SANTA BARBARA COUNTY MENTAL HEALTH TREATMENT COURT PROCESS EVALUATION

June 2016

Santa Maria Mental Health Treatment Court

The UCSB Evaluation Team conducted a process evaluation of the Santa Barbara County Mental Health Treatment Court in Santa Maria from October 2015 through January 2016. 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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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.

Stakeholder Roles

Team members indicated that they understood each other's roles on the team. The judge was perceived to have a strong leadership role, was represented as an intermediary between the court and clients, and was perceived to have established relationships with the clients. Team members identified the role of the district attorney and the public defender in MHTC as having both non-traditional and traditional characteristics. Substance abuse treatment providers and County mental health treatment providers were all seen as individuals providing various treatment and case management services to the clients. The role of the County's psychiatrist/psychologist was described as screening clients for program eligibility and connecting clients with services. All of these individuals were also seen as important parts of the MHTC team. Individuals identified as having less involvement in the MHTC were the coordinator, bailiff, and community law enforcement.

Large differences in the amount of professional training received between team members were reported. The majority of the team members indicated that they had received little to no training on MHTC prior to serving on the MHTC team. Team members suggested various potential preparations for serving on the MHTC team would possibly be helpful for future team members. Some team members also indicated that there was perceived to be some degree of adversarial functioning within various roles of the team, suggesting that there may be difficulties in adjusting to this difference in working in treatment courts for individuals in some roles.

MHTC Relationships

The majority of MHTC team members indicated that their team exhibited cohesion and collaboration, and that the team generally worked well together and exhibited many aspects of effective teamwork. Team members indicated both areas of strength and weakness in team functioning. The feedback suggested an overall cohesive team with some experiences of disagreement. Team members indicated several ways in which team cohesion could be improved. Many of the suggestions addressed programmatic improvements, suggesting that the team did not perceive that they are unable to connect cohesively, but rather that team discord may instead be a result of programmatic structures that need improvement (e.g., improved assessment process, increased resources, trainings, improvements to staffing/status review processes). The relationship between the MHTC team and the treatment providers was generally reported to be positive, and characterized by good communication and collaboration between the agencies. The relationship between the court and the clients was generally reported to be positive by both the team members and the MHTC clients. The relationship between the treatment providers and the clients was also noted as being generally positive. However, a few clients indicated negative or neutral perceptions of their relationship with the court and with their treatment provider.

Treatment

The team reported a flexible and open-minded approach to medication management of MHTC clients, and cognizance of the lifelong struggle with mental illness that clients experience. It was reported that client treatment plans are individualized and based on client needs, and treatment plans are flexible to adjustment. The clients were perceived as being held accountable for compliance with their treatment plans. Team members perceived that the court was supervising both the client mental health and substance use plans fairly well, and that the court stays well informed on client progress on their treatment plans. The evaluation found that MHTC clients received individual counseling and regularly attended peer support groups, and that gender-specific treatment and cultural-specific treatment options were available to MHTC clients. The participating agencies reported engaging in numerous best practices in treatment courts and providing interventions with individuals with mental illness in general. In addition, it was reported that clients' criminal and legal issues and graduation requirements were addressed in treatment. Team member feedback suggested that clients were quickly entered into substance abuse treatment programs; however, concerns were raised that the court lacked a wide enough array of treatment options for clients and that the time to receipt of mental health treatment was too long.

MHTC Perceptions

General perceptions of mental health courts were examined; the majority of the MHTC team and treatment counselors reported positive perceptions. Team members identified a number of aspects of MHTC that they felt were the court's strengths, including teamwork and the team working together in the clients' best interests. Treatment counselors generally reported positive perceptions of their clients' interactions and experiences with MHTC. Treatment counselors indicated that they felt MHTC clients comply with various treatment aspects better than non-MHTC clients. Treatment counselors reported that they generally felt that the MHTC has assisted in promoting positive outcomes and program compliance for clients. A major benefit to MHTC participation was identified as being the increased access to treatment afforded by client participation in MHTC. Treatment counselors did not identify many disadvantages to client participation in MHTC. Team members and treatment counselors also identified areas for improvement and suggestions to ameliorate any perceived weaknesses in the MHTC process, such as improving the team processes, trainings,

obtaining various additional resources, improving suitability/eligibility processes, improving the sanction process, improving services, and creating policies and procedures/administrative documents for the MHTC. Lastly, there was some sentiment endorsed regarding defense counsel marginalization in MHTC processes.

Non-traditional Characteristics

Courtroom observations indicated that the clients' families were incorporated in some of the hearings. The majority of team members reported a nonadversarial MHTC and a belief that team members are committed to the program. The team members and treatment counselors identified particular personality characteristics, attitudes/beliefs, knowledge bases, and the ability to form relationships with clients and other team members as being important for a well-functioning MHTC; they also indicated that they felt the MHTC exhibited these characteristics. Team members and treatment counselors indicated mixed attitudes toward mental illness. It appeared that there were some perceptions of community support, but that the support was not perceived to be strong. Team members noted several suggestions for improving community support. The team also brought up concerns regarding client confidentiality in seeking additional community support.

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; clients participated in their hearings, and families were involved in some of the hearings. However, the majority of MHTC cases were heard for less than three minutes in court, and, observers noted that there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members. Additionally, the majority of clients indicated neutrality with the statement that they have a good relationship with the judge.

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 reported that sanctions were administered in a fair and graduated manner, and that responses to client noncompliance were individualized. Individually, a majority of team members indicated that jail was not often used as a sanction; however, in the focus group several team members indicated that jail was used as a method for connecting clients to access with medication or for stabilization of emotional concerns. There was some feedback that jail actually impeded the ability of clients to efficiently obtain medication and stabilization. In addition, some MHTC clients indicated neutrality or dissent to a statement reflecting that the MHTC team does not get angry with them when administering sanctions. Finally, there were varying perceptions of whether or not the MHTC team representatives were notified quickly when clients were arrested.

Clients and team members indicated that support was provided to prepare clients for program completion, more so with regard to future treatment and less so for housing and employment.

Program Entry

Program entry processes into MHTC (i.e., target population, case referral process, eligibility/suitability) were identified as areas that could benefit from improvement. Team members noted that the case referral process was working as well as it could, and feedback indicated that the eligibility process generally worked well. Feedback from some team members indicated that validated assessment tools were utilized in order to determine various aspects of client appropriateness for MHTC (i.e., recidivism risk, mental health needs), with others indicating a desire for standardized assessments in determining clients' mental health needs. It appeared that there was a lack of understanding of a universally accepted eligibility and suitability criteria, a lack of standardized assessment process, and a lack of understanding of differences between MHTC and other treatment courts. The main barriers identified within the case referral process were a lack of timeliness of assessment completion and inappropriate clients being referred.

Administrative Processes

The majority of clients reported that the MHTC reviewed program expectations and sanction procedures with them, although there were clients who indicated that they thought neither of these had occurred. Clients were also asked if they felt they were participating in MHTC on their own free will, with client responses varying across the spectrum of responses. The majority of treatment counselors felt well-informed about MHTC processes, but almost half did not agree with this sentiment. Similarly, the focus group indicated that staff did not have easy access to written materials for MHTC as suggested or recommended within the literature. Team feedback indicated that the intention is to keep the program as individualized as possible, and thus standardized materials were difficult to develop.

RECOMMENDATIONS

1) One of the more common themes that emerged in the evaluation was a lack of common understanding as to what constitutes a severe mental illness, what is meant by substance abuse and addiction, and how these co-occurring disorders interact. In addition, there appeared to be a lack of knowledge of research on evidence-based interventions and treatment for individuals with severe mental illness. The court could consider seeking out training on these topics. A training could also help to better evaluate the MHTCs eligibility and suitability criteria, which some team members felt were too inclusive of clients who were inappropriate for the MHTC. It is recommended that the court collaborate with the other treatment courts (i.e., dual diagnosis court (DDC), substance abuse treatment court (SATC)) to ensure that explicit target populations are defined.

2) The court also reported a lack of documentation of policies and procedures specific to the MHTC. There was some feedback that this was due to an attempt to individualize each client's case to their specific treatment need; however, there are benefits to having basic program structures in place with the knowledge that individualization would occur. It is recommended that the court consider compiling a written policies and procedures manual that reflects elements of the following: the court's background, objectives, and goals; target population; graduation requirements; treatment requirements, sanctions/incentives protocols; and narratives on team members' roles.

3) There was indication that the assessment process was creating barriers for the clients. In particular, there was a reported lack of timeliness of completion of assessments (and thus, a lack of ability for clients to receive services until the assessment was completed). Additionally, there was a reported lack of a standardized process that led to multiple clients being incorrectly referred or placed into MHTC. There was also a desire to see written assessments for the court to be able to review as a team. 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 ways in which the time from referral to assessment can be expedited, and how to obtain physical copies of client assessments. By targeting both improvements in understanding the target population and addressing issues with the assessment process, it may help the team to connect clients with 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 being assessed by their psychiatrist(s), which, in turn, may reduce turnaround time on assessment completion.

4) There was concern noted by interviewees as well as observers that there are some inconsistencies in team member attendance at the team meetings and status review hearings. There were also differences noted in the level of engagement and participation of team members during both of these processes. There was indication that this may be due to turnover and limited availability of some of the team members. The team may benefit from having discussions surrounding how to improve communication regarding client cases for team members that are unable to consistently attend MHTC, or if alternative representatives would be available to attend team meetings and court hearings.

5) Judicial interactions with clients during court hearings were, on average, shorter than the recommended minimum of three minutes. Increasing the time spent with each client 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. In addition, it may improve perceptions of the judicial relationship with clients, and offer opportunities for more team members to be involved in client hearings (as it was noted that fewer team members are involved in client hearings than the judge). Having clear guidelines for how to handle difficult situations that commonly arise may help create a more streamlined and efficient staffing process. A specific recommendation of a time breakdown is provided in Appendix 1.

6) Client access to medication was a frequent problem. Some team members indicated that they would sometimes incarcerate MHTC clients in order to link clients with medication or achieve emotional stability. However, there was also feedback that jail actually impedes the ability of clients to efficiently obtain medication, and that incarceration can be counteractive in attempts at stabilization. The team should investigate alternative solutions, and may benefit from reconsidering their position on utilizing jail as a therapeutic intervention. The team could also consider forging partnerships with urgent care facilities and primary care providers within the community.

7) Some treatment programs were able to separate MHTC from non-MHTC clients, while this was not done at all treatment facilities. The MHTC team could work with the treatment providers to examine ways to ensure this occurs more frequently. The literature suggests that clients benefit most from being in treatment with individuals with similar issues, and that placing clients of differing risk levels together can actually contribute to iatrogenic treatment effects.

8) The majority of individuals interviewed indicated that there was minimal community outreach occurring for the MHTC, and that community support for the MHTC was not strong. The program may consider creating a plan for increasing publicity and community partnerships. Hosting events, such as panels, to increase community awareness of the MHTC and understanding of mental illness could help promote public approval.

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 offenders (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 offenders.

Traditional courts have 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 offenders 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 offenders often worsen in prison (Goldkamp & Irons-Guynn, 2000). Following the stress of incarceration, these offenders 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 offenders with mental health needs has resulted in alarmingly disproportionate rates of incarceration and recidivism for offenders with mental health needs (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 these offenders. 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 offenders 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 offenders (Goldkamp & Irons-Guynn, 2000). By limiting the damaging experiences of confinement and providing offenders 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 (Blanford, Fader-Towe, Ferriera, & Greene, 2015). Often, MHC populations are referred to as experiencing either a severe and persistent mental illness (SMPI) or a serious mental illness (SMI; also referred to as a severe mental illness). MCH 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 (Blanford 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 (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 cut-off (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 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 severe and persistent mental illness (SPMI). Offenders 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 offender 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; client time in the program is dependent on need and treatment progress.

Purpose

The purpose of this report was to describe the adherence of the Santa Maria MHTC to the known guiding principles, implementation documents, and MHTC process documents in the field.

Methods

DATA COLLECTION

Data were collected in nine ways: 1) observations of team staffings on clients; 2) observations of corresponding courtroom proceedings; 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 counselors at treatment agencies serving MHTC clients; 9) survey responses from counselors 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 one 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 checklist (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. All forms are attached in the Appendix.

Team Meeting Observations

Standardized 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, 2012; Cumming & Wong, 2008; Giacomazzi & Bell, 2007; Rossman, Roman, Zweig, Rempel, & Lindquist, 2011; 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, as well as perceptions of team cohesion.

Data Collection

Data were collected over two days of team meetings in Santa Maria. Meetings were observed at the Santa Maria courthouse. Three to four 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 obtained on clients from treatment courts than MHTC were not recorded or reported on.

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, Mackin, & Finigan, 2012; Cumming & Wong; 2008; Rossman et al., 2011a; Rossman et al., 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, only MHTC cases were recorded, despite other treatment court calendars being heard at the same time.

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 the role of each team member and 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, and other items were created for the purpose of evaluating local treatment court processes within Santa Barbara County. The adapted protocol contained 19 questions on team members' perceptions of the MHTC, roles of the different team members, how well different aspects of the MHTC process functioned, how MHTC differs from other treatment courts in the County, and suggestions for program improvement.

A total of 16 collaborative court team members of the Santa Maria MHTC were interviewed for this report. A majority of the interviews were conducted during lunch on either of the observation days (October and November of 2015), or prior to the team focus group (January of 2016). All of the interviews took place at the Santa Maria courthouse. Research assistants obtained informed consent from each team member and attempted to conduct the interviews in private locations. Interviews ranged from 20 to 45 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, Fader-Towe, Ferreira, & Greene, 2015). The survey was created to assess various aspects of the MHTC process, team cohesion, attitudes about MHCs in general, and attitudes toward mental illness. 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. The adapted survey contained 63 questions. Each question solicited agreement ranging from *1= Strongly Disagree* to *5=Strongly Agree.* Team members completed the survey before or after in-person interviews with the research team.

A total of 12 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-week 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. 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 16 questions. The survey was constructed from various different sources (Blandford, Fader-Towe, Ferreira, & Greene, 2015; Hiller et al., 2010; National Association of Drug Court Professionals, 2013) and tapped into perceptions of the MHC program and structure, specific treatment practices, and attitudes toward MHC clients and clients with mental illness. Supporting quotes were not provided in the analysis of interview question themes for treatment counselor interview responses in order to maintain the anonymity of treatment counselors, due to the low number of respondents. The survey consisted of 52 questions. Forty-five questions solicited agreement ranging from *1= Strongly Disagree* to *5=Strongly Agree,* and seven questions that solicited answers of *True* or *False*. For select questions, an option of answering "I Don't Know" was also available.

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. Interviews ranged from 25 to 45 minutes in length. One person completed only the survey, for a total of 6 respondents on the treatment counselor survey. Research assistants obtained informed consent from each treatment counselor.

Consumer Surveys

Data was 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 November 2015 through February 2016.

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 21 MHTC Clients in Santa Maria's program. The ethnic breakdown of the clients was as follows: 57% Hispanic, 33% White, and 10% Native American. For about half (52%) 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 10% of clients, the third time for 10% of clients, the fourth time for 5% of clients, and the fifth or more time for 24% of clients. About half of the clients (52%) surveyed had been in the MHTC program for less than six months. It is important to note that, while 21 clients were surveyed, not all clients answered every question (i.e., there are not 21 responses for every question).

Focus Group

A structured focus group was conducted with all 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, 2012; National Association of Drug Court Professionals, 2013).

Program Entry

This section focuses on examining the quality of functioning of the following program entry processes within the Santa Maria MHTC: identifying and serving the appropriate target population, the case referral process, and client eligibility and suitability.

TARGET POPULATION

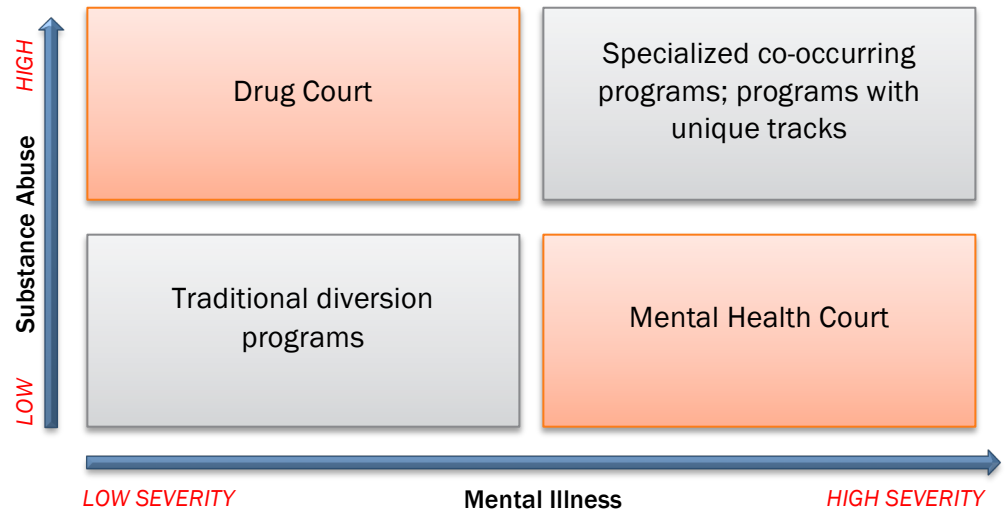
A universal MHC target population is not currently recognized, outside of the criteria that clients' mental illnesses are somehow related to the commission of their entry offense(s) (Council of State Governments, 2005; Thompson, Osher, & Tomasini-Joshi, 2007). In addition, most MHCs tend to focus on offenders that have a persistent and severe mental illness (SMI; The Council of State Governments, 2012). However, The Council of State Governments has created a website dedicated to providing information for implementing MHCs, and addresses the topic of target populations. Based on their recommendations, MHCs should focus on: (A) offenders demonstrating significant impairments due to mental illness or co-occurring disorder (COD) that are in most need of intensive treatment resources (often seen as the more "difficult" individuals whom often funnel through the criminal justice system frequently and require intensive programming); and (B) those who demonstrate a moderate to high probability of recidivating (due to the added benefits of increased supervision and programming and the iatrogenic impact of over-treating low-risk offenders; The Council of State Governments, 2012).

Because target population focuses can vary across MHC's, it is also recommended that the target population for an MHC be clearly differentiated from other related treatment courts that may serve similar or overlapping populations. For example, due to the high rate of CODs within the SMI population, MHCs have been found to serve similar populations as drug courts (The Council of State Governments, 2005); however, it has been noted that, despite the "similarities, the two types of courts have important differences. While serious mental illness and drug addiction can both lead to criminal justice system involvement, they are different types of disorder with distinct treatment methods and relationships to the criminal justice system" (Council of State Governments, 2005, p.6). Specific examples of how these treatment courts differ in processes can be found below in Table 1, with a difference in target populations depicted in Figure 2. (MHCs may differ in operationalized target population, which may not follow the figure provided in Figure 2; however, MHCs should have operationalized target populations that are clearly differentiated in some fashion). Furthermore, it has been demonstrated within the research that treatment that is inappropriately targeted or evaluated for use with populations can have inadvertent negative impacts (i.e., iatrogenic effects; for more information see: Marlowe, 2006; McCord, 2003; Petrosino, Turpin-Petrosino, & Finckenauer, 2000). It is imperative that MHCs have clearly operationally defined target populations to avoid these confusions between treatment courts, as well as any unintended negative treatment impacts.

Table 1. *Key differences between drug courts and MHCs*. (Adapted from The Council of State Governments, 2005, p. 7).

Component	Drug Courts	Mental Health Courts
Charges accepted	Drug- or alcohol-motivated crimes	Include a wider array of charges because mental illness itself is not a crime
Monitoring	Rely on urinalysis of other types of drug testing to monitor adherence	Do not have an equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions
Response to Violations	Apply behavior management grid that includes incentives and sanctions for compliance/noncompliance. Graduated sanctions culminate in brief jail sentences	Adjust treatment plans and apply sanctions in response to non-adherence; rely more heavily on incentives; use jail less frequently
Service delivery	Often establish independent treatment programs for their clients	Usually contract with community agencies; require more resources to coordinate services for clients
Expectations of clients	Require sobriety, education, employment, self-sufficiency, payment of court fees, and stabilization of co-occurring disorders; some charge participation fees	Recognize that even in recovery, clients are often unable to work or take classes and require ongoing case management and multiple supports; few charge a fee for participation

Figure 2. Distinctions in target populations for problem-solving treatment courts. (Adapted from The Council of State Governments, 2005, p. 34).



In Santa Maria, there are three different treatment courts that serve similar or overlapping populations: MHTC, DDX, and SATC. The presence of more than two related treatment courts would likely require a clear and concise understanding of what designates a MHTC eligible client and crime from the other two similar treatment courts. The purpose of the lines of inquiry in this section are intended to examine the extent to which this designation is apparent in Santa Maria's MHTC.

Feedback: MHTC Team

During the team interview, team members were asked how well the process works of targeting the intended population for MHTC (see Table 2). In general, team members reported that this process usually works well. Some team members reported that mental health needs are prominent in their target population, which is the intention of MHTC. Other team members indicated issues with the target population criteria being too inclusive, and thus not accurately capturing the intended target population. A couple of team members also indicated improvements that are needed in the assessment process.

Table 2. MHTC team's qualitative responses to the question, " How well do the following processes work… Targeting the intended population?"

Response Category	Descriptions	Sample Quotes
Works Well	▪ Doing well ▪ Reaches intended population ▪ Separates between treatment courts well ▪ Are multiple places that do screening	*"I think we do very well with that. The people I'm seeing in MHTC tend to fit the criteria."*
Inclusion Too Broad	▪ Many clients in other treatment courts ▪ Too broad of criteria ▪ Many clients with moderate mental illnesses	*"We are casting too wide of a net. We are taking people in that have moderate mental health problems. Clients with moderate mental health issues should not be in MHTC. These people are not causing problems to society. We shouldn't be taking everyone in."*
Assessment Process Needs Improvement	▪ Some clients not found eligible ▪ Need to screen before assessments	*"It works well for the most part, with the exception of clients who are sent over to MHTC and then are assessed as not being eligible."*
Mental Health Needs as Prominent	▪ Mental health more prominent than substance use ▪ More people saying they need mental health	*"There are more and more people in society saying that there's mental health issues in their lives, so this is starting to get bigger."*

Feedback: Treatment Counselors

Treatment counselors were interviewed regarding their knowledge of the intended target population for MHTC (see Table 3). The treatment counselors generally identified that clients in MHTC had mental health struggles. However, there were variations in their perceptions of what the target population of MHTC is intended to be.

Table 3. Treatment counselors' qualitative responses to the question, " What is the target population for MHTC?"

Response Categories	Descriptions
Mental Health Needs	▪ Clients already enrolled with Mental Health ▪ Clients self-medicating due to mental health needs ▪ Severe and persistent mental illness and substance use issues ▪ Clients with substance use issues ▪ Mental health struggles ▪ Co-occurring disorders
Criminal Justice Needs	▪ High risk/high needs ▪ Clients with legal issues

Treatment counselors were interviewed regarding what the differences are between MHTC, DDX, and SATC treatment courts (see Table 4). The treatment providers reported varying responses to this question. In general, it appeared that counselors were not firm on the specific differences between the treatment courts in terms of mental health presentation and inclusion criteria. However, the counselors appeared to be able to distinguish more differences in substance use and mental health criteria for SATC as opposed to MHTC and DDX courts. Treatment counselors suggested that guidelines and differences be made clear to the treatment programs via written communication.

Table 4. Treatment counselors' qualitative responses to the question, "What is the difference between MHTC, DDX, and SATC?"

Response Categories	Descriptions
Unclear	▪ Not explained to us ▪ No written guidelines to refer to ▪ Not the focus of treatment ▪ Unclear on differences
Administrative Differences Between Courts	▪ Length of time ▪ Pre/post plea ▪ Felony/misdemeanor focus ▪ Different charges in DDX and MHTC
Mental Health Aspect	▪ All clients have mental health disorders (in all treatment courts) ▪ Severe and persistent mental illness in MHTC ▪ Co-occurring disorder clients in DDX and MHTC
Substance Abuse Aspect	▪ Primarily substance abusers for SATC ▪ See behavior change when abstinent from substances in SATC

Focus Group

Team members were asked to collaborate on responses to questions about what the target population is for MHTC. The team responded with statements to the effect that severe and persistent mental illnesses are targeted for MHTC, and that diagnosis and functional impairments are examined in order to determine client appropriateness for the MHTC program and match to the intended target population.

Team members were also asked to describe the differences between the MHTC, DDX, and SATC populations. The team responded with statements to the effect that MHTC and DDX courts reflect clients with mental illness driving their criminal behavior, while SATC is comprised primarily clients with substance use-driven criminal behaviors. Clear distinctions between DDX and MHTC populations were not articulated.

CASE REFERRAL PROCESS

MHC teams are recommended to identify potential clients as quickly as possible (Thompson et al., 2007). Thompson et al. (2007) recommend that referrals be allowed from various sources, including "law enforcement officers, jail and pretrial services staff, defense counsel, judges, and family members" (p. 3). MHCs might consider pretrial programs as a source of program referrals, if applicable. Furthermore, MHCs should promote their cause and criteria through education of these referral sources in order to capture their intended population quickly and efficiently.

Sections below outline stakeholder perceptions on the case referral process in three different ways; (1) general perceptions of the case referral process, (2) perceptions of the referral process from arrest to MHTC program entry, and (3) perceptions of the referral process from MHTC program entry to treatment entry.

General Perceptions

Feedback: MHTC Team

During the team interview, team members were asked how well the case referral process works in general (see Table 5). Team members reported varying degrees of how well they felt the case referral process works. The team members identified difficulties

with the assessment process, inappropriate referrals, other court's referrals, and how treatment determinations are made. Team members also reported that there are times when information the court receives on a client is scarce.

Table 5. MHTC team qualitative responses to the question, " How well do the following processes work… The case referral process (in general)?"

Response Categories	Descriptions	Sample Quotes
Range of Perceptions	▪ Somewhat ▪ Works well ▪ The best they can be ▪ Improvements needed	*"I think it works okay and I know that everybody is stretched thin. It would be better if we had quicker responses. In general, referrals are handled the best that they can."*
Difficulties with Assessment Process	▪ Clients not deemed in need of services after sentenced to MHTC ▪ Difficulty telling substance use or mental health as primary for DDX clients ▪ Could be improved by a standardized assessment ▪ Requiring 30 days clean can be detrimental to some clients	*"Recently I've been hearing the court team say a person is eligible, and we send them to mental health and another staff assesses them and tells us they don't need services. This is a problem. We are running at full capacity. Why are we putting people in who aren't eligible? At intake they the clients didn't meet criteria. The clients need to have a severe and persistent mental health disorder, and the mental health liaisons will let us know about this. We are currently trying to resolve that; before a client is sentenced to MHTC, first they were screened then assessed, and the assessment was saying they are not eligible. Now, we want to try to wait to sentence the clients until we have a confirmed assessment."*
Inappropriate Referrals	▪ Many inappropriate referrals ▪ Clients referred with ineligible charges ▪ Need better communication between judges	*"Sometimes we get referrals form other court rooms and they are just referring the clients because in the past they have had a mental health diagnosis, but person is not open to MHTC, so maybe better communication between judges. Some people have come over with charges that you can't have them in here."*
Difficulty with Other Courts' Referring	▪ Rely on others for referrals ▪ Courts are understaffed ▪ Lack of follow through	*"We have to rely on other courts and attorneys to make those referrals. The screening process is designed to work well, but they are understaffed so it takes time."*
Treatment Determinations	▪ Treatment based on geography vs. need ▪ Unsure how determinations of treatment provider are made	*"Clients are sent to programs based on geography rather than what serves them best. I know transportation is an issue."*
Client Information Scarce	▪ Client history not readily available	*"We don't get a lot of information up front. We don't get a lot of information about past treatment, current treatment, we don't know. We rely on the doctor and his word."*

Arrest to MHTC Referral

Feedback: MHTC Team

During the team interview, team members were asked how well the case referral process works, particularly the time from offender arrest to court referral (see Table 6). Team members reported inconsistencies in their perceptions of how well the referral process from arrest to MHTC entry works, with about a third of the team members indicating that this process is inconsistent. Some team members felt the process was quick, while others indicated that the process took a while at times. Team members indicated that the nature of assessing for mental health needs can often cause delays in this process, and team members also identified the main referral sources during this process.

Table 6. MHTC team qualitative responses to the question, " How well do the following processes work… The case referral process (time from arrest to referral)?"

Response Categories	Descriptions	Sample Quotes
Inconsistent	▪ Inconsistent	*"It seems so variable, I think this could be looked into."*
Takes a While	▪ Can take a while ▪ Depends on time to recognize MH needs ▪ Could be improved ▪ Hard to get clients into court to assess	*"It varies based on the person and the charges. As soon as they get to the arraignment court if they have MH, they get referred right over. If it's not recognized it might take longer."*
Quick	▪ Works well ▪ Is quick	*"I think that's been for the most part pretty quick."*
MH Component Can Cause Delays	▪ Nature of MHTC prevents it from being quicker ▪ If have MH history is easier ▪ Client MH needs should trump structure	*"The clients could have been arrested three months ago and we are just getting them now. This could be due to the severity of the mental illness, if they were incarcerated, or if the client fails to appear because of the severity of their mental illness. Quite often we have cases sitting in for IST consideration, which makes the process longer. The clients needs need to be met prior to court's desire to follow structure."*
Referral Sources	▪ Up to the defense attorney to identify ▪ Many referrals from other courts	*"That works pretty well because in the other courtrooms they are sending a lot of people over who have been arrested at their arraignment hearing and they think this person will be eligible and they send them over."*

MHTC Referral to Treatment Entry

Feedback: MHTC Team

During the individual interviews, team members were asked how well the case referral process works, particularly the time from client referral to the time they enter treatment (see Table 7). Team members generally reported that this process varies by client and program. Some team members reported the process was relatively quick, generally in reference to entry into substance abuse treatment programs. However, the team indicated that getting clients linked with mental health services and a psychiatrist was often a long process. Team members also identified multiple situations where the time from MHTC referral to treatment entry varied.

Table 7. MHTC team qualitative responses to the question, " How well do the following processes work… The case referral process (time from referral to treatment)?"

Response Categories	Descriptions	Sample Quotes
Quick	▪ Within a day ▪ Two weeks ▪ Clients typically enter as planned ▪ Quickly ▪ A week to enter treatment	*"Quickly. They're told to report within 24 hours. They typically do unless they're going to run completely. Most of the time, the clerks will follow through with faxing the referral form so we know whom to expect."*
Mental Health as Slow	▪ Psychiatrist is 3-4 months ▪ Limited access to psychiatrist ▪ People 'fall off' while waiting	*"Getting the clients an assessment…they don't even see a psychiatrist for 16-18 weeks. It's a real problem. It might be a problem of resources. For a while we didn't really have a psychiatrist, they had to contract out. I would love to see improvements in this area. It's an issue of timeliness."*
Variations	▪ Depends on the case ▪ Quicker if history of mental illness ▪ Slow when providers are full ▪ In jail is difficult ▪ Sometimes transportation is provided ▪ Out of custody is quick	*"If they are in custody it's a problem because jail mental health has to get involved."* *"I think those with severe and persistent mental illness or already in treatment are quicker. For those who are on the onset of their symptoms it's slower because they have to go through the entire process."*

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which they felt clients were referred to and received treatment in a quick manner (see Table 8). The majority of treatment counselors reported this occurred quickly. In addition, treatment counselors were interviewed about any suggestions they had for improving the process of clients getting quickly and efficiently referred into treatment. Treatment counselors indicated that clients received treatment quickly, except for medication services. Specific suggestions for improvement were not offered.

Table 8. Treatment counselors' perceptions of the process of MHTC referral to treatment entry.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Clients are referred to and receive treatment as quickly as possible in MHTC.	0%	17%	0%	33%	50%

ELIGIBILITY & SUITABILITY

Eligibility and suitability have been focal points for treatment courts, in that researchers and government agencies have continuously recommended that both be documented, outlined clearly and understandably (e.g., Thompson et al., 2007), and adhered to in order to promote positive outcomes for participants (e.g., within the SATC community; 2013; NADCP). Furthermore, researchers have posited that the high degree of overlap that is likely to be found across similar treatment courts demands that clinical eligibility be differentiated well (Thompson et al., 2007). For this reason, it is also suggested that the various treatment courts coordinate between one another to ensure a clear understanding of one another's eligibility and suitability and how to remain separate entities. It is also recommended that the ultimate decision regarding a potential client's eligibility should be made with all team input (Thompson et al., 2007; GUIDE). Lastly, MHCs should have a developed protocol for when client competency concerns arise and how to ameliorate those situations.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt clients had to meet distinct criteria for the program, and that they were quickly identified as eligible for the program (see Table 9). The majority of team members reported that both of these processes occurred; however, there was some neutrality and/or dissent regarding both questions.

Table 9. MHTC team perceptions of the eligibility process.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A potential client must meet distinct treatment criteria to be eligible for the program.[1]	0%	9.1%	27.3%	63.6%	0%
The MHTC quickly identifies clients who are eligible for the program.	0%	0%	33.3%	50%	16.7%

During the individual interviews, team members were asked how well the client eligibility/exclusionary process works (see Table 10). Team members identified various aspects of the eligibility/exclusionary process that need improvement. Some of the team members felt the process works well, some stated that the eligibility process is based on an assessment, and one team member indicated that they felt the eligibility process was unclear. One team member also identified instances where eligibility criteria are bent in order to include clients in MHTC.

Table 10. MHTC team qualitative responses to the question, " How well do the following processes work… Determination of client eligibility/exclusion?"

Response Categories	Descriptions	Sample Quotes
Works Well	▪ Works well ▪ Quick ▪ Are screened well	*"It works fairly well because the clients get screened and if they don't meet criteria for SPMI (Severe and Persistent Mental Illness) they would not be accepted."*
Based on Assessment	▪ Based on risk/needs assessment ▪ Doctor has requirements	*"The clients have to be eligible and suitable. Probation determines suitability, depending on risk/needs assessment."*
Don't Know	▪ Unclear about eligibility	*"I know to qualify for service for MH you need to have severe persistent mental illness that is causing impairment to normal living. I am unclear about the legal criteria to qualify."*
Criteria Bent	▪ Sometimes reclassify clients for entry	*"There are occasions when we have found a way to reclassify certain information to allow the clients to come in, and they could also consider DDX so they can get treatment."*
Improvements Needed	▪ Needs improvement ▪ Too inclusive ▪ No written criteria ▪ No standardized assessments ▪ Need written treatment plans ▪ Need written assessments ▪ Rely on doctor's word ▪ Inconsistent	*"Problematic. Nothing is in written form; there is nothing to review. We are relying on the word of the doctor, without knowing how the diagnosis was determined. Written treatment plans would be helpful. Written assessments are more important before the clients are accepted into treatment court."*

Feedback: Treatment Counselors

Treatment counselors were surveyed about whether or not they felt that potential MHTC clients have to meet distinct criteria to be eligible for the program (see Table 11). The majority of counselors reported that clients did need to meet distinct criteria.

[1] Only 11 out of the 12 respondents answered this question. Responses reflect the valid percent totalling 100% for the 11 surveys.

Table 11. Treatment counselor perceptions of the MHTC eligibility criteria.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
A potential client must meet distinct treatment criteria to be eligible for the MHTC program.	0%	0%	17%	50%	17%	17%

Focus Group

Team members were asked to collaborate on responses to questions about eligibility and suitability criteria for MHTC clients (see Table 12). The focus group revealed that subjective criteria were sometimes applied to determine client suitability, and that evidence-based practices were not used to design MHTC eligibility criteria. On the latter point, it was noted during the focus group that best practices for MHCs have not yet been established. Team members were also asked about validated eligibility assessments utilized for program entry into MHTC (see Table 13). The team reported that they are using validated assessment tools to determine various aspects of client appropriateness for MHTC. However, the name of the assessment tools they use were not provided; it was unclear if the tools they use have been empirically standardized and validated or if they were created by the team for their purposes.

Table 12. Focus group collaborative responses to questions regarding MHTC eligibility and suitability.

Objective Eligibility and Exclusion Criteria	True/False
Eligibility and exclusion criteria are: a. - defined objectively, b. - specified in writing, and c. - communicated to potential referral sources (including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers).	a. True b. True c. True
The MHTC team does not apply subjective criteria or personal impressions to determine clients' suitability for the program.	False
Evidence-based practices were used to design eligibility criteria.	False

Table 13. Focus group collaborative responses to questions regarding validated eligibility assessments.

Validated Eligibility Assessments	True/False
Candidates for the MHTC are assessed for eligibility using validated risk-assessment and clinical-assessment tools.	True
Eligibility assessments are made on both risk (to determine supervision level) and needs (to determine need of treatment services).	True

Table 14. Open-ended questions asked during the team focus group regarding the eligbility and suitability process in MHTC.

Open-ended Questions
1. How are MHTC clients assessed for appropriateness for the program? How does this differ from SATC/DDX?
2. What MH diagnostic tools are used to determine client risk and needs? How does this differ from SATC/DDX?
3. How does the MHTC team know that someone meets psychiatric criteria?
4. How are client competency concerns addressed?
5. What criminal offenses may disqualify candidates from participation in the MHTC? How does this differ from SATC/DDX?
6. Are females and males equally as well represented in MHTC? Why/why not?
7. Are different ethnicities equally as well represented in MHTC? Why/why not?
8. Is sexual orientation equally as well represented in MHTC? Why/why not?

The team was asked eight open-ended questions regarding eligibility and suitability (see Table 14). The team was first asked to describe the process by which client appropriateness for MHTC was determined, and how this differed from SATC and DDX courts. The team response was to the effect that in MHTC the client appropriateness is determined by whether or not they meet the eligibility requirements and if they are willing to participate in the program. Differences between the various treatment court processes were not directly elaborated on.

The second open-ended question the team was asked addressed what diagnostic tools are used to determine client risk and needs, and how this differs from SATC and DDX courts. The team responded to the effect that they use the same tools for all three treatment courts to assess risk and needs, which includes a psychosocial assessment. The team indicated that they are gathering more tools to determine client severity.

The third open-ended question the team was asked addressed how the MHTC team knows that a client meets psychiatric criteria for program inclusion. The team responded that the psychiatrist and Justice Alliance program make these determinations and bring them back to the court.

The fourth open-ended question the team was asked addressed how client competency concerns are addressed. The team responded to the effect that if there are doubts regarding client competency to stand trial, the court will immediately investigate the concern and either have the defendant receive a psychiatric evaluation or attempt to assist the client in gaining the proper access to treatment/medication prior to making the full declaration of incompetency.

The fifth open-ended question the team was asked addressed what criminal offenses disqualify candidates from participation in MHTC, and how this differs from SATC and DDX populations. The team responded by referring to the exclusionary criteria document. The team indicated that this was the same exclusionary criteria for SATC and DDX courts.

The sixth open-ended question the team was asked addressed whether females and males were equally represented in MHTC, and why this may or may not occur. The team responded that both genders are offered the same access to the MHTC program, though the actual numbers may differ.

The seventh open-ended question the team was asked addressed how various ethnic groups were equally represented within MHTC and why this may or may not occur. The team responded that when there are small ethnic groups that are represented within the MHTC clients, it poses a challenge in addressing their treatment needs in a culture-specific manner, and sometimes clients from these groups may experience limited access to some of the treatment programs due to a language barrier. However, the team identified treatment programs cater to lesser represented populations within MHTC clients.

The eighth open-ended question the team addressed whether or not various sexual orientations are equally represented in the MHTC. The team responded that they felt sexual orientations were equally represented in MHTC, and that treatment programs welcomed all clients.

SUGGESTIONS FOR IMPROVEMENT

Team members were solicited to provide feedback on how any of these processes could be improved upon (i.e., target population, case referral process, eligibility). Their suggestions are outlined below.

Feedback: MHTC Team

During the individual interview, team members were asked to provide suggestions for improving any of the following processes: case referral, determination of client eligibility/exclusion, and targeting the intended population. Their answers are summarized in Table 15. Team members reported a variety of ways in which these processes could be improved upon. Team members identified ways to improve the screening and eligibility process, improve court processes, and improve service provisions. Team members also identified trainings as an area that could help improve the court, with team members mentioning throughout other parts of the evaluation that trainings in mental illness specifically were needed. Furthermore, team members indicated that team building exercises and more involvement from mental health providers and therapists in MHTC would likely improve the program.

Table 15. MHTC team responses to the question, "How could these processes be improved?"

Response Categories	Descriptions	Sample Quotes
Improving Screening/Eligibility	▪ Identifying/screening for mental illness ▪ More time to discuss eligibility as a team ▪ Written assessments ▪ Interview of family members ▪ Need better communication between judges	*"Written assessment is more important before they are accepted into treatment court. I think we used to do that. Interview the client's family members. We have short-cutted that by having the doctor just talk to them."*
Improving Court Processes	▪ Consistent team participation ▪ Written treatment plans ▪ Consistency	*"Consistent participation in staffing and court calendars…"*
Trainings	▪ Trainings ▪ Consistent team trainings	*"Consistent team trainings…"* *"I definitely think that we could all use a little bit more of an educational class. We could use some training [on mental illness]. Our clients are all across the spectrum."*
Improving Service Provision	▪ More treatment staff ▪ More treatment providers ▪ See psychiatrist quicker ▪ Clients to receive individual therapy ▪ More involved with clients sent out of county ▪ Visit treatment providers to ensure treatment provision	*"The clients don't even see a psychiatrist for 16-18 weeks. This is a real problem. That may be a problem of resources. For a while we didn't really have a psychiatrist, they had to contract out. I would love to see improvement here. It's an issue of timeliness."*
Team Building	▪ More teamwork ▪ Team building activities	*"Get-togethers outside of court for the team to get to know each other. There are always moving parts and a lot of turnover. Maybe just taking the time to get to know one another a little bit. Maybe a retreat?"* *"Team building exercises for process improvement and team cohesion and communication."*
More Involvement from Therapists/MH	▪ Communication with mental health on client progress ▪ Therapists to see what MHTC is	*"It would be great if we were all on the same page. The more we could get the therapists to come in and check out the courts and just see what is going on, the better off we are. But you know, they are really booked up. It's really about getting on board with the whole treatment court process."*

SUMMARY

Program entry processes into MHTC (i.e., identification of target population, case referral process, and eligibility/suitability determinations) were examined. In general, feedback from team members and treatment counselors indicated that these were areas that could benefit from some improvement. Nearly all of the individuals interviewed for the evaluation recognized that a significant mental health component was present in the offenders targeted for MHTC. In addition, individuals in the treatment counselor interviews and the team focus group were easily able to distinguish differences in a SATC versus an MHTC client; whereas, differences in the DDX and MHTC populations were not well articulated. Individual team member interviews revealed some concerns with the inclusion criteria for MHTCs being too broadly interpreted. It was unclear if this was primarily due to the eligibility criteria itself, the assessment process, or both. In addition, there appeared to be different understandings on what constituted severe and persistent mental illness, and how this should be defined within the context of MHTC.

Perceptions of the case referral process were also ascertained. The literature on the case referral process has emphasized quickly identifying appropriate clients for MHTCs, allowing referrals from various sources, and educating others on the program to promote referrals. There were mixed perceptions regarding the case referral processes. Team members often noted that the process was working well, or as well as it could. However, two main barriers were identified within the general case referral process: (1) lack of timeliness of assessment completion, and (2) inappropriate clients being referred to MHTC. Interviewees also noted inconsistencies in the process of arrest to MHTC referral, but this was mostly attributed to the nature of the mental health assessment process being long, as well as a lack of resources (i.e., not enough psychiatrists to complete assessments in a timely manner). The results of the evaluation indicated that the process of MHTC referral to client entry into treatment worked efficiently for entry into substance abuse treatment, but that entry into mental health treatment was delayed.

The literature on MHTC eligibility and suitability has indicated that these criteria should be clearly conveyed, understood, and adhered to. In general, team members indicated that the eligibility process works well. More team members than treatment counselors believed that clients must meet distinct treatment criteria in order to meet MHTC eligibility, with the majority of team members indicating that this was true, and half of the treatment counselors indicating this was true. There was an indication that criteria are sometimes bent in order to help clients gain access to treatment. Focus group feedback indicated that competency issues were addressed appropriately, exclusionary criteria for criminal offenses were straightforward (and are the same for all treatment courts), and that the court was not engaging in practices that marginalize historically disadvantaged populations by limiting their access to treatment through participation in MHTC.

Results indicated mixed feedback about the use of assessments for client risk and needs. Focus group participants noted that validated assessment tools were utilized in order to determine various aspects of client appropriateness for MHTC (i.e., recidivism risk, mental health needs), and were used with all three treatment courts (i.e., MHTC, DDX, SATC) in order to assess risk and needs. However, this directly conflicts with feedback from some team members indicating a desire for standardized assessments in determining clients' mental health needs. In addition, there was no mention of any specific standardized assessment being utilized with MHTC clients in regards to their mental health needs; it was often asserted that subjective criteria were utilized by mental health programs in order to determine if a client met criteria for a serious mental illness. It may be that the team members were unclear as to what was meant by standardized assessment. The focus group indicated that subjective criteria were sometimes applied in order to determine client suitability, as well.

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.

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 (Bedell, 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 clients with 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 for the offenders, team members were surveyed about MHTC clients' access to educational/vocational training, and substance abuse treatment (see Table 16). The majority of team members reported that clients are connected to substance abuse treatment if necessary, and also reported neutrality to the idea that clients have access to educational and vocational assessment and training. However, team members appeared to be split on their perceptions that the treatment court had a wide range of treatment resources available to MHTC clients.

Table 16. MHTC team members' perceptions of client access to various treatment resources.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
MHTC clients have access to educational and vocational assessment and training.	0%	0%	58%	42%	0%
Clients are connected to resources for substance abuse as needed.	8%	0%	8%	17%	67%
The treatment court has a rich network of treatment resources.	0%	33%	17%	50%	0%

TREATMENT DETERMINATIONS

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

Feedback: Treatment Counselors

During interviews with treatment providers, they were asked about how MHTC clients' treatment needs (i.e., dosage, duration) are determined (see Table 17). Most of the treatment counselors reported that they used the Addiction Severity Index (ASI) in part to make treatment determinations. Several counselors indicated that treatment needs were individualized, while others indicated that there was a set programmatic structure. One counselor indicated that MHTC allows flexibility of treatment plans, and another indicated that the MHTC team dictates some specifics of the treatment plan.

Table 17. Treatment counselors' qualitative responses to the question, "How are client treatment needs (i.e., dosage, duration) determined?"

Response Categories	Descriptions
Assessment	▪ Addiction Severity Index (ASI)
Individualized	▪ Individualized ▪ Based on clients' problem areas ▪ Housing needs addressed ▪ Employment needs addressed ▪ Number of groups is determined by client needs ▪ Case manager creates
Court Determined	▪ Court ordered treatment attendance ▪ Length of stay is court-determined
Program Determined	▪ Number of groups is program-determined ▪ Mental Health designates number of groups
Flexible	▪ MHTC allows modifications to treatment plans

Feedback: MHTC Clients

The clients were asked whether or not they were linked to treatment for a substance use issue (see Table 18). The majority of clients reported that the MHTC has helped to link the clients to treatment for substance use. Some neutrality and disagreement was noted, however.

Table 18. MHTC client perceptions of program linkage to substance use treatment.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The MHTC team has helped me to find treatment for a substance use issue.[2]	0%	6%	33%	44%	17%

Focus Group

Team members were asked to collaborate on responses to three open-ended questions about client treatment in MHTC (see Table 19). First, the team was asked what the policy was for clients being prescribed medication for potentially addictive substances. The team responded with statements to the effect that there was not any set policy against clients being prescribed potentially addictive substances; however, the team indicated that they are open to allowing this if the psychiatrist suggests that it is important to the client's medication regimen, or if they can help to at least wean the clients from the addictive medications. Secondly, the team members were asked if there were any medications that MHTC clients were not allowed to take; the team indicated that there were not any medications that were not allowed. Lastly, the team was asked what the typical dosage and duration of both mental health and substance use treatment was for MHTC clients, and how this differed from treatment received by SATC and DDX clients. The team responded that treatment duration for MHTC clients with mental health struggles is likely to be life-long, with the MHTC program intended on getting the clients to a point of stability where they can function on their own outside of the program. The team indicated that MHTC is different from SATC and DDX clients, where they have a set program duration that is more dependent on relapse-related occurrences than stability of mental health symptoms.

Table 19. Open-ended questions asked during the team focus group regarding medication policies and treatment determinations in MHTC.

Open-ended Questions
1. What is the policy on medication prescriptions for potentially addictive substances?
2. What medications are and are not allowed?
3. What is the typical dosage and duration of mental health treatment for MHTC clients? Of substance use treatment? How does this differ from SATC and DDX?

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, 20013; 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 20). The majority of team members reported that client treatment plans are individualized, client treatment is based on client need, treatment plans are flexible to adjustment, and the judge holds the clients accountable for compliance with their treatment plan.

[2] Out of N=18 clients; 1 client indicated that they did not have a substance use issue, and 2 clients did not respond.

Table 20. Team member perceptions of how MHTC client treatment plans are constructed, maintained, and adjusted.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
MHTC clients' treatment plans are individualized to the needs of each client.	0%	0%	17%	67%	17%
Client treatment is decided based on the client's level of need (vs. availability or other factors).	0%	8%	25%	67%	0%
Client treatment plans are flexible to adjustments throughout their time in MHTC.	0%	0%	8%	67%	25%
The judge holds clients accountable for their compliance with their treatment plan.	0%	0%	17%	67%	17%

Each team member was asked about how well the court supervises the clients' mental health treatment plans (see Table 21). Team members suggested that overall the court was supervising client mental health plans fairly well, the court stays well informed on client progress, and team members identified different aspect's of the court's role in the supervision of the plans. However, the team members seemed to have some differences in perceptions on who supervises the clients' mental health treatment plans (the team or treatment providers), and some identified a few concerns with the supervision of these plans.

Table 21. MHTC team qualitative responses to the question, "How well does the court supervise clients' mental health treatment plans?"

Response Categories	Descriptions	Sample Quotes
Court's Role	▪ Monitors and reviews plans ▪ Keep clients accountable ▪ Recognize client progress	*"The plans are monitored and reviewed. The clients keep coming back, and they are brought back to court many times. Gives a sense of accountability and being recognized for their progress. I hear all the time the clients say how excited they are they don't have to come back for a month; it's important for newcomers to see this increase in freedom."*
Who Supervises Plans?	▪ MHTC team effort ▪ Treatment providers	*"The providers directly supervise the treatment plans, but if there are issues it comes back to the plan and the team addresses any issues to the plan. Maybe the "team" supervises on a larger scale, because it will always be brought back to the team. But the everyday it is the treatment staff."*
Works Well	▪ They do well ▪ They do "okay"	*"I think the team is doing a pretty good job by actually assisting the clients to get reacquainted with mental health. The team does a decent job just getting the clients back participating."*
Unsure	▪ Don't know ▪ There is no plan	*"I don't know. I mean I think they are supervised pretty well I guess."*
Informed on Client Progress	▪ Requests information on client progress ▪ Email frequently ▪ Stay well informed on client progress	*"They request information up to date on the client's progress in their programs; whether the clients are attending, interacting, in what other areas might they need help, extra areas they're getting help in."*
Concerns with this Process	▪ Sometimes staff a case but make different decisions in court ▪ Treatment based more on availability ▪ Not always consistent across clients	*"It's fitting the round peg into the square hole. They plug people in where they can and hope they don't have any issues."*

Each team member was asked about how well the court supervises the clients' substance use treatment plans (see Table 22). Team members suggested that the court was overall supervising client substance use treatment plans well, the court stays in frequent contact with providers regarding client progress, and identified different aspect's of the court processes involved in the supervision of the plans. However, team members seemed to have some differences in perceptions on who supervises the clients' mental health treatment plans (the team or treatment providers), and suggested that treatment is too long or treatment plans should be brought to court for better supervision of the plans.

Table 22. MHTC team qualitative responses to the question, "How well does the court supervise clients' substance use treatment plans?"

Response Categories	Descriptions	Sample Quotes
Court Processes	▪ Focus on appropriate behavior versus using ▪ Plans are monitored and reviewed ▪ More access to plans than in other courts	*"The team concerns themselves with appropriate behavior at program instead of if they're using."*
Who Supervises Plans?	▪ Treatment providers ▪ Court broadly supervises plans ▪ Collaborative with the team	*"The local providers are really good about relaying information to probation and to the court and making it more of a collaborative thing."*
Works Well	▪ Supervision is done well	*"Very closely monitored. Two primary providers immediately report to entire team. Usually within a day they report to team."*
Frequent Contact	▪ Email frequently (court, providers) ▪ Report immediately on client progress to the court	*"A lot of the substance abuse programs address probation and then the court. They provide issues/concerns that get addressed pretty fast in court, especially with the team here. We get an email or call pretty quickly when stuff is going on."*
Concerns with this Process	▪ Treatment length too long ▪ Treatment plans should be brought to court	*"Maybe the treatment plans could be brought to court for all of the team to see."*

Feedback: Treatment Counselors

Treatment providers were surveyed about the various aspects of MHTC client treatment plans (see Table 23). Treatment counselors generally agreed that the level of care MHTC clients received was individualized based on need, clients are allowed to participate in education/vocational training, and treatment plans are flexible to adjustment. There appeared to be some disagreement on whether or not treatment plans are similar for MHTC clients; however, this could be a reflection of differences in treatment agency practices.

Table 23. Treatment counselor perceptions of MHTC treatment plans.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
Adjustments to the level of care are predicated on each client's response to treatment and are not tied to the MHTC's programmatic phase structure.	0%	17%	0%	50%	33%	0%
Clients can participate in educational and vocational assessment and training in MHTC.	0%	0%	17%	50%	17%	17%
MHTC clients' treatment plans are individualized to the needs of each client.	0%	0%	0%	33%	67%	0%
MHTC client treatment plans are flexible to adjustments throughout their time in MHTC.	0%	0%	0%	33%	67%	0%
Treatment plans are similar for each MHTC client.	0%	67%	0%	17%	17%	0%

Treatment providers were also interviewed about how MHTC clients' treatment plans differ from those of non-MHTC clients (see Table 24). There were some differences in opinions reported across counselors in response to this question. Some treatment counselors reported that treatment plans for MHTC clients generally had more of a mental health emphasis, and that they may attend different types of groups. Other counselors indicated that there are not any differences in treatment plans.

Table 24. Treatment counselors' qualitative responses to the question, "Is an MHTC client's treatment plan different than non-MHTC clients?"

Response Categories	Descriptions
Mental Health Emphasis	▪ More mental health needs addressed ▪ Medications ▪ Under psychiatrist's care ▪ Have mental health goals
No Difference	▪ No differences ▪ Needs for treatment plan still based on the ASI ▪ Same number of groups to attend
Group Differences	▪ Attend different types of groups

During interviews with treatment counselors, they were also asked information on who MHTC clients were in groups with (i.e., "When MHTC clients are in groups, who are they with [e.g., other MHTC clients, clients with substance abuse issues only, DDX clients, etc.]?"), and if MHTC clients received individual counseling (i.e., "Do MHTC clients receive individual counseling?"). There was some variation in responding to the former question. Some counselors indicated that clients are only in groups with other MHTC clients, clients with mental health struggles, or co-occurring disorders groups; while other counselors indicated that there was no matching based on client mental health or MHTC status, or that matching was attempted but did not always occur. However, all of the treatment providers indicated that MHTC clients received individual counseling.

Focus Group

Team members were asked to collaborate on responses to questions about MHTC clients' participation in peer support groups (see Table 25). The focus group suggested that MHTC clients regularly attend peer support groups, these groups are 12-step or Smart Recovery models, and clients are prepared for attendance at peer support groups.

Table 25. Focus group collaborative responses to questions regarding MHTC clients' participation in peer support groups.

Peer Support Groups	True/False
Clients regularly attend self-help or peer support groups in addition to professional counseling.	True
The peer support groups follow a structured model or curriculum such as the 12-step or Smart Recovery models.	True
Before clients enter the peer support groups, treatment providers use an evidence-based preparatory intervention, such as 12-step facilitation therapy, to prepare the clients for what to expect in the groups and assist them to gain the most benefits from the groups.	True

Table 26. Open-ended questions asked during the team focus group regarding treatment plan development, monitoring, and adjustments in MHTC.

Open-ended Questions
1. Who develops MHTC clients' treatment plans?
2. Who monitors client progress on their treatment plans?
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 four open-ended questions regarding treatment plan development and monitoring, and therapeutic adjustments to MHTC clients' treatment plans (see Table 26). 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 separate treatment plans for the MHTC clients, and that County Mental Health would sometimes coordinate efforts with other community-based organizations on client treatment plans.

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.

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. The team provided examples of a client having a child or relapsing as being applicable.

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 the team often discussed changes together, but that the respective treatment agencies are often the ones who executed the changes to the treatment plans. The court also reported that they used the MHTC platform to encourage clients to adhere to these changes and their treatment plans, but ultimately it was up to the treatment agencies to closely enforce them.

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 offenders 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 27). The majority of team members reported that they felt gender-specific treatment was available; however, there was some dissent regarding this question.

Table 27. MHTC team perceptions of the availability of gender-specific treatment for MHTC clients.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Gender-specific treatment is available to those who want it.	8%	8%	0%	67%	17%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which gender-specific treatment was offered at their treatment program (see Table 28). All of the treatment counselors stated that their treatment program offers gender-specific treatment.

Table 28. Treatment counselor perceptions of the avaiability of gender-specific treatment for MHTC clients.

Question	True	False	Don't Know
My treatment program offers gender-specific treatment.	100%	0%	0%

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 (U.S. 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 29). The majority of team memberss reported that they felt culturally sensitive treatment was available; however, there was some notable dissent and neutrality regarding this question.

Table 29. MHTC team perceptions of client access to culturally sensitive treatments.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Culturally-sensitive interventions are utilized at treatment programs.	8%	0%	33%	50%	8%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which culturally-sensitive treatment interventions were offered at their treatment program (see Table 30). All of the treatment counselors reported that their programs offered culturally sensitive treatment interventions.

Table 30. Treatment counselor perceptions of the availability of culturally sensitive treatments at their treatment programs.

Question	True	False	Don't Know
Culturally-sensitive interventions are utilized at my treatment program.	100%	0%	0%

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, supervision, treatment fidelity, confidentiality, and who MHTC clients are placed with in groups. In addition, this section explored how treatment agencies addressed MHTC clients' legal struggles and graduation requirements.

Feedback: Treatment Counselors

Treatment counselors were surveyed about various practices at their respective treatment agencies (see Table 31 and Table 32). All of the treatment counselors reported that their agencies utilize manualized and evidence-based treatments, supervision is routinely provided to ensure treatment fidelity, clients are assessed for suitability for groups, clients are placed in groups by use of evidence-based selection criteria, and that confidentiality is prioritized.

Table 31. Treatment counselor perceptions of practices occurring at their treatment agency.

Question	True	False	Don't Know
My treatment agency administers behavioral or cognitive-behavioral treatments that are documented in manuals.	100%	0%	0%
Clients at my treatment agency receive evidence-based treatments.	100%	0%	0%
At my treatment agency, I received regular supervision to ensure continuous fidelity to evidence-based practices.	100%	0%	0%
Clients at my treatment program are screened for their suitability for group interventions.	100%	0%	0%
Clients at my treatment program are placed in groups based on evidence-based selection criteria (including clients' gender, trauma histories and co-occurring psychiatric symptoms).	100%	0%	0%

Table 32. Treatment counselor perceptions of the importance of confidentiality at the treatment agencies.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Confidentiality of clients is a priority at my treatment agency.	0%	0%	0%	0%	100%

During interviews with treatment providers, they were asked about how MHTC clients' criminal and legal issues are addressed in treatment (see Table 33). Treatment counselors reported that clients' criminal and legal issues were addressed through specific treatment interventions, through broad treatment goals, client participation in MHTC, and by connecting clients with appropriate services.

Table 33. Treatment counselors' qualitative responses to the question, "How are MHTC clients' criminal/legal issues addressed in treatment?"

Response Categories	Descriptions
Treatment Interventions	▪ Seeking Safety ▪ Relapse prevention ▪ Parenting ▪ Moral Reconation Therapy
Treatment Goals	▪ Treatment addresses criminal thinking fueling substance use ▪ Treatment addresses what is behind criminal actions in general
MHTC	▪ Through participation in MHTC ▪ Treatment reports to probation ▪ Clients are coming in to treatment in general addresses them (i.e., charges are dropped if they complete)
Connecting with Services	▪ Connecting clients with the services they need

Treatment providers were also interviewed regarding how MHTC clients' graduation requirements are addressed in treatment (see Table 34). Treatment counselors indicated that these are addressed through the clients' treatment plans and through preparing the clients for program completion. Some treatment counselors identified specific graduation criteria that are applicable to some MHTC clients, and another counselor indicated that the process regarding addressing graduation requirements depends on the client's particular time left in MHTC.

Table 34. Treatment counselors' qualitative responses to the question, "How are the MHTC clients' graduation requirements addressed in their treatment program?"

Response Categories	Descriptions
Treatment Plan	▪ Can be addressed through clients' treatment plans
Specific Requirements	▪ 6 months clean/sober ▪ Pay fines ▪ Community service ▪ 1-1.5 years in program
Preparation for Completion	▪ Prepare for discharge ▪ Connect with aftercare ▪ Connect to a community primary care provider to continue services
Varies	▪ Depends on how long they are in the program

Focus Group

Team members were asked to collaborate on responses to questions about various treatment agency practices of programs serving MHTC clients (see Table 35). The focus group revealed that clients are regularly screened for suitability for group treatment, client placement into treatment groups is guided by evidence-based selection methods, clients meet with a counselor at least once during the first part of their program, treatment groups usually do not have more than twelve clients total in the group, and treatment agencies are utilizing documented and evidence-based treatment programs with MHTC clients. The focus group also revealed that MHTC clients are often placed in treatment programs and groups with other clients of differing risk and need levels and that most groups do not have at least two facilitators. The team also indicated that the treatment programs attempt to keep MHTC clients in groups with other MHTC clients or similar populations, but that they are sometimes in mixed groups of clients of varying populations

and clients with primarily substance-related problems. The final question, regarding whether or not treatment agencies conducted fidelity checks on their offered intervention programs, was not addressed by the team due to a miscommunication error.

Table 35. Focus group collaborative responses to questions regarding treatment practices of agencies services MHTC clients.

Treatment Practices	True/False
The MHTC does not mix clients with different risk or need levels in the same counseling groups, residential treatment milieu, or housing unit.	False
Clients meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program.	True
Clients are screened for their suitability for group interventions.	True
Group membership is guided by evidence-based selection criteria (including clients' gender, trauma histories and co-occurring psychiatric symptoms).	True
Treatment groups ordinarily have: a. – No more than twelve clients b. – At least two leaders or facilitators.	 a. True b. False
Treatment groups do not mix a. – MHTC clients with other populations b. – MHTC clients with clients with primary substance use problems.	 a. False b. False
Treatment providers administer behavioral or cognitive-behavioral treatments that are: a. – Documented in manuals b. – Have been demonstrated to improve outcomes for persons involved in the criminal justice system.	 a. True b. True
Treatment providers are proficient at delivering the interventions are supervised regularly to ensure continuous fidelity to the treatment models.	Unknown

SUMMARY

Treatment related aspects of MHTC (i.e., client treatment plans, diversity options in treatment, and specific treatment agency practices) were examined. In general, feedback indicated that these were aspects of the MHTC that worked well and were in line with established best practices in treatment and treatment courts.

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 treatment for substance use; however, team members appeared to be split on their perceptions that the treatment court had a wide range of treatment resources available to MHTC clients.

The evaluation also examined the manner in which client treatment determinations were made. The focus group indicated that the team is flexible on medication regimens for MHTC clients and takes an individualized approach to assisting clients in weaning undesired medications when necessary. In addition, the focus group articulated differences in treatment determinations between MHTC and non-MHTC clients. The team pointed to the lifelong struggle with mental illness that defines the MHTC population, and also indicated longer treatment duration for MHTC clients that is likely to focus on mental health stability versus relapse prevention (the latter of which is the focus of SATC and DDX treatment courts).

The literature on MHC treatment plans suggests that plans be individualized, that adjustments be made as necessary throughout a client's time in the program, that clients be given a voice in the planning process, and that clients with CODs have treatment plans that reflect substance use goals as well. In addition, the research has suggested that treatment plans be revisited for modification when clients are considered for sanctions. Team members and treatment counselors agreed that client treatment plans are individualized and based on client needs, and treatment plans are flexible to adjustment. 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 provided examples of a client having a child or relapsing as being applicable; however, clients receiving sanctions were not specifically discussed. The team may benefit from examining client treatment plans more closely when clients are sanctioned, in accordance with the literature suggestion on this matter. It also may be beneficial to have treatment plans available for review to team members throughout clients' time in MHTC. In addition, it is unclear the extent to which clients get to participate in their treatment planning; adding this component into treatment planning may be beneficial to the treatment court.

The MHTC team perceived that the judge held clients accountable for compliance with treatment plan. Team members reported that the court was supervising both the client mental health and substance use plans fairly well, and that the court stays well informed on client progress on their treatment plans. Treatment counselors indicated that MHTC clients received individual counseling, and the focus group suggested that MHTC clients regularly attend peer support groups (i.e., 12-step or Smart Recovery groups). There were differences in perceptions on who supervises the clients' mental health treatment plans (the team or treatment providers), although during the focus group the MHTC team indicated that the treatment team monitors the clients' treatment plans and the respective treatment agencies execute any necessary changes to the treatment plans.

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. The present evaluation revealed that the

majority of team members and all of the treatment counselors surveyed reported that gender-specific treatment and cultural-specific treatment options are available to MHTC clients.

Treatment agency practices were examined as they relate to the research on client outcomes. All of the treatment counselors reported that their agencies utilized manualized and evidence-based treatments, supervision was routinely provided to ensure treatment fidelity, clients were assessed for suitability for groups, clients were placed in groups by use of evidence-based selection criteria, and that confidentiality was prioritized. These assertions were supported by the feedback from the focus group, which also indicated that clients met with a counselor at least once per week during the first part of their program and that treatment groups usually do not have more than twelve clients total in the group. Counselors reported that clients' criminal and legal issues and graduation requirements are addressed in treatment.

However, the focus group revealed that MHTC clients are often placed in treatment groups with other clients of differing risk and need levels and that most groups do not have at least two facilitators. The team also indicated that the treatment programs attempt to keep MHTC clients in groups with other MHTC clients or similar populations, but that they are sometimes in mixed groups of clients including groups with clients with primarily substance-related problems. This corresponded with treatment counselor feedback on group composition.

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 an offender'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).

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, 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 cases discussed during the formal staff meetings over two calendar days. Average time spent on each case was three minutes and 46 seconds, with a range from one minute to 13 minutes and 19 seconds (see Table 36).

Table 36. Team staffing time-related statistics.

Observation	Time
Total staffing time coded	2 hr., 30 min.
Cases coded	40
Average time per case	3 min., 46 sec.
Range in time per case	1 min. – 13 min., 19 sec.

The most frequent topic of discussion was treatment progress (83% of cases[3]; see Table 37). Other frequent topics of discussion (i.e., discussed in over half of the cases) included: sanctions and incentives, mental health symptoms and progress, and probation supervision-related matters. Observers anecdotally noted that there appeared to be varying levels of engagement in client discussions among team members.

Table 37. Team staffing topics discussed.

Discussion Topics	% MHTC cases
Treatment progress	83%
Sanctions/incentives	75%
Sanctions	*50%*
Incentives	*33%*
Mental health symptoms & progress	55%
Probation supervision	50%
Housing	40%
Vocational activities*	39%
Substance use symptoms & progress	35%
Medication	28%
Drug testing	28%
Positive test	*15%*
Negative test	*13%*
Failure to test	*3%*
Medical issues	15%

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

[3] In 10% of cases, only general client progress was discussed without specific mention of treatment; in 5% of cases, researchers were unable to determine if treatment progress was being discussed.

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

Researchers reported on who they observed making the final decision regarding a client's case during team meeting discussions. The observers indicated that 65% of the cases were decided by way of team consensus, 20% of cases were determined by the judge, and in 15% 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.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt that major decisions were made collaboratively by the team, and that participation is encouraged in staffings (see Table 38). The majority of team members reported that they felt major decisions were made collaborative and that participation in staffing was encouraged.

Table 38. MHTC team perceptions of the decision making process and team meetings.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Major decisions are made collaboratively by the MHTC team.	0%	0%	17%	58%	25%
Participation is encouraged in our team meetings.	0%	0%	25%	42%	33%

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 39). These scores were averaged across observers and across 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, and as sharing information freely. However, it was noted that there appeared to be a lack of knowledge of some of the cases discussed, with observers anecdotally noting that there appeared to be varying degrees of team member preparedness.

Table 39. 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).	4.5
There appeared to be a mutual respect between the agencies.	4.2
Team members shared information and knowledge freely with one another.	4.2
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.	3.7
Team members appeared to know a lot about the cases discussed.	3.0

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 31 MHTC cases observed over one hour and 36 minutes (see Table 40). The average time spent per case was three minutes and seven seconds. While the majority of the cases (71%) were heard for less than three minutes (see Figure 3), there was a range from 26 seconds to 13 minutes and ten seconds per case.

Figure 3. Percentage of time the observed cases were heard for their status review hearings.

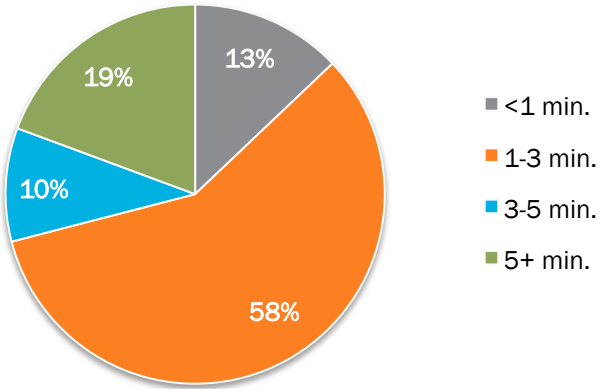


Table 40. Status review hearing time-related statistics.

Observation	Time
Total time coded for status hearings	1 hr., 36 min.
Cases coded	31
Average time per case	3 min., 7 sec.
Range in time per case	26 sec. – 13 min., 10 sec.
Percentage of cases heard for:	
>1 minute	13%
1-2 minutes	58%
3-7 minutes	10%
8+ minutes	19%

In addition, after each observation day, researchers rated the status review hearings in whether or not they perceived that the treatment team exemplified four different characteristics (see Table 41). Researchers checked either "yes" or "no," next to each characteristic. Results were pooled and reported as percentage of raters that endorsed the characteristic, as to whether or not the MHTC generally appeared to exhibit these characteristics. 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 appeared to be a lack of knowledge of some client cases, and that there was less of a focus on future behavior.

Table 41. 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")?	100%
Client was given a voice in the MHTC hearing and was encouraged to take an active role.	80%
Did the team demonstrate extensive knowledge of the clients' cases?	60%
Court proceedings focused on changed future behavior rather than past behavior.	50%

Feedback: Treatment Counselors

Treatment counselors were surveyed whether or not they felt their MHTC clients regularly attend status review hearings (see Table 42). All of the counselors reported that they perceived their clients to regularly be in attendance at status review hearings.

Table 42. Treatment counselor perceptions of client attendance at status review hearings.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Clients attend regular status/review hearings with the judge.	0%	0%	0%	17%	83%

Feedback: MHTC Clients

The clients were asked about whom they perceived to be the leader of the MHTC team. The majority of clients felt that the treatment team worked together as a team (67%), while 28% felt that the judge was the team leader, and 5% felt that a treatment representative was the team leader.

The clients were also asked about if they were reminded about consequences for positive and negative behaviors (see Table 43). The majority of clients agreed that this occurred, while the rest of the clients indicated that they felt neutral about this statement.

Table 43. MHTC client perceptions of reminders of consequences of behavior.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The members of the MHTC team often remind me of what will happen if I do well or if I fail.	0%	0%	39%	50%	11%

Focus Group

Team members were asked to collaborate on responses to two open-ended questions about MHTC status review hearings and phase structures (see Table 44). The team was asked if there are phase structures in MHTC; the team responded that there are not phase structures in MHTC, though there was discussion about whether or not phases should or could be implemented within the MHTC. The team was also asked what the frequency of status review hearings is for MHTC clients, and they indicated that they are more frequent than for the other treatment courts.

Table 44. Open-ended questions asked during the team focus group regarding status review hearings and phase structures in MHTC.

Open-ended Questions
1. Are there phase structures in MHTC?
2. What is the frequency of status review hearings for MHTC clients in the program?

Offenders

Information is reported in this section only on offenders whose cases were observed during the evaluation. Offender 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 (55%) than female (42%)[4]. A majority of cases heard were regular status hearings (77%). A few were pre-participation hearings (6%), while no offenders were observed during sentencing hearings (0%). Approximately 19% 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 (35% of cases), probation officers (29% of cases), the prosecutor (13% of cases), clients' family members (10% of cases), and treatment liaisons (6% of cases). However, the public defender and conflict attorney who are usually assigned to the MHTC calendar were each absent during one of the observation days, and the assigned probation officer (PO) was absent during both observation days, all due to unforeseen circumstances. This may have contributed to a possible underreporting of their participation in the MHTC cases. It was noted by individuals involved with MHTC that the current data was particularly likely to significantly skew the perceptions of the assigned PO; anecdotal feedback regarding the assigned PO indicated that this individual is highly involved with and knowledgeable of client cases, and was a strong contributor to the MHTC team. Most MHTC clients spoke in their hearings (84%), and some of them shared a success story (35%). The clients' families were mentioned in 23% of the cases, and were present in 23% of the cases observed.

Judicial Interactions

While there are variations in the ways in which MHCs 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 central point in determining best practices and client outcomes in treatment courts (e.g., SATC; NADCP, 2013).

Observations

The judge made eye contact (94%) and spoke directly to the clients (97%) in almost every hearing. The judge engaged with the client most of the time (94%) by eliciting questions/statements, imparting instructions, and providing advice. In 97% 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 68% 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 45). These scores were averaged across observers and across 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

[4] Demographic information was not recorded on one client.

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

Question	Average
The judge made an effort to establish/maintain a rapport with clients (i.e., general rapport).	4.8
The judge demonstrated empathy for clients.	5.0
The judge utilized active listening with the clients.	5.0
The judge encouraged the clients to take an active role in their hearings.	4.0
The judge encouraged the clients to take an active role in their treatment.	4.6
The judge gave the clients a voice in court.	4.0

Feedback: MHTC Team

Team members were surveyed about client relationships with the judge (see Table 46). The majority of team members reported the judge made an effort to establish rapport with clients and demonstrates empathy and active listening with clients.

Table 46. MHTC team perceptions of judicial interactions with the clients.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The judge makes an effort to establish rapport with clients.	0%	0%	8%	25%	67%
The judge makes an effort to demonstrate empathy and active listening with the clients.	0%	0%	17%	17%	67%

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 47). There was a range of agreement noted within the MHTC client feedback. The majority of MHTC clients reported that the judge makes supportive comments during their hearings, reminds clients of how important it is to work their treatment program, believes they can improve their health and behavior, has all of the facts available to make good decisions about their case, and holds them accountable for their decisions; however, there was also some neutrality and dissent noted in all of these statements. The majority of the clients also reported disagreement with statements that the judge embarrassed them and says mean things to them. The majority of clients indicated neutrality with the statement that they have a good relationship with the judge.

Table 47. MHTC client perceptions of the nature of judicial interactions and their relationship with the judge.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The judge makes supportive comments to me during my hearings.	5%	0%	24%	52%	19%
During my hearings, the judge tells me how important it is to do my treatment program.	5%	0%	14%	52%	29%
The judge believes that I can improve my health and behavior.	5%	0%	33%	33%	29%
The judge embarrasses me.	35%	40%	20%	5%	0%
The judge says mean things to me.	40%	45%	10%	5%	0%
The judge lets me tell my side of the story when there are disagreements.[5]	6%	6%	24%	53%	12%
The judge usually has all of the facts available to make good decisions about my case.	0%	11%	16%	58%	16%
I have a good relationship with the judge.	0%	0%	61%	28%	11%
The judge holds me accountable for my actions.	0%	0%	16%	53%	32%

Focus Group

Team members were asked to collaborate on responses to questions about judicial participation and interactions with clients (see Table 48). The focus group revealed that clients were allowed to have their attorney assist in providing any necessary clarifications when clients are struggling to express themselves during the hearings, the clients regularly appear before the same judge, the judge regularly attends staffings, the judge has the final say in deciding the court's response to client behavior and after taking into consideration the input of others, and the judge refers to the expertise of treatment professionals when imposing treatment-related conditions.

[5] Out of N=17; 3 clients indicated that there had not been disagreements about their case, and 1 client did not respond.

Table 48. Focus group collaborative responses to questions regarding judicial interactions with team members and MHTC clients.

Judicial Interactions	True/False
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.	True
Clients ordinarily appear before the same judge throughout their enrollment in the MHTC.	True
The judge regularly attends pre-court staff meetings during which each client's progress is reviewed and potential consequences for performance are discussed by the MHTC team.	True
The judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect a client's legal status or liberty.	True
The judge makes these decisions after taking into consideration the input of other team members and discussing the matter in court with the client or the client's legal representative.	True
The judge relies on the expert input of duly trained treatment professionals when imposing treatment-related conditions.	True

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). Furthermore, it has 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, pp. 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 58% of the cases (see Table 49 for summary of all characteristics of status review hearings). Program noncompliance included treatment absences (26%), violating rules at treatment (13%), violating probation terms (10%), missed appointments (10%), poor attitude (6%), positive drug test(s) (6%), missed probation meeting (3%), having gotten into a fight (3%), having received a citation (3%), re-arrest (3%), missed court date(s) (3%), drug/alcohol use (3%), unwilling to sign terms/conditions (3%), and failure to report (unknown source; 3%).[6] None of the noncompliance observed was related to medication noncompliance (0%).

Sanctions were administered in 45% of all cases heard. In 16% of cases heard, noncompliance was addressed but sanctions were not administered; and in 3% of cases heard, noncompliance was not addressed but sanctions were administered. Sanctions were administered as follows: admonishment from the judge (35%), client directed to report to probation (13%), increase in treatment requirements (6%), remand to custody/jail (6%), client directed to enter into anger management (3%), client directed to see their doctor (3%), client moved into a residential treatment program (3%), client ordered to stay out of a restricted city (3%), client put on a 30 day review that could result in dismissal (3%), and client reminded of a no contact order (3%). None of the clients were observed to have failed MHTC as a result of their noncompliance (0%).

Recognition was given in 74% of all MHTC cases observed. Recognition was observed for a variety of behaviors and accomplishments, including: doing well overall (74%), compliance with treatment (45%), compliance with medication (6%), entrance into a residential treatment program (6%), remaining substance abstinent (3%), job/school accomplishment (3%), artwork/poetry (3%), maturity (3%), client getting close to graduation (3%), never testing positive for substances (3%), paid a debt (3%), finished parenting classes (3%), and reported to treatment (3%).[7]

Incentives were administered in 71% of the cases observed. Incentives included: praise from judge (61%), released from custody/jail (13%), eligible for graduation (6%), seen early on the docket (6%), courtroom applause (3%), phase advancement (3%), given a second chance at treatment (3%), reduction in fines (3%), received a token (3%), and a term/condition was removed (3%).

[6] Note that multiple types of noncompliance could have been observed occurring per client; these percentages will not add up to 100%.
[7] Note that multiple types of noncompliance could have been observed occurring per client; these percentages will not add up to 100%.

Table 49. Characteristics of status review hearings.

Characteristic	Percentage of Observed Hearings
Appearance Type	
Regular status hearing	77%
In-custody	19%
Noncompliance	58%
Sanctions	45%
Recognition	74%
Incentives	71%

Feedback: MHTC Team

Team members were surveyed about aspects of the use of sanctions in the program, as well as their notification of client noncompliance in the form of client arrests (see Table 50). The majority of team members reported that the MHTC uses a graduated system of sanctions for noncompliance, rewards are matched to the level of client compliance, the severity of sanctions are matched with the seriousness of the noncompliance, and that jail time is not used as a sanction more often than not. However, there were varying perceptions of whether or not the MHTC team representatives were notified within two days of client arrests while they are in the program.

Table 50. MHTC team perceptions on sanctions, incentives, and offender (non)compliance.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The MHTC uses a graduated system of sanctions to address non-compliant behavior.	0%	0%	17%	67%	17%
Rewards are matched to the level of compliance shown by the client.	0%	0%	17%	75%	8%
The severity of the sanction is matched with the seriousness of the infraction.	0%	0%	25%	67%	8%
Sanctions are effective for influencing client compliance.	0%	0%	25%	67%	8%
Jail time is used as a sanction more often than not.	17%	67%	8%	8%	0%
MHTC representatives are notified within 24 to 48 hours of client arrests while clients are actively in the MHTC program.	8%	8%	25%	33%	25%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the use of sanctions in MHTC with their clients (see Table 51). The majority of treatment counselors reported that the MHTC uses a graduated system of sanctions, and that sanctions are effective for influencing client compliance.

Table 51. Treatment counselor perceptions of MHTC use of sanctions.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The MHTC uses a graduated system of sanctions to address noncompliant behavior.	0%	0%	0%	83%	17%
Sanctions are effective for influencing client compliance.	0%	0%	17%	67%	17%

Feedback: MHTC Clients

The clients were asked about the perceived fairness of the sanctions and incentives received in MHTC (see Table 52). The majority of clients reported that they felt they received the same incentives as other clients in the program. However, a notable number of clients indicated neutrality or dissent to statements reflecting that they felt they received the same sanctions as other clients, and that the MHTC team does not get angry with them when administering sanctions.

Table 52. MHTC client perceptions of sanctions and incentives.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
When I do not do well in MHTC, I feel that I receive the same sanctions (consequences) as other people in MHTC.[8]	5%	0%	37%	47%	11%
When I do not do well in MHTC, I feel that I receive the same rewards as other people in MHTC.[9]	5%	0%	20%	65%	10%
When I receive sanctions (consequences), members of the MHTC team do not get angry with me.[10]	0%	0%	43%	50%	7%

[8] Out of N=19 responses; 2 clients indicated that they had never received sanctions and thus this question was not applicable to them.
[9] Out of N=20 responses; 1 client indicated that they had never received rewards and thus this question was not applicable to them.
[10] Out of N=18 responses; 4 clients indicated that they had never received sanctions and thus this question was not applicable to them.

Focus Group

Team members were asked to collaborate on responses to questions about the general use of sanctions (see Table 53). The focus group revealed that the MHTC has a range of sanctions of varying magnitudes that could be administered in response to client behavior. In addition, sanctions are administered in an individualized manner, such that not all clients receive the same sanctions for similar actions undertaken by other clients in the program. The focus group indicated that sanction severity is often imposed due to the perceived necessity of safety for the client and others, and as a result of an examination of the clients' present behavior versus an accumulation of prior noncompliances. In addition, the focus group indicated that sanctions are often heavier toward the end of the clients' program when they are more aware of what behaviors are unacceptable, versus in the beginning of the program when this may be less clear to them. Thus, there are times when sanctions are increased progressively and when they are not, depending on the client's unique situation.

Table 53. Focus group collaborative responses to questions regarding the general use of sanctions.

Sanctions	True/False
Clients receive consequences that are equivalent to those received by other clients in the same place in the program who are engaged in comparable conduct.	True/False
The MHTC has a range of sanctions of varying magnitudes that may be administered in response to infractions in the program.	True
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/False
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/False

Team members were also asked to collaborate on responses to questions about the general use of the use of jail sanctions (see Table 54) and incentives (see Table 55). 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, but that sometimes the clients are held longer in order to stabilize clients or for clients to obtain access to medication. The group indicated that clients always have access to counsel, including if they receive a jail sanction. Lastly, the focus group has indicated that they emphasize incentivizing productive behavior and provided positive examples of various MHTC team members using incentives to reinforce MHTC client behavior.

Table 54. Focus group collaborative responses to questions regarding the general use of jail sanctions.

Jail Sanctions	True/False
Jail sanctions are imposed judiciously and sparingly.	True
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
Jail sanctions are definite in duration and typically last no more than three to five days.	True
Clients are given access to counsel and a fair hearing if a jail sanction might be imposed because a significant liberty interest is at stake.	True

Table 55. Focus group collaborative responses to questions regarding incentives.

Incentives	True/False
The MHTC places as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance abuse, and other infractions.	True

The team was asked three open-ended questions regarding client noncompliance and failure to complete the program (see Table 56). The team was first asked to describe how client noncompliance was handled in the program and how this differed from SATC and DDX courts. The team response was to the effect that client noncompliance was addressed on an individualized basis, and varied across a spectrum from courtroom admonishment to removal from MHTC. The group indicated that MHTC clients are sensitive to receipt of sanctions, making addressing noncompliance different for this population. The focus group indicated that all of these factors indicate divergences from other forms of treatment courts.

The second open-ended question the team was asked was regarding what circumstances they terminate clients from the program. The team responded to the effect that clients that continually are in noncompliance and that are not making progress with treatment are at risk for program termination, though the team indicated that this is not an exact formula.

The third open-ended question the team was asked was in regards to what happens if the clients do not complete the program. The team responded that in some cases clients are put on informal probation, but they mostly receive a terminal disposition and serve the remainder of their sentence in jail.

Table 56. Open-ended questions asked during the team focus group regarding client noncompliance and failure to complete MHTC.

Open-ended Questions
1. How is noncompliance handled in the program? How does this differ from SATC and DDX?
2. Under what circumstances do you terminate clients from the program?
3. What happens if the clients do not complete the program?

PREPARATIONS FOR PROGRAM COMPLETION

Researchers have recommended that offender program completion be related to their 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

Team members were surveyed about the extent to which they felt that clients were prepared for program completion (see Table 57). The majority of team members reported that adequate support was not readily available for connecting clients with housing, employment, and treatment services after completion with MHTC. However, team members reported that they generally felt the team prepares clients for when they finish MHTC.

Table 57. MHTC team perceptions of preparations for clients' program completion.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The court provides adequate support for helping clients secure safe housing after their successful participation in MHTC.	0%	33%	50%	17%	0%
The court provides adequate support for helping clients find employment after their successful participation in MHTC.	0%	33%	50%	17%	0%
The court provides adequate support for helping clients secure treatment services after their successful participation in MHTC.	0%	33%	50%	17%	0%
The MHTC team helps clients to prepare for when they finish MHTC.	0%	17%	0%	83%	0%

Feedback: MHTC Clients

The clients were asked about help they have received in preparing to complete MHTC (see Table 58). About half of the clients surveyed indicated that they felt that the court is helping them to prepare for completion from MHTC. In addition, 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, and reported agreement that the court has assisted in providing treatment for when the clients complete MHTC.

Table 58. MHTC client perceptions of available assistance in preparing for program completion.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The court is helping me to prepare for when I complete MHTC.	0%	5%	42%	37%	16%
The court has helped me find treatment and/or medication for when I complete MHTC. [11]	0%	6%	18%	59%	18%
The court has helped me find housing for when I complete MHTC.[12]	0%	21%	50%	21%	7%
The court has helped me find employment for when I complete MHTC.[13]	0%	27%	40%	27%	7%

Focus Group

Team members were asked to collaborate on responses to questions about continuing care for MHTC clients (see Table 59). The focus group revealed that clients are completing aftercare, are working with the court on a continuing care plan for when they complete MHTC, and are contacted for at least three months after their release from the MHTC program in order to ensure continuity of care.

Table 59. Focus group collaborative responses to questions regarding preparations that are made for client program completion from MHTC.

Continuing Care	True/False
Clients complete aftercare.	True
Clients prepare a continuing-care plan together with their counselor to ensure they continue to engage in prosocial activities and remain connected with a peer support group after their discharge from the MHTC.	True
For at least the first 90 days after discharge from the MHTC, treatment providers or clinical case managers attempt to contact previous clients periodically by telephone, mail, e-mail, or similar means to check on their progress, offer brief advice and encouragement, and provide referrals for additional treatment when indicated.	True

[11] Out of N=19 clients; 2 clients indicated that they will not be making changes to their treatment and/or medication regimen, and 2 clients did not respond.
[12] Out of N=14 clients; 5 clients indicated that they do not need help finding housing, and 2 clients did not respond.
[13] Out of N=15 clients; 4 clients indicated that they already had employment or were unable to work, and 2 clients did not respond.

SUMMARY

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

TEAM MEETINGS AND COURT HEARINGS

In observations of team meetings and court hearings numerous representatives were present. The data collected on team meetings indicated that the most frequent topic of discussion was treatment progress. Decisions on client progress appeared to be made collaboratively by the treatment team, with the judge serving as the final arbitrator when necessary. Team members were perceived by observers to be respectful toward each other, respectful toward clients. However, observers noted that there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members present. 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. In the evaluation, all of the treatment counselors reported that they perceived their clients to regularly be in attendance at status review hearings. The majority of MHTC clients reported that they perceived that treatment and court personnel worked together as a team and that there was not a team leader, which coincides with observer ratings in team meetings that team decisions were often how final decisions regarding client behavior were made.

The judge participated in all of the status review hearings, with less participation observed from other team members. The focus group revealed several aspects of judicial interactions with the team and with clients that have 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, judicial interactions observed by the evaluators were positive, individualized, and direct with the clients. This coincided with feedback from team members; the majority of team members reported that the judge made an effort to establish rapport with clients and demonstrates empathy and active listening with clients. While the majority of MHTC clients reporting that they had positive interactions with the judge during their status review hearings, the majority also indicated neutrality with the statement that they have a good relationship with the judge. The literature on treatment courts points to the relationship between the judge and the clients as a central part of promoting positive outcomes; thus, examining ways in which the relationship between the clients and judge can be improved may be beneficial for the clients.

The court frequently used recovery-sensitive language, and encouraged clients to be active participants in their hearings. In general, clients reported that they were reminded about consequences for positive and negative behaviors by the team during their hearings. Most MHTC clients spoke in their hearings, with some of them sharing success stories. Per literature suggesting this is an important component of MHTCs, clients' families were mentioned and observed in approximately a quarter of the MHTC cases observed.

The focus group reported that there are not phase structures in MHTC, though there was discussion about whether or not phases should be implemented. Some team members believe that implementing phase structure may be beneficial for clients; further discussion may be helpful.

The majority of MHTC cases were heard for less than three minutes for their status review hearings. A best practice in drug courts is for clients' hearings to be for no less than three minutes. While MHTC is not a drug court, the team, treatment counselors, and observers alike all noted that MHTC clients may benefit even more than drug court clients from the court meeting this minimum time limit in court.

SANCTIONS/INCENTIVES

During court hearings, more time was spent in recognition and incentives than sanctions. MHTC members attempted to reinforce clients even when clients were struggling. The majority of team members reported that the MHTC uses a graduated system of sanctions for noncompliance, rewards are matched to the level of client compliance, and that the severity of sanctions are matched with the seriousness of the noncompliance.

Respondents indicated that clients always have access to counsel. The team indicated that responses to client noncompliance were made on an individualized basis, and varied from courtroom admonishment to removal from MHTC. Further, the team indicated that clients are sensitive to receipt of sanctions.

The majority of clients surveyed reported that they felt they received the same incentives as other clients in the program, but some disagreed with this. It is unclear to what extent clients perceive incentives and sanctions received to be fair and this could be further explored. In addition, there were varying perceptions of whether or not the MHTC team representatives were notified within two days of client arrests while they are in the program.

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, the majority of team members indicated that jail was not often used as a sanction, and 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 no more than three to five days. However, members of the focus group also indicated that jail was used as a method for connecting clients to access with medication or for stabilization of emotional concerns. Still others have stated that jail actually

impedes the ability of clients to efficiently obtain medication and stabilization and that jail is not a therapeutic setting. The team may benefit from reconsidering their position on utilizing jail as a therapeutic intervention, 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[14] 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.

PREPARATIONS FOR PROGRAM COMPLETION

Preparing clients for program completion is another important aspect of MHTCs. About half of the MHTC clients surveyed indicated that they felt that the court helped them to prepare for completion from MHTC, while the majority of team members also felt that the team prepared clients for when they finished MHTC. The majority of clients did not feel that the MHTC has assisted them in finding housing and employment, but reported that they felt the court has assisted in connecting clients with treatment for when the clients complete MHTC. This was generally supported by team member feedback.

Additionally, the focus group revealed that clients completed aftercare, prepare a continuing care plan with the court for when they complete MHTC, and are contacted for at least three months after their release from the MHTC program in order to ensure continuity of care.

[14] This distinction is important, as merely connecting clients with medication that is not within their prescribed regimen may not necessarily be beneficial to the clients.

Stakeholder Roles

TEAM MEMBERS' ROLES & TRAINING

It has been suggested that members of the MHTC team be "willing to adapt to a nontraditional setting and rethink core aspects of their professional training" (Thompson et al., 2007, p.8). In particular, choosing team members who are able to adequately adopt a non-adversarial attitude is essential for the success of a MHC (Council of State Governments, 2005). Team members should also generally consist of individuals with criminal justice and mental health experience. Team members should be trained prior to beginning in the court, should receive ongoing training throughout their time in MHTC, and should be provided the opportunity to conference and visit other MHCs (Thompson et al., 2007).

Team members were surveyed about whether or not they felt that team members understand each other's roles (see Table 59). The results suggested that the majority of the team felt that this element was present within their MHTC team.

Table 59. MHTC team perceptions of understanding team members' roles.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Team members understand each other's roles.	0%	0%	8%	58%	33%

Judge

The role of the judge is thought to be essential to the extent to which treatment courts are successful (Thompson et al., 2007). Thompson et al. (2007, p. 8) describe the judge as: "He or she oversees the work of the mental health court team and encourages collaboration among its members, who must work together to inform the judge about whether participants are adhering to their terms of participation."

Feedback: MHTC Team

Team members were interviewed regarding what they felt the role of the judge in MHTC was (see Table 60). The judge was primarily described as being the ultimate decision maker of the team. She was also described as having a strong leadership role, having established a relationship with clients, holding clients accountable, and acting as the court intermediary between the court and clients. In addition, the judge was seen as having a non-traditional role in the courtroom and serving as an arbitrator of the team.

Table 60. MHTC team perceptions of the role of the judge on the team.

Roles	Descriptions	Sample Quote
Team Leader	▪ Fosters collaboration ▪ Team leader ▪ Leads team discussions ▪ Keeps the team focused ▪ Calls cases	*"I view the judge as the manager of the team, the head coach. She should be the one that keeps the focus together, keeps things moving and on point."*
Relationship with Clients	▪ Acknowledges client progress ▪ Recognizes client strengths and weaknesses ▪ Creates safe space for clients ▪ Builds rapport with clients ▪ Praises clients ▪ Engages with clients	*"Provides a safe place for individuals to come in, and maintains a welcoming environment. Very different from other courtrooms. Recognize their strengths and weaknesses and goals in a safe place. This sets the stage for the other team members to accommodate the client. Recognize their accomplishments. Helps the team see where there is progress made."*
Client Accountability	▪ Administers sanctions ▪ Communicates expectations ▪ Enforces rules	*"She communicates to the clients what the treatment team's expectations are."*
Court Intermediary	▪ Communicates team decisions to clients ▪ Intermediary between court and client	*"She's the direct connection between the court and the client."*
Non-Traditional Role	▪ Accepts/denies clients ▪ Program advocate ▪ Treat clients different than in other courts ▪ Keeps clients best interests	*"Helps them treat the clients differently from other courts. An ear to everyone, but clients interests kept."*
Arbitrator	▪ Arbitrator of the court ▪ Mediates between prosecution and defense	*"The judge is the ultimate decision maker. She helps mediate between the sides, between treatment and public defenders, probation, district attorney."*
Decision Maker	▪ Makes decisions ▪ Has final say in team ▪ Takes into account team opinions	*"Makes the decisions with regard to the defendant, after consulting with team members. Final decision lies with the court. Upon disagreement, the judge decides."*

Focus Group

Team members were asked to collaborate on responses to questions about whether or not the judge was assigned to the calendar voluntarily and if the judge's term was indefinite (see Table 61). The focus group indicated that the judge was not assigned to the MHTC voluntarily, and that the judge's term was indefinite.

Table 61. Focus group collaborative responses to questions regarding the role of the judge.

Length of Term	True/False
The judge was assigned to the MHTC on a voluntary basis.	False
The judge's term on the MHTC bench is indefinite in duration.	True

Coordinator

Feedback: MHTC Team

The majority of the SATC team expressed confusion when asked about the role of the coordinator. Several team members suggested that the coordinator was involved in court publicity, treatment monitoring, coordinating trainings, overseeing best practices, and generally ensuring the program is running smoothly (see Table 62).

Table 62. MHTC team perceptions of the role of the coordinator on the team.

Roles	Descriptions
Publicity	▪ Publicity ▪ Fundraisers
Treatment Monitor	▪ Ensures treatment is compliant with contract ▪ Liaison between programs
Trainings	▪ Ensure ongoing trainings
Overseer of Best Practices	▪ Ensure adherence to best practices
Program Maintenance	▪ Ensure program is running smoothly

District Attorney

Feedback: MHTC Team

Team members were interviewed regarding what they felt the role of the district attorney was in MHTC (see Table 63). The district attorney was described as primarily having aspects of both non-traditional and traditional district attorney roles. A number of team members indicated that the district attorney was a representative of 'The People' and his role is to hold clients accountable. The district attorney was also seen as a team member, one who promotes client treatment, and as having a non-adversarial role. The district attorney was also identified as the gatekeeper of MHTC.

Table 63. MHTC team perceptions of the role of the district attorney on the team.

Roles	Descriptions	Sample Quotes
Represents 'The People'	▪ Best interest of The People ▪ Represents the government ▪ Community/public safety	*"His role is to represent the community within the courtroom and to keep in mind the community's safety first, in regards to the clients."*
Team Member	▪ Team member ▪ Listens to treatment recommendations ▪ Makes recommendations to the judge	*"Listen to the recommendations from the treatment team and make their own recommendation to the judge. The treatment team comes to an agreement in some cases…[in the end] we always come to an agreement."*
Client Accountability	▪ Holds clients accountable ▪ Ensures sentencing is handled properly ▪ Recommends jail sanctions ▪ Prosecute clients ▪ Ensure justice is served	*"Ensures that the defendant is getting proper treatment and sentencing. He also ensures that the sentencing is being handled properly."*
Gatekeeper	▪ Presents initial cases ▪ Eligibility assessments ▪ Gatekeeper	*"They are the gatekeeper; they make determinations on who is eligible for MHTC based on history and rap sheet."*
Promotes Treatment	▪ Promotes client treatment	*"Not every DA has the disposition to do this court; it takes a DA who is willing to promote treatment over incarceration, who recognizes the potential exposure to public safety but is wiling to give the clients a chance for treatment."*
Non-adversarial	▪ Has a non-adversarial role	*"Typically here the DA is not seen as a punitive body, whereas in most other courts they are."*

Public Defender/Defense Attorney

Feedback: MHTC Team

Team members were interviewed regarding what they felt the role of the public defender was in MHTC (see Table 64). The public defender was described as having aspects of both non-traditional and traditional public defender roles. In addition, the public defender was seen as a member of the MHTC team, a social worker to the client, and a client advocate and protector.

Table 64. MHTC team perceptions of the role of the public defender on the team.

Roles	Descriptions	Sample Quotes
Non-Traditional Role	▪ Client's best interest ▪ Supposed to be less adversarial	*"To look out for the clients' best interests legally, and mental and physical health wise."*
Traditional Role	▪ Represent clients ▪ Keep the client out of custody ▪ Provide information to the clients	*"Their role is to represent their client and to provide information to their clients."* *"To keep the clients out of custody; that's the primary goal."*
Team Member	▪ Represent clients on the team ▪ Make recommendations to the court	*"They act as a mouthpiece for the clients when the clients have concerns or problems."*
Protect the Client	▪ Protect the client's constitutional rights ▪ Protect the client	*"For the most part, to make sure that clients aren't being taken advantage of or put in a position where they can't comply with court orders. To protect the clients' rights."*
Social Worker	▪ Make sure clients get proper treatment ▪ Social worker to clients ▪ Make sure client needs for treatment are assessed	*"Make sure that clients' needs are assessed. If they see mental health issues, they ask for an assessment for their client."*
Client Advocate	▪ Advocate for clients	*"They advocate for the best interest of their client and get placement in an appropriate treatment for all their needs."*

Bailiff

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the bailiff to be (see Table 65). Team members described the role of the bailiff as maintaining the safety and order of the court. He was also described as remanding the clients, communicating with the team about clients, and having a good relationship with the clients.

Table 65. MHTC team perceptions of the role of the bailiff on the team.

Roles	Descriptions	Sample Quotes
Keeps Order of Court	▪ Enforces court rules ▪ Keep order ▪ Keep clients in line	*"Maintain structure and expected behaviors. Teach appreciation for the court. Uniquely trained and maintains peace in the court."*
Relationship with Clients	▪ Works well with the clients ▪ Relationship with clients ▪ Intuition about clients ▪ Can deescalate clients	*Been incredible how they have an intuition about when someone is having a bad time. Reaching out and communicating to the clients, "We care about you, you can do it." A lot of clients could be paranoid, and bailiffs have to not react.*
Courtroom Safety	▪ Maintains courtroom safety/security ▪ Protect the judge	*"Maintains security of the judge and whoever is on this side of the room. Anything could happen and cause damage to the judge and anyone. But the main priority is safety and security of the courtroom."*
Remands Clients	▪ Arrests remanded clients	*"They have the job of arresting defendants when they are remanded."*
Communicates with Team	▪ Communicates information about clients	*"If there is an issue with a client, keeping everyone in the loop."*

Community Law Enforcement

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of community law enforcement to be (see Table 66). Over half of the team members described community law enforcement as having little to no role in the MHTC team. Community law enforcement was also described as having roles related to maintaining community safety, initiating the MHTC process, having minimal client contact, being an important relationship for the MHTC team itself to have, and as demonstrating concern for clients.

Table 66. MHTC team perceptions of the role of community law enforcement on the team.

Roles	Descriptions	Sample Quotes
Not Active on the Team	▪ No involvement ▪ Not part of the team ▪ Minimal contact ▪ Will appear if called	*"Community law enforcement usually isn't involved in the MHTC."*
Community Safety	▪ Keep community safe	*"Their role is to keep the community safe."*
Initiate MHTC Process	▪ Initiate the MHTC process ▪ Cite/arrest clients ▪ Refer clients to treatment courts	*"They initiate the whole process. They cite them or arrest them, which puts them into the system."*
Client contact	▪ Respond to calls	*"Occasionally they may be getting calls for our clients and they might respond to them."*
Important Relationship with MHTC	▪ It is important for them to understand the MHTC process	*"As a whole, the sheriff's department is important for their recognition of the program and understanding how our procedures are different. For example, we have flash incarcerations, remanding for nights and weekends, and catch and release. [For these procedures to work], we need them to know our program and be receptive to our procedures."*
Concern for Clients	▪ Concern for client well being	*"They will bring in people they have arrested. Lots of things are happening then, and I watch other clients react to this. We have had many positive experiences with this. This is a unique setting. There is a concern for the clients' well being. They could be initially afraid of police but they can see that this is a different environment. There is not that tension. The defendants who have been in the program can recognize that the police are trying to help."*

Probation

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the probation team representatives to be (see Table 67). Probation officers were seen as primarily being responsible for monitoring clients in the community and as integral team members. They were seen as individuals who have frequent contact with clients and are in charge of holding clients accountable, as well as being involved in some case management, client suitability determinations, and promoting community safety. The probation team members' role was described as a 'dual role,' where they reflect both an authority figure and a promoter of client recovery.

Table 67. MHTC team perceptions of the role of probation on the team.

Roles	Descriptions	Sample Quotes
Monitoring Clients	▪ Supervise clients ▪ Home visits ▪ Ensure clients are in compliance ▪ Keep in contact with programs ▪ Ensure rules are followed	*"Directly supervises any of the people in the program. Interfaces the most with the defendant outside of program. In the community, they complete home supervision; make sure that the home environment is what it should be. Supervising the defendant out in the community."*
Team Member/Role	▪ Provide recommendations on clients ▪ Provide information to court on clients ▪ Big part in decision making ▪ Recommend sanctions ▪ Reinforce team's recommendations	*"Probation's role is to supervise the clients and report back what the course of their treatment is. They keep in contact with programs and clients. They're supposed to report back to the treatment team about what's going on."*
Relationship with Clients	▪ Keeps in contact with clients ▪ Spends a lot of time with clients ▪ Have relationship with clients ▪ Provides clients with structure ▪ Ensures clients succeed in program	*"They are the frontline troops, they have the most contact with our clients."*
Client Accountability	▪ Holds clients accountable ▪ Involved in client sanctions	*"They hold clients accountable, make sure they do what they are supposed to be doing."*
Case Management	▪ Provide case management ▪ Liaison with jail for medication	*"Offer case management, which is much different than many law enforcement positions."*
Suitability	▪ Assesses suitability for the program	*"To assess for client suitability for the program."*
Community Safety	▪ Promotes community safety	*"Make recommendations for the clients' safety, as well as the safety of others."*
Dual Role	▪ Dual role of authority and promoting recovery	*"Probation is more on the, you know making sure they are staying clean. More on the authority side. They are also on the recovery side too. They kind of have to play both roles there."*

Substance Abuse Treatment Provider

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the substance abuse treatment providers to be (see Table 68). Substance abuse treatment providers were viewed as individuals providing various treatment and case management services to the clients. They were seen as individuals who exhibited important attitudes and knowledge about the clients, and that had the most client contact. The substance use providers were also seen as an important part of the MHTC team.

Table 68. MHTC team perceptions of the role of the subsatnce abuse treatment provider(s) on the team.

Roles	Descriptions	Sample Quotes
Provides Treatment Services	▪ Provide treatment ▪ Help clients with sobriety ▪ Help clients with mental health needs ▪ Counseling ▪ Assessment of client needs	*"Provide clients with treatment. Provide different kinds of group (ex: co-occurring, trauma informed), complete individualized treatment plans and goals."*
Important Attitudes and Knowledge	▪ Compassion ▪ Patient with clients ▪ Know what works with clients	*"They KNOW what is most likely to work for each client. They are knowledgeable about different types of interventions. They come in with compassion [for the clients]. This is the key to all of this, the whole court."*
Team Member	▪ Keep court informed of client progress ▪ Recommend sanctions	*"They keep probation and the court informed of client's progress, attendance, testing results, employment, and education. They provide any information necessary to let the team know what kind of progress the client is making. They share about the happenings in their programs, aside from confidential matters."*
Case Management	▪ Drug testing ▪ Track client attendance ▪ Ensure client compliance with medication ▪ Provide clients with additional referrals ▪ Aftercare support ▪ Prepare for program completion	*"They support client abstinence and help prepare for after care for long-term maintenance; recovery is a life long struggle. Their role is to support the clients and connect them to community resources outside that support recovery. A lot of referring out to other community programs, and figuring out what they clients are going to do when they are done. That is a huge role of the Providers."*
Client Contact	▪ Spend the most time with the client ▪ Relationship with the clients	*"They are with the clients most of the time. They have an ongoing relationship with clients."*

County Mental Health

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the County mental health to be (see Table 69). The County mental health treatment providers were seen as individuals who provided various treatment and case management services to the clients. They were seen as individuals who exhibited various aspects of particular approaches and goals with clients that were viewed as important. The substance use providers were also viewed as a part of the MHTC team, individuals who carefully considered safety with clients, and who maintained client confidentiality.

Table 69. MHTC team perceptions of the role of County mental health on the team.

Roles	Descriptions	Sample Quotes
Provide Treatment Services	▪ Provide mental health treatment (individual, group) ▪ Medication ▪ Client assessments ▪ Treatment planning ▪ Diagnose clients	*"They conduct assessments for client needs, provide ongoing mental health counseling to clients, and provide clients with medication as needed."*
Case Management	▪ Transportation ▪ Ensure clients follow-up with treatment ▪ Coordinate with providers ▪ Ensure clients keep appointments ▪ Connect clients to services quickly ▪ Facilitate services in jail	*"They are following up with the clients at the program, and making sure the clients are meeting with the medication person and keeping psychologist appointments."*
Team Member	▪ Report on client progress ▪ Team member ▪ Provide information to court on services and mental illness ▪ Help identify appropriate clients	*"They provide continual updates to court about client progress and participation. What else is going on? (father just died, accident, hearing voices, etc.); not just whether the clients are participating. They give the team information so that the team can try to understand what is going on with the individual so we can tailor their treatment program."*
Approach/Goals with Clients	▪ Help prevent re-engagement in criminal activity ▪ Help clients learn to make better decisions ▪ Reinforce clients ▪ Encourage clients ▪ Maintain client mental health	*"Their role is two-fold, based on the type of client they have. There are clients that they are coaching and those they are cheerleading. They are reinforcing their strengths, encouraging them to continue with their outpatient program, providing case management and treatment. They encourage them to participate in treatment and outside self help groups."*
Consider Safety	▪ Safety as a primary concern	*"They really look at clinical stability and looking at safety for everybody. A challenge is bringing up this issue when they are not safe to others. There are times when issues can't be discussed because of confidentiality, but knowing when safety should trump this is key. They balance how to bring about safety and still protect their client. They are looking at issues of client and community safety; for example, the safety of clients' children, perhaps."*
Client Confidentiality	▪ Maintain client confidentiality	*"They are constantly aware of issues surrounding how much information to present in the courtroom regarding the clients."*

Other Mental Health Providers

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the "other" outside treatment providers to be. Team members generally indicated that other providers were not heavily involved with MHTC, and indicated there were minimal roles that were fulfilled for their MHTC clients by these outside treatment providers.

County Psychiatrist/Psychologist

Feedback: MHTC Team

Team members were interviewed regarding what they perceived the role of the psychiatrist/psychologist to be (see Table 70). The role of the County's psychiatrist/psychologist was described as being a team member for the MHTC team, providing services to clients, performing crisis intervention with clients, and screening clients for program eligibility. Additionally, the psychiatrist/psychologist is seen as one who connects clients with services and works well with the clients.

Table 70. MHTC team perceptions of the role of the psychiatrist/psychologist on the team.

Roles	Descriptions	Sample Quotes
Team Member	▪ Provides input on available services ▪ Liaison between providers and court ▪ Makes recommendations ▪ Updates team on client progress ▪ Hands-on	*"The head of the mental health treatment provider team in court. We never interface with the psychiatrist. Psychiatrist is not direct member of the team, but part of the mental health system. The psychologist is the head of the larger mental health team. He will give his input, and will be the one to go between psychiatrist and the court for medications."*
Services Provision	▪ Intervention ▪ Medication ▪ Mental health services	*"They provide individual therapy."* *"Their role is to prescribe medications if needed, or to adjust medications."*
Crisis Intervention	▪ Risk assessments ▪ Crisis intervention in the courtroom	*"He does crisis intervention right in the courtroom."* *"He makes 5150 declarations."*
Screens Clients	▪ Screens clients ▪ Client assessments ▪ Client eligibility	*"He does the screenings, sometimes he's our connection to getting clients into mental health. Sometimes they're just not connected and it's easier to introduce them to him and he facilitates the assessment."* *"He is also there to assist the team in deciding if a client is appropriate for MHTC or another program like drug court or DDX."*
Works with Clients	▪ Good with clients ▪ Works closely with clients	*"He is great, fantastic with the clients. He treats them with respect."*
Client Referrals	▪ Connects clients with services	*"He is here at court and connects the clients with the services that are appropriate for them."*

Professional Training

Focus Group

Team members were asked to collaborate on responses to questions about professional trainings they have received that are relevant to MHCs or to treatment courts in general (see Table 71). The focus group revealed there was a large amount of variance in the amount of professional training received between team members, with some team members receiving more or less training than others. The members of the focus group indicated that mental health trainings are more available to mental health staff, but less so for other types of MHTC team members. The focus group reported that the judge regularly attends conferences and workshops.

Table 71. Focus group collaborative responses to questions regarding team members' professional training.

Professional Training	True/False
The MHC judge attends current training events (e.g., conferences, webinars, workshops) on: a. - legal and constitutional issues in MHTC, b. - judicial ethics, c. - evidence-based substance abuse treatment, d. - evidence-based mental health treatment, e. - behavior modification, and f. - community supervision.	 a. True b. True c. True d. False e. True f. True
The judge attends annual training conferences and workshops.	True
Each member of the MHC team attends up-to-date training events on mental health topics.	True/False

Preparations for MHTC

Feedback: MHTC Team

During the team member interview, team members were asked about how they were prepared for working on the MHTC team in terms of training, observations and advice (see Table 72). The majority of the drug court team members indicated that they had received little to no training prior to serving on the MHTC. Team members stated that formal training, on-the job experiences, observation and consultation, and prior experience helped to prepare them for serving on MHTC. Multiple team members indicated that there were not any preparations provided for serving on MHTC.

Table 72. MHTC team member qualitative responses to the question, "How were you prepared for working on the MHTC team in terms of training, observation, advice?"

Response Categories	Descriptions	Sample Quotes
Prior Experience	▪ Previous experience with treatment courts ▪ Background working in the legal system ▪ Background working with mental health ▪ Psychology background	*"I did have experience working with mental health in jobs previously held, but that's it."*
Observation and Consultation	▪ Observed court ▪ Talked to people involved in other courts/positions ▪ Learned treatment providers ▪ Asking a lot of questions ▪ Talking with Mental Health	*"Just talking to mental health and asking a lot of questions."* *"I observed the court; talked to lots of attorneys and judges and clinicians; and talked to people from other states."*
Formal Training	▪ Degree in mental health field ▪ Classes offered at job ▪ Some mental health trainings ▪ Conferences	*"We go to the annual conference and there are many sessions there on disorders. We have also gone to trauma trainings."*
Experiential Learning	▪ Trained by prior person in position ▪ Learning on-the-job	*"I was trained by my predecessor. I observed them."*
Not Enough Training	▪ Not enough training ▪ No training ▪ No convention available	*"Thrown into the fire. No preparation was provided. No advice or warnings."*

Suggestions for Preparations for MHTC

Feedback: MHTC Team

During the team member interview, team members were asked about what preparations they would advocate for in order to help someone else in their position transition to working on the MHTC (i.e., training, advice). Their answers are summarized in Table 73. Several team members recommended training and gaining knowledge on mental illness, substance use, and the interaction of these two domains in CODs. Team members also highlighted the importance of the following: observations and consultation, changes in ways of thinking, and the finding supportive others with whom to communicate. In addition, de-escalation training for use with clients, attending conferences, and the creation of orientation materials for new staff were also recommended. A couple of team members suggested that there aren't trainings adequate to prepare new team members for serving on MHTC.

Table 73. MHTC team member qualitative responses to the question, "What preparation would you advocate to help someone else in your position transition to working on the MHTC team with regard to training and advice?"

Response Categories	Descriptions	Sample Quotes
Knowledge of Mental Illness and Substance Use	▪ Education/training on mental illness ▪ Knowledge of relapse/recovery ▪ Education on the mental illness/substance use interaction	*"Get educated in mental health, understand what the disorders are and how they interact with substance abuse, and how to treat them."*
Ways of Thinking	▪ Work to keep clients out of jail ▪ Change your mindset about your role ▪ Emphasize communication with others ▪ Be prepared for a long day	*"Communication. Constant communication between the court staff and the resources and the clinic team. For this treatment court, saying, 'What can we do to help support this client to stay out of jail? Do we have to give a little to get a little?'"*
Observation and Consultation	▪ Review staffing notes ▪ Observe ▪ Know resources ▪ Partner with someone in the role ▪ Ask questions ▪ Communicate with treatment providers	*"You learn a lot just by asking questions and having more communication with mental health providers and treatment providers. They're easy to speak to and easy to work with."*
No Training	▪ No possible training ▪ People will acclimate	*"It's one position you can't really be trained for, you just have to observe and participate. Every MHTC will be different."*
De-escalation Training	▪ De-escalation training for work with clients	*"It would be good to have training in regards to how to deescalate mental health clientele, and having specific training in regard to different disorders."*
Conferences	▪ Attend conferences	*"I would recommend that they go to conferences that have special sessions on CODs."*
Find Supportive Others	▪ Find people supportive of clients with CODs	*"Align yourself with people that believe in a dual diagnosis approach. This is important. It's hard to stay with this job unless you have like-minded support. It can be so easy to give up on it."*
Orientation Materials	▪ Creation of orientation materials	*"I think that we should have an orientation manual, similar as they have in SATC."*

TREATMENT COUNSELOR ROLES & TRAINING

Treatment counselors are an important part of the MHC process. The treatment counselors are on the 'front lines' of having regular contact with the client, and are often the ones to report to the MHCs regarding client progress in treatment.

Treatment counselors were surveyed regarding whether or not they felt treatment agencies were represented as core members of the MHTC team (see Table 74). All of the treatment counselors surveyed indicated that treatment representatives are core members of the MHTC team.

Table 74. MHTC team perceptions of treatment agencies as members of the MHTC team.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Representatives from treatment agencies are core members of the MHTC team.	0%	0%	0%	80%	20%

Formal Education and Trainings

Feedback: Treatment Counselors

During interviews with treatment providers, they were asked to identify any trainings that they had received: formal education, training at their agency, other formal trainings, trainings regarding recognizing implicit cultural biases (e.g., cultural sensitivity training), and trainings regarding correcting disparate impacts for members of historically disadvantaged groups. In addition, the treatment counselors were asked about any training they had received about working with clients involved in the criminal justice system. The answers are outlined in Table 75. The counselors indicated a wide variety of trainings, certifications, and degrees received. Some counselors indicated more training than others; however, all indicated some form of formal training.

Table 75. Treatment counselor reports of their formal education and trainings received.

Response Categories	Descriptions
Formal Training	▪ College degrees ▪ Alcohol and Other Drug Abuse certifications (e.g., CADAC) ▪ Seeking Safety ▪ Motivational interviewing ▪ Trauma-informed care ▪ Co-occurring disorders/treatment ▪ Cultural diversity ▪ Moral Reconation Therapy ▪ Employment group training ▪ Administration of Justice certification/degree
On-the-job Training	▪ Internships ▪ On-the job (past and present) ▪ Shadowing
Prior experiences	▪ Prior experience with treatment courts ▪ Prior experience in criminal justice system ▪ Prior experience in mental health

Focus Group

Team members were asked to collaborate on responses to questions about treatment providers' training and supervision (see Table 76). The focus group indicated that most treatment providers are licensed and/or certified, have experience working with clients in the criminal justice system, and are supervised regularly to ensure fidelity of practices.

Table 76. Focus group collaborative responses to questions regarding treatment providers' training and supervision.

Treatment Provider Training and Supervision	True/False
Treatment providers are:	
a. - licensed or certified	a. True
b. - have substantial experience working with criminal justice populations, and	b. True
c. - are supervised regularly to ensure continuous fidelity to evidence-based practices.	c. True

Trainings for Working With Offender Populations

Feedback: Treatment Counselors

In general, treatment counselors reported that they received informal training in working with offender populations, often comprised of on-the-job training. The counselors indicated that they felt there should be more explanation of what is expected of their offender populations while they participate in treatment, in order to better serve their clients. One counselor also indicated that training had been received on an evidence-based curriculum for group work with clients.

SUMMARY

The literature on MHCs has emphasized incorporating stakeholders into the MHC team who are open-minded to a nonadversarial courtroom, and who have prior experience working with populations similar to MHTC clients. However, there are not set role duties prescribed to MHC models. In general, members of the MHTC team indicated that they felt they understood each other's roles on the team. The judge was perceived as having a strong leadership role, was represented as an intermediary between the court and clients, and was perceived to have established relationships with the clients. These characteristics are in line with research in the area of other treatment courts, suggesting that the judge should maintain a leadership role in the court, while serving as a collaborative team member and having good relationships with the clients. In addition, the judge's term has been set as an indefinite term, allowing for clients to have a stable figure in the judge.

Team members identified the role of the district attorney and the public defender in MHTC as having both non-traditional and traditional characteristics. The district attorney was seen as a representative of 'The People,' but was also seen as a team member who promoted treatment; the public defender was described as a team member, as well as a social worker and advocate to the

client. Similarly, probation officers were seen as primarily being responsible for monitoring clients in the community and as integral team members; their role was described as a 'dual role,' where they reflect both an authority figure and a promoter of client recovery.

Substance abuse treatment providers and County mental health treatment providers were all seen as providing treatment and case management services to the clients. The role of the County's psychiatrist/psychologist was described as screening clients for program eligibility and connecting clients with services. All of these individuals were also seen as important parts of the MHTC team.

Roles that were identified as having less involvement in the MHTC were the coordinator, bailiff, and community law enforcement. The majority of the SATC team expressed confusion when asked about the role of the coordinator. It may be of benefit to the team to explore ways to incorporate the coordinator more in MHTC proceedings. In addition, team members did not necessarily identify the bailiff and community law enforcement as being team members. Team members described the bailiff's role as maintaining the safety and order of the court, and described the role of community law enforcement as an important relationship to the MHTC but not as being directly involved on the MHTC team. The lack of active presence of law enforcement in either domain on the MHTC team may indicate an area where improvements can be made; some team members had suggested that it would be beneficial to have law enforcement representatives present on the team in general.

The focus group revealed differences in the amount of professional training received between team members. The members of the focus group indicated that mental health trainings are more available to mental health staff than to other types of MHTC team members. The focus group reported that the judge regularly attends conferences and workshops. Team members without prior experience in the mental health field may benefit from additional trainings in this area.

Team members were also interviewed about how they were prepared for working on the MHTC team. The majority of the MHTC team members indicated that they had received little to no training prior to serving on the MHTC. Team members suggested that the following preparations for serving on the MHTC team would be helpful for future team members: training on mental illness, substance use, and the interaction of these two domains in CODs; observation and consultation with knowledgeable others; addressing attitudes and thought processes important for working in treatment courts; finding supportive others to communicate with; de-escalation training for use with clients; attending conferences; and the creation of orientation materials for new staff.

The role and training of the counselors treating the MHTC clients was also examined. All of the team members surveyed indicated that treatment representatives are core members of the MHTC team; this was corroborated by team member interviews indicating that the role of the treatment providers included integral 'team member' roles and functions. Treatment providers indicated a range of training they had received: formal education, training at their agency, and other formal trainings. The counselors indicated a wide variety of trainings, certifications, and degrees received; some counselors indicated more training than others, however all indicated some form of formal training. In addition, treatment counselors reported that they received informal on-the-job training in working with offender populations. The focus group indicated that most treatment providers are licensed and/or certified, have experience working with clients in the criminal justice system, and are supervised regularly to ensure fidelity of practices.

It is important to note that a few team members indicated that there was some degree of adversarial functioning within the team, suggesting that there may be some difficulties in adjusting to the differences that come with working in treatment courts. Furthermore, it was suggested that some team members lacked understanding of the clients being served in terms of mental illness and the appropriate treatments for this population. These issues may be ameliorated by the appropriate trainings for team members with less experience working with mentally ill, substance using, and/or criminal justice involved offenders.

Non-Traditional Characteristics

NECESSARY ATTITUDES

Two types of attitudes have been asserted to be important in working in MHCs: (1) openness to a non-adversarial approach to court (Council of State Governments, 2005), and (2) informed attitudes regarding mental illness (Blandford et al., 2015). Both of these attitudes are essential; without either, MHCs are likely to experience discord or dysfunction in one or more areas, and may inadvertently contribute to negative client outcomes.

Attitudes Toward Non-adversarial Approaches

Literature has suggested that adaptation to nonadversarial approaches is a necessary aspect of team members' roles on MHC teams, and "is not a matter of role switching, but rather ensuring that team members are able to and comfortable with rethinking and expanding their professional roles to adapt to the new context" (Blandford et al., 2015, p. 27). The goal of the nonadversarial approach is essentially for all team members to collaborate on what is in the client's best interest.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt adversarial roles were set aside, the court focuses on future behaviors, and that the team is committed to the MHTC program (see Table 77). The majority of team members reported that traditional adversarial roles were set aside in MHTC and that team members are committed to the program. However, team members were evenly split on whether or not they agreed that the court focuses on future behavior rather than past transgressions.

Table 77. MHTC team member perceptions on the presence of non-adversarial attitudes within MHTC.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Traditional adversarial roles are set aside during the MHTC process.	0%	0%	8%	67%	25%
The court focuses on clients' future behaviors, rather than clients' past behaviors.	0%	8%	42%	25%	25%
Team members are committed to the MHTC program.	0%	0%	17%	42%	42%
Clients are encouraged to take an active role in the MHTC process.[15]	0%	0%	18%	55%	27%

During the team member interviews, each team member was asked if there were any necessary attitudes for a well-functioning mental health treatment court team (see Table 78). A number of specific particular personality characteristics and attitudes/beliefs were identified as being necessary for a well-functioning MHTC. Team members indicated that having knowledge of mental illness, substance use, and the interaction of CODs and the corresponding courses of treatment were also imperative. In addition, collaboration and working toward a common goal were identified as important approaches.

[15] Data for this question was reported for the 11 of the 12 team members for whom survey data was available.

Table 78. MHTC team qualitative responses to the question, "Are there certain attitudes that are necessary for a well-functioning mental health treatment court team?"

Response Categories	Descriptions	Sample Quotes
Personal Characteristics	▪ Empathy ▪ Open-minded ▪ Appropriate expectations ▪ More patience ▪ Positive ▪ "Thick skinned" ▪ Flexible	*"Receptive. You have to be empathic. You have to have thick skin. You can be insulted if someone swears and walks out of the courtroom. It takes a certain disposition or temperament to work on the team."*
Knowledge of Treatment Aspects	▪ Knowledge of mental health treatment ▪ Knowledge of substance use treatment ▪ Treating CODs ▪ Understanding relapse/recovery ▪ Emphasis on treatment ▪ Individualization of client programs	*"Have a good understanding of mental illness and treatment, both drug treatment and mental health treatment."* *"Understanding that you can't cookie cut the treatment or program. Everyone's mental illness is so different. Got to be very individualized. Individualization is key."*
Interaction of Substance Use and Mental Illness	▪ Knowledgeable about the relationship between mental health and substance use ▪ Knowledge of CODs ▪ Understanding of mental illness	*"I guess an attitude of understanding that addiction and mental health are a process. I do believe the court has that attitude. I guess an attitude of understanding of CODs"*
Attitudes/Beliefs	▪ Crime will be reduced with treatment ▪ Clients aren't criminals ▪ People can get better ▪ Clients are trying to cope by using substances ▪ Incarceration should be used as a last resort	*"I always thought that anyone could be trained to do this, but there has to be a belief that people can get better. People with mental illness are not criminals; crime will be reduced if they get treatment. People want to feel better, and they are self-medicating. They are not just trying to get high, but they are TRYING to cope and feel better. If individuals do not believe that people are not criminals, they don't understand relapse, and they will miss the point of the court. I believe that jail is not the place for people to deal with substance abuse. It cleans them up but doesn't address the problem."*
Collaboration	▪ Work as a team ▪ Defense/prosecution work well together ▪ Nonadversarial	*"The district attorney and public defender have to work together as a team to best benefit the client. You have to try to not be defensive or aggressive."*
Goals	▪ Work toward a common goal ▪ Best interest of client ▪ Getting clients healthy	*"I think it's so important to work as a toward a common goal which is the treatment of the defendant and getting the defendant healthy and law abiding citizen. Just because they are in the court system doesn't mean they should be treated like a criminal."*

Feedback: Treatment Counselors

During interviews with treatment providers, they were asked about what attitudes are necessary for a well-functioning mental health treatment court, and if they felt that the MHTC displays these attitudes toward the clients (see Table 79). Treatment counselors reported that there were attitudes that were essential for a well-functioning MHC, and identified various relevant personal characteristics, personal boundaries, personal beliefs, and knowledge that were deemed necessary. Treatment counselors also identified aspects of team relationship and relationships with clients that supported these necessary attitudes. The treatment counselors generally indicated that they felt the MHTC exhibited these characteristics.

Table 79. Treatment counselor qualitative responses to the question, "Are there certain attitudes that are necessary for a well-functioning mental health treatment court?"

Response Categories	Descriptions
Personal Characteristics	▪ Passion ▪ Empathy ▪ Patience ▪ Kindness ▪ Compassion ▪ Understanding ▪ Openness
Relationship with Clients	▪ Have to have boundaries with clients ▪ Have to lift clients up ▪ Increase expectations of clients ▪ Focus on client strengths
Team Relationships	▪ Everyone has to get along ▪ Need to be able to manage different personalities
Personal Boundaries	▪ Don't bring personal issues in ▪ Meet the clients' needs, not yours
Personal Beliefs	▪ These clients are different ▪ There is more to an individual than their diagnosis ▪ Anyone can have a mental illness ▪ With treatment clients can do well
Knowledge	▪ Need to understand metal illness

Attitudes Toward Mental Illness

In addition to being able to embrace a nonadversarial approach, it has been suggested that team members' attitudes toward mental illness be assessed (Blandford et al., 2015). The intention of evaluating these attitudes is to ensure that team members feel comfortable working with the population they are serving, and assessment of attitudes toward mental illness may indicate areas of need and training (e.g., on mental illness, substance use, criminal justice system) that are essential for members to effectively serve on an MHC team. In addition, negative attitudes toward mental illness can result in unintended consequences, such as implicit biases or stigmatizing clients (Centers for Disease Control and Prevention et al., 2012). In the present evaluation, members of the MHTC team and treatment counselors working with MHTC clients answered questions assessing attitudes toward mental illness using a survey derived by Blandford et al. (2015).

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt mental illness was treated like a medical condition, as well as their level of agreement with various attitudes toward mental illness (see Table 80). The results suggested that the team members generally felt that mental illness was treated like a medical condition, increased spending on mental health services was not a waste of money, anyone can have a mental health disorder, mental health should be provided in the community as much as possible, that mental illness is not caused by a lack of self-discipline, and that treatment can help people lead normal lives. The results also indicated mixed attitudes toward mental illness, particularly on whether or not individuals with mental illness are more violent than individuals without mental illness, if the team members felt more comfortable interacting with someone who is receiving treatment for a health condition than a mental disorder, if the team members felt they could always tell if someone has a mental disorder, and if people are generally sympathetic to people with mental illnesses.

Table 80. MHTC team member endorsements of attitudes toward mental illness.

Question[16]	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
In the MHTC, mental illness is treated like a medical condition rather than something to be punished for.	0%	0%	8%	75%	17%
People with mental disorders are more violent than people without mental disorders.	9%	55%	27%	9%	0%
Increased spending on mental health services is a waste of money.	55%	45%	0%	0%	0%
Anyone can have a mental health disorder.	0%	9%	0%	36%	55%
Mental health services should be provided in the community as much as possible.	0%	0%	0%	55%	45%
I feel more comfortable interacting with someone who is receiving treatment for a health condition (e.g., cancer, diabetes) than a mental disorder (e.g., depression).	18%	46%	18%	18%	0%
One of the main causes of mental illness is a lack of self-discipline and willpower.	64%	27%	9%	0%	0%
You can always tell if someone has a mental disorder.	36%	46%	9%	9%	0%
Treatment can help people with mental illness lead normal lives.	0%	0%	27%	36%	36%
People are generally caring and sympathetic to people with mental illness.	9%	55%	27%	9%	0%

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which they agreed with various attitudes toward mental illness, using most of the same survey items as the MHTC team members (see Table 81). The results indicated mixed attitudes toward mental illness, particularly on whether or not individuals with mental illness are more violent than individuals without mental illness, if the counselors felt that anyone can have a mental disorder, if the counselors felt more comfortable interacting with someone who is receiving treatment for a health condition than a mental disorder, if the counselors felt, and if people are generally sympathetic to people with mental illnesses. Treatment counselors generally felt that spending money on mental health services was not a waste of money, mental health should be provided in the community as much as possible, mental illness is not caused by a lack of self-discipline, you cannot always tell if someone has a mental disorder, and that treatment can help people lead normal lives.

Table 81. Treatment counselor endorsements of attitudes toward mental illness.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
People with mental disorders are more violent than people without mental disorders.	17%	17%	67%	0%	0%
Increased spending on mental health services is a waste of money.	67%	33%	0%	0%	0%
Anyone can have a mental health disorder.	0%	0%	40%	0%	60%
Mental health services should be provided in the community as much as possible.	0%	0%	0%	17%	83%
I feel more comfortable interacting with someone who is receiving treatment for a health condition (e.g., cancer, diabetes) than a mental disorder (e.g., depression).	50%	17%	33%	0%	0%
One of the main causes of mental illness is a lack of self-discipline and willpower.	67%	33%	0%	0%	0%
You can always tell if someone has a mental disorder.	50%	50%	0%	0%	0%
Treatment can help people with mental illness lead normal lives.	0%	0%	0%	33%	67%
People are generally caring and sympathetic to people with mental illness.	17%	0%	50%	33%	0%

FAMILY INVOLVEMENT

Literature on MHCs have posited that involving family members in the process of the MHC treatment program may be beneficial (Blandford et al., 2015; Council of State Governments, 2005). It has been suggested that having supportive family members is a favorable component in the recovery of individuals with mental illness in general (CDC, 2012), which could be facilitated by somehow involving family members in the MHTC process or encouraging their involvement with the client throughout their program. In addition, treatment programs that are considered to be 'highly integrated' for populations with CODs usually also involve a family component; considering that a large portion of the MHC populations usually have CODs, this suggests that involving families into the MHC process may be beneficial for client outcomes (Council of State Governments, 2005).

[16] Data for this question was reported for the 11 of the 12 team members for whom survey data was available.

Observations

During courtroom observations, the clients' families were mentioned in 23% of the cases, were present in 23% of the cases, and spoke in 10% of the cases observed.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt that the MHTC engages clients' family members or social supports in the clients' treatment (see Table 82). There were mixed perceptions on this item, with about half of the team members indicating that they agreed with this statement.

Table 82. MHTC team member perceptions of engagement with clients' family members.

Question	Strongly Disagree	Disagree	Do not Agree or Disagree	Agree	Strongly Agree
The MHTC engages family members or other client social supports in the treatment process.	8%	0%	33%	50%	8%

Feedback: MHTC Clients

Clients were asked about whether or not the MHTC involved their family in the proceedings (see Table 83). There were mixed responses to this question, with clients appearing to be split almost evenly in dissent, neutrality, and agreement to this statement.

Table 83. MHTC client perceptions that the MHTC has involved their families.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The MHTC has involved my family in the court process.	0%	32%	26%	26%	16%

COMMUNITY SUPPORT

Linking community support to the MHC programs is another non-traditional aspect of MHCs. Community support plays an important part in providing psychoeducation on mental illness, providing information on MHCs to potential clients and referral sources, and fostering program sustainability (Council of State Governments, 2005). In addition, continual outreach allows MHC programs to promote the program successes (Council of State Govermnments, 2005; Thompson et al., 2007). Newspapers have been identified as a viable media outlet, with some courts finding success in promoting MHCs through this venue as a way to address the "overrepresentation of people with mental illnesses in the criminal justice system" (Council of State Govenments, 2005, p. 80).

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt that the community is supportive of the MHTC's efforts (see Table 84). The team appeared to be largely neutral in responding to this question, with some agreement and some dissent as well.

Table 84. MHTC team member perceptions of community support.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The community is supportive of the MHTC's efforts.	0%	8%	58%	33%	0%

During the team member interviews, the team members were asked to identify ways in which the MHTC had obtained community support (see Table 85). Team members varied widely in their perceptions of whether or not the court had strong community support. On one hand, team members indicated that they felt there is a lack of media support, as well as concern that media support would stigmatize clients. Team members also suggested there is a lack of fundraisers and lack of support from other court systems. Conversely, team members identified community needs to be consistent with the MHTC, and indicated strong support from family members of MHTC clients as well as treatment providers in the community. Team members indicated that confidentiality and negative perceptions of MHTC clients may contribute to the lower degree of community support for MHTC.

Table 85. MHTC team qualitative responses to the question, "Do you feel that the MHTC program has garnered community support? In what ways?"

Response Categories	Descriptions	Sample Quotes
Varying Perceptions of Support	▪ No one knows about it ▪ Not enough ▪ Somewhat ▪ Yes ▪ Don't know ▪ Not important	*"I don't know. I don't know how to answer that one. I'm sure the community likes more people trying to get help."*
Media Issues	▪ No media support ▪ Publicity would cause stigma	*"I would say there isn't much community support, just in the sense that there isn't a lot of media attention. I think that other treatment courts get more attention that the MHTC does. That's not to say that the community doesn't care about MHTC."*
No Fundraisers	▪ No fundraisers for MHTC	*"We don't have any fundraisers or anything like that."*
Confidentiality	▪ Work is confidential, making garnering support difficult	*"It's a unique population, and confidentiality may play a role in [garnering community support]."*
Community Needs	▪ Needs for MH services is high	*"I think that there are more community demands for services than what is available, particularly for the mental health population. I don't know that the community knows what MHTC is, but the community is very active in stating their interests to treat mentally ill populations."*
Community Perceptions of Clients	▪ Community is scared of clean and sober homes ▪ Community scared to have clients in community ▪ Lack of community awareness of mental illness	*"I think aspects of the community are scared of clean and sober homes, and are worried about having more clients in the community."*
Treatment Support	▪ Shelters supportive of MHTC ▪ Treatment has relationships with MHTC	*"The shelter is more open to accepting the clientele if they are in MHTC because they know they are getting support and know who they can call. They also know that the clients have status reviews so they are more likely to behave."*
Family Support	▪ Family members appreciative	*"I see the family members. They are so appreciative. The community and family know, this is not just drugs. Their loved one is mentally ill and they couldn't convince anyone else. They are hoping someone hears that before they go to prison."*
Lacking Court Support	▪ Lack support from traditional court systems	*"I don't feel like we have the support of the court system and I don't know if that falls under community or not. A lot of people don't feel that drug court or mental health treatment court works. I think we're working on it and it would be really great if we could get the rest of the court system on our side."*

Team members were subsequently asked to identify ways in which more community support could be obtained for MHTC (see Table 86). Team members indicated that community support could be garnered by increasing community awareness of mental illness and MHTC, as well as increasing the number of mental health-related events in the community and publicizing them. Team members indicated that educating others close to MHTC (other courts, clients' family members) on the MHTC processes would be helpful, as well as involving local law enforcement more in MHTC in general. Some team members suggested community outreach efforts, as well as publicizing client engagement in community service work. Finally, the issue of how to maintain client confidentiality while improving increased public awareness of MHTC was raised.

Table 86. MHTC team qualitative responses to the question, "In what ways would you like this to be improved upon?" (asked in relation to current levels of perceived community support; see Table 85).

Response Categories	Descriptions	Sample Quotes
Increased Community Awareness (General)	▪ Raise community awareness ▪ More media attention ▪ Raise awareness of treatment ▪ More newspaper articles	*"More information to release to the community, I don't know how. But I think the community should know this court exists and that it's serving a huge purpose in mental health/substance abuse. We're taking people who might not have been employable or able to get an education and some of these people are becoming able to do these things; they're functioning at a higher level, even with mental disorders. At some level, the community should be aware that this is something that the court is doing; the role of more traditional courtrooms is to incarcerate and convict, and ours is to rehabilitate and reintegrate. Our clients are criminals, but they are not are a danger to our society."*
Increased Awareness of Events	▪ Awareness of mental health events ▪ More mental health events ▪ Publicity for graduation	*"We're getting a little more exposure on our graduations. That's a big deal because when we can showcase our graduations and the number of recidivisms going down that would really garner support. Media support would be really helpful and maybe more functions through providers. We've put on other functions like that in the past."*
Education of Others on MHTC	▪ Training for court staff, law enforcement ▪ Education for family members on processes	*"In terms of family and support system, education of family members would help. Just to raise awareness of what to expect in the program and to be supportive of the clients, as opposed to being irritated that they have to take them to court and to treatment, etc."*
Law Enforcement Involvement	▪ More involvement from law enforcement	*"It would be great if local law enforcement was more involved."*
Community Service Work	▪ More community services work	*"We have talked about more community work service. With publicity. So that people know it's the participants that are giving back to the community."*
Confidentiality Issues	▪ Unsure with confidentiality	*"With the confidentiality aspects I'm not sure how that would work. That's a private thing for each of these folks. We don't talk about details in court hearings."*
Outreach	▪ Outreach for MHTC ▪ Outreach for mental illness in general	*"It would be nice to have outreach in general. There are people who are not committing crimes but need mental health."*

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which they felt the community was supportive of the MHTC (see Table 87). The results suggested a range of perceptions of community support for MHTC, with half of the counselors indicating community support existed, and half split between neutrality and not being sure of the level of community support there was.

Table 87. Treatment counselor perceptions of community support for MHTC.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
The community is supportive of the MHTC's efforts.	0%	0%	33%	33%	17%	17%

SUMMARY

Three non-traditional aspects of MHTCs were explored: attitudes relevant to MHCs (i.e., openness to nonadversarial treatment approaches, knowledge of mental illness), family involvement, and community support.

Attitudes relevant to MHCs were assessed in terms of openness to adversarial approaches, and knowledge and attitudes toward mental illness. The majority of team members reported that traditional adversarial roles were set aside in MHTC and that team members were committed to the program. During interviews, team members and treatment counselors were asked if there were any necessary attitudes for a well-functioning MHTC team. They identified personality characteristics and attitudes/beliefs that are important, as well as having knowledge about mental illness, substance use, the interaction of CODs and corresponding courses of treatment. In addition, working toward a common goal, having good team relationships, and having good relationships with the clients were identified as important. Team members and treatment counselors generally indicated that they felt the MHTC exhibited these characteristics.

Team members and treatment counselors were surveyed about their agreement with various attitudes regarding mental illness. The results indicated mixed attitudes toward mental illness, including differences in opinions as to whether or not individuals with mental illness are more violent than individuals without mental illness, whether or not the interviewee felt more comfortable

interacting with someone who is receiving treatment for a health condition than for a mental disorder, and whether or not the interviewee felt that people are generally sympathetic to people with mental illnesses. Generally, those interviewed perceived that increased spending on mental health services was not a waste of money, mental health should be provided in the community as much as possible, mental illness is not caused by a lack of self-discipline, and that treatment can help people lead normal lives. The overlap of shared perceptions between the two groups interviewed is notable, and may reflect similar experiences for individuals in contact with the clients in both the treatment and the court settings. Responses also highlighted areas where additional improvements could be made; for example, they noted that more information on mental illness could be provided, enhanced community outreach might reduce perceptions of stigma around mental illness (and thus, increase empathy/sympathy), and better information on best practices in working with individuals with serious mental illnesses might reduce the discomfort in working with the population.

Literature on MHTCs have posited that involving family members in the process of treatment may be beneficial. Courtroom observations revealed that the clients' families were mentioned in some cases, and also were present and/or spoke during client hearings. Team members and clients were surveyed regarding their perceptions that the MHTC involved their families and had mixed perceptions. The MHTC was not routinely perceived as involving clients' social supports in the program. While the court was open to involvement of social supports, it was not involved in outreach to them. This could be a reflection of a lack of resources or could point to a lack of responsivity of family and social supports in the clients' lives.

Community support was identified in the literature as important in promoting support for the MHTCs and for reducing stigma for clients with serious mental illnesses. Team member interviews regarding perceptions of community support varied. Half of the treatments counselors surveyed on the same question indicated that community support existed. Thus, there appears to be some perceptions of the existence of community support, though that support is not perceived to be strong. However, the team members indicated strong support from family members of MHTC clients as well as treatment providers in the community.

Team members indicated that community support could be garnered by increasing community awareness of mental illness and MHTC, as well as by increasing the number of mental health-related events in the community. Team members indicated that educating others close to MHTC (other courts, clients' family members) on the MHTC processes would be helpful, as well as involving local law enforcement more in MHTC in general. Some team members suggested community outreach efforts, as well as publicizing client engagement in community service work. Finally, the issue of how to maintain client confidentiality while increasing public awareness of MHTC was raised.

Some team members had concerns that raising community awareness would further stigmatize clients. While this was well intended, Blandford et al. (2015) has suggested that stigmatization may be combated by increasing the knowledge of others; thus, by not increasing awareness, one could potentially contribute to the stigmatization of that population in question. In theory, raising awareness on mental illness and MHTCs could help to inform the public and address misconceptions about mental illness, which could contribute to the reduction of stigma. The team also brought up concerns regarding client confidentiality in pursuing raising community awareness for MHTCs. This is a valid concern, which should be addressed among treatment team members prior to implementing any actions that may potentially violate the clients' rights to privacy.

MHTC Relationships

The various relationships within the treatment court are important in determining client responses to the process. There are many relevant relationships to consider; the relationships within the MHTC team itself, between the court and the clients, the court and the treatment providers, and the treatment providers and the clients.

TEAM RELATIONSHIPS & FUNCTIONING

Group cohesion has been studied for several years, with literature suggesting that group cohesion can be related to group effectiveness (Vinokur-Kaplan, 1995), and can protect team members from experiencing burnout (Ronen & Mikulincer, 2009). Similarly, team collaboration has been found to be important in team processes; team collaboration has been found to be significant in predicting team performance (Chiocchio, Forgues, Paradis, & Iordanova, 2011) and job satisfaction (Chang, Ma, Chiu, Lin, & Lee, 2009). Recommendations for collaboration and cohesion have also been emphasized within MHC functioning (Thompson et al., 2007).

MHTC Team Cohesion

This section examines team cohesion and the nature of the relationships between the MHTC team members.

Feedback: MHTC Team

Team members were surveyed about various aspects of team cohesion and the team relationships (see Table 88). The majority of team members indicated that they work hard to understand each other's perspectives, defense and prosecution work well together, the team manages conflict constructively, the team shares information effectively, and team members listen to one another. In addition, the majority of team members indicated that they feel valued on the team, feel that they can raise concerns to the team and be heard, and feel they can count on team members to follow through on decisions made in team meetings.

Table 88. MHTC team perceptions of team cohesion and team relationship characteristics.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The team works hard to understand each other's perspective.	0%	8%	0%	83%	8%
Defense and prosecution work well together.	0%	0%	25%	67%	8%
The team manages conflict and disagreement in a constructive and supportive way.	0%	0%	8%	67%	25%
I feel valued on the team.	0%	0%	25%	25%	50%
I feel that I can raise concerns to the team members and that I will be heard.	0%	0%	17%	42%	42%
The team members share information effectively.	0%	0%	8%	67%	25%
The team members listen well to each other.	0%	0%	17%	58%	25%
I can count on the team members to follow through on what we decide upon in our meetings.	0%	0%	25%	50%	25%

During the team member interviews, team members were asked how well they felt the MHTC team works together (see Table 89). The majority of team members indicated that in general the team works well together and exhibits many aspects of effective teamwork. Team members indicated areas of strength and weakness in team functioning, with some pointing out that the team is new and highlighting the importance of having a team.

Table 89. MHTC team qualitative responses to the question, "How well do you think the MHTC team works together?"

Response Categories	Descriptions	Sample Quotes
Work Well Together	▪ Work well together ▪ No real issues	*"I think everyone works well, I don't see any real issues."*
Areas of Strength	▪ Team wants clients to get better ▪ Team gets along ▪ Open-minded ▪ Come to agreements ▪ Good collaboration ▪ Communicate well ▪ Awareness/knowledge of mental illness	*"Everyone is open-minded to suggestions, which is nice. Sometimes there's a disagreement, but when people have suggestions, others are able to see the perspective of everyone and come to an agreement."*
New Team	▪ The team is new	*"Considering it's a new team, I think the team works very well together."*
Team as Important	▪ Having a team helps	*"I think we are doing well. It's a lot easier to have a team than doing everything on your own."*
Areas of Weakness	▪ Agreeing on amenability to treatment ▪ Agreeing on appropriateness for MHTC ▪ Occasional disagreements ▪ Lack of consistency in treatment and plans ▪ Fragmented	*"There is lack of consistency in the treatment plan and plans of action."* *"It's kind of fragmented and maybe it's just the way."*

Team members were subsequently asked how improvements could be made to the way the MHTC team works together (see Table 90). A couple of team members indicated that the MHTC did not need any improvements. Other team members identified potential improvements to be made in the areas of assessments, mental health services, and team trainings. In addition, team members also generated a wide range of miscellaneous suggestions (i.e., suggestions without a common theme).

Table 90. MHTC team qualitative responses to the question, "How could improvements be made to the way the team works together?"

Response Categories	Descriptions	Sample Quotes
None	▪ No suggestions ▪ Issues have been resolved	*"Everyone does their job, works well together. No improvements to recommend specifically."*
Assessments	▪ Written reports ▪ Structured/evidence-based assessments ▪ Client appropriateness	*"Receiving written assessment reports from mental health. Also, what are they basing these assessments on? Often our clients' problems don't rise to the level of using our resources."*
Mental Health Services	▪ Improvements in MH services ▪ More psychiatrists/psychologists	*"There could be improvement in mental health services, having someone in addition the psychologist."*
Trainings	▪ Training/education ▪ Training in MHTC/roles ▪ Training in mental health for team members	*"There are struggles when new staff come in and they don't know how MHTC operates. There are not a lot of discussions of the functions of each team member. This causes confusion. Even now, people barely have an idea of what everyone is supposed to do. Everyone has to jump in, and it can be overwhelming."*
Miscellaneous	▪ More case managers in MHTC ▪ Monthly MHTC meetings ▪ Cap on numbers ▪ More individualization with clients ▪ Improvements in communication ▪ Sensitivity with mental illness ▪ Providers not always present ▪ Recognition for team members ▪ Have treatment counselors come to court to see the process	*"Sometimes we have to remember that the clients struggle with mental health and we have to be compassionate in that area. Mental illness is something that clients don't know that they have. We have to be kinder and softer. Sometimes they don't realize that the client may not know they're mentally ill. Sensitivity to what mental health is and how to talk about it."*

Court and Treatment Relationships

This section examines the nature of the relationships between the MHTC team and treatment providers.

Feedback: MHTC Team

Team members were surveyed about the extent to which they felt that the judge was responsive to treatment feedback, as well as the extent to which there are difficulties in communications between the court and treatment staff (see Table 91). The majority of team members reported the judge was responsive to feedback from treatment providers and that court and treatment staff did not have difficulties communicating with one another.

Table 91. MHTC team member perceptions of court and treatment provider relationships.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The MHTC judge is responsive to feedback from treatment providers.	0%	0%	8%	25%	67%
Court and treatment staff have a difficult time communicating with each other.	25%	50%	17%	8%	0%

Feedback: Treatment Counselors

Treatment counselors were surveyed about their perceptions of the relationship between the court and treatment (see Table 92). The majority of treatment counselors reported the judge was responsive to feedback from treatment providers and that court and treatment staff did not have difficulties communicating with one another.

Table 92. Treament counselor perceptions of court and treatment provider relationships.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Court and treatment staff have a difficult time communicating with each other.	17%	67%	0%	0%	17%
The MHTC judge is responsive to feedback from treatment providers.	0%	0%	0%	17%	83%

During interviews with treatment providers, they were asked about how they would characterize the relationship between MHTC and the treatment agency for which they worked. The treatment counselors generally indicated that the relationship was good, and was characterized by good communication and collaboration between the agencies. One treatment counselor noted that their staff was extensively trained in MHTC procedures, and another indicated that the MHTC team being open to treatment was helpful to the relationship.

THERAPEUTIC RELATIONSHIPS

Therapeutic alliance with clients has consistently been shown to be a strong factor related to client outcomes in therapy over several decades of research (Horvath and Luborsky 1993; Ogles et al. 1999; Wampold 2001). While treatment courts are not therapy per se, the relationship that clients have with the courts should be considered a therapeutic relationship in that clients are receiving treatment interventions from the treatment court. Furthermore, the success of treatment courts hinge on client engagement in treatment; thus, the clients' therapeutic alliance with their respective treatment agencies is also relevant to explore.

Team and Client Relationships

This section explores perceptions of the relationship between the MHTC team and the MHTC clients.

Feedback: MHTC Team

Team members were surveyed about confidentiality, respect, and rapport with MHTC clients (see Table 93). The majority of team members reported that client confidentiality is a priority, the team treats clients respectfully, and that the team makes an effort to establish rapport with clients.

Table 93. MHTC team perceptions of characteristics of the relationship beween the court and clients.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Confidentiality of clients is a priority at MHTC.	0%	0%	17%	58%	25%
The MHTC team treats clients respectfully.	0%	0%	17%	42%	42%
The MHTC team makes an effort to establish rapport with clients.	0%	8%	0%	58%	33%

Feedback: MHTC Clients

The clients were surveyed about their relationship with the MHTC team (see Table 94). In general, most clients indicated that they felt respected by members of the team and that the MHTC team wants the clients to succeed. While most clients indicated they felt respected by the MHTC team, clients also indicated neutrality and dissent with this statement. There was also notable neutrality indicated in client perceptions that they have a good relationship with the whole MHTC team, and that the MHTC is concerned about the client as a person.

Table 94. MHTC client perceptions of characteristics of the relationship beween the court and clients

Question	Strongly Disagree	Disagree	Do not Agree or Disagree	Agree	Strongly Agree
I have a good relationship with the whole MHTC team.	0%	0%	37%	53%	11%
I feel that the MHTC team respects me.	0%	5%	16%	63%	16%
MHTC is concerned about me as a person.	5%	0%	32%	58%	5%
The MHTC team wants me to succeed.	0%	0%	11%	63%	26%

Treatment and Client Relationships

This section examines perceptions of the relationship between the MHTC clients and their treatment providers.

Feedback: Treatment Counselors

Treatment counselors were surveyed about whether or not they felt they have a good relationship with their MHTC clients (see Table 95). The results indicated that all of the treatment counselors strongly agreed that they have a good therapeutic relationship with MHTC clients at their program.

Table 95. Treatment couneslor percpetions of having a good therapeutic relationship with MHTC clients.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have a good therapeutic relationship with MHTC clients at my treatment program.	0%	0%	0%	0%	100%

Feedback: MHTC Clients

MHTC clients were asked questions about their therapeutic relationship with the treatment program they attend (see Table 96). Their responses indicated that the majority of clients indicated that they feel their treatment program is helpful, they are treated fairly at treatment, and that they have a good relationship with the workers at their treatment program.

Table 96. MHTC client perceptions of aspects of the therapeutic relationship with the treatment program they attend.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel that the treatment program I attend is helpful.	0%	0%	21%	42%	37%
I am treated fairly by the workers at the treatment program I attend.	0%	0%	26%	47%	26%
I have a good relationship with the workers at the treatment program I attend.	0%	0%	26%	42%	32%

SUMMARY

The relationships within the MHTC team itself, between the court and the clients, the court and the treatment providers, and the treatment providers and the clients, were examined.

TEAM RELATIONSHIPS & FUNCTIONING

Team cohesion and collaboration have been found to be integral aspects in team performance and effectiveness. The majority of MHTC team members indicated that their team exhibited team cohesion and collaboration (i.e., they work to understand each other's perspectives, defense and prosecution work well together, the team manages conflict constructively, the team shares information effectively, team members listen to one another). In addition, the majority of team members indicated that they felt valued on the team, felt that they could raise concerns to the team and be heard, and felt they could count on team members to follow through on decisions made in team meetings. The survey results were echoed in interviews with team members, where the majority of team members indicated the team generally works well together and exhibits many aspects of effective teamwork.

During the team interviews, team members indicated both areas of strength and weakness in team functioning. Strengths were that the team wants the clients to get better, they get along, members are open-minded, they are able to come to agreements, there is good collaboration and communication, and there is some level of knowledge of mental illness on the team. Weaknesses were identified as being a lack of agreement on client amenability to treatment and appropriateness for MHTC, occasional disagreements, lack of consistency in treatment and plans, and fragmentation in the processes.

Team members indicated a few ways in which team cohesion could be improved; these included improvements in the assessment process (i.e., having written reports and structured assessments for addressing client appropriateness for MHTC), improvements in mental health services (i.e., more psychiatrists/psychologists), and increased trainings (i.e., trainings in team roles and knowledge of mental health/treatment). Other suggestions included: more case managers, monthly MHTC meetings, a cap on program numbers, increased individualization with clients, improvements in communication, increased sensitivity toward mental illness, increased presence of some treatment providers on the team, and recognition for team members.

Taken together, the feedback suggests an overall cohesive team with some experiences of disagreement, as would be expected within any collaborative team. Many of the suggestions appeared to be surrounding programmatic improvements versus differences in personal ability to relate to one another, suggesting that the team does not perceive that they are unable to connect cohesively, but rather that any of the team discord may instead be a result of programmatic structures that need improvement.

The relationship between the MHTC team and the treatment providers was also examined. Both team members and treatment counselors indicated that the majority of individuals felt the judge was responsive to feedback from treatment providers and that court and treatment staff did not have difficulties communicating with one another. This was corroborated by treatment provider interviews, where treatment counselors generally indicated that the relationship was characterized by good communication and collaboration between the agencies. However, it is important to note that there were some individuals from both the treatment team

and the counselors themselves that indicated that there are difficulties communicating with one another. While this is not a pervasive problem, the court may benefit from being mindful that this perception does exist among some staff members.

THERAPEUTIC RELATIONSHIPS

The relationship between the court and the clients was generally positive. The majority of team members reported that client confidentiality is a priority, that the team treats clients respectfully, and that the team makes an effort to establish rapport with clients. The clients generally indicated that they felt respected by members of the team and that the MHTC team appears to want the clients to succeed. While most clients indicated they felt respected by the MHTC team, some clients were did not agree with this statement. There was also notable neutrality indicated in client perceptions that they have a good relationship with the whole MHTC team, and that the MHTC is concerned about them as a person. Thus, while the MHTC team perceives a good relationship with the clients, some of the clients may not be experiencing this as a reciprocally positive relationship. The amount of negative or neutral client perceptions was not pervasive, but was still worth noting. The team may benefit from exploring ways in which they can enhance their relationships with their clients.

The relationship between the treatment providers and the clients was also noted as being generally positive. All of the treatment counselors strongly agreed that they have a good therapeutic relationship with MHTC clients at their program, and the majority of clients indicated positive aspects of a relationship with the providers (i.e., they feel their treatment program is helpful, they are treated fairly at treatment, and they have a good relationship with the workers at their treatment program). However, some clients were less positive in describing their relationships with their counselors than were their treatment providers. Treatment providers may consider involving client feedback as to how their relationships could be improved. However, neither of the relationships (i.e., between court personnel and client, between treatment provider and client) were pervasively negative.

MHTC Perceptions

Individuals' perceptions of the MHTC and its processes have implications for MHTC functioning. Research in other fields of study has suggested that perceived versus actual characteristics are more important in determining outcomes (e.g., Seegan, Welsh, Plunkett, Merten, & Sands, 2012), indicating that the perceptions of those individuals involved in MHTC (i.e., team members, treatment counselors, clients) may in themselves have the ability to impact outcomes of the MHTC process. For this reason, the following areas of perceptions were examined: general perceptions of MHCs, team member perceptions of the MHTC, and the treatment counselor's perceptions of the MHTC.

GENERAL PERCEPTIONS OF MHTCs

In this section, general perceptions of MHCs from the perspective of the MHTC team and the treatment counselors were examined using a survey created by Blandford et al. (2015) on thoughts about the efficiency and importance of mental health courts. The same survey was administered to both the team members and treatment counselors for comparison.

Feedback: MHTC Team

Team members were surveyed about their general perceptions of MHCs (see Table 97). The majority of team members indicated that they felt mental health courts are the best way for courts to address defendants' mental health issues, mental health courts are an efficient use of resources, defense counsel is not marginalized in proceedings, prosecutors do not pose a barrier to getting clients into the program, and that mental health courts are not 'soft' on criminals. However, there was neutrality noted in all of the questions, with the highest amount of neutrality found in the items stating that defense counsel is marginalized in MHCs, and that MHCs are the best way to address client mental health issues.

Table 97. MHTC team member general perceptions of the MHTC processes.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Mental health courts are the best way for courts to address defendants' mental health issues.	0%	0%	27%	55%	18%
Mental health courts are an efficient use of resources.	0%	0%	18%	46%	36%
Defense counsel is often marginalized in mental health court programs.	9%	55%	36%	0%	0%
Prosecutors are often a barrier to getting clients into the program.	18%	64%	9%	9%	0%
Mental health courts and other alternatives are soft on criminals.	0%	73%	18%	9%	0%

Feedback: Treatment Counselors

Treatment counselors were surveyed about their general perceptions of MHCs (see Table 98). The majority of treatment counselors indicated that they felt mental health courts are the best way for courts to address defendants' mental health issues, mental health courts are an efficient use of resources, prosecutors do not pose a barrier to getting clients into the program, and that mental health courts are not 'soft' on criminals. However, there was a large amount of variance and neutrality reported to the statement that defense counsel is marginalized in MHCs.

Table 98. Treatment counselor general perceptions of the MHTC processes.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Mental health courts are the best way for courts to address defendants' mental health issues.	0%	0%	0%	67%	33%
Mental health courts are an efficient use of resources.	0%	0%	0%	50%	50%
Mental health courts and other alternatives are soft on criminals.	17%	67%	0%	17%	0%
Defense counsel is often marginalized in mental health court programs.	0%	17%	50%	33%	0%
Prosecutors are often a barrier to getting clients into the program.	0%	67%	17%	17%	0%

TEAM MEMBER PERCEPTIONS OF SANTA MARIA MHTC

This section specifically explored the MHTC team members' perceptions of the functioning of their MHTC program, including strengths, areas for improvement, and suggestions for improvement.

Perceived Strengths

During the individual team interviews, team members were asked about what they perceived the MHTC team's greatest strengths to be (see Table 99). Team members identified a number of aspects of MHTC that they felt were the court's biggest strengths, including aspects of teamwork and the team all working together in the client's best interest. Team members also suggested that the nonadversarial process and individualized nature were great strengths, as was the team's dedication, and the ability of the MHTC to instill hope. Some team members also identified the presence of specific team representatives as the team's greatest strength.

Table 99. MHTC team qualitative responses to the question, "What do you think are your MHTC team's greatest strengths?"

Response Categories	Descriptions	Sample Quotes
Teamwork	▪ Work well together ▪ Team members willing to listen ▪ Teamwork ▪ Can make team decisions ▪ Communication ▪ Follow through on decisions ▪ The relationships ▪ Trust	*"[The team's] ability to work together. We don't always agree, but we work together. It's congenial, no sniping."* *"Communication and teamwork. No one goes behind anybody's back to hide things, we're all open."*
Clients' Best Interest	▪ Sensitive to clients' needs ▪ Do what's best for the clients ▪ Care about the clients ▪ Understanding of CODs	*"The heart that's in there. I think there's heart behind wanting them to do well and succeed."*
Team Members	▪ Good judge ▪ Mental Health is present often ▪ Treatment providers	*"Having mental health present all the time; this is ESSENTIAL. They need to be present all the time."*
Individualized	▪ Individualized program	*"This team is so much more individualized than other treatment courts. With others you tend to have a cookie cutter approach. It's the nature of mental health populations [that it can't be]."*
Established Program	▪ Long-standing program	*"I would say probably the fact that it's been a fairly long-standing program."*
Instill Hope	▪ Instilling hope in others	*"Instilling hope."*
Team Dedication	▪ Commitment ▪ Dedication	*"Commitment and dedication."*
Nonadversarial	▪ District attorney and public defender work well together ▪ Nonadversarial process	*"I think the greatest strength of our team is that the district attorney and public defender work together. Normally in the other court world they are opposing parties, but here they do work together towards the best interest of the client. That's really what it's about."*

Areas of Improvement

During the team interviews, team members were asked about what they perceived the MHTC team's greatest weaknesses to be (see Table 100). Team members identified several areas for improvement: not having enough resources in varying types of areas, aspects of the team process, addressing client appropriateness for MHTC, the referral process, team members' understanding of mental illness, team turnover, not having enough time with the clients, and not linking family members of clients with appropriate services.

Table 100. MHTC team qualitative responses to the question, "What do you think are your MHTC team's greatest weaknesses?"

Response Categories	Descriptions	Sample Quotes
Not Enough Resources	▪ Not enough resources ▪ Lack of places for employment for clients ▪ Not enough housing ▪ Not enough shelter space ▪ No transportation ▪ Too many clients in MHTC ▪ Need quicker entry to receive mental health treatment	*"Not having a way when we release them out of custody to plug them into mental health treatment immediately. We are developing that; we are having mental health pick them up and transport them right to treatment. Not having a system of transportation for this population. This is an overarching problem. In an ideal world having transportation link individuals to services. Not sufficient shelter space, not enough."*
Team Processes	▪ Giving clients too many chances ▪ Making team decisions but later actions do not match ▪ Clients should be treated equally ▪ Inconsistency ▪ Being adversarial ▪ Understanding each others roles	*"Sometime a team decision is made and the final action doesn't happen. Everyone agrees to the one thing they're going to do and the decision has changed."*
Client Appropriateness	▪ Not serving target population (not severely mentally ill) ▪ Need to focus on client willingness	*"Sometimes we put people in here who are not severely mentally ill. We might let people in who have 'just' depression, and we should let people in who have more severe mental illness. Better screening would help improve this process."*
Referral Process	▪ Coordination of referrals	*"Not having some type of coordination with the trial courts for their referrals coming over."*
Understanding Mental Illness	▪ Lack of understanding of mental illness	*"Lack of understanding and education in mental health, whether experience or education."*
Team Turnover	▪ Turnover	*"Turnover. The right fit."*
Not enough time with clients	▪ More days in court ▪ Not enough time spent in court with clients	*"Acknowledgment of the individual is too brief in the courtroom. There are too many clients. I think this could be improved. MHTC could be two days a week, not one. The clients should not suffer. Contact is so important. You hear them say, "I can do it for the judge.""*
Family Services	▪ Not linking family members with appropriate services	*"Services available to the family members. When we have moms in here that are drug addicted and have mental health issues, but we never deal with the trauma for the kids or have them in counseling together. If we address the stressor, maybe the situation would improve."*

Suggestions for Improvement

During the team interviews, team members were asked about what changes they felt could be made that would improve the program or make it more effective (see Table 101). Team members identified a number of different areas in which the team could improve, including in team processes, team training, community support, spending more time with clients, and improving client services. Team members also indicated that more resources were generally needed for the program, and one team member suggested that a discharge planner be implemented into the program. Administrative aspects of the program were also targeted for improvement, including in the eligibility/suitability process, sanctioning guidelines, and having written materials. In addition, team members suggested finding ways to distinguish MHTC from other treatment courts and as well as ways to better understand program failure rates.

Table 101. MHTC team qualitative responses to the question, "Are there any changes you would like to see happen that you think would improve the program or make it more effective?"

Response Categories	Descriptions	Sample Quotes
Team Processes	▪ Focus on being nonadversarial ▪ More consistency	*"Working together more as a team toward a common goal for the client, as opposed to each individual party of the team. And consistency."*
Team Training	▪ Mental health training	*"I definitely think that we could all use a little bit more of an educational class. We could use some training [on mental illness]. Our clients are all across the spectrum."*
Client Services	▪ Individual therapy for clients ▪ Alumni treatment support ▪ Clients shouldn't be in MHTC for 2+ years	*"I don't think there is any kind of alumni treatment support. Recovery is a life long process, so when they graduate they need something in the community. Let's set up an event or something to make the clients feel like they are still a part of the whole recovery process or family."*
Discharge Planner	▪ Position akin to discharge planner	*"One thing they do need in this courtroom is a discharge planner that can actually go to the treatment programs to see how the clients are living, what services are actually being provided, and kind of like in juvenile court where they see the clients once a month, something like that."*
More Time With Clients	▪ More time in staffing ▪ Another day for MHTC	*"Maybe a team meeting with no rush or pressure due to the courtroom would be beneficial."*
More Resources	▪ More resources ▪ More housing ▪ Treatment programs underfunded ▪ Treatment providers overworked ▪ Currently only one psychiatrist	*"The biggest thing for us is housing. That's got to be the biggest improvement. We are really lacking in Santa Maria. Our hands are tied with the treatment programs we do have. Some are expensive; the clients can't afford $600 or $500 a month for a sober living home."*
Improve Eligibility/Suitability	▪ Focus on willing clients ▪ More selective criteria ▪ Written assessments ▪ Include family input in diagnostic assessment	*"Have written assessments, and be more selective. We need to spend more time working on clients who are willing to participate, and less time on clients who are either unwilling or incapable of participating. We need to work with the people who are struggling but trying."*
Community Support	▪ More media attention ▪ Increased public support	*"Media attention and public support would make it more effective."*
Distinguish From Other Treatment Courts	▪ Collaborate with other treatment courts on defining differences ▪ Increased awareness of MHTC criteria	*"I would like to see a document shared with the collaborating departments so that those who are involved in treatment courts can see what the options and eligibility criteria are for each program, who the target population is. There is not enough awareness. Attorneys need to know about all of this."*
Sanctions	▪ More objective guidelines for treatment sanctions	*"I've seen more sanctions for being rude rather than using. If they are on drugs, we need to get them the services they need."*
Understand Failure Rates	▪ Better understand the nature of failure to complete rates	*"We have a high failure to complete rate, which is expected. Maybe we should be more selective. Why is it that we have this rate? Are we failing those who are in? Or allowing in the wrong people?"*
Written Materials	▪ Have written assessments ▪ Bring treatment plans to court for team to view	*"Client progress is given based on verbal feedback updates to the team. I think maybe we should have copies of treatment plans for the team."*

TREATMENT PERCEPTIONS OF SANTA MARIA MHTC

This section specifically explored the MHTC treatment counselors' perceptions of the MHTC program, including the perceived impact of MHTC on their clients, personal experiences with MHTC, and suggestions for improvement.

Impact on Clients

Treatment counselors were surveyed regarding the impact they perceived the MHTC has had on their clients (see Table 102). The results indicated that treatment counselors generally felt that clients were empowered by their interactions with MHTC, MHTC is an asset for their clients, clients have improved partially due to their participation in MHTC, MHTC involvement has helped clients adhere to their mental health and substance use treatment plans, and that MHTC does not create barriers for client success.

Table 102. Treatment counselor perceptions on the impact of MHTC involvement on their clients.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Clients feel empowered by their interactions with the MHTC.	0%	0%	33%	33%	33%
I feel that MHTC is an asset for my clients.	0%	0%	0%	20%	80%
I have seen my clients improve, in part, because of their participation in MHTC.	0%	0%	0%	17%	83%
Involvement with the MHTC has helped my clients to adhere to their MH treatment plan.	0%	0%	0%	17%	83%
Involvement with MHTC has helped my clients to adhere to their substance use treatment plan.	0%	0%	0%	50%	50%
I feel that the MHTC creates barriers for my clients in achieving success.	33%	33%	0%	33%	0%

Treatment counselors were also interviewed regarding their perceived benefits of client participation in MHTC (see Table 103), as well as perceived disadvantages for clients being a part of MHTC (see Table 104). Treatment counselors generally indicated that MHTC has been a great benefit to their clients, with a major benefit identified as being the increased access to treatment afforded by client participation in MHTC. In addition, treatment counselors indicated that participation in MHTC has contributed to less recidivism, has provided a major source of support for the clients, and that clients enjoy participation in MHTC. Treatment counselors did not identify many disadvantages to client participation in MHTC, with some stating there were not any disadvantages. The disadvantages identified were being remanded for sanctions, being on probation, and that the program can be overwhelming for the clients at times.

Table 103. Treatment counselor qualitative responses to the question, "How has MHTC benefited your clients?"

Response Categories	Descriptions
Client Access to Treatment	▪ Links clients to mental health services ▪ Access to a psychiatrist ▪ All mental health needs addressed ▪ All substance abuse needs addressed ▪ Mental health access might otherwise not have been available or taken too long to access
Great Benefit	▪ Has benefited clients greatly ▪ Gives clients structure
Less Reoffending	▪ MHTC clients reoffend less after participation in MHTC
Clients Enjoy Court	▪ Clients love going to court ▪ Clients do not want to leave program
Support System	▪ Achievements verbally rewarded ▪ Incentives offered ▪ Reinforces their efforts ▪ Motivates engagement in program ▪ Extra support for clients ▪ Clients are encouraged by being a part of MHTC

Table 104. Treatment counselor qualitative responses to the question, "Have there been any disadvantages to your clients for being a part of the MHTC?"

Response Categories	Descriptions
None	▪ No disadvantages
Jail	▪ Being remanded for sanctions
Overwhelming	▪ The program can be overwhelming
Probation	▪ Being on probation

Experiences with MHTC

Treatment counselors were surveyed regarding their overall experiences with MHTC (see Table 105). Treatment counselors all reported that they have had positive experiences with MHTC, with the majority of treatment counselors also indicating that they have not had negative experiences with the MHTC. Interviews with treatment counselors regarding their experiences with the MHTC (i.e., "What has your overall experience with MHTC been like?") corroborated this feedback, with treatment counselors generally indicating positive experiences with the court.

Table 105. Treatment counselor perceptions of the nature of their experience with the MHTC.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have had positive experiences with the MHTC.	0%	0%	0%	17%	83%
I have had negative experiences with the MHTC.	50%	33%	0%	17%	0%

Treatment counselors were also surveyed regarding their experiences with MHTC clients in comparison to non-MHTC clients (see Table 106 and Table 107). While survey results in Table 106 indicated that treatment counselors generally did not see any difference in their MHTC clients versus non-MHTC clients, there were differences noted in perceptions of these populations of clients in Table 107. In particular, treatment counselors reported that they felt MHTC clients adhere to treatment rules better, are more motivated to complete treatment, comply with medication regimens better, and are more likely to be abstinent from using substances. About half of treatment counselors indicated that MHTC clients adhere to their treatment plans better.

Table 106. Treatment counselor perceptions of the differences between MHTC and non-MHTC clients (1 of 2).

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I see no difference in my clients who participate in MHTC and other clients not involved with MHTC that have similar issues.	33%	50%	0%	17%	0%

Table 107. Treatment counselor perceptions of the differences between MHTC and non-MHTC clients (2 of 2).

Compared to clients who do not participate in MHTC that have similar issues, my clients that DO participate in MHTC…	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Adhere to their treatment plans better	0%	0%	50%	17%	33%
Adhere to treatment rules better	0%	0%	17%	50%	33%
Are more motivated to complete treatment	0%	0%	0%	67%	33%
Comply with medication regimens	0%	0%	0%	83%	17%
Are more likely to be abstinent from using substances	0%	0%	0%	83%	17%

Suggestions for Improvement

During interviews with treatment providers, they were asked about how the MHTC could be improved (see Table 108). Treatment counselors reported on ways in which the following aspects could be improved upon: sanctioning, increasing awareness for MHTC, improving service provision for offenders, MHTC policies and procedures, and providing certificates for clients.

Table 108. Treatment couneslor qualitative responses to the question, "Are there any changes you would like to see happen that you think would improve the MHTC program or make it more effective?"

Response Categories	Descriptions
Sanctions	▪ Less jail sanctions ▪ More sanctioning ▪ More treatment sanctions
None	▪ None ▪ Courts' hands are tied
Increased Awareness	▪ More awareness of mental illness in community ▪ More awareness for MHTC
Improved Services	▪ Improved services ▪ More services available ▪ More psychiatrists ▪ MHTC clients treated by treatment professionals with appropriate training
MHTC Policies and Procedures	▪ Need to explain MHTC more ▪ Orientation packet for new staff working with MHTC clients ▪ Clear conditions in MHTC ▪ Clear differences between SATC, DDX, and MHTC ▪ Guidelines/best practices in MHTC
Client Certificates	▪ Court certificates for client progress

SUMMARY

The following areas were examined: general perceptions of MHTCs, team member perceptions of the MHTC, and the treatment counselors' perceptions of the MHTC.

GENERAL PERCEPTIONS OF MHTC'S

The majority of team members and treatment counselors indicated that they felt MHCs are the best way for courts to address defendants' mental health issues, mental health courts are an efficient use of resources, defense counsel is not marginalized in proceedings, prosecutors do not pose a barrier to getting clients into the program, and that MHCs are not 'soft' on criminals. However, there was neutrality noted in all of the questions answered by the team members, with the highest amount of neutrality found in the items stating that defense counsel is marginalized in MHCs, and that MHCs are the best way to address client mental health issues. There was also a large amount of variance and neutrality reported to the statement that defense counsel is marginalized in MHCs, by treatment counselors. It appeared that team members and treatment counselors generally shared similar perceptions about the importance and functioning of MHCs, though there were some differences in responding overall. There was also shared sentiment about defense counsel marginalization; this could potentially be addressed by team trainings on MHTC processes (i.e., nonadversarial processing) and roles, in order to reduce this perception, though there has been mixed feedback on the extent to which nonadversarial processing is present within the MHTC, with some individuals identifying the nonadversarial aspect as a strength of the program.

TEAM MEMBER PERCEPTIONS OF SANTA MARIA MHTC

MHTC team members' perceptions of the functioning of their MHTC program, including strengths, areas for improvement, and suggestions for improvement were also examined. Generally speaking, team members suggested that the MHTC functions well and is doing good work. In particular, team members identified a number of aspects of MHTC that they felt were the court's biggest strengths, including aspects of teamwork and the team all working together in the client's best interest. Team members also suggested that the nonadversarial process and individualized nature were great strengths, as is the team's dedication, and the ability of the MHTC to instill hope. Some team members also identified the presence of specific team representatives as the team's greatest strength.

While team members generally perceived the MHTC to be functioning well, they also identified areas for improvement: not having enough resources in varying types of areas, aspects of the team process, addressing client appropriateness for MHTC, the referral process, team members' understanding of mental illness, team turnover, not having enough time with the clients, and not linking family members of clients with appropriate services. In order to address these perceived weaknesses in the MHTC, team members identified a number of different areas in which the team could improve: team processes, team training, community support, spending more time with clients, and improving client services. Team members also indicated that more resources were generally needed for the program, and one team member suggested that a discharge planner be implemented into the program. Administrative aspects of the program were also targeted for improvement, including in the eligibility/suitability process, sanctioning guidelines, and having written materials. In addition, team members suggested finding ways to distinguish MHTC from other treatment courts and to better understand program failure rates. It was interesting to note the juxtaposition between feedback stating that there was a lack of ability to serve the current clients due to a lack of resources in several domains, with the desire to expand MHTC to more days and allow in more clients; it is recommended that the court manage the current challenges facing MHTC prior to expanding the option to participate to larger numbers of clients.

TREATMENT PERCEPTIONS OF SANTA MARIA MHTC

Treatment counselors' perceptions of the MHTC program (i.e., perceived impact of MHTC on their clients, personal experiences with MHTC, suggestions for improvement) were examined as well. Treatment counselors generally reported positive perceptions of their clients' interactions and experiences with MHTC. Treatment counselors indicated that they felt MHTC clients adhere to treatment rules better, are more motivated to complete treatment, comply with medication regimens better, and are more likely to be abstinent from using substances. About half of treatment counselors indicated that MHTC clients adhere to their treatment plans better. Treatment counselors reported on ways in which the following aspects could be improved upon: sanctioning, increasing awareness for MHTC, improving service provision for offenders, MHTC policies and procedures, and providing certificates for clients.

Treatment counselors reported that they felt that clients were empowered by their interactions with MHTC, MHTC is an asset for their clients, clients have improved partially due to their participation in MHTC, MHTC involvement has helped clients adhere to their mental health and substance use treatment plans, and that MHTC does not create barriers for client success.

Treatment counselors generally indicated that MHTC has been a great benefit to their clients, with a major benefit identified as being the increased access to treatment afforded by client participation in MHTC. In addition, treatment counselors indicated that participation in MHTC has reduced client reoffending, has provided a major source of support for the clients, and that clients enjoy participation in MHTC. Treatment counselors did not identify many disadvantages to client participation in MHTC, with some stating there were not any disadvantages. The disadvantages identified were being remanded for sanctions, being on probation, and that the program can be overwhelming for the clients at times.

Administrative Processes

POLICIES AND PROCEDURES

Generally speaking, it has been recommended that treatment courts across domains maintain clear and detailed documentation on program policies and procedures (NADCP, 2013; Thompson et al., 2007), even being deemed a best practice in such treatment courts as SATC (NADCP, 2013). This includes general information about the court, program goals, eligibility and suitability criteria, protocols on sanctions and incentives, referral protocols, and any other materials that would assist new team members to integrate into the treatment team (Council of State Governments, 2005; Thompson et al., 2007). Clients should be participating voluntarily in a MHC, clients should be made aware of the consequences for both completing and failing to complete a MHC program, and the range of available incentives and sanctions should be governed by documented protocols and described to clients before they enter MHTC (Council of State Governments, 2005; Thompson et al., 2007).

Feedback: MHTC Clients

Clients were asked if the MHTC went over what is expected of the clients in order to finish the program, as well as what types of things for which they could get sanctioned (see Table 109). The majority of clients reported that both of these processes happened, though there were clients that indicated that neither of them had occurred. Clients were also asked if they felt they were participating in MHTC on their own free will (see Table 110), with client responses varying across the spectrum of responses.

Table 109. MHTC client reports of whether or not they were informed of program completion requirements and sanction protocols.

Question	Yes	No
Before you started MHTC, did someone talk to you about what you need to do to finish the program?	76%	24%
Before you started MHTC, did someone talk to you about what kinds of things you can get sanctions (consequences) for?	86%	14%

Table 110. MHTC client reports of whether or not they are participating in MHTC on their own free will.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am participating in MHTC on my own free will.	5%	21%	37%	26%	11%

Focus Group

Team members were asked to collaborate on responses to questions about the existence of written materials for MHTC (see Table 111 and Table 112). The focus group revealed that there was a two-page description on mental health and the court, but that there isn't any documentation of policies and procedures. The team also indicated that they often referred to an incentives and sanctions list that was used with drug court, but that there was not one formally included within the MHTC packet or indicated for MHTC. The team indicated that treatment requirements are individualized for each client, and therefore there were no set treatment requirements or graduation requirements. The team did not indicate that there were written documents regarding client behaviors that would result in termination from the program, nor were there communication protocols with treatment agencies.

Table 111. Focus group collaborative responses to questions regarding the existence of written materials.

Documentation	True/False
Are there written documents pertaining to MHTC for: a. – general policies and procedures b. – incentives/sanctions c. – treatment requirements d. – requirements for graduation e. – behaviors resulting in termination	 a. False b. False c. False d. False e. False

Table 113. Focus group collaborative responses to questions regarding the existence of communication protocols with treatment agencies.

Documentation	True/False
If more than two agencies provide treatment to MHTC clients, communication protocols are established to ensure accurate and timely information about each client's progress in treatment is conveyed to the MHTC team.	False

Feedback: Treatment Counselors

Treatment counselors were surveyed about the extent to which they felt that they were informed about MHTC processes (see Table 113. The results indicated that the majority of treatment counselors felt well-informed, but almost half felt neutral about or disagreed with this sentiment.

Table 113. Treatment counselor perceptions that they are informed about MHTC processes.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel well informed about MHTC processes.	0%	20%	20%	40%	20%

USE OF DATA COLLECTION AND EVALUATION

MHCs should routinely collect a variety of types of data on their program, and use this information to then inform program improvements on a regular basis. Examples of data that could be collected include: feedback from offenders, feedback from team members, observations, and program outcome data (Thompson et al., 2007). The purpose of data collection is not just program improvement, but also for ensuring sustainability through exemplifying evidence of an effectively functioning program for existing and potential funding sources (Council of State Governments, 2005; Thompson et al., 2007).

Feedback: MHTC Team

Team members were surveyed about the extent to which data collection and evaluation were used for program improvement (see Table 114). The majority of team members indicated neutrality to the perceptions that evaluation data have been used to make changes in the MHTC, the team regularly uses data to assess operations of the program, and that client progress is tracked after completion of MHTC.

Table 114. MHTC team member perceptions about the use of data collection and evaluation for program improvement.

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Evaluation data have been used to make changes in the MHTC.	0%	17%	58%	25%	0%
The team regularly uses data to assess the operations of the program.	0%	25%	67%	8%	0%
Client progress and/or recidivism are tracked after completion of MHTC.	0%	17%	67%	17%	0%

Focus Group

Team members were asked to collaborate on responses to questions about data that they collect on the MHTC program (see Table 115). The focus group indicated that they did not collect data in any of the recommended areas of data collection.

Table 115. MHTC recommended data collection elements.

Recommended Data Collection Points
Percentage of current jail inmates with mental disorders
Types of charges of jail inmates with mental disorders compared to those of the general population (e.g., what percentage are felony or misdemeanor, or violent or nonviolent)
Costs resulting from the 25-50 heaviest users of jail, detoxification, psychiatric hospital, emergency room, and community-based mental health services
Percentage of law enforcement calls for services that involve individuals with mental health disorders
Dispositions of law enforcement calls for service involving people with mental disorders (e.g., how many are arrested, taken to the emergency room, or diverted to other community resources)
Percentage of jail inmates with mental disorders in past years receiving mental health treatment or psychotropic medications in jail
Percentage of jail inmates with mental disorders who have been involved in treatment in the community
Specific diagnoses of jail inmates receiving mental health treatment or psychotropic medications in jail
Average length of stay for inmates with mental disorders compared to that of the general population
Percentage of all current jail inmates who have five or more prior bookings
Percentage of jail inmates with mental disorders who have five or more prior bookings
Average length of time required for competency evaluations
Disparities in eligibility determinations (e.g., minorities, women)
Disparities in retention rates (e.g., minorities, women)
Treatment differences within the MHTC population (e.g., minorities, women)

SUMMARY

It has been recommended that treatment courts maintain clear and detailed documentation on all relevant program policies and procedures. In addition, clients should be participating voluntarily in a MHTC, and should be made aware of the consequences for both completing and failing to complete a MHTC program. The majority of clients reported that staff members from the MHTC went over program expectations and sanction procedures, although there were clients that indicated that neither of them had occurred. Clients were also asked if they felt they were participating in MHTC on their own free will, with client responses varying across the spectrum of responses. The team may benefit from creating written materials for the clients (and others supporting the clients) to be able to view and refer back to. In addition, modifications to the eligibility and suitability criteria may help to ensure that clients do not

feel that they are not participating in the program willfully; this would ensure that only clients who are motivated to participate in the program and who are appropriate for the program would be included in the program.

The majority of treatment counselors felt well-informed about MHTC processes, but some disagreed with this sentiment. Similarly, participants in the focus group indicated that there were no written materials for MHTC as are suggested or recommended within the literature. The focus group feedback indicated that, for many of these materials, the intention is to keep the program as individualized as possible in order to best serve their client population. The emphasis on individualizing client programs is important; however, the team may still benefit from having some structure by way of written documentation, with the knowledge that individualization would still occur within those boundaries.

MHTCs should routinely collect data on their program and use this information to make program improvements. Participants in the focus group indicated that they did not collect data in any of the recommended data collection areas. Similarly, team members indicated neutrality to the perceptions that evaluation data have been used to make changes in the MHTC, the team regularly uses data to assess operations of the program, and that client progress is tracked after completion of MHTC. It is recommended that the MHTC look into ways in which program outcomes can be better examined. A guide for data collection on program outcomes specifically for MHCs has been compiled and is available at no cost at https://csgjusticecenter.org/wp-content/uploads/2013/05/MHC-Outcome-Data.pdf (*"A Guide to Collecting Mental Health Court Outcome Data"*). The guide was created with the intention of assisting stakeholders with limited time and resources in collecting data on their programs, to ensure data collection and evaluation are able to be a critical part in the processing of their MHTC.

Conclusions

SUMMARY OF FINDINGS

This 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.

Stakeholder Roles

Team members indicated that they understood each other's roles on the team. The judge was perceived to have a strong leadership role, was represented as an intermediary between the court and clients, and was perceived to have established relationships with the clients. Team members identified the role of the district attorney and the public defender in MHTC as having both non-traditional and traditional characteristics. Substance abuse treatment providers and County mental health treatment providers were all seen as individuals providing various treatment and case management services to the clients. The role of the County's psychiatrist/psychologist was described as screening clients for program eligibility and connects clients with services. All of these individuals were also seen as important parts of the MHTC team. Stakeholders identified as having less involvement in the MHTC were the coordinator, bailiff, and community law enforcement.

Large differences in the amount of professional training received between team members were reported. The majority of the team members indicated that they had received little to no training on MHTC prior to serving on the MHTC team. Team members suggested various potential preparations for serving on the MHTC team would possibly be helpful for future team members. Some team members also indicated that there was perceived to be some degree of adversarial functioning within various roles of the team, suggesting that some roles may be difficult to adjusting to this difference in working in treatment courts.

MHTC Relationships

The majority of MHTC team members indicated that their team exhibited cohesion and collaboration, and that the team generally worked well together and exhibited many aspects of effective teamwork. Team members indicated both areas of strength and weakness in team functioning. The feedback suggested an overall cohesive team with some experiences of disagreement. Team members indicated several ways in which team cohesion could be improved. Many of the suggestions addressed programmatic improvements, suggesting that the team did not perceive that they are unable to connect cohesively, but rather that team discord may instead be a result of programmatic structures that need improvement (e.g., improved assessment process, increased resources, trainings, improvements to staffing/status review processes). The relationship between the MHTC team and the treatment providers was generally reported to be positive, and characterized by good communication and collaboration between the agencies. The relationship between the court and the clients was generally reported to be positive by both the team members and the MHTC clients. The relationship between the treatment providers and the clients was also noted as being generally positive. However, a few clients indicated negative or neutral perceptions of their relationship with the court and with their treatment provider.

Treatment

The team reported a flexible and open-minded approach to medication management of MHTC clients, and cognizance of the lifelong struggle with mental illness that clients experience. It was reported that client treatment plans are individualized and based on client needs, and treatment plans are flexible to adjustment. The clients were perceived as being held accountable for compliance with their treatment plans. Team members perceived that the court was supervising both the client mental health and substance use plans fairly well, and that the court stays well informed on client progress on their treatment plans. The evaluation found that MHTC clients received individual counseling and regularly attended peer support groups, and that gender-specific treatment and cultural-specific treatment options were available to MHTC clients. The participating agencies reported engaging in numerous best practices in treatment courts and providing interventions with individuals with mental illness in general. In addition, it was reported that clients' criminal and legal issues and graduation requirements were addressed in treatment. Team member feedback suggested that clients were quickly entered into substance abuse treatment programs; however, concerns were raised that the court lacked a wide enough array of treatment options for clients and that the time to receipt of mental health treatment was too long.

MHTC Perceptions

General perceptions of MHTCs were examined; the majority of the MHTC team and treatment counselors reported positive perceptions. Team members identified a number of aspects of MHTC that they felt were the court's strengths, including teamwork and the team working together in the clients' best interests. Treatment counselors generally reported positive perceptions of their clients' interactions and experiences with MHTC. Treatment counselors indicated that they felt MHTC clients comply with various treatment aspects better than non-MHTC clients. Treatment counselors reported that they generally felt that the MHTC has assisted in promoting positive outcomes and program compliance for clients. A major benefit to MHTC participation was identified as being the increased access to treatment afforded by client participation in MHTC. Treatment counselors did not identify many disadvantages to client participation in MHTC. Team members and treatment counselors also identified areas for improvement and suggestions to ameliorate any perceived weaknesses in the MHTC process, such as improving the team processes, trainings,

obtaining various additional resources, improving suitability/eligibility processes, improving the sanction process, improving services, and creating policies and procedures/administrative documents for the MHTC. Lastly, there was some sentiment endorsed regarding defense counsel marginalization in MHTC processes.

Non-traditional Characteristics

Courtroom observations indicated that the clients' families were incorporated in some of the hearings. The majority of team members reported a nonadversarial MHTC and a belief that team members are committed to the program. The team members and treatment counselors identified particular personality characteristics, attitudes/beliefs, knowledge bases, and the ability to form relationships with clients and other team members as being important for a well-functioning MHTC; they also indicated that they felt the MHTC exhibited these characteristics. Team members and treatment counselors indicated mixed attitudes toward mental illness. It appeared that there were some perceptions of community support, but that the support was not perceived to be strong. Team members noted several suggestions for improving community support. The team also brought up concerns regarding client confidentiality in seeking additional community support.

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; clients participated in their hearings, and families were involved in some of the hearings. However, the majority of MHTC cases were heard for less than three minutes in court, and, observers noted that there appeared to be varying levels of engagement in the proceedings and preparedness regarding client cases among team members. Additionally, the majority of clients indicated neutrality with the statement that they have a good relationship with the judge.

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 reported that sanctions were administered in a fair and graduated manner, and that responses to client noncompliance were individualized. Individually, a majority of team members indicated that jail was not often used as a sanction; however, in the focus group several team members indicated that jail was used as a method for connecting clients to access with medication or for stabilization of emotional concerns. There was some feedback that jail actually impeded the ability of clients to efficiently obtain medication and stabilization. In addition, some MHTC clients indicated neutrality or dissent to a statement reflecting that the MHTC team does not get angry with them when administering sanctions. Finally, there were varying perceptions of whether or not the MHTC team representatives were notified quickly when clients were arrested.

Clients and team members indicated that support was provided to prepare clients for program completion, more so with regard to future treatment and less so for housing and employment.

Program Entry

Program entry processes into MHTC (i.e., target population, case referral process, eligibility/suitability) were identified as areas that could benefit from improvement. Team members noted that the case referral process was working as well as it could, and feedback indicated that the eligibility process generally worked well. Feedback from some team members indicated that validated assessment tools were utilized in order to determine various aspects of client appropriateness for MHTC (i.e., recidivism risk, mental health needs), with others indicating a desire for standardized assessments in determining clients' mental health needs. It appeared that there was a lack of understanding of a universally accepted eligibility and suitability criteria, a lack of standardized assessment process, and a lack of understanding of differences between MHTC and other treatment courts. The main barriers identified within the case referral process were a lack of timeliness of assessment completion and inappropriate clients being referred.

Administrative Processes

The majority of clients reported that the MHTC reviewed program expectations and sanction procedures with them, although there were clients who indicated that they thought neither of these had occurred. Clients were also asked if they felt they were participating in MHTC on their own free will, with client responses varying across the spectrum of responses. The majority of treatment counselors felt well-informed about MHTC processes, but almost half did not agree with this sentiment. Similarly, the focus group indicated that staff did not have easy access to written materials for MHTC as suggested or recommended within the literature. Team feedback indicated that the intention is to keep the program as individualized as possible, and thus standardized materials were difficult to develop.

RECOMMENDATIONS

1) One of the more common themes that emerged in the evaluation was a lack of common understanding as to what constitutes a severe mental illness, what is meant by substance abuse and addiction, and how these co-occurring disorders interact. In addition, there appeared to be a lack of knowledge of research on evidence-based interventions and treatment for individuals with severe mental illness. The court could consider seeking out training on these topics. A training could also help to better evaluate the MHTCs eligibility and suitability criteria, which some team members felt were too inclusive of clients who were

inappropriate for the MHTC. It is recommended that the court collaborate with the other treatment courts (i.e., DDX, SATC) to ensure that explicit target populations are defined.

2) The court also reported a lack of documentation of policies and procedures specific to the MHTC. There was some feedback that this was due to an attempt to individualize each client's case to their specific treatment need; however, there are benefits to having basic program structures in place with the knowledge that individualization would occur. It is recommended that the court consider compiling a written policies and procedures manual that reflects elements of the following: the courts' background, objectives, and goals; target population; graduation requirements; treatment requirements, sanctions/incentives protocols; and narratives on team members' roles.

3) There was indication that the assessment process was creating barriers for the clients. In particular, there was a reported lack of timeliness of completion of assessments (and thus, a lack of ability for clients to receive services until the assessment was completed). Additionally, there was a reported lack of a standardized process that led to multiple clients being incorrectly referred or placed into MHTC. There was also a desire to see written assessments for the court to be able to review as a team. 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 ways in which the time from referral to assessment can be expedited, and how to obtain physical copies of client assessments. By targeting both improvements in understanding the target population and addressing issues with the assessment process, it may help the team to connect clients with 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 being assessed by their psychiatrist(s), which, in turn, may reduce turnaround time on assessment completion.

4) There was concern noted by interviewees as well as observers that there are some inconsistencies in team member attendance at the team meetings and status review hearings. There were also differences noted in the level of engagement and participation of team members during both of these processes. There was indication that this may be due to turnover and limited availability of some of the team members. The team may benefit from having discussions surrounding how to improve communication regarding client cases for team members that are unable to consistently attend MHTC, or if alternative representatives would be available to attend team meetings and court hearings.

5) Judicial interactions with clients during court hearings were, on average, shorter than the recommended minimum of three minutes. Increasing the time spent with each client 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. In addition, it may improve perceptions of the judicial relationship with clients, and offer opportunities for more team members to be involved in client hearings (as it was noted that fewer team members are involved in client hearings than the judge). Having clear guidelines for how to handle difficult situations that commonly arise may help create a more streamlined and efficient staffing process. A specific recommendation of a time breakdown is provided in Appendix 1.

6) Client access to medication was a frequent problem. Some team members indicated that they would sometimes incarcerate MHTC clients in order to link clients with medication or achieve emotional stability. However, there was also feedback that jail actually impedes the ability of clients to efficiently obtain medication, and that incarceration can be counteractive in attempts at stabilization. The team should investigate alternative solutions, and may benefit from reconsidering their position on utilizing jail as a therapeutic intervention. The team could also consider forging partnerships with urgent care facilities and primary care providers within the community.

7) Some treatment programs were able to separate MHTC from non-MHTC clients, while this was not done at all treatment facilities. The MHTC team could work with the treatment providers to examine ways to ensure this occurs more frequently. The literature suggests that clients benefit most from being in treatment with individuals with similar issues, and that placing clients of differing risk levels together can actually contribute to iatrogenic treatment effects.

8) The majority of individuals interviewed indicated that there was minimal community outreach occurring for the MHTC, and that community support for the MHTC was not strong. The program may consider creating a plan for increasing publicity and community partnerships. Hosting events, such as panels, to increase community awareness of the MHTC and understanding of mental illness could help promote public approval.

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.

TREATMENT

- MHTC members should visit treatment providers to ensure service provision is occurring as it is supposed to function;
- Treatment staff should visit MHTC sessions for a better understanding of the program;

- Someone should 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 and bridge client access to appropriate treatment;
- Someone should conduct fidelity checks on manualized/evidence-based treatment interventions across treatment providers;

ASSESSMENT & TREATMENT PLANS

- Consider interviewing family members for relevant background information, in the determination of client eligibility
- Consider involving clients more in the treatment planning process
- Review client treatment plans when clients need sanctions
- Have written treatment plan materials for the team to be able to review

PROGRAM COMPLETION

- Identify ways in which clients can be better prepared for program completion in the areas of housing, treatment, and employment

ADMINISTRATIVE

- Examine dispersion of sanctions and if they follow the program's guidelines
- Consider options for building a training program for new team members
- Creation of an orientation manual for new team members, with explicit expectations for the various team member roles included
- Monthly MHTC meetings
- Cap on program numbers
- Explore the potential benefits of implementing phase structures within MHTC

TEAM PROCESSES

- Incorporate the coordinator into the treatment team
- Increase relationship with law enforcement as a formal representative on the MHTC team

COURT PROCESSES

- Emphasize behaviors needed for program completion from the outset of client entry into MHTC
- Encourage family/social support involvement in clients' programs
- More individualization of program

OUTREACH

- Provide psychoeducation on MHTCs to community stakeholders and client social supports
- Link client family members with appropriate services
- Consider implementing an alumni support program for MHTC clients

RESOURCES

- Seek additional funding to increase resources for MHTC clients, including housing and mental health services
- Seek out employment prospects for MHTC clients
- Investigate options for increasing availability of transportation for clients to program and appointments

DATA COLLECTION/EVALUATION

- Examine client failures to better understand why some clients do not complete the program
- Increase understanding of program outcomes

TRAININGS

- Implement trainings on target population for MHTCs
- Implement trainings on how to adapt to the nonadversarial nature of treatment courts
- Implement trainings on team member roles

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Appendix

Santa Barbara County Drug Court Process Evaluation

SANTA MARIA MENTAL HEALTH TREATMENT COURT (MHTC)

Fall 2015 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 2 hours and 30 minutes were spent in staffing. This equates to approximately 1 hour and 15 minutes and 20 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 36 minutes were spent in status review hearings across 31 cases. This equates to approximately 48 minutes and 15 cases per day. Other calendar(s) were heard during this time, but not coded in the report. It was anecdotally reported that MHTC represented approximately half of the cases heard during each day.

Status review hearings are currently designated to occur between 11 a.m. and 12 p.m., and then again from 1:30 p.m. and 5:30 p.m. on MHTC days. However, additional time during court hearings is sometimes used for staffing cases, to let private and court-appointed attorneys make arrangements, wait for results for drug tests, and complete other administrative duties.

Ideal vs. Actual Time

Because all of the other cases being heard were not coded in the present evaluation, the following numbers are provided as a demonstration based on anecdotal feedback that suggested MHTC represented approximately half of the cases being heard.

If 30 cases are heard on average a day (15 MHTC and 15 'Other'), there is potential to spend at least three minutes with a client during status review hearings (30 cases X 3 minutes = 90 minutes = 1 hour, 30 minutes). Currently, status review hearings are occurring over an average of 48 minutes a day with MHTC clients; the potential for spending 3 minutes with each client exists. In addition, there are currently 5 hours designated for status review hearings, only 48 minutes of which are currently being utilized for the sole purpose of holding MHTC client status review hearings; while almost double the time is spent in staffing (1 hour and 15 minutes a day, on average).

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:

- Holding all staffings in the morning, followed by all status review hearings in the afternoon;
- 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;
- Determine as a team if any other efforts can be made to minimize time taken away from status review hearings and increase time spent with clients.