



A CASE STUDY OF THE AKRON MENTAL HEALTH COURT

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Studies conducted nationwide show the disproportionately large number of individuals with a severe mental illness currently held in our jails and prisons.¹ There is a growing need to identify and divert this growing population out of the criminal justice system and into the mental health system where they can receive proper treatment. In 2001, Akron Ohio established a mental health court, the first of its kind in Ohio. According to its mission statement,

The Akron municipal mental health court is dedicated to diverting persons with mental illness from the local jail and the criminal justice systems. The Akron municipal mental health court offers a therapeutically jurisprudient approach to support a psychiatrically stable and crime-free lifestyle for persons with mental illness.

Given the relative newness of the court and its potential to serve as a model for other mental health courts in Ohio, the Ohio Office of Criminal Justice Services (OCJS) conducted a case study of the court. This study focused on the structure and function of the Akron mental health court—how the court was initiated, what agencies and individuals are instrumental in the court's day-to-day operations, how collaborations among entities were developed and how they are sustained, and how the Akron mental health court functions as a whole to serve the client. One goal of this study is to provide feedback to the Akron mental health court so that the court can more effectively meet the needs of not only the clients but also the team members working within the mental health court system. An additional goal of the study is to provide information to other courts that are considering implementing a mental health court in their own jurisdictions.

Overview of the Akron mental health court program

The Akron mental health court is a specialty court designed to divert from jail individuals who, as a result of their illness, commit crimes. The court accepts as clients those individuals diagnosed with a severe mental disorder. The clients must meet the following requirements for eligibility into the program:

- The defendant must have a primary Axis I diagnosis of Schizophrenia, Schizoaffective disorder, or Bi-polar disorder (Other Axis I diagnoses may be considered on a case-by-case basis).
- The defendant must be charged with a misdemeanor offense. Fourth degree misdemeanors are only accepted when he or she has multiple prior offenses that require a minimum ninety-day jail sentence. Violent offenders may be taken into the program with the victim's consent. Sex offenders are not eligible.
- The defendant must be willing to take medication.
- The defendant must understand the requirements of mental health court, and the consequences of failing to comply with the requirements.
- The defendant must be able and willing to comply with the orders set forth by the court.
- Repeat offenders are targeted for the program; however, first-time offenders who are otherwise eligible for mental health court are also considered.

Clients who enter the program plead no-contest after consultation with a public defender, and are placed on probation for a period of two years. The goal of the program is to transition the client

¹ Ditton, P.M. (1999). *Mental Health and Treatment of Inmates and Probationers*. Bureau of Justice Statistics Special Report NCJ174463.

from a highly restrictive environment involving intensive case management to a much less restrictive environment involving minimal case management. There are two phases to the program, each consisting of several steps. In Phase I, the client's needs are assessed. In addition to receiving intensive case management, the client is provided with numerous services, including temporary housing placement, vocational and residential counseling, chemical dependency treatment, group and individual therapy, and medication monitoring. Beginning in Phase I and continuing throughout the duration of the program, the client is expected to meet regularly in court with the Judge so that the Judge can assess client progress.

Court sessions in mental health court are quite different than in a traditional municipal court. The atmosphere is less adversarial and more relaxed than what is seen in a traditional court session. If the defense attorney senses that the client is anxious or uncomfortable in the courtroom, she can take the client out of the courtroom and talk to him in a calmer setting. The client has a great deal of interaction with the Judge, starting with weekly visits to the courtroom and decreasing in frequency as the client demonstrates his or her responsiveness to the program. In all follow-up visits to the courtroom, the Judge speaks primarily to the client rather than to the case manager about his progress. The Judge demands to be given updates on all clients in her courtroom prior to her meetings with the clients, and acknowledges their success or failures throughout their involvement in the program.

The client is expected to remain in Phase I for approximately a year, although this can vary from client to client. If the client demonstrates the ability to maintain significant periods of psychiatric stability, crime-free and drug-free behavior, stable housing, and participation in structured activities of daily living, the client is then transitioned to Phase II, in which he or she is paired with a more 'traditional', less intensive case manager. Successful completion of the two-year program culminates in the client's graduation from mental health court. The client's original charges are subsequently dropped.

Rewards and sanctions are a fundamental component of the mental health court. Positive behaviors are reinforced with public acknowledgment, certificates of achievement, gift certificates, and rewards such as hats and umbrellas. Typically, rewards are given as a person moves to a new step or phase of the program, although they may also be given for periods of sobriety and for faithfully keeping appointments. Sanctions are given for a variety of behaviors, including drug/alcohol use, foul or inappropriate behavior, and failure to keep appointments. The severity of the sanctions is graduated, such that repeated misconduct by the client results in a harsher sanction than an isolated or first-time incident. In the extreme case of noncompliance with mental health court rules, a person may be terminated from the program.

History of the Akron mental health court

Discussion of the mental health court began in 2000. There impetus for implementing the court was the growing awareness that severely mentally ill individuals were increasingly finding themselves caught in a 'revolving door' in and out of the criminal justice system. This growing awareness was partly attributed to the establishment of a drug court in Akron. A significant proportion of the clients entering drug court suffered not only from substance abuse but also from a mental disorder. At that time, Judge Elinore Marsh Stormer, the judge who initiated mental health court, presided over the drug court. Other municipal court judges were also very aware of the significant number of individuals with mental illness who were passing through their courtroom. One judge estimated that over fifty percent of the people he saw prior to the establishment of a mental health court had a substance abuse problem, a mental illness, or both.

Before the mental health court began, individuals suspected of mental illness had to wait up to six weeks in jail before a psychological assessment could be performed. For those individuals who were put on probation, one judge stated that he would try to pair the individual with a probation officer who was more knowledgeable of mental health issues, but doing so still did not provide the many services that a person with mental illness needs.

Meetings initially involved Judge Stormer and members of the Akron ADM board. The ADM board asked the National GAINS Center for People with Co-Occurring Disorders in the Justice System to do an evaluation of the courts and make recommendations. Several steps were taken on the basis of their recommendations: a forum was created to facilitate criminal justice-treatment interactions (the criminal justice forum), a law enforcement Crisis Intervention Team (CIT) was formed, and a mental health court was initiated. The criminal justice forum was organized first, and CIT was begun shortly after. Once it was determined that a mental health court should be developed and the concept was approved of by the other Akron municipal court judges, those individuals and agencies who were critical to the court's implementation met beginning in May 2000. Besides Judge Stormer and members of the ADM board, these individuals included the chief probation officer and an additional probation officer (who would later become chief probation officer), treatment providers and administrators from mental health agencies including CSS, Oriana House, Northcoast Behavioral Healthcare System, and from Psycho-diagnostic Clinic, a representative from the defender's office, a member of law enforcement, and a representative from the Adult Parole Authority. This group met monthly until November 2000. The program started in January 2001.

Resources required for the Akron mental health court

Very few additional financial resources were required to implement the mental health court. The majority of resources were obtained by reassigning and expanding job duties. The financial and non-financial resources needed for each component of the program are described below.

The Court. The court consists of the judge, probation officer, prosecutor, defense attorney, bailiff, and court security personnel. The roles of the primary court employees—the Judge, the defense attorney, and the prosecutor—expanded to include working in the mental health court as well as in the traditional municipal court. The probation officer was reassigned to the mental health court docket, where he serves full time. The remaining probation officers increased their caseloads to make up for this loss, but no longer have the mentally ill in their caseload. Other secondary mental health court employees (bailiff, court security) also saw their duties expand to include the mental health court.

Other courts were relatively unaffected by the creation of the mental health court. The municipal court judges reported that that they saw no change in their court hours. They also had no reassignment of court cases, although one judge commented that the mental health court judge's regular municipal docket should have been reduced. Court space was not reassigned to mental health court, but one judge noted that accommodations should have been made to designate more space for this court, as the courtroom gets very crowded and there is a great deal of traffic and noise in the hallway outside the courtroom prior to court time. Neither judge seemed annoyed by this, however. The municipal court judges who were interviewed reported no decrease in their court dockets as a result of the establishment of mental health court. Given that this is a fairly large jurisdiction with six judges, the caseload reduction amounts to approximately two cases a month. One judge commented that it might appear as though there were a larger caseload reduction because cases involving mentally ill individuals can be complex.

The Treatment System. The treatment system consists of six full-time community living specialists (CLSs), a full-time treatment manager, a full-time treatment supervisor, a part-time treatment psychiatrist, a part-time in-jail screening psychiatrist (who is also involved in their treatment while they are in jail), a part-time nurse, a part-time competency assessment team, a full-time court liaison, part-time clinicians, part-time substance abuse counselors and screeners, and two full-time vocational specialists. In the context of this paper, a full-time employee means that the employee devotes all of his or her time to the mental health court. A part-time employee is one who spends part of his time working in the mental health court, and the remainder of his time working in another capacity not directly related to mental health court.

CSS employs the majority of treatment positions, including the CLSs, a treatment manager and a treatment supervisor, the treatment and screening psychiatrists, a nurse, the SAMI/PACT case managers, the vocational specialists, and a court liaison. Oriana House, Inc. employs residential treatment counselors and substance abuse counselors. Summit County ADM employs the Psycho-diagnostic Clinic, which conducts competency evaluations. Clinicians at Summit Psychological Associates provide individualized counseling using Ph.D. forensic psychology consultants.

The majority of the treatment staff assigned to serve mental health court clients were either reassigned to this position or they had these clients added to their existing caseloads. Many of the CLSs employed by CSS originally held traditional caseworker duties. Because of the intense involvement required of the mental health court CLSs, their caseloads were changed (and reduced) to accommodate only mental health court clients, and as a result, the remaining traditional CLSs saw their caseloads increase. The ADM board supplied CSS with \$250,000 to hire a few additional mental health court CLSs (including one supervisor). The total number of mental health court CLSs is currently at six. This allows for a CLS-to-client ratio of about 1:15. Two vocational specialists were hired by CSS through a Byrne formula grant to work full-time with mental health court clients. The court liaison is also employed by CSS. The psychiatrists, substance abuse counselors, competency and chemical dependency evaluators, and the nurse see mental health court clients in addition to their normal caseload.

Currently, the treatment component of the mental health court is funded by ADM local levy funds. The funds do not expire until 2008.

The mental health court team

The mental health court could not exist without the involvement of the ADM board, the court, and the treatment providers. These agencies and the individuals who serve in these agencies help contribute to the success of the program. The individuals who directly serve the clients or the court in some capacity are considered part of the mental health court 'team.'

The ADM board. The ADM board essentially oversees the mental health system for indigents. The board was critical in determining what resources were needed and in helping to provide those resources for direct services. The ADM board is not involved in the day-to-day operations of the mental health court. If a system-level conflict arises, such as a disagreement between the treatment system and the criminal justice system or if there is a problem with a treatment provider, the ADM board may step in to help resolve the conflict. A forensic monitor employed by the ADM board attends mental health court sessions as an impartial observer of the court and reports to the ADM board on the actions that take place in the courtroom. She also attends all bi-weekly team meetings and keeps team members informed of any cross-discipline trainings held by her agency and other county agencies.

The Court. The key players in the court include the Judge, the probation officer, and the attorneys.

- The Judge. The judge is seen by the mental health court team as the single most important element in mental health court. Team members and other municipal court judges interviewed expressed that while the judge's position of authority certainly impacts what gets accomplished by the court, it is the judge's philosophy of therapeutic jurisprudence combined with her outgoing personality that truly makes the court a success. An effective mental health court judge was described as one who looks beyond the crime to the underlying issues, who believes in the program and has a willingness to learn, the capacity to be stern yet compassionate, and who desires to do the job for little in return, other than personal satisfaction. The role of the judge is different from the traditional 'authoritarian' figure common to most courtrooms. The judge's role is to determine, with the help of the treatment team, who is eligible for the program, and to oversee their involvement in the program by requiring the client to appear in court on a frequent basis. While the judge does deliver sanctions for noncompliant behavior while a person is in the program (which vary in intensity depending on the infraction committed), she also delivers rewards for good behavior and for successful completion of phases in the program.
- The program manager/probation officer. The program manager for the mental health court is also the mental health court's only probation officer. As a mental health court probation officer, his role is to monitor the progress and actions of the mental health court clients. He assists the CLSs in determining appropriate sanctions for the client. The probation officer meets with the client when the client first enters the program to sign the necessary forms, to explain what the program goals and expectations are, and to determine the level of services required. The probation officer relies heavily on reports from CLSs to monitor the clients' progress. In practice, there exists a probation 'team' rather than a probation 'officer,' and the identified CLS is one member of that team.

As program manager, he, along with the treatment manager, is responsible for program planning and development. He oversees the day-to-day operations of the mental health court. He runs the court meetings (the judge is generally not present at court meetings), and is seen by other members of the team as the person 'in charge' of the criminal justice component of mental health court (next to the judge). He will make recommendations to the team and to the judge as to appropriate sanctions and rewards for clients.

It is important to note that the program manager for the Akron mental health court has expertise in the area of mental health treatment. He was a case manager (CLS) at CSS for several years, as well as a forensic case manager, and he was a liaison and coordinator for the program that links the treatment providers with the local jail. Several team members and a municipal court judge noted how vital his expertise is in the development and operation of the mental health court.

- The attorneys. Attorneys play a small role in mental health court; not much legal maneuvering is necessary. The prosecutor is present at the arraignment, but he or she is not involved with the client beyond this point. The public defender's primary goal is to get the defendant the help he or she needs if there is enough evidence for a conviction. If there is not enough evidence for a conviction, her goal is to keep the client out of mental health court. Mental health court requires a lengthy and involved commitment on the part of the defendant, and it is the public defender's responsibility to make sure the defendant is aware of this. If the defendant opts for mental health court, the defense attorney's role is over, unless the client is re-arrested. If the defendant is rearrested within

the court's jurisdiction, she will take over the case; otherwise, the case is out of her hands.

The treatment providers. The treatment providers are employed by several agencies, including CSS, Oriana House, Northcoast Behavioral Healthcare, and Summit Psychological Associates, Inc.

- Treatment manager. The treatment manager, employed by CSS, supervises all CLSs. She is a Professional Clinical Counselor (PCC) as well as a Certified Rehabilitation Counselor. She assists the case managers when a client is in crisis or is decompensating. The treatment manager is also in charge of assessing and recommending those potential mental health court clients who are referred to mental health court but are released on bond. The treatment manager, in conjunction with the program manager, has the ultimate say in making recommendations to the judge on a client's treatment, rewards, and sanctions.
- Treatment supervisor. The treatment supervisor, employed by CSS, is involved in the day-to-day needs of the clients. Her background is in criminal justice, so she complements the treatment manager's background well. She carries a reduced caseload in comparison to other CLSs to allow for her additional supervisory duties. The supervisor has frequent contact with all CLSs, and ensures that all services are properly documented. She will accompany CLSs to visit a client, and may help the CLS if his or her client is decompensating.
- Court liaison. The court liaison, who is employed by CSS, attends morning and afternoon misdemeanor court sessions and determines whether defendants are appropriate for mental health court. The court liaison is a licensed social worker who worked for several years as a team leader of CLSs at CSS, so she has the qualifications to make an initial eligibility recommendation. She has access to the defendants' court cases and compares their names to a list of clients at CSS. If she finds that the individual has a mental health history (at CSS), she may then refer the person to mental health court. If she can find no mental health history on the defendant, but feels the person may be eligible, she can also make a referral. She will meet with all defendants either in person or via phone or video to do a preliminary screening in order to obtain more information regarding their current mental status, as well as any diagnoses and medication requirements (if they have a history of documented mental health problems). If the individual already has an extensive mental health support system, she may screen them out of the mental health court program and instead talk with the defendant's CLS and judge to request a reduced sentence (the intended population being targeted by the mental health court are those individuals who are in need of services but for whatever reason are unable to use them). The court liaison will also take referrals from other sources, including judges, attorneys, probation officers, and jail screeners. Copies of the referral form are given to the probation department, the mental health court bailiff, the prosecutor's office, and the defender's office. Ultimately, the referral form is received by either the in-jail screening psychiatrist (if the defendant is returned to jail) or by the treatment manager at CSS (if the defendant is released) to make eligibility recommendations.

- Community living specialist. All CLSs are employed by CSS. The role of a CLS is varied. Once the CLS is assigned a client, the CLS will conduct an assessment to determine the client's needs. CLSs are described as 'brokers of services,' in that they arrange for housing, set appointments for vocational counseling, line up and monitor medications (after they are prescribed by the treatment psychiatrist), get SSI reinstated, and assist with Medicaid issues. Several of the CLSs are now trained to administer the LSI (Level of Service Inventory) assessment to all of the MHC clients when they first enter the program. In addition, they make unannounced visits to clients' residences and order random drug tests. CLSs visit their clients several times a week initially, with the goal of decreasing the frequency over time in order to make the individual self-sufficient. The CLS will work with the client during Phase I of the treatment plan, and if the client appears to be doing well, he or she will transition the client to Phase II, which involves less intensive monitoring by a more 'traditional' CSS case manager.
- Vocational specialist. The vocational specialist positions were added after the mental health court's inception to aid clients in promoting job development. There are two vocational specialists employed by CSS, and each has specific duties. One specialist (the Intake specialist) is the first contact for clients. He is responsible for helping the client determine what is best for the client to pursue: GED, volunteering, or employment. He also conducts vocational assessments. This vocational specialist is also involved in issues of treatment non-compliance, as non-compliance strongly affects a client's ability to successfully engage in work, training, or education. The other vocational specialist's duties involve job development. She assists the client in achieving whatever goal the client decides to pursue. She helps clients perform job searches, acquire skill training, and find a job. She teaches the clients how to interview, how to handle rejection, and how to behave on the job. Often she must deal with anger management issues that arise because of the client's difficulty in working with or for others, especially for those who have never been in a work environment prior to their entering the program. The caseload is fairly steady and manageable, at about fifty clients each. Some clients are put 'on hold' for being non-compliant with medication or for being absent without permission. Occasionally if the vocational specialists are busy, they will receive assistance from the CSS vocational department. Usually this assistance involves job coaching and job transportation.
- Treatment psychiatrist. CSS employs the treatment psychiatrists. Two treatment psychiatrists serve both mental health court clients and non-mental health court clients. The treatment psychiatrist meets at minimum on a monthly basis with each client and prescribes and monitors the medication that best meets the client's needs. Appointments are primarily conducted at CSS; however, on occasion the doctors will go to the individuals.
- Jail Screening Psychiatrist. The jail-screening psychiatrist is employed by CSS. He spends approximately half of his time working in the Behavioral Health Unit in the Summit County jail. He interacts with all mentally ill clients who are jailed. He conducts an assessment on those individuals in jail who have a referral to mental health court (additionally, he works with the Akron drug court by screening inmates for their appropriateness for the drug court program). If any documented information is available on the client (past mental health treatment, hospitalizations, etc.), this information is given to the screening psychiatrist by the probation department to assist in his assessment. If no information is available, the screener must do the best he can in making

an assessment, given the limited time he has to spend with the client (approximately fifteen minutes). The screener makes recommendations for or against the person to be involved in mental health court. In addition to conducting assessments, the psychiatrist will treat those clients (and other mentally ill inmates) in the jail by prescribing medications to those who agree to take them.

- Clinical Therapists. An individual therapy program was provided after the onset of the mental health court program in response to the Judge's recommendation that some individuals would greatly benefit from one-on-one therapy. The individual therapy program is provided by Summit Psychological Associates, Inc. Four clinicians meet with their clients once or twice a week, depending on what needs the client has and what phase the client is in. Clinicians carry a small caseload of mental health court clients, among the other clientele they serve. The clinician does not make a diagnosis or conduct any assessments. Usually, diagnostic information has already been collected and is given to the clinicians to assist in their treatment plan.
- Substance abuse counselors. Oriana House, Inc provides the majority of substance abuse counselors. Oriana House provides several counseling options to chemically dependent clients from the criminal justice system. Most substance abuse counseling programs involve group therapy sessions. CSS also offers some substance abuse treatment programs.
 - Nonresidential programs. The nonresidential programs available to mental health court clients include an intensive outpatient program (four-week, sixteen-sessions), a relapse prevention program (four-week, twenty-sessions), and an aftercare program (twelve-week, twelve-sessions). Some substance abuse counselors are also trained in mental health issues, and are therefore able to provide integrated treatment to those who are dually diagnosed. The Oriana House SAMI program is aimed towards less severely mentally ill clients. They provide integrated cognitive-behavioral treatment, based on the Dartmouth-New Hampshire treatment model. In addition to group therapy, clients receive three individual sessions with a counselor.
 - The only substance abuse treatment provided by CSS comes in the form of a SAMI/PACT program. This program is available to all mentally ill individuals (not just those in mental health court) and therefore only those mental health court clients who were in the SAMI/PACT program prior to being involved in mental health court are involved. The SAMI/PACT program involves even more intense community treatment than that provided by the mental health court program. It offers integrated treatment consisting of crisis intervention, housing assistance, case management, substance abuse assessment, outreach, payeeship, assertive community treatment, psychiatry, and psycho-educational groups. Those who are in the CSS SAMI/PACT program prior to mental health court generally remain in the program.
 - Residential programs. Oriana House also provides a residential treatment center which allows mental health court clients (among other qualifying individuals) to stay up to six months while they receive substance abuse counseling.
 - Special Housing Adjustment Residential Program (SHARP). Oriana House provides a residential program for severely mentally ill male and female clients with a substance abuse problem. All referrals come from mental health court and other courts. The program is aimed towards those clients who are low functioning and who would not perform well in

a large group environment, which is the structure of traditional residential programs. The maximum length of stay is six months.

- Chemical assessment counselors. All clients referred to mental health court are required to undergo a chemical assessment to determine whether they have chemical dependency treatment needs in addition to their mental health needs. Oriana House provides this service.
- Competency evaluators. Psychologists at Psycho-diagnostic Clinic perform competency evaluations. They are conducted on those jailed individuals referred by the courts. Getting the competency evaluation set up usually takes seven to fourteen days.

Mental health court clients

Mental health court clients are those individuals diagnosed with a severe mental disorder and who have been arrested for (and who plead no contest to) a misdemeanor offense of the kind described earlier. Mental health court team members acknowledge that there are clients who do not meet the criteria for eligibility and are still admitted into the program. If a client is not eligible, but a team member (including the judge) feels the individual would do well in the program, he or she will be considered on an individual basis. Those who have been taken into the program as an exception include first time offenders, those with a different Axis I diagnosis (such as Major Depression) or no Axis I diagnosis, those who committed a 4th degree misdemeanor, and those who simply ask to be put in mental health court because they know of its benefits. Early in the program, dually-diagnosed mentally retarded/mentally ill clients were included in mental health court; however, because these individuals pose a special challenge which the mental health court personnel felt they were not equipped to handle, they are currently screened out. One individual indicated that the screening out of all such dually-diagnosed individuals might have been premature, as there may be some individuals with mild mental retardation and an appropriate mental illness who would do well in the program.

All clients are required to take medication prescribed by the treating psychiatrist in order to be eligible for mental health court. Failure to continue this form of treatment is grounds for sanctions. Team members commented that treatment including medication is necessary to create and maintain client stability, which is critical for the client's success in the program.

At the end of 2002, 272 individuals were initially screened for their eligibility for mental health court. Of the 272, approximately 102 were active in the program and 101 did not become involved in the program due to their diagnosis or their refusal to participate. Those who refused participation usually did so because they felt they were innocent of the crime in which they were charged (or they felt there was not enough evidence to convict them), because they did not understand the benefit of the mental health court, or because they did not want to commit to the large amount of time that is required of the program. If an offender is offered a light sentence, it may be more desirable to the offender to take the sentence than to enter a two-year probation program.

Sixty-eight of the 272 clients had been terminated from the program by the end of 2002. The primary reasons for termination included a new arrest that required termination (e.g., the person is arrested in a different jurisdiction), a failure to respond to an increasing level of sanctions, or non-compliance with treatment plans. Often the underlying cause of the termination is drug addiction or a failure to stay on medication. A number of those who were terminated from the program were misdiagnosed at the onset and as a result of their true diagnosis had great difficulty complying with treatment plans.

Team members expressed concern during the weekly meeting that there were a small number of clients in the program who should have been terminated early on in the program but were not. These clients are now approaching the end of the program and will most likely graduate; however, one team member commented “Graduation implies that you did something good!” This appeared to be a source of frustration to some in the team. Later, it was expressed by several team members that the court is doing a much better job in selecting clients to mental health court who are truly appropriate for the program. This stems in large part from better communication between the treatment leaders and the judge on eligibility requirements.

Nearly all team members expressed hope that diagnostic eligibility requirements would be expanded to include other Axis I diagnoses. Several team members suggested Major Depression be included in the eligibility requirements, and a few also suggested Post-Traumatic Stress Disorder (PTSD) be included. At least one team member felt that PTSD should not be included, as there are so many individuals suffering from this disorder that it would overwhelm the court. All members, however, acknowledged that the current restricted diagnostic requirements were necessary during the program’s infancy. Two misdemeanor court judges implied that diagnostic and other restrictions are potentially keeping individuals out of the mental health court who would benefit from it. Both judges have made referrals to mental health court on a regular basis (approximately one to four times a month, depending on the judge), and some of their referrals are bumped back to municipal court, often without an explanation. Both judges have high regard for the mental health court, and would like precise guidelines regarding mental health court eligibility requirements.

Collaborative Efforts among Agencies

Initial collaborative efforts

The success of the mental health court depends on the ability of the criminal justice system and the treatment system to collaborate, from the planning stage through the implementation and operation phases. In the planning stage, collaboration begins with the mutual understanding and agreement on a mission statement and goals. The goals of the mental health court, broadly defined, were straightforward: to divert mentally ill non-violent repeat offenders from jail and into treatment. The role of the treatment providers is to provide assertive case management. The role of the court is to reward and sanction the offender’s behavior while in the program. Given the different philosophies that are endorsed by the treatment system and the criminal justice system, ideas regarding how the program should achieve the stated goals were fundamentally different between the two systems. The two systems have always made an attempt to collaborate; however, several team members and secondary sources indicated that a lack of awareness or acknowledgment of these underlying philosophical differences was the primary contributor to the collaborative difficulties that were encountered at the onset of the mental health court program.

At the heart of the difficulties experienced by the mental health court was the lack of information sharing between the treatment systems and the criminal justice system. A clash between systems immediately occurred in regard to the individual’s right to privacy and confidentiality. The courts were repeatedly frustrated by their inability to obtain information on an individual’s history and treatment from some of the mental health treatment providers. Another issue where the two systems clashed was in regards to appropriate client treatment. Treatment providers are well aware of, and even accepting of, setbacks in their clients’ treatment, and traditionally they are freely able to make decisions on the proper way to handle such a setback. When a mental health court client experienced a setback (e.g., recent drug/alcohol use), CLSs were at times hesitant to share this information to the judge, in part because the judge would then have the ultimate say on the course of action to take regarding the client’s treatment (which was usually in the form of a

sanction). It was this lack of information sharing that ultimately led to a breakdown in the collaborative efforts between the two systems.

Attempts at facilitating collaborations between the treatment system and the criminal justice system were made by holding numerous meetings to discuss the expectations and roles of each system. The expectations of the court were made more explicit to the treatment providers, including the need for the court to have all information on the client's mental health status (including mental health history and treatment), and the need for the treatment system to hold the client ultimately accountable for his or her actions (and thus justifying the necessity of making the court aware of the client's setbacks for the purpose of giving sanctions). Given the number of unresolved philosophical differences that still remained between court officials and the treatment manager, a new treatment team consisting of a different treatment manager, treatment supervisor, and several new CLSs was formed in June 2002.

Current collaborative efforts

Ongoing efforts have been made by both the treatment providers and the criminal justice officers to rebuild the collaborative ties between the systems. The most important way in which collaboration is now fostered is through improved information sharing.

At the system/agency level, the mental health court client signs releases for every prior and/or present treatment facility (hospital, mental health agency, etc.) with which he has been involved so that the necessary information on the client's history and treatment is available to all agencies and team members involved in his case. The greatest difficulty encountered by the mental health court is the court screener's inability to access defendants' mental health histories from treatment facilities (other than CSS) to determine their appropriateness for this specialized court.

Information sharing is facilitated through court meetings, which are held to discuss mental health court clients' progress. The court meetings consist of the treatment manager, the treatment supervisor, the CLSs, the forensic monitor, representatives from vocational services, program manager of the SHARP program, a clinician, the chief probation officer, the mental health court screener, and other non-team members (visitors, researchers, etc.). These meetings were held weekly through December 2003; now they are held bi-weekly. One team member expressed concern that the team meetings are now held less frequently, and felt that the weekly meetings were the *minimum* necessary.

The chief probation officer appears to facilitate the meetings by asking questions of the various CLSs regarding their clients' status. The CLSs report primarily on the status of those clients who are experiencing difficulties regarding issues of housing, treatment, employment, or behavior. In addition, the team discusses those clients who are transitioning into new phases of the program (and the rewards that are given as a result of the transition). The team meeting is also a place where members appear to feel fairly comfortable in raising concerns regarding the program, such as who the program is serving, what services are needed, etc.

While the bi-weekly team meetings are the primary way in which all team players are able to interact as a group, individuals within the team interact on a more frequent basis. The CLSs are seen as the main point of contact for a client. Therefore, almost all information pertinent to that client is given directly to the CLS, even if the CLS is not directly affected by the information. Information sharing between the CLSs and the treatment providers is done very well. Several team members commented that 'voicemail tag' is very common; however, none mentioned specifically that this was a problem. A few team members commented that information sharing between different treatment providers/agencies was also very good but could be improved. Some

rely on the CLSs to relay information from one treatment source to another, rather than contacting the source directly, which is the recommended route. Overall, however, the team was in agreement that information sharing has improved greatly since the court's onset, and especially since the treatment team's overhaul.

The team also uses the weekly court sessions to interact with one another. Several team members are required by the judge to attend court with their clients (case managers, treatment manager, treatment supervisor, forensic monitor, clinicians, screener), and this provides the members another opportunity for interaction. Finally, yearly retreats and occasional team meetings to discuss important issues that may arise foster ongoing collaborative efforts.

Sanctions and Rewards

Several team members indicated that the sanctions and rewards component of the mental health court program is critical to changing the behavior of the clients in a positive way. The team members involved in the client's care determine sanctions and rewards for that individual. The chief probation officer seems to have the final say regarding what type of sanctions and rewards are recommended to the Judge, although the treatment manager can (and does) challenge the recommendation when necessary. The Judge has the power to take the recommendation or to impose her own sanction or reward, but will usually defer to the recommendations of the team.

Sanctions can be given to a client at any point in the program in which the client deviates from acceptable behavior. Sanctions are graduated and are dependent on the severity of the behavior and on the frequency of misconduct. Examples of sanctions include community service, courtroom observation, increased therapy or attendance to group meetings, in-house arrest, or referral to a residential treatment facility. Next to termination, the most severe sanction given is jail time. Jail time is used only when deemed absolutely necessary, and is usually for a short period of time (three, five, or ten days). If the client is eventually terminated from the program, any jail time served as the result of a sanction is credited towards the remaining time the client may have in his or her original sentence. Team members were very consistent in agreeing that appropriate sanctions can be an effective way to alter a mental health court client's behavior. Some team members expressed disbelief that a mental health court could instill change in client behavior without the threat of sanctions held over them.

Rewards can, in theory, be given to a client at any point in the program in which the client displays consistently acceptable behavior, but in reality, rewards are most often given when the client moves from one step or phase to another. Most team members agreed that the reward system works well with this population of clients and several suggested that rewards should be given on a more frequent basis, rather than simply to mark a transition to a new step or phase.

Interestingly, individuals in two separate interviews noted that relapses in behavior seem to occur shortly after a reward is given. One of the individuals suggested it might be that the clients do not truly understand the purpose of a reward, and they see the reward as acceptance of the client rather than acceptance of the client's behavior.

Impediments to success

While the mental health court team has overcome many obstacles to get the mental health court operational, the team acknowledges several challenges that impede their ability to serve clients or that impede the client's ability to be successful. Most of the problems stem from a lack of resources in the mental health system. Some of these obstacles were touched on already, and are expanded on here.

Housing. Every team member interviewed expressed great concern over the lack of housing available to clients, especially for those in the first year of the program. Oriana House provides some housing for clients through their SHARP program, but the SHARP program is available to all eligible individuals, not just those in the mental health court program. Additionally, the male SHARP program consists of only 12 beds, and individuals may stay as long as six months. The result is that there is currently a waitlist for this program. The male SHARP program is spoken very highly of by CLSs, and they commented that they would like to see the SHARP program expanded to allow for a greater number of clients to reside there temporarily, not simply for the sake of housing but for the services that are available on-site and for the calmer, quieter atmosphere this facility provides. The female SHARP program has even fewer beds, and the impression is that the females in this program are not segregated from females in other Oriana House programs (i.e., programs that are not geared towards mentally ill individuals). This mixing of populations makes for a more disordered environment. Some commented that this is unfortunate, because greater structure and a less chaotic environment are the hallmarks of the male SHARP program. Also, one CLS commented that it is more difficult to place women released from SHARP into other housing, in part because of a short release notice.

Beyond the SHARP program, there is little temporary housing for mentally ill offenders. CLSs indicate that one of their biggest struggles and time consumers is finding appropriate shelter for their clients. It is estimated that fifty percent have only temporary housing (may live with family, friends, etc., or may have such chaos where they live that they need to move to more appropriate housing) and twenty-five percent have no housing. There are a few shelters that are available to all homeless individuals (not specifically those in the mental health court program), but the length of time in which they can stay is minimal. It is not uncommon for the client to sleep on the streets if the CLS is unable to find shelter. One CLS commented (and others agreed) that in worst-case scenarios such as extreme weather conditions, they will recommend to the client public places where they can seek shelter (e.g., hospital lobby). Otherwise, the CLS may beg the SHARP program to take a client. The SHARP program is for particularly low-functioning clients, and it is unclear whether all individuals placed in the program meet the criteria required, or if this facility is sometimes used for the shelter it provides. CLSs are strongly encouraged to actively seek housing arrangements for clients who are in the SHARP program so that when the client's time is done, he can move on and allow another individual to take his place. Given the frustration faced by CLSs regarding the housing shortage, the CLSs are not always able to arrange subsequent housing in a timely manner.

As the client progresses in the program, there is an increasing level of expectation that the client is progressing towards self-sufficiency—he is engaged in some sort of employment (volunteering or paid) or training, is stable on medications, is crime-free, and is not consuming alcohol or drugs. Housing is no exception. It is expected that the client find and maintain stable housing by the end of year one. The types of housing typically available to clients are either group home placement or individual apartments. CLSs help individuals obtain stable housing after the first year by finding resources for housing subsidies, and by advocating for the client to potential landlords. Some clients can be particularly hard to place if they have not done well through the program or have a bad history with previous landlords.

Dual-diagnosis treatment. The court provides dual-diagnosis (SAMI) treatment through both Oriana House and CSS (SAMI/PACT), but the programs are limited in the number of people who can be taken. One team member estimated that between fifty to seventy percent of the clients are dually diagnosed. Another team member stated that nearly eighty percent of her caseload has a dual diagnosis. Several members supported the assessment that a majority of their clients have a

substance abuse problem in addition to a mental illness. In general, the court reserves the limited SAMI treatment for less high functioning clients.

Determining eligibility. In the first year of the mental health court program, there was concern among many team members that people inappropriate for the program were being accepted to the program. These individuals did not fully meet the eligibility requirements set forth in the program guidelines. It was suggested that the court was more willing to take individuals initially in order to test the system. Several team members acknowledged that the court follows the eligibility guidelines much more closely now, and that the court is becoming better at taking the advice of the mental health experts regarding who should and should not be accepted into the program. A few members advised that the court needs to continue to be prudent in determining who is eligible for mental health court.

Obtaining and sharing information. Obtaining and sharing client information among the numerous individuals and agencies involved in the mental health court is critical to successful collaboration. Team members commented that overall, once a client begins the mental health court program, their ability get information on the client is very good, as clients are required to sign information for releases to any mental health agency with which they have ever been involved. Only a few problems with receiving client information were noted.

Being able to obtain information on defendants at their initial hearing prior to being identified as potential mental health court clients is one area where some team members expressed concern. The court liaison, who works for CSS, has access to a CSS patient database, and is able to cross-reference the court list with this database to identify those defendants who may have a mental health history. She cannot access, without a release of information, any information about people who are receiving, or have received treatment at other agencies within Summit County. Thus, there is the possibility for a client to be overlooked as a potential candidate for mental health court. There are still other ways an arrestee can be referred to mental health court (arresting officer, judge, court screener—a LSW, in-jail screening psychiatrist); however, identifying the individual early on in the adjudication process will result in a much more timely handling of the case and may minimize the amount of time the individual will have to spend in jail awaiting court.

Obtaining drug test results in a timely manner is also problematic. One source stated that on more than one occasion drug results for a client were not even returned. One of the hallmarks of successfully changing a person's maladaptive behavior is to acknowledge it as soon as it is identified. If the drug test results are not available in time for a court appearance, there can be no consequences (positive or negative) for the client's behavior. The clients need to be acutely aware that their behavior is being monitored.

Another area where a few felt improvements could be made is the timely sharing of background information with the jail screener. Prior to arraignment, the arrestee's mental health history is given to the jail screener for an evaluation. In most cases, the information is obtained quickly and the arrestee's time in custody is within seven days of arrest. But there are cases where this seven-day window is extended, and some feel that this could be improved. A team member stated that once a potential mental health court client is identified, the information-gathering process should begin immediately, but this is not always done. Additionally, the information that is given to the jail screener lacks the source of the referral, which does not hinder the evaluation, but would be informative nonetheless.

Team members repeatedly commented that the team regularly and for the most part consistently shared client information with one another, and a few noted that they could not see how information sharing could be improved. Others stated that information sharing was done very well, but could always be improved. As one put it, “ninety-five percent of information that needs to be shared is shared, it’s the other five percent we need to work on.” CLSs are perceived as the primary point of contact for information—all other individuals working with clients will usually contact the CLS to update him or her of anything pertaining to the client. One member commented that individuals sometimes count on the CLS to relay information from one source to another, and that more effort should be made to have sources contact each other directly.

A suggestion that was voiced by more than one individual was to give office space within the probation department to CLSs and other individuals who spend a great deal of time in at the court. Besides the convenience factor (which was the primary reason the idea was shared), doing so may further enhance information sharing process and cut down on the ‘voicemail tag’ that many of the team members experience.

Given the wealth of information that is collected by each agency on a particular client, and given that all team members have access to this information, one team member suggested that a single database, or management information system, be created to incorporate all this disparate and in many cases duplicate information. This way, all agencies could access accurate and up-to-date information on all aspects of the client’s interaction with the mental health court program.

Appropriate use of rewards. Team members view rewards as a necessary component of the mental health court program. Several individuals commented that rewards provide clients the positive reinforcement they need to make the lifestyle changes necessary to succeed. They noted that rewards given at times other than transition points may motivate clients to continue to work hard. It is important, however, that the court and the team members express to the client the purpose of the rewards they are being given.

Mental health court capacity. There is a conflict between the number of clients that team members want to have in the program and the number of clients that team members can successfully handle in the program. Several team members commented that the eligibility criteria should be expanded (specifically the diagnosis requirements) to allow for more clients to become involved in the mental health court program. Others stated that the number of clients in mental health court is manageable at this time, but more would be difficult to handle. One individual stated that both the judge and CLSs are spread too thin with the load they currently have, and that 78 clients (the number currently in mental health court) is simply too many from a case management/treatment perspective. Interestingly, those who have the most one-on-one contact with clients tended to be the ones who suggested the program be expanded. Employee burnout does not yet seem to be occurring because most of the team members are new to the program (less than one year), but this may become an issue in the future. Concern was also expressed about the large number of clients and the extensive demand on his CLSs’ time devoted to activities that are not billable (e.g., attending court with the clients). The question arises as to who should pay for this ‘down time.’

Review process. One comment was made that clients have no resource to turn to in order to voice a complaint regarding any process or individual working in the mental health court. It was suggested that an individual be identified to all clients as a neutral party to which complaints or comments be directed.

What makes the Akron mental health court work?

Team members were asked what makes their court work well and what other courts need to have in place in order to implement a mental health court. The following is a list of what team members felt are the components necessary for a successful mental health court.

- A criminal justice forum that includes all parties to be involved in the mental health court
- Buy-in of the mental health court concept from all participating agencies
- A good probation department
- Collaboration and open communication among the various agencies involved
- Careful diagnostic selection of clients
- State-of-the-art pharmacological therapy that is made available to all clients
- Availability of SAMI treatment
- Access to vocational services
- A treatment system that is willing to accept the increased responsibility and increased clientele that comes with a mental health court
- A pre-diversion program (e.g., police Crisis Intervention Teams, or CIT) that is able to filter the flow of individuals into mental health court so that it is not overwhelmed
- Desire of the judge to make the court successful
- Creation of common goals and language, as well as agreement of all parties on *how* to achieve stated goals
- A rewards and sanctions component
- A tracking system that allows the court to know who may be eligible for the program
- A single judge (rather than multiple judges) to get the program off the ground, otherwise, too much time is spent in negotiation, conflicts of interest, etc.

Recommendations by team members for program enhancement

Team members offered several recommendations that they felt would enhance the mental health court program. These recommendations are not critical to the program's survival, but rather are recommendations that would provide greater breadth to the program, its clients, and its team members.

Family support. One team member suggested that greater family involvement, *in the right capacity*, could facilitate client success in the program. Families can provide the extra encouragement and support that is necessary for a client's success in the program. It is important that the family understand (or be taught) *how* to appropriately support the client, without enabling the client to continue in his or her maladaptive behaviors.

Spiritual support. One individual suggested that the team should encourage a spiritual component to clients' treatment if the client so desires. Virtually no attempts have been made to take advantage of this source of guidance and support.

Support of graduated clients. One team member suggested that the program incorporate those who have graduated a chance to come back to talk to others currently in the program.

Training opportunities. Team members are made aware of the numerous cross-disciplinary training opportunities available to them by the ADM board and other agencies. However, more than one team member noted the difficulty they had in finding the time to attend these trainings. Additionally, one individual stated that there are numerous conferences within Ohio and across the country that would benefit team members, but budget cuts prevented them from being able to

attend. Having the time and the money to attend these trainings and conferences was identified as important to them.