

***Norfolk Mental Health Court  
Evaluation Study***



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## EXECUTIVE SUMMARY

### PURPOSE OF THE STUDY

The purpose of the evaluation was to assess the extent to which the Norfolk Mental Health Court (NMHC) had achieved its goals. The study was designed to answer the following questions:

1. Do program participants make use of therapeutic and social services during their enrollment in the program?
2. Does participation in the program reduce the number of times that persons with mental illness and/or co-occurring disorders come in contact with the criminal justice system?
3. Does the program reduce the amount of time that persons with a mental illness and/or co-occurring disorders spend in jail?
4. Does the program enhance effective interactions between the criminal justice and mental health systems?

### METHODS

The evaluation of the NMHC was designed as an outcome evaluation that examined its effects on offenders with mental health disorders. The progress of a cohort of program participants was followed for a period of 18 months, beginning July 2006 and ending December 2007. A mixed-method approach was used to collect data to answer the evaluation questions. Prior studies of mental health courts and drug courts (which enroll offenders with similar characteristics to those enrolled in mental health courts) were reviewed to identify reliable sources of data and data collection methods. The data for the evaluation were obtained from multiple sources: (1) NMHC progress reports; (2) observations of court sessions and team meetings; (3) CSB client case files; (4) public-access court records; and (5) interviews with the NMHC participants themselves.

### FINDINGS

**Access to services.** Participation in the NMHC provided mentally ill offenders with access to case management services, social services and therapeutic services, which the vast majority of them found helpful. NMHC participants found the case management services particularly helpful, as well as the support they received from the presiding judge. The close supervision provided by case managers and regular meetings with the judge and probation officer promoted compliance with conditional treatment plans, and helped offenders stabilize their conditions and remain clean and sober.

**Contact with justice system.** The majority of program participants reported that participation in the NMHC had helped them to avoid individuals who might get them into trouble and also avoid

engaging in illegal activities. The majority of NMHC participants had committed minor property and drug crimes or minor assaults. The incidents of assault and battery generally were the result of mental instability, rather than a premeditated attempt to harm others. And some were lured into criminal activity by association with others. Regular drug screens helped to reduce the likelihood that participants would use drugs (except for those with severe addiction). Close supervision, and frequent communication between court and probation officers, case managers and other service providers ensured that risky behavior or signs of deteriorating functioning were quickly detected and actions taken to prevent participants from getting themselves into serious trouble.

The main sanction used by the NMHC judge for noncompliance was to jail participants for brief periods (usually a week). Slightly more than half of the participants who had been in the program for more than 9 months had been jailed for noncompliance. The majority of these participants had been sanctioned for using alcohol/other drugs. These tended to be individuals with severe, long-term addictions who did not have access to intensive substance abuse treatment. While continued drug use was not uncommon among program participants, committing new offenses was much less common. Only six of the 26 participants who had been in the program longer than 9 months committed new offenses and none of them committed a new offense during the first 9 months of the program.

**Time in jail.** Without access to appropriate treatments, many mentally ill offenders are repeatedly incarcerated. One of the objectives of mental health courts is to reduce the amount of time mentally ill offenders spend in jail and the number of times are incarcerated. The number of days that NMHC graduates remained out of jail while actively participating in the program was 11,610 (for all those who had graduated from the program since it began operating). After completing the program, NMHC graduates remained out of jail a total of 9,600 days (calculated from the time they graduated through December 31, 2007). A conservative estimate of the jail costs saved as a result of the NMHC program amounted to \$1.63 million dollars (21,210 total days @ \$76.85 per day).

The recidivism rates for those who completed the NMHC program were considerably lower than baseline rates for mentally ill offenders and non-mentally ill offenders who completed their jail sentences reported in prior studies. Recidivism rates for NMHC graduates were: 3.5 percent at 6 months, 5.0 percent at 12 months, 12.5 percent at 18 months, and 30 percent at 24 months. Prior studies report baseline recidivism rates for mentally ill offenders that range from 64 percent at 18 months after release to 77 percent at two years after release. While the small sample size did not allow for statistical analyses of between group differences, these are very promising results.

**Between systems interactions.** The creation of the NMHC itself is an example of effective between-systems collaboration, in that no external funds were required to support its operations - a reallocation of agency resources has enabled it to operate. The collaboration between the justice system and the social services system was a critical factor in the formation of the mental health docket and continues to be critical to its capacity to promote effective outcomes for offenders with mental health disorders. Too often, individuals with multiple and complex needs fall between the cracks of the network of human services agencies and providing them with appropriate assistance becomes even more challenging when working across systems. The

NMHC provides a unique example of effective between-systems interactions for other jurisdictions and agencies that would like to develop programs for offenders who suffer from mental illness and co-occurring disorders.

## **CONCLUSIONS**

The findings of the evaluation study conducted by the SSRC support the findings of prior studies of specialty courts. The evaluation study provides empirical evidence of the program's success in achieving its goals, and the benefits it provides to individual participants, as well as the corrections system (in the form of reduced operating costs). The evidence in this report indicates that mental health courts help mentally ill offenders to achieve stability over an extended period without incarceration and without risking public safety. The findings indicate that diversion programs for mentally ill offenders may also provide social and economic benefits to individuals and communities by enabling offenders to work to support themselves and eliminating the need for governmental subsidies and incarceration costs.

# NORFOLK MENTAL HEALTH COURT EVALUATION

## I. PURPOSE OF THE STUDY

Judge Charles E. Poston, the presiding judge of Norfolk Circuit Court's Mental Health Court<sup>1</sup> requested that the Social Science Research Center (SSRC) at Old Dominion University in Norfolk, Virginia conduct an evaluation of its effectiveness. Since its inception in 1998, the Social Science Research Center's mission has been to apply social science theory and rigorous research methods to the study of social problems and the development of effective remedies. In keeping with its mission, the SSRC conducted an evaluation study with the cooperation of the Norfolk Circuit Court officers, the Public Defender's and Commonwealth Attorney's Offices, and Probation and Parole Department, and the Norfolk Community Services Board staff members who worked collaboratively with the Norfolk Mental Health Court. The purpose of the evaluation was to determine whether the Norfolk Mental Health Court had achieved its goals and to provide credible evidence of any potential benefits identified.

## II. SOCIAL SIGNIFICANCE OF THE STUDY

Starting in the 1960's, there was growing concern about the treatment and numbers of the mentally ill committed to state mental hospitals (Denckla and Berman, 2001). A 1972 case originating in Alabama, *Wyatt v. Stickney*, recognized a constitutional right to treatment for the mentally ill but also specified that many of those hospitalized did not require lengthy stays. States thus felt pressured to turn to community-based options for treatment (Perez, Leifman, and Estrada, 2003). Eventually, policies changed and the number of involuntary commitments decreased and states moved towards a system of care which was out-patient and community based. Out-patient treatment was further facilitated by the increasing effectiveness of psychiatric medications (Denckla and Berman, 2001). However, money saved from the closure of state mental hospitals was not channeled into improved community-based services. "Ironically, instead of deinstitutionalization, we have witnessed the reinstitutionalization of individuals with mental illnesses from deplorable state psychiatric hospitals to correctional institutions, where conditions are often worse" (Perez, Leifman, and Estrada, 2003: 63). Some advocates, noting the link between the decline of the psychiatric hospital population and the increase of the mentally ill population in jail, have labeled this shift: "transinstitutionalization" (Torrey & Zdanowicz, 2000).

The de-institutionalization of mental health hospitals placed a great strain on the community mental health system during the 1960's and 1970's (Drapkin, 2003). Without adequate resources to deal with the increased volume of mental health clients, the mentally ill in many communities were left without services and resources. Some became homeless and others engaged in criminal behavior as a result of their untreated mental health problems or in order to survive on the streets (Drapkin, 2003). Arrests and incarceration rates are higher for individuals who are mentally ill

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<sup>1</sup> The Norfolk Mental Health Court is actually a specialized docket that handles the needs of small group of mentally ill offenders but is not an independently operating or funded mental health *court*. However, it is commonly known, and will be referred to in this document, as the Norfolk Mental Health Court, NMHC, or "program" (Ragbir, 2007).

compared to those without a mental illness (Denckla and Berman, 2001). By the end of 2000, there were nearly one million people with mental illness in the criminal justice system (Bureau of Justice Statistics, 2001). The increasing numbers of mentally ill have found themselves incarcerated without adequate treatment services and are often released without sufficient discharge and transitional services (Denckla and Berman, 2001).

In partial response to restrictive sentencing policies and the growing numbers of addicted, mentally ill, and other types of offenders, several types of specialty or problem solving courts emerged (McCoy, 2003). Drug courts were one of the original and now very widely used specialty court models. They have received considerable attention from federal agencies, academicians and social scientists (Goldkamp, 2000, McCoy, 2003). “Specialty courts have emerged in the past decade to provide significant national leadership in developing treatment and supervision approaches that reduce criminal recidivism, engage individuals in the recovery process, and that safely retain people in their communities rather than in jails or prisons” (Peters and Osher, 2004: 34). The National Institute of Justice analyzed data from several NIJ-funded research efforts on drug court effectiveness and found that:

1. drug courts can reduce criminal recidivism and achieve positive outcomes but the specific court processes which are related to which outcomes has not been determined;
2. treatment should be based on theories regarding dependency and abuse, use best practices, and allow participants to build cognitive skills;
3. juveniles can be more difficult to diagnose and treat;
4. interactions with the drug court judge may be one of the most important factors influencing participants’ drug court experience and may be influenced by the judges’ interpersonal skills, ability to expedite legal issues and provide access to services (NIJ, 2006).

Mental health courts are another type of specialty court which have emerged following the model of drug courts but have not received quite as much attention from the federal government or from researchers (Steadman, Davidson and Brown, 2001).

Virginia’s Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) formed a multi-agency workgroup in 2003 to study options for diversion and jail mental health services. This group identified 4 key problems including: lack of basic community resources for the mentally ill, lack of jail diversion programs and resources throughout the state, insufficient treatment resources within jails, and a high demand for limited state hospital beds (Morris, 2007). To better understand the real demand for mental health services within the state’s criminal justice system, all 67 local and regional jails in Virginia were surveyed in 2005 as to the population of mentally ill jail inmates and other needs. There were 24,595 jail inmates on the day of the survey with 4,006 reportedly suffering from a mental illness (16%) (Morris, 2007). [A 1999 survey found that 16 percent of the inmates in U.S. prisons and jails reported having a mental condition or prior psychiatric hospitalization (Bureau of Justice Statistics, 1999).] Despite the large number of mentally ill jail inmates, only 22 of the 67 jails reported having specialized mental health housing for inmates and there were only a total of 873 mental

health treatment beds in jails (Morris, 2007). Over half of mentally ill inmates also had co-occurring substance abuse disorders and needed treatment for substance abuse (n=2270, 56.7%). Most inmates suffered from bipolar disorder, schizophrenic disorders, or depressive disorders. The total cost for psychotropic medications in 2005 was almost \$4 million and over \$4 million in additional costs were incurred for non-medical mental health services (e.g., individual and group counseling) (Morris, 2007).

A major factor that has contributed to the number of mentally ill jail inmates has been the lack of services available to the mentally ill in Virginia. The findings of the National Alliance on Mental Illness' (NAMI) 2006 comprehensive state-by-state analysis of mental health systems corroborated these earlier findings. NAMI gave Virginia a grade of "D" for its mental health infrastructure and overall availability of services (NAMI, 2006). Virginia also scored low on the availability of jail diversion programs. In response to these and the jail survey findings, the DMHMRSAS task force recommended that Virginia: implement diversion programs to prevent the arrest and incarceration of the mentally ill; improve jail mental health services; ensure timely mental health hospital admission for inmates in need of inpatient treatment and services; and *establish mental health courts in selected localities* (Morris, 2007).

### **III. NORFOLK'S MENTAL HEALTH COURT**

The Norfolk Mental Health Court (NMHC) has been in operation since February 2004 and uses a multi-disciplinary team to adjudicate mentally ill offenders. The initial planning and development began in the summer of 2002, and key partners visited other programs in communities similar to Norfolk. The Norfolk Mental Health Court's structure reflects some of the features of the circuit court program in Broward County, Florida, and the Superior Court program in San Bernardino County, California. A feature of the NMHC that may be unique among existing mental health courts is that it has operated without any special funding. The staffing was accomplished by forming a team consisting of a representative from each of the collaborating agencies (courts, probation, jail, human services) and the allocation of funds from agencies' operating budget.

At the time that the Norfolk Mental Health Court was implemented, 140 total inmates were identified in the local and regional jail who were seriously mentally ill (Phillips, 2002). The Norfolk Mental Health Court multidisciplinary team includes a Norfolk Circuit Court judge, Commonwealth attorneys, attorneys from the Norfolk Public Defender's office, representatives from the Norfolk Sheriff's Department, Hampton Roads Regional Jail, Norfolk Probation and Parole, and the Norfolk Community Services Board (CSB). The purpose of the Norfolk Mental Health Court is to "address the unique needs of persons with mental illness and/or co-occurring disorders in our criminal justice system in such a manner to increase public safety and improve successful community integration" (Phillips, 2002).

The goals of the Norfolk Mental Health Court are to (Poston, 2005):

1. Increase public safety by ensuring NMHC participants are engaging in community treatment and follow-up services during their enrollment in the program.

2. Reduce the contact of persons with mental illness and/or co-occurring disorders with the criminal justice system.
3. Ensure that persons with a mental illness and/or co-occurring disorders do not languish in jail because of their mental condition or lack of available treatment.
4. Enhance effective interactions between the criminal justice and mental health systems.

The Norfolk Mental Health Court program is available to criminal defendants who are current or former CSB clients or receive mental health treatment through a private provider and who have an Axis I diagnosis (with mental illness the primary diagnosis) that was a factor in their arrest. Participation in the NMHC is voluntary for defendants and offers delayed sentencing while the defendant is in treatment. Members of the mental health court team or defendants themselves may make referrals to the program. At any time in the legal proceedings it may be decided that mental health court is not appropriate for any given defendant. Referrals to NMHC are reviewed by staff to determine if they meet the eligibility criteria which include both legal and psychiatric requirements. Non-violent felonies, or non-violent misdemeanor appeals are cases that are heard in the Circuit Court and are eligible for NMHC, with the exception of sex offenses or driving under the influence. Individuals who have a prior record of violent offenses or sex offenses also are not eligible for the program. Violent felony cases are considered on a case-by-case basis. To be eligible, defendants must have a serious and continuous mental illness that would be responsive to the services currently available from the Norfolk Community Services Board (Phillips, 2002; Ragbir, 2005).

Those defendants who meet the eligibility criteria and agree to participate in the program are referred to the Commonwealth Attorney's Office for review. If a case does not satisfy the admissibility criteria, then the case is sent back to the circuit court, or passed on to the mental health court team if it does meet the criteria. The mental health court team members meet to review each case and to discuss services and requirements that should be included in a defendant's treatment plan before the eligibility hearing. The Public Defender and the CSB staff meet with defendants to review the proposed treatment plan. If the defendant does not agree to comply with the plan, then his/her case is sent back to the circuit court.

If the participant agrees to comply with the conditional release plan, including being compliant with the medication regimen, participating in group counseling or other therapy, and seeking and maintaining employment when appropriate, then she/he is admitted to the program and the defendant's case is docketed with the NMHC. Entry into the program does not require a plea of guilty or a waiver, but there is a finding of guilt, and the defendant must still be sentenced at the end of the program. The program simply provides an opportunity for the defendant an opportunity to resolve the problems that were triggers to the commission of a crime.

The mental health court team, which includes the presiding judge, prosecuting attorney, defense attorney, court advocate, case managers, and director of the jail's mental health ward, meets every week prior to court to review each defendant's progress, compliance with treatment and other issues. Once a defendant enters the program she/he is placed on immediate probation supervision. While participating in the NMHC, defendants are monitored by the NMHC team as well as a probation officer. A CSB case manager provides case management services based

upon the existing case management model utilized by the Norfolk's CSB. If a defendant is successful and completes the program, the finding of guilt prior to program entry may be vacated and another disposition imposed (e.g., dismissal of the charge, conviction of a lesser-included offense). If a defendant does not comply with the requirements of the program and/or commits new offenses, she/he will be dropped from the program and sentenced.

The Norfolk's CSB is a key partner to the Circuit Court and provides centralized case management for NMHC participants. In addition, the CSB provides an array of services that include: psychiatric consultation, psycho-social day treatment rehabilitation, 24/7 psychiatric crisis/emergency counseling, and residential and community in-home support services. The CSB provides staffing for the Norfolk Mental Health Court in the form of a coordinator who manages CSB case managers, who provide housing and employment assistance to offenders and coordinate services provided to them. The director of the mental health unit in the Norfolk City jail also provides therapeutic, substance abuse, and follow-up services to the offenders while they are detained in the jail, and provides information to the court officers about their behavior while they are incarcerated for violations of their probation. The coordination among key agencies helps to ensure that defendants participating in the NMHC comply with their conditional treatment plan, but also that they receive the services that they need to resolve their mental health problems. For some defendants, lack of access to services has impaired their ability to resolve their problems in the past.

#### **IV. STUDY DESIGN & METHODOLOGY**

The purpose of the evaluation was to assess the extent to which the NMHC had achieved its goals. The study was designed to answer the following questions:

5. Do program participants make use of therapeutic and social services during their enrollment in the program?
6. Does participation in the program reduce the number of times that persons with mental illness and/or co-occurring disorders come in contact with the criminal justice system?
7. Does the program reduce the amount of time that persons with a mental illness and/or co-occurring disorders spend in jail?
8. Does the program enhance effective interactions between the criminal justice and mental health systems?

The evaluation team used a mixed-method approach to collect the data to answer the four evaluation questions. Prior studies of mental health courts and drug courts (which enroll offenders with similar characteristics to those enrolled in mental health courts) were reviewed to identify reliable sources of data and data collection methods. The design and methods used by the SSRC to conduct the program evaluation are described in this section.

## IV.1. STUDY DESIGN

The evaluation of the NMHC was designed as an outcome evaluation that examined the program effects on a cohort of offenders with mental health disorders, some of whom had co-occurring disorders. The progress of this cohort of program participants was followed for a period of 18 months, beginning in July of 2006 and ending in December of 2007. Initially, their progress was going to be monitored for 12 months, but there were adequate resources available to continue the study for an additional 6 months. The following program characteristics and participant outcomes, program effects were examined:

1. measures of individual outcomes – compliance with treatment plans and conditions of probation, contacts with criminal justice system, commission of new crimes and incarcerations while in the program, commission of new crimes and incarcerations after termination/graduation from the program;
2. factors that might affect successful completion of the program – personal characteristics, familial factors, alcohol/other drug (AOD) abuse, and features of the program; and
3. program participants' perceptions about the program and services they received.

The progress of the cohort of NMHC participants included in the study was monitored for the duration of the study. Outcome data for those who successfully completed the program or who had been terminated (due to non-compliance with court requirements or because they were incarcerated or institutionalized) continued to be collected for the duration of the study. Because some individuals with mental health and co-occurring (e.g., substance abuse) disorders have periods in which they are stable and/or sober/drug-free followed by relapse, most evaluations of treatment or intervention/diversion programs attempt to track outcomes for an extended period beyond program completion or termination to assess long-term effects. Those who successfully complete an intervention/diversion program have positive outcomes at completion; however, they may relapse after intensive monitoring and case management services end and their mental health and stability deteriorate and the benefits of the program decline over time.

Given the chronic nature of mental health and co-occurring disorders, it was anticipated that many policy makers and practitioners would want evidence of longer-term positive outcomes in order to judge the program successful. Because of this, the evaluation attempted to assess some of the key outcomes over an extended period of time. The current cohort of NMHC participants were followed for the duration of the evaluation; however, because many remained in the program for a year or longer, they could be followed for only a short period after they had completed or were terminated from the program. Because data on contacts with the criminal justice system were available from public sources, the criminal activities and incarceration of all individuals that had graduated or been terminated from the program could be studied. Therefore, it was possible to examine the long-term impact of the NMHC on former cohorts, as well as those individuals who participated in the program during the time of the study.

As is common with intensive interventions, such as substance abuse treatment programs, the number of individuals that could be enrolled in the NMHC was limited to a relatively small number (about 30) and participants remained in the program for at least 12 months (sometimes much longer). Due to these factors, the number of individuals who could participate in the study was relatively small. The small size of the potential study sample limited the design options and the types of analyses that could be conducted with data collected from program participants. A multiple case study design was used for the NMHC evaluation, and a new methodology, the “success case method,” was used to make between-group comparisons. This method does not require the use of separate control or comparison groups, and is used when it is difficult or impossible to identify an appropriate control/comparison group. Given the unique NMHC admission criteria and procedures, it would have been impossible, or at least extremely difficult, to obtain an adequate control or comparison group. This new method allows the evaluator to compare individuals who complete a program – “success” cases – with those individuals who did not complete the program for whatever reason – the “unsuccessful” cases, and to identify the factors that promote the best client outcomes (e.g. individual characteristics, program features, situational or social factors).

#### **IV.2. DATA COLLECTION METHODS**

The data for the evaluation were obtained from multiple sources: (1) NMHC progress reports; (2) observations of court sessions and team meetings; (3) CSB client case files; (4) public-access court records; and (5) interviews with the NMHC participants themselves.

**NMHC Progress Reports.** The CSB case managers prepare weekly progress reports that assess the progress of each program participant and identify any problems that the individual has had during the week. These problems might include: use of controlled substances; failure to attend required substance abuse recovery meetings, appointments with doctors or therapists, or meetings with case managers or probation officers; refusal to provide samples for drug tests; failure to take prescribed medications; lack of compliance with probation requirements, court orders, or case manager’s requests; arrest/incarceration for new criminal charges; and any behavioral problems. These reports are reviewed and discussed at weekly team meetings with the NMHC’s presiding judge, prosecuting attorney, defense attorney, court advocate, and coordinator of the jail’s mental health unit and decisions are made about what actions to take to help the individual to resolve each problem and whether it is appropriate to sanction or reward him or her. The weekly progress reports were obtained, a scale was developed to rate the level of progress made by each individual program participant and the data were coded. These data provided a numerical measure of the rate of progress of individual participants and extent to which they had been compliant or noncompliant over time.

**Observations of Court Sessions and Team Meetings.** Observations were conducted of the weekly court sessions and pre-court team meetings. Informal notes were recorded about the weekly progress of program participants and the directives, rewards and/or sanctions given by the judge.

**CSB Client Files.** With the consent of program participants, the intake forms from CSB client records were obtained. These forms were obtained only for those participants who were enrolled in the program at the time the study was conducted and graduates who could be located and interviewed. Because active consent had to be obtained in order to gain access to these files, it was not possible to obtain them for dropouts or graduates who could not be located. The most current information about client's mental health and co-occurring disorders, level of psychosocial functioning, treatment plan, and services received was obtained from the CSB client files.

**Public Access Court Records.** Information about NMHC participants' contact with the criminal justice system was collected from public-access court records that contain information about criminal cases that are tried in the Norfolk Circuit Court. Information about program participants' criminal activities and sentences received was downloaded from the Virginia Circuit Court Case Information web site that contained an historical record of each individual's past and current court cases, charges, date of offense, and status of each case. This information was available for all past and current cohorts of NMHC participants, including those that had absconded, been terminated, or graduated from the program.

**Participant Interviews.** Interviews were conducted with the current cohort of program participants to collect information about personal, familial, and social factors that might affect their compliance with the conditions of probation and their treatment plans and continued participation in the NMHC. For many programs, personal, familial, and environmental factors result in differences in outcomes, so background data about program participants was collected so that any potential effects of these factors could be examined. In addition, participants were surveyed about different features of the NMHC and asked to assess the helpfulness of the various services they received and the impact of the program on their stability. The interviews were conducted at the Circuit Court offices, after the program participants met with the presiding judge at the weekly court sessions. Conducting interviews at the court house had several benefits. It protected the privacy of subjects, because access to these facilities was controlled, and it did not require them to travel to an unfamiliar site (which was difficult for many who used public transportation).

### **IV.3. THE SAMPLE**

The study sample initially consisted of all former and current NMHC participants, including those who dropped out (a few voluntarily left) or were terminated by the judge (usually for non-compliance and/or alcohol/drug abuse). Because it was not possible to locate the majority of those who had been terminated or graduated from the program, the subjects for the study primarily consisted of the cohort of individuals who were participating in the program during the period that the study was being conducted. The sample included those individuals who were actively participating in the program during the period that the study was being conducted and had been in the program for at least 9 months. To ensure as large a sample as possible the duration of the evaluation was extended from 12 months (as was initially planned) to 18 months.

The sample of NMHC participants who were interviewed consisted of those who were currently active in the program and who had been enrolled in the program for at least 9 months. Since the purpose of the interviews was to obtain feedback about the impact of the NMHC on participants' lives, it was necessary for them to have been in the program for an extended period of time before they could make meaningful assessments. A number of individuals, who actively participated in the NMHC during the period of the study, could not be included in the survey sample because they had not been in the program long enough (i.e., for 9 months). A total of 23 usable surveys were obtained from the current cohort of NMHC participants.

A larger sample of NMHC participants was used to evaluate program effects on recidivism, which was used as a long-term indicator of stability. Because data on criminal charges for all offenders were available through publicly accessible court records, recidivism among NMHC graduates and those participants who were terminated from the program before the study was initiated could be examined. Therefore, for the analyses of longer-term outcomes, the initial cohort of NMHC participants was included in the analytical sample, as well as those who completed or were terminated from the program during the period the study was being conducted.

Informed consent (in writing) was obtained before interviews were conducted with program participants, and a separate consent (also, in writing) was obtained to get access to CSB client files. No problems were encountered either obtaining informed consent or conducting interviews with the program participants.

## **V. FINDINGS**

### **V.1. PROGRAM PARTICIPANTS' USE OF SERVICES**

The NMHC sought to promote public safety by ensuring that participants receive services for their mental health and substance abuse disorders while in the program. The Circuit Court's partnership with the Community Services Board and the assignment of a CSB case manager to each participant was intended to ensure that they received needed services and they were closely monitored so that appropriate services could be provided if their behavior deteriorated or new needs emerged. Each week the NMHC team members – presiding judge and court attorneys, probation officer, CSB case managers – met to review each participant's behavior during the past week and to discuss any problems that have arisen and possible solutions. These meetings are part of a collaborative effort to proactively help program participants. Case managers were responsible for following through with the recommendations the team made to address problem behaviors or relapses.

#### **V.1.1. USE OF SERVICES**

One of the goals of the NMHC was to ensure that the NMHC participants received appropriate social services and treatment and follow-up services to help them stabilize their lives. One of the

factors that contributed to participants illegal activities was their failure to comply with their medical treatment plans and the resulting mental and emotional instability. In addition, a number of NMHC participants had unstable housing arrangements and limited financial support because they could not maintain employment and their families could or would no longer house or support them. Receiving social services, therapeutic and substance abuse treatment and follow-up services, and other needed assistance was essential to promoting their stability and safety and preventing them from becoming a public nuisance.

One of the strengths of the NMHC program was that the case managers were able to help program participants obtain the services that they needed and to monitor their compliance with their medical treatment plans and their mental and emotional stability on a weekly basis. In the event that an individual was not taking prescribed medication or not attending support groups or meeting with doctors and/or therapists, the case manager and other members of the NMHC team would be discuss appropriate actions to remedy the situation at weekly meetings and the presiding judge would then discuss these with each program participant. This approach to case management not only ensured that the behavior of the NMHC participants did not deteriorate to the point that they were unable to care for themselves and were a threat to themselves, but also facilitated access to needed services. For those who did not have family members who could help them deal with service agencies, this assistance was particularly important.

The survey responses of the NMHC participants indicated that they have received a variety of different services during the time that they participated in the NMHC program. Table 1 lists the services received by NMHC participants during the most recent 6 months. The services that were most needed by NMHC participants were counseling/therapeutic services and assistance finding jobs or housing. One of the most needed, but difficult services to obtain, was substance abuse treatment. A large proportion of NMHC participants suffered from substance abuse disorders, but due to the limited availability and high cost of these services, they were not always able to obtain them. One of the major advantages of the collaboration between the Circuit Court and the CSB was that the NMHC participants had a better chance of receiving access to such services than others who were trying to access them on their own. Moreover, NMHC participants recognized this advantage: when asked why they decided to participate in the NMHC, almost as many participants reported that they wanted to get services (8 out of 23) as reported that they did not want to go to jail (10 out of 23).

<b>Services Received in Past 6 Months</b>	<b>Yes</b>	<b>No</b>
Counseling or therapeutic services	15	7
Day support or medical maintenance program	8	15
Drug or alcohol treatment services	7	14
Help applying for benefits (SSI or food stamps)	10	10
Help applying to training or educational program	4	16
Employment services	6	14
Housing services	10	11

Not only did NMHC participants have greater access to social services, therapeutic and substance abuse treatment services, but the vast majority of those that received these services reported that they were moderately or very helpful. Fourteen of the fifteen program participants who received counseling or therapeutic services found them moderately or very helpful. All eight of those who participated in a day support or medical maintenance program reported that they were moderately or very helpful, and all but one of those who received drug/alcohol treatment services found them to be moderately or very helpful. In addition to the favorable assessment given to the social, therapeutic and substance abuse treatment services, almost all of the NMHC participants reported that their case manager had been extremely helpful and were very appreciative of her efforts and support. A number of NMHC participants also reported that they appreciated the support they received from the presiding judge and the fact that he had continued to be supportive even when they had violated one of the conditions of their probation.

<b>Therapeutic Services Received</b>	<b>Very</b>	<b>Moderately</b>	<b>Slightly</b>	<b>Not at All</b>
Counseling or therapy from CSB	13	1	1	0
Day support or medical maintenance program	7	1	0	1
Drug or alcohol treatment services	4	2	0	0

<sup>2</sup> Total number of respondents for all tables is 23, except for 6 and 10. Total numbers of responses for some items may not equal 23 because some respondents may not have provided an answer to a particular item because it was not applicable to them or they chose not to respond. For some survey questions, multiple responses were allowed.

### V.1.2. COMPLIANCE WITH TREATMENT PLANS

For a variety of reasons, individuals with mental health disorders do not always want to take prescribed medications, and some prefer to “self-medicate” with alcohol or illicit drugs (e.g., cocaine) because “they always make you feel good, and those other ones don’t always help” (in the words of one NMHC participant). Unfortunately, for many NMHC participants, their mental instability and erratic behavior resulting from failure to comply with their treatment plan contributed to their involvement in criminal activity. To reduce the likelihood that they would continue to engage in undesirable and illegal activities, it was necessary to first ensure compliance with treatment plans to promote the mental stability of NMHC participants. The NMHC team attempted to promote compliance by closely monitoring NMHC participants’ behavior to ensure that they were taking prescribed medications and that it was having the desired effect on their mental condition and behavior. In addition, weekly urine screens were conducted to determine whether program participants were using controlled substances.

While relatives or therapists may have unsuccessfully tried to make NMHC participants comply with their treatment plans, only the NMHC presiding judge had the ability to actually require compliance and to apply legal sanctions for violations. The close monitoring of NMHC participants was very successful at detecting when NMHC participants failed to take prescribed medications and when they used alcohol or illicit drugs, and promoted a high degree of compliance while they participated in the program. The survey of current NMHC participants indicated that their long-term compliance with their treatment plans while in the program actually may have made it easier for them to comply by making these behaviors habitual (i.e., taking prescribed medications and using therapeutic support services). The survey responses which are summarized in Table 3 indicate that the majority of NMHC participants found it very easy or easy to take their prescribed medications and to attend support groups after participating in the program for an extended period of time. Almost all of the NMHC participants reported that participation in the NMHC program had helped them to deal with their mental health problems and to avoid using alcohol and illicit drugs (see Table 4). Several factors made it difficult for participants to avoid the use of alcohol or other drugs. It was very difficult to gain access to more intensive treatment (e.g., residential) due to limited beds in public facilities and most participants could not afford to pay for private facilities. For some, the only option was to enter a program in one of the local jails, but they still had to wait for an available spot. Also, drugs were readily available in some of the residential facilities where participants were placed. Again, lack of financial resources affected the options available to them.

<b>Compliance Indicators</b>	<b>Very Easy</b>	<b>Easy</b>	<b>Not Sure</b>	<b>Hard</b>	<b>Very Hard</b>	<b>Not App.</b>
How easy has it been to continue taking prescribed medications?	6	12	1	3	0	0
How easy has it been to continue attending support groups?	3	7	1	3	0	6
How easy has it been to avoid using alcohol or other drugs?	4	9	0	7	0	1

<b>Table 4. NMHC Participants' Ratings of Program Benefits</b>					
<b>Beneficial Effects of MHC</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
Helped me deal with mental health problems	9	12	0	0	0
Helped me avoid the use of alcohol or (illicit) drugs	8	12	0	0	0

### **V.1.3. THE IMPACT OF COMPLIANCE ON PUBLIC SAFETY**

The types of crimes that NMHC participants allegedly had committed were relatively minor property and drug crimes, and minor assaults. The incidents of assault and battery were the result of mental instability, rather than a premeditated attempt to harm others. Some NMHC participants were drawn into criminal activity by association with others who were regularly engaged in criminal activity. In most cases, the likelihood that NMHC participants would be a threat to public safety or victimized by others would be greatly reduced if they simply complied with their treatment plans. The survey responses of NMHC participants indicated that this was indeed the case. The majority of program participants reported that it was easy to avoid individuals who might get them into trouble, and also that it was easy to avoid engaging in illegal activities (see Table 5 for a summary of survey responses). Because of their limited financial resources, a number of program participants had to live in areas with high crime rates, including drug activity, or group homes, where drugs were easily accessible. It was much more difficult for these individuals to avoid involvement in illegal activities, particularly use of illegal substances. Moreover, it was difficult to find suitable, affordable housing for some NMHC participants, especially those with chronic health problems or those that continued to exhibit symptoms of their mental disorders. For the most part, however, most NMHC participants reported that they were able to avoid engaging in illegal activities that put them at risk and/or threatened the safety of others. This improvement in their behavior and stability also had the unintended effect of improving participants' relationships with their families that had become strained because of their unstable and sometimes dangerous behavior. For many participants, this was an important benefit because the majority had few or no friends, and therefore, no social support system.

<b>Table 5. NMHC Participants' Compliance With Terms of Probation</b>						
<b>Compliance Indicators</b>	<b>Very Easy</b>	<b>Easy</b>	<b>Not Sure</b>	<b>Hard</b>	<b>Very Hard</b>	<b>Not App.</b>
How easy has it been to avoid contact with people who might get you into trouble?	7	11	0	3	0	0
How easy has it been to avoid illegal activities?	8	13	0	1	0	0

## **V.2. SHORT-TERM & LONG-TERM OUTCOMES OF THE NMHC PROGRAM**

The second goal of the NMHC was to reduce the number of contacts that persons with mental illness and/or co-occurring disorders have with the criminal justice system. A state survey of regional jails in Virginia found that the Hampton Roads Regional Jail had one of the largest populations of offenders with mental health disorders in the state (Morris, 2007). Not only did the region have a large incarcerated population with mental health disorders, but many of them had been incarcerated multiple times. Many of these individuals languish in jail for long periods of time without appropriate therapeutic services or medication. Some jurisdictions, like Norfolk have established special mental health units within their jails to make sure the mentally ill are not victimized by other offenders and receive some services. Despite efforts to provide some help to mentally ill offenders in jail, it is not the ideal setting for them, as most criminal justice and mental health professionals realize. Consequently, there is great interest in the ability of mental health courts to divert the mentally ill who are charged with minor offenses from incarceration and to reduce recidivism among those who have been incarcerated.

In light of the interest in alternatives to long periods of incarceration for the mentally ill, the evaluation examined the effect of the NMHC on re-offending and re-arrest rates of participants. The three short-term indicators of program success that were examined included: (a) the number of program participants who had not re-offended while in the program; (b) the number of participants who had not been sanctioned for noncompliance while in the program; and (c) perceptions about the likelihood of re-offending while in the program. The long-term indicators of program success included the number of program graduates who had not been charged with new offenses at: (a) six months following program completion; (b) 12 months following program completion; and (c) 18 months following program completion.

### **V.2.1. SHORT-TERM OUTCOMES: NONCOMPLIANCE & NEW OFFENSES**

The thirty-seven subjects who the sample for the analysis of short-term outcomes included both participants who had actively participated in the program between 6 and 9 months, as well those who had actively participated in the study and graduated before the end of the study (December 2008). The two groups were separated and the short-term outcomes for each group of NMHC participants are summarized in Table 6. Slightly more than half of the participants who had been in the program for more than 9 months had been incarcerated by the presiding judge for noncompliance with their conditional release plan (referred to as the “treatment plan” by mental health professionals). The majority of these participants had been re-incarcerated as a sanction for using alcohol/other drugs. These participants had had substance abuse problems for many years, but lacked health care insurance that would cover the costs of private residential treatment or could not get into public facilities due to limited capacity. Four of the eleven participants, who had been in the program between 6 and 9 months, had been sanctioned for noncompliance by the judge, and the reason also was use of alcohol/other drugs.

Only six of the 26 participants who had been in the program longer than 9 months were incarcerated for committing new offenses while participating in the program, and none of participants who had been in the program less than 9 months were incarcerated for new offenses.

Rather than languishing in jail for long periods of time without needed services, the NMHC enabled mentally ill offenders to live with family or in supervised settings most of the time, where they could continue to work and receive needed services to help them stabilize their lives. A review of the weekly progress reports prepared by the CSB case managers revealed that participants in Phase 3 and Phase 4 were seldom sanctioned, which indicates that compliance increased the longer they remained in the NMHC. Prior studies of drug courts indicate that if offenders are allowed to stay in a program longer (i.e., not terminated for noncompliance during initial phase), they are more likely to successfully complete the program and to have positive post-program outcomes (Goldkamp, 2000, McCoy, 2003).

The analysis of short-term outcomes indicated that mentally ill offenders with co-occurring disorders tended to have less successful outcomes than offenders without addiction problems. Those NMHC participants who had substance abuse problems made slower progress and were more likely to be incarcerated while in the program and to be terminated from the program. Some participants who struggled with severe addiction problem were given the option to actively participate in the NMHC after completing drug treatment in jail. This appears to be an effective approach for helping those with long-term addictions, as long as they are committed to overcoming their addictions and trying to stabilize their lives. One NMHC participant requested that he be incarcerated so that he could enter a drug treatment program in jail to deal with his cocaine addiction because he knew he could not “kick his habit” on his own. During the year since his release, he has remained drug-free and has become involved in helping other recovering addicts deal with their mental health and drug problems. Although it may have taken mentally ill offenders with co-occurring disorders longer to complete the program and they may have had to be incarcerated to obtain drug treatment (due to lack of available beds in residential treatment programs), those who eventually graduated spent less time in jail than if they had not been diverted into the NMHC program. One of the critical features of the NMHC, which probably contributed to the success of addicted offenders who completed treatment, was that the judge gave them “second chances,” and let them remain in the program even though they tested positive for drug use as long as they remained committed to managing their addiction.

<b>Behavioral Indicator</b>	<b>Number of Participants</b>	
	<b>Enrolled More than 9 months</b>	<b>Enrolled at least 6 months</b>
Participants incarcerated for noncompliance	15	4
Participants incarcerated for new offenses while in program	6	0
<b>TOTAL =</b>	26	11

### V.2.2. FACTORS THAT PROMOTED COMPLIANCE WHILE IN THE PROGRAM

In order to identify factors that promoted successful program outcomes, the survey of NMHC participants questioned them about how likely it was that they would be non-compliant, and whether or not they would be caught and sanctioned for noncompliance. The majority of participants (18 out of 23) reported that they were unlikely or very unlikely to violate conditions of their probation. Their perceptions about the likelihood of getting caught for violating one of the judge’s conditions and sanctioned probably affected their responses to this question about compliance. The majority of participants (16 out of 22) thought it was likely that they would get caught for noncompliance and the majority thought that it was very likely (16 out of 22) that they would be incarcerated for noncompliance. The weekly or monthly meetings with the judge, probation officer and case managers and weekly urine screens created the impression that their behavior was closely monitored and the judge’s reputation for strict enforcement undoubtedly promoted the belief that noncompliance would be sanctioned. The comments of participants who were interviewed indicated that they realized that would be held accountable for their mistakes, perhaps for the first time in their lives, and the desire to avoid incarceration resulted in more responsible behavior.

Another factor that may have affected their compliance was their perceptions that they had been treated fairly. Almost all (21 out of 22) of the NMHC participants surveyed felt that they had been treated fairly by the judge. Social science research indicates that perceptions about the likelihood of being sanctioned for infractions and the fairness of sanctions and rewards affect an individual’s compliance with rules and regulations. Comments by the participants interviewed indicated that they understood that noncompliance would be sanctioned and that sanctions were applied consistently. Those with co-occurring disorders who had urine screens that were positive for drug use came to their meetings with the NMHC team expecting to be incarcerated, and often would admit that they had been using drugs prior to the drug screen. Comments made by many program participants indicated that they respected the judge’s decisions and felt that they had let him down when they were sanctioned for noncompliance.

<b>Table 7. Factors That Promote Compliance</b>					
<b>Factors</b>	<b>Very Likely</b>	<b>Likely</b>	<b>Not Sure</b>	<b>Unlikely</b>	<b>Very Unlikely</b>
Likelihood of violating at least one conditions for participating in the MHC	0	3	1	6	12
Likelihood of getting caught for violating conditions of treatment plan	1	16	2	2	1
Likelihood of being jailed for violating conditions of treatment plan	16	4	2	0	0
<b>Perception</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
Participant felt s/he had been treated fairly by the MHC Judge and Team	11	10	0	0	0

Research indicates that mentally ill individuals function better in a structured environment (Belcher, 1988). The regular meetings (weekly during the initial phase of the program) with the judge, weekly reviews of each participants' progress and adjustments to treatment plans, periodic drug screens and consistent use of sanctions created a structured environment that promoted compliance. Studies of recidivism among mentally ill offenders indicates that aggressive case management is one of the more effective methods of reducing recidivism (Feder, 1991). The proactive case management provided by the NMHC ensured that participants' material needs were met (e.g., housing and SSI benefits) and that they continued to take prescribed medications and did not have problems related to dosage or drug interactions. The close monitoring of NMHC participants by case managers also helped to create a structured environment in which problems were detected and resolved early before they reached a crisis stage.

### **V.2.3. LONG-TERM OUTCOMES**

The 2005 Jail Survey conducted in Virginia found that the Hampton Roads Regional Jail had the largest number (510) inmates with a mental disorder (Morris, 2007). With the “deinstitutionalization” of individuals with mental illnesses, our jails have become *de facto* mental health facilities for homeless and other mentally ill individuals who have not adequately adapted to living in the community without supervision and supportive services. Often, numbers of mentally ill are incarcerated without adequate treatment services which creates serious health and safety concerns for corrections systems. Not surprisingly, many ex-offenders find themselves re-incarcerated within a short time (Barr, 1999). Forty-nine percent of inmates in federal prisons have had three or more prior probations, incarcerations, or arrests (Ditton, 1999). Repeated incarceration is particularly harmful to mentally ill offenders because their condition tends to deteriorate while in jail or prison (Belcher, 1988), and when they do return to the community, they often are unable to obtain needed services because service providers are reluctant to serve them (Lamb & Weinberger, 1998). Sadly, many mentally ill are repeatedly incarcerated without ever receiving the support and structure that they need to stabilize their conditions (Finkelstein & Brawley, 1997). Norfolk's Mental Health Court was established to provide an alternative to incarceration for mentally ill offenders and to reduce recidivism so that they can receive the services and structure that they need in a setting more conducive to recovery.

The behavior of NMHC participants while they were enrolled in the program and monitored closely was expected to reduce their noncompliance and involvement in illegal activities. The second goal of the program was to produce long-term changes in mentally ill offenders' behavior, that is, to reduce or eliminate involvement in criminal activities after program completion when they were no longer closely monitored. The long-term indicators of program success that were examined were the number of program graduates who had not been charged with new offenses at: (a) six months following program completion; (b) 12 months following program completion; (c) 18 months following program completion, and (c) 24 months following program completion. For the examination of the long-term outcomes, all NMHC participants who had completed the program from the time it began operating in the spring of 2004 through December 31, 2007. The CJ case information from the Virginia Department of Corrections

website was examined to determine whether graduates of the program had re-offended after completing the program and whether they had been incarcerated for new offenses.

The analysis of the case information indicates that very few NMHC graduates had re-offended and been re-arrested following completion of the programs. The following numbers of graduates had re-offended and been re-arrested since completing the program:<sup>3</sup>

- At 6-months post-graduation, 3.4% of graduates had re-offended (2 out of 59).
- At 12-months post-graduation, 5.0% of graduates had re-offended (2 out of 40).
- At 18-months post-graduation, 12.5% of graduates had re-offended (3 out of 24).
- At 24-months post-graduation, 30% of graduates had re-offended (3 out of 10).

Because recidivism rates for the mentally ill offenders in Virginia’s jails or regional jails were not available, statistics from research studies that examined recidivism among mentally ill offender groups had to be used for comparison with the recidivism rates for NMHC graduates.<sup>4</sup> The recidivism rates for the NMHC graduates and those for other mentally ill offenders (MIOs) and non-mentally ill offenders (non-MIOs) are displayed in the Figure 1. The recidivism rates for NMHC graduates were considerably lower than baseline rates for mentally ill offenders and non-mentally ill offenders who completed their jail sentences reported in prior studies (Lamb and Weinberger, 1998; Steadman and Naples, 2005). Recidivism rates for NMHC graduates were: 3.5 percent at 6 months, 5.0 percent at 12 months, 12.5 percent at 18 months, and 30 percent at 24 months. Baseline recidivism rates for mentally ill offenders after release from jail or prison ranged between 64 percent at 18 months to 77 percent at two years, which were not statistically different from rates for non-mentally ill offenders. While the small sample size does not allow for statistical comparisons between sub-samples, these are very promising results.

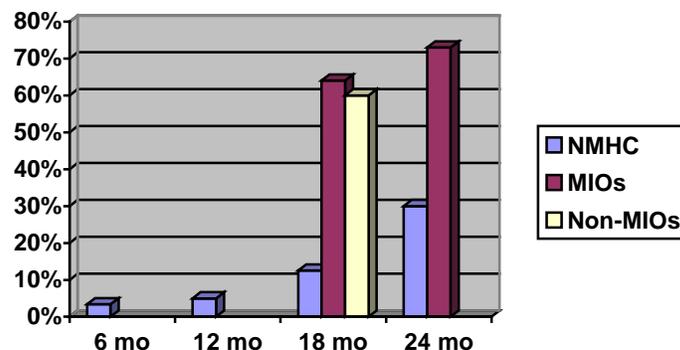


Figure 1. Recidivism Rates for NMHC Graduates & Comparison Groups

<sup>3</sup>NOTE: Because participants graduated at different time points, the length of time they had been out of the program varied and consequently the numbers of graduates for each time category vary. The number who had been out of the program for 24 months was small due to the short time the NMHC had been in operation.

<sup>4</sup> Recidivism rates for MIOs and non-MIOs at 18-months was reported in Feder (1991) and rates for MIOs at 24-months was reported in Gagliardi, Lovell, Peterson & Jemelka (2004).

Only three of the NMHC participants who had graduated from the program since its beginning had committed new criminal offenses. The new offenses committed by the graduates were similar to those committed prior to participation in the NMHC: possession of drugs and minor property crimes. These findings indicate that the close monitoring and services provided to participants of the NMHC had positive effects that extended beyond the end of the program.

<b>Table 8. Long-term Indicators of Program Effectiveness</b>				
<b>Indicators</b>	<b>Graduates Who Committed New Crimes</b>			
	<b>Type of Crime Committed</b>			<b>SUB-TOTAL</b>
	<b>Violent</b>	<b>Drug</b>	<b>Property</b>	
6 months after program completion	0	1	1	2
12 months after program completion	0	0	0	0
18 months after program completion	0	0	0	0
24 months after program completion	0	1	0	1
<b>TOTAL =</b>				<b>3</b>

#### **DAYS OUT OF JAIL DURING AND AFTER COMPLETING THE PROGRAM**

The third goal of the NMHC program was to decrease the amount of time that mentally ill offenders spent in jail. Because the NMHC participants would have been in jail had they not been enrolled in the NMHC program, the time they actively participated in the program was considered reduced jail time, as well as the time they remained out of jail following completion of the program. The amount of reduced jail time while in the program was calculated by counting the number of days that graduates actively participated in the NMHC program. Active participation was defined as days that mentally ill offenders were enrolled in the program and were not incarcerated (as a sanction for noncompliance), not in drug treatment program in jail, or not institutionalized in a public or private mental or substance abuse treatment institution. The amount of reduced jail time after graduation was calculated by counting the number of days between graduation and December 31, 2007 that had not been spent in jail. The number of days that NMHC graduates remained out of jail while actively participating in the program and after they graduated is illustrated in Figure 2. Participation in the NMHC program reduced the number of jail days for graduates by 11,610 while they were enrolled in the program. After completing the program, NMHC graduates remained out of jail a total of 9,600 days. The total number of reduced jail days through December 31, 2007, was 21,210. An estimated \$1.63 million dollars (@ \$76.85 per day) in jail costs saved resulted from the NMHC program.

### Days In the Community

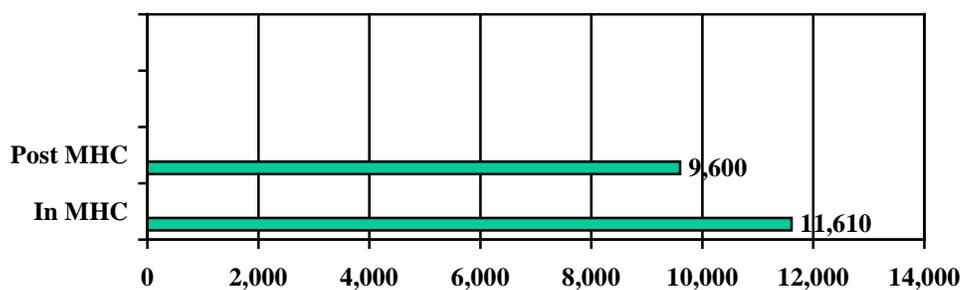


Figure 2. Number of Day NMHC Graduates Lived in Community Rather Than In Jail During & After Program

### FINANCIAL BENEFITS

Mental health courts have the potential to save substantial public funds for the costs associated with arrest, court processing, and incarceration. The NMHC reduced incarceration costs that would have been incurred by local jails for those who participated in the program. Prior studies also have reported similar cost savings for drug and mental health courts (National Institute of Justice, 2006; Steadman and Naples, 2005). An additional economic benefit not reported by other prior studies is the economic benefit to individual program participants. Because the NMHC participants remained in the community, they were able to work. While some were unable to work because of physical or mental impairments or family responsibilities (e.g., caring for children), the majority of those who could work did maintain employment while in the program. These participants were able to support themselves without relying on social security benefits (i.e., SSI) or family support. Those who worked were financially better off than those whose only source of income was SSI payments. In addition to providing them with greater income, employment also provided participants with structure and meaningful use of their time. Employment may be an important contributing factor for maintaining stability and compliance with treatment plans, especially for younger offenders and single males (who don't usually have child-rearing or other family responsibilities), because it gives them a sense of self-efficacy and normalcy, and a compelling reason for compliance with treatment plans.

It should be noted that women who were not employed did not seem as prone to noncompliance (unless they had severe addictions). But a number of women were stay-at-home mothers caring for young children and these child-care responsibilities probably served the same function as paid employment. In fact, some women reported that their desire to live with and care for their children was what motivated them to participate in the program. Research indicates that re-

gaining custody of children is a major motivation for addicted women to enter treatment. Allowing participants to work unquestionably is beneficial for them, but it also results in economic benefits to governmental agencies. Program participants who work do not require government subsidies to live on and they also generate tax revenue. While prior studies have reported the savings from reduced jail costs, they have failed to estimate cost-savings from reduced use of social security benefits or tax revenues generated by offenders who are able to continue to work. As a result the economic benefits of mental health courts and other specialty courts have been underestimated.

### V.3. PROMOTION OF EFFECTIVE BETWEEN-SYSTEMS INTERACTIONS

The fourth goal for the NMHC program was to promote effective between-systems interactions. Observations of the NMHC team during weekly meetings and discussions with team members indicates that the professional staff from the Norfolk Circuit Court, Norfolk Commonwealth Attorney’s Office, Norfolk Public Defender’s Office, Norfolk Sheriff’s Department, Norfolk Probation and Parole Offices, and the Norfolk Community Services Board had developed very effective and positive working relationships. The creation of the NMHC itself is an example of effective between-systems collaboration, in that no external funds were required to support its operations -- a reallocation of agency resources has enabled it to operate. The collaboration between the justice system and the social services system was a critical factor in the formation of the mental health docket and continues to be critical to its capacity to promote effective outcomes for offenders with mental health disorders. Too often, individuals with multiple and complex needs fall between the cracks of the network of human services agencies and providing them with appropriate assistance becomes even more challenging when working across systems. The NMHC provides a unique example of effective between-systems interactions for other jurisdictions and agencies that would like to develop programs for underserved populations like offenders who suffer from mental illness and substance abuse disorders. Some examples of benefits resulting from the cross-systems collaboration are listed in Table 9.

<b>Table 9. Benefits of Cross-Systems Collaboration</b>	
<b>A. Organizational Benefits</b>	
1.	New programs developed without external funding
2.	Initial commitment from agency heads and key staff promotes institutionalization of programs.
3.	Involvement of key agency heads and staff in development and planning reduces implementation problems and promotes program effectiveness.
4.	Facilitates the sharing of expertise and information among professionals from different fields.
5.	Promotes organizational learning and improvement.

**Table 9. Benefits of Cross-Systems Collaboration (cont'd)**

**A. Client Benefits**

The criminal justice-social services alliance:

1. Allows for cross-agency/system sharing of information about clients.
2. Allows for the use of sanctions to promote compliance and stabilizer client behavior.
3. Allows for closer monitoring of clients.
4. Enables CSB practitioners to share insights about client behavior and effective interventions with court officers.
5. Enables jail personnel to share information about clients' behavior while incarcerated.
6. Promotes effective case management.
7. Promotes greater access to services for clients.
8. Promotes resolution of legal problems because the judge can intervene on behalf of clients.
9. Promotes the application of restorative justice.

**VI. DISCUSSION OF FINDINGS**

The results of the evaluation of the Norfolk Mental Health Court indicate that it has achieved its goals. The most notable of the findings was that the recidivism rates for NMHC graduates were considerably lower than baseline rates for mentally ill offenders and non-mentally ill offenders than have been reported in studies of recidivism. Moreover, the findings indicate that mentally ill offenders are able to stabilize their conditions while in the community, some even maintaining employment, and not pose a risk to themselves or public safety. The evidence is growing that mental health courts may promote better outcomes for mentally ill offenders. One recent study of Santa Barbara's mental health court that used randomized, experiment designs found that offenders who participated in the mental health program demonstrated slightly better psychosocial functioning and better quality of life than those who did not (Cosden et. al., 2005), but because the comparison group received intensive services, it did not constitute a true "no treatment" comparison and the between-group differences might have been underestimated. Another study of Butte County's (California) court found a drop in recidivism rates associated with participation in the mental health court and a statistically significant improvements in functioning and symptomatology (O'Keefe, 2006). At this point in most research and evaluation studies, the question arises: What factors contributed to these positive findings? Recent research and cross-site studies of specialty courts (i.e., drug and mental health courts) that report similar positive effects provide probable answers to this question.

**Treatment of co-occurring disorders.** Most professionals, whether in the mental health or court systems, who deal with individuals with mental illness have come to realize that co-occurring disorders are prevalent among this population (and even more prevalent in offender population than the general population) and this complicates efforts to help them stabilize their lives. In addition, those with co-occurring disorders are likely to have multiple other problems including trauma, lack of family support, HIV, homelessness, and employability problems (Peters and Hills, 1997). Not surprisingly, people with co-occurring disorders have lower rates of treatment compliance, more severe symptoms and higher relapse rates than those with a single disorder (Peters and Hills, 1997). Without effective and appropriate treatment, offenders with co-occurring disorders are more likely to be jailed again and again (Draine and Solomon, 1994). This helps to explain why those NMHC participants who had more severe addictions and could not get into residential treatment programs, tended to be less successful than those for whom outpatient services were appropriate. Due to the lack of residential treatment services in the region, some participants were incarcerated so that they could receive treatment services offered in jail. While this is not the most ideal method of treating those with severe addictions, it was the only opportunity for some offenders to receive services in a controlled setting, and a number of them successfully completed treatment programs in jail and were re-admitted to the NMHC upon release and then graduated from the program.

**Integrated services.** Typically, sequential treatment has been provided to those with co-occurring disorders, but there is growing evidence that this is not effective, and that “parallel” treatment (simultaneous treatment of substance abuse and mental health disorders) is somewhat better (Peters and Hills, 1997). Recent research indicates that the provision of “integrated” services that treat both substance abuse and mental health disorders in a continuous and comprehensive manner have been found to be more effective than other approaches (Drake et al., 2001). A number of NMHC participants had co-occurring disorders, as well as serious health problems (including HIV) and problems finding appropriate housing and work, and yet they managed to complete the program. Studies by Drake et al. (2001), Mueser, et al. (1997) and Pepper and Hendrickson (1996) identify service delivery features that might account for the success of these participants: case management, integration of services, and provision of an array of other supportive services (including assistance with housing and financial problems). Almost all of the NMHC participants reported that their case manager had helped them resolve a number of problems and they felt that her assistance was a significant factor in their success in the program. An objective review of the services received by participants and observations of team meetings indicated that the regular review of their progress by judge, probation officer, and case managers served to identify needs and actions were taken to ensure appropriate services were received or problems were resolved in a timely manner. In some cases, the judge was able to intervene to ensure that service providers responded to requests for assistance for NMHC participants and also was able to resolve some of their legal problems. It appears that the collaborative supervision, provision of needed services and proactive case management created a strong safety net for NMHC participants that prevented them from falling through the cracks between the social service and judicial systems and ending up in crisis or back in jail.

**Relationship with the judge.** Studies of drug courts indicate that the judge who presides over the court is an important component of the program. Offenders who participate in drug courts

report that the judge is one of the most influential factors that affects their experience (NIJ, 2006). The judge's interpersonal skills and ability to resolve legal problems expeditiously and to facilitate access to services shapes the quality of the experience. Studies have found that the more judges offenders deal with, the greater the likelihood of poor treatment attendance, which affects outcomes in general (NIJ, 2006). Offenders who participate in courts where there is only one judge are far less likely to be terminated early or to miss more than a few treatment sessions than those exposed to multiple judges or rotating referees (NIJ, 2006). When the effects of exposure to one judge and length of treatment are factored together, the studies indicate that exposure to multiple judges predicts re-arrest for non-drug offenses (NIJ, 2006). A recent evaluation of a mental health court in New York, indicates that offenders value the direct conversations with the presiding judge and the questions he asks them about their progress and their problems. They report that this attention makes them feel that the judge respects them and cares about what happens to them. The presiding judge reports that he started asking defendants questions as a way "to engage them human to human," and to compensate for the fact that they had been given short shrift all their lives and to give them hope (O'Keefe, 2006).

Comments made by the NMHC participants who were interviewed indicated that they valued the relationship that they had established with him and that they respect his authority. While they did not doubt that he would sanction them if they violated the conditions of their probation, they also felt that he had treated them fairly and were grateful for the "second chances" that he had given them. Observations of the interactions between the judge and NMHC participants during court that were conducted over time allowed the evaluator to see the relationship between the judge and participants to develop over time. Initially, participants tended to be very reserved and nervous during initial sessions – many male participants responded to the judge's questions with just a "yes" or "no." Over time as they became more comfortable, they would share more information with the judge and tell him about important milestones they had achieved in their treatment (e.g., reaching one-year sober or drug-free). The judge would always congratulate them on their progress or accomplishments, and their promotion from one phase of the program to another was acknowledged by the award of a certificate. The change in the interaction between the male participants and the judge was particularly dramatic. Some male defendants who initially would stare at their feet and barely respond to questions, over time would approach the bench with a smile and talk openly and even joke with the judge. It appeared that the weekly (and eventually monthly) meeting with the judge, provided another source of support for participants and helped to keep them connected to the program. This regular interaction with a single judge also might be important because it promotes effective judicial supervision, continuity of monitoring, and consistency in practices and application of sanctions.

## **VII. SUMMARY**

The evaluation of the Norfolk Mental Health Court indicates that the program achieved its four goals. The NMHC:

1. promoted access to therapeutic and social services for mentally ill offenders who found them helpful, especially the case management services;

2. reduced the number of times that mentally ill offenders came into contact with the criminal justice system;
3. reduced the number of days that mentally ill offenders spent in jail; and
4. promoted effective interactions between the criminal justice and mental health systems.

The findings of the evaluation study conducted by the SSRC support the findings of prior studies of specialty courts. The evaluation study provides empirical evidence of the program's success in achieving its goals, and the benefits it provides to individual participants, as well as the corrections system (in the form of reduced operating costs). The evidence in this report indicates that mental health courts help mentally ill offenders to achieve stability over an extended period without incarceration and without risking public safety. The findings indicate that diversion programs for mentally ill offenders may also provide social and economic benefits to individuals and communities by enabling offenders to work to support themselves and eliminating the need for governmental subsidies and incarceration costs.

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**APPENDIX A**  
**DATA COLLECTION INSTRUMENTS**

**NORFOLK MENTAL HEALTH COURT EVALUATION**  
**NMHC CLIENT INTERVIEW**

**INSTRUCTIONS FOR ADMINISTERING SURVEY:** Read or paraphrase the following text. Informed consent should be obtained prior to beginning the interview and the consent form should be signed by both the interviewer and the respondent.

*Before we begin the interview, I want to thank you for agreeing to speak with me today. The primary reason for this interview is to hear about how your life has been since you began participating in the Norfolk Mental Health Court. I'll be asking you questions about different experiences you've had since you first met in court with Judge Posten, your opinions about the court and the Community Services Board, and how easy or hard it has been for you to comply with your treatment plan and court orders, to find a place to live, to get a job, and so forth. Throughout the interview I will be taking notes about what you tell me on this form. If any question I ask you makes you feel uncomfortable, please let me know and I will skip it and go on to the next one. I also want to remind you that you can refuse to answer a question at any time. Finally, I want to emphasize that everything you tell me today will be kept in the strictest confidence. I will be asking about lack of compliance with treatment plans or court orders and your responses to these questions will be kept completely confidential also. The only exception to this is if you tell me that you intend to hurt yourself or someone else in the future – in which case, I may have to report it. Do you have any questions before we get started?*

*Since we would like to interview you again in 6 months to see how you are doing, we'd like to check your current address. Could you also give us the name, address and phone number of one person who will know how to locate you in the future? We will first try to contact you at your current address, and will only contact this person to get your new address and phone number if you have moved. We will not reveal any information about why we want to talk with you or your participation in the study. Whether you participate in an interview in the future is entirely up to you, and we will give you a gift card valued at \$50 just like we will for today's interview.*

**NORFOLK MENTAL HEALTH COURT EVALUATION  
NMHC CLIENT INTERVIEW**

**COVER PAGE**

1. Demographics	<p>a. Respondent's name: _____</p> <hr/> <p>b. Current address: Street: _____ City/State/Zip: _____ Phone: (757) _____ - _____</p> <hr/> <p>c. NMHC Study ID Number: _____</p>
2. Date entered NMHC	<p>_____ / _____ / _____ [MM/DD/YYYY]</p>
3. Contact person	<p>Contact's name: _____</p>
4. Contact's address & phone	<p>Current address: Street: _____ City/State/Zip: _____ Phone: (757) _____ - _____</p>

**NORFOLK MENTAL HEALTH COURT EVALUATION  
NMHC CLIENT INTERVIEW**

**CODING FORM**

**Living Situation**

1. With whom do you currently live?  
*Probe to find out whether they live with others*

- Live alone
- With family or relatives
- With friends or roommate
- In a supervised setting
- Incarcerated
- In shelter / transitional housing
- Homeless
- Other / specify: \_\_\_\_\_  
\_\_\_\_\_

2. How long have you lived (in current residence)?

\_\_\_\_\_ # of years OR \_\_\_\_\_ # of months

*If s/he has changed residence within past 6 months, ask:*

3. What was the reason you moved?  
*Probe to find out whether their behavior was a cause (i.e., disruptive behavior, substance abuse, etc.).*

3. Reason moved:
- Was evicted / asked to move
  - Other / specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family & Other Relationships**

1. How many close family relationships do you have now?  
*Close means people who look out for you, do things for you, and give you advice.*

- 0    1    2    3    4    5    6+

<p>2. Of your close family members and friends, who have you had contact with in the last 30 days? <i>Read all choices.</i></p>	<p><i>Check all that apply</i></p> <p><input type="checkbox"/> Nobody (0)                      <input type="checkbox"/> Spouse (1)</p> <p><input type="checkbox"/> Parents (2)                      <input type="checkbox"/> Girl/boyfriend/fiance (3)</p> <p><input type="checkbox"/> Brother/sister (4)              <input type="checkbox"/> Children (5)</p> <p><input type="checkbox"/> Friend(s) (6)                    <input type="checkbox"/> Other / specify: _____</p>
<p>3. Have you received any type of assistance from your family in past 6 months?</p>	<p><input type="checkbox"/> Financial support</p> <p><input type="checkbox"/> A place to live</p> <p><input type="checkbox"/> Obtaining things s/he needs: a job, etc.</p> <p><input type="checkbox"/> Obtaining services that s/he needs</p> <p><input type="checkbox"/> Complying with treatment plan (taking medication, regularly attending support group meetings or therapy sessions or visiting the doctor)</p> <p><input type="checkbox"/> Dealing with legal problems</p> <p><input type="checkbox"/> Other / specify: _____</p> <p>_____</p>
<p>4. How many close friends do you have now? <i>Close means people who look out for you, do things for you, and give you advice.</i></p>	<p><input type="checkbox"/> 0    <input type="checkbox"/> 1    <input type="checkbox"/> 2    <input type="checkbox"/> 3    <input type="checkbox"/> 4    <input type="checkbox"/> 5    <input type="checkbox"/> 6+</p>
<p>5. Have your friends been able to provide you with assistance in the past 6 months?</p>	<p><input type="checkbox"/> Financial support</p> <p><input type="checkbox"/> A place to live</p> <p><input type="checkbox"/> Obtain things s/he needs: a job, etc.</p> <p><input type="checkbox"/> Obtain services that s/he needs</p> <p><input type="checkbox"/> Comply with treatment plan (take medication, attend support group meetings and therapy sessions)</p> <p><input type="checkbox"/> Deal with legal problems</p> <p><input type="checkbox"/> Other / specify: _____</p> <p>_____</p>
<p>6. Have any of your family members or friends complained about or been disturbed by your behavior in the past 6 months? If so, what was the reason?</p>	<p>6. <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>Reason: _____</p> <p>_____</p>

<p><i>Probe to find out if the problem was caused by their MH condition and failure to take their medication or because of their alcohol/drug use.</i></p>	<p>6a. Cause of problem (<i>check all that apply</i>):</p> <p><input type="checkbox"/> Result of / affected by his/her MH condition and/or not taking medication</p> <p><input type="checkbox"/> Result of / affected by his/her AOD use</p>
<p>7. Have you been involved with any groups or organizations in the past 6 months (e.g., clubs, churches, support groups)?</p> <p>a. <i>If so, ask:</i> How often did you meet with [the group(s)]?</p> <p>b. <i>If so, ask:</i> In what way has it been helpful to you?</p>	<p>7. Groups (<i>check all that apply</i>):</p> <p><input type="checkbox"/> Church-affiliated group    <input type="checkbox"/> Club / social group</p> <p><input type="checkbox"/> Mental health / substance abuse support group</p> <p><input type="checkbox"/> Other / specify: _____</p> <p><input type="checkbox"/> Other / specify: _____</p> <p>7a. _____ (e.g. once a week)</p> <p>7b. How it helped him/her: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<p><u>Financial Support &amp; Employment</u></p>	
<p>1. Currently, what are your main sources of income?</p> <p><i>SSI = Supplemental Security Income</i> <i>SSDI = Social Security Disability Income</i></p>	<p><input type="checkbox"/> Wages</p> <p><input type="checkbox"/> Retirement</p> <p><input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Public assistance / SSI / SSDI</p> <p><input type="checkbox"/> Other / specify: _____</p> <p><input type="checkbox"/> None</p>
<p>2. About how much is your monthly income?</p> <p>a. Does someone manage your money for you?</p>	<p>\$ _____ per month</p> <p>2a. <input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p><i>If s/he was employed, ask:</i></p> <p>3. During the past 6 months, did you work for pay?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>

<p>3a. During the past 6 months, how long were you employed?</p> <p>3b. What type of work did you do?</p>	<p>3a. _____ # of weeks / month</p> <p>3b. Type of work: _____ _____</p>
<p>4. During the past 6 months, did you change jobs or stop working?</p> <p><i>If so, ask:</i></p> <p>4a. What was the reason?</p> <p><i>Probe to find out whether mental disorder or AOD use was a factor.</i></p>	<p>4. <input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>4a. <input type="checkbox"/> Laid off      <input type="checkbox"/> Quit      <input type="checkbox"/> Fired</p> <p>Reason quit/fired: _____ _____ _____</p>
<p>5. What is the longest you've ever held a job?</p>	<p><input type="checkbox"/> Never worked (0)</p> <p><input type="checkbox"/> Less than 6 months (1)</p> <p><input type="checkbox"/> 6 months to 1 year (2)</p> <p><input type="checkbox"/> 1+ to 2 years (3)</p> <p><input type="checkbox"/> 2+ to 5 years (4)</p> <p><input type="checkbox"/> 5+ years (5)</p>

<p><b><u>NMHC Participation</u></b></p> <p>1. What made you decide to participate in the Mental Health Court?</p>	<p><input type="checkbox"/> Didn't want to go to jail</p> <p><input type="checkbox"/> Wanted to get services</p> <p><input type="checkbox"/> Other / specify: _____ _____ _____</p>
<p>I'm going to make a number of statements about the MHC. Tell me if you: strongly agree, agree, disagree, strongly disagree with each statement. If you can't decide, say you are not sure.</p>	
<p>2. Being under Judge Posten's supervision has helped you to deal with your mental health problems.</p>	<p><input type="checkbox"/> SA    <input type="checkbox"/> Agree    <input type="checkbox"/> Not sure    <input type="checkbox"/> Disagree    <input type="checkbox"/> SD</p>
<p>3. Being under Judge Posten's supervision has helped you avoid criminal activity.</p>	<p><input type="checkbox"/> SA    <input type="checkbox"/> Agree    <input type="checkbox"/> Not sure    <input type="checkbox"/> Disagree    <input type="checkbox"/> SD</p>

4. Being under Judge Posten's supervision has helped you to avoid the use of alcohol or drugs.	<input type="checkbox"/> SA <input type="checkbox"/> Agree <input type="checkbox"/> Not sure <input type="checkbox"/> Disagree <input type="checkbox"/> SD
5. I have treated me fairly by the judge and Mental Health Court staff.	<input type="checkbox"/> SA <input type="checkbox"/> Agree <input type="checkbox"/> Not sure <input type="checkbox"/> Disagree <input type="checkbox"/> SD

<b><u>Anti-Social &amp; Illicit Behavior</u></b>	
Please tell me how difficult or easy it has been to do the following things. For each one, tell me if it has been very easy, pretty easy, pretty hard or very hard. If you can't decide, say you are not sure.	
1. How easy or hard has it been to find a permanent place to live?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable if institutionalized
2. How easy or hard has it been to get help and support your family?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable if have no family
3. How easy or hard has it been to get enough money to support your self?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable if can't/doesn't work
4. How easy or hard has it been to find or to keep a job?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable if can't/doesn't work
5. How easy or hard has it been to continue taking your prescribed medications?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard
6. How easy or hard has it been to continue going to support groups (e.g., AA/NA)	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable (if never attended)
7. How easy or hard has it been to avoid using alcohol or other drugs?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable (if never used them)
8. How easy or hard has it been to obey the Judge Posten's orders?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard <input type="checkbox"/> Not applicable if no longer in NMHC
9. How easy or hard has it been to avoid contact with people who	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard

might get you into trouble?	
10. How easy or hard has it been to avoid illegal activities?	<input type="checkbox"/> Vy easy <input type="checkbox"/> Easy <input type="checkbox"/> Not sure <input type="checkbox"/> Hard <input type="checkbox"/> Vy hard

<p>11. During the past 6 months, how often did you take your prescribed medication? Would you say: all the time, most of the time, some of the time, once in awhile, never?</p> <p>11a. If there were days when you haven't taken your medication, what were the reasons?</p>	<p><input type="checkbox"/> all   <input type="checkbox"/> most   <input type="checkbox"/> some   <input type="checkbox"/> once/while   <input type="checkbox"/> never</p> <p>11a. _____</p> <p>_____</p> <p>_____</p>
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<p>12. During the past 6 months, how often did you drink alcohol or use other drugs -- all the time, most of the time, some of the time, once in awhile, never?</p> <p><i>If s/he has used alcohol/drugs, ask:</i></p> <p>12a. What made it difficult for you to avoid using alcohol or other drugs?</p>	<p><input type="checkbox"/> all   <input type="checkbox"/> most   <input type="checkbox"/> some   <input type="checkbox"/> once/while   <input type="checkbox"/> never</p> <p>12b. _____</p> <p>_____</p> <p>_____</p>
--	--

<p>13. How likely is it that you will violate at least one of the judge's conditions for participation in Mental Health Court?</p>	<p><input type="checkbox"/> Very likely   <input type="checkbox"/> Likely   <input type="checkbox"/> Not sure</p> <p><input type="checkbox"/> Unlikely   <input type="checkbox"/> Very unlikely</p>
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<p>14. How likely do you think it is that you will get caught if you violate one of the judge's conditions for participating in Mental Health Court?</p>	<p><input type="checkbox"/> Very likely   <input type="checkbox"/> Likely   <input type="checkbox"/> Not sure</p> <p><input type="checkbox"/> Unlikely   <input type="checkbox"/> Very unlikely</p>
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<p>15. How likely do you think it is that you will be sent to jail if you get caught violating one of the judge's conditions?</p>	<p><input type="checkbox"/> Very likely    <input type="checkbox"/> Likely    <input type="checkbox"/> Not sure</p> <p><input type="checkbox"/> Unlikely    <input type="checkbox"/> Very unlikely</p>
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<p>16. What is your current legal status (i.e., on probation, released and awaiting trial, etc.)?</p>	<p><i>Check all that apply:</i></p> <p><input type="checkbox"/> Diverted into program/treatment</p> <p><input type="checkbox"/> On probation</p> <p><input type="checkbox"/> On parole</p> <p><input type="checkbox"/> Awaiting trial</p> <p><input type="checkbox"/> Other / specify: _____</p> <p>_____</p> <p>_____</p>
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<p>17. During the past 6 months, have you had contact with police?</p> <p>a. Number of times arrested?</p> <p>b. Number of times jailed?</p>	<p>17a. _____ # of arrests</p> <p>17b. _____ # of times jailed</p>
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<p>18. During the past 6 months, have you been to court? (<i>not including visits to Judge Poston for MHC</i>)</p> <p>a. Was case dismissed?</p> <p>b. Did case go to trial?</p> <p>c. What was the result of the trial?</p>	<p>18. Been to court for a hearing?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> REFUSED</p> <p>18a. Case dismissed?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> REFUSED</p> <p>18b. Case go to trial?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> REFUSED</p> <p>18c. Results of trial: _____</p> <p>_____</p> <p>_____</p>
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<p>19. During the past 6 months, have</p>	<p>19. Been institutionalized?</p>
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<p>you been institutionalized?</p> <p>a. What was the reason?</p> <p>b. How long were you institutionalized?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> REFUSED</p> <p>19a. Reason: _____</p> <p>19b. _____ weeks / months institutionalized</p>
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<b><u>Community Services Received</u></b>	
<p>1. During the past 6 months, did you get counseling or therapy from CSB?</p> <p>1a. How helpful were services?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p> <p>1a. <input type="checkbox"/> Very    <input type="checkbox"/> Moderately    <input type="checkbox"/> Slightly    <input type="checkbox"/> Not at all</p>
<p>2. During the past 6 months, were you in a day support or medical maintenance program?</p> <p>2a. How helpful were services?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p> <p>2a. <input type="checkbox"/> Very    <input type="checkbox"/> Moderately    <input type="checkbox"/> Slightly    <input type="checkbox"/> Not at all</p>
<p>3. During the past 6 months, did you receive drug or alcohol treatment services?</p> <p>3a. How helpful were these services?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p> <p>3a. <input type="checkbox"/> Very    <input type="checkbox"/> Moderately    <input type="checkbox"/> Slightly    <input type="checkbox"/> Not at all</p>
<p>4. During the past 6 months, did any agency or person help you get benefits – like SSI or food stamps?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p>
<p>5. During the past 6 months, did any agency or person help you get into a training program or get into school?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p>
<p>6. During the past 6 months, did any agency or person help you find a job?</p>	<p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <input type="checkbox"/> NOT SURE</p>

7. During the past 6 months, did any agency or person help you find housing?

YES     NO     NOT SURE