given the quasi-experimental nature of our approach, the reader is reminded that the term ''effect'' used here in describing effect sizes refers to the magnitude of pre–post differences or differences between groups, rather than a firm inference that participation or nonparticipation in a MHC was the only defensible explanation of the observed differences.

Table 2 summarizes quantitative evidence relevant to evaluating the effectiveness of these MHCs. Each MHC is summarized separately, as are the evidence from one or both of two methods used to assess effectiveness indicators. Significance levels from the original analyses (*t*-test, paired *t*-test, nonparametric test, correlation, etc.) are provided in the table but not the full statistical test. Where available, but only when the original statistical test was significant at or below $P < .05$, Cohen's *d* and the effect size *r* are reported for each indicator. The final column of this table summarizes the type and direction of impact and range of effect sizes for each indicator. We chose not to combine the effect sizes, as in a meta-analysis, since we considered a single composite measure based on only two studies as less informative than providing the effect sizes from both studies.

11. Qualitative discussion

The effectiveness ratings we derived from key informant and key stakeholder responses tended to be highest for indicators that were within the direct control of the MHCs such as the indicators the public safety domain, and lowest for indicators that were primarily contingent on external resources, such as linkage/referral to housing and linkage/referral to substance abuse treatment services. Similarly, ratings of indicators in the program gatekeeping domain, which are generally in the control of the MHC, tended to be moderate to high.

Although we attempted to be as objective and inclusive as possible in identifying indicators of effectiveness that might be applicable to MHCs, this task is inextricably connected to the prescriptive aspect of evaluation, that is, the process of deciding what MHCs should be and do. We found both low to moderate ratings and lower informant consensus on those indicators that were related to contested characteristics of an effective MHC. For example, the MHCs received low ratings on the reduced jail days indicator in the decriminalization domain. Some informants viewed the diversion prior to arraignment indicator as undesirable, as an indicator of effectiveness, arguing that many MIMDs who may be characteristically lacking in insight into their illness, or for some other reason are unmotivated or unable to consistently engage in treatment on their own, may be capable of responding to the structure of an MHC, which includes formal criminal charges and the possibility of sanctions.

Informants also disagreed about the value of reduced jail days as an indicator or performance for several reasons. The expectation of immediately reducing detention costs by reducing jail days served by MIMDs (who were to be managed in more appropriate, treatment-oriented facilities or community-based treatments) had been a major rationale offered for establishing and maintaining these MHCs, which required transferring some resources from the criminal justice system to the mental health system, and dedicating court resources, thus reducing case processing productivity. Nonetheless, our informants often counterbalanced the value of reducing jail days with other values, such as for need to be sure that the MIMD was stable and had a well-formulated placement plan, complete with appropriate housing and treatment that was likely to be effective at maintaining the stability achieved during incarceration and enabling the MIMD to remain in the community at longer intervals without psychiatric or legal setbacks. Many informants argued that either a break-even in jail days or even a slight increase might result from effective MHC case management. The goal of breaking the revolving door cycle was also cited, with the accompanying expectation that initially the number of episodes of incarceration and their duration might increase, due to increased surveillance by probation counselors, but that over longer intervals of observation than those used in the studies reported here, reductions in number of incidents, incident severity, jail days per booking, and total annual jail days would be demonstrable.

We found that although many informants felt that some indicators might have value, they were skeptical concerning their feasibility, given the limited timeframes and staff resources that MHC work within. Indicators such as access/use of standardized assessment instruments, requires/strongly encourages clinician testimony/reports were sometimes viewed as unattain-

able due to the need for rapid turnaround of assessments and the perception that time spent preparing for and appearing at hearings would detract from the ability of clinicians to provide needed services to MHC participants. Some informants were not optimistic about the ability of MHCs to impact systems and resources as reflected in indicators such as monitoring/intervention regarding treatment effectiveness and adds resources for MIMDs, although they saw indicators as reflecting these as acceptable goals. Other informants saw these areas as outside the appropriate purview of the courts, being rather the responsibility of the various administrations overseeing mental health services.

12. Quantitative discussion

Statistically significant evidence from both courts suggested impacts on relevant criminal justice and mental health indicators of effectiveness. In most cases, the measured effects were in the direction that would be expected for programs intended to reduce crime and criminal justice sanctions while increasing treatment for the mentally ill. Although we have no other comparable studies to compare our effect sizes, applying the general interpretation guidelines suggested by Cohen (1988) would lead us to consider most of the measured effect sizes as medium or medium to large in magnitude. Since most of the effect sizes were based on comparisons between two groups of unequal sizes, it is likely that they reflect attenuated estimates, that is they probably underestimate the true effect sizes (Kermery, Dunlap, & Griffeth, 1988). The effect sizes in the range of those reported for many MHC effectiveness indicators for these two MHCs are likely to have practical consequences for individual defendants, rather than reflecting group-level subtleties. For example, evidence for increased treatment referral and engagement was unequivocal. Some of the evidence was suggestive of an important prevention role, or at least negative predictive function, for participation in MHCs, in that individuals who chose not to participate fared worse after MHC referral, not only compared to those who did participate, but when compared to their own pre-referral history. In some cases, the indicators showing this pattern were not within the primary control of the court system, such as new charge severity (controlled mainly by the arresting officer), and clinician rated level of psychosocial functioning (i.e., global assessment of functioning (GAF) scores). However, some of the findings on criminal justice indicators—such as significant increases in jail days for post-referral bookings and increased total jail days served for opt-out defendants—could be interpreted as resulting from additional sanctions and recriminalization after referral to a MHC.

13. Recommendations

Both MHCs requested that the evaluators formulate recommendations for improvement based on the evaluation results. In each case, recommendations were made to the MHC, to its larger court structure, and to its governing body (city or county). Because many of the services

on which these courts depend are managed at the state level, some recommendations also involved state agencies. Our research protocol allowed us to capture the many useful suggestions and observations of those we had interviewed and surveyed. Among the recommendations with potential applicability to other MHCs was our recommendation to the Seattle Municipal Court that some formal organizational identity be established for the SMMHC by explicitly adopting its model, and incorporating the SMMHC into assignment lists, budgets, and other routine aspects of court management. Other recommendations were aimed at either increasing or preserving the degree to which the MHC staff and courtroom were dedicated solely to the adjudication of MIMDs without competing responsibilities. Among recommendations of this type were to narrow mental health and public defender agencies to those who demonstrated a willingness and ability to work with MIMDs and within the MHC model. We also recommended that linkages between the jail psychiatric staff and jail health staff and the courts be strengthened and that the mission of jail psychiatric and health services be expanded to include participating in transition planning and treatment linkages for defendants under their care.

Because defendants present with a broad continuum of problems at various stages of progression or amelioration, we recommended the use of standardized clinical assessment instruments, such as the Brief Psychiatric Rating Scale (Lachar et al., 2001) in addition to diagnosis, for use by MHC clinicians, probation counselors and associated mental health provider programs. In addition to promoting more detailed understanding and awareness psychiatric status, standardization of assessment would assist in more objectively establishing the degree of current psychiatric impairment, assessing progress in treatment and changes in risk for reoffending related to psychiatric symptoms, and thereby, indirectly, evaluating the appropriateness of treatment received by MIMDs. Objective assessment would also assist in clarifying whether a defendant with a history of diagnosed mental disorder and substance use problems was more appropriate for participation in an MHC or in a drug court.

Although these MHCs were actively and successfully involved in linking clients to treatment and supporting the continuation of treatment engagement, especially medication compliance, little scrutiny was being made of the effectiveness of the treatments that clients were required to participate in. A series of brief trainings was recommended designed to familiarize court teams with on evidence-based medication and psychosocial interventions for mental illness and substance abuse and ways of working with treatment providers that might improve the effectiveness of the treatment offered through concentration attention on defendant progress.

Several recommendations addressed limitations in the MHCs as currently configured. For example, several informants felt that the MHC process should not be limited to misdemeanors and that these courts should also adjudicate lower level felonys. The tendency for MHCs to be under-resourced relative to drug courts observed by Steadman et al. (2001) applied to these courts, which intermittently faced threats of reductions in staff members, dedicated staff time, and perhaps abolishment, due to budget cuts resulting from shrinking city and county tax revenues. It was recommended that a state and local task force on mentally ill offenders, similar to the one that had resulted in the founding of these courts, be convened to engage the organizations and agencies that have broad

responsibility to shape and implement criminal justice policy in addressing the needs of MHCs.

14. Conclusions

The evaluations described in this report were limited in scope and purpose. As in the case of MHCs, relatively little in the way of resources were allocated to support the evaluation process. Each evaluation was designed and completed in less than 6 months, after the courts themselves had been in existence for only a short time. These restrictions precluded obtaining institutional review board approval to interview patients. Other data sources that were potentially available, such as records of hospitalization and substance abuse treatment, were not utilized. The quasi-experimental quantitative analyses were performed on relatively small samples. These limitations should tend to predispose the studies toward Type II errors, that is, to failing to find any existing differences related to MHC involvement. Nonetheless significant differences were found with substantial effect sizes. Although causality cannot be clearly attributed from studies of this type, we find it more reasonable than not to conclude that both MHCs described here made significant impacts on both the participants and nonparticipants referred to them. Both interviewees and quantitative data indicators point to a criminal justice system in that has been positively impacted by a new ecological presence, the MHC.

Acknowledgements

This study could not have been completed without the openness and support of Judge Jim Cayce, formally of the King County District Court, and Judge Anne Levinson, formally of the Seattle Municipal Court.

Two co-investigators, David M. Wertheimer, of Kelly Point Partners, Seattle and Barbara Lucenko, Ph.D., of the Washington State Administrative Offices of the Court, Olympia made invaluable contributions to the Seattle Municipal MHC evaluation and the King County District MHC evaluations, respectively.

References

Brickman, L. (2002). The death of treatment as usual: an excellent first step on a long road. *Clinical Psychology: Science and Practice*, *9*(2), 195–199.

Casey, P., & Rottman, D. B. (2000). Therapeutic jurisprudence in the courts. *Behavioral Sciences and the Law*, *18*, 445–457.

Goldkamp, J. S., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal caseload: mental health courts in Fort Lauderdale, Seattle, San Bernandino, and Anchorage.* Washington, DC: Bureau of Justice Assistance.

Henggeler, S. W., Lee, T., & Burns, J. A. (2002). What happens after the innovation is identified? *Clinical Psychology: Science and Practice*, *9*(2), 191–194.

Kermery, E. R., Dunlap, W. P., & Griffeth, R. W. (1988). Correction for variance restriction in point-biserial correlations. *Journal of Applied Psychology*, *73*(4), 688–691.

Lachar, D., Bailley, S. E., Rhoades, H. M., Espadas, A., Aponte, M., Cowan, K. A., Gummatira, P., Kopecky, C. R., & Wassef, A. (2001). New subscales for an anchored version of the Brief Psychiatric Rating Scale: construction, reliability, and validity in acute psychiatric admissions. *Psychological Assessment*, *13*(3), 384–395.

McGaha, A., Boothroyd, R. A., Polythress, N. G., Perila, J., & Ort, R. G. (2002). Lessons from the Broward County Mental Health Court Evaluation. *Evaluation and Program Planning*, *25*, 125–135.

Poythress, N., Petrila, J., McGaha, A., & Boothroyd, R. (2002). Perceived coercion and procedural justice in the Broward Mental Health Court. *International Journal of Law and Psychiatry* (in press).

Slobogin, C., & Fondacaro, M. (2000). Rethinking deprivations of liberty: possible contributions from therapeutic and ecological jurisprudence. *Behavioral Sciences and the Law*, *18*, 499–516.

Steadman, H. (1992). Boundary spanners: a key component for effective interactions of justice and mental health systems. *Law and Human Behavior*, *16*, 75–87.

Steadman, H. J., Davidson, S., & Brown, C. (2001). Law and psychiatry: mental health courts: their promise and unanswered questions. *Psychiatric Services*, *52*(4), 457–458.

Trupin, E., Richards, H. J., Lucenko, B., & Woods, P. (2000). *Phase I process evaluation and preliminary outcomes data for the King County District Court Mental Health Court.* Available from King County Metropolitan Government Website: http://www.metrokc.gov.

Trupin, E., Richards, H. J., & Wertheimer, D. M. (2001). *Phase I process evaluation and preliminary outcomes data for the City of Seattle Municipal Court Mental Health Court.* City of Seattle Website: http://www.cityofseattle.net.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services*, *52*, 477–481.

Wexler, D. B., Winick B. J. (Eds.) (1996). *Law in a therapeutic key.* Durham, NC: Carolina Academic.