

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 those individuals can receive proper treatment. In 1999, Akron, Ohio took steps to respond to this need by establishing a mental health court, the first of its kind in Ohio. According to its mission statement,

[t]he 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 jurisprudential approach to support a psychiatrically stable and crime-free lifestyle for persons with mental illness.

The Ohio Office of Criminal Justice Services (OCJS) is currently funding a project led by Dr. Christian Ritter (Kent State University), Dr. Karen Gil (NEOUCOM), and Dr. Mark Munetz (NEOUCOM, Akron ADM board) that addresses the court's impact on recidivism and other criminal justice and non-criminal justice measures. Given the relative newness of the court, and the potential impact its success or failure could have on the implementation of other mental health courts in Ohio, OCJS conducted a case study of the court. This study focused on the structure and function of the Akron mental health court, including 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. The 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.

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

I. WHAT IS THE AKRON MENTAL HEALTH COURT?

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 to be eligible for the program:

- The defendant must have a primary Axis I diagnosis of schizophrenia, schizoaffective disorder, or bi-polar disorder.
- The defendant must be charged with a non-violent misdemeanor offense. Fourth degree misdemeanors are not accepted unless they have multiple prior offenses that require them to be jailed for a minimum of ninety days. Violent offenders may be taken into the program only 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 with a finding of guilt to the crime for which they are charged, and they are placed on probation for a period of two years. The goal of the program is to transition the client 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 phase consists of several steps that the client must progress through. 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. The client is expected to meet regularly with the judge, starting with weekly visits to the courtroom that decrease in frequency as the client demonstrates his or her responsiveness to 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.

II. HISTORY OF THE AKRON MENTAL HEALTH COURT

Discussion of the mental health court began in 2000. There was no real impetus for implementing the court, other than 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 and were never able to receive the assistance they required. 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 the 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 more than 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 came first, and CIT began shortly thereafter. Once it was determined that a mental health court should be developed and the concept was approved by the other Akron municipal court judges, those individuals and agencies who were determined to be critical to the court's implementation were brought in to meetings. These meetings began in May 2000. Other than 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 of the mental health court, treatment providers and administrators from mental health agencies including CSS, Oriana House, Northcoast Behavioral Healthcare System, and 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. At this point, Judge Stormer decided to begin implementing the program in January 2001.

III. RESOURCES REQUIRED FOR THE AKRON MENTAL HEALTH COURT

Very few 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.

A. *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—were expanded to include working in the mental health court as well as in the traditional municipal court. The probation officer was transferred out of municipal court and reassigned to the mental health court, where he serves full time. The remaining probation officers increased their caseloads to make up for this loss. Other secondary mental health court employees, such as the bailiff and 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 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 was a larger caseload reduction because cases involving mentally ill individuals can be complex.

B. The Treatment System

The treatment system consists of ten 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 the individual's 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 counselors, the vocational specialists, and a court liaison. Oriana House, Inc., employs residential treatment counselors, substance abuse counselors, and SAMI counselors. Northcoast Behavioral Healthcare System employs the Psycho-diagnostic Clinic, which conducts competency evaluations. Clinicians at Summit Psychiatric Associates provide some individualized counseling.

The majority of the treatment staff members who are assigned to service 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; as a result, the remaining traditional CLSs saw their caseloads increase. The ADM board supplied CSS with money to hire a few additional CLSs to fill the remaining mental health court CLS positions. The total number of mental health court CLSs is currently at ten, which was the goal from the onset of the program. This allows for a CLS-to-client ratio of about 1:12. Two vocational specialists were hired by CSS through a Byrne formula grant to work full-time with mental health court clients. The court liaison was also hired 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.

1. *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.”

a. *The ADM Board*

The ADM board essentially oversees the mental health court. The board was critical in determining what resources were needed and in helping to provide those resources. 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 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 all 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.

b. *The Court*

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

- *The Judge.* The judge is viewed by most of the mental health court team as the single most important character 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 needs to be able to look beyond the crime at the underlying issues, and who has to believe in the program and to have a willingness to learn, the capacity to be stern, yet compassionate, and the desire to do the job for little in return, other than personal satisfaction. The role of the judge is different from the traditional, “adversarial” 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 involvement in the program by requiring the client to appear in court on a frequent basis. While the judge does deliver sanctions (which vary in intensity depending on the infraction committed) for noncompliant behavior while a person is in the program, 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 administer an LSI, and to explain what the program goals and expectations are. Additionally, the probation officer is updated with information pertaining to a client's re-arrest. The probation officer relies heavily on reports from CLSs as to 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 team meetings, because the judge is generally not present at team meetings, and he is viewed 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 of the mental health court.

- *The Attorneys.* Attorneys play a much smaller role in mental health court. There is not much legal maneuvering in mental health court. 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 her 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 re-arrested within the court's jurisdiction, she will take the case; otherwise, the case is out of her hands.

- *Court Liaison.* The court liaison 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 one of the mental health treatment centers (CSS). If she finds that the individual has a mental health history, 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 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 persons targeted by the mental health court are those individuals who are in need of services, but for whatever reason are unable to get them. The court liaison also will 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 supervisor at CSS if the defendant is released, to make eligibility recommendations.

c. 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 licensed practical counselor (LPC) 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 released on bond. The treatment manager, in conjunction with the program manager, has the ultimate say in making recommendations to the judge about 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.
- *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. In addition, they make unannounced visits to clients' residences and administer 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 position was added after the mental health court's inception to aid clients in promoting job development. They are employed by CSS. There are two vocational specialists, 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, be it 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 skills 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 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 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, including past mental health treatment and hospitalizations, 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 (approximately 15 minutes) he has to spend with the client. 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 individuals, including offenders. Most substance abuse counseling programs involve group therapy sessions.
- *Nonresidential Programs.* The nonresidential programs available to mental health court clients include an intensive outpatient program lasting four weeks and sixteen sessions, a relapse prevention program lasting four weeks and twenty sessions, and an aftercare program lasting twelve weeks and 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 toward 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.
- *Drug Treatment Programs.* 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 who are not willing to take medication prior to their trial. Getting the competency evaluation set-up takes seven to fourteen days on average.

III. MENTAL HEALTH COURT CLIENTS

Mental health court clients are those individuals who have 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, however, that there are clients who do not meet the criteria for eligibility yet 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 fourth 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.

At the onset of the program, more people were generally taken into the program than were eligible. Clients who were deemed not appropriate for the program by the screening psychiatrist or the treatment coordinator were

sometimes accepted into the program despite objections by the mental health professionals. This happens much less frequently now.

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 dismissal from the program. Team members commented that treatment including medications is necessary to create and maintain client stability which is critical for the client's success in the program.

In year one, approximately 263 individuals were initially screened for their eligibility for mental health court. Of the 263, approximately 247 were not eligible, and sixteen were eligible, but refused mental health court. Those who decline usually do so because they feel they are innocent of the crime of which they are charged or they feel there is not enough evidence to convict them, because they do not understand the benefit of the mental health court, or because of the huge time commitment that is required to complete the program. If an offender is given a light sentence, it may be more desirable to the offender to take the sentence than to enter a two-year probation program.

Last year, forty clients were terminated from the program. The primary reasons for termination include a new arrest that requires 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 are 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 members of the team. Later, several team members expressed 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 that 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. 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.

IV. COLLABORATIVE EFFORTS AMONG AGENCIES

A. *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 of 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 he is 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 in 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. The two systems also clashed in regards to appropriate client treatment. Treatment providers are well aware of, and even expecting 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 such as recent drug or 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 court made its expectations more explicit to the treatment providers. These expectations included 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. 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.

B. 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, or mental health agency 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 court continues to be challenged by treatment agencies that refuse to release basic information, including whether a person has been seen at their facility, prior to the client's signing of a release. This presents the most difficulty for the mental health court screener, who is unable to determine whether a potential mental health court client has a history of mental health treatment.

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.

Information sharing is also facilitated through team meetings, which are held to discuss mental health court clients' progress. The team meetings, which are held in the municipal court probation department, 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 including visitors and researchers. 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 meetings should be weekly at a minimum.

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 and what services are needed.

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 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 very efficient. 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 and 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 agreed 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 including case managers, treatment manager, treatment supervisors, forensic monitors, clinicians, and screeners are required by the judge to attend court with their clients, 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.

V. 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 team's recommendations.

A client can receive sanctions at any point in the program at 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 at group meetings, in-house arrest, or referral to a residential treatment facility. Next to termination, the most severe sanction is jail time. Jail time is used only when deemed absolutely necessary, and is usually for a short period of time such as three, five, or ten days. If the client is eventually terminated from the program, any jail time served is put towards the remaining time the client may have on 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.

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 view the reward as acceptance of the client rather than acceptance of the client's behavior.

VI. IMPEDIMENTS TO SUCCESS

While the mental health court team has overcome many obstacles to make the mental health court operational, the team acknowledges several challenges that impede its ability to serve clients or that impede the client's ability to be successful. Some of these obstacles were addressed already, and are expanded on here.

A. *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 twelve 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 such as 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 is finding appropriate shelter for their clients, the majority of whom are homeless. 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 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, he will recommend to the client public places where they can seek shelter such as a 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.

B. 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 and 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.

C. Determining Eligibility

In the first year of the mental health court program, there was great concern among many team members that people inappropriate for the program were being accepted into 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 increasingly 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.

Related to this, several team members expressed concern regarding those individuals who are inappropriate for the program but are in the program nonetheless. As some of these clients have been in the program the greater part of two years, it is difficult to justify terminating them at this point. There does not appear to be an official protocol for ultimately deciding when a person should be terminated (although it is apparent several elements must occur before the court decides whether termination should take place). It is likely, however, that as the court continues to improve in determining appropriate clients for mental health court, the issue of candidate termination will lessen.

D. 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, their ability to obtain information is very good, as clients are required to sign information for releases to any mental health agency with which they have ever been involved. However, prior to their signing such releases, some agencies are unwilling to share even the most basic information with the court, such as whether the arrestee has ever been involved with their

agency, which can impede the court's ability to address the cases in a timely manner. As a result, the court screener is able only to cross-reference her court case list with a few mental health agencies to determine whether an arrestee has a mental health history. If the arrestee does not show up on her list of mental health clients, the individual may be overlooked as a potential mental health court client. There are still other ways an arrestee can be referred to mental health court, including through the arresting officer, judge, court screener—a LSW, or an in-jail screening psychiatrist. However, catching 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 or sanction 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.

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 efficient, but could always be improved. As one put it, "95 percent of information that needs to be shared is shared, it's the other 5% 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.

More than one individual suggested that there be office space within the probation department for CLSs and other individuals who spend a great deal of time at the court. Besides the convenience factor, doing so may further enhance information-sharing processes and cut down on the "voicemail tag" that many of the team members experience.

One 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.

Finally, other municipal court judges reported that they would like to have information on the status of arrestees whom they recommend to be involved in mental health court but for some reason are not accepted into the program. The judges commented that arrestees whom they were certain would be a good fit for the mental health court program were denied, but no explanation was given to the judge why the individual was returned to their courtroom. One judge suggested that the mental health court explain in more detail the conditions under which a person is accepted into the program so that the judges do not keep making the same referral mistakes.

E. 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 receive, as more than one individual noted that relapses often occurred shortly after a client received a reward. It was suggested that perhaps the client does not fully understand the purpose of the reward as an indicator of achievement, but rather the client sees the reward as acceptance of him or herself as an individual irrespective of the illness.

F. 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 120 clients, the approximate number currently in mental health court, is simply too many from a case management and 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 having been there less than one year, but this may become an

issue in the future. The CEO of CSS also expressed his concern over the large number of clients and the extensive demand on his CLSs' time devoted to activities that are not billable such as attending court with the clients. The question arises as to who should pay for this "down time."

F. *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 as a neutral party to which complaints or comments could be directed.

VII. 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:

- criminal justice forum that includes all parties to be involved in the mental health court;
- acceptance 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 available for 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;
- pre-diversion program such as police Crisis Intervention Teams (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; and
- a single judge rather than multiple judges to get the program off the ground; otherwise, too much time is spent in negotiation and with conflicts of interest, etc.

VIII. 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.

A. *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 learn how to appropriately support the client, without enabling the client to continue in his or her maladaptive behaviors.

B. *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.

C. *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.

D. *Training Opportunities*

Team members are 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. They later stated that having the time and the money to attend these trainings and conferences was important.