SANTA BARBARA COUNTY MENTAL HEALTH TREATMENT COURT PROCESS EVALUATION

May 2017

The UCSB Evaluation Team conducted a process evaluation of the Santa Maria County Mental Health Treatment Court in Santa Maria from November 2016 through January 2017. Team meeting observations, court session observations, stakeholder surveys and interviews, a focus group, review of administrative data, consumer surveys, and treatment provider interviews and surveys were conducted. Results of this evaluation are presented and discussed.

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SANTA MARIA MENTAL HEALTH TREATMENT COURT

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Executive Summary

SUMMARY OF FINDINGS

This mental health treatment court (MHTC) process evaluation utilized six sources of information: 1) observations of team staffings; 2) observations of the corresponding courtroom proceedings; 3) interviews and surveys from MHTC team members; 4) a focus group of team members regarding MHTC adherence to guiding principles and promising practices; 5) interviews and surveys with treatment counselors; and 6) consumer surveys with MHTC clients. Each addressed elements of known best practices or guiding principles in MHTC or treatment courts, or has demonstrated associations with outcomes in other fields.

Treatment

Team members shared that high-quality substance abuse treatment is available to clients who need it; however, they were divided about the availability of other services, such as mental health treatment, trauma-specific services, criminal thinking interventions, family or interpersonal counseling, and medical or dental treatment. Unmet client needs most commonly included housing, vocational opportunities, and access to medication.

Counselors agreed that that their treatment agency utilizes evidence-based treatments, treats co-occurring disorders concurrently, provides individual counseling and regular supervision, delivers treatment that improves outcomes for clients, and addresses clients' criminal and legal issues; clinicians were viewed as proficient at delivering interventions, and having a good therapeutic relationship with MHTC clients. However, MHTC clients were largely neutral about whether they had a good relationship with treatment staff and are treated fairly by them.

Team members reported that treatment plans are individualized, based on client need, flexible, and reinforced through accountability provided by the court; however, team members suggested that accountability could be improved, and knowledge or communication about clients' compliance, progress, or treatment plans was sometimes inadequate. Client assessment was reported to occur quickly; on the other hand, team members and counselors shared that initial assessments were unstandardized and brief, and sometimes contradicted later assessments from treatment programs, creating disagreements about treatment needs and client eligibility. Furthermore, when standardized assessments were used they were applicable to substance abuse populations only.

Gender-specific treatment, culturally-sensitive interventions, and various population-specific groups were reported to be available by team members and treatment counselors, yet cultural sensitivity and specificity was identified in the focus group as an area for growth. Although treatment counselors were able to share successful strategies used to support clients with PTSD or severe trauma, most counselors shared there was no formal process for screening or assessment of trauma issues or whether group interventions were appropriate.

Courtroom Processes

Treatment progress was a focus for MHTC case discussions. Decisions on client progress were made collaboratively by the treatment team, with the judge serving as the final arbitrator when necessary. The judge participated in all of the status review hearings. Judicial interactions with the clients were reported and observed to be were positive, individualized, and direct. The court frequently used recovery-sensitive language and encouraged clients to be active participants in their hearings. Clients reported being held accountable by the team and clients participated in their hearings. However, client feedback was divided about whether the judge makes supportive comments during their hearings, lets them tell their side of the story, or has all the facts available to make good decisions. Further, the majority of MHTC cases were heard for less than three minutes in court, and there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members, with mental health representatives sometimes absent from court when they were needed. Additionally, both team members and clients were somewhat neutral about whether the court encourages family and prosocial supporters to participate in the process.

During court hearings, more recognition and incentives than sanctions were observed. It appeared that the staff were attempting to reinforce clients even when clients were struggling. Team members shared that sanctions were graduated, individualized and matching the severity of the infraction, but were divided about whether jail time was used as a sanction sparingly and after other sanctions have been tried. There was some feedback that jail actually impeded the ability of clients to efficiently obtain medication and stabilization. Additionally, some team members thought sanctions and incentives were administered inconsistently between different clients, possibly due to individualizing sanctions and incentives to diverse clients, as well as lacking formal guiding documentation about the application of sanctions and incentives.

Programmatic Structure

Identified strengths of the MHTC included collaboration and communication between strong staff and partners, facilitation and accountability for effective treatment, and a client-centered approach. Identified weaknesses included insufficient mental health resources to meet the demand, and caseloads may be too high in some agencies. Additionally, team members expressed challenges in agreeing on criteria for MHTC clients, and in attaining adequate assessment of whether clients meet criteria. Further,

team members identified that the informed consent process could be made more understandable to clients; clients were divided about whether they had a choice to participate in MHTC.

Team members largely agreed that implementing a phasing structure would be beneficial, yet also challenging due to widely varying levels of functioning among MHTC clients. Suggested solutions included defining criteria for phase levels that reward client effort and are based on client progress above their baseline. Team members also identified various foci and elements of phase structures that could be beneficial to implement which are detailed in the report.

Drug testing procedures were reported to be valid, reliable, random, unpredictable, rapid, comprehensive, and largely within best practices. The only potential improvement was tests that measure drug use over extended time periods should be applied for at least 90 days and stakeholders reported this sometimes occurs.

Clients and team members indicated that some support was provided to prepare clients for program completion, yet the support was seen to be inadequate by counselors and team members, especially for housing and employment needs.

RECOMMENDATIONS

The lack of clear guiding principles for MHTC in the research literature creates challenges for MHTC teams; however, the research that does exist across other domains lends to the following conclusions/recommendations:

1. The court reported a lack of documentation of policies and procedures specific to the MHTC. There were also largely conflicting perceptions on how well various processes within the MHTC work, and how they should work, which is likely a result of having unstructured processes. It is recommended that the court consider compiling a written policies and procedures manual that reflects elements of the following:
    a. The court's background
    b. Objectives and goals
    c. Target population
        i. Eligibility and suitability criteria
    d. Intake procedures
        i. Guidelines to assess client competency and attain consent so that clients perceive a choice.
        ii. How diagnoses are to be determined in a valid and reliable way (e.g., through use of standardized instruments agreed upon by the team, and by securing adequate time with the client to conduct such assessments)
        iii. Treatment determinations - Formalize a decision tree about which treatment program a client is referred to.
    e. Treatment requirements
        i. What aspects of treatment plans and progress are to be supervised by the court, and how.
        ii. Duration minimum and maximum for MHTC involvement.
    f. Sanctions/incentives protocols
    g. Graduation requirements
        i. Guidelines for phasing clients through MHTC
    h. Narratives on team members' roles and responsibilities
    i. Orientation and training procedures for new team members

    This could be conceived as the primary overarching recommendation for this evaluation, as achieving this recommendation would likely address several areas of the evaluation. For example:
    a. There was indication that the assessment process was creating barriers for the clients. In particular, there was a reported lack of a standardized process, and a lack of sufficient time spent with clients during assessment, that led to differences of opinion between team members and treatment providers, and multiple clients being incorrectly referred or placed into MHTC. Additionally, there was some indication that attaining access to a psychiatrist and getting on medication sometimes took a long time, delaying clients' recovery. The team may benefit from exploring ways in which a standardized assessment process can be approached, including advocating for using validated and evidence-based assessment tools in determining client diagnoses. In addition, the court could explore how to secure sufficient time for client assessments, obtain physical copies of client assessments, and expedite client access to psychiatrists when needed. By targeting these improvements in understanding the target population and addressing issues with the assessment process, it may help the team to connect clients with appropriate treatment quicker, reduce confusion between the team and potential referral sources, and reduce the load on the mental health teams conducting the assessments by decreasing the number of inappropriate referrals.
    b. There were competing values on the team of whether sanctions should be flexibly individualized or applied consistently between different clients with the same behavior. Both values could be met by providing guiding documents which explicitly allow for ranges in consequences for specific behaviors based on individual client considerations at distinct phases in the program. Team members also suggested keeping track of the receipt of sanctions and incentives over time to see trends for each client. Further, team members suggested broadening the array of sanctions and incentives that are used. Adding more incentivizing options, such as reinstating the use of stickers, could serve to reinforce and motivate clients better and decrease the need for sanctions.

Conversely, expanding sanction alternatives, such as those involving increased treatment, could provide the team with more options to use before jail, as the literature does not support the use of jail as a stabilization mechanism. The creation of a guiding document could serve as a springboard for the team to brainstorm additional options for sanctions and incentives.

c. There appeared to be a need for better communication regarding client progress across team members and agencies/organizations. This includes achieving better attendance for treatment representatives, and collecting more than superficial information on clients. It is important to note that, in prior years, there was a concern that unimportant information was being disseminated in a time-consuming fashion, but also that not everyone was providing information to the team. Again, this points to the need to establish set criteria for what is of interest to the court, so as to be sure to exclude extraneous information that is time consuming and irrelevant to the supervision of the team on the client, but to be sure to include enough information to effectively supervise the clients. This could even take the form of a face sheet/checklist that generally guides what good information may be helpful to pass on to the team. For this to be effective, treatment representatives will need to be present in court when needed, and the team might benefit from attempting to address any structural challenges that lead to treatment representatives not being present, for instance by advocating for more manageable caseloads for some treatment providers, improving communication regarding client cases for team members that are unable to consistently attend MHTC, or exploring if alternative representatives would be available to attend team meetings and court hearings.

d. Phasing is a best practice in other treatment courts and several successful MHTCs use phasing to conceptualize, structure, and reward client advancement through the MHTC. Team members generally agreed that implementing phasing would be beneficial, though challenging due to the wide range in MHTC client abilities and diagnoses. Suggested solutions generally involved defining criteria for phase levels that are flexible to different client ability levels, such as: commitment to treatment, client engagement, client stability, client personal life improvement, mastery of curriculum material, and client goals and progress measured against client baselines. In addition, team members suggested it would be beneficial to define what the team means by "doing well" at different phases, outline the consequences for specific behaviors for clients in different phases, and build more after-care supports into the last phase of the program. Several additional suggestions for foci of the phases and practices surrounding phasing can be found in the Program Structure section of the report as well as in Appendix B.

2. It is worth noting that clients' reports of their relationship with the team and their treatment providers is decidedly neutral and not overwhelmingly positive. This could be the result of many things, but the practice of not seeing all clients for three minutes, and in particular not spending time in court at all with clients on the "A list," may be contributing to clients' perceptions. One of the cornerstones of treatment courts is judicial interaction, and thus taking this aspect away is likely to deteriorate court-client relations. Additionally, behaviorism theories reliably tell us that when individuals desire attention but do not receive it, they are likely to act out in negative ways to obtain this attention; by giving less attention to clients who are doing well, the team may be perpetuating a cycle whereby clients will self-sabotage in order to get recognized and feel cared for again. Spending time with all clients would give the team more opportunities to praise pro-social activities, check in with clients about their progress, and remind clients of the importance of complying with program requirements. It is recommended that the court cease the process of not spending time with clients who are doing well, and focus on establishing agreed-upon methods of functioning within MHTC; this could enable the team to spend less time negotiating processes and more time promoting positive alliances with the MHTC clients themselves.

3. There were differences in opinion among team members as to how effective the court was at reducing recidivism, and team members seemed to be making these assessments anecdotally. It may benefit to the team to conduct an outcome evaluation to determine client outcomes and if there are common factors among those who are recidivating or succeeding.

Introduction

WHAT ARE MENTAL HEALTH COURTS?

Mental health courts (MHCs) are a recent and rapidly growing part of the problem-solving court movement that includes drug courts, community courts and other specialized courts (Council of State Governments, 2005). Over the last several decades, rates of incarceration and recidivism among offenders with mental illness have steadily increased (Thompson, Osher, & Tomasini-Joshi, 2007). Seeking to reduce this disproportionality, MHCs combine elements of criminal justice and mental health treatment to address the unique rehabilitative needs of these individuals (Denckla & Berman, 2001). By replacing the traditional role of the courts with a model of therapeutic jurisprudence, MHCs seek to address underlying causes of criminality and recidivism by way of coordinating treatment goals in order to stabilize client mental health symptomology. MHCs operate under the knowledge that mental illness and criminogenic factors are not correlated, and that disentangling the mental illness and criminogenic factors to treat both factors separately are the most effective ways to assist mentally ill clients.

Traditional courts have typically failed to address the unique challenges at the intersection of mental illness and criminal justice. Unable to identify the mental health needs and appropriate treatment for offenders with mental illness, judges instead rely on standard sentencing options that send these individuals into crowded jails and prisons (Denckla & Berman, 2001). Once incarcerated, access to appropriate treatment is rare and ineffective, and the mental health conditions of these individuals often worsen in prison (Goldkamp & Irons-Guynn, 2000). Following the stress of incarceration, these individuals are released without being connected to the community treatment programs and support systems they need to avoid committing further offenses. This failure to address the unique needs of individuals with mental health needs within the criminal justice system has resulted in alarmingly disproportionate rates of incarceration and recidivism for these individuals (Lamb, Weinberger, & Gross, 1999; Watson, Hanrahan, Luchins, & Lurigio, 2001).

MHCs seek to reduce these disproportionate outcomes by utilizing alternative sentencing and effective treatment methods that address the mental health needs of individuals involved in the criminal justice system that have persistent and identified mental health needs. Under the guidance of the judge, a streamlined and collaborative team of prosecutors, defense attorneys, and mental health service agencies work together to provide eligible clients with community-based mental health treatment programs in lieu of incarceration (Thompson et al., 2007). Interagency cooperation and thorough judicial monitoring of program participation allow priorities of public safety to be met while simultaneously addressing the underlying problems contributing to the criminality of these individuals (Goldkamp & Irons-Guynn, 2000). By limiting the damaging experiences of confinement and providing clients with the option to undergo restorative treatment, MHCs address the root causes of recidivism and incarceration of the mentally ill.

WHO ARE MENTAL HEALTH COURT CLIENTS?

While MHCs do not share a universally agreed-upon or evidence-based target population, researchers assert that the majority of such treatment courts focus on individuals with a diagnosed mental illness that experience functional impairments related to their symptoms (Blandford, Fader-Towe, Ferriera, & Greene, 2015). Often, MHC populations are referred to as experiencing either a severe and persistent mental illness (SPMI) or a serious mental illness (SMI; also referred to as a severe mental illness). MHC researchers have suggested that teams examine the distinctions between these populations as well as the MHC's available treatment resources, and make decisions on what type of population their MHC should serve based on this collection of information (Blandford et al., 2015).

MHC populations typically comprise either SMI and/or SMPI populations of mental health clients that are involved in the criminal justice system. (This may also be expressed in terms of clients with identified mental health needs and criminogenic risk factors when discussed within the literature and MHC research). However, the distinction between SMI and SPMI populations is often confusing and not explicit. Researchers have suggested that the delineations between the two terms have been more reflective of legal and policy-related forces, each definition with its own political history behind it (Torres, 2003). In particular, the assertion has been made that SMI and SPMI were designations constructed in order to aid states in providing funding for mental health programs for individuals affected by debilitating mental conditions, by way of defining mental health eligibility criteria. In addition, there have been differences found within policy (e.g., which informs eligibility for treatment provision) and scientific research definitions (e.g., which informs treatment efficacy). Furthermore, each individual state can create differences in their legal and policy-related definitions of SMI and SPMI.

In 1993, the Substance Abuse and Mental Health Services Administration (SAMHSA) established the following criteria to define a person with SMI: (1) 18 years old and older; (2) currently or within the last year; (3) was diagnosed with a psychiatric disorder in the Diagnostic Statistic Manual (DSM, 3rd edition, revised); (4) which "resulted in functional impairment which substantially interferes with or limits one or more major life activities." (SAMHSA, 1993, p. 29425). The federal register goes on to explain: "These disorders include any mental disorders…listed in the DSM-III-R…with the exception of "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. All of these disorders have

episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects." The federal register also goes on to explain functional impairments: "Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts." In California, the California Mental Health Parity Act focuses exclusively on diagnostic criteria, and defines SMI as being either: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa (Health care coverage: Mental illness, Assemb. B. 88, 1999).

In the 1990's, the National Institute of Mental Health (NIMH) released their supposition of what would constitute an SPMI. Various secondhand sources have cited a 1987 document that outlines these criteria, though this document is not widely available. Other sources have pointed to a 1993 article that is also not readily available. While NIMH itself does not provide an easily accessible definition of SPMI, the consensus of various secondhand sources is that NIMH has asserted the following definition of SPMI: a DSM-diagnosed mental illness; the mental illness is severe and recurring (e.g., long-term); the mental illness causes functional impairments in multiple areas of functioning (in specific areas identified within their criteria); and has either been hospitalized or received residential treatment care (Parabiaghi, Bonetto, Ruggeri, Lasalvia, & Leese, 2006; Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000; Torres, 2003). Some psychological researchers have also suggested a more operationalized definition of SPMI, such as determining a time duration cutoff (i.e., two years) and a GAF score cutoff of 50 or lower (Ruggeri et al., 2000). However, it should also be noted that within the psychological research, researchers sometimes use the terms SMI and SPMI interchangeably, further complicating the issue of distinction.

The Center for Prevention and Health Services more recently published a document distinguishing SMI from SPMI by virtue of SPMI being more severe and significant of impairments experienced (Finch & Phillips, 2005). This distinction appears to be corroborated by the definitions themselves. It can be observed in the differences in the SMI and SMPI definitions that duration and severity are focal points of the SPMI criteria; SPMI is focused on persistent and long-term mental illnesses, versus being inclusive of potential mental illnesses that present short-lived challenges at a given time in a person's life, and also indicates that significant impairments caused by the mental illness need to be demonstrated by way of more severe criteria being met.

In addition, it should be emphasized that a diagnosis of a legally qualifying mental illness does not in itself indicate that the person is experiencing functional impairments that may necessitate the level of services that rise to that of an MHC or other intensive treatment. MHC team members should be mindful that SMI and SPMI definitions have been created for the purpose of assisting in access to treatment, but that actual treatment services provided should be guided by symptom presentation and functional impairments of individual clients versus a rote diagnosis. Furthermore, in accordance with some of the definitions of SMI and SPMI provided above, a diagnosis itself that falls within the SMI or SMPI eligible range does not mean the person immediately qualifies as experiencing an SMI or SMPI; by being guided by a diagnosis-based criteria for eligibility, an MHC will likely inadvertently capture many clients who do not require (and could be harmed by iatrogenic effects of) more intensive services such as that provided by an MHC. MHCs should be mindful of the difference between the definitions of SMI and SPMI, especially when designating treatment for individuals with specific diagnoses. MHCs may benefit from focusing more on the psychological aspect and functional impairments, as doing so would avoid inaccurately placing clients in an MHC when their appropriate level of care is a lesser program (i.e., DDX).

GUIDING PRINCIPLES OF MENTAL HEALTH COURTS

As of 2005, The Council of State Governments asserted that establishing a set of best practices for MHCs was in its infancy and not yet a realistic goal (The Council of State Governments, 2005). However, there are several documents from various MHCs across the country and other authoritative government agencies that document sets of principles in implementing MHCs that should be considered when implementing and evaluating MHCs. In addition, evidence-based practices in related fields are useful to examine while the literature specifically on Mental Health Treatment Court (MHTC) expands. Because the documents often vary widely in nature and scope, an attempt to synthesize the information from these documents will not be recited here. Instead, these documents will be cited throughout the present evaluation and in the appropriate corresponding sections in order to further facilitate an understanding of the findings from the report.

SANTA MARIA MENTAL HEALTH TREATMENT COURT

The Santa Barbara County MHTC in Santa Maria was established in 1999. MHTC is a post-plea program for adults charged with a misdemeanor or felony who have been diagnosed as experiencing a SPMI. Clients are generally *in*eligible if they have been charged with a violent crime, the distribution of drugs, or a sex crime (though there is some room for professional discretion in determining eligibility). In additional to meeting eligibility criteria, clients must be determined suitable by the treatment team, which includes the judge, prosecutor, defense attorney, probation officer and treatment provider. The target population has been defined as an individual meeting the criminal qualifications who also exhibits an impeding SMPI. There are MHTC programs in North and South Santa Barbara County (Santa Maria and Santa Barbara), though the focus of the present evaluation is on the North County's MHTC.

The program does not have a phase structure or time limit beyond the minimum of 12 months; client time in the program is dependent on need and treatment progress.

Purpose

The purpose of a process evaluation is to assess the procedural aspects of a given program and provide feedback for teams to better understand their strengths and weaknesses. However, the goals and aims of each process evaluation will differ based on program type, and will further be directed by the purpose of the evaluation. For the present process evaluation on the Santa Maria MHTC, there were four broad goals:

1. **Assessing adherence to best practices/guiding principles** in the chosen areas of focus for the process evaluation of Santa Maria's MHTC. For this report, this will be focused in the areas of Treatment, Courtroom Processes, and Programmatic Structure.

2. When best practices/guiding principles are not available in relation to MHCs, **best practices/guiding principles in related areas of the literature will be utilized** in providing recommendations and areas for potential growth.

3. Providing more **in-depth coverage** of the substantive areas chosen for investigation, beyond adherence to best practices.

4. Due to the lack of overall literature on phase promotion specifically within the literature of MHCs, as well as the wide variation of implementation of programmatic structure in general within MHCs across the country, the evaluation will focus on a **preliminary investigation of how various aspects of Santa Maria's program could be strengthened with the implementation of various structures and guidelines** to be made more clear as clients progress through the program. Recommendations will be made based on the feedback from the team, their strengths and weaknesses, the literature on other related disciplines on similar topics, and what steps might be most beneficial given all of this knowledge.

Methods

MODULES

Treatment court process evaluations conducted by the UCSB Evaluation Team have historically examined a large number of factors present within the treatment courts, across most of the best practices and guiding principles within the specific type of court that was being investigated (i.e., SATC, MHTC). However, for the present and future reports, the process evaluations will mostly focus on a module approach, whereby specific program aspects are investigated more in-depth; in this way, breadth is being passed over in favor of depth. Modules are chosen by Santa Barbara County Probation department, in conjunction with the UCSB Evaluation Team, based on past observed team needs and areas of interest for further expansion within the evaluation.

In the present report, Module 2 (Treatment), Module 3 (Courtroom Processes), and Module 4 (Programmatic Structure) were chosen for investigation in Santa Maria's MHTC. All of the modules are displayed below for reference; however, only Modules 2, 3, and 4 will be evaluated in the present report.

MODULE 1: PROGRAM ENTRY	
1A.	Target Population
1B.	Case Referral Process - *General perceptions* - *Arrest to treatment-court-referral* - *Treatment-court-referral to treatment entry*
1C.	Eligibility & Suitability

MODULE 2: TREATMENT***	
2A.	Treatment and Social Service Availability
2B.	Treatment Determinations
2C.	Treatment Plans
2D.	Diversity in Treatment - *Gender-specific practices* - *Culture-specific practices*
2E.	Treatment Agency Practices

MODULE 3: COURTROOM PROCESSES***	
3A.	Team Meetings - *Case discussions* - *Decisions* - *Team processes*
3B.	Courtroom Hearings - *Proceedings* - *Clients* - *Participating stakeholders* - *Judicial interactions*
3C.	Sanctions & Incentives

MODULE 4: PROGRAMMATIC STRUCTURE***	
4A.	Phase Progression - *Phase promotion structure and sequence* - *Phase promotion requirements*
4B.	Preparations for Program Completion
4C.	Graduation/Termination
4D.	Census and Caseload

MODULE 5: STAKEHOLDER ROLES	
5A.	Team Member Roles *- Judge* *- Coordinator* *- District Attorney* *- Public Defender/Defense Attorney* *- Bailiff* *- Community law enforcement* *- Probation* *- Substance abuse treatment provider* *- County mental health* *- Other mental health providers* *- County psychiatrist/psychologist*
5B.	Team Member Training *- Recent team transitions* *- Professional training* *- Preparations for working on the treatment team* *- Suggestions for preparations for working on the treatment team*
5C.	Treatment Counselor Roles and Training *- Formal education and trainings* *- Training for working with criminal justice-involved populations* *- Training for working with clients in the treatment court*

MODULE 6: NON-TRADITIONAL CHARACTERISTICS	
6A.	Necessary Attitudes *- Attitudes toward non-adversarial approaches* *- Attitudes toward mental illness (if applicable)* *- Attitudes toward substance abuse (if applicable)*
6B.	Family Involvement
6C.	Community Support

MODULE 7: TREATMENT COURT RELATIONSHIPS	
7A.	Team Relationships and Functioning *- Team cohesion* *- Court and treatment relationships*
7B.	Therapeutic Relationships *- Team and client relationships* *- Treatment and client relationships*

MODULE 8: TREATMENT COURT PERCEPTIONS	
8A.	General Perceptions of the Treatment Court
8B.	Team Member Perceptions of the Treatment Court *- Perceived strengths* *- Areas of improvement*
8C.	Treatment Perceptions of the Treatment Court *- Impact on clients* *- Experiences with the treatment court*

MODULE 9: ADMINISTRATIVE PROCESSES	
9A.	Policies and Procedures *- Team cohesion* *- Court and treatment relationships*
9B.	Use of Data Collection and Evaluation* *- General considerations* *- Historically disadvantaged groups* *- Eligibility criteria* *- Program retention* *- Treatment* *- Incentives and sanctions* *- Recidivism* *- Sentencing dispositions*

***Modules being evaluated in the present report.**

DATA COLLECTION

Data were collected in nine ways: 1) observations of team staffing of client cases; 2) observations of corresponding courtroom proceedings of status review hearings; 3) interviews with MHTC team members; 4) survey responses from MHTC team members; 5) a focus group of team members regarding MHTC adherence to guiding principles; 6) a review of MHTC administrative documents and data; 7) consumer surveys with MHTC clients; 8) interviews completed by treatment representatives at treatment agencies serving MHTC clients; and 9) survey responses from treatment representatives at treatment agencies serving MHTC clients. Three types of instruments were used: observation measures (two to assess the process of the team staffing prior to the court session and two to assess the court process itself), self-report instruments (a structured survey and a semi-structured interview for MHTC team members and treatment counselors, a structured survey for MHTC clients, a structured focus group survey to assess adherence to guiding principles), and an administrative data review (to assess adherence to guiding principles and best practices). By obtaining information from multiple sources we were able to provide stronger documentation of program activities.

MEASURES

Measurement tools were used to systematically observe team meetings and courtroom hearings and to obtain open-ended and survey information from various stakeholders. Instruments were adapted from various studies and existing measures, and were developed to meet the goals of this report. Specifically, the measures were chosen and modified with the intention of providing multiple sources of information on the extent to which the program adhered to the guiding principles and best practices related to mental health court functioning.

Team Meeting Observations

Formalized observations of the MHTC team's staffing were conducted by the program evaluators in order to describe the staffing process. Areas noted included time spent talking about each of the clients, the topics discussed, and observer perceptions of team cohesion.

Instrument

An instrument was adapted from several sources in the treatment court literature (e.g., drug court; Carey, Mackin, & Finigan, 2012a; Cumming & Wong, 2008; Giacomazzi & Bell, 2007; Rossman, Roman, Zweig, Rempel, & Lindquist, 2011a; Salvatore, Henderson, Hiller, White, & Samuelson, 2010). The instrument was used to assess time spent discussing each case, as well as the content of the discussions; evaluators noted whether or not the team talked about client progress in various areas of functioning, case management, vocational and educational goals, drug urine analyses (negative and positive), sanctions, and incentives. Researchers also coded who made final team decisions.

Data Collection

Data were collected over two days of team meetings in Santa Maria. Meetings were observed at the Santa Maria courthouse. Three researchers attended each staffing. Researchers remained as inconspicuous as possible during their observations. Team meetings typically ran from 9 a.m. until 11 a.m. Additional staffings were completed during court hearings as needed

During the team meetings observed, case discussions about other treatment court clients were interspersed with those of regular MHTC clients. Data presented in the current report only reflect MHTC cases and do not include clients from other treatment courts.

Courtroom Observations

Standardized observations of the courtroom process were conducted by the program evaluators in order to describe the status review process. Information was recorded on time spent on each client; client characteristics; judicial interactions with clients; and the use of sanctions, recognition, and incentives with clients.

Instrument

One instrument was used to capture information on the court proceedings. This instrument was adapted from the literature on best practices in Drug Courts (Carey et al., 2012a; Cumming & Wong; 2008; Rossman et al., 2011a; Rossman, Roman, Zweig, Rempel, & Lindquist, 2011b; Satel, 1998), with one instrument used to record information for each client. Variables recorded included time spent on each case, case characteristics, judicial interactions with the client, client behavior in court, recognition of client noncompliance and compliance, and the use of sanctions and incentives.

Data Collection

Data were collected over two days of status review hearings for the MHTC in Santa Maria. Court hearings ran from 11 a.m. to 12 p.m. and then resumed after lunch recess and continued through the afternoon. Similar to the team meeting observations, data presented in the report are for MHTC clients only and do not include cases from other treatment courts.

Interviews & Surveys

The UCSB Evaluation Team studied the MHTC team members' perceptions of the MHTC team and the MHTC process in Santa Maria. In order to capture this information, an interview protocol and survey were adapted. Interviews and/or surveys were conducted with mental health court team members, treatment counselors, and mental health court clients.

MHTC Team Members

A semi-structured interview of the MHTC process was conducted with each team member, with each team member also completing a corresponding survey. Across these measures, respondents were asked about how well different aspects of the court process function. They were also asked about the strengths of the program and areas they would like to see improved.

Interview questions were derived from two sources; some items were adapted from NPC Research (2006) interview protocols designed for drug court process evaluations, others were developed from National Association of Drug Court Professionals (NADCP, 2013; NADCP, 2015), and other items were created for the purpose of evaluating local mental health treatment court processes within Santa Barbara County. The adapted protocol contained 13 questions on team members' perceptions of the MHTC, roles of the different team members, how well different aspects of the MHTC process functioned, what team members thought about implementing a phase structure, and suggestions for program improvement.

A total of 12 collaborative court team members of the Santa Maria MHTC were interviewed for this report. A majority of the interviews were conducted during lunch on an of the observation day (December 2016), or prior to the team focus group (January of 2017). All of the interviews took place at the Santa Maria courthouse or in the offices of treatment program representatives. Research assistants obtained informed consent from each team member and attempted to conduct the interviews in private locations. Interviews ranged from 20 to 60 minutes in length.

A survey protocol was adapted from three scales by Hiller and colleagues (Hiller, Unpublished; Hiller, et al., 2010; NPC Research, 2006) and an MHTC document by the Council of State Governments Justice Center (Blandford et al., 2015). The survey was created to assess various aspects of the MHTC process, attitudes about MHCs in general, and attitudes toward implementing a phase structure. Several questions in the surveys created from Hiller and colleagues were modified to reflect the MHTC model. In addition, several questions were created for the purpose of this evaluation in order to assess adherence to aims, scopes, and purposes of the MHTC model. Questions about phase structure were derived by extracting common elements of existing MHC's around the country that use phasing. The adapted survey contained 86 questions. Forty questions solicited agreement ranging from *1= Strongly Disagree* to *5=Strongly Agree* and also allowed the option of *DK=Don't Know.* Three questions asked whether the MHTC currently has a phase structure, and 43 questions asked about whether various practices associated with MHTC phasing currently exist or might be beneficial for this MHTC.

A total of 18 team members involved in the MHTC completed the survey. Surveys were distributed to the team members prior to the in-person interviews, and were completed at various times before and after the in-person interviews took place, but within the same two-month period as the interviews were conducted. Research assistants obtained informed consent prior to surveying each team member and made every attempt to facilitate the team members completing the surveys in private locations.

Treatment Counselors

Semi-structured interviews assessing treatment counselors' perceptions of the MHTC process were conducted with treatment counselors who worked with MHTC clients or represented treatment programs to the MHTC. Treatment counselors also completed a corresponding structured survey. Respondents were asked about aspects of the court process, aspects of their treatment agency's protocols with MHTC clients, and their perceptions of how MHTC benefits their clients. They were also asked about the strengths of the program and areas they would like to see improved.

The interview protocol was created for the purpose of the present evaluation, and consisted of 13 questions. The survey was constructed from various different sources (Blandford et al., 2015; Hiller et al., 2010; National Association of Drug Court Professionals (NADCP, 2013; NADCP, 2015) and tapped into perceptions of the MHC program and structure and specific treatment practices. The survey consisted of 16 questions. Every question solicited agreement ranging from *1= Strongly Disagree* to *5=Strongly Agree,* or *DK=Don't Know*.

A total of five treatment counselors serving clients in the Santa Maria MHTC were interviewed for this report. All of the interviews were conducted in person though one started in person and was finished over the phone due to scheduling. Interviews ranged from 20 to 45 minutes in length. Four people completed only the survey, for a total of 9 respondents on the treatment counselor survey. Research assistants obtained informed consent from each treatment counselor.

Drug Testing Survey

As not all MHTC clients have substance abuse issues, and only a subset of team members and treatment counselors were familiar with drug testing procedures for the MHTC clients, only those who identified themselves as familiar with drug testing were surveyed about drug testing. A separate drug testing survey was developed from National Association of Drug Court Professionals (NADCP, 2013; NADCP, 2015) asking about various best practices in the area of drug testing. The survey consisted of 14 questions. Twelve questions solicited agreement ranging from *1= Never* to *5=Always,* and two questions were opened ended and asked about the time between the drug test and communication about the drug test to (1) the client and (2) the team. The survey is attached in Appendix C.

A total of nine treatment counselors and team members serving clients in the Santa Maria MHTC were surveyed about drug testing, either before or after they were interviewed. Research assistants obtained informed consent from each treatment counselor and team member.

Consumer Surveys

Data were collected from the drug court clients relative to their perceptions regarding the quality of their interactions with team members, communication between themselves and the MHTC team, fairness and equality in treatment and consequences, and their understanding of the process. MHTC clients were surveyed as part of their Probation check-in procedures at the kiosks in the Probation Department. Clients' responses reflected in the current report were collected by Probation during December 2016 through January 2017.

The consumer survey instrument was adapted from National Association of Drug Court Professional's (NADCP) 2013 best practices document, in order to address adherence to specific best practices that are best addressed by the clients themselves (e.g., perceptions of judicial interactions). The instrument also included questions for the purposes of the evaluating client perceptions of MHTC functioning, satisfaction with court proceedings, MHTC assistance in preparing the client for program completion, and perceived relationship with the MHTC team and treatment program.

Responses were available for 13 MHTC Clients in Santa Maria's program. The ethnic breakdown of the clients was as follows: 85% Hispanic, and 15% White. For over half (64%) of MHTC clients, it was their first time in any treatment court program, while this was the second time going through a treatment court program for 9% of clients, the fourth time for 9% of clients, and the fifth or more time for 18% of clients. About half of the clients (56%) surveyed had been in the MHTC program for less than six months. It is important to note that, while 13 clients were surveyed, not all clients answered every question (i.e., there are not 13 responses for every question).

Focus Group

A structured focus group was conducted with all ten members of the MHTC team in order to assess the team's adherence to guiding principles in the field and best practices in other treatment court fields. Each of these principles was discussed, and adherence was evaluated in part based on the team's responses. Some questions were created for the purpose of the present evaluation, while other questions were derived from known best practices in drug courts (i.e., Carey, Mackin, & Finigan, 2012c; NADCP, 2013; NADCP 2015).

Treatment

Treatment is a critical component of the MHC process. For this reason, it is important to review the way treatment agencies and the MHTC make client treatment determinations and treatment plans, diversity options in treatment, and specific treatment agency practices.

TREATMENT RESOURCES

The literature on working with clients who have a serious mental illness in general suggests an emphasis on addressing multiple domains of a client's life by utilizing such methods as therapy, social skills training, multimodal functional model, therapeutic contracting model, case management, family interventions, and support groups (see Hunter, & Corrigan, 1997). In addition, although MHCs target individuals with severe and persistent mental illnesses, many also often have co-occurring substance use problems. In the instance of these clients with co-occurring disorders (CODs), integrated treatment for both disorders is recommended (Council of State Governments, 2005; SAMHSA, 2009). Integrated treatment that is applied with fidelity includes the following components: (a) use of a multidisciplinary team to address the client's issues; (b) treatment staff trained in integrated treatment; (c) stage-wise interventions (based on client factors); (d) access to comprehensive services (residential housing, supported employment, family interventions, symptom management, recovery support, assertive community treatment); (e) time-unlimited treatment (based on client need); (f) case management and outreach to additional services as needed; (g) motivational interventions; (h) substance abuse counseling; (i) co-occurring disorders group treatment; (j) family interventions; (k) community-based substance use self-help groups; (l) medication; (m) promotion of client health; and (n) referrals to secondary interventions for clients who do not initially respond to co-occurring interventions (SAMHSA, 2009).

In essence, treatment for MHC clients needs to be comprehensive, varied, and wide-ranging in order to effectively address the clients' multiplicity of presenting problems. In order to investigate the extent to which there were varied modalities of treatment available for the clients, team members were surveyed about MHTC clients' access to resources (see Table 1). Team members appeared split on the extent to which there were a wide array of resources that clients could access that would meet all of clients' identified needs. However, there was general consensus that high quality substance abuse treatment *is* available and high quality housing *is not* available to clients.

Table 1. MHTC team members' perceptions of client access to various treatment resources (*n* = 17-18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The treatment court has a rich network of treatment resources.	12%	18%	24%	35%	12%	0%
Clients receive services for all areas where needs have been identified.	6%	28%	33%	28%	6%	0%
Sufficient high-quality services are available to treatment court to address the following needs: a. Housing assistance	24%	35%	18%	18%	6%	0%
b. Mental health treatment	12%	18%	12%	29%	29%	0%
c. Trauma-informed services	6%	12%	24%	41%	18%	0%
d. Criminal thinking interventions	6%	12%	24%	47%	0%	12%
e. Family or interpersonal counseling	12%	12%	35%	35%	0%	6%
f. Vocational or educational services	18%	6%	41%	35%	0%	0%
g. Medical or dental treatment	24%	12%	29%	24%	0%	12%
h. Substance abuse treatment	6%	0%	0%	53%	41%	0%

Team members were interviewed about client needs that are currently unmet through MHTC (Table 2). Most team members agreed that there were unmet needs, with only one team member stating that needs are generally met. Several team members indicated that there are not enough mental health services or staff, and as a result mental health representatives are not always in court, not all potential clients receive sufficient services, and many clients with mild or moderate mental health symptomology go untreated until their mental health needs become more severe. In addition, one team member shared that clients might benefit if there were more drug treatment programs that were tailored specifically for clients with significant mental health issues.

Team members also identified several other areas of need that are not met by current services, including: housing, vocational, educational, access to the appropriate medication, and trauma-specific services (e.g., for PTSD, domestic violence, sexual trauma).

Table 2. MHTC team members' qualitative responses to the question, "Are there client needs that are not met by currently available services?" (*n* = 12).

Response Categories	Descriptions
Mental health services	▪ Some treatment providers are spread thin and are not always in attendance at court when they are needed (particularly BeWell) ▪ Disagreements about criteria for MHTC and treatment leaves some clients not receiving treatment ▪ More mental health prevention for mild and moderate mental health issues or smaller crimes ▪ Drug treatment tailored for mental health population
Other services	▪ Housing ▪ Vocational ▪ Educational ▪ Medications out of custody ▪ Medications while in custody ▪ Transportation ▪ PTSD treatment ▪ Domestic violence treatment ▪ Sexual trauma treatment
None	▪ None

TREATMENT DETERMINATIONS

This section describes perceptions regarding how MHTC client treatment determinations are made in the program.

Feedback: MHTC Team

Feedback from the MHTC team members on the extent to which client treatment is based on need can be found in Table 3. The majority of team members either agreed that treatment was based on the client's level of need; however, almost 40% of team members disagreed or were neutral about this statement. This suggests that some team members may believe other factors contribute to deciding a client's treatment, including availability.

Table 3. MHTC team members' perceptions of how treatment determinations are made (*n* = 17 – 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Client treatment is decided based on the client's level of need (vs. availability or other factors).	6%	6%	28%	56%	6%	0%

MHTC team members were asked about the strengths and weaknesses of the process of assessing client diagnosis (Table 4). Some team members shared that the current process works well and that a particular strength is the quality of the clinicians working with clients. There were also strengths relating to working with clients in custody, such as being able to see the clients in-custody frequently to conduct assessments or drug tests, and how the team has streamlined the transfer of medications from jail to community treatment. Some challenges that were noted were related to clients being in custody, such as difficulty in the diagnostic assessment process due to limited time available with the client (i.e., 10-15 minutes per visit), not being able to bill for a full assessment, concerns that clients in custody might sometimes dramatize their symptoms in order to be released, and that good rapport can be difficult to achieve with clients who are being detained.

There were also several comments from the team about the differences in perspective in determining eligibility for treatment, such as whether clients display severe and persistent mental health issues, what are the clients' diagnosis and needs. Additionally, it was noted that there is a greater need for mental health treatment in the community than there is a supply of providers, creating a triage situation. However, one team member shared that the team has been making progress regarding determinations of eligibility and treatment needs recently.

Other challenges shared included communication issues; sometimes mental health is not present in court when they are needed, and information about clients from treatment staff in jail is not always communicated to the court. In addition, other courts and lawyers don't always understand MHTC eligibility and send clients who do not qualify. One team member shared that the process of getting a client assessed and established in treatment takes longer than it could, and another staff members shared that a challenge for the team is high turnover. Two team members expressed not being sure about this question.

Table 4. MHTC team members' qualitative responses to the question, "What are the strengths and weaknesses to the process of assessing client diagnosis?" (*n* = 12).

Response Categories	Descriptions
It works well	▪ Assessment and treatment works ▪ Good clinicians
In-Custody strengths	▪ Able to see client frequently when in custody to assess and drug test ▪ Streamlined transition from jail to community treatment for medications
In-Custody challenges	▪ Difficult to assess client in custody - only 10-15 minutes ▪ Can't bill for full assessment if client is in custody ▪ Sometimes clients dramatize symptoms to try to get out earlier ▪ Difficult to get rapport with clients in custody
Eligibility for Treatment	▪ Disagreement regarding assessment and treatment ▪ Criteria for severe and persistent mental health is difficult to assess and agree upon ▪ Assessment process isn't standardized so disagreements arise between treatment programs regarding clients' diagnostic eligibility ▪ Disagreement between mental health programs and team members about whether clients should stay in treatment ▪ Assessing and getting treatment established takes too long ▪ More agreement about diagnosis and eligibility now
Communication with treatment providers	▪ Information about client from treating staff in jail is not communicated to court ▪ Can't find mental health representatives when they are needed in court
Communication with other courts	▪ Other courts and lawyers send clients who aren't eligible
Treatment	▪ Greater demand for treatment than supply ▪ High turnover of staff
Don't know	▪ Don't know

Team members were asked "What are the strengths and weaknesses to the process of assessing client treatment needs?" (Table 5). Team members shared that strengths included having various treatment resources, good clinicians, and that the process of assessment is usually quick. Challenges shared often related to limitations of resources, such as needing more time, staff, or treatment options (e.g. housing or employment options). In addition, the high level of needs of the population served by MHTC made it challenging to set up meetings with clients or to entice clients that MHTC could be beneficial for them; relatedly, some clients have learned to manipulate in order to survive and this sometimes affects staff's understanding of the client. One team member shared that having multiple team members with differing perspectives was challenging, and another was not sure how to answer this question.

Table 5. MHTC team members' qualitative responses to the question, "What are the strengths and weaknesses to the process of assessing client treatment needs?" (*n* = 12).

Response Categories	Descriptions
Strengths	▪ Various treatment resources ▪ Good clinicians ▪ Usually quick, with treatment plan done by second court review
Limitations of resources	▪ Department of Behavioral Wellness needs more time to assess ▪ Mental health not always present when needed ▪ Clients can miss appointments without follow-through due to limited staff ▪ Lack of housing and employment options
Challenges with mental health population	▪ Setting up a meeting with client is hard ▪ Clients sometimes manipulate staff ▪ Enticing client that MHTC is a good thing is hard
Different opinions	▪ Different opinions
Don't know	▪ Don't know

Feedback: Treatment Counselors

During interviews with treatment providers, they were asked about how MHTC clients' mental health needs were assessed, and which assessments were used. Counselor responses were varied depending on their role and which treatment program they work for; thus, answers were not coded together. However putting the comments of the treatment counselors together paints a picture, with three levels of assessment: informal, screening, and formal. The informal assessment is done by probation officers, attorneys, or other staff in contact with the clients who perceive that a mental health issue may relate to their criminal case. The client is referred to the MHTC, and a screening is conducted by the psychologist or other representatives for the Justice Alliance to determine whether the client meets criteria for a severe and persistent mental health issue. If they do, they are referred to one of several treatment agencies that are determined to fit the client's needs the best (including geographic determinations). There are no clear criteria to determine which agency would be best but it is generally decided by the judge in collaboration with the team. Finally, a more formal assessment may be conducted at the assigned treatment agency, though this varies from program to program. At least

one program uses the Addiction Severity Index (ASI). Others use screening tools that have been developed by their agency and ask questions about client mental health history, suicidality, treatment history, family history, education, work history, substance abuse, legal history, and current symptoms. In some cases clients may be given a psychosocial assessment including psychosocial history, developmental delays, prior medications and diagnoses, cultural background, and allergies. Some clients may have been assessed for diagnosis elsewhere (and the treatment agency may or may not receive this assessment). Regular visits with a psychologist or psychiatrist is in some cases used to determine changing mental health needs.

Treatment counselors were asked whether the assessments result in a psychiatric diagnosis (Table 6), and they responded that generally this is the case. However, some caveats were noted, including that it can take 30-90 days before the client sees a psychiatrist, that the diagnosis is only provisional and is attained in only 10-20 minutes of screening, that the diagnosis cannot be shared with the court without client consent, and that the diagnosis can change over time and is not the main focus of treatment.

Table 6. Treatment counselors' qualitative responses to the question, "Does the assessment result in a psychiatric diagnosis for the client?" (*n* = 4).

Response Categories	Descriptions
Yes	▪ Yes ▪ It is documented in the clinician's Gateway ▪ It is on the actual assessment form
Limitations	▪ Sometimes ▪ Can take 30-90 days before client sees a psychiatrist ▪ The screening is only 10-20 minutes; a provisional diagnosis ▪ The diagnosis can change, and is not the focus of treatment. ▪ It requires consent to be able to share the diagnosis with the court.

Treatment counselors were asked how case managers determine client needs for treatment and complementary services, and which assessments are used. Counselors' answers varied depending on their position and treatment agency. Several indicated this is mainly done through interactions with the client in individual or group counseling, though other sources are used, such as staffing meetings or client history and client assessments. Some counselors noted there is no formal process, while others cited the ASI as their formal assessment tool.

Table 7. Treatment counselors' qualitative responses to the questions, "How do case managers determine client needs for treatment and complementary services? and "Which assessments are used?" (*n* = 4).

Response Categories	Descriptions
Talking with client	▪ Meeting with the client ▪ Individual and group counseling ▪ Goals come from the client.
Other sources	▪ Staffing ▪ Read the client history ▪ Read the client assessment
No formal process	▪ Informal only ▪ No formal case management
Formal tool	▪ ASI

Focus Group

Team members were asked to collaborate on responses to six questions about client treatment and assessment in MHTC (see Table 8). First, the team was asked what the typical dosage and duration of both mental health and substance use treatment was for MHTC clients. The team responded that it varies based on client needs, but generally ranges from 6 months to 18 months depending on how well the client is doing in treatment. Treatment generally starts more intense, with therapy as much as 9 times a week, and decreases, to as low as two days a week as the client progresses through the program; the average is 2-3 times a week.

Second, the team was asked how a client's diagnosis is established. The team answered that a screening is generally done by Justice Alliance, though in some cases if the client has a history of mental health treatment the team can access outside diagnoses and assessments.

Third, the team was asked how mental health needs are assessed. The team answered that this is done through the same screening from Justice Alliance, but also takes into account information from the attorney or from other professionals in contact with the client.

Fourth, the team was asked how substance abuse needs are assessed. The team answered that this occurs in various ways: probation conducts a screening that includes drug screening, and if the screening suggests drug use, or if there is a history of drug use or a violation related to drug use, then the client is referred to a drug abuse program which also conducts a screening as part of its intake.

Fifth, the team was asked what assessments are used, and whether they provide information about formal diagnoses. The team responded that probation uses the Texas Christian University (TCU) Drug Screen, and some treatment programs use the Addiction

Severity Index (ASI). The team responded that the assessments do provide information about formal diagnoses; however, these assessments are geared toward providing structured information on substance use diagnoses and not mental health diagnoses.

Lastly, the team was asked whether psychosocial assessments are created and whether they are made available to the MHTC team. Team members answered that psychosocial assessments are conducted as part of the intake process, but that they are not necessarily written or shared with the MHTC team unless specifically requested, which occurs rarely.

Table 8. Open-ended questions asked during the team focus group regarding treatment determinations in MHTC. (*n* = 10).

Open-ended Questions
1. What is the typical dosage and duration of mental health treatment for MHTC clients? Of substance use treatment?
2. How is a client's diagnosis established?
3. How are mental health needs assessed?
4. How are substance use needs assessed?
5. Which assessments are used? a. Do the assessment tools provide information on formal diagnoses or symptoms of psychiatric illnesses/addiction?
6. a. Are written psychosocial assessments created by a mental health professional for clients in order to determine a client diagnosis, justify medical necessity/receipt of services, and determine client needs? b. Are these psychosocial assessments made available to the MHTC team to review and reference, in order to appropriately coordinate services

TREATMENT PLANS

Treatment requirements for MHC clients should be individualized to the client and their specific needs (The Council of State Governments, 2005; Thompson et al., 2007). While best practices in MHCs have not yet been established, this is a documented best practice in other treatment courts (i.e., SATC; NADCP, 2013). It has also been recommended in treatment courts that adjustments to clients' treatment plans be made as needed throughout the client's time in the treatment court program (NADCP, 2013; Thompson et al., 2007). Furthermore, it has been recommended that MHC clients be given a voice in the planning of their treatment plans (The Council of State Governments, 2005; Thompson et al., 2007).

The Council of State Governments (2005) recommends the following steps occur in treatment planning: (1) identifying the client's presenting problem(s) in smaller and manageable ways, (2) defining the problem(s) in terms of client behavior, (3) setting long-term goals for addressing the issues, (4) identifying measurable objectives to meet each treatment goal, and (5) identify the specific interventions that the client will require to address their individual issues. They also advise that clients with co-occurring disorders (i.e., diagnosed mental illness and substance use disorder) have treatment plans that reflect goals and objectives that address both sets of disorders.

Lastly, the Council of State Governments (2005) recommended that treatment plans be revisited when clients are being considered for a sanction; a lapse in client recovery (whether mental health or substance use) may suggest a change is needed in their treatment regimen, or that something is not being adequately or appropriately addressed in their current treatment plan.

Feedback: MHTC Team

Team members were surveyed about various aspects of client treatment plans (see Table 9). While the majority of team members reported that client treatment plans are individualized, based on client need, flexible to adjustment, and that the judge holds the clients accountable for compliance with their treatment plan, between 24-45% of team members disagreed, felt neutral, or did not know how to respond to all of these questions.. Noteworthy patterns among these responses: almost half of the team (45%) disagreed or felt neutral that the judge held clients accountable, while three quarters of the team (76%) agreed that client plans were individualized. This suggests that there may be some variability in the perceived strength of the process of creating and maintaining client treatment plans, with individualization being a strength and accountability being a weakness.

Table 9. Team member perceptions of how MHTC client treatment plans are constructed, maintained, and adjusted (*n* = 17 - 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
MHTC clients' treatment plans are individualized to the needs of each client.	0%	6%	18%	47%	29%	0%
Client treatment is decided based on the client's level of need (vs. availability or other factors).	6%	6%	28%	56%	6%	0%
Client treatment plans are flexible to adjustments throughout their time in MHTC.	0%	6%	22%	56%	11%	6%
The judge holds clients accountable for their compliance with their treatment plan.	0%	6%	39%	44%	11%	0%

Each team member was asked about how well the court supervises the clients' mental health treatment plans (see Table 10). Most team members suggested that overall the court was supervising client mental health plans well, stating that the court is very involved with clients, clients return to court frequently when needed, and that probation does a good job working with the clients.

Supervision of client treatment plans was described to occur in staffing, with all team members hearing from all team members about the client in order to discuss or dialogue about the client. Information shared in staffing included client progress, drug test results, goals, compliance, engagement, setbacks, needs, and potential interventions. Team members also identified some issues with supervision of treatment plans, such as a conflicting treatment philosophy between treatment agencies and the court, a lack of in-depth knowledge from treatment representatives about client compliance and progress, inappropriate treatment due to poor planning or follow through in the MHTC team, and even occasionally too frequent supervision. Some team members shared that only treatment *progress* is supervised, not the actual treatment plans; these team members also reported that they felt this was appropriate, given that the plans are within the purview of the treatment agency. Further, it was reported that some agencies may not even have a release to share treatment plan information.

Table 10. MHTC team qualitative responses to the question, "How well does the court supervise clients' mental health treatment plans?" (*n* = 12).

Response Categories	Descriptions
Works well	▪ The court does a good job ▪ Very involved ▪ Clients frequently return to court when needed ▪ Probation does a good job working with clients
Occurs in staffing	▪ Everyone hears from everyone ▪ Discuss and dialog about each client
Information shared	▪ Drug test results ▪ If client is doing well or not ▪ Client goals ▪ Client compliance ▪ Client engagement ▪ Client setbacks ▪ Possible interventions ▪ Assessed client needs
Issues with supervising plans	▪ Conflicting treatment philosophy between the court and treatment agencies ▪ Court needs to ask more detail about plans beyond "how are they doing?" ▪ Inappropriate treatment due to poor planning and follow through ▪ Sometimes clients return to court too often
No supervision of treatment plans	▪ Treatment plans are not shared by treatment providers or supervised by court ▪ Sharing treatment plans may not be on the release of information at some treatment agencies ▪ Treatment plans should not be supervised by the court

Each team member was asked about how well the court supervises the clients' substance use treatment plans (see Table 11). Team members suggested that overall the court supervises client substance use treatment plans well – similar to, or even better than, how the court supervises mental health treatment plans. Counselors reported that drug-testing procedures were reliable and results to drug tests are shared with the court promptly. Like mental health treatment plans, one counselor noted that treatment *progress* is shared with the court, not the actual treatment *plans*; another team member added that the court allows some autonomy to the treatment providers instead of making all the decisions, which facilitates engagement and cooperation between treatment professionals in different treatment programs.

Table 11. MHTC team qualitative responses to the question, "How well does the court supervise clients' substance use treatment plans?" (*n* = 9).

Response Categories	Descriptions
Works well	▪ The court does a good job ▪ Very involved
Compared to mental health supervision	▪ Same as mental health treatment plan supervision; happens at the same time ▪ Better than mental health treatment plan supervision
Drug testing	▪ Strict testing procedures ▪ MHTC hears about drug tests within 1-2 days
Treatment program autonomy	▪ Court doesn't see the treatment plans ▪ Court allows autonomy to providers ▪ Cooperation between agencies is good

Focus Group

Team members were asked to collaborate on a question about MHTC clients' participation in peer support groups (see Table 12). The focus group suggested that MHTC clients with substance abuse issues regularly attend peer support groups about three times a week; however, this depends on client needs and some clients do not have substance abuse issues. If a client is particularly isolated, they might be referred to a community volunteer project, for instance.

Table 12. Focus group collaborative response to a question regarding MHTC clients' participation in peer support groups. (*n* = 10).

Peer Support Groups	True/False
1. Clients regularly attend self-help or peer support groups in addition to professional counseling.	True

The team was also asked four open-ended questions regarding treatment plan development and monitoring, and therapeutic adjustments to MHTC clients' treatment plans (see Table 13). The team was first asked who develops the MHTC clients' treatment plans. The team response was to the effect that the different treatment agencies develop their own treatment plans for the MHTC clients, and include input from the MHTC team. The team also sometimes coordinates efforts with other community-based organizations on client treatment plans, such as community service or employment readiness organizations.

The second open-ended question the team was asked was regarding who monitors the clients' progress on their treatment plans. The team responded to the effect that the team monitors the clients' treatment plans in staffing based on the reports from the treatment programs.

The third open-ended question the team was asked was in regards to what types of situations would necessitate adjustments to client treatment plans. The team responded that treatment plans could change for any reason that would necessitate a change, and indicated that there are numerous possibilities that would necessitate such a change during any of the staffing reviews. Examples provided included new violations, crises, regression in treatment, reaching a plateau in treatment, or particularly good progress in treatment.

The fourth open-ended question the team was asked was in regards to who is allowed to make adjustments to client treatment plans. The response was that treatment counselors are responsible for regularly updating the treatment plans and this is monitored by the quality assurance department within the treatment programs. The team distinguished between treatment plans and the *program plan*, which is the overall plan that the court has for each client and includes all aspects of treatment and program requirements such as community service or appointments. The team stated that the program plan adjustment is a collaborative team process occurring in staffing and recorded inside the notes of the team members.

Table 13. Open-ended questions asked during the team focus group regarding treatment plan development, monitoring, and adjustments in MHTC (*n* = 10).

Open-ended Questions
1. Who develops MHTC clients' treatment plans?
2. How is client progress on treatment plans monitored? By whom?
3. When are adjustments made to client treatment plans?
4. Who (i.e., which professional[s]) are allowed to make adjustments to client treatment plans?

The team was also asked three open-ended questions regarding medical or dental treatment and medications (Table 14). The team was first asked how clients are provided with medical or dental treatment for serious or painful conditions. The team responded that medical treatment is difficult to access but clients are referred to the Community Health Center and often use MediCal to pay, though sometimes clients see the emergency shelter doctor. The team stated that serious dental needs are usually treated faster than medical needs.

The second open-ended question that the team was asked regarded the policy on medication prescriptions for potentially addictive substances. The team responded that probation has clear documented rules stating that addictive medications are not to be used if they can be replaced by non-addictive substitutes, they must be for a medical necessity, any medications need to be cleared by probation, and the client's doctor needs to be given permission to speak with probation. If the client is taking an opiate or narcotic, then a plan is made to wean them off it and replace with a non-addictive substance if possible.

The last open-ended question that the team was asked was what medications were permitted. The team responded that the only medication that is strictly prohibited at this time is medical marijuana.

Table 14. Open-ended questions asked during the team focus group regarding medical treatment, dental treatment, and medications in MHTC (*n* = 10).

Open-ended Questions
1. How are clients provided with medical or dental treatment for serious or painful medical and dental conditions?
2. What is the policy on medication prescriptions for potentially addictive substances?
3. What medications are and are not allowed?

DIVERSITY IN TREATMENT

It has been recommended that MHCs "pay special attention to the needs of women and ethnic minorities and make gender-sensitive and culturally competent services available" (Thompson et al., 2007, p. 6). This recommendation has been iterated across other treatment courts (e.g., best practices for SATC; NADCP, 2013), and is the source of much attention in general in therapeutic

communities. Suggestions for gender-specific practices have included trauma-informed services for women in MHCs; for cultural-specific practices, provision of interpreters and peer counselors have been recommended (The Council of State Governments, 2005).

Gender-Specific Practices

Research has suggested that men and women involved in the criminal justice system have different needs, and that the different genders engage in criminal behavior and substance use for different reasons (see Covington, 1998 for a review of relevant literature). For these reasons, offering gender-specific treatment options have been emphasized in criminal justice arenas. A review of gender-specific treatment programs suggests that examples of gender-specific practices include gender-specific residential treatment, mentorship programs, parenting programs, trauma treatment, treatments emphasizing building trust and safety in social relationships, and exploration of cultural differences (Covington, 1998). Much of the literature reviewed also seemed to suggest that female-specific programming for female clients would likely benefit from simultaneously addressing multiple domains relevant to the lives of females, and should be conducted within the context of same-sex treatment programming.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt clients had access to gender-specific treatment (see Table 15). Over half of the team members reported that they felt gender-specific treatment was available; however, nearly half reported they were neutral, did not know, or disagreed, suggesting some room for improvement.

Table 15. MHTC team perceptions of the availability of gender-specific treatment for MHTC clients (*n* = 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Gender-specific treatment is available to those who might benefit	0%	6%	28%	39%	17%	11%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which gender-specific treatment was offered at their treatment program (see Table 16). The majority of counselors stated that their treatment program offers gender-specific treatment.

Table 16. Treatment counselor perceptions of the availability of gender-specific treatment for MHTC clients (*n* = 9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
My treatment program offers gender-specific treatment.	0%	11%	22%	22%	44%	0%

Focus Group

Team members were asked to collaborate on a question about whether female MHTC clients receive trauma-related services in gender-specific groups (see Table 17). The focus group agreed that they do.

Table 17. Focus group collaborative response to a question regarding female MHTC clients' receiving trauma-related services (*n* = 10).

	True/False
1. Female participants receive trauma-related services in gender-specific groups.	True

Culture-Specific Practices

In addition to gender-specific processes, treatment courts are advised to engage in culture-specific practices with the populations in which they serve. Culturally sensitive treatments have been emphasized in the literature on client treatment in recent years (see Herman et al., 2007 for a discussion on the importance of culturally sensitive health care treatments). Examples of cultural-specific practices include provision of interpreters, use of peer counselors (The Council of State Governments, 2005), culture-specific treatments (The Council of State Governments, 2012), and the provision of materials in clients' dominant languages (Department of Justice: Office of Justice Programs, 2003).

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt clients had access to culturally sensitive treatment interventions (see Table 18). The majority of team members were neutral, disagreed, or did not know the answer to both of these questions, though nearly half of team members agreed with the questions. It may be the case that there is potential for improvement regarding cultural practices in treatment.

Table 18. MHTC team perceptions of client access to culturally sensitive treatments (*n*= 17 - 18)

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Culturally-sensitive interventions are utilized at treatment programs.	0%	11%	33%	33%	11%	11%
Culture-specific groups or treatment are available for clients of diverse backgrounds.	6%	18%	29%	29%	12%	6%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which culturally-sensitive treatment interventions were offered at their treatment program (see Table 19). Most treatment counselors reported that their programs offered culturally sensitive treatment interventions.

Table 19. Treatment counselor perceptions of the availability of culturally sensitive treatments at their treatment programs (*n* = 9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Culturally-sensitive interventions are utilized at my treatment program.	0%	0%	11%	33%	57%	0%

Focus Group

Team members were asked to collaborate on a question about what culture-specific practices look like in MHTC (see Table 20). The team shared that this is an area that needs development but that there are existing groups for Spanish-speakers and Native-Americans.

Table 20. Open-ended question asked during the team focus group regarding culture-specific practices in MHTC (*n* = 10).

Open-ended Question
1. What do culture-specific practices look like in MHTC?

Suitability for Group Interventions

Research suggests that group interventions can help improve outcomes for participants in treatment courts; however, groups are only effective if they use evidence-based practices and they screen participants for suitability for groups (NADCP, 2015). Certain types of participants should not be served using group modalities. In particular, evidence suggests that individuals with serious brain injury, paranoia, sociopathy, major depression, and traumatic disorders should not be treated in group settings unless those groups are specifically focused on their unique circumstances (Yalom, 2005). Many participants who fail drug court report that group-based services were significant contributors to their failure (Fulkerson, Keena, & O'Brien, 2012; Gallagher, 2013). As such, it is important to screen participants for suitability for groups. For participants who are not well-suited for groups, other service modalities should be utilized.

Feedback: Treatment Counselors

Treatment counselors were interviewed about whether and how clients with PTSD or severe trauma were evaluated for their suitability for group interventions (Table 21). Most counselors reported that clients are evaluated. Some reported formal processes such as the ASI intake tool, or screening and assessment by a licensed clinician. Most treatment counselors reported no formal process, but that their agency talks to the client and to other providers, and then assesses the client by observing how they respond to treatment, for instance by watching how the client behaves in group and by talking about the client in team meetings. One counselor shared that triggers for PTSD can widely vary and individualizing a treatment plan for PTSD takes time to develop. Even though this question was about the evaluation of PTSD, counselors spoke about equally between evaluating for PTSD and treating for PTSD, and some counselors only spoke about treating for PTSD. It may be the case that counselors are more familiar with how PTSD is treated than how it is assessed in their agency. Counselors' answers relating to how clients were treated for PTSD were omitted from Table 21 and combined with their answers to the next question below, "what happens if they are deemed unsuitable?"

Table 21. Treatment counselors' qualitative responses to the question, "Are clients with PTSD or severe trauma evaluated for their suitability for group interventions? If so: How?" (*n* = 5).

Response Categories	Descriptions
Assessment	▪ Yes ▪ ASI ▪ Screening/Assessment by licensed clinician ▪ No formal process ▪ Talk to the client ▪ Talk to other providers
Assess through treatment	▪ Individualizing treatment for PTSD takes time, e.g. understanding triggers ▪ Watch how the client behaves in group ▪ Team meetings
Treatment	▪ Just provide individual counseling ▪ Evidence-based PTSD curriculum (Seeking Safety) ▪ Teach coping skills ▪ Gender separate groups ▪ Refer out ▪ Send to a group more geared towards mental illness
Trauma-Informed Care	▪ Trauma-Informed Care ▪ Non-confrontational approach

Treatment counselors were then asked what happens if clients with PTSD or severe trauma are deemed unsuitable for group interventions (Table 22). All counselors answered that the client is worked with one-on-one, and several indicated creating an individualized treatment plan. Some counselors mentioned connecting to outside resources, such as informing the court about the client's needs, sending the client to a more appropriate program, or finding a suitable group for the client. Finally, some counselors discussed how they interact with the client, whether it be showing firm boundaries, or being gentle with the client and not singling them out.

Table 22. Treatment counselors' qualitative responses to the question, "What happens if they are deemed unsuitable?" (*n* = 5).

Response Categories	Descriptions
Individualize treatment	▪ Individualize treatment ▪ Only work with client one-on-one
Connect to resources	▪ Inform the court ▪ Send to a more appropriate program ▪ Find a suitable group
Interaction with the client	▪ Firm boundaries ▪ Gentle ▪ Don't single the client out

Similarly, treatment counselors were asked whether clients were screened for their general suitability for group interventions. Some counselors responded that clients were screened, and one cited the ASI as the screening tool at their agency. Another counselor shared that the client has to be severe in order to be considered unsuitable for group interventions, which could include exhibiting violence or odd behavior, or not being medicated. Another counselor shared that at their agency there is no screening process but the counselors do have the discretion to place a client in a group or not.

Table 23. Treatment counselors' qualitative responses to the question, "Are clients at your treatment program screened for their suitability for group interventions? If so: How?" (*n* = 3).

Response Categories	Descriptions
Yes	▪ Yes ▪ ASI ▪ Have to be severe to be deemed unsuitable
No	▪ No screening but counselor discretion

Treatment counselors were asked if clients were placed in groups based on evidence-based selection criteria (Table 24). Counselors responded that they were and provided examples of groups for specific populations or interests including gender-specific, co-occurring, hearing voices, bipolar, art, and Spanish-speaking mothers. One counselor shared that at their agency clients start off attending all applicable groups then as they progress they stay only in the groups they need the most. No counselor discussed how criteria are evaluated.

Table 24. Treatment counselors' qualitative responses to the question, "Are clients at your treatment program placed in groups using evidence-based selection criteria (including clients' gender, trauma, histories and co-occurring substance abuse issues). If so, examples?" (*n* = 4).

Response Categories	Descriptions
Yes	▪ Gender-specific groups ▪ Trauma history group ▪ Co-occurring group ▪ Hearing voices group ▪ Bipolar group ▪ Art group ▪ Spanish-speaking mothers group

TREATMENT AGENCY PRACTICES

The evaluation examined various practices that the treatment agencies working with the MHTC engaged in that could contribute to MHTC client outcomes. The treatment agency practices that were of interest in the present evaluation included: the use of evidence-based treatment and agency practices, confidentiality, how client legal struggles are addressed in treatment, and who MHTC clients are placed with in groups.

Feedback: MHTC Team

MHTC team members were surveyed about their perceptions of treatment received by MHTC clients (Table 25). The majority of team members reported that co-occurring disorders are treated concurrently with evidence-based curriculum, that mental health treatment is emphasized for all MHTC clients, and that substance abuse treatment is emphasized for MHTC clients with co-occurring disorders. About half of the MHTC team indicated that they felt clients received evidence-based interventions that focus on improving interpersonal communication and problem solving, reducing family conflicts, and eliminating associations with antisocial peers; almost a quarter of individuals indicated that they did not know if this was happening.

Table 25. MHTC team perceptions of treatment received by MHTC clients (*n* = 16 – 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
For clients with co-occurring disorders, mental illness and addiction are treated concurrently using evidence-based curriculums that focus on simultaneously treating both conditions.	6%	6%	28%	57%	6%	0%
For all clients, an emphasis is placed on helping clients manage their mental health symptoms.	6%	0%	24%	35%	35%	0%
For clients with both mental health and substance use disorders, an emphasis is placed on helping clients manage their substance use problem.	0%	0%	13%	63%	25%	0%
Evidence-based interventions are provided that:						
a. focus on improving interpersonal communication and problem solving	0%	12%	18%	47%	0%	24%
b. focus on reducing family conflicts	0%	12%	12%	53%	0%	24%
c. focus on eliminating associations with antisocial peers and relatives	0%	0%	24%	53%	0%	24%
d. offered after clients are stabilized clinically	0%	6%	29%	41%	0%	24%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the administration of services at their treatment agency (Table 26). Almost all counselors reported they were neutral or agreed, suggesting that their treatment providers administer behavioral or cognitive-behavioral treatments, receive regular supervision, deliver treatment that improve outcomes for clients, are proficient at delivering interventions, and have a good therapeutic relationship with MHTC clients.

Table 26. Treatment counselor perceptions of practices occurring at their treatment agency (*n* = 9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
My treatment agency administers behavioral or cognitive-behavioral treatments that are documented in manuals.	0%	0%	0%	33%	67%	0%
At my treatment agency, I received regular supervision to ensure continuous fidelity to evidence-based practices.	0%	0%	0%	33%	67%	0%
Treatment providers administer treatments that have been demonstrated to improve outcomes for persons involved in the criminal justice system	11%	0%	11%	78%	0%	0%
Treatment providers at my program are proficient at delivering the interventions they provide.	0%	0%	22%	44%	33%	0%
Treatment providers at my program are supervised regularly to ensure continuous fidelity to the treatment models.	0%	0%	22%	44%	33%	0%
I have a good therapeutic relationship with MHTC clients at my treatment program.	0%	0%	22%	44%	33%	0%

Treatment counselors were surveyed about some of the client services at their treatment agency (Table 27). The majority of counselors agreed that their treatment agency utilizes evidence-based treatments, provides individual counseling, and provides at least one individual session per week to clients in the beginning of the program. About a third to a half of counselors were neutral or did not know about questions regarding individual counseling.

Table 27. Treatment counselor perceptions of practices occurring at their treatment agency (*n* = 8-9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Clients at my treatment agency receive evidence-based treatments.	0%	0%	0%	11%	89%	0%
MHTC clients receive individual counseling	0%	0%	25%	25%	38%	13%
Participants meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program.	0%	0%	33%	44%	11%	11%

Treatment counselor perceptions on group practices at their treatment agency can be found in Table 28. Two-thirds to three-quarters of treatment counselors reported that their treatment groups normally have no more than twelve participants and mix MHTC clients with other populations. About half of treatment counselors agreed that groups have at least two facilitators and mix MHTC clients with clients with primary substance abuse problems. Best practices suggests that groups should have at least two facilitators and that, to the extent possible, clients with different needs or risk levels should not be mixed in the same groups.

Table 28. Treatment counselor perceptions of practices occurring at their treatment agency (*n* = 9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Treatment groups ordinarily have no more than twelve participants.	0%	0%	11%	33%	44%	11%
Treatment groups ordinarily have at least two leaders/facilitators.	11%	22%	11%	44%	11%	0%
Treatment groups mix MHTC clients with other populations.	0%	22%	11%	67%	0%	0%
Treatment groups mix MHTC clients with clients with primary substance use problems	0%	22%	22%	44%	0%	11%

Treatment counselors were surveyed about the confidentiality of their clients (Table 29). All counselors were either neutral or agreed that their clients' confidentiality is a priority at their agency.

Table 29. Treatment counselor perceptions of the importance of confidentiality at the treatment agencies (*n* = 9).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Confidentiality of clients is a priority at my treatment agency.	0%	0%	11%	11%	78%	0%

Treatment providers were interviewed about how MHTC clients' criminal and legal issues are addressed in treatment (see Table 30). Treatment counselors reported that clients' criminal and legal issues were addressed through helping clients make better choices, applying forms of treatment that address the needs of the client, addressing drug use (when present) as a way to bridge the

connection between crime and mental health needs, discussing the clients charges, having charges dismissed upon program completion, and showing the client that they are cared for.

Table 30. Treatment counselors' qualitative responses to the question, "How are MHTC clients' criminal/legal issues addressed in treatment?" (*n* = 5).

Response Categories	Descriptions
Skill acquisition	▪ Making better choices ▪ Impulse control ▪ Teach coping skills ▪ Skills to deal with emotions.
Forms of treatment	▪ Criminal thinking curriculum ▪ Parenting classes ▪ Anger management classes ▪ Individual counseling
Drug treatment	▪ Substance abuse can bridge the connection between crime and mental health treatment needs ▪ Explore how drugs affect the client ▪ DUI classes
Charges	▪ Talk about charges in counseling ▪ Dismissal of charges upon program completion
Care	▪ Showing that we care about the client helps

Treatment providers were also asked "how are participants treated for dual-diagnosis issues?" Responses were not coded due to the wide range in responses depending on position and treatment agency. Some clients are mandated by the judge to attend an outpatient drug treatment program, and some elect to do so on their own. At least one treatment agency has a co-occurring treatment group; others refer out. Some counselors mentioned that most of their clients have dual-diagnosis issues, and that the general theory is that both illnesses are treated concurrently.

Treatment counselors were asked what cognitive-behavioral interventions were used in treatment (Table 31). Some were not sure how to answer the question while others listed several interventions, many of which are evidence-based (those that are highly rated or rated as promising by the Results First Clearinghouse are bolded and italicized). In addition, some counselors indicated using specific methods such as teaching the client to use a coping statement, or reminding the client that this will pass.

Table 31. Treatment counselors' qualitative responses to the question, "What cognitive-behavioral interventions are used in treatment?" (*n* = 5).

Response Categories	Descriptions
Treatment Interventions	▪ ***Seeking Safety**** ▪ ***Relapse prevention therapy**** ▪ ***Moral Reconation Therapy**** ▪ ***The Matrix**** ▪ ***Nurturing Parenting**** ▪ ***Thinking for a Change**** ▪ Helping Men Recover ▪ Grief and Loss ▪ Living in Balance
Methods	▪ Teaching the client a coping statement ▪ Reminding client that this will pass
Don't know	▪ Don't know

* ***Bolded and italicized*** are highly rated or rated as promising by the Results First Clearinghouse.

Feedback: MHTC Clients

MHTC clients were surveyed about their relationship with their treatment program (Table 32). The majority of clients indicated neutrality to statements reflecting that they have a good relationship with treatment staff and that they feel they are treated fairly by treatment staff, while half of the clients reported that they agreed that the program they attend is helpful. This suggests that the clients may not perceive their treatment programs in a strong positive manner, and may indicate room for improvement in the therapeutic relationship between clients and treatment staff.

Table 32. MHTC clients' perceptions about their relationship with their treatment program (*n* = 10).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Other
I feel that the treatment program I attend is helpful.	0%	10%	40%	30%	20%	0%
I have a good relationship with the workers at the treatment program I attend.	0%	0%	60%	40%	0%	0%
I am treated fairly by the workers at the treatment program I attend.	10%	0%	60%	20%	10%	0%

Focus Group

Team members were asked to collaborate on responses to three questions about various treatment agency practices of programs serving MHTC clients (see Table 33). First, the focus group shared that information about client progress is communicated from treatment programs out outpatient programs to probation, who forward it to the team. Second, the team shared that clients receive information about sexually transmitted diseases in trainings and HIV testing twice per year that most clients elect to participate in. Last, team members indicated that participants with substance abuse histories complete educational curriculum describing how to respond to drug overdose, including the Matrix curriculum, SAMSA curriculum, and training in how to use naloxone inhalers in kits that are placed in treatment programs.

Table 33. Focus group collaborative responses to questions regarding treatment practices of agencies services MHTC clients (*n* = 10).

Treatment Practices	True/False
1. Are communication protocols are established between treatment agencies and the MHTC team to ensure accurate and timely information about each participant's progress in treatment is conveyed to the MHTC team?	True
2. Participants complete a brief evidence-based educational curriculum describing concrete measures they can take to reduce their exposure to sexually transmitted and other communicable diseases.	True
3. Participants with an identified history of substance use complete a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose.	True

SUMMARY

Treatment related aspects of MHTC (i.e., client treatment plans, diversity options in treatment, and specific treatment agency practices) were examined. Feedback indicated that there were areas of the MHTC that worked well and others that needed improvement.

Literature on clients with severe mental illness has suggested that the treatment needs to be comprehensive, varied, and wide-ranging in order to effectively address the clients' multiplicity of presenting problems, especially if clients present with co-occurring substance use disorders. The majority of team members and clients reported that the MHTC has helped to link the clients to high-quality treatment for substance use; however, team members appeared to be split on their perceptions that clients' received high-quality mental health treatment, trauma-informed services, and criminal thinking interventions, family or interpersonal counseling, and medical or dental treatment. The most commonly identified unmet needs were housing, vocational, educational, trauma-specific services (i.e., PTSD, domestic violence, sexual trauma), and access to medication.

Treatment Determinations

There were strengths and weaknesses observed in the process of client treatment determinations. In general, team members shared that a particular strength of MHTC is the quality of the clinicians working with clients, that there were multiple levels of assessment of client treatment needs (from informal, to screening, to some formal assessments), and that the time to assessment is quick. Team members also identified some benefits to being able to work with clients while clients are in custody, and noted various ways in which they assess for co-occurring substance use needs to provide the most comprehensive treatment possible for clients.

Conversely, almost 40% of team members disagreed or were neutral that treatment was based on the client's level of need, suggesting that some team members may believe other factors contribute to deciding a client's treatment, including availability. This was corroborated by team member statements that there simply are not enough mental health services or staff to meet the demand and as a result mental health representatives are not always present in court, not all potential clients receive sufficient services, and many mild or moderate need clients go untreated once their severe needs have been stabilized in treatment. The team could benefit from advocacy for more treatment staff, decreased caseloads, or more prevention treatment options for mild and moderate mental health needs.

Additionally, the various levels of assessing client diagnosis treatment needs appears to often be conflicting, working in tandem across organizations (including the team) but not collaboratively, and is often based on unstandardized assessments (when applicable). In particular, the only standardized assessment that was noted as being used was the ASI or TCU screener, which are geared towards substance use assessment, not mental health. Some other issues with assessment that the team identified are that it can take a long time before the client sees a psychiatrist, that the diagnosis is only provisional and can be attained in only 10-20 minutes of screening, that other courts sometimes send clients to MHTC who do not qualify, and that there are differences in

perspectives in determining eligibility for treatment (i.e., whether clients display severe and persistent mental health issues, what the the clients' diagnosis and needs are). The team may benefit from detailing and documenting an assessment procedure that includes adequate assessment time, standardized mental health assessments, and communication with other courts and attorneys about the target MHTC population.

Treatment Plans

While the majority of team members reported on their surveys that client treatment plans are individualized, based on client need, flexible to adjustment, and that the judge holds the clients accountable for compliance with their treatment plan, between 24-45% of team members disagreed, felt neutral, or did not know how to respond to all of these questions. Noteworthy patterns among these responses: almost half of the team (45%) disagreed or felt neutral that the judge held clients accountable, while three quarters of the team (76%) agreed that client plans were individualized. This suggests that there may be some variability in the perceived strength of the process of creating and maintaining client treatment plans, with individualization being a strength and accountability being a weakness. Qualitative feedback from the team member interviews and the focus group seemed to corroborate this information; team members suggested that there were a lack of knowledge and communication regarding various aspects of client engagement in the program (e.g., client compliance, client progress, clients' treatment goals/plans at treatment) by different team members. This sort of knowledge would likely aid in keeping clients accountable. Furthermore, the focus group suggested that treatment plans can be modified and that there could be numerous possibilities that would necessitate such a change. The team may benefit from focusing on coming to a team consensus or policy regarding (a) sharing of information between team members and agencies, and (b) how client accountability should be addressed consistently and appropriately.

Whereas most team members thought the court supervises treatment plans well (especially for substance abuse treatment plans), others thought that the court does not, and should not, supervise treatment plans since they are within the purview of treatment programs. There was also some indication that the court does not request more than superficial information from treatment providers in evaluating client progress. The focus group shared that they do have an overarching "program plan" for each client that is developed collaboratively by the team and recorded in the notes of team members. The team may benefit from creating program materials that explicitly indicate which plan(s) is/are being supervised and disseminating this information to all involved parties. If the team elects not to supervise clients' treatment plans through MHTC, the team may also benefit from standardizing a process from which they can receive more elaborate information from treatment agencies regarding what "progress" on their respective treatment plans means in an operational way, so that the court can ensure they are providing the most effective supervision possible of clients' treatment progress. It should also be noted that the team's lack of uniformity of perceptions on supervising treatment plans – especially as it pertains to mental health versus substance use treatment plans – is somewhat expected; due to the lack of guidance available on MHCs in general, MHC teams are often left to sort out these nuances on their own within the context of mental health treatment participation, whereas there is a plethora of guidance and literature on supervising substance use treatment within the context of treatment courts.

Diversity in Treatment

The literature on diversity in treatment options (i.e., gender-specific, culture-specific practices) for criminal justice-involved clients has suggested that offering treatment that accounts for diversity differences is critical. Around half of team members and 2/3rd of treatment counselors thought that gender-specific programming is available to clients, and almost all counselors agreed that culturally-sensitive interventions were utilized at their agency. Treatment counselors also identified several groups available to clients in different treatment programs, including gender-specific, co-occurring, hearing voices, bipolar, art, and Spanish-speaking mothers groups. However, during the focus group the team identified cultural sensitivity and specificity as an area for growth. This suggests that treatment counselors perceive that diversity-specific treatment is occurring and available to a larger extent than the MHTC team itself does. The team may benefit from exploring this disparity in opinions, as well as ways in which they feel they could benefit from increasing cultural sensitivity in their practices and available treatment modalities. It may be that there is a lack of knowledge of available treatment options that are contributing to the confusion.

Screening for PTSD/trauma as a precursor for group suitability was also examined in the process evaluation. Most counselors reported there was no formal process of assessment for PTSD or severe trauma; counselors were more familiar with treatment for trauma than assessment. Similarly, there was no formal screening process for identifying whether group interventions were appropriate for clients However, the treatment counselors were able to identify ways in which they effectively managed situations where clients were deemed unsuitable for groups. The team may consider exploring if there are concerns regarding clients who are unsuitable for group for any reasons related to trauma, and if so, how they can support treatment programs in assessing for suitability prior to placing clients in groups.

Treatment Agency Practices

Treatment agency practices were examined as they relate to the research on client outcomes. Treatment practices were generally seen as strong, with most of the evidence-based practices identified as being implemented within the treatment agencies that serve MHTC clients. The majority of treatment counselors agreed that their treatment agency utilizes evidence-based treatments, provides individual counseling, and provides at least one individual session per week to clients in the beginning of the program. They agreed that they administer behavioral or cognitive-behavioral treatments, receive regular supervision, deliver treatment that improve outcomes for clients, treat co-occurring disorders concurrently, are proficient at delivering interventions, and have a good therapeutic relationship with MHTC clients. The focus group shared that clients are provided with drug overdose and STD prevention education. Treatment counselors shared various ways in which clients criminal/legal issues are addressed in treatment, as well (e.g., helping clients make better choices, addressing client needs, addressing drug use (when present), discussing the clients' charges, showing clients they are cared for).

Counselors also shared a few ways in which the practices could be improved upon. For example, counselors shared that groups usually have less than 12 clients but sometimes only one facilitator (best practices is to have two). They further indicated that MHTC clients are sometimes in mixed groups including groups with clients with primarily substance-related problems. They reported that confidentiality is a strong value at their agency, though there could be problems with sharing HIPPA protected information over email with the MHTC team. While some of these practices may be largely out of the control of the treatment counselors, the team may benefit from investigating a logistical solution to sharing HIPAA information over email, and initiating discussions with treatment team administration staff in order to determine if any of these additional issues can be addressed, particularly the best practice regarding mixing groups of clients with different primary presentations.

Lastly, MHTC clients were surveyed regarding their relationship with their treatment providers. The majority of clients indicated neutrality to statements reflecting that they have a good relationship with treatment staff and that they feel they are treated fairly by treatment staff, while half of the clients reported that they agreed that the program they attend is helpful. Additionally, during interviews with treatment counselors it was expressed that some clients have learned to manipulate in order to survive and this sometimes affects staff's understanding of the client. This suggests that the clients may not perceive their treatment programs in a strong positive manner, and may indicate room for improvement in the therapeutic relationship between clients and treatment staff. In particular, training specific to populations that are commonly present within MHTC clients may be helpful for the treatment providers that work with them.

Courtroom Processes

There are multiple aspects of the courtroom processes that are important in the functioning of MHCs. Of particular interest in the present report are aspects of team meetings, status review hearings, the administration of sanctions and incentives, supervision of treatment plans, and preparations for program completion. Among other areas of interest in courtroom processes, MHTC researchers have asserted that a comprehensive array of MHC team members should be assembled that are engaged in all aspects of a client's entry through completion of their MHC experience (Thompson et al., 2007).

TEAM MEETINGS

MHC experts assert that team meetings should be used as a time for sharing information on client progress and discussing the court's response to client behavior (Council of State Governments, 2005; Thompson et al., 2007). Accordingly, data were collected on various aspects of the team meetings, including the content and processes of the client case discussions, how decisions were made regarding client behavior, and perceptions of team functioning. The following individuals were observed to be present during one or more of the team meetings observed: judge, coordinator, public defender, prosecutor, probation officer, conflict attorney, private attorney for client, psychiatrist, and multiple treatment agency staff.

Case Discussions

Data collected in this section reflect the time spent during team staffings and the nature of staffing discussions.

Observations

Researchers coded all of the MHTC cases discussed during the formal staff meetings over two calendar days. Average time spent on each case was three minutes and nine seconds, with a range from 28 seconds to 9 minutes and 18 seconds (see Table 34).

Table 34. Team staffing time-related statistics.

Observation	Time
Total staffing time coded	1hr., 6 min.
Cases coded	21
Average time per case	3 min., 9 sec.
Range in time per case	28 sec. – 9 min., 18 sec.

The most frequent topic of discussion was treatment progress (95% of cases; see Table 35). Other frequent topics of discussion (i.e., discussed in over half of the cases) included: mental health symptoms and progress, probation supervision, sanctions and incentives, and substance use symptoms and progress. In 90% of cases the team appeared to have up-to-date information about the client.

Table 35. Team staffing topics discussed (*n* = 21).

Discussion Topics	% MHTC cases
Treatment progress	95%
Mental health symptoms & progress	76%
Probation supervision	76%
Sanctions/incentives	71%
Sanctions	*38%*
Incentives	*48%*
Substance use symptoms & progress	52%
Housing	43%
Medication	38%
Relationships and support	38%
Social or daily living skills	38%
Drug testing	33%
Positive test	*14%*
Negative test	*19%*
Vocational activities*	19%
Medical issues	14%
Criminal thinking	5%

*Includes vocational, employment, educational, and volunteering activities.

Decisions

Data were also examined in relation to how decisions on responses to client behavior were made during the team staffings. Data for this section were obtained through observations and feedback from the MHTC team.

Observations

Decision-making processes during staffings were examined by way of evaluator observations of team staffings. Researchers reported on who they observed making the final decision regarding a client's case during team meeting discussions. The observers indicated that 71% of cases were determined by the judge, and in 24% of the cases it was unable to be determined if the team or the judge had made the final decision. In these latter cases, the data are likely better attributed to a team decision; the ambiguity of whether or not the judge made the final decision versus the team implies that a noticeable team effort had been made during the decision-making process in general.

Additionally, researchers completed a scale that examined aspects of decision-making after the conclusion of each observation day (see Table 36). These scores were averaged across the three observers and across both observation days to obtain scores on each item. The questions were rated on a scale of *1=Strongly Disagree* to *5=Strongly Agree.* Results indicated the judge was generally perceived to be the ultimate arbitrator and final decision maker; however, the judge considered the input of other team members, participants, and treatment professionals.

Table 36. Observer ratings of judicial interactions with team members.

Judicial Interactions	Average
The judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions.	4.2
The judge makes these decisions after taking into consideration the input of other Drug Court team members.	4.0
The judge makes these decisions discussing the matter in court with the participant or the participant's legal representative	3.7
The judge relies on the expert input of duly trained treatment professionals when imposing treatment-related conditions.	3.5

Feedback: MHTC Team

MHTC team members were surveyed on the decision making process (Table 37). The majority of team members agreed that the team handled decision-making, conflict resolution, and sharing information in a constructive and efficient way. While the majority of team members also reported that communication methods between team members are efficient and that they are notified quickly when a client has been arrested, there was notable neutrality to statements. Thus, it appears that the team feels their internal manner of collaborating and managing team processes is efficient, though outside communication may benefit from improvement.

Table 37. MHTC team perceptions of the decision making process and team meetings (*n* = 17 - 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
Major decisions are made collaboratively by the MHTC team.	0%	6%	6%	56%	33%	0%
The team manages conflict and disagreement in a constructive and supportive way.	6%	0%	22%	67%	6%	0%
The team members share information effectively.	0%	6%	17%	61%	17%	0%
The current methods of communication within the team allow me to be well informed and up to date about clients' progress in treatment at all times.	0%	6%	35%	53%	6%	0%
MHTC representatives are notified within 24 to 48 hours of client arrests while clients are actively in the MHTC program.	0%	0%	39%	56%	6%	0%

MHTC team members were interviewed about how well they think team meetings work (Table 38). Most team members shared that team meetings work well, stating that they are respectful, helpful, productive, and that team members are free to share information and disagreements openly in a collaborative dynamic that works towards shared goals of safety and recovery for the client. Some team members highlighted some problems they see in team meetings, stating that collaboration often breaks down due to contentious disagreements and distrust between team members. In addition, sometimes mental health representatives are not present when they are needed, and one team member felt that the meetings are slower than they would like.

Table 38. MHTC team members' qualitative responses to the question, "How well do you think these processes work: Team meetings?" (*n* = 12).

Response Categories	Descriptions
Works well	▪ Works well ▪ Respectful ▪ Productive ▪ Safe environment for disagreement and sharing opinions ▪ All have the same goal - safety and recovery ▪ Equal contributions among team members ▪ Helpful ▪ Hear information about client from various perspectives ▪ Communicate well
Problems	▪ Collaboration break down ▪ Contention ▪ Some lack of trust between the team and treatment ▪ Want more detailed information from treatment about treatment plans, client participation and issues. ▪ Mental health representatives are sometimes absent ▪ Too slow

Feedback: Treatment Counselors

Treatment counselors were asked "how is treatment progress communicated to the MHTC?" (Table 39). All counselors mentioned court staffing. Other methods of communication included progress reports, emails, and informal contact. One counselor shared that face-to-face communication works best, and another counselor shared that communication is sometimes limited due to the release of information.

Table 39. Treatment counselors' qualitative responses to the question, "How is treatment progress communicated to the MHTC?" (*n* = 5).

Response Categories	Descriptions
Communication medium	▪ Staffing ▪ Email ▪ Informal contact or word-of-mouth ▪ Progress reports
Preferred method	▪ Face to face
Limitations	▪ Release of Information

Treatment counselors were then asked what kinds of information are communicated to the MHTC (Table 40). Counselors indicated that information was communicated regarding client cooperation and attitude towards treatment, medication and drug use, treatment interventions and progress, and major life events or other big-picture information about the client as a person.

Table 40. Treatment counselors' qualitative responses to the question, "What kinds of information are communicated?" (*n* = 5).

Response Categories	Descriptions
Medications and drugs	▪ Medication compliance ▪ Drug testing results
Treatment progress	▪ Treatment interventions ▪ Progress
Holistic summary	▪ Holistic summary of the person ▪ Major life events

Treatment counselors were asked the questions "How are clients' treatment plans at your treatment agency communicated to the MHTC?" and "What kinds of information are communicated?" Some counselors referred to their answer to the previous question about treatment progress (Table 40 above) so answers to this question were not coded. However, counselors who answered shared that plans are communicated verbally in staffing, and that information shared includes the clients' goals, medication compliance, drug testing results, group participation, employment status, life events, home life, and family obligations. In addition, sometimes the court will add or change the treatment plan, which can create conflict if there is not client buy-in. Relatedly, treatment plans may be shared broadly so as to minimize conflict between multiple parties, and some treatment programs may share more or less about client plans than others. The team could benefit from exploring differing philosophies in terms of whether or not treatment plans should be shared as part of an MHTC protocol.

Treatment counselors were asked how well clients' treatment is coordinated between the treatment agencies and the MHTC (Table 41). Most counselors shared that treatment is coordinated well, citing team collaboration and an especially good collaboration with the primary substance abuse treatment program. Counselors also mentioned that coordination, especially with mental health treatment providers, does still need improvement; for example, sometimes client behaviors or needs go unseen by the treatment

providers or court, and sometimes clients with private attorneys attend outside treatment agencies without well-established connections to MHTC. Further, the team needs to improve their protection of sensitive information that is communicated over email, per HIPAA. Counselors also mentioned some challenges and limitations that make coordination more difficult, such as needing a release of information signed in order to share information with the court, or that clients sometimes hide their issues from the court. Lastly, there were some comments that related to the differences of point of view between the court and treatment providers. For instance, it can be difficult for treatment providers, as advocates for their clients, to share everything with the court if the client might be taken into custody as a result. And as mentioned elsewhere, conflicts can arise within the team over how to work with a client when a client is exited from the Department of Behavioral Wellness (BeWell) prior to completing MHTC. Relatedly, requiring treatment through the court can be incongruent with treatment programs' inability to force treatment or philosophy to not force treatment. Finally, the court may request more supervision than the treatment program is equipped to provide, and the treatment program may view intense supervision as contrary to building client independence.

Table 41. Treatment counselors' qualitative responses to the question, "How well is clients' treatment coordinated between the treatment agencies and the MHTC?" (*n* = 5).

Response Categories	Descriptions
Is coordinated well	▪ Coordinated well ▪ Team collaborates on the plan ▪ Especially good with substance abuse treatment
Needs improvement	▪ Needs improvement ▪ Communication with mental health treatment providers needs improvement ▪ Need to improve protection of sensitive information shared over email per HIPAA ▪ Some clients' needs or behaviors go unseen. ▪ Clients with private attorneys sometimes seek outside treatment and communication with treatment can be worse in those cases
Limitations/challenges	▪ Need a release of information signed to communicate with court ▪ Sometimes the clients hide their issues from the court
Differing points of view between treatment providers and the court	▪ Can be conflict when a client is exited from BeWell but is still in MHTC. ▪ Can be hard for treatment to share everything with the court if the client might be taken into custody as a result ▪ Requiring treatment through the court can be incongruent with treatment programs' inability to force treatment ▪ The court may desire more supervision than treatment programs have capacity to provide; treatment programs may view intense supervision as contrary to building client independence

Team Processes

Team cohesion and related processes during staffings specifically were examined by way of evaluator observations of team staffings. Researchers completed a scale that examined aspects of team cohesion after the conclusion of each observation day (see Table 42). These scores were averaged across the three observers and across both observation days to obtain scores on each item. The questions were rated on a scale of *1=Strongly Disagree* to *5=Strongly Agree.* Results indicated that team members were perceived as respectful toward each other, respectful toward clients, as knowledgeable about the cases, as sharing information freely, and as collaborating well together. However, observers reported that some of the team members appeared disengaged and at times information about clients seemed shallow or out of date.

Table 42. Observer ratings of team processes and team cohesion during team staffing meetings.

Question	Rating
There appeared to be a respect for clients being discussed (i.e., intrinsic worth, rights, capacities, uniqueness, commonalities).	3.8
There appeared to be a mutual respect between the agencies.	4
Team members shared information and knowledge freely with one another.	4.3
There appeared to be a general sense of teamwork and partnership between the team members.	3.8
There appeared to be an openness of information and communication between the team members.	4.2
Team members appeared to know a lot about the cases discussed.	3.8
All team members appeared engaged in client discussions.	2.5
The team appeared to work well together.	3.7

COURTROOM HEARINGS

Status review hearings are the primary method in which the clients are kept accountable for their participation in MHTC. Thompson et al. (2007, p.9) describe status hearings in the following way: "Status hearings allow mental health courts publicly to reward

adherence to conditions of participation, to sanction nonadherence, and to ensure ongoing interaction between the client and the court team members. These hearings should be frequent at the outset of the program and should decrease as clients progress positively." Thus, the status review hearings represent an important aspect of the MHTC process for both the court and the client.

Proceedings

In this section, the amount of time that each case was heard during status review hearings was examined, as well as overall characteristics of status review hearings.

Observations

There were 20 MHTC cases observed over one hour and 15 minutes (see Table 44). The average time spent per case was three minutes and 44 seconds. While half of the cases were heard for less than three minutes (see Figure 43), there was a range from 54 seconds to 15 minutes and four seconds per case.

Figure 43. Percentage of time the observed cases were heard for their status review hearings.

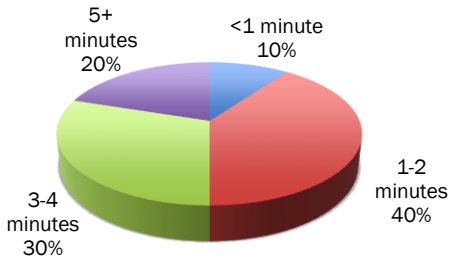

Table 44. Status review hearing time-related statistics (*n* = 20).

Observation	Time
Total time coded for status hearings	1 hr., 15 min.
Cases coded	20
Average time per case	3 min., 44 sec.
Range in time per case	51 sec. – 15 min., 4 sec.

In addition, after each observation day, researchers rated the status review hearings on whether or not they perceived that the treatment team exemplified four different characteristics (see Table 45). The questions were rated on a scale of *1=Strongly Disagree* to *5=Strongly Agree.* These scores were averaged across the three observers and across both observation days to obtain scores on each item. The results suggest that the MHTC used recovery-sensitive language, and clients were encouraged to be active participants in the hearing while being given a voice. However, the results suggest that there was less of a focus on future behavior.

Table 45. Observer ratings of status review hearing characteristics.

Question	Percentage
In the MHTC proceedings, was language used to promote recovery (e.g. using "participant" or "client" instead of "defendant")?	4.3
Client was given a voice in the MHTC hearing and was encouraged to take an active role.	4.2
Did the team demonstrate extensive knowledge of the clients' cases?	3.8
Court proceedings focused on changed future behavior rather than past behavior.	3.0

Feedback: MHTC Team

MHTC team member's perception on clients' MHTC experience can be found in Table 46. Majority of team members agreed that the court focuses on the clients' present and future behaviors as well as encourages clients to take an active role in the MHTC process, however there was also substantial neutrality to the former statement.

Table 46. MHTC team members' perceptions of clients' MHTC experience (*n* = 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The court focuses on clients' present and future behaviors, rather than clients' past behaviors.	6%	0%	39%	56%	0%	0%
Clients are encouraged to take an active role in the MHTC process.	0%	6%	17%	56%	22%	0%

MHTC team members were interviewed about how well status review hearings work (Table 47). Most team members reflected that the hearings go well: the team works collaboratively and smoothly, aided by good decision making that has occurred in staffing; the judge is patient and kind and treats each client with respect and dignity, providing positive reinforcement when the client will respond well to it. A common challenge that team members shared relates to managing time – there is a high caseload and working with each client in the hearing takes time; as a result the calendar can seem rushed. A solution is that the court will only talk to clients with issues, and reward clients who are doing well by handing them their docket; however, it may be the case that some clients get handed their docket to speed up the process when really they are not doing well. Further, some team members felt time could be focused differently, for instance by arguing with clients less or by focusing less on violations and more on crisis intervention. Some team members also shared that rewards or sanctions can be inconsistent, and the court might benefit from guiding documents that detail criteria for sanctions and rewards at different phases of the program. Lastly, one team member shared that it can be challenging when mental health representatives are not always present during hearings.

Table 47. MHTC team members' qualitative responses to the question, "How well do you think these processes work: Status review hearings?" (*n* = 12).

Response Categories	Descriptions
Works well	▪ Well ▪ Smoothly ▪ Collaborative ▪ Good decision making in staffing helps ▪ Patient, kind judge ▪ Treat each client respectfully as a person ▪ Provide positive reinforcement when client will respond to that
Managing time	▪ Lengthy process ▪ High caseload ▪ Rushed calendar ▪ Only talk to clients with issues ▪ Clients get put in good stack to speed up calendar ▪ Could move quicker - can't argue with clients with mental health issues ▪ Focus on violation cases over crisis intervention
Inconsistent	▪ Inconsistent with rewards ▪ Inconsistent sanctions ▪ Would benefit from guiding documents detailing sanction criteria at different phases
Team member attendance	▪ Mental health sometimes absent

Feedback: MHTC Clients

MHTC clients were surveyed about their perceptions of their relationship with the MHTC (Table 48). The majority of clients agreed that MHTC reminds them what will happen if they do well or fail, and wants them to succeed. However, half of clients disagreed or were neutral regarding whether the MHTC respects them, is concerned about them, and has a good relationship with them. This suggests that the MHTC clients may not perceive a strong relationship with the court, which could be an impeding factor to client progress.

Table 48. MHTC client perceptions of their relationship with the MHTC (*n* = 9 – 10).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Other
The members of the MHTC team often remind me of what will happen if I do well or if I fail.	0%	11%	11%	56%	22%	0%
I have a good relationship with the whole MHTC team.	0%	0%	50%	40%	10%	0%
I feel that the MHTC team respects me.	0%	10%	40%	40%	10%	0%
MHTC is concerned about me as a person.	10%	10%	40%	40%	0%	0%
The MHTC team wants me to succeed.	10%	0%	20%	40%	30%	0%

Clients

Information is reported in this section only on clients whose cases were observed during the evaluation. Client data was ascertained by way of observation data.

Observations

Of the cases observed in the status review hearings, more MHTC clients were thought to be male (65%) than female (35%). A majority of cases heard were regular status hearings (85%). A few were pre-participation hearings (15%), while no clients were observed during sentencing hearings (0%). Approximately 25% of the clients observed were in custody at the time of their hearing.

Stakeholders Participating in Hearings

Of interest in the current evaluation was the extent to which various stakeholders participated in client status review hearings. This was obtained via observation methods; if a team member was observed speaking during a client's status review hearing, the team member was indicated as having participated in the client's hearing.

The judge participated in all status hearings. Other team members who spoke during status hearings included the defense attorney (50% of cases), probation officers (35% of cases), the prosecutor (35% of cases), the ADMS representative (20%), the psychiatrist or psychologist (15%), the clerk (10%), and the conflict attorney (5% of cases). Most MHTC clients spoke in their hearings (85%), and about half of clients shared a success story or discussed their progress (50%). The clients' families were mentioned in 25% of the cases and were present in 20% of the cases observed. If some clients were given their docket without being called to see the judge then they would not have been measured by this evaluation; thus the true percentages may be somewhat lower.

Judicial Interactions

While there are variations in the ways in which MHTCs approach status review hearings, judicial interactions are an important aspect of the clients' experience during these hearings. Judicial interactions have been identified as a key component of treatment courts, and have been asserted to be a best practice and contribute to positive client outcomes in treatment courts (e.g., SATC; NADCP, 2013).

Observations

The judge engaged with the client by eliciting questions/statements, imparting instructions, and providing advice in almost every hearing (90%). In addition, the judge made eye contact (85%) and spoke directly to the clients (85%) in the majority of hearings. In 85% of cases, the feedback given to clients was specific to their circumstances. The judge sometimes explained the consequences of compliance or noncompliance in the program to the client (55% of the time) and provided positive reinforcement in 65% of the hearings (by way of praise, head nodding, smiling, hand shake, etc.).

Researchers completed a scale that examined aspects of judicial interactions with MHTC clients after the conclusion of each observation day (see Table 49). These scores were averaged across the three observers and across both observation days to obtain scores on each item. The questions were rated on a scale of *1=Strongly Disagree* to *5=Strongly Agree.* Results indicated that the judge was perceived as making an effort to establish rapport with clients, was empathic with and listened to clients, encouraged clients to take a role in their hearing and treatment, and gave clients a voice in court.

Table 49. Observer ratings of judicial interactions with clients during status review hearings.

Question	Average
If a client has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge permits the client's attorney or legal representative to assist in providing such explanations.	4.8
The judge encouraged the clients to take an active role in their hearings.	4.5
The judge made an effort to establish/maintain a rapport with clients (i.e., general rapport).	4.3
The judge gave the clients a voice in court.	4.2
The judge utilized active listening with the clients.	4.0
The judge encouraged the clients to take an active role in their treatment.	4.0
The judge demonstrated empathy for clients.	4.0

Feedback: MHTC Team

Team members were surveyed about client relationships with the judge (see Table 50). The majority of team members reported the judge made an effort to establish rapport with clients and demonstrates empathy and active listening with clients. Half of the team members were neutral as to whether the MHTC engages family members or other social supports in the treatment process, and the remaining team members either agreed or disagreed.

Table 50. MHTC team perceptions of judicial interactions with the clients (*n* = 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The judge makes an effort to establish rapport with clients.	6%	0%	17%	44%	33%	0%
The judge makes an effort to demonstrate empathy and active listening with the clients.	6%	0%	17%	44%	33%	0%
The MHTC engages family members or other client social supports in the treatment process.	6%	6%	50%	33%	6%	0%

Feedback: MHTC Clients

The clients were asked about the judge's interactions with them in MHTC, as well as their perceived relationship with the judge (see Table 51). There was a range of agreement noted within the MHTC client feedback. MHTC clients largely agreed that the judge tells them how important their treatment is, and holds them accountable for their actions; they also disagreed that the judge embarrasses them or says mean things to them. MHTC clients were split between agreeing and neutrality as to whether the judge believes they can improve their health and behavior, whether they have a good relationship with the judge, and whether the MHTC has involved their family in the court process. MHTC clients were split between agreeing and disagreeing as to whether the judge makes supportive comments during their hearings, lets them tell their side of the story, or has all the facts available to make good decisions.

Table 51. MHTC client perceptions of the nature of judicial interactions and their relationship with the judge (*n* = 10 -11).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Other
The judge makes supportive comments to me during my hearings.	0%	20%	30%	50%	0%	0%
During my hearings, the judge tells me how important it is to do my treatment program.	0%	0%	27%	64%	9%	0%
The judge believes that I can improve my health and behavior.	0%	10%	40%	40%	10%	0%
The judge embarrasses me.	40%	20%	40%	0%	0%	0%
The judge says mean things to me.	20%	50%	20%	0%	10%	0%
The judge lets me tell my side of the story when there are disagreements.	10%	10%	40%	20%	10%	10%
The judge usually has all of the facts available to make good decisions about my case.	0%	30%	30%	20%	20%	0%
I have a good relationship with the judge.	0%	20%	40%	40%	0%	0%
The judge holds me accountable for my actions.	0%	0%	10%	70%	20%	0%
The MHTC has involved my family in the court process.	0%	10%	50%	30%	10%	0%

SANCTIONS & INCENTIVES

All participant noncompliance should be addressed, whether or not they result in official sanctions (Thompson et al., 2007). When it has been determined that a client has been noncompliant, the court's response should be dictated by a series of graduated sanctions, with jail being an ultimate last resort; reports from MHC team members have generally suggested that punitive sanctions are unsuccessful with MHC's unique population and should be avoided if at all possible (Council of State Governments, 2005). It has also been suggested that incarcerating MHC populations can further serve to victimize this population, and restricts their access to the wide range of services that are often required by this very high-needs population. Additionally, positive client behavior should be emphasized and focused on, in order to provide encouragement and facilitate modification of participant behavior toward more productive goals (Thompson et al., 2007). The Council of State Governments (2005, p.72-73, 75-76) has provided suggestions for incentives for rewarding positive behavior and sanctions for noncompliant behavior.

Observations

Noncompliance with some aspect of the program was noted in 25% of the cases (see Table 52 for summary of all characteristics of status review hearings). Program noncompliance included treatment absences (10%), violating rules at treatment (10%), violating probation terms (10%), poor attitude (5%), positive drug test(s) (5%), using drugs in jail (5%), falling behind in treatment (5%), and not reporting to detox (5%). None of the noncompliance observed was related to medication noncompliance, re-arrests, or missed court dates.

Sanctions were administered in 30% of all cases heard. Sanctions were administered as follows: admonishment from the judge (20%), client directed to report to probation (20%), increase in treatment requirements (5%), community service (5%), client directed to see their psychiatrist (5%), and fees (5%). None of the clients observed failed MHTC as a result of their noncompliance (0%).

Recognition was given in 50% of all MHTC cases observed. Recognition was observed for a variety of behaviors and accomplishments, including: doing well overall (50%), complying with treatment (45%), a job/school accomplishment (5%), complying with medication (5%), writing a nice letter to the judge (5%), making payments, (5%), having regular contact with probation (5%), having a good attitude (5%), doing community work (5), supporting others (5%), and a perfect program (5%).

Incentives were administered in 60% of the cases observed. Incentives included: praise from judge (55%), released from custody/jail (20%), eligible for graduation (15%), reduced/suspended fees (10%), praise from psychiatrist (5%), released from probation (5%), and potential release from residential treatment (5%).

Table 52. Characteristics of status review hearings (*n* = 20).

Characteristic	Percentage of Observed Hearings
Appearance Type	
Regular status hearing	85%
In-custody	25%
Noncompliance	25%
Sanctions	30%
Recognition	50%
Incentives	60%

Feedback: MHTC Team

MHTC team members were surveyed on their perceptions of sanctions, incentives, and client non/compliance (Table 53). The majority (50-65%) of the team reported the MHTC uses a graduated system of sanctions, rewards are matched to the level of compliance, sanctions match the severity of the infraction, and clients are given access to council if a jail sanction might be imposed. Similarly, 50% of the team indicated that they felt jail is *not* used as a sanction before others are attempted, while half of the team had varying opposition levels of agreement. However, team members were much more dispersed between disagreement, neutrality, and agreement as to whether sanctions are effective in influencing compliance, jail sanctions are used sparingly, whether the administration of consequences is evaluated, and whether the MHTC focuses on incentives as much as sanctions.

It should be noted that the team was widely dispersed on their answers to all of the questions within this section, which in and of itself could suggest differences in perceptions on these topics and a need for approaches to sanctions, incentives, and non/compliance to be formalized and agreed upon within the team itself. Furthermore, the results indicated that the manner in which graduated sanctions are used are mostly agreed to work well, but that other processes – particularly the manner in which jail sanctions are used, how consequences are evaluated, and the emphasis on incentivizing productive behavior – may benefit from examination and discussion within the team. These aspects reflect philosophical differences and are borrowed best practices from drug courts; while they are helpful guidelines, they are not established best practices for MHCs, and as such present an opportunity for the Santa Maria MHTC to individualize their court to the needs of this specific team. However, without team members being "on the same page" regarding these aspects, the team may experience corrosion in team cohesion and relationships with the wide array of individuals that are in contact with the MHTC.

Table 53. MHTC team perceptions on sanctions, incentives, and client (non)compliance (*n* = 17 - 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The MHTC uses a graduated system of sanctions to address non-compliant behavior.	6%	11%	22%	50%	11%	0%
Rewards are matched to the level of compliance shown by the client.	0%	6%	39%	33%	17%	6%
The severity of the sanction is matched with the seriousness of the infraction.	6%	17%	17%	50%	11%	0%
Sanctions are effective for influencing client compliance.	11%	11%	39%	33%	6%	0%
Jail time is sometimes used as a sanction before all other sanctions have been tried	6%	44%	17%	22%	6%	6%
The administration of consequences to clients is evaluated, to ensure that equivalent consequences are being administered for all clients who engage in comparable conduct.	0%	24%	24%	47%	0%	6%
The MHTC places as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance abuse, and other infractions.	0%	18%	47%	29%	6%	0%
Jail sanctions are imposed judiciously and sparingly.	6%	0%	47%	41%	6%	0%
Participants are given access to counsel and a fair hearing if a jail sanction might be imposed, in cases where a significant liberty interest is at stake.	0%	6%	29%	41%	24%	0%

MHTC team members were interviewed about how well the process of administration of sanctions works (Table 54). Answers were varied, with some team members stating it usually works well, and some feeling that sanctions were used too much, not enough, or inconsistently. Team members described the process as the judge deciding after listening to the client and listening to the team discuss the issue. Several team members stated that they felt big sanctions were used too quickly, especially jail time, which some thought was generally not good for clients since they may stop taking medications, use drugs, become anxious or depressed, or lose their jobs by being in jail. Instead, some team members recommended that rewards and interventions work better than sanctions, especially for clients with mental health issues. Examples of softer sanctions that could be used more included sanctions that are treatment, such as attending more groups, writing a letter, or doing community service. However, one team member felt the opposite: that the court is too lenient on the clients just because they have mental health issues. Lastly, some team members thought that the administration of sanctions was inconsistent in that clients with similar behavior might receive very different levels of sanctions. Team members recommended using criteria guidelines to decide sanctions fairly, and to keep track of sanctions over time to see trends for individual clients.

Table 54. MHTC team members' qualitative responses to the question, "How well do you think these processes work: Administration of sanctions?" (*n* = 12).

Response Categories	Descriptions
Usually works well	▪ Works well ▪ Usually fair ▪ Usually works ▪ Ok
Decision making process	▪ Team discusses ▪ Judge listens to team input ▪ Judge listens to client ▪ Judge decides
Sanctions are too big	▪ Jail time often isn't good for client ▪ Put into custody too quickly ▪ Interventions instead of sanctions can be a big deal for clients with mental health issues ▪ Rewards work better than sanctions ▪ Could do more sanctions that are treatment (attending more groups, writing a letter, community service)
Not enough sanctions	▪ Too lenient because they have metal health issues
Inconsistent	▪ Inconsistent ▪ Inconsistency could reflect bias or be perceived as such ▪ Use guidelines for sanctions ▪ Need to keep track of sanctions over time to see trends

MHTC team members were interviewed about how well the process of administration of incentives works (Table 55). Team feedback was mixed, with some stating that it works well and others saying that it rarely occurs or occurs inconsistently. Some team members report that incentives are offered by both the treatment programs and the court, and that they have become a common philosophy over the years. They suggest that incentives work better when they are individualized to the client strengths and interests. Others report that they have rarely seen incentives used in court. Regarding physical incentives, team members report that the court used to offer money, gift cards, or stickers and that clients responded well; however, they shared that funding was a challenge and currently physical incentives are not used, except for the occasional gift card. The most common incentives noted were verbal praise, reduction of charges for program completion, and placement on the "A list" during the hearing so that they are allowed to leave court right away; however, the "A list" may be used inconsistently or more to manage time than to reward clients.

Table 55. Treatment counselors' qualitative responses to the question, "How well do you think these processes work: Administration of incentives?" (*n* = 12).

Response Categories	Descriptions
Works well	▪ Works well ▪ Given in both treatment program and court ▪ Individualizing rewards to client strengths and interests works well ▪ Rewarding clients has become a common philosophy over the years
Infrequently used	▪ Incentives are not often used
Physical incentives	▪ No physical incentives ▪ Physical incentives are important ▪ Clients used to like receiving stickers ▪ Occasional gift card ▪ Used to give money ▪ Funding is a challenge
Other incentives	▪ Verbal praise ▪ "A list" ▪ "A list" is used inconsistently ▪ Applause ▪ Reward for program completion is reduced charges
Inconsistent incentives	▪ Inconsistent incentives

Feedback: MHTC Clients

MHTC clients were surveyed about their ideas on the sanctions and incentives administered, which can be found in Table 56. Between a third and half of clients agreed that sanctions and incentives are similar to those of other clients with similar behavior, with the rest being largely neutral or not knowing, and a small percentage of clients suggesting that incentives and sanctions are distributed unfairly. A larger percentage (22%) of clients reported that team members sometimes get angry at them; however, the double-negative wording of the question may have caused some confusion and these results should be interpreted with some caution.

Table 56. MHTC client perceptions of sanctions and incentives (*n* = 9 - 11).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
When I do not do well in MHTC, I feel that I receive the same sanctions (consequences) as other people in MHTC.	0%	9%	18%	46%	0%	27%
When I do well in MHTC, I feel that I receive the same rewards as other people in MHTC.	0%	9%	27%	36%	9%	18%
When I receive sanctions (consequences), members of the MHTC team do not get angry with me.	0%	22%	33%	22%	0%	22%

Focus Group

Team members were asked to collaborate on responses to questions about the general use of sanctions (see Table 57). The focus group revealed that the MHTC sanctions increase progressively in magnitude for goals that are difficult to accomplish, however this is tempered by the mental health of the client so that clients with more severe mental health issues do not receive severe sanctions as quickly. For goals that are relatively easy to accomplish, the focus group shared that higher magnitude sanctions may be administered after only a few infractions; however, this is also tempered by the mental health status of the client. The team asks themselves whether the issue is that the client can't or won't perform the desired behavior, and acts accordingly with supports or sanctions as appropriate.

Table 57. Focus group collaborative responses to questions regarding the general use of sanctions (*n* = 10).

Sanctions	True/False
1. For goals that are difficult for clients to accomplish, such as abstaining from substance use or obtaining employment, the sanctions increase progressively in magnitude over successive infractions.	True
2. For goals that are relatively easy for clients to accomplish, such as being truthful or attending counseling sessions, higher magnitude sanctions may be administered after only a few infractions.	True

Team members were also asked to collaborate on responses to questions about the general use of the use of jail sanctions (Table 58). Team members indicated that jail sanctions are used sparingly and less frequently than in other treatment courts, and that jail is used as a sanction only after less severe consequences have been ineffective at curbing noncompliance. The focus group also suggested that they usually try to sanction MHTC clients to jail for no more than three to five days, and frequently less such as over the weekend, or sometimes even evaluated and discharged in the same day. Sometimes the clients are held longer, for instance if they have gone missing from the program for months. However, the team generally asks for input from the treatment program about what would likely work best for the client's recovery.

Table 58. Focus group collaborative responses to questions regarding the general use of jail sanctions (*n* = 10).

Jail Sanctions	True/False
1. Unless a client poses an immediate risk to public safety, jail sanctions are administered after less severe consequences have been ineffective at deterring infractions.	True
2. Jail sanctions are definite in duration and typically last no more than three to five days.	True

The focus group was asked to describe how client noncompliance was handled in the program (Table 59). The team response was to the effect that client noncompliance was addressed by considering the underlying cause of the non-compliance, then ideally creating a sanction that addresses that issue, such as additional services, extension of a program, or community service. Sanctions are graduated so that lighter sanctions are tried first, and the client's mental health is taken into account so that clients are not unduly punished if they are presently unable to understand or meet an expected behavior.

Table 59. Open-ended question asked during the team focus group regarding client noncompliance and failure to complete MHTC (*n* = 10).

Open-ended Questions
1. How is noncompliance handled in the program?

SUMMARY

Various aspects of the courtroom processes were examined, including team meetings, status review hearings, and sanctions and incentives.

Team Meetings and Status Review Hearings

Most team members agreed that the team handled decision-making, conflict resolution, and overall communication in a constructive and effective way. Team members were perceived by observers as respectful toward each other, respectful toward clients, as knowledgeable about the cases, as sharing information freely, and as collaborating well together. Decisions on client progress appeared to be made collaboratively by the treatment team, with the judge serving as the final arbitrator when necessary. In 90% of cases the team appeared to have up-to-date information about the client. However, observers noted that there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members present. Further, some team members expressed that mental health representatives were not always present in court when they were needed. The literature suggests that team meetings are a critical venue for sharing and discussing client information and making decisions on client behavior; thus, it is important that the necessary and relevant client information is readily available during these processes.

Similarly, the literature on client status review hearings point to this as a critical component in the clients' MHTC experience. Most team members reflected that the hearings go well; they report that the team works collaboratively and smoothly, aided by good decision making that has occurred in staffing. Observers noted that the MHTC used recovery-sensitive language and that clients were encouraged to be active participants in the hearing. Observer ratings were neutral as to whether there was a focus on future behavior over past behavior; however, the majority of clients agreed that MHTC reminds them what will happen if they do well or fail, and felt that the MHTC wants them to succeed. Most MHTC clients spoke during their hearings (85%), and about half of clients shared a success story or discussed their progress (50%). Clients agreed or were neutral regarding whether the MHTC respects them, is concerned about them, and has a good relationship with them, suggesting this is an area of strength that could still be improved.

Clients' families and prosocial supporters were mentioned and observed in approximately a quarter of the MHTC cases observed. MHTC clients were split between agreeing and neutrality as to whether the MHTC has involved their family in the court process, and the team members were neutral as to whether the MHTC engages family members or other social supports in the treatment process, explaining in interviews that whether family engagement is positive for the client seems to depend upon the client and the client's family. The literature suggests that family and prosocial supporters are important for client recovery; the team may wish to consider ways to further support positive interactions with family members and prosocial supporters.

Team members shared that a common challenge with status review hearings is managing limited time and a high caseload. They noted that one present solution is that the court will only talk to clients with issues, and reward clients who are doing well by handing them their docket; however, some team members shared that some clients may get handed their docket to speed up the process when really they are not doing well. Whereas the average time spent per case was three minutes and 44 seconds, half of the cases were heard for less than three minutes; further, this calculation may not include clients who were handed their docket and not called. Best practice for substance abuse treatment courts is to provide each client with at least 3 minutes, and clients in mental health treatment courts would likely benefit from time in status review hearings as much or more than clients in other courts. Further, clients who are doing well could benefit from the positive reinforcement of attention from the court, just as clients in the audience may benefit from witnessing clients who are doing well receive positive attention. Relatedly, client feedback was divided about whether the judge makes supportive comments during their hearings, lets them tell their side of the story, or has all the facts available to make good decisions. The team may wish to consider schedule adjustments that secure more time for MHTC hearings.

The judge participated in all of the status review hearings, with less participation observed from other team members. Team feedback indicated the presence of several aspects of the judge's role that are often related to positive outcomes in treatment courts, including: consistency in bench term, attendance at team meetings, fostering collaboration in the decision-making process while maintaining the role as final decision-maker, and deferring to the expertise of treatment professionals when relevant. Additionally, the judge was perceived by observers as making an effort to establish rapport with clients, was empathic with and listened to clients, encouraged clients to take a role in their hearing and treatment, and gave clients a voice in court. The judge engaged with the client by eliciting questions/statements, imparting instructions, and providing advice in almost every hearing (90%). In addition, the judge made eye contact (85%) and spoke directly to the clients (85%). In 85% of cases, the feedback given to clients was specific to their circumstances. The judge sometimes explained the consequences of compliance or noncompliance in the program to the client (55% of the time) and provided positive reinforcement in 65% of the hearings (by way of praise, head nodding, smiling, hand shake, etc.). This coincided with feedback from team members; the majority of team members reported the judge makes an effort to establish rapport with clients and demonstrates empathy and active listening with clients. MHTC clients largely agreed that the judge tells them how important their treatment is, holds them accountable for their actions, and does not embarrass them or say mean things to them. However, MHTC clients were split between agreeing and neutrality as to whether the judge believes they can improve their health and behavior and whether they have a good relationship with the judge; while judicial interactions is an area of strength there may still be room for improvement regarding client perceptions.

Sanctions/Incentives

MHTC members attempted to reinforce clients even when clients were struggling. During court hearings, recognition and incentives were used in more cases than sanctions. Noncompliance was noted in 25% of cases and sanctions were administered in 30% of cases heard; sanctions were most commonly admonishment from the judge or being referred to probation. Recognition was noted in 50% of cases for a variety of behaviors, most commonly the client doing well overall or complying with treatment. Incentives were offered in 60% of cases and most often included praise from the judge or being released from custody.

Team members appeared to have wide variation in their responses to questions regarding the use of sanctions and incentive in addressing client (non)compliance. The largest majority (50-65%) of team agreement was reported for questions that asked if there were graduated sanctions, and that sanctions/incentives were matched to the seriousness of the precipitating event. Similarly, half of the team indicated that they felt jail is *not* used as a sanction before others are attempted. Lastly, team members were unable to reach uniform agreement as to whether sanctions are effective in influencing compliance, jail sanctions are used sparingly, whether the administration of consequences is evaluated, and whether the MHTC focuses on incentives as much as sanctions. Additionally, in interviews with team members some individuals stated the administration of sanctions and incentives usually works well, whereas others felt that sanctions were used too much, too quickly, not enough, or inconsistently; team members suggested that the court might benefit from guiding documents that detail criteria for sanctions and rewards at different phases of the program, as well as keeping track of the receipt of sanctions and incentives over time to see trends for each client. However, other team members highlighted that responses to client noncompliance were made on an individualized basis, taking into account the mental health status of the client, so there appeared to be conflicting values on the team between consistency and individualized treatment. There may be a way for the team to meet both values by creating guiding documents that explicitly allow for ranges in responses based on individual client considerations. These findings were also corroborated by MHTC clients; a little over half of clients (with valid responses) agreed that sanctions and incentives are similar to those of other clients, and that team members do not get angry with them. This may indicate that some clients believe that incentives and sanctions are distributed unfairly, and that some team members may get upset with them.

These widely varying opinions reflect differences in perceptions on these topics and a need for approaches to sanctions, incentives, and non/compliance to be formalized and agreed upon within the team itself. These aspects are borrowed best practices from drug courts; while they are helpful guidelines, they are not established best practices for MHCs, and as such present an opportunity for the Santa Maria MHTC to individualize their court to the needs of this specific team. However, without team members being "on the same page" regarding these aspects, the team may experience challenges in team cohesion and relationships with other individuals that are in contact with the MHTC (including the clients themselves).

Literature on sanctions and incentives in MHTC suggests that they should be frequently and appropriately implemented. The literature has also strongly discouraged against the use of jail as a sanctioning method. To this point, team members were split between agreement and neutrality as to whether jail sanctions are used sparingly, and split between agreement and disagreement as to whether jail time is sometimes used as a sanction before all other sanctions have been tried. During the focus group the team indicated that jail sanctions were utilized much less than in other treatment courts, only after less severe consequences have been ineffective at curbing noncompliance, and for usually no more than three to five days. However, during interviews some team members stressed that jail time was generally not good for clients since they may stop taking medications, use drugs, become anxious or depressed, or lose their jobs by being in jail; team members also stressed the challenges in connecting clients to treatment or medication both in custody and after release. The team may benefit from broadening the array of sanctions that can be utilized before jail, as the literature on incarceration does not support the use of jail as a stabilization mechanism. The team may also benefit from monitoring time from incarceration to receipt of the clients' prescribed and appropriate medication within jail, as well as within the community. The team may also consider forging partnerships with urgent care facilities and primary care providers within the community that could assist in the medication management issue that clients face.

Program Structure

PHASE PROGRESSION

Within MHCs, the processes and structures that determine phase progression are of particular importance as they can have a major impact on client outcomes. Specifically, the program structure and sequence, program and phase requirements, drug testing, program completion, and census and caseload have all been found to be important components of an effective treatment court. The following section explores how Santa Maria's MHTC implements each of these elements.

Program Structure/Sequence

Best practices with treatment courts generally indicate that the sequence and timing of services is essential in ensuring that clients are at an appropriate stage of change to maximize their ability to benefit from services. In general, the first phase of treatment court should focus on addressing responsivity needs, such as mental health symptoms, housing needs, substance-related cravings, withdrawal, and anhedonia (NADCP, 2015). Mental illness and homelessness or unstable housing are commonly observed among treatment court participants (Cissner et al., 2013; Green & Rempel, 2012; Peters, Kremling, Bekman, & Caudy, 2012), and these conditions often undermine the effectiveness of treatment courts and other correctional rehabilitation programs (Hickert, Boyle, & Tollefson, 2009; Johnson et al., 2011; Mendoza, Trinidad, Nochajski, & Farrell, 2013). In order for clients to remain in treatment court and engage in the services provided, they must have these needs met first (Hubbard & Pealer, 2009; Karno & Longabaugh, 2007). The second phase of treatment courts usually targets criminogenic needs, including drug and alcohol abuse, criminal-thinking patterns, impulsivity, associations with deviant peers, and family conflict (Green & Rempel, 2012; Hickert et al., 2009; Jones, Fearnley, Panagiotopoulos, & Kemp, 2015; NADCP, 2015). Treatment courts that teach participants prosocial decision-making skills and interpersonal functioning report better outcomes for clients (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007; Lowenkamp, Hubbard, Makarios, & Latessa, 2009). Thus, helping clients build these skills once they have stabilized can lead to long-term positive outcomes. In the final phases, treatment courts should provide services that are designed to maintain treatment gains and enhance long-term functioning through activities such as vocational training, parent training, or educational assistance (NADCP, 2015). Studies have found that when these types of needs are addressed, they tend to lead to longer sustainability of treatment gains (Leukefeld, Webster, Staton-Tindall, & Duvall, 2007); however, addressing these needs before criminogenic needs are attended to has actually been associated with increased recidivism and treatment failure (Andrews & Bonta, 2010; Smith, Gendreau, & Swartz, 2009; Vieira, Skilling, & Peterson-Badali, 2009). For this reason, the timing of different types of treatment services is critical.

Feedback: MHTC Team

MHTC team members' perceptions on the requirements for completion of the program, as well as the vocational and educational services can be found in Table 60. About 47% of team members agree that the requirements of completion of MHTC are clear. This suggests that work could be done to improve clarity for team members and clients alike. Most team members reported that they didn't know, disagreed, or were neutral regarding whether educational and vocational services are delivered after clients have found stable housing, resolved their substance abuse issues, completed a criminal-thinking intervention, and spent time with sober peers. This may suggest that team members are not sure when educational and vocational services are being given to members, or they don't agree they are being given at the appropriate time.

Table 60. MHTC team members' perceptions on the requirements and vocational and educational services (*n* = 16 -17).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The requirements of participation in and completion of MHTC are clearly delineated for participants and team members alike.	0%	18%	35%	35%	12%	0%
Vocational or educational services are delivered <u>after</u> clients:	13%	19%	38%	19%	0%	13%
a. have found safe and stable housing,						
b. have substantially resolved their substance abuse and mental health symptoms,	13%	13%	38%	25%	0%	13%
c. have completed a criminal-thinking intervention,	13%	19%	44%	0%	0%	25%
d. are spending most or all of their time interacting with prosocial and sober peers.	13%	19%	38%	13%	0%	19%

MHTC team members were interviewed about whether and how clients' family or friends are enlisted to help in treatment (Table 61). Team members together painted a complex picture, with mixed responses as to whether family participation is encouraged, and a general sentiment that family involvement can be either helpful or detrimental depending upon the client and family. Ways family participation is encouraged include family therapy at some treatment programs, toys in court for children in attendance, and the

judge talking to family members present in court. Family involvement was seen to be beneficial in assisting with appointments and transportation for clients with severe mental health needs, though some clients lack any contact with their families and families might be a negative influence if they have substance abuse or mental health issues themselves. In addition, for treatment programs to communicate with families, a release of information needs to be signed by the client, and in some cases clients will not sign this even if the family could be a benefit to their recovery.

Table 61. MHTC team members' qualitative responses to the question, "Are there participants' family or friends enlisted to help in the treatment court? How so? How often?" (*n* = 12).

Response Categories	Descriptions
Family participation is supported	▪ The judge is good about talking to families if they are present in court ▪ Family therapy is provided at some treatment programs ▪ Toys in the courtroom for kids to take home
Family can be beneficial	▪ Can help especially for clients with severe mental health needs ▪ Assist with appointments and transportation
Depends on client and family	▪ Depends on client and family ▪ Family participation is encouraged when family is deemed positive
Not often	▪ Not aware of this occurring ▪ Not often
Limitations	▪ Some clients lack contact with their family ▪ Family can also be a negative influence ▪ Confidentiality limits interaction in treatment if release is not signed ▪ Sometimes client won't sign a release even if their family could be beneficial

Focus Group

Team members were asked to collaborate on responses to questions about the program structure of MHTC, how program requirements are communicated to clients, how client progress is understood, and how housing needs are addressed within the program (see Table 62). The focus group indicated that it is difficult to summarize the current program structure, but developing phases would be helpful in this regard. Program requirements are individualized to each client but there is a 12-month minimum in the program, and clients must comply with mental health treatment and receive mental health treatment at least once per week or more. Clients are informed of the above requirements and informed that they may also be recommended to attend substance abuse treatment or other programming on a case-by-case basis; they are also informed that MHTC completion may take longer than 12 months depending on client progress in treatment. This information is reviewed with the client whenever there is a significant change (e.g., a new violation or new employment that interferes with treatment). Client progress or regression is mainly determined by probation and the treatment providers who see the client the most, sometimes as often as 3-5 days a week. There is no current phase structure in MHTC. Housing needs are assessed at the beginning of sentencing and confirmed by site visits through probation, and this is continued in an ongoing fashion in case of changes in housing status. Attaining housing can be a particular challenge for this MHTC because shelters are sometimes full and clients are often low-income.

Table 62. Focus group collaborative responses to questions regarding program structure (*n* = 10).

Open-ended Questions
1. What is the general program structure of MHTC like?
2. What are the program requirements?
3. Are program requirements reviewed with participants? (Y/N) a. How often and by whom?
4. How do participants (and team members) know when clients are progressing or regressing in the program? a. Is there any sort of phase structure in MHTC? (Y/N)
5. How and when are clients' housing needs addressed? a. If stable housing is lost later in the program, how is this addressed? b. If the client is found ineligible for current [housing] programs, how is this addressed?

Feedback: MHTC Clients

MHTC clients were surveyed regarding their perception of choice to participate in MHTC or not (Table 63). Clients were divided, with 30% disagreeing and 40% agreeing. The MHTC team may benefit from considering how to make the informed consent process more clear to MHTC clients.

Table 63. MHTC client perception of their ability to choose to participate in MHTC (*n* = 10).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Other
I am participating in MHTC on my own free will.	20%	10%	40%	20%	20%	0%

Program/Phase Requirements

Phasing is a well-established best-practice for Substance Abuse Treatment Courts (SATC), but current research has not yet determined whether phasing is a best-practice for Mental Health Treatment Courts. Some MHTCs implement phasing whereas others do not. There are many similarities in philosophies and practices between SATC's and MHTC's, and MHTC clients may also require substance abuse treatment; however, there are specific challenges that arise in implementing phasing for MHTC populations. For instance, MHTC clients may have wide range in what they can be expected to achieve during MHTC due to different diagnoses and prognoses; thus phasing for MHTC needs to be particularly flexible and individualized to each client.

Feedback: MHTC Team

MHTC team members were interviewed about how participants and team members know when clients are progressing or regressing in the program (Table 64). Team members shared that this mainly occurs through multiple team members being in contact with the client and reporting back to the team what they know. Probation and treatment programs were viewed as the experts on client progress, and the judge depends on them to make decisions about the client. Communication among team members was generally seen as frequent and effective both inside the courtroom (staffings, hearings) and outside (emails, phone calls), though some team members were less responsive to email than others. Finally, some team members shared that the best way to understand the client is through getting to know the client personally and building trust and rapport – sometimes building trust entails keeping certain information confidential from the court.

Table 64. MHTC team members' qualitative responses to the question, "How do participants (and team members) know when clients are progressing or regressing in the program?" (*n* = 12).

Response Categories	Descriptions
Roles	▪ Probation know the clients well ▪ Treatment programs know client progress well ▪ Judge listens and decides
Good communication	▪ Good communication ▪ Regular updates to the team ▪ Multiple people in contact with clients ▪ Team collaboration ▪ Staffing ▪ Hearings ▪ Frequent emailing information to the team ▪ Can call each other ▪ 24/7 communication between some team members
Personal connection	▪ Really knowing the client personally is the best way ▪ Being able to keep information confidential from court is important for rapport ▪ Some clients need more supervision than others

MHTC team members were interviewed about the challenges to implementing a phase structure in MHTC (Table 65). The most common challenge related to the particularly wide variation in client capacity in the MHTC population – thus it would be challenging to develop criteria for phases that work for all clients. Other challenges included the complexity of determining how mental health issues affect criminal behavior (if at all), the limitation that there are not many clients in MHTC to justify spending a lot of time developing the program, and the idea that implementing phasing might create more work for already overworked team members. Interestingly, various team members also offered various solutions to these implementation challenges, despite this not being a part of the question, suggesting a large desire within the team to improve the current process. Solutions generally involved defining criteria for phase levels that are flexible to different client ability levels, by focusing on commitment to treatment, mastery of curriculum material, and defining goals and progress relative to client baselines. In addition, team members thought it would be beneficial to define what the team means by "doing well," as well as outline the consequences for specific behaviors for clients in different phases. Lastly, one team member shared that phasing would help clients move through the program quicker, and a few team members did not know how to answer this question.

Table 65. MHTC team members' qualitative responses to the question, "What are some challenges to implementing a phase structure in MHTC?" (*n* = 11).

Response Categories	Descriptions
Challenges to implementation	▪ Phases can't be based on time due to variation in client capacity ▪ Some can get jobs and some cannot ▪ Not like drug court ▪ MHTC clients have more varied needs than other courts ▪ Would be challenging to agree on phase structure ▪ Usually complex and difficult to determine how mental health affects criminal behavior ▪ Not many MHTC clients ▪ Might make more work for team members
Solutions to implementation	▪ Commitment to treatment is more important than progress because of variation in what is possible to achieve ▪ Goals should be based on client baseline ▪ Mastery of information might be good criteria for phasing ▪ Defining what "doing well" looks like ▪ Outline consequences for different behaviors in different phases
Benefits of phasing	▪ Phases would help clients move through program quicker
Don't know	▪ Don't know

MHTC team members were interviewed about the potential benefits of implementing a phase structure (Table 66). Team members shared some generally positive comments about how phasing would be worthwhile, works well in other courts, and would help to motivate clients. In particular, they shared that it would help the client feel successful at completing something, which could be a rare and important feeling for some clients. It could also diminish client anxiety by helping them understand where they are in the program and what is coming next – one team member noted that sometimes clients feel so anxious about the current unknowns of how long they will be in the MHTC program that they prefer to deal with the knowns of jail. Similarly, team members shared about the benefits of providing structure in that it pushes client progress, prepares clients for the real world, and helps clients see the value of creating structure for themselves. Finally, team members thought that phasing could help the team understand the client's progress better, and help them know when the client has completed the program.

Similar to the previous interview question, team members shared some challenges to implementing phasing, such as the difficulty in deciding on guidelines for the phases, and that phase progress should not be based on phase duration for this population. However, team members also shared some potential criteria that could work for phase progression, such as client engagement, client stability, client personal life improvement, and client change from their baseline.

Table 66. MHTC team members' qualitative responses to the question, "What are some potential benefits to implementing a phase structure to MHTC?" (*n* = 11).

Response Categories	Descriptions
Generally positive	▪ Worthwhile endeavor ▪ Works in other courts ▪ Will motivate clients
Helps client feel successful	▪ Helps client feel successful at something ▪ Helps client see they are making progress
Helps client anxiety and understanding	▪ Helps clients anticipate what's coming ▪ Helps client understand what to do ▪ Ease client stress/discomfort ▪ Sometimes anxiety about the unknowns of the current structure makes clients prefer to be in jail
Benefits of structure	▪ Structure pushes progress ▪ Prepares clients for the real world ▪ Teaches clients about the benefits of structure
Helps team understand client	▪ Helps to know for sure when client is done ▪ Helps team to know where the client is at
Challenges to implementation	▪ It will be challenging to figure out the guidelines ▪ Should not be based on time
Potential criteria for phases	▪ Client engagement ▪ Client stability ▪ Client personal life improvement ▪ Client change from baseline

In other mental health treatment courts that use a phasing structure, there are commonly four main phases: initial, interim, later, and maintenance phases. During the initial phases, mental health treatment courts often focus on engagement, stabilization, and resolving conflicts that are likely to interfere with retention or compliance in treatment. During the interim phases, mental health

treatment courts usually focus on treatment and resolving needs that increase the likelihood of criminal recidivism and substance abuse. Later phases are typically focused on skill building and the remaining needs that are likely to undermine the maintenance of treatment gains. Finally, the maintenance is usually used as an opportunity for clients to maintain skill development, demonstrate increasing independence, and prepare for transition out of the court's care.

Common treatment foci at different phases were extracted from various mental health treatment courts around the country (see Appendix B) and placed into the team member survey. Stakeholders were asked to indicate whether or not the MHTC in Santa Maria includes these various treatment foci within their phase promotion and whether they believe it would be helpful to incorporate these elements (see Table 67). Overall, the majority of stakeholders reported that the MHTC currently includes the following elements in phasing: building rapport, acceptance, and hope (70.6%); sustaining abstinence from drug and alcohols (70.6%); stabilizing mental health symptoms (64.7%); developing problem-solving and decision-making skills (64.7%); developing an understanding of mental illness, substance abuse, recovery tools, and relapse prevention (64.7%); and establishing routines of treatment and supervision (64.7%).

In addition, about half of stakeholders reported that the MHTC addressed the following topics at some point during phasing: establishing and rewarding honesty and attendance (58.8%); addressing dysfunctional or antisocial thought patterns (58.8%); ensuring all medications are taken as prescribed (58.8%); completing community service obligations (56.3%); assessing risk and needs and drafting a treatment plan (52.9%); anger management (52.9%); ameliorating acute psychological or physiological symptoms of addiction (52.9%); and strengthening support systems and establishing prosocial peer supports (52.9%). Most team members who didn't believe the team currently implemented these elements reported that incorporating the elements would be beneficial. In particular, there was a consensus that establishing and rewarding honesty and attendance would be helpful.

A little less than half of stakeholders reported that the following topics are currently being addressed by the MHTC: establishing clients' understanding and consent for MHTC's requirements and goals (47.1%); addressing basic housing, food, transportation, and safety needs (47.1%); eliminating delinquent peer association (47.1%); identifying potential relapse issues and how to address them (41.2%); maintaining effective performance in prosocial life roles (41.2%); strengthening connections to the community resources and relationships (41.2%); and reducing family conflict (41.2%). Team members who didn't believe these elements were being implemented in MHTC were mixed in their opinions regarding whether or not these elements would be useful to add. All team members agreed that establishing clients' understanding and consent for MHTC's requirements and goals and parent training would be beneficial. Moreover, the vast majority of stakeholders reported that addressing basic housing, food, transportation, and safety needs and identifying potential relapse issues and how to address them would also be useful.

Finally, relatively few stakeholders reported that the MHTC includes parent training (35.3%); focusing on client strengths (35.3%); practicing aftercare plans (35.3%); establishing prosocial leisure/recreational activities (35.3%); providing vocational or educational assistance (29.4%); developing time management skills (29.4%); maintaining continuing care and wellness plans to continue activities after graduation (29.4%); utilizing recovery and cognitive restructuring skills in progressively challenging situations (29.4%); supporting the development of other clients in earlier phases (29.4%); establishing long-term housing and financial stability (23.5%); enhancing participants' activities of daily living skills (23.5%); and developing financial management skills (17.6%). Although these types of activities do not seem to be occurring frequently in the current program, many stakeholders indicated that they could be beneficial for clients if they are not already being implemented. In particular, all stakeholders agree that parent training and vocational or educational training would be beneficial. In addition, the majority of stakeholders also indicated that focusing on client strengths, developing time management skills, and maintaining continuing care and wellness plans after graduation would also be useful.

Table 67. MHTC team members responses to questions about foci of program phases (*n* = 17).

Potential focus of phase	Percent who believe MHTC is currently doing this	If not presently doing this, could it be beneficial?
Build rapport, acceptance, and hope	70.6%	100.0%
Sustain abstinence from drugs and alcohol	70.6%	100.0%
Stabilize mental health symptoms	64.7%	100.0%
Develop problem-solving and decision-making skills	64.7%	100.0%
Develop understanding of mental illness, substance abuse, recovery tools, and relapse prevention	64.7%	83.3%
Establish routines of treatment and supervision	64.7%	66.7%
Establish and reward honesty and attendance	58.8%	100.0%
Address dysfunctional or antisocial thought patterns	58.8%	85.7%
Ensure all medications are taken prescribed	58.8%	71.4%
Complete community service obligations (if applicable)	52.9%	75.0%
Assess risk and needs and draft a treatment plan	52.9%	87.5%
Anger management (if applicable)	52.9%	87.5%
Ameliorate acute psychological or physiological symptoms of addiction	52.9%	87.5%
Strengthen support system and establish prosocial peer support person	52.9%	87.5%
Establish client's understanding and consent for MHTC requirements and goals	47.1%	100.0%
Address basic housing, food, transportation, and safety needs	47.1%	88.9%
Eliminate delinquent peer associations	47.1%	66.7%
Clients demonstrate ability to identify their potential relapse issues and how to intervene to avoid relapse, from both emotional and addiction (if applicable) recovery	41.2%	90.0%
Clients maintain effective performance in prosocial life roles	41.2%	70.0%
Strengthen connections to community resources and relationships	41.2%	70.0%
Reduce family conflict	41.2%	52.9%
Parent training (if applicable)	35.3%	100.0%
Focus on client strengths; don't "fix" everything in earlier stages	35.3%	90.9%
Clients practice their aftercare plan mostly on their own with infrequent supervision as a safety net	35.3%	81.8%
Establish prosocial leisure-recreational activities	35.3%	81.8%
Provide vocational or educational assistance (if applicable)	29.4%	100.0%
Develop time management skills	29.4%	91.7%
Maintain continuing care and wellness plans to continue these activities after graduation	29.4%	91.7%
Clients demonstrate ability to utilize recovery and cognitive restructuring skills in progressively challenging situations	29.4%	83.3%
Clients support the development of other clients in earlier phases of MHTC	29.4%	83.3%
Establish long-term housing and financial stability	23.5%	76.9%
Other interventions designed to enhance participants' activities of daily living (ADL) skills	23.5%	76.9%
Develop financial management skills	17.6%	71.4%

In mental health treatment courts, movement between phases is often predicted by a number of different factors, including progression in treatment, skill building, compliance with elements of phasing, and duration spent in the current phase. Each treatment court develops its own strategy for determining how phase promotion occurs. Stakeholders were asked to indicate whether or not the MHTC in Santa Maria includes various aspects of phasing and whether they believe it would be helpful to incorporate these elements (see Table 68 for a summary of results). Stakeholders seemed to differ in their perspectives regarding the extent to which different elements of phasing were utilized.

Stakeholders were most likely to report that drug testing and drug treatment continues based on need throughout the program (70.6%); supervision conditions are based on need and risk level (70.6%); a standard range in duration of the MHTC program is determined (64.7%); and court attendance is diminished across phases (64.7%). Moreover, the majority of stakeholders who didn't believe the MHTC implemented these elements endorsed these elements as being beneficial.

A little over half of stakeholders agreed that program completion is based on engagement with treatment and law-abiding behavior (58.8%); treatment plans and phasing requirements are flexible to individual needs (52.9%); and phase progression should not be delayed for outstanding fees, fines, or restitution (52.9%). Stakeholders who didn't believe these elements were being implemented differed on the extent to which they thought these elements would be useful. While all stakeholders agreed that program completion should be based on engagement with treatment and law-abiding behavior, only 75% thought that phase progression should not be delayed for outstanding fees, fines, or restitution.

A little less than half of stakeholders reported that the following elements are incorporated in phasing: phases build on previous skills (47.1%); recognition that some goals of treatment may not be attainable within time in mental health court (47.1%); clients

demonstrate progress to proceed to the next phase (41.2%); and treatment intensity and phase are based on client needs rather than used as a sanction (41.2%). While many stakeholders were skeptical that these elements were being implemented, those who thought they weren't being implemented thought that they could be helpful. In particular, stakeholders all agreed that phases should build on skills of prior phases and the vast majority indicated that it would be helpful if treatment intensity and phase were based on clients' needs and if clients demonstrated progress to proceed to the next phase.

Finally, only 17.6% of stakeholders reported that requirements to proceed from phase to phase are clearly delineated and communicated, yet 71.4% of those remaining stated that it would be beneficial for the MHTC to do this. Thus, moving forward it may be helpful for the court to clearly define and communicate the requirements for phase promotion. Anecdotally, one team member also stated that graduation (which is a type of phase promotion) may have to address victim restitution.

Table 68. MHTC team members responses to questions about treatment foci of program phases (*n* = 17).

Potential aspects of phasing	Percent who believe MHTC is currently doing this	If not presently doing this, could it be beneficial?
Drug testing and drug treatment continues based on need throughout the program.	70.6%	100.0%
Supervision conditions are based on need and risk level.	70.6%	80.0%
A standard range in duration of the MHTC program is determined and agreed upon.	64.7%	83.3%
Court attendance is diminished across phases.	64.7%	83.3%
Program completion is based on engagement with treatment and law-abiding behavior.	58.8%	100.0%
Treatment plans and phasing requirements are flexible to individual needs of clients.	52.9%	87.5%
Phase progression should not be delayed for payment of outstanding fees, fines or restitution.	52.9%	75.0%
Phases build on skills of previous phases	47.1%	100.0%
Recognition that some goals of treatment may not be attainable within time in mental health court.	47.1%	77.8%
Clients demonstrate progress from each phase in order to proceed to the next.	41.2%	90.0%
Treatment intensity and phase are based on client needs and not used as a sanction for noncompliance unless such noncompliance indicates a need for more intensive treatment.	41.2%	90.0%
Requirements to proceed from phase to phase are clearly delineated and communicated.	17.6%	71.4%

DRUG TESTING

Although clients enter MHTC due to severe and persistent mental health issues, a majority of MHTC clients also suffer from co-occurring substance abuse issues. For clients with substance abuse issues, best practices in treatment courts dictate that alcohol and drug testing should occur frequently throughout the client's participation in the program (NADCP, 2015). Specifically, urine testing should occur at least twice a week until participants reach the final phase of treatment court (NADCP, 2015). In addition, participants should be monitored for at least 90 days using ankle monitors or other tests that measure drug use over an extended period of time (NADCP, 2015). Breathalyzers or oral fluid tests should also be used when recent substance use is suspected or likely to occur (NADCP, 2015). Regular drug testing is important because research indicates that outcomes are significantly better for participants when it is likely that substance use will be detected (Kilmer, Nicosia, Heaton, & Midgette, 2012; Marques, Jesus, Olea, Vairinhos, & Jacinto, 2014; Schuler, Griffin, Ramchand, Almirall, & McCaffrey, 2014). In addition, sanctions and incentives are key components of substance use courts, and they cannot be applied accurately without frequent testing (Hawken & Kleiman, 2009; Marlowe, Festinger, Foltz, Lee, & Patapis, 2005). Moreover, treatment providers can use results from drug and alcohol tests to confirm diagnostic impressions and to challenge clients in denial about their substance use problems (American Society of Addiction Medicine (ASAM), 2013; DuPont, Goldberger, & Gold, 2014; Srebnik, McDonell, Ries, & Andrus, 2014). Given that clients in substance use programs, especially those involved in the criminal justice system, are unlikely to admit when they have used drugs or alcohol (Peters, Kremling, & Hunt, 2015), mandatory testing is necessary to ensure compliance. In addition, studies of treatment courts and probation programs report that programs with more frequent drug testing also have higher graduation rates, lower drug use, and lower recidivism rates (Gottfredson, Kearley, Najaka, & Rocha, 2007; Hawken & Kleiman, 2009).

Drug and alcohol tests should occur randomly and unpredictably, including on weekends and holidays (Marlowe, 2012; NADCP, 2015). A number of studies have found that drug testing is most effective when it is performed on a random basis otherwise participants can adjust the timing of their usage or take measures to create fraudulent results (Auerbach, 2007; Cary, 2011; McIntire, Lessenger, & Roper, 2007). Tests should be comprehensive, assessing for all unauthorized substances it is suspected participants might use, and trained personnel should witness the collection of test specimens to ensure there is no tampering or substitution (ASAM, 2013; NADCP, 2015). These practices can help prevent participants tampering with tests and or switching to substances not detected by standard test panels (ASAM, 2013; Cary, 2011; Perrone, Helgesen, & Fischer, 2013). Additionally, scientifically valid and reliable testing procedures should be utilized, test results should be available to the treatment court within 48 hours, and tests should be regularly examined for dilution or adulteration (NACDP, 2015). Studies of drug courts have found that drug courts that receive test results within 48 hours are 73% more effective at reducing crime and 68% more cost effective (Carey,

Mackin, & Finigan, 2012b). Participants should be informed of their rights and responsibilities to comply with testing requirements (Carey et al., 2012b; NACDP, 2015).

Feedback: Drug Testing Survey

Team members and treatment counselors who self-identified as being knowledgeable about drug testing procedures for MHTC were surveyed about their perceptions of the frequency of drug testing procedures (Table 69). Procedures that reported to occur *always* or *often* included: tests with short detection windows are administered when recent substance use is suspected, the schedule of drug testing is unpredictable, the probability of being tested on weekends is the same as during weekdays, testing is conducted on all suspected unauthorized substances, collection is witnessed by a staff member trained in specimen collection, a chain of custody is established for each specimen, a portion of the same sample is subjected to confirmatory analysis upon client dispute, scientifically valid and reliable methods of testing are used, and drug concentrations falling below cutoff levels are used as evidence for changes in drug use patterns. All items are in accordance with best practices, except the last item which *should not* be occurring per best practices (NADCP, 2015); however, a follow up discussion with probation revealed that the contract with the drug testing lab prohibits the lab to report levels falling below the cutoff point. Therefore, team members are unlikely to have access to this information at all. It may be the case that team members found the wording of this question confusing, given that it is one of the few questions worded such that best practices is for it to occur *never* instead of *always.*

For procedures that were reported to be less frequent, one procedure reportedly occurred *sometimes*: tests that measure drug use over extended time periods are applied for at least 90 days; best practices suggest this should always occur. Regular drug testing is only interrupted *rarely* for changes in treatment, which is in close to best practices (ideally it should be never). Finally, stakeholders report that clients are *never* allowed to use independent drug testing, and this is in line with best practices as well.

Table 69. Team member and treatment counselor responses to drug testing survey (*n* = 8-9).

Question	Never	Rarely	Sometimes	Often	Always
Tests that measure substance use over extended periods of time, such as ankle monitors, are applied for at least ninety consecutive days followed by urine or other intermittent testing methods.	0%	25%	38%	38%	0%
Tests that have short detection windows, such as breathalyzers or oral fluid tests, are administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays.	0%	0%	11%	44%	44%
The schedule of drug and alcohol testing is random and unpredictable.	0%	0%	11%	22%	67%
The probability of being tested on weekends and holidays is the same as on other days.	0%	0%	22%	56%	22%
Regular drug and alcohol testing is interrupted for changes in treatment.	11%	56%	22%	11%	0%
Test specimens are examined for all unauthorized substances of abuse that are suspected to be used by MHTC participants.	0%	0%	11%	33%	57%
Collection of test specimens is witnessed directly by a staff person who has been trained to prevent tampering and substitution of fraudulent specimens	0%	0%	0%	33%	67%
Clients may use independent drug or alcohol testing in lieu of being tested by trained personnel authorized by the MHTC.	67%	22%	0%	11%	0%
The MHTC establishes a chain of custody for each drug test specimen.	0%	0%	0%	25%	75%
If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis.	0%	0%	0%	57%	44%
Drug concentrations falling below cutoff levels are interpreted as evidence of changes in participants' substance use patterns.	11%	11%	22%	56%	0%
The MHTC uses scientifically valid and reliable testing procedures for clients with substance abuse.	0%	0%	0%	44%	56%

In addition to the above questions, team members and treatment counselors who were familiar with drug testing were asked two open ended questions (Table 70). Stakeholders were asked how long clients have to test after they have been notified. Responses ranged from immediately to 3 hours, and 3 hours was the most common response. Stakeholders were also asked how long after testing are results provided to the court; responses ranged from immediately to 24 hours if the result is positive, with the most common response being immediately. If the test is negative then it might not be shared until the next status review hearing. These answers are within best practices (NADCP, 2015).

Table 70. Observer ratings of status review hearing characteristics (*n* = 10).

Open-ended Questions
1. How long do clients have to test after being notified of testing?
2. How long after drug testing are results provided to the court?

Focus Group

Team members were asked to collaborate on responses to questions about the frequency and procedures for communication of drug testing (see Table 71). The focus group indicated that drug testing is conducted randomly at least twice per week for the duration of the program for clients with substance abuse issues, and that they can also be asked to test at any time by the court. This response is within best practices. The focus group was then asked about the procedures for communicating drug test results to the team. They indicated that results are communicated to the team very quickly, often within 30-60 seconds, when they are positive.

Table 71. Open-ended questions to the focus group regarding drug testing frequency and communication (*n* = 10).

Open-ended Questions
1. For clients with substance use issues, how often is drug testing conducted?
2. What are the general procedures for communicating drug test results to the team?

PROGRAM COMPLETION

Researchers have recommended that program completion criteria be related to clients' progress in the MHC and their treatment program (Thompson et al., 2007), though planning for program completion should begin immediately upon program entry (Council of State Governments, 2005). While the time period that a client spends in MHC is limited, the team should assist clients in obtaining access to treatment that will be long-term and not time-limited (Council of State Governments, 2005). MHC team members should also work to assist clients in other practical preparations for after they complete the MHC program, including ensuring linkages to treatment and other services (Council of State Governments, 2005; Thompson et al., 2007). Examples may include assisting in providing access to health care, general relief, financial assistance, social security benefits, and food stamps (Council of State Governments, 2005).

Feedback: MHTC Team

MHTC team members were interviewed about their perceptions on the preparation they feel that the court gives to clients who are approaching completion (Table 72). Although the majority of team members agree that clients know what is required of them to graduate the program, the majority disagree or are neutral that the MHTC provides adequate support to clients to prepare them for success after graduation. This may indicate that team members feel that the MHTC needs to provide more support to clients to secure employment, housing, and treatment services after program completion.

Table 72. MHTC team perceptions of preparations for clients' program completion (*n* = 17 - 18).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
The court provides adequate support for helping clients secure safe housing after their successful participation in MHTC.	6%	33%	33%	11%	6%	11%
The court provides adequate support for helping clients find employment after their successful participation in MHTC.	12%	24%	47%	6%	0%	12%
The court provides adequate support for helping clients secure treatment services after their successful participation in MHTC.	6%	22%	28%	28%	6%	11%
The MHTC team helps clients to prepare for when they finish MHTC.	11%	11%	39%	39%	0%	0%
Clients know specifically what is required of them in order to graduate from the program.	0%	24%	18%	47%	12%	0%

MHTC team members were interviewed about how clients' treatment is continued or bridged after completion of MHTC (Table 73). The team shared that while there are some supports in place for clients after graduation, it is largely up to the clients themselves whether to use them or not once they are no longer on probation, and the MHTC could make improvements in this area to encourage treatment after graduation. Currently, aftercare supports include a recently started alumni program, treatment programs are required to have transition plans with their clients, some treatment programs have aftercare, the court has an open-door policy for clients to return to court to check in, and clients with severe and persistent mental health issues often continue to qualify for mental health treatment after graduation. However, team members shared that in some cases few if any aftercare occurs, there is a high recidivism rate among MHTC clients, and it would be beneficial to employment options and a lower-level of treatment for clients who

no longer qualify for intense mental-health treatment due to making progress. Lastly, team members shared that making improvements to the current MHTC program would improve client treatment use after graduation, for instance by providing more education to clients about mental illness and treatment, by building more trust with clients, or by decreasing anxiety levels in the courtroom so that clients do not associate treatment with stress.

Table 73. MHTC team members' qualitative responses to the question, "How are clients' treatment continued or bridged for after completion in MHTC?" (*n* = 11).

Response Categories	Descriptions
Client choice after supervision	▪ Some remain on probation and some terminate ▪ If terminated from supervision, it's up to the clients ▪ If termination from supervision, difficult to know how clients are doing after MHTC ▪ Can still continue with some mental health treatment after graduating ▪ Court can only mandate treatment when clients are enrolled and it is medically necessary
Current aftercare supports	▪ Currently starting an alumni program ▪ Providers are required to have a transition plan with client ▪ Some programs have aftercare ▪ Open door policy to return to check in with the court ▪ Severe and persistent mental health issues get continued care
Need for more aftercare support	▪ This doesn't happen ▪ Would be good to do this ▪ No official aftercare ▪ High recidivism rate ▪ Once no longer qualify for treatment, drop to nothing. Need a lower level. ▪ Can't know how long clients will continue needing mental health ▪ Would be great to have employment options for graduates
Improving MHTC would improve client treatment post-graduation	▪ Building more trust with clients during MHTC would help them to continue treatment after ▪ More education during MHTC would help clients to continue treatment after ▪ Clients are very anxious about attending court and seeing sanctions, so they associate treatment with stress.

Feedback: MHTC Clients

The clients were asked about help they have received in preparing to complete MHTC (see Table 74). Clients indicated that they agreed or were neutral about whether the court is helping them to prepare for completion from MHTC. In addition, clients reported neutrality that the court has assisted them in providing treatment or medication for when they complete MHTC. Lastly, the majority of clients reported dissent or neutrality to statements that indicated that the MHTC has assisted them in finding housing and employment after completing MHTC.

Table 74. MHTC client perceptions of available assistance in preparing for program completion (*n* = 10).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Other
The court is helping me to prepare for when I complete MHTC.	0%	20%	40%	30%	10%	0%
The court has helped me find treatment and/or medication for when I complete MHTC.	10%	20%	50%	20%	0%	0%
The court has helped me find housing for when I complete MHTC.	30%	30%	30%	0%	0%	10%
The court has helped me find employment for when I complete MHTC.	20%	40%	20%	10%	10%	0%

Focus Group

Team members were asked to collaborate on responses to four questions about the completion of the MHTC program (see Table 75). First the focus group indicated that MHTC terminates clients from the program when they refuse to participate in treatment, when they have acquired multiple violations, when they show repeated non-compliance, or when they have absconded for a prolonged period. Second, the team indicated that if clients to not complete the program, they generally are either placed on standard probation or are given prison time, depending on the crime and the client. Third, the focus group indicated that most clients continue receiving some form of mental health treatment after completion, though substance abuse treatment generally ends unless the client finds a way to continue it on their own. Lastly, the focus group shared that clients' treatment is bridged after completion of MHTC by referring to community 12-step programs, or by connecting them to the MHTC alumni group that has recently started meeting.

Table 75. Open-ended questions to the focus group regarding completion of the MHTC program (*n* = 10).

Open-ended Questions
1. Under what circumstances do you terminate clients from the program?
2. What happens if the clients do not complete the program?
3. Do most clients continue receiving care after completing MHTC?
4. How are clients' treatment continued or bridged for after completion in MHTC?

CENSUS AND CASELOAD

Since treatment courts serve important public health and safety functions, the goal of treatment courts is to provide evidence-based services for all individuals who meet eligibility criteria (Fox & Berman, 2002). However, it is important that the caseload of treatment courts does not become so large that the quality of services and fidelity to best practice standards are sacrificed (NADCP, 2015). Caseloads should be determined according to the availability of resources, local need, and the court's ability to apply best practices (NADCP, 2015). Research on drug courts indicates that treatments courts that serve over 125 participants are not able to serve participants as well, and treatment courts become less effective at reducing recidivism once this threshold is crossed (Carey, Finigan, & Pukstas, 2008, Carey et al, 2012b). In fact, one study found that drug courts with less than 125 participants were over five times better at reducing recidivism than courts with over 125 participants (Carey et al., 2012b). Therefore, best practices dictate that once caseloads increase to over 125 participants, operations should be carefully monitored and any deviations from best practice standards should be addressed (NADCP, 2015). In particular, the following departures from best practices have been observed in courts with more than 125 participants: judicial interactions are half as long, team members are less likely to attend pre-court meetings and status hearings, drug and alcohol testing is less frequent, treatment agencies are less likely to communicate with courts, team members are less likely to receive trainings, and participants are treated by a larger number of treatment agencies with different practices and expectations (Carey et al., 2012c). Thus, large treatment courts should be especially vigilant about monitoring the aforementioned practices.

In addition to monitoring the overall number of participants served by treatment courts, it is also important to monitor the number of participants that probation officers and counselors are expected to serve. Probation officers (and other individuals who provide supervision in the community) should not be responsible for more participants than they can successfully monitor and provide with behavioral consequences (NADCP, 2015). Recent studies examining the impact of probation caseloads on probation services and outcomes have found that individuals with probation officers that have caseloads of 50 or less receive more frequent contacts and treatment, and increases in these services are associated with more positive probation outcomes, namely fewer positive drug tests and other technical violations (Jalbert & Rhodes, 2012). For this reason, it is recommended that supervision caseloads should not exceed 50 individuals per probation officer (NADCP, 2015), and program operations should be monitored closely if the probation officer caseload ever surpasses 30 clients. Similarly, it is recommended that treatment counselors' caseloads do not exceed the number of individuals for whom they can reasonably be expected to assess needs and deliver appropriate services (NADCP, 2015). Substance use treatment providers who are responsible for large caseloads of clients tend to have clients that receive fewer services and are more likely to use illegal substances (King, Meadows, & LeBas, 2004; Stewart, Gossop, & Marsden, 2004). The following thresholds are recommended for clinicians: 50 clients for case management, 40 clients for individual therapy or counseling, and 30 clients for both case management and individual therapy or counseling (NADCP, 2015). It is important to note that these numbers were derived from substance abuse treatment courts; it is likely the case that mental health treatment courts should have smaller caseloads than these thresholds since clients with severe and persistent mental health issues have higher needs.

Feedback: Treatment Counselors

Treatment counselors were asked "How many clients do individual clinicians provide case management for?" Responses varied widely from 5-80 clients per clinician depending on the treatment program. Two treatment counselors reported having caseloads above best practice thresholds, and they were asked whether their program was monitored to ensure adequate services are delivered (Table 76). Counselors responded that programs are monitored closely through data reports, process reviews, outcome evaluations and data review of intakes and discharges, and that BeWell conducts some of this monitoring.

Table 76. Treatment counselors' qualitative responses to the question, "Given these high caseloads, is the program monitored to ensure adequate services are delivered? How?" (*n* = 2).

Response Categories	Descriptions
Yes	▪ Yes ▪ BeWell monitors treatment programs ▪ Quarterly data reports ▪ Process reviews twice per quarter ▪ Outcome evaluations ▪ Data review of intakes and discharges

Focus Group

Team members were asked to collaborate on responses to questions about caseload (see Table 77). The focus group indicated that probation officers currently have around 45 cases on their caseload, but in the past have been in the high sixties. Since this number

was over 30 and nearing the best practice maximum of 50, the focus group was asked whether program operations were monitored to ensure probation officers perform their duties adequately. The team responded that probation is not monitored by the court but if the probation officer is not able to perform their duties the are expected to report this to their supervisor.

The team members were asked whether the team has a goal for the minimum or maximum number of MHTC clients. The focus group responded that there is no minimum or maximum number, but the theoretical maximum is set by how many clients probation can supervise. They reported currently having 16 MHTC clients, which is well under the maximum of 125 from the literature.

Table 77. Open-ended questions to the focus group regarding completion of the MHTC program (*n* = 10).

Open-ended Questions
1. How many active participants do probation officers have?
a. Are program operations monitored to ensure supervision officers can perform their duties adequately?
2. Does the team have a goal for minimum or maximum for number of participants?

STRENGTHS AND WEAKNESSES

The overall pattern of strengths, weaknesses and potential improvements to the MHTC were evaluated by interviewing team members.

Feedback: MHTC Team

Team members were asked about this MHTC's greatest strengths (see Table 78). The most common response was about the teamwork and collaboration between multiple strong partners and staff, including a judge who cares about the clients, connects well with them, and is also firm with them. Team members also appreciated the client-centered approach of the team, achieving good rapport with clients by meeting clients where they are at (including in jail) and focusing on the client's best interest. Another reported strength was the MHTC's ability to facilitate effective treatment by referring to the appropriate treatment, coordinating services, and helping the clients succeed in moving through treatment. One way the court reportedly achieves this is through providing accountability for clients and treatment programs, functioning as a "net among nets," and by starting the treatment on the right foot by providing increased accountability and supervision to clients at the beginning of their MHTC program. Taken together, team members shared that these strengths allow the team to effectively create substantial changes in clients' lives and provide clients treatment to keep them out of jail.

Table 78. MHTC team members' qualitative responses to the question, "What do you think are your MHTC's greatest strengths?" (*n* = 12).

Response Categories	Descriptions
Team	▪ Teamwork and collaboration ▪ Flexible, calm and patient staff ▪ Strong partner agencies ▪ Judge is connected, firm, and cares
Client-centered	▪ Good rapport with clients ▪ Client best-interest focus ▪ Team sees clients in jail
Facilitating treatment	▪ Refer clients to appropriate treatment ▪ Coordinate services ▪ Move clients through treatment
Providing accountability	▪ The court is a net among nets of treatment programs ▪ A lot of accountability in the beginning builds success then independence
Effective	▪ Make big changes in clients' lives ▪ Provide treatment and keep clients out of jail

Team members were asked about the greatest weaknesses of their MHTC (Table 79). The most common response related to the assessment of treatment needs and eligibility. Some team members disagreed about the appropriateness of existing inclusion and exclusion criteria, such as whether the client meets "severe and persistent mental illness," or whether clients should be excluded for violent crimes, DUI's, or domestic violence. Similarly, some team members shared that there was difficulty in determining and agreeing on whether the client's mental health issue is the cause of the crime that resulted in being referred to MHTC. Further, the process of assessing the client happens in multiple phases by multiple people, and sometimes disagreements arise about the client diagnosis or treatment needs; in particular it sometimes occurs that the client graduates from their treatment program before they graduate from MHTC and the question arises as to how to treat the client or whether the client should have been in MHTC in the first place if the treatment provider determines they no longer need treatment. Also, the team shared that the criteria for determining the appropriate treatment program for each client is unclear.

Another theme that arose from the team members regarding the MHTC's greatest weaknesses was communication challenges. Team members shared that mental health representatives are not always present in court when they are needed; further, communication between treatment programs could be better, and BeWell sometimes does not have fully up-to-date information

about each client. Further, communications with other courts could be improved so that other courts and lawyers only refer clients to MHTC who are likely to be eligible and suitable. Lastly, communication with clients is a challenge in that the clients might not always understand enough for informed consent to participate.

Relating to the above to themes, team members shared that currently there are unresolved disagreements among the team and inconsistencies in how clients are treated. Team members shared that the desires for (a) equal treatment of clients for the same behavior, and (b) tailoring treatment and sanctions to the individual needs, strengths and challenges of each client, often create a conflict of values that is difficult to resolve. Relatedly, it was shared that informed consent may need to be individualized to each client's treatment plan.

Finally, one team member shared that the team might benefit from more actively doing self-care, since client tragedies can be emotionally hard on the team sometimes. And one other team members shared that there were no weaknesses that they could think of.

Table 79. MHTC team members' qualitative responses to the question, "What do you think are your MHTC's greatest weaknesses?" (*n* = 12).

Response Categories	Descriptions
Assessment, treatment needs and eligibility criteria	▪ Determining criteria for MHTC eligibility ▪ Determining if mental health issue is the cause of legal problems ▪ Have to send people away for exclusion criteria (violence, DUI, domestic violence) but crime could be mental health related ▪ Determining client diagnosis ▪ Need to fully assess before accepting into MHTC ▪ Unclear criteria for determining appropriate treatment program ▪ Disagreement between BeWell and treatment providers about client needs
Communication	▪ Mental health representatives are not always present when needed. ▪ Communication between treatment programs can be unclear ▪ Lack of client information from BeWell ▪ Need better communication with other courts so appropriate clients come in ▪ Clients might not understand informed consent
Treatment Interventions	▪ ***Seeking Safety**** ▪ ***Relapse prevention therapy**** ▪ Parenting ▪ **Moral Reconation Therapy***
Self-care	▪ The team could do more to take care of team members; client tragedies are hard on the team
None	▪ None

* ***Bolded and italicized*** are highly rated or rated as promising by the Results First Clearinghouse.

MHTC team members were asked about potential improvements to the program structure of MHTC (Table 80). Team members suggested various changes to the intake criteria, whether it be defining criteria, broadening criteria to not deny clients with violent behavior if the team thinks it can be treated, or tightening criteria to accept only clients who want help or whose mental illness directly relates to the crime. Team members also suggested changes to exit criteria for clients who want out of the program or are doing well; shortening the program, providing a way for the client to pull out of MHTC, and finding ways to continue mental health treatment were all options suggested. Relatedly, some team members shared that mental health is spread thin and needs more to be more present. Further, streamlining access to mental health was important, in that clients with mental health issues and few resources (no cell phone, etc.) sometimes have a difficult time getting themselves to a new treatment program from jail or from a different treatment program. Team members also suggested increasing the use of incentives, potentially linking incentives to phases for drug testing, and making the use of sanctions more consistent and based on clear criteria. Several team members suggested phasing would be a beneficial structural change. One team member shared that a manual would be useful in order to guide decisions and make them more consistent. Lastly, a few team members thought that the current structure worked well and no changes are needed.

Table 80. MHTC team members' qualitative responses to the question, "What are some potential improvements to the program structure of MHTC that you would like to see?" (*n* = 11).

Response Categories	Descriptions
Intake criteria	▪ Better assessment ▪ Specify criteria for eligibility - criminal factors and diagnoses ▪ Tighten criteria to only allow clients if treating mental illness would stop the crime. ▪ Accept only clients who want help, not just dismissal of charge. ▪ Rewrite exclusion criteria to not deny violent behavior if it can likely be controlled
Exit criteria	▪ Allow program to be shorter if client is doing well ▪ Provide a way out for clients who want out ▪ Don't turn away clients who need mental health treatment just as they begin to do well
Increased mental health	▪ BeWell is spread thin ▪ mental health more present
Access to treatment	▪ Improve transition to mental health from jail ▪ Improve transition between programs when clients are referred.
Incentives and sanctions	▪ Reward with phases of drug testing requirements ▪ Bring back incentives ▪ Consistency in sanctions
Phasing	▪ Phasing
Manual	▪ Create a manual for the program ▪ Manual should contain guidelines for aspects of client's case (e.g.. different client environmental contexts, funding sources, or drugs-of-choice and what to do for each).
No changes	▪ Works well ▪ Don't change structure

SUMMARY

Program Structure Strengths and Weaknesses

Team members were interviewed about MHTC strengths, weaknesses, and suggested changes. The most commonly shared strength was about the teamwork and collaboration between multiple strong partners and staff, including excellent clinicians and a judge who cares about the clients, connects well with them, and is also firm with them. Probation and treatment programs were viewed as the experts on client progress, and the judge depends on them to make decisions about the client. Communication among team members was generally seen as frequent and effective both inside the courtroom (staffings, hearings) and outside (emails, phone calls), though some team members were less responsive to email than others. One limitation team members shared is that mental health representatives are not always present in court when they are needed; further, communication between treatment programs could be better, and sometimes treatment providers do not provide up-to-date information about each client. Team members shared that there are not enough mental health services available to meet the existing demand for such services, creating a triage situation; thus, finding ways to increase mental health resources and staff would be beneficial to the court.

Another strength that team members reported was the MHTC's facilitation of effective treatment by referring to appropriate treatment, coordinating services, and providing accountability to clients and programs. A suggested point of growth for this area was clarifying criteria for entry into MHTC, as well as how the criteria are assessed. For instance, some team members disagreed about the appropriateness of existing inclusion and exclusion criteria, such as whether all clients meet "severe and persistent mental illness," or whether clients should be excluded for violent crimes, DUI's, or domestic violence. Similarly, some team members shared that there was difficulty in determining and agreeing on whether a client's mental health issue is the cause of the crime that resulted in their being referred to MHTC. Further, the process of assessing the client happens in multiple phases by multiple people, and sometimes disagreements arise about the client diagnosis or treatment needs; in particular, it sometimes occurs that the treatment program determines the client no longer needs treatment before they graduate from MHTC, and the question arises as to how to treat the client or whether the client should have been in MHTC in the first place. Additionally, the team shared that the criteria for determining the appropriate treatment program for each client is unclear. Team members suggested various changes to address these issues, such as conducting more thorough or formalized assessments, creating a manual to clarify criteria and guide decision points, communicating MHTC criteria to other courts so that more appropriate clients are referred to MHTC, or defining criteria more clearly – whether it be broadening criteria to not deny clients with violent behavior if the team thinks it can be treated, or tightening criteria to accept only clients who want help or whose mental illness directly relates to the crime. Team members also suggested changes to exit criteria for clients who want out of the program or are doing well, including shortening the program, providing a way for the client to cancel MHTC participation, and finding ways to continue mental health treatment if the primary treatment program declares they no longer need such a high level of care.

Team members also identified the client-centered approach of the team as an area of strength, achieving good rapport with clients by meeting clients where they are at (including in jail) and focusing on the clients' best interests. However, clients were divided as to whether they perceived they had a choice in participating in MHTC or not. Team members identified a way to further improve this area could be making the informed consent process more clear and understandable to clients.

Program Sequence and Phasing

Phasing is a well-established best-practice for Substance Abuse Treatment Courts (SATC), but current research has not yet determined whether phasing is a best-practice for MHTCs. Some MHTCs implement phasing whereas others do not. Less than half of team members agreed that requirements for completion of MHTC are clear. Further, it is a best practice from drug courts that educational or vocational services be delivered only after a client resolve housing, substance abuse, criminal thinking, or peer support issues, yet less than half of team members agreed that educational and vocational services are delivered after clients achieved stability in these areas. These may be signs that the team could benefit from a phasing structure that guides goals, treatment, and expected progress at different phases of the program; however, it could also be an byproduct of the nature of MHCs themselves, in that clients in MHCs may not be as likely to pursue educational or vocational opportunities due to the limitations of their mental health symptomology and presentation. Furthermore, although some team members thought the current structure worked well and no changes were needed, many team members shared that phasing would be a beneficial structural change that could help the client feel successful at completing something, help clients understand where they are in the program, diminish client anxiety, push client progress, help clients see the value of creating structure for themselves, prepare clients for the real world, facilitate the team's understanding of the clients' progress, and clarify when the client has completed the program.

The most common challenge team members shared to implementing phasing related to the particularly wide variation in client capacity in the MHTC population – thus phase progress should not be simply based on phase duration, and it would be challenging to develop criteria for phases that work for all clients. Suggested solutions generally involved defining criteria for phase levels that are flexible to different client ability levels, such as: commitment to treatment, client engagement, client stability, client personal life improvement, mastery of curriculum material, and client goals and progress measured against client baselines. In addition, team members suggested it would be beneficial to define what the team means by "doing well," as well as outline the consequences for specific behaviors for clients in different phases.

Elements of phasing that are common in other MHC's around the country were gathered, and team members rated whether they felt this MHTC currently implements those elements or whether it would be helpful to implement them as part of phases. Elements that were identified as beneficial but not occurring now included establishing and rewarding honesty and attendance, establishing clients' understanding and consent for MHTC's requirements and goals, parent training, teaching how to identify and address potential relapse issues, vocational or educational training, focusing on client strengths, developing time management skills, maintaining continuing care and wellness plans after graduation, and addressing basic housing, food, transportation, and safety needs. In addition, stakeholders identified aspects of moving between phases that do not currently occur but could be beneficial, such as: program completion should be based on engagement with treatment and law-abiding behavior, phases should build on skills of prior phases, requirements to proceed from phase to phase are clearly delineated and communicated, and treatment intensity and phase should be based on clients' needs and if clients demonstrated progress to proceed to the next phase.

Drug Testing, Program Completion, and Caseload

Substance abuse was reported by team members to frequently co-occur with mental health issues for Santa Maria MHTC clients. Literature about drug testing suggests that establishing valid, reliable, random, unpredictable, rapid, and comprehensive drug tests administered by trained staff with a clear chain of custody is vital to understanding and treating clients who suffer from substance abuse. Drug testing procedures for MTHC clients with substance abuse issues were found to largely be in line with best practices established from substance abuse treatment courts. Only 1 of 14 best practices needed improvement: tests that measure drug use over extended time periods should be applied for at least 90 days and stakeholders reported this sometimes occurs.

Preparing clients for program completion is another important aspect of MHTCs. Current aftercare supports include transition plans in treatment programs, aftercare in some treatment programs, an open-door policy for clients to return to court to check-in, a recently started alumni program, and clients with severe and persistent mental health issues often continue to qualify for mental health treatment after graduation. However, team members shared that it is largely up to clients whether they utilize these services, in some cases few if any aftercare occurs, and there is a high recidivism rate among MHTC clients. The majority of team members disagree or are neutral that the MHTC provides adequate support to clients to prepare them for success after graduation. MHTC clients were neutral about whether MHTC helped them to succeed after graduation, but negative that MHTC helped with housing or employment after graduation. Team members suggested it would be beneficial to have employment options and a lower-level treatment option for clients who no longer qualify for intense mental health treatment. The team might also benefit from building more after-care supports into the last phase of the program, and doing an outcome evaluation to determine how many clients are recidivating and if there are common factors among those who are recidivating.

Best practices from substance abuse treatment courts outline maximum caseloads for case managers, clinicians, and probation officers, as caseloads higher than these numbers has been associated with decreased outcomes for clients. As MHTC likely have similar or greater needs than SATC clients, these caseload thresholds may be useful to MHTCs. Treatment team and counselor interviews revealed that current caseloads require caution for probation officers and may be well beyond best practices for some treatment providers. Treatment programs and probation should be monitored closely for program processes and outcomes, or more staff should be hired in agencies where caseloads are high.

Conclusions

SUMMARY OF FINDINGS

This mental health treatment court (MHTC) process evaluation utilized six sources of information: 1) observations of team staffings; 2) observations of the corresponding courtroom proceedings; 3) interviews and surveys from MHTC team members; 4) a focus group of team members regarding MHTC adherence to guiding principles and promising practices; 5) interviews and surveys with treatment counselors; and 6) consumer surveys with MHTC clients. Each addressed elements of known best practices or guiding principles in MHTC or treatment courts, or has demonstrated associations with outcomes in other fields.

Treatment

Team members shared that high-quality substance abuse treatment is available to clients who need it; however, they were divided about the availability of other services, such as mental health treatment, trauma-specific services, criminal thinking interventions, family or interpersonal counseling, and medical or dental treatment. Unmet client needs most commonly included housing, vocational opportunities, and access to medication.

Counselors agreed that that their treatment agency utilizes evidence-based treatments, treats co-occurring disorders concurrently, provides individual counseling and regular supervision, delivers treatment that improves outcomes for clients, and addresses clients' criminal and legal issues; clinicians were viewed as proficient at delivering interventions, and having a good therapeutic relationship with MHTC clients. However, MHTC clients were largely neutral about whether they had a good relationship with treatment staff and are treated fairly by them.

Team members reported that treatment plans are individualized, based on client need, flexible, and reinforced through accountability provided by the court; however, team members suggested that accountability could be improved, and knowledge or communication about clients' compliance, progress, or treatment plans was sometimes inadequate. Client assessment was reported to occur quickly; on the other hand, team members and counselors shared that initial assessments were unstandardized and brief, and sometimes contradicted later assessments from treatment programs, creating disagreements about treatment needs and client eligibility. Furthermore, when standardized assessments were used they were applicable to substance abuse populations only.

Gender-specific treatment, culturally-sensitive interventions, and various population-specific groups were reported to be available by team members and treatment counselors, yet cultural sensitivity and specificity was identified in the focus group as an area for growth. Although treatment counselors were able to share successful strategies used to support clients with PTSD or severe trauma, most counselors shared there was no formal process for screening or assessment of trauma issues or whether group interventions were appropriate.

Courtroom Processes

Treatment progress was a focus for MHTC case discussions. Decisions on client progress were made collaboratively by the treatment team, with the judge serving as the final arbitrator when necessary. The judge participated in all of the status review hearings. Judicial interactions with the clients were reported and observed to be were positive, individualized, and direct. The court frequently used recovery-sensitive language and encouraged clients to be active participants in their hearings. Clients reported being held accountable by the team and clients participated in their hearings. However, client feedback was divided about whether the judge makes supportive comments during their hearings, lets them tell their side of the story, or has all the facts available to make good decisions. Further, the majority of MHTC cases were heard for less than three minutes in court, and there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members, with mental health representatives sometimes absent from court when they were needed. Additionally, both team members and clients were somewhat neutral about whether the court encourages family and prosocial supporters to participate in the process.

During court hearings, more recognition and incentives than sanctions were observed. It appeared that the staff were attempting to reinforce clients even when clients were struggling. Team members shared that sanctions were graduated, individualized and matching the severity of the infraction, but were divided about whether jail time was used as a sanction sparingly and after other sanctions have been tried. There was some feedback that jail actually impeded the ability of clients to efficiently obtain medication and stabilization. Additionally, some team members thought sanctions and incentives were administered inconsistently between different clients, possibly due to individualizing sanctions and incentives to diverse clients, as well as lacking formal guiding documentation about the application of sanctions and incentives.

Programmatic Structure

Identified strengths of the MHTC included collaboration and communication between strong staff and partners, facilitation and accountability for effective treatment, and a client-centered approach. Identified weaknesses included insufficient mental health resources to meet the demand, and caseloads may be too high in some agencies. Additionally, team members expressed challenges in agreeing on criteria for MHTC clients, and in attaining adequate assessment of whether clients meet criteria. Further,

team members identified that the informed consent process could be made more understandable to clients; clients were divided about whether they had a choice to participate in MHTC.

Team members largely agreed that implementing a phasing structure would be beneficial, yet also challenging due to widely varying levels of functioning among MHTC clients. Suggested solutions included defining criteria for phase levels that reward client effort and are based on client progress above their baseline. Team members also identified various foci and elements of phase structures that could be beneficial to implement which are detailed in the report.

Drug testing procedures were reported to be valid, reliable, random, unpredictable, rapid, comprehensive, and largely within best practices. The only potential improvement was tests that measure drug use over extended time periods should be applied for at least 90 days and stakeholders reported this sometimes occurs.

Clients and team members indicated that some support was provided to prepare clients for program completion, yet the support was seen to be inadequate by counselors and team members, especially for housing and employment needs.

RECOMMENDATIONS

The lack of clear guiding principles for MHTC in the research literature creates challenges for MHTC teams; however, the research that does exist across other domains lends to the following conclusions/recommendations:

1. The court reported a lack of documentation of policies and procedures specific to the MHTC. There were also largely conflicting perceptions on how well various processes within the MHTC work, and how they should work, which is likely a result of having unstructured processes. It is recommended that the court consider compiling a written policies and procedures manual that reflects elements of the following:
    a. The court's background
    b. Objectives and goals
    c. Target population
        i. Eligibility and suitability criteria
    d. Intake procedures
        i. Guidelines to assess client competency and attain consent so that clients perceive a choice.
        ii. How diagnoses are to be determined in a valid and reliable way (e.g., through use of standardized instruments agreed upon by the team, and by securing adequate time with the client to conduct such assessments)
        iii. Treatment determinations - Formalize a decision tree about which treatment program a client is referred to.
    e. Treatment requirements
        i. What aspects of treatment plans and progress are to be supervised by the court, and how.
        ii. Duration minimum and maximum for MHTC involvement.
    f. Sanctions/incentives protocols
    g. Graduation requirements
        i. Guidelines for phasing clients through MHTC
    h. Narratives on team members' roles and responsibilities
    i. Orientation and training procedures for new team members

    This could be conceived as the primary overarching recommendation for this evaluation, as achieving this recommendation would likely address several areas of the evaluation. For example:
    a. There was indication that the assessment process was creating barriers for the clients. In particular, there was a reported lack of a standardized process, and a lack of sufficient time spent with clients during assessment, that led to differences of opinion between team members and treatment providers, and multiple clients being incorrectly referred or placed into MHTC. Additionally, there was some indication that attaining access to a psychiatrist and getting on medication sometimes took a long time, delaying clients' recovery. The team may benefit from exploring ways in which a standardized assessment process can be approached, including advocating for using validated and evidence-based assessment tools in determining client diagnoses. In addition, the court could explore how to secure sufficient time for client assessments, obtain physical copies of client assessments, and expedite client access to psychiatrists when needed. By targeting these improvements in understanding the target population and addressing issues with the assessment process, it may help the team to connect clients with appropriate treatment quicker, reduce confusion between the team and potential referral sources, and reduce the load on the mental health teams conducting the assessments by decreasing the number of inappropriate referrals.
    b. There were competing values on the team of whether sanctions should be flexibly individualized or applied consistently between different clients with the same behavior. Both values could be met by providing guiding documents which explicitly allow for ranges in consequences for specific behaviors based on individual client considerations at distinct phases in the program. Team members also suggested keeping track of the receipt of sanctions and incentives over time to see trends for each client. Further, team members suggested broadening the array of sanctions and incentives that are used. Adding more incentivizing options, such as reinstating the use of stickers, could serve to reinforce and motivate clients better and decrease the need for sanctions.

Conversely, expanding sanction alternatives, such as those involving increased treatment, could provide the team with more options to use before jail, as the literature does not support the use of jail as a stabilization mechanism. The creation of a guiding document could serve as a springboard for the team to brainstorm additional options for sanctions and incentives.

c. There appeared to be a need for better communication regarding client progress across team members and agencies/organizations. This includes achieving better attendance for treatment representatives, and collecting more than superficial information on clients. It is important to note that, in prior years, there was a concern that unimportant information was being disseminated in a time-consuming fashion, but also that not everyone was providing information to the team. Again, this points to the need to establish set criteria for what is of interest to the court, so as to be sure to exclude extraneous information that is time consuming and irrelevant to the supervision of the team on the client, but to be sure to include enough information to effectively supervise the clients. This could even take the form of a face sheet/checklist that generally guides what good information may be helpful to pass on to the team. For this to be effective, treatment representatives will need to be present in court when needed, and the team might benefit from attempting to address any structural challenges that lead to treatment representatives not being present, for instance by advocating for more manageable caseloads for some treatment providers, improving communication regarding client cases for team members that are unable to consistently attend MHTC, or exploring if alternative representatives would be available to attend team meetings and court hearings.

d. Phasing is a best practice in other treatment courts and several successful MHTCs use phasing to conceptualize, structure, and reward client advancement through the MHTC. Team members generally agreed that implementing phasing would be beneficial, though challenging due to the wide range in MHTC client abilities and diagnoses. Suggested solutions generally involved defining criteria for phase levels that are flexible to different client ability levels, such as: commitment to treatment, client engagement, client stability, client personal life improvement, mastery of curriculum material, and client goals and progress measured against client baselines. In addition, team members suggested it would be beneficial to define what the team means by "doing well" at different phases, outline the consequences for specific behaviors for clients in different phases, and build more after-care supports into the last phase of the program. Several additional suggestions for foci of the phases and practices surrounding phasing can be found in the Program Structure section of the report as well as in Appendix B.

2. It is worth noting that clients' reports of their relationship with the team and their treatment providers is decidedly neutral and not overwhelmingly positive. This could be the result of many things, but the practice of not seeing all clients for three minutes, and in particular not spending time in court at all with clients on the "A list," may be contributing to clients' perceptions. One of the cornerstones of treatment courts is judicial interaction, and thus taking this aspect away is likely to deteriorate court-client relations. Additionally, behaviorism theories reliably tell us that when individuals desire attention but do not receive it, they are likely to act out in negative ways to obtain this attention; by giving less attention to clients who are doing well, the team may be perpetuating a cycle whereby clients will self-sabotage in order to get recognized and feel cared for again. Spending time with all clients would give the team more opportunities to praise pro-social activities, check in with clients about their progress, and remind clients of the importance of complying with program requirements. It is recommended that the court cease the process of not spending time with clients who are doing well, and focus on establishing agreed-upon methods of functioning within MHTC; this could enable the team to spend less time negotiating processes and more time promoting positive alliances with the MHTC clients themselves.

3. There were differences in opinion among team members as to how effective the court was at reducing recidivism, and team members seemed to be making these assessments anecdotally. It may benefit to the team to conduct an outcome evaluation to determine client outcomes and if there are common factors among those who are recidivating or succeeding.

SECONDARY RECOMMENDATIONS

A number of secondary and less urgent recommendations also emerged from the evaluation. Most of these recommendations emerged from the team members and treatment counselors themselves, with a few derived from the evaluators. The purpose of providing these secondary recommendations is to ensure that the feedback from all of the stakeholders involved in MHTC is heard; the team can consider if any of these recommendations are actually 'primary' concerns and make appropriate changes.

Intake

- Consider broadening eligibility criteria to not deny clients with violent behavior if the team thinks it can be treated, or tightening criteria to accept only clients who want help or whose mental illness directly relates to the crime.
- Broaden exit criteria for clients who want out of the program or are doing well, including shortening the program, providing a way for the client to pull out of MHTC, and finding ways to continue mental health treatment if the primary treatment program declares they no longer need such a high level of care.
- Accelerate process of clients seeing a psychiatrist when needed.
- Streamline the process of attaining clinical assessments that have been done by other agencies.
- Conduct formal standardized screening for group suitability and PTSD/trauma as part of the court intake process, or support treatment programs to do this as part of their intake process.

- Communicate MHTC criteria and goals to other courts and attorneys so that appropriate clients are referred to MHTC.

Treatment

- Explore ways the MHTC could benefit from increasing cultural sensitivity in their practices and available treatment modalities. This could include:
  - Supporting peer counseling.
  - Using more culture-specific treatments and providing treatment in primary language.
  - Providing training specific to populations that are commonly present within MHTC clients to improve client perceptions of treatment relationship.
- Provide two facilitators per group.
- To the extent possible, provide separate groups for clients with and without substance abuse issues or at different levels of risk.
- Include families in treatment.
- Investigate all interventions to ensure there is research support for their positive benefit to clients. Results First Clearinghouse is one easily accessible meta-analytical database.

Resources

- Compile and provide information for all stakeholders and clients to review on gender-specific and culture-specific practices available to clients at each treatment agency and during court and probation appearances, to ensure all individuals involved in MHTC are aware of the array of diversity accommodations in the program, bridge client access to appropriate treatment, and springboard the development of further accommodations as needed.
- Seek additional funding to increase resources for MHTC clients, including housing and mental health services.
- Provide drug treatment options specifically for clients with severe mental health issues.
- Find employment options in the community for MHTC clients and graduates.
- Provide an option for a lower--level of mental health care once clients see some progress and start to do well (and are discharged from their primary treatment program).
- Forge partnerships with urgent care facilities and primary care providers within the community that could assist in the medication management issue that clients face.
- Treatment programs, BeWell, and probation should be monitored closely for program processes and outcomes, or more staff should be hired, when caseloads are high.

Structure

- Consider ways to further support positive interactions with family members and prosocial supporters, including, interviewing family members and social supporters to attain information about clients' eligibility and needs, encouraging family/social support involvement in clients' programs, and linking family members and social supporters to appropriate services.
  - Advocate that the release of information between the MHTC and the treatment agencies, and between treatment agencies and client family members or prosocial supporters, to be a streamlined part of the intake process for each agency.
- Monitor time from incarceration to receipt of the clients' prescribed and appropriate medication within jail, as well as within the community.
- Consult with lawyers on the team as to whether current practices of sharing HIPAA protected information over email is within legal guidelines; if not, seek a solution and create a protocol.
- Drug testing
  - For drug tests that measure drug use over extended time periods, apply them for at least 90 days.
- Create a general contract or MOU for outside treatment agencies to sign outlining the necessary treatment and communication needed by the court in order to work with MHTC clients. Clients and lawyers who want to use outside treatment agencies can advocate for those agencies signing the agreement.

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Appendix A

Santa Barbara County Drug Court Process Evaluation

SANTA MARIA MENTAL HEALTH TREATMENT COURT (MHTC)

Fall 2016 Evaluation

Supplemental Handout

THE "THREE-MINUTE" BEST PRACTICE

The recommendation of spending at least three minutes per client at status review hearings is one of the most well-known best practices in the drug court field, and one that sometimes seems unattainable. The following is a breakdown of numbers and statistics from the current report, in order to help facilitate the team's efforts toward achieving this three-minute goal.

CALCULATIONS

Team Staffings

Over the two-day period, a total of 1 hours and 6 minutes were spent in staffing. This equates to approximately 33 minutes and 10 cases per day. Staffing is currently designated to occur between 9 a.m. and 11 a.m. on MHTC days, as well as additional time as needed during status review hearings in the afternoon.

Courtroom Hearings

Over the two-day period, a total of 1 hour and 15 minutes were spent in status review hearings across 20 MHTC cases. This equates to approximately 38 minutes and 10 cases per day. Other calendar(s) were heard during this time and recorded, but not coded for this the report. 66 total cases were seen by the court across the two days, so MHTC cases amounted to about a third of the cases. In addition, team members and observers reported that some clients are handed their docket and not seen for hearings when the team determines that they are doing well.

Ideal vs. Actual Time

If 33 cases are heard on average a day (10 MHTC and 23 'Other'), there is potential to spend at least three minutes with a client during status review hearings (33 cases X 3 minutes = 99 minutes = 1 hour, 39 minutes). Currently, status review hearings are occurring over an average of 38 minutes a day with MHTC clients; and the average amount of time spent with an MHTC client is over 3 minutes. However, there are significant differences across clients regarding how much time is spent in status hearing. While 20% of clients were seen for over 5 minutes, 50% of clients were seen for less than 3 minutes and 10% were seen for less than 1 minute. Thus, the team may have to reallocate time to ensure that all clients are seen for an appropriate amount of time. Moreover, it was reported by team members that some clients are not seen for status review hearings at all if the team deems that they are doing well. This practice violates established best practices as it does not provide the team with opportunities to reinforce clients' successes. Moreover, it is important to have clients who are doing well in status review hearings so they can serve as models for other participants. Further, if some clients were given their docket but not called, they would not have been recorded by this evaluation, so the average amount of time spent per client could be lower.

RECOMMENDATIONS

The team may benefit from restructuring their current MHTC timetable and working to designate specific and explicit times for their staffings and status review hearings. This could potentially be achieved by:

- Using a timer to ensure each client is heard for at least three minutes during status review hearings;
- Utilizing the strong communication skills demonstrated between team members during the week (e.g., through emails and other communications) to discuss details about clients, and avoid discussing these details at length when the team meets, unless necessary;
- Rearranging the calendar so that MHTC client hearings are allotted a specific time at the beginning of the hearings block with sufficient time to see all MHTC clients.
- Having a clear guiding manual may serve streamline a more efficient staffing process by reducing disagreements about goals and procedures for difficult cases.

Appendix B

Summary of Phasing Practices Of Mental Health Treatment Courts

Phasing is a well-established best-practice for Substance Abuse Treatment Courts (SATC), but current research has not yet determined whether phasing is a best-practice for Mental Health Treatment Courts (MHTC). There there are many similarities in philosophies and practices of SATCs and MHTC's, and MHTC clients may also require substance abuse treatment; however, there are specific challenges that arise in implementing phasing for MHTC populations. For instance, MHTC clients may have wide range in what they can be expected to achieve during MHTC due to different diagnoses and prognoses; thus phasing for MHTC needs to be particularly flexible and individualized to each client.

Some MHTCs implement phasing whereas others do not. A compilation of numerous MHTC phasing practices across the county were compiled and condensed for broad themes/program aspects. These themes are reflected in the phases below.

Initial phases of MHCs often focus on engagement, stabilization, and resolving conditions that are likely to interfere with retention or compliance in treatment.

- Establish client's understanding and consent for MHTC requirements and goals.
- Assess risk and needs and draft a treatment plan.
- Address basic housing, food, transportation and safety needs.
- Stabilize mental health symptoms.
- Ameliorate acute psychological symptoms or physiological symptoms of addiction (if present).
- Build rapport, acceptance, and hope.
- Focus on client strengths; don't "fix" everything at this stage.
- Establish and reward honesty and attendance.
- Establish routines of treatment and supervision.

Interim phases focus on treatment and resolving needs that increase the likelihood of criminal recidivism and substance abuse if present (criminogenic needs).

- Develop understanding of mental illness, substance abuse, recovery tools, and relapse prevention.
- Ensure all medications are taken prescribed.
- Sustain abstinence from drugs and alcohol.
- Address dysfunctional or antisocial thought patterns.
- Eliminate delinquent peer associations.
- Strengthen support system and establish prosocial peer support person.
- Reduce family conflict.

Later phases address skill building and the remaining needs that are likely to undermine the maintenance of treatment gains (maintenance needs).

- Provide vocational or educational assistance (if applicable).
- Establish long-term housing and financial stability.
- Strengthen connections to community resources and relationships.
- Complete community service obligations (if applicable).
- Parent training (if applicable).
- Anger management (if applicable).
- Develop problem-solving and decision-making skills.
- Develop financial management skills.
- Develop time management skills.
- Establish prosocial leisure-recreational activities.
- Other interventions designed to enhance participants' activities of daily living (ADL) skills.
- Clients demonstrate ability to utilize recovery and cognitive restructuring skills in progressively challenging situations.
- Create continuing care and wellness plans to continue these activities after graduation.

Many MHC's with phases include a last "maintenance" phase, where clients have an opportunity to maintain their skill development, demonstrate increasing independence, and prepare for transition out of the court's care.

- Clients practice their aftercare plan mostly on their own with infrequent supervision as a safety net.

- Clients demonstrate ability to identify their potential relapse issues and how to intervene to avoid relapse, from both emotional and addiction (if applicable) recovery.
- Clients support the development of other clients in earlier phases of MHTC.
- Clients maintain effective performance in prosocial life roles.

Movement between phases is often predicated by a number of different factors, including progression in treatment and/or skill building, compliance with the above-decided elements of phasing, and duration spent in their current phase. Each MHTC often develops their own strategy for tackling how they will decide when phase promotion occurs. Some frequent elements of how clients move between phases include:

- Phases build on skills of previous phases.
- Treatment plans and phasing requirements are flexible to individual needs of clients.
- Clients demonstrate progress from each phase in order to proceed to the next.
- Requirements to proceed from phase to phase are clearly delineated and communicated.
- Treatment intensity and phase are based on client needs and not used as a sanction for noncompliance unless such noncompliance indicates a need for more intensive treatment.
- A standard range in duration of the MHTC program is determined and agreed upon.
- Program completion is based on engagement with treatment and law-abiding behavior.
- Recognition that some goals of treatment may not be attainable within time in mental health court.
- Phase progression should not be delayed for payment of outstanding fees, fines or restitution.
- Court attendance is diminished across phases.
- Supervision conditions are based on need and risk level.
- Drug testing and drug treatment continues based on need throughout the program.

Appendix C

Mental Health Treatment Court (MHTC) Drug Testing Survey Questions ***Date:*** _____

Name: _____ **Time working with MHTC:** _____

For MHTC clients with substance abuse problems, please rate the frequency MHTC implementation of each of the following items:	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
	1	**2**	**3**	**4**	**5**
Tests that measure substance use over extended periods of time, such as ankle monitors, are applied for at least ninety consecutive days followed by urine or other intermittent testing methods.	1	2	3	4	5
Tests that have short detection windows, such as breathalyzers or oral fluid tests, are administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays.	1	2	3	4	5
The schedule of drug and alcohol testing is random and unpredictable.	1	2	3	4	5
The probability of being tested on weekends and holidays is the same as on other days.	1	2	3	4	5
Regular drug and alcohol testing is interrupted for changes in treatment.	1	2	3	4	5
Test specimens are examined for all unauthorized substances of abuse that are suspected to be used by Drug Court participants.	1	2	3	4	5
Collection of test specimens is witnessed directly by a staff person who has been trained to prevent tampering and substitution of fraudulent specimens.	1	2	3	4	5
Clients may use independent drug or alcohol testing in lieu of being tested by trained personnel authorized by the MHTC.	1	2	3	4	5
The MHTC establishes a chain of custody for each drug test specimen.	1	2	3	4	5
If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis.	1	2	3	4	5
Drug concentrations falling below cutoff levels are interpreted as evidence of changes in participants' substance use patterns.	1	2	3	4	5
The MHTC uses scientifically valid and reliable testing procedures for clients with substance abuse.	1	2	3	4	5

How long do clients have to test after being notified of testing? _____

How long after drug testing are results provided to the drug court? _____