A Limited Evaluation of the Shelby County Mental Health Court*

Submitted to the Tennessee Association of Recovery Court Professionals (TARCP) & the Tennessee Department of Mental Health and Substance Abuse Services (TNDMHSAS)

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INTRODUCTION

In response to an August 2018 solicitation from the Tennessee Department of Mental Health and Substance Abuse Services (TNDMHSAS), in partnership with the Tennessee Association of Recovery Court Professionals (TARCP), the Shelby County Mental Health Court (MHC) partnered with the University of Memphis Public Safety Institute (PSI) to develop an evaluation proposal. The proposal was funded and the project began Oct. 1, 2018. Although the project period was initially to be 12 months, we requested and received a six-month extension due to difficulty in obtaining some of the necessary data. Just before the final report was due, the COVID-19 pandemic hit the United States and we were forced to request another extension. This report provides details of the quantitative and qualitative methods used in the evaluation, analysis and results, as well as some conclusions and recommendations.

The purpose of the evaluation was to determine whether MHC clients were less likely than others to be rearrested, and reincarcerated and whether they have fewer days incarcerated and fewer days of psychiatric hospitalization. Specifically, the MHC was interested in whether quality of life was improved after participation.

The proposed design would have compared individuals who were accepted for participation with similar individuals who were referred, but not accepted for participation. During the research process, however, the PSI team discovered several challenges that precluded this design. The most critical problem was that the MHC did not continue to collect data on clients who were referred but not accepted. A significant volume of missing data also limited the ability to conduct an in-depth evaluation. As a result, the PSI team was only able to use MHC data to provide descriptive information about individuals referred to the program, as well as information about some outcomes of interest (i.e., whether clients were compliant with medications, arrests during the program, etc.). Data from a client satisfaction survey also were collected and analyzed, as well as data from qualitative interviews with MHC staff and the presiding judge, Judge Gerald Skahan.

LITERATURE REVIEW

Mental health courts are still relatively new in the United States, with the first one established in 1997 in Broward County, Fla., (Boothroyd, Pythress, McGaha, & Pertila, 2003). Canada then adopted its first MHC in 1998 to tackle the growing number of justice-involved individuals with mental health needs (Slinger & Roesch, 2010). According to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2019), 477 adult MHCs and 56 youth MHCs are in operation across the United States.

In general, MHCs aim to balance the obligation of protecting the public with helping those accused of crimes who have mental health issues. To find this balance, these courts incorporate mental health and social service treatments into the court's options (Campbell, Canales, Wei, Totten, Alex, Macaulay & Wershler, 2015). Since MHCs are still young and being implemented around the country, little research examines how these programs are structured and their effects on those with underlying mental health issues (Watts & Weinrath, 2017). One of the biggest challenges to evaluating these types of courts is securing reliable, complete and consistent data across various sources (Prince, Jaggers, Walker, Shade, & Worwood, 2020). It can be tasking for MHCs with limited staff to maintain data on participants, services, criminal justice outcomes and mental health outcomes, while sustaining the effectiveness of the court.

While MHC structures vary, many use a team approach. At a minimum, these teams usually are comprised of legal, mental health and public safety professionals. Cases determined to be eligible and eventually accepted into MHCs (i.e., diverted) typically appear on a separate docket from other courts and legal sanctions are enforced against clients not fulfilling the requirements of their participation. In most MHCs, participation is

voluntary, and clients can remove themselves from MHC care at any time. For those who complete the program, individuals usually are rewarded with a reduction or dismissal of the original criminal charge that preceded their referral to MHC (Wales, Hiday, & Ray, 2010).

In addition to variations in structure, MHCs across the nation also vary on the types of individuals that they accept as clients. In one review of 38 MHCs, most clients had committed either a misdemeanor or felony, only a few were admitted with infractions (traffic/technical) (Worwood, Erin, Sarver, Borgia, & Butters, 2015). Defendants with records of violent felonies were excluded in nearly half of courts, while other courts included those with violent charges, but usually on a case-by-case basis. Several MHCs only accepted defendants charged with either a misdemeanor offense or infraction and denied entry to all defendants with felony charges. Only one of the 38 MHCs reviewed accepted individuals with histories of violent felonies.

MHCs also vary on their target populations, although research has shown that most aim to treat individuals with diagnosed mental illnesses leading to functional impairments that could potentially contribute to criminal behavior (Blandford, Fader-Towe, Ferriera, & Greene, 2015). Although mental diagnoses among accepted clients vary among MHCs, most courts accept individuals with psychoses, schizophrenia and/or depression. In the review of 38 MHCs mentioned above, about half also accept individuals with anxiety disorders (Worwood, et al., 2015). Fewer MHCs, however, accept clients with mental health issues such as traumatic brain injury, personality disorders, developmental disabilities, attention deficit/hyperactivity disorder, or substance related disorders, unless they also suffer from an accepted disorder.

Several studies have shown MHC completion to have a positive impact on mental health and recidivism outcomes. With respect to mental health outcomes, studies have shown a link between MHC participation and increased access to mental health services, enhanced ability for independent functioning, reduced substance use and generally improved mental health (Boothroyd et al, 2003; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005). Studies also have found that individuals who successfully complete MHC tend to continue treatment, have higher General Assessment of Functioning (GAF) scores, and fewer inpatient treatment days (Burns, Hiday, & Ray, 2013; Hiday, Ray & Wales, 2014; Ray, 2014).

With respect to recidivism, MHC clients experience fewer days in jail (Watts & Weinrath, 2017), longer time to recidivism, fewer arrests and fewer self-reported violent acts after MHC involvement (Anestis & Carbonell, 2014; Herinckx, et al., 2005; Hiday & Ray, 2010; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). Also noteworthy is that MHC completers depict their time as positively and report feeling a meaningful difference, a view directly contrary to the view of individuals who experience traditional court environments (Lane & Campbell, 2008; Redlich, Hoover, Summers, & Steadman, 2010). In a meta-analysis of 20 studies, researchers found that MHCs help to reduce recidivism rates but the impact on police contact is less clear (Long, Bonato, Barnsley, & Dewa, 2019). This meta-analysis also found access to vocational and housing services critical to client success.

MHCs, however, are not without concerns. One potential problem is with the appropriate referral of clients to MHC and potential selection bias. A selection bias is when an entity recruits or selects certain individuals to achieve a certain outcome with the results. A specific form of selection bias endemic to these types of programs is “creaming,” screening out those clients less likely to succeed and/or screening in those clients more likely to succeed. If those least likely to succeed are screened out and those most likely to succeed are screened in, the program will appear effective, even when it may not be. This problem is more common in programs that have an incentive to provide positive results. If most clients accepted into MHC programs have mild symptoms and minor offenses, using costly resources is unlikely to reduce the use of custody (because these types of defendants already are unlikely to end up in custody anyway), and may artificially inflate the success rates (because these types of defendants already are more likely to succeed anyway).

Client characteristics also may impact referral to and acceptance into MHC programs. Women, for example, tend to be over-represented, while black and brown populations tend to be under-represented. Other factors, such as being male, illicit drug use, having a more serious criminal history and having fewer serious mental health symptoms decrease the chances of being accepted into and completing an MHC program (Frailing, 2011; Luskin & Ray, 2015).

Another potential issue with many diversion options is "net-widening." Net-widening refers to the unintended tendency of a program to increase a population's contact with the criminal justice system (Prichard, 2010). Simply having the option of an MHC may increase the number of individuals becoming subject to criminal justice sanctions than might otherwise have done so. Additionally, sanctions for program non-compliance may be worse than those to which they might otherwise have encountered.

In addition to impacting referral to and acceptance into MHC, client demographics, legal and risk characteristics significantly impact reoffending, jail days and graduation (Burns, Hiday, & Ray, 2013; Reich, Picard-Fritsche, Cerniglia, & Hahn, 2013). For example, being homeless, having co-occurring substance abuse diagnosis, and having prior jail days were negatively associated with successful MHC completion (Burns, Hiday, and Ray (2013). However, upon graduating from an MHC program, those individuals were less likely to serve jail time after completion. Additionally, histories of substance abuse and prior incarceration are predictors of persistent noncompliance with MHC orders (Burns, Hiday, & Ray, 2013; Hiday, Ray, & Wales, 2014). Others argue that the positive impacts of MHC participation on mental health and recidivism only manifest if clients graduate; little positive impact is seen among clients who do not (Anestis & Carbonell, 2014; Herinckx, et al., 2005; Hiday Wales, & Ray, 2013; Hiday, Ray, & Wales, 2014; Steadman et al., 2011).

Description of the Shelby County Mental Health Court

In operation since January 2016, the Shelby County MHC provides diversion from incarceration and judicial monitoring for eligible individuals with severe and persistent mental illness and connects them to community-based agencies for mental health services and/or substance abuse treatment, medical care, housing, childcare, transportation, education and vocational programs. It is funded by a federal grant, which funds one judge, one coordinator and two case managers. These grant-funded staff are assisted by five public defenders and one assistant District Attorney.

The court's goal is to specifically help nonviolent, misdemeanor offenders with mental health challenges (i.e., "clients") to reduce the burden on other courts and to help prevent them from becoming repeat offenders. By helping these clients, the court provides a diversion option instead of incarceration for eligible individuals and connects them to community-based agencies for mental health services, substance abuse treatment, housing, childcare, medical care, transportation, education and vocational programs.

The Shelby County MHC program consists of four phases that each participant must complete prior to successful completion and graduation. Phase 1 is "Stabilization and Orientation," which is anticipated to take approximately four weeks. This phase focuses on the attainment of medications, obtaining financial support and attaining stable housing. During this phase, the participant must complete the program orientation, and any individual/group counseling treatment in agreement with their treatment plan. They also are required to participate in an initial assessment and submit an initial case management plan.

After completion of Phase 1, participants enter Phase 2, "Intensive Treatment", which takes a minimum of 24 weeks. During this phase, participants may be required to attend up to two support meetings such as Alcoholics Anonymous or Narcotics Anonymous. They also are required to meet with their case manager at least four times

per month and may be asked to maintain a curfew. Participants also may be required to submit to up to two random drug tests per week to help maintain their sobriety.

Clients who successfully complete Phase 2 move on to Phase 3, "Healthy Living Skills Development," which takes a minimum of 20 weeks. In this phase, participants may be required to attend a minimum of three community support meetings, maintain all compliance with court orders and be sanction-free for at least 90 days. They also may be subject to at least one random drug test per week.

Finally, participants who move successfully through Phase 3 will enter Phase 4, "Transition to Aftercare," which takes approximately four weeks. During this phase, participants are required to develop a transition plan to community services and supports needed to maintain their mental health and sobriety. Prior to graduation, participants must maintain compliance with all court orders and be sanction free for at least 120 days. After graduation, participants are encouraged to maintain contact with MHC staff to help them with connections they may subsequently need. After successful program completion and graduation, the charges that brought the participant to the court are expunged from their record.

METHODS

Data Collection

We used a mixed methods approach to conduct this research. The MHC Coordinator provided coded quantitative and qualitative client-level data in an Excel spreadsheet with multiple tabs for various program components (e.g., referrals, participants) and outcomes (e.g., program progress, criminal justice outcomes, mental health outcomes). This data was collected for internal MHC purposes and not necessarily collected with external monitoring or evaluation in mind. As a result, many data were missing, or incompletely or inaccurately recorded. This negatively impacted our ability to fully address some of the research questions. For example, certain quality of life variables such as "days homeless," "number of victimizations," and "days employed" were omitted due to the lack of consistent data. Some initial data were omitted due to the volume of missing data (e.g., only two clients had a fourth referral, only one client had more than two charges and only one client had a third diagnosis).

Additional quantitative data were collected from MHC clients via a "client satisfaction" survey with three items to measure respondent demographics, 21 items to measure satisfaction on a 5-level Likert-type scale of agreement (strongly agree to strongly disagree) and an open-ended question asking about ways to improve. The cover letter accompanying the survey is Appendix A and the survey is Appendix B.

To collect qualitative data, we conducted a group interview with the MHC coordinator and two case managers, as well as an individual interview with Judge Skahan using the same four questions and accompanying probes (Appendix C). Although client focus group interviews were planned, they were not conducted due to the COVID-19 pandemic. Finally, we attended and observed a pre-court case review session with the case managers and sat through one of the MHC docket sessions. Notes from these observations provide context for quantitative data and are summarized below.

ANALYSIS AND RESULTS

Referrals to MHC

Through 2019, 247 individuals were referred a total of 368 times to the Shelby County MHC. More than seven in 10 referrals came from public defenders and nearly three in 10 came from private attorneys. Of the total number of clients referred, 170 (69%) were invited to participate in MHC (Table 1). [1]

[1] Some values may not add to 247 or 100% due to missing data.

Most clients referred to MHC were male, black and between the ages of 18 and 29, although the average age of referrals was 36 years old. Bipolar disorder was the most common diagnosis, followed by schizophrenia, depression disorders and others (e.g., psychotic disorders, mood disorders). Finally, the average "risk assessment score" was 27, which indicates "high risk," a prerequisite for invitation to participate.

The number of referrals by month, and how many of those were later accepted, denied, or withdrawn are described in Figure 1. Since opening, the second quarter of each year tends to be when it receives most of its referrals, followed by the third quarter (Figure 2). On average, the program accepts just more than one in three of the referrals it receives each month (Note: Two people are excluded who were referred to the MHC but had not yet received a decision.)

Characteristics of those Referred to MHC (N = 247)			
		N	%
Sex			
Female		112	45.3%
Male		135	54.7%
Age			
Mean (SD)		36.0 (SD)	
18-29		85	34.4%
30-39		81	32.8%
40-49		32	13.0%
50 +		49	19.8%
Race			
Black		147	59.5%
White		96	38.9%
Other		4	1.6%
Mental Health Diagnosis (n = 198)			
Bipolar Disorder		67	33.8%
Schizophrenia		51	25.8%
Depression Disorder		42	21.2%
Other		38	19.2%
Offender Invited to MHC			
No		77	31.2%
Yes		170	68.8%
	Range	Mean	SD
Risk Assessment Score	14-44	27.1	5.3

Table 1: Characteristics of those referred to MHC

The most serious criminal charge among offenders referred to MHC involved property offenses, with theft of property the most common (Table 2). The most serious charge for one in five referrals was a drug-related offense. Nearly one in four referrals had multiple charges, 35 previously had been arrested at least once, and 25 had been arrested at least once in the 12 months preceding referral to MHC.

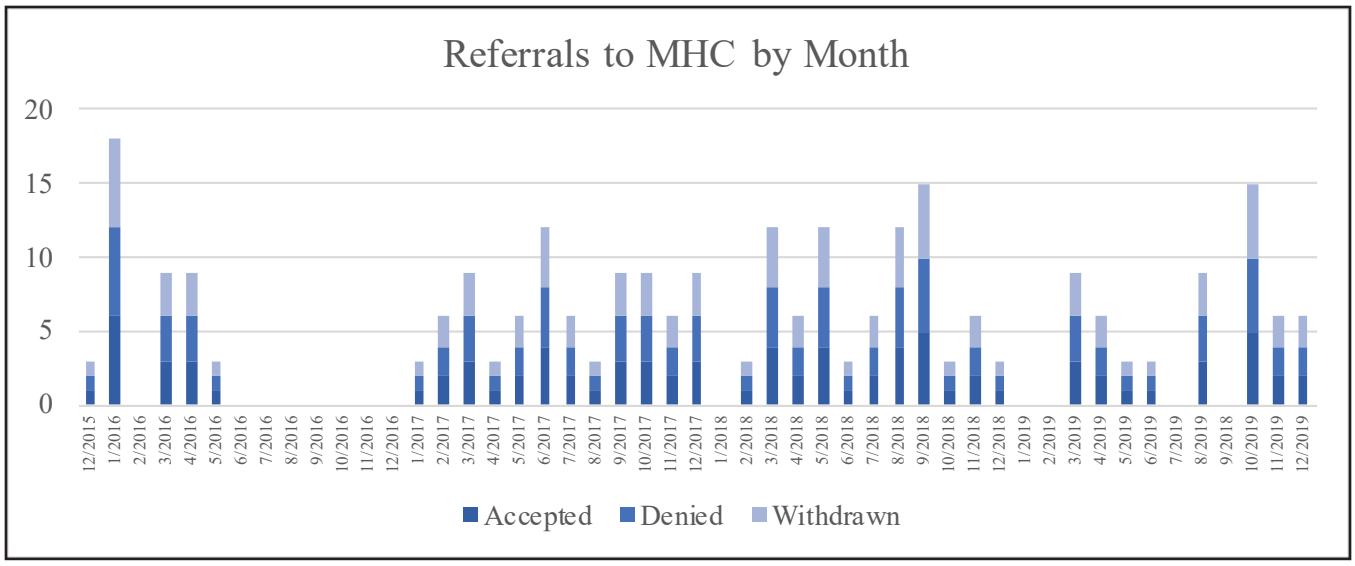

Figure 1: Referrals to MHC by Month

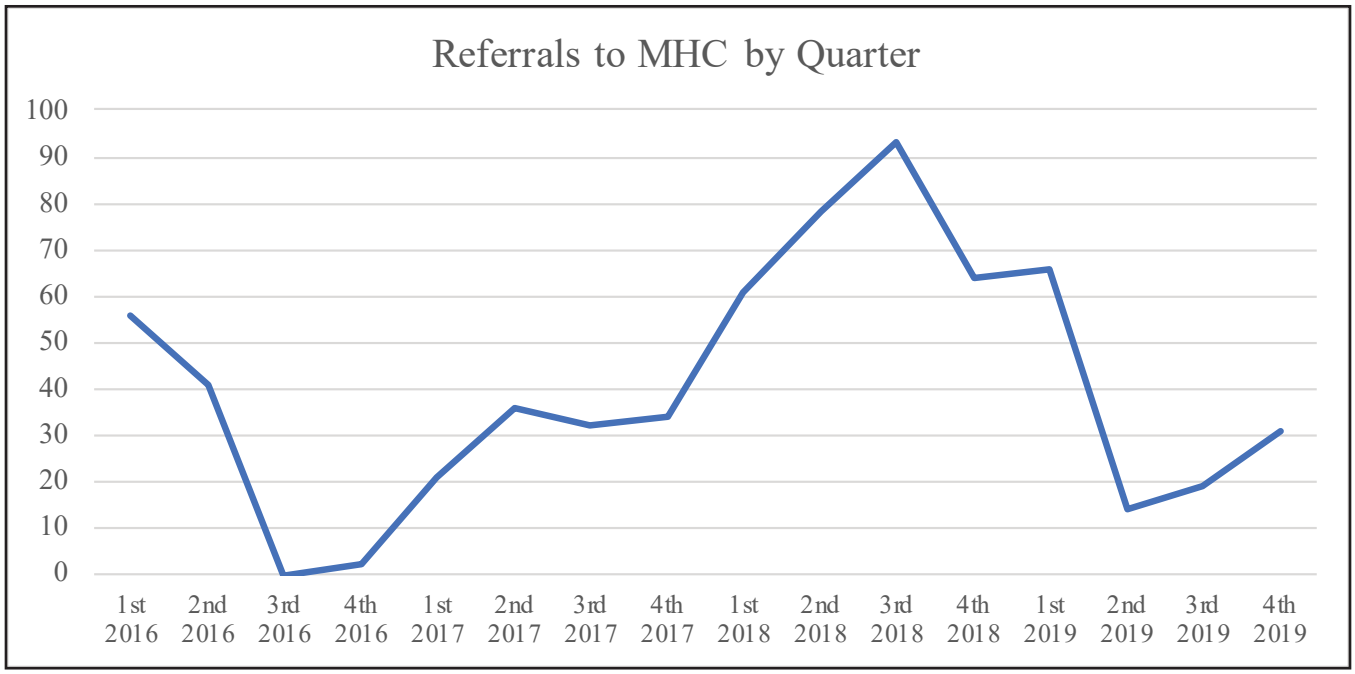

Figure 2: Referrals to MHC by quarter

Referrals Denied Entry

Nearly one in three individuals (31.2%) referred to the program was not invited to participate (Figure 3), primarily due to being low risk (44%) or having a violent criminal history (35%). Otherwise, these individuals were comparable to those who were invited in terms of race, sex, age, mental health diagnoses and criminal histories.

Invited to Participate in MHC

Of the 247 individuals referred to MHC, 170 were invited to participate and 156 accepted. Most participants were black (63%), male (53%), between the ages of 18 and 29 (37.0%), with 203 total charges (Table 3). Their most serious mental health diagnoses were bipolar disorder, depression disorder and schizophrenia.

Referral Criminal Charges & Criminal Histories			
		N	%
Charges for Violent Offenses		32	13%
Charges for Property Offenses		72	29%
Charges for Drug-Related Offenses		49	20%
Charges for Other Minor Offenses		39	16%
Violation of Parole		37	15%
Unknown		18	7%
	Range	Mean	SD
Number of charges against client upon referral	1-9	1.5	1.0
Lifetime number of arrests upon referral	1-254	28.5	51.7
Number of arrests in 12 months prior to referral	1-12	2.8	2.3

Table 2: Distribution of charges and criminal history of MHC referrals

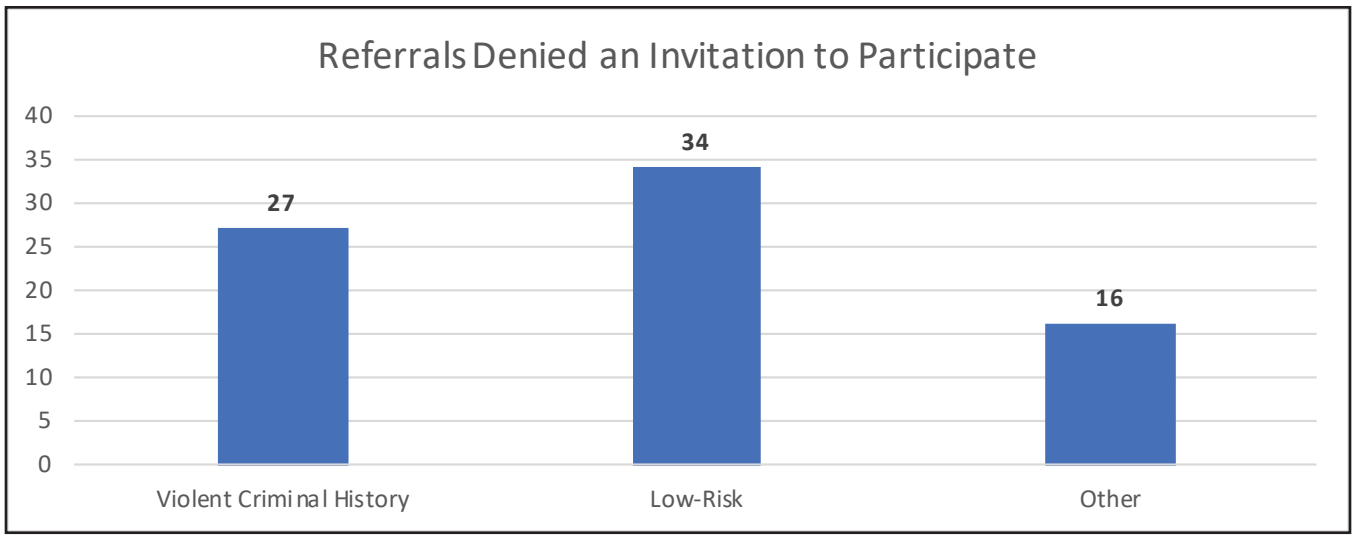

Figure 3: Denials by reason

Among this population, property offenses were most commonly the most serious charge, followed by drug-related offenses and violation of parole. Violent offenses were the least common type of charge. Upon referral to the MHC, each invitee had an average of 1.5 charges against them. The average number of arrests over the lifetime was much smaller than the total sample, but the number of arrests in the 12 months prior to acceptance was only slightly lower.

Program Exit

Among the 156 accepted into the MHC program, 48 people graduated (30.8%), two of whom each graduated twice. Although data on program entry and exit dates were sporadic, individuals spent an average of about 300 days in the program prior to graduation. Among the nearly 70% who did not graduate, a few (n = 9) voluntarily left the program, but most were involuntarily discharged because of non-compliance or new crime.

Characteristics of MHC Participants (N = 156)			
	N		%
Sex			
Female	73		46.8%
Male	83		53.2%
Age			
Mean (SD)	35.4 (11.24)		
18-29	58		37.2%
30-39	48		30.8%
40-49	23		14.7%
50 +	27		17.3%
Race			
Black	98		62.8%
White	56		35.9%
Other	2		1.3%
Mental Health Diagnosis			
Bipolar Disorder	47		30.1%
Depression Disorder	39		25%
Schizophrenia	36		23.1%
Other (e.g., psychotic disorder, mood disorder)	34		21.8%
Most Serious Charge (n = 163)			
Charges for Violent Offenses	19		11.7%
Charges for Property Offenses	54		33.1%
Charges for Drug-Related Offenses	42		25.8%
Charges for Other Minor Offenses or Unknown	22		13.5%
Violation of Parole	26		16.0%
	Range	Mean	SD
Number of charges against client upon referral	1-9	1.5	1.2
Lifetime number of arrests upon referral	1-254	2.5	48.9
Number of arrests in 12 months prior to referral	1-5	2.4	1.3

Table 3: Characteristics of those accepted into MHC

Graduates and Non-Graduates

A true comparison of graduates and non-graduates was precluded by the volume of missing data. However, it was possible to determine whether these two populations were significantly different in terms of characteristics (Table 4). Graduates were significantly more likely than non-graduates to be male, white and older. Graduates also were significantly more likely to be diagnosed with bipolar disorder or psychotic disorder. Schizophrenia and depression disorder diagnoses were significantly more likely among non-graduates.

GRADUATES (N = 48)				NON-GRADUATES (N = 108)			
		N	%			N	%
Sex				Sex			
Female		19	39.6%	Female		54	50.0%
Male		29	60.4%	Male		54	50.0%
Age				Age			
Mean (SD)		36.8 (11.2)		Mean (SD)		34.7 (11.2)	
18-29		14	29.2%	18-29		44	40.7%
30-39		15	31.3%	30-39		33	30.6%
40-49		10	20.8%	40-49		13	12.0%
50 +		9	18.8%	50 +		18	16.7%
Race				Race			
Black		28	58.3%	Black		70	64.8%
White		19	39.6%	White		37	34.3%
Other		1	2.1%	Other		1	0.9%
Mental Health Diagnosis (n = 54)				Mental Health Diagnosis (n = 102)			
Bipolar Disorder		18	33.3%	Bipolar Disorder		29	28.4%
Depression Disorder		13	24.1%	Schizophrenia		27	26.5%
Schizophrenia		9	16.7%	Depression Disorder		26	25.5%
Psychotic Disorder		8	14.8%	Psychotic Disorder		10	9.8%
Other		6	11.1%	Other		10	9.8%
	Range	Mean	SD		Range	Mean	SD
# charges upon referral	1-9	1.9	1.9	# charges upon referral	1-5	1.5	1.0
Lifetime arrests	1-98	22.2	28.0	Lifetime arrests	1-254	24.8	64.5
12-month arrests	1-5	2.7	1.5	12-month arrests	1-4	2.2	1.2

Table 4: Comparison of MHC graduates to non-graduates

Client Satisfaction Survey

MHC clients were recruited by MHC staff to complete a questionnaire about their perceptions of and experiences with the program. A total of 21 MHC clients agreed to respond. In nearly unanimous fashion, MHC clients indicate strong positive opinions with respect to four questions about MHC staff (Figure 4).

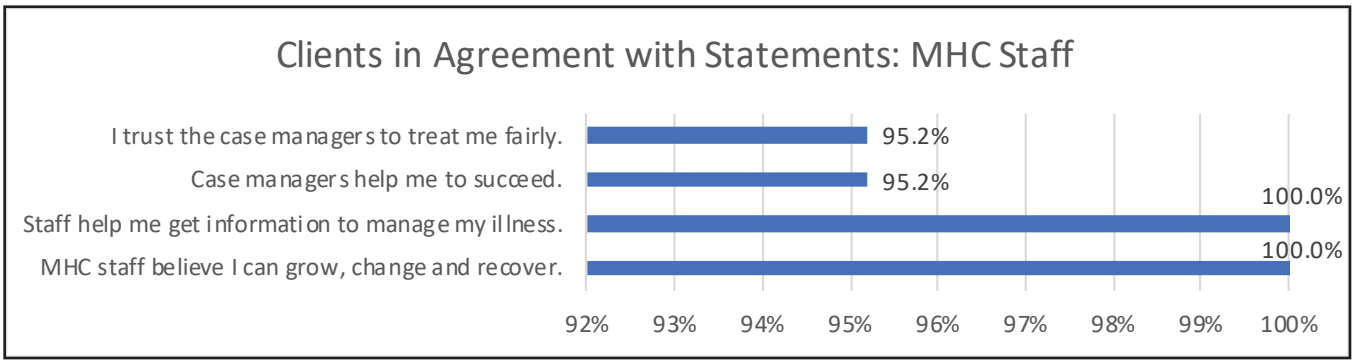

Figure 4: MHC clients in agreement with statements about staff

Six questions were asked to measure respondents' perceptions of judicial interactions and their relationship with the judge (Figure 5). Once again, responses were overwhelmingly positive. Questions about the judge elicited universally positive responses. He is well-liked and well-respected by the MHC clients. Fewer felt that coming to court on a regular basis encouraged them to continue treatment or always understood what was happening with their case in court. Finally, respondents were least likely to believe that others who committed the same offense were treated the same.

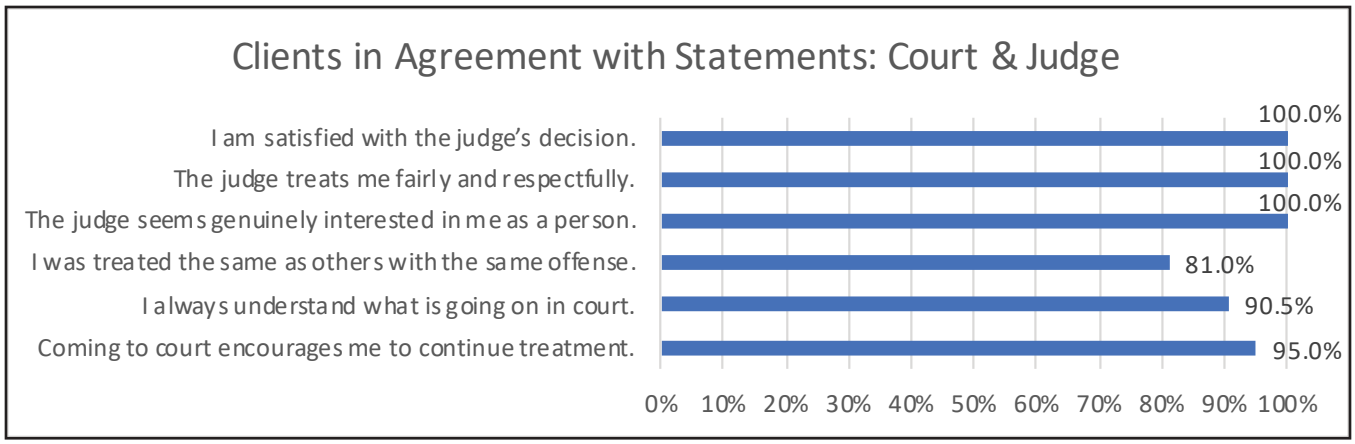

Figure 5: MHC clients in agreement with statements about court & Judge

Clients also were asked three questions about service providers (Figure 6). Once more, clients were overwhelmingly and nearly universally positive about the service providers. They like the services and feel cared for, respected, and treated fairly.

Finally, clients were asked eight questions about the program, in general (Figure 7). Although there was more variation in responses to this set of questions, most were again

extremely positive. Seven questions generated 90% or more agreement. The last question was not about the program, per se, but about whether the location was convenient. Overall, MHC clients perceive the program as helpful and effective.

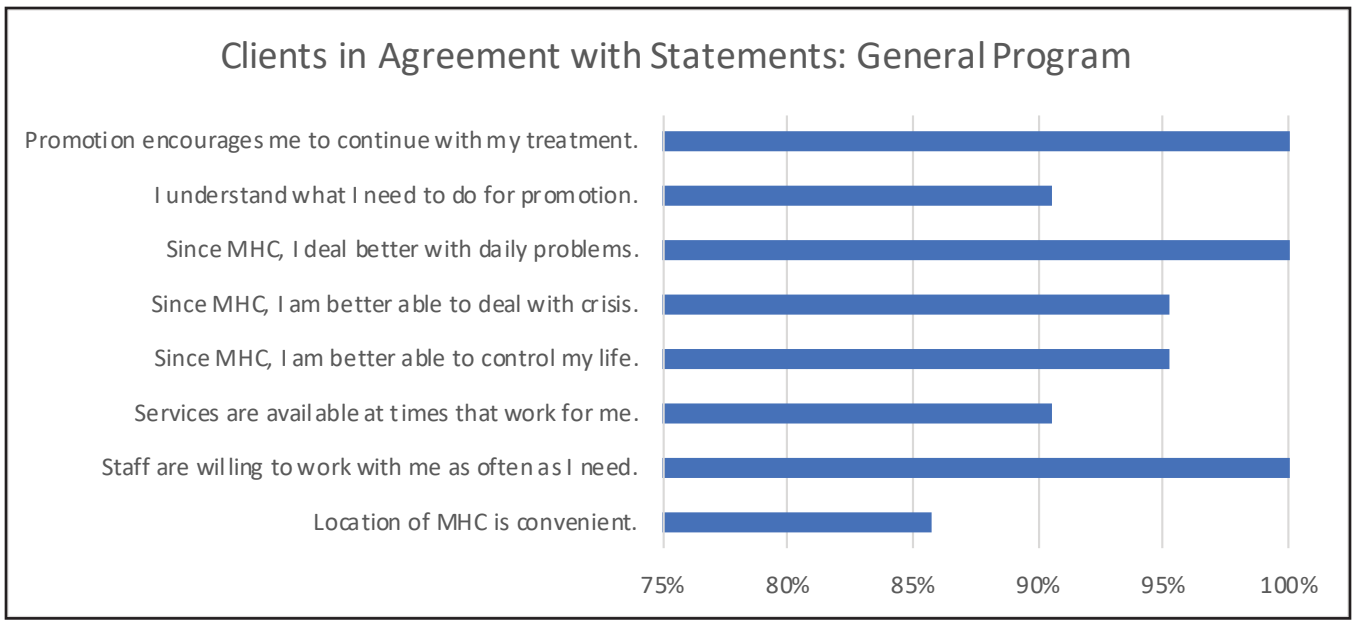

Figure 6: MHC clients in agreement with statements about service providers

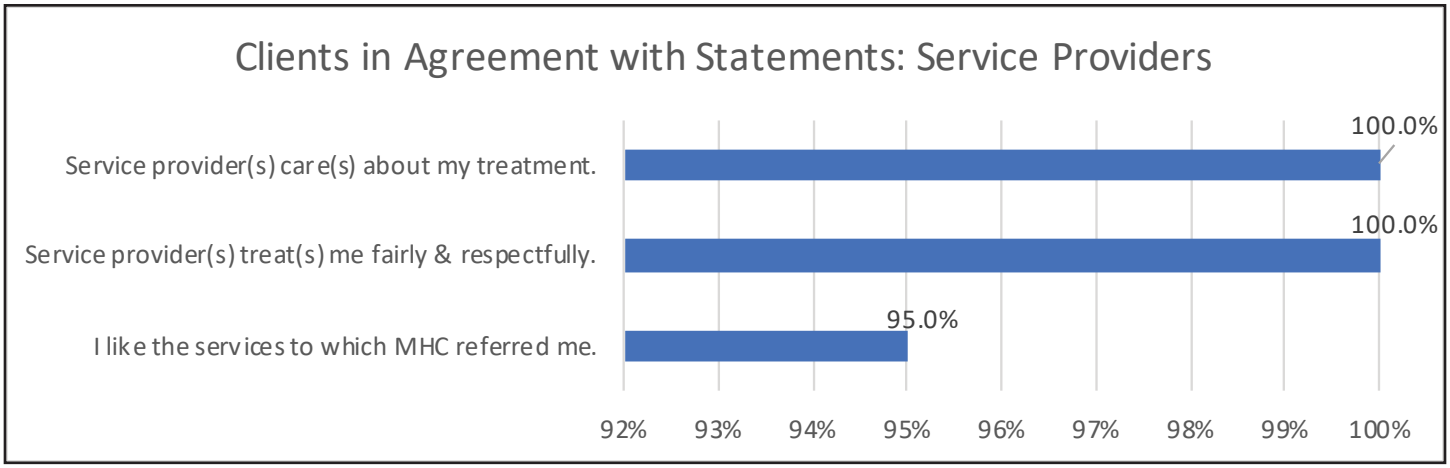

Figure 7: MHC clients in agreement with statements about the program

Qualitative Interviews

Due to availability, we interviewed MHC staff in a focus group and Judge Skahan in a face-to-face interview. The same four questions were asked in both interviews. For purposes of brevity, we summarize them together. Although we provide some examples within each question, we used "word clouds" to summarize the narrative comments, developed using an online word cloud generator (wordart.com). One word cloud was developed for each question. Word clouds are visual summaries of the frequency with which words are mentioned by a specific group of people in a specific context. In this case, each word cloud represents a visual summary of the comments made within the interviews by question with the size of each word relative to its frequency of mention (larger words mentioned more frequently).

1. Discuss what you see as the purpose of the MHC and whether you believe it is currently fulfilling that purpose.

Staff and the judge identified the primary mission of MHC to help identify people with mental health challenges who require treatment rather than incarceration. Although everyone involved perceives the MHC as helpful to offenders and helpful in reducing recidivism, they each acknowledged the need for more to be done.

The staff gave several examples of how the MHC had been able to assist offenders struggling with mental health issues. One example given by a staff member involved a man with trauma resulting from abuse and addiction. They got him into therapy and connected him with his father, who was in prison and have been able to deter him from criminal activity. Another example involved a client who was unaware he had bi-polar disorder. Once he was diagnosed and connected to treatment, he was able to successfully complete the program.

Several people mentioned, however, that MHC and its connections is just a "short-term" remedy. Most of the clients need long-term help for chronic conditions and have difficulty because they most often are uninsured. When a sex offender is the client, the problem is magnified because they already are very difficult to place, so housing becomes a serious challenge. As exemplified in the word cloud below (Figure 8), in addition to the words "mental" and "ill," words that came up frequently were "help," "meet," "needs," "reduce" and "issues."

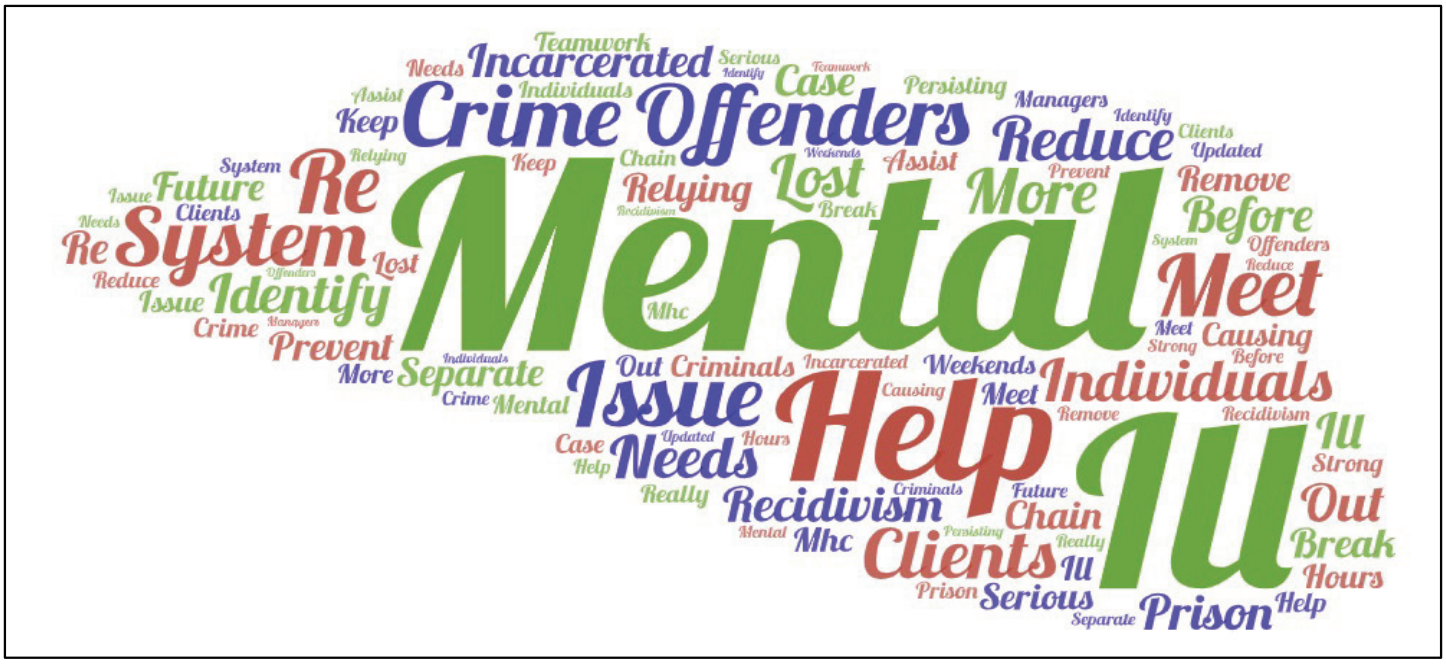

Figure 8: Word cloud for Question 1

2. Discuss the major strengths of the MHC.

Universally, the major strength mentioned was the fact that everyone involved worked as a team with the client's best interests at heart. According to the staff and judge, the primary strengths of the MHC are teamwork and the ability to build trust with the clients by working closely with them to connect them to treatment and services (Figure 9). Important words were "trust," "building," "closely," "help," "support" and "teamwork."

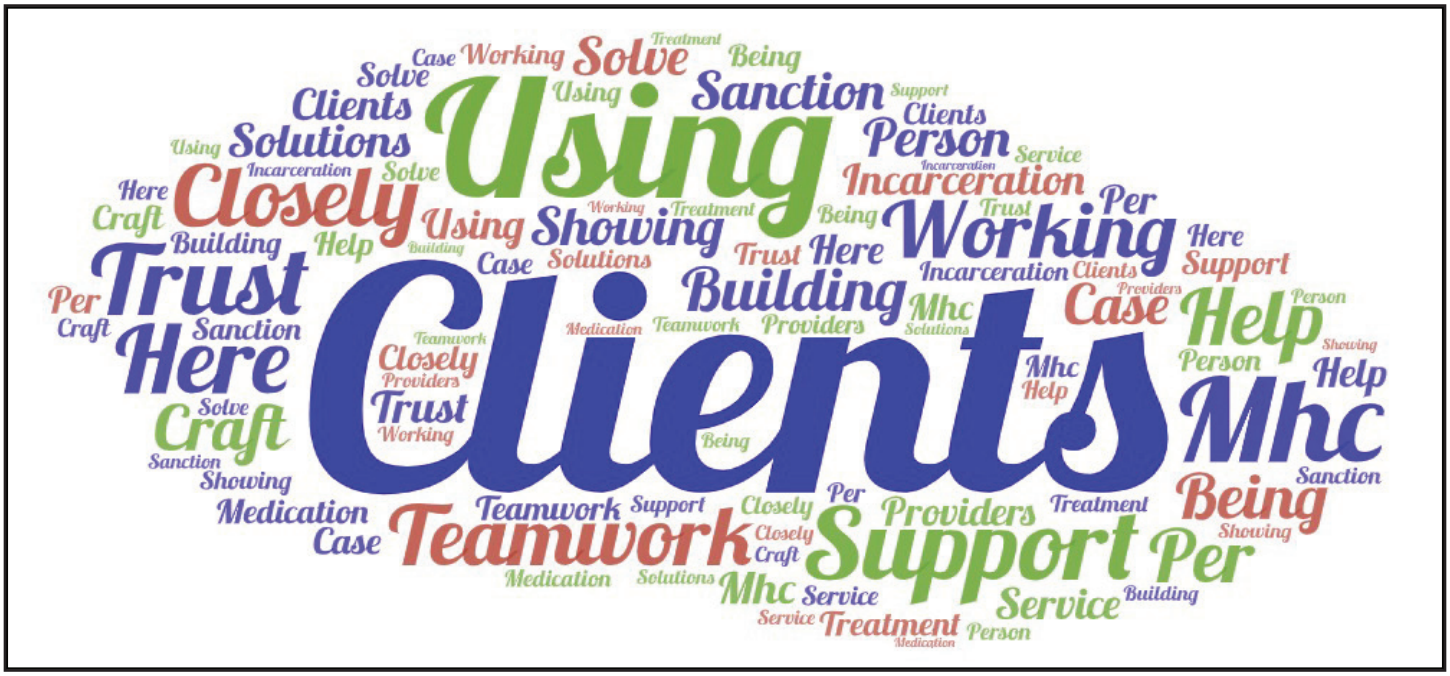

Figure 9: Word cloud for Question 2

3. Discuss the major weaknesses of the MHC.

As plainly depicted in Figure 10, staff and the judge believed major weaknesses to be limits on money, time, other resources, treatment and housing. One staff member expressed frustration that the MHC's work has to fit in the existing schedule of the court, which does not necessarily fit best with the needs of the client population.

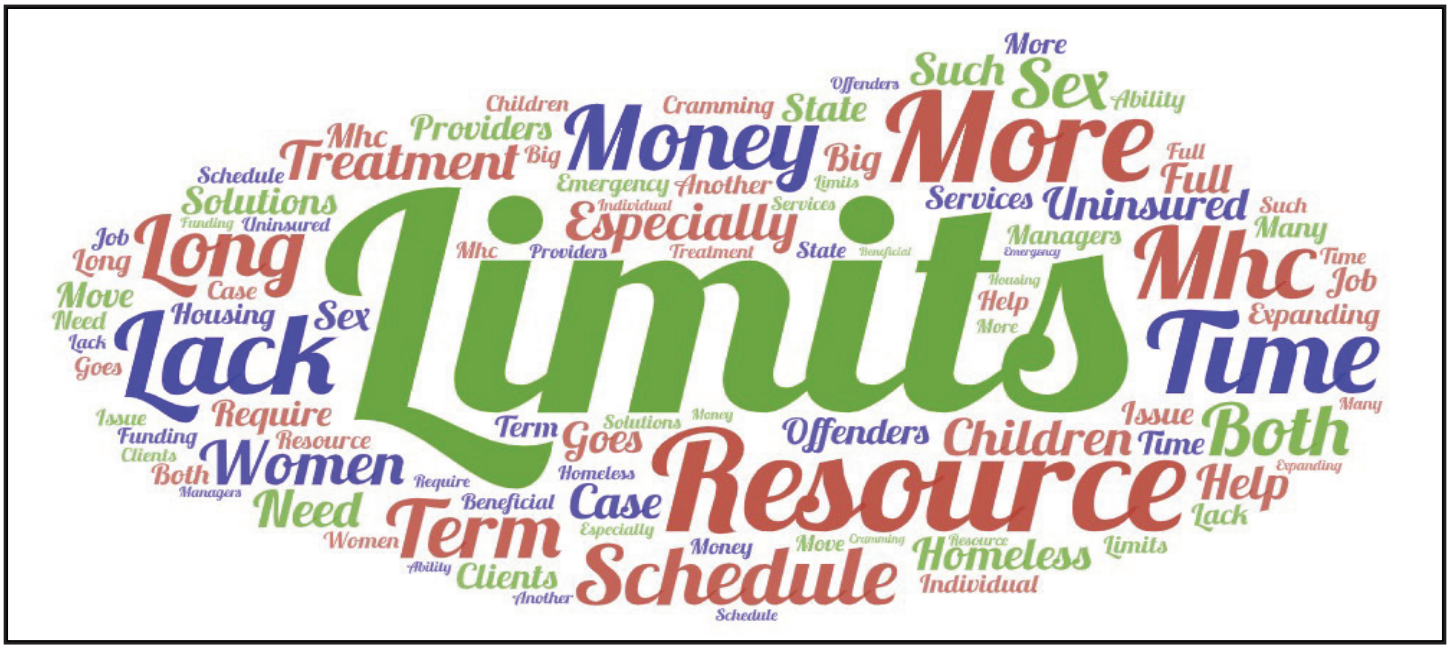

Figure 10: Word cloud for Question 3

4. If you had a limitless supply of money, what would you do to make the MHC even better?

One of the primary suggestions on how to improve the MHC was to add a "peer support" person who had been through the program. This person would serve as a sort of role model and work with clients in the program as a coach to help them in ways that staff may not be able to. Other common suggestions were to expand the hours of the court, to provide more and better options for housing, especially for women and to provide more and better options for transportation. Prominent in Figure 11 are the words "peer," "support," "help," "health," "housing" and "women."

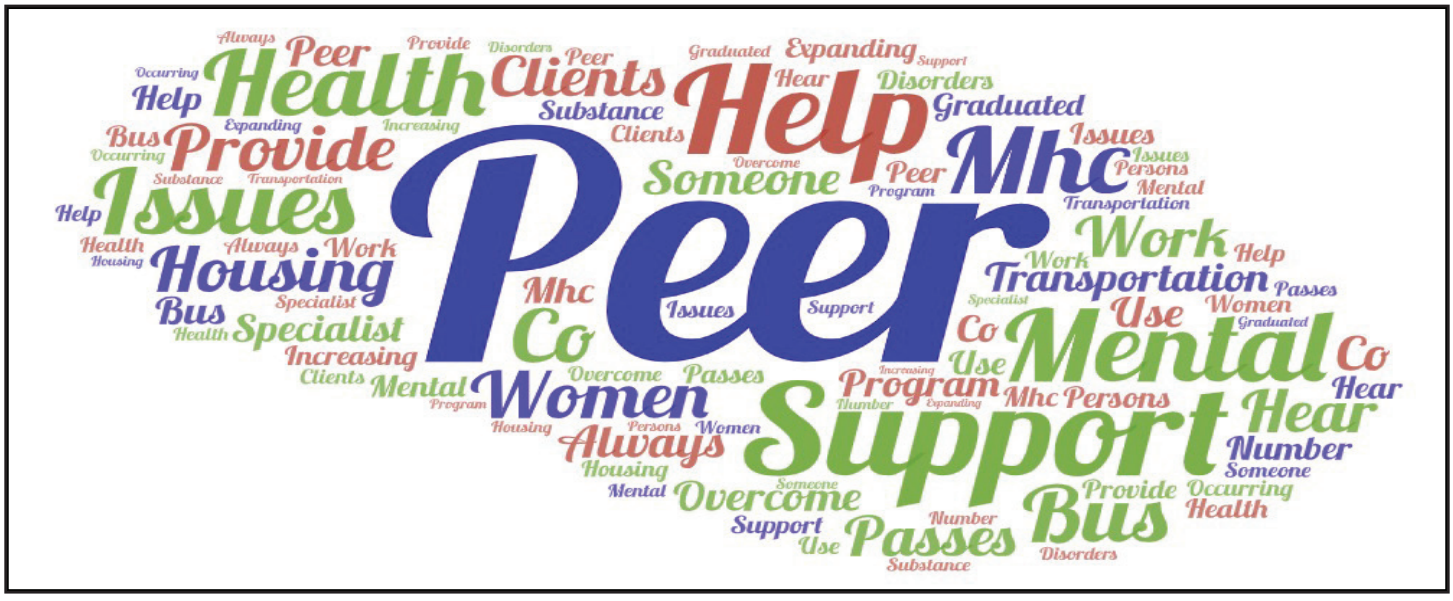

Figure 11: Word cloud for Question 4

Qualitative Observations

As a final measure, we observed a pre-court staff meeting and an MHC session. Staff meetings, which take place immediately prior to each Tuesday MHC session, last about 1.5 hours. At these meetings, MHC staff review pending referrals with attorneys and sometimes service providers. Discussion in these reviews pertain to whether potential MHC clients have outstanding warrants, whether they already have been diagnosed with a mental health issue, whether they are on medication or need help getting back on medication, and whether the defense attorney and the prosecutor supports their entry into MHC.

Other things considered during these reviews are whether the client is stable and compliant with any medications. This is a requirement of program entry. Pretrial release bond conditions and release options are also considered. Release on recognizance (ROR) is a possibility with MHC clients to avoid imposing a financial burden on them and their families.

A critical part of this review process is to develop innovative ways for the MHC to maintain contact with clients and make things as convenient as possible for them. One innovation is a telehealth option for Judge Skahan to communicate with potential clients and current clients who may be under the care of a facility, such as Alliance Healthcare Services (AHS). Other innovations include flexibility in Court availability to meet with referrals about missing appointments, non-compliance, screening appointments, etc. Although these generally are set for the morning, the judge can intervene and ask the clerks to allow referrals to be in the afternoon.

Staff also conduct status reviews of current MHC participants prior to the upcoming court session. The group is briefed on each MHC participant's activity and status, and staff brainstorm solutions for participants who appear to be having trouble. For example, they discuss the results of random drug screens, medication compliance or non-compliance, any outstanding warrants, whether the client has absconded, and their status with any service providers to whom they were referred (e.g., Judicare, CAAP, Grace House, Serenity, Salvation Army). Rewards (carrots) are discussed for clients who might need some encouragement to graduate and discharges for those who are non-compliant.

A representative from the jail provided updates on MHC clients held there. For example, one MHC client did not show for psychological and chronic care appointment and is not on his medications. They discussed whether that client could have been detoxing. In addition, a representative from a drug screening company presented results from recent drug screens among MHC clients.

For clients who continue with non-compliance and positive drug screens, instead of immediate discharge, the MHC attempts to develop compassionate solutions. For example, one recommendation was made for a struggling client to be sentenced to 28 days in detox rather than jail. Another example involved a client with several missed appointments and positive drug screens who might be better served by out-of-town detox facilities with longer programs. One staff member stated, "we don't want to be too heavy handed because he has been mostly compliant."

Failure to show is a primary reason that warrants are issued for MHC clients. Transportation, however, is a major issue for clients, leading to missed appointments and court dates. Bus passes are provided to MHC clients, but bus transportation in Memphis is well-known to be unreliable and slow. This remains a conundrum because warrants are issued for clients who do not show up for MHC when they are scheduled and could potentially be discharged.

MHC Observation

On the date of the observation, the Tuesday afternoon courtroom was about half full of MHC staff, attorneys, MHC participants and their supporters. Judge Skahan presided and congenially welcomed everyone. He specifically welcomed several individuals from Calvary Church who function as an ad hoc support group for MHC clients.

During the session, it became clear that the judge is careful to take steps to protect MHC participants from themselves and from the risks of their own success. Several times, Judge Skahan warned clients to "step back and refocus more on

recovery." He provided encouragement for those who are testing every day and promised to reduce testing frequency if they continued to have negative screens. In fact, at one point, he cheerfully shouted to a successful participant "stay negative!"

Although the Judge is willing to listen to participants explain lapses, he is firm about imposing the intervention that is in the participant's best interest, with a focus on rehabilitation. He actively tries to avoid sending anyone to jail. For example, one participant who had several lapses and could have been sent to jail, explained that she needed inpatient treatment but wanted to go to a specific facility rather than one to which she had been referred. Judge Skahan reset her case to find out about availability at that facility. He told her, "you've had a rough week, but you're not a bad person. You just have a disease that is trying to kill you."

Limitations

All research has limitations that should be considered before discussion. Given that this program is very new, it is reasonable to expect the investigation to reveal challenges to implementation or to the evaluation of impact. This is not necessarily undesirable because one cannot resolve a problem until it has been identified. In this case, program implementation is on track, but some procedural problems limit the ability of an evaluation to determine program impact.

The quality and quantity of data were the primary limitations to this evaluation. This is not surprising given the small staff were occupied with managing clients and running the program, rather than data collection and maintenance. Most programs, especially court-centered programs, struggle with collecting data to capture measures required for evaluation.

Although data on individuals referred to the program (i.e., demographics, referral source, criminal histories) were mostly complete and consistent, and data on individuals who entered the program were mostly complete and consistent for their progression through the program, many data points lacked clarity and completeness. Outcome information (i.e., criminal justice outcomes, mental health outcomes) and information about housing status, family connections, and medical care while in the program were missing or incomplete. Given these data were not routinely and consistently collected, determining the program impact in these areas was not possible.

Another limitation was lack of consistency and clarity in participant acceptance. Although the MHC explicitly excludes violent offenders, some accepted participants came in with charges such as aggravated assault, aggravated burglary, and sexual battery, while similar referrals were excluded. Some flexibility is necessary in guidelines for deciding which clients to accept, however, program administrators should consistently document any deviations from the guidelines. Selection bias is a real threat to program evaluation (selecting the "best" potential participants and excluding the "worst"), and it needs to be minimized as much as possible.

Although these factors limited the extent of the evaluation, they can be addressed by developing a more consistent process for collecting and managing both individual-level program data (phase completion, non-compliance), as well as program level data (number of referrals, invitations, acceptances, number completing each phase, etc.). A process also can be developed and implemented for case managers to track and enter criminal justice and mental health outcomes, as well as other "quality of life" measures (housing, employment) critical to continued client success beyond program graduation. Focusing on data collection and management, however, is difficult when staff is limited, and resources already are strained.

Discussion

A complete and rigorous evaluation was not possible given the extent of missing data. For example, we were unable to determine the extent to which program participants were arrested during the program (recidivism), or the extent to which housing and/or employment was secured. Data on participant compliance and non-compliance with program requirements also were missing. Finally, we could not compare program participants with non-participants because data were not kept on non-participants.

While the MHC accepts a monthly average of about one in three individuals who are referred, referrals had dropped near the end of the study period. Through 2018, referrals continuously and steadily climbed each quarter, indicating that the court was gaining a reputation among lawyers, becoming more willing to refer their clients to the program. However, during the first and second quarters of 2019, there was a notable drop in referrals, rebounding slightly in the last half of the year.

While a drop in referrals could indicate a problem with the referral process, it also could be a good problem with such a small number of program staff. With one coordinator, two case managers, and one judge and an average of more than 300 days between program entry and graduation, more referrals and more accepted participants could overwhelm the program and negatively impact participating clients. Maintaining a small number of participants is likely the best strategy until the number of program staff is expanded.

In addition to concern over referrals, the graduation rate is less than desirable. While nearly 70% of individuals referred to the program were invited to participate and nearly 92% of those invited agreed to participate, fewer than one in three (n = 48) graduated. With so few graduates, it seems likely that the program faces some challenges that impede participant success. Resources are strained and challenges beyond the program's control impact the program's effectiveness. Adequate housing is scarce for those with criminal backgrounds who are also struggling with mental health and co-occurring substance use disorders. The population generally is transient and difficult to keep connected to services. Moreover, transportation was cited as the biggest hurdle for participants trying to keep treatment, counseling and court appointments. Although bus passes are available, bus service is unreliable and slow. Finally, the data suggest the need for additional mental health support service since non-graduates were diagnosed with mental health disorders that, arguably, are more life-altering and difficult to manage (e.g., bipolar disorder, schizophrenia and depression).

Review of both the MHC participant satisfaction survey and the qualitative interviews and observations, however, provides evidence that the MHC is perceived as beneficial to people struggling with mental health issues who become involved with the criminal justice system. Participants report extremely positive views of the staff, the judge and the process, and believe their best interests are being kept in mind.

While we cannot definitively determine whether the MHC program is effective in reducing recidivism and improving the quality of life for its graduates, our community clearly has a need for this type of program. The risk of "net-widening," however, must be considered and mitigated, if possible. We certainly do not want to be increasing the reach of the criminal justice system into lives and increasing the potential for punishment for these individuals.

The strongest components of this program are its staff, its focused strategies and its strong partnerships with service providers. The participants have faith in the program and the staff, and the staff are passionate, committed and dedicated to assisting offenders who suffer with mental health issues. If data issues are addressed and procedures are made more consistent, it is likely a future evaluation could be productive in assessing effectiveness.

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APPENDIX A

Shelby County Mental Health Court Client Satisfaction Survey

The Public Safety Institute at the University of Memphis is working with the staff at Shelby County Mental Health Court (MHC) to find out whether the MHC helps clients address mental health concerns and stay out of jail. As a client, we invite you to answer some questions about your experiences with the court. Your answers will help us understand how you feel about the MHC and whether you believe it is helpful.

We do not want your name on your questionnaire because we only want to look at responses overall. Your responses will be combined with everyone else's so there is no way anyone will be able to connect you to your answers at any time. A report will be developed from all responses and shared with MHC and the state funders of the project.

You are not required to do this. If you decide to start answering questions, you may stop at any time or may skip questions with no penalty to you. This is completely voluntary but we encourage you to participate as your opinion matters and will be helpful in improving the MHC!

If you have any questions or concerns, please contact Dr. Angela Madden, Research Associate Professor at the Public Safety Institute at 901.801.8500 or angela.madden@memphis.edu.

To get a better understanding of client experiences, we may conduct interviews with some clients later in the month. If you want to be interviewed about your experiences with MHC, please let Ms. Hilson or another member of the MHC staff know.

Thank you for sharing your experiences and thoughts with us to help improve the MHC!

APPENDIX B

Mental Health Court Participant Satisfaction Survey

Sex: ☐ Female ☐ Male ☐ Other ☐ Decline to Answer

Race/Ethnicity: ☐ Black, Non-Hispanic ☐ White, Non-Hispanic ☐ Hispanic ☐ Other
☐ Decline to Answer

Age at Last Birthday: _____

Below is a list of statements dealing with general aspects of the Mental Health Court Process. Please indicate how strongly you agree or disagree with each statement by marking an X in the box.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1. Location of Mental Health Court is convenient.					
2. Mental Health Court staff are willing to work with me as often as I need.					
3. Services are available at times that are good for me.					
4. Mental Health Court staff believe I can grow, change and recover.					
5. Mental Health Court staff help me get the information I need so I can take charge of managing my illness.					
6. Coming to court on a regular basis encourages me to continue with my treatment.					
7. Since coming to the MHC, I am better able to control my life.					
8. Since coming to the MHC, I am better able to deal with crisis.					
9. Since coming to the MHC, I deal more effectively with daily problems.					
10. I like the services that I receive at Mental Health Court.					
11. I always understand what is going on with my case in court.					
12. I understand what I need to accomplish to be promoted to the next phase in the program.					
13. Promotion into the next phase encourages me to continue with my treatment.					
14. I believe that other people who committed the same offense I did were treated the same way.					
15. The judge seems genuinely interested in me as a person.					
16. I believe that the judge treats me fairly and respectfully.					
17. I am satisfied with the judge's decision.					
18. The case managers help me to succeed.					
19. I trust the case managers to treat me fairly.					
20. The service provider(s) to which I was referred treat me fairly and respectfully.					
21. The service provider(s) to which I was referred care about my treatment.					

Is there anything we can do to improve Mental Health Court?

APPENDIX C

SC Mental Health Court

Administrator/Staff & Judge Interviews

1. Discuss what you see as the purpose of the MHC and whether you believe it is currently fulfilling that purpose.

    Probe: How, specifically, is it helping people?

2. Discuss the major strengths of the MHC.

    Probe: How can these be made even stronger?

3. Discuss the major weaknesses of the MHC.

    Probe: How can these be remedied?

4. If you had a limitless supply of money, what would you do to make the MHC even better?


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