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A Descriptive Overview Of The Jefferson County Mental Health Court

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A DESCRIPTIVE OVERVIEW OF THE JEFFERSON COUNTY MENTAL HEALTH COURT

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ABSTRACT

Mental health courts have been established to help meet the treatment needs of the mentally ill offender. If mentally ill offenders commit crimes because of their mental illness, then "by treating [them], society may benefit through reduced recidivism and improvements in social outcomes" (Mears, 2004, 258). This study focuses on the Jefferson County Mental Health Court and its participants. It addresses two main research questions: 1) Who participants in the Jefferson County Mental Health Court; and 2) What factors exist to help predict who successfully completes the Jefferson County Mental Health Court? Unlike the majority of other mental health courts, this mental health court only accepts felony offenders. The unique structure of this particular mental health court makes this study crucial, as a mental health court model is in the development stages.

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INTRODUCTION

The rights extended to mentally ill individuals living in the United States have changed dramatically in the past fifty years. This process began around 1955 with deinstitutionalization and continued with the development of thought known as therapeutic jurisprudence and the creation of specialty courts. All of these changes culminated with the development of mental health courts – specialized courts designed to aid mentally ill individuals that find themselves in contact with the criminal justice system.

Deinstitutionalization or the release of patients from mental health institutions began with the introduction of medications that would allow individuals suffering from mental illness to function in society (Krieg, 2001). Two landmark Supreme Court decisions facilitated deinstitutionalization efforts: *Shelton v. Tucker* (1960) and *O'Connor v Donaldson* (1975). While the original ruling in *Shelton v. Tucker* (1960) applied to the placement of disabled children in regular classroom settings, it set the precedent that mentally ill individuals cannot be held in a more restrictive environment than required for treatment. Since this ruling, researchers have found that mental health treatment is most effective when it is administered in the least restrictive environment (Rice & Harris, 1997). In *O'Connor v. Donaldson* (1975), the Supreme Court ruled that mentally ill individuals who are not dangerous and have the ability to care for themselves cannot be held against their will in a mental institution but must be treated and released.

Although deinstitutionalization of the mentally ill seemed to be a good idea, there were some unintended consequences associated with this reform. First, it left many mentally ill individuals living in poverty without their medications. Second, mental health facilities were unwilling to provide long-term care for the mentally ill. When the mentally ill sought treatment in these facilities, they were only kept for the minimum amount of time necessary to stabilize their medications before being released back into the community. Finally, the population of mentally ill exceeded the mental health services available in communities (Lamb & Weinberger, 1998; Mechanic & Rochefort, 1990). As a result, the criminal justice system became the alternative for dealing with the mentally ill in the community.

The Criminalization of the Mentally Ill

As early as 1939, Penrose found that geographic areas with more mental institutions had fewer prisons and areas with more prisons had fewer mental institutions. He suggested that there are certain individuals who are considered "undesirable" within a given society and will be removed from society or institutionalized, and it is up to each geographic area to determine if they will be institutionalized in a mental facility or a prison. Palermo, Smith, and Liska (1991) found similar results in their comparison of the number of offenders in jails and prisons in the United States with the number of individuals that were admitted to psychiatric hospitals from 1904 to 1981. They found that higher incarceration rates were coupled with lower admissions to psychiatric hospitals. The conclusions of these studies suggested that the "criminalization of the mentally ill" has indeed occurred in American society.

The terminology "criminalization of the mentally ill" was first used by Marc Abramson (1972), a California psychiatrist employed in the criminal justice system who saw the passage the of new mental health law as an unintended consequence of deinstitutionalization. Once individuals were released into the communities, they drew attention to themselves through such crimes as public drunkenness, disorderly conduct, or malicious mischief. After the initial introduction to the criminal justice system, these mentally ill individuals never seemed to break the cycle of incarceration. It became increasingly difficult for hospitals to admit mentally ill individuals for more than a 72-hour stabilization period. Jails and prisons did not have the resources to deal with this increasing population. One psychiatrist stated:

> We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses… The crisis stems from recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections (qtd in Abramson, 1972, 104).

Prior to 1976, research focusing on the mentally ill population in prisons and jails was non-existent. The first study that examined this issue was the Bolton Study (1976) in California (Lamb & Weinberger, 1998). Therefore, it is unclear whether or not deinstitutionalization led to an increase in the prison and jail population of mentally ill offenders. While the decreasing numbers of patients in mental health facilities is documented, there is no way to definitively know if more of the mentally ill population was being funneled through the criminal justice system.

While no empirical evidence exists to show that more mentally ill individuals are incarcerated today than before deinstitutionalization, numerous studies have found

evidence to suggest that the mentally ill are being funneled through the criminal justice system at a rate higher than the general population causing an increase in mentally ill offenders in jails and prisons (Lamb & Weinberger, 1998). Teplin (1983) identified three factors that relate to the criminalization of the mentally ill: an overall increase in the number of mentally ill individuals living in communities, the manner in which police handle situations involving the mentally ill, and the refusal of service to mentally ill patients by mental health facilities. The first factor, an overall increase in the number of mentally ill individuals living in communities, is a direct result of deinstitutionalization. If these individuals were living in mental health facilities, they would not be living in the communities. Public perceptions of the mentally ill tend to be negative, yet if "deinstitutionalization [is] to be successful, it must have community support" (Krieg, 2001, 373). Certain mental illnesses, such as schizophrenia, cause the public to fear individuals with mental illness. Angermeyer, Cooper, and Link (1998) found that the public fear of individuals with mental illness far exceeds the dangers posed by this population. In fact, very few studies have found significant relationships between mental illness and crime and mental illness and violence. "[I]t is often assumed that risk of crime and violence is tied to mental disorder, and that treating the mental disorder will reduce the risk of crime and violence" (Rice & Harris, 1997, 130). However, many individuals with a mental illness tend to have a co-occurring substance abuse problem. In these cases, treating the mental illness without treating the substance abuse problem generally will not yield favorable results (Laudet et al, 2000).

The second factor, how police handle situations with mentally ill individuals, tends to follow the bureaucratic trends within the mental health and criminal justice

system. Most crimes committed by the mentally ill are misdemeanor offenses (Palermo, Smith, & Liska, 1991). The easiest way to handle a mentally ill individual is through arrest, which is also the solution that is most acceptable to the public (Lamb & Weinberger, 1998). Referrals by police into the mental health system can be a lengthy process, which acts as a deterrent for police to make a referral.

The third factor, some mentally ill individuals may not be accepted by mental health facilities, only leaves the option of the criminal justice system as an alternative (Teplin, 1983; Palermo, Smith, & Liska, 1991). The criminal justice system has an open-door policy; it cannot turn individuals away as long as a crime has been committed. However, some mental health facilities refuse to admit individuals with a pending legal case or individuals that the mental health facility deems dangerous (Teplin, 1983). The mentally ill population in prisons and jails has contributed to the overcrowding problem experienced across the nation (Palermo, Smith, & Liska, 1991). The stress from overcrowding, accompanied with abuse by other inmates, has a tendency to worsen the symptoms of mental illness (Teplin, 1983).

Mental Health Courts: A History

Rise of Therapeutic Jurisprudence

The theoretical framework of therapeutic jurisprudence began in the late 1980s in response to mental health laws. Therapeutic jurisprudence focuses on "the relationship between the law and its agents on the one hand, and those individuals who become caught up in it… on the other" (McGuire, 2000, 420). This framework suggests that an individual's interaction with the criminal justice system can result in either a therapeutic

or anti-therapeutic consequence. Laws can be used as helping agents by minimizing anti-therapeutic interactions and maximizing therapeutic interactions (Winick, 2003).

The main objective of therapeutic jurisprudence is to reduce recidivism through rehabilitative, therapeutic means. The ideology is that by promoting therapeutic jurisprudence in courts, "courts themselves might facilitate rehabilitation directly through a number of adjustments to procedure" (McGuire, 2000, 421). The first adjustment is that the attorneys, judges, and any other legal personnel involved would need to stay abreast of any new research findings that can maximize therapeutic interactions, thereby minimizing recidivism. Also, offenders would have the central role in proceedings; even aiding in the creation of their own treatment plans. Finally, courts have to be given the authority to order offenders into relapse prevention or other programs that can help offenders in their rehabilitation (McGuire, 2000).

Creation of Specialty Courts

"Recently, a range of new kinds of problems, many of which are social and psychological in nature, have appeared before the courts. These cases require the courts to not only resolve disputed issues of fact, but also to attempt to solve a variety of human problems that are responsible for bringing the case to court" (Winick, 2003, 1055). These courts are typically referred to as specialty courts or problem-solving courts. The problem-solving court model can be traced to the establishment of the first juvenile court in 1899. The goal of the juvenile court and specialty courts is to rehabilitate offenders. The first modern day specialty court to develop was the drug court in 1989, which emphasizes drug treatment over punishment. Since the establishment of drug courts,

other specialty courts have been developed such as domestic violence courts, re-entry courts, dependency courts, youth courts, and mental health courts (Winick, 2003).

The criminal justice system uses problem solving courts to better understand "human problems" of domestic violence, drug addiction, and mental illness. A better understanding of these problems leads to better treatment models and reduced recidivism. Specialty courts also play an advocacy role for needed resources within a community such as shelters, inpatient treatment facilities, and outpatient treatment facilities. Once these resources are available, these courts can work with the community counterparts to improve the effectiveness of the treatment that is provided (Winick, 2003).

Mental Health Courts

"The creation of specialty mental health courts has emerged as a strategy to address the impact of persons with mental illness in the criminal justice system by consolidating management of certain types of cases into a single court" (McGaha, Boothroyd, Poythress, Petrila, & Ort, 2002, 125). This consolidation is believed to increase judicial efficiency and help defendants receive better treatment (McGaha et al, 2002). The role of mental health courts is to connect mentally ill offenders with community treatment alternatives with the goal to stop recidivism (Wolff, 2003).

There is some debate regarding when the first mental health court was established. It is commonly believed that the first mental health court was established in Broward County, Florida, in 1996 (Goldkamp & Irons-Guynn, 2000); although some point to the establishment of the mental health court in Marion County, Indiana, in 1980

as the first (Wolff, 2003). Currently, there are over 500 mental health courts in the United States, and that number is growing (Goldkamp & Irons-Guynn, 2000).

Mental health courts were established to alter the outcome of the mentally ill individual. An individual becomes hospitalized because of acute mental illness. Once the mentally ill individual begins to show improvements through the use of medication, the individual is released from the hospital. Without the hospital dispensing medication, the symptoms of mentally illness return. These symptoms cause the individual to commit minor crimes, bringing the criminal justice system into the equation (Winick, 2003). Since the creation of mental health courts, these individuals are receiving treatment as opposed to punishment for their mental illness.

Statement of the Problem

Eleven million people are arrested each year in the United States (Petrila, 2002). Six hundred thousand of those arrested have an acute mental illness, and approximately seven million have a substance abuse problem and/or a mental illness (Petrila, 2002). Mental health courts have been established to help meet the treatment needs of the mentally ill offender. If mentally ill offenders commit crimes because of their mental illness, then "by treating mentally ill offenders, society may benefit through reduced recidivism and improvements in social outcomes" (Mears, 2004, 258).

This study focuses on the Jefferson County Mental Health Court and its participants. It addresses two main research questions. First, who participates in the Jefferson County Mental Health Court? The data used to answer this question was collected from participants as they both entered mental health court and includes offender

characteristics, mental health information, prior criminal history, and prior substance abuse history. Second, what factors exist to help predict who successfully completes the Jefferson County Mental Health Court? The data used to answer this question was collected when the participant left mental health court and includes whether or not the client completed mental health court. Unlike the majority of other mental health courts, the Jefferson County Mental Health Court only accepts felony offenders. The unique structure of this particular mental health court makes this study crucial, as a mental health court model is in the development stages.

LITERATURE REVIEW

Mental Health Courts: An Overview

The mission of mental health courts is to connect mentally ill offenders with community treatment alternatives with the goal to end their criminal behavior (Wolff, 2003). Mental health courts seek to identify potential clients as early as possible (Goldkamp & Irons-Guynn, 2000). These clients are identified within 48 hours of arrest (Wolff, 2003).

To be eligible for mental health court, the offender must have a mental illness (Goldkamp & Irons-Guynn, 2000). This is determined by an Axis I diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (Wolff, 2003). The DSM-IV provides a classification for mental disorders that can be used by psychiatrist, physicians, psychologists, social workers, and many other professionals that deal with mental health. The DSM categorizes mental disorders across five axes. Mental health court only focuses on the first axis. Axis I contains Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention (DSM-IV-TR, 2000). Another eligibility criterion is that the mentally ill offender agrees to participate (Wolff, 2003). All mental health courts are voluntary. Mentally ill offenders can choose for their cases to be processed through the criminal justice system instead of entering mental health court (Goldkamp & Irons-Guynn, 2000; Wolff, 2003).

All mental health court cases are heard by one designated judge at a designated mental health court time (McGaha et al, 2002; Winick, 2003; Wolff, 2003). Mental health court judges also communicate directly with the clients of mental health court (Winick, 2000; Wolff, 2003). This procedural change negates the adversarial approach of regular courts. Mental health courts are non-adversarial. There is not a question as to whether the mentally ill offender committed the criminal act. Instead, the mentally ill offender is in mental health court to receive needed mental health treatment (Wolff, 2003).

All participants of mental health court are supervised within the community and are held accountable both for compliance and non-compliance. Rewards are given for compliance, such as praise or a termination of supervision. Sanctions for non-compliance are on a graduated scale and begin with a hearing in front of the judge (Wolff, 2003).

Differences in Mental Health Courts

Mental health courts do not accept all offenders with mental illness. Both the type of offense and the nature of the crime are critical (Wolff, 2003). Most mental health courts only accept misdemeanants. A few will accept both misdemeanants and felons. Mental health courts choose which Axis I diagnoses they will accept. There is also variation in how this diagnosis is determined (Wolff, 2003).

Another difference centers on if mental health courts are pre-adjudication or post-adjudication. This is important because some participants emerge from mental health court without a criminal record and some do not (Goldkamp & Irons-Guynn, 2000; Wolff, 2003). There are also varying procedures if a potential mental health court client decides to go to trial (Goldkamp & Irons-Guynn, 2000). Each court determines the

maximum amount of time a participant can be involved in mental health court (Wolff, 2003).

Previous Research on Mental Health Courts

The Broward County Mental Health Court is the most researched mental health court. The goals of this mental health court were to reduce the amount of time spent in jail by mentally ill misdemeanants and to aid those individuals in getting mental health treatment (Petrila, 2002). Clients must have a diagnosis of mental illness or mental retardation by a mental health expert or show symptoms of a mental illness or mental retardation at any point during arrest, confinement, or court appearances. There is no formal diagnostic criterion that the clients must meet. However, through evaluations, it has been found that 18 percent of clients were diagnosed with schizophrenia, 10 percent with depression, 29 percent with dual diagnoses (mental illness and alcohol and/or drug problem), 13 percent with bipolar disorder, and two percent with mental retardation (Petrila, Poythress, McGaha, & Boothroyd, 2001). The judge must decide if the case should be disposed of immediately or remain open. If the case remains open, the misdemeanant is released conditionally to seek mental health treatment within the community. Charges are dismissed when the judge determines that the misdemeanant has found treatment within the community and has been connected with any other needed services (McGaha et al, 2002; Petrila, Poythress, McGaha, & Boothroyd, 2001).

The Broward County Mental Health Court hears an average of 40 cases per month. Clients can remain in mental health court for up to one year. Sixty-nine percent of the clients are male. Approximately 25 percent of the clients are homeless (Petrila,

Poythress, McGaha, & Boothroyd, 2001). Research has shown that misdemeanants in mental health court are better able to get connected with community resources than misdemeanants with mental illnesses who are placed in misdemeanor court (Petrila, 2002). Christy, Poythress, Boothroyd, Petrila, and Mehra (2005) found that mental health court clients serve significantly less jail time than individuals who did not enter mental health court.

The Broward County Mental Health Court does not use punishments for noncompliance to treatment but instead attempts to convince the client that treatment is the best option. Punishing an individual with a mental illness for failure to comply with treatment requirements would be punishing the individual for having a mental illness (Petrila, Poythress, McGaha, & Boothroyd, 2001).

Teller, Ritter, Rodriguez, Munetz, and Gil (n.d.) conducted a study on the Akron Mental Health Court comparing graduates to non-graduates. They concluded that graduates were predominately male (80 percent), black (58 percent) and had spent an average of 734 days under supervision by mental health court. Seventy percent of the non-graduates were male and 66 percent were black. The non-graduates spent an average of 437 days under mental health court supervision. Graduates of the mental health court had fewer incarcerations and hospitalizations before entering the mental health court than non-graduates. Also, graduates experienced a decrease in incarcerations and hospitalizations throughout the duration of the mental health court while non-graduates experienced an increase in incarcerations and hospitalizations throughout the mental health court process.

The Santa Barbara County Mental Health Treatment Court accepts non-violent misdemeanants and felons. Mental health court clients are monitored by case managers for 18 months while receiving community mental health treatment. The median time in jail at a 24 month follow-up for mental health court clients after program completion was less than the median time in jail for the treatment as usual group. Approximately 10 percent of the mental health court clients were in prison within 24 months after program completion. The severity of alcohol and drug problems was the main factor in whether or not an individual recidivated (Cosden, Ellens, Schnell, & Yamini-Diouf, 2004).

JEFFERSON COUNTY MENTAL HEALTH COURT

Origins of the Jefferson County Mental Health Court

The Jefferson County Mental Health Court was created with two major objectives: 1) to aid mentally ill, felony offenders with specialized treatment and 2) to expedite the cases of mentally ill, felony offenders. The Jefferson County Mental Health Court was established in 2000 through a Bureau of Justice Assistance grant. The framework for the structure of the mental health court is the drug court model. Currently, the mental health court is funded by Jefferson County through Treatment Alternatives for a Safer Community (TASC).

The Jefferson County Mental Health Court is not a diversion program. Clients are placed on probation and must remain in mental health court for at least one year, but typically it takes clients 18 months to complete the specialized treatment plan. Once the treatment plan is completed, clients have their case closed and are referred to community mental health treatment for aftercare.

Mental Health Court Process

Eligibility and Intake

The Jefferson County Mental Health Court does not target misdemeanants. It is the belief of TASC that misdemeanor actions of the mentally ill should not be criminalized. If this cohort were allowed to enter mental health court, their behavior

would essentially be criminalized. Clients become eligible for mental health court if they have committed a felony (either a Class C felony or a Class B property offense), have no violent felony convictions within the past five years, are diagnosed with a serious mental illness (see Table 1), are 18 years of age or older, and are a resident of Jefferson County, Alabama.

Table 1

Serious mental illness as defined by the Jefferson County Mental Health Court

Schizophrenia and Other Psychotic Disorders	**Mood Disorders (Major)**	**Anxiety Disorders (Severe)**
295.xx Schizophrenia	296.xx Major Depressive Disorder	300.01 Panic Disorder without Agoraphobia
295.30 Paranoid Type	296.2x Single Episode	300.21 Panic Disorder with Agoraphobia
295.10 Disorganized Type	296.3x Recurrent	300.22 Agoraphobia without History of Panic Disorder
295.20 Catatonic Type	296.xx Bipolar I	300.3 Obsessive Compulsive Disorder
295.90 Undifferentiated Type	296.0x Single Manic Episode	
295.60 Residual Type	296.40 Most Recent Episode Hypomanic	
295.40 Schizophreniform Disorder	296.4x Most Recent Episode Manic	
295.70 Schizoaffective Disorder	296.6x Most Recent Episode Mixed	
297.1 Delusional Disorder	296.5x Most Recent Episode Depressed	
298.8 Brief Psychotic Disorder	296.7 Most Recent Episode Unspecified	
297.3 Shared Psychotic Disorder	296.89 Bipolar II Disorder	
298.9 Psychotic Disorder NOS	296.80 Bipolar Disorder NOS	

DSM-IV-TR (2000)

After an individual is arrested and booked into the Jefferson County Jail for a qualifying offense, a deputy sheriff screens the individual to determine his or her classification for housing. The deputy sheriff flags the individual if he or she believes

there is a possibility of a mental illness. Those individuals that are flagged for a possible mental illness are interviewed by the mental health social worker in the jail. In the interview, the mental health social worker tries to determine if there are indications of a mental illness, such as past hospitalizations, past episodes related to mental health issues, and/or if medication was taken in the past for the treatment of a mental illness. If the mental health social worker believes that there is the possibility of an Axis I diagnosis, he or she refers the individual to the jail psychiatrist. If the jail psychiatrist supports an Axis I diagnosis, the individual is brought to the attention of the mental health court staff. The staff checks the criminal history of the individual to ensure there is no violent felony conviction within the past five years and that the current offense is a qualifying offense for mental health court. The individual can either be in jail or bonded out of jail in order to enter mental health court.

The mental health court staff has three months to verify that the individual is eligible for entry into mental health court. The staff tracks down any information available in the community related to the mental illness of the individual, including records from doctors' visits, hospitalizations or other facilities where a diagnosis of a severe mental illness occurred, and information about medications. Throughout the three month period, the individual must appear before the mental health court judge monthly to ensure case accountability. While the individual is not formally in mental health court, he or she is being supervised by mental health court staff. At the end of the three month period or when enough information has been gathered, a determination is made whether or not the individual will have the opportunity to enter mental health court.

After a client applies for mental health court, a case manager helps the new client develop a home plan so the client can be released from jail. Usually, the client is not able to make bond, so he or she is dependant on the case manager in order to get released. This is a difficult task because many of the entering clients do not have employment or a place to live. The case manager attempts to find a family support network, mental health/substance abuse treatment, temporary shelter, and medication for the client. It is important to note that at this stage, the client has not pleaded guilty in mental health court. If sufficient evidence is not found to support an Axis I diagnosis, the client will not be allowed to plead guilty in mental health court.

As a requirement to enter mental health court, the individual must appear before the mental health court judge and plead guilty to the current charges. Since the sentence is not deferred, the individual will have a criminal record by pleading guilty. Occasionally, if the district attorney approves, an individual's guilty plea can be deferred upon completion of mental health court. This can only occur if the individual would have qualified for drug court, except for the fact that he or she has a mental illness. Unlike the Jefferson County Mental Health Court, the Jefferson County Drug Court is a diversion program that excludes those individuals with a serious mental illness. When a mental health court client who would otherwise qualify for drug court if not for an Axis I diagnosis appears in mental health court, his or her guilty plea may be deferred with the approval of the district attorney. Some individuals do not utilize the treatment available in mental health court because they refuse to plead guilty and want to have a trial.

Supervision

The Jefferson County Mental Health Court staff consists of four case managers and one staff member. The case managers operate as probation officers for clients in mental health court. Offenders are referred to as "clients" in mental health court because they are essentially going through treatment. The case managers ensure their clients follow their treatment programs, administer drug tests when necessary, help clients acquire access to community treatment programs, and advocate for the clients both within the community and before the judge. One day a month, the judge hears all the mental health court cases. This consistency enables the judge to play an active role in the clients' treatment.

The Jefferson County Mental Health Court utilizes three program phases to mark a client's progress through mental health court. Clients are unaware of the three program phases; they are used by the case managers to aid them in giving their clients the best possible treatment while living independently and controlling their own mental illness. During Phase One, the client must meet with his or her case manager three times per week, plus have telephone contact on Saturday and Sunday. Drug tests are administered weekly, unless the case manager makes other recommendations. The client appears before the judge monthly. In order to move to Phase Two, the client must have spent at least one month in Phase One, applied for government benefits, had negative urinalysis for drugs, demonstrated an understanding of his or her responsibilities in the program, initiated services within the community, and demonstrated stability on his or her medication. Ultimately, the case manager makes the recommendation for the client to move to Phase Two.

During Phase Two, the client must meet with his or her case manager two times per week, plus have telephone contact one other time during the week and one on Saturday and Sunday. Drug tests can continue into this phase if the case manager recommends them to continue. The client appears before the judge whenever the case manager recommends an appearance. In order to move to Phase Three, the client must have continued progress and compliance with his or her treatment plan, visible signs of success in daily functioning, negative urinalysis for drugs, and established and maintained services within the community. Again, the case manager makes the recommendation for the client to move to Phase Three.

During Phase Three, the client must meet with his or her case manager one to two times per week, plus have telephone contact one other time during the week and once on the weekend. During this phase, drug tests may or may not be required at the case manager's discretion. The client appears before the judge whenever the case manager recommends an appearance to update the judge on the client's progress. In order to graduate from mental health court, the client must adopt an aftercare plan, have negative urinalysis for drugs, and successfully complete the treatment plan goals. After this occurs, the case manager can recommend that the client graduate from the program. The client will remain on probation until restitution is paid in full.

Violation of Program Requirements

Program violations involve non-compliance to program requirements. These include positive urinalysis, not properly taking medications or attending appointments, and not contacting case managers as instructed. There are two types of sanctions for

clients who are not adhering to the program requirements: case manager imposed sanctions and judicially imposed sanctions. Case manager imposed sanctions include retention in the current phase of the program for a specific period of time, demotion to the previous phase of the program for a specific period of time, increased drug testing, and case manager disapproval. Judicially imposed sanctions include disapproval by the judge about the actions or inactions of the client, judicial review of the case, and failure of the mental health court program.

Another type of violation is the commission of a new crime while under the supervision of mental health court. If this occurs, the mental health court judge determines whether the client is able to stay in mental health court. If the judge allows the client to stay in mental health court, the new charge will he handled by the mental health court judge.

Comparison of the Jefferson County MHC with the Broward County MHC

According to the Survey of Mental Health Courts by NAMI (2005), the Jefferson County Mental Health Court is one of two mental health courts in the United States that accepts only felony offenders. The unique structure of the Jefferson County Mental Health Court makes this study crucial, as a mental health court model is in the development stages. The Broward County Mental Health Court is the most research mental health court. The structure of the Broward County Mental Health Court is differs from the Jefferson County Mental Health Court in numerous ways (see Table 2). The goals of both of these mental health courts are similar. The first goal of both courts is to connect mentally ill offenders with treatment. The second goal of the Jefferson County

Mental Health Court is to expedite the cases of mentally ill offenders. A major step in the process is to get the offender released from jail. This reduces the amount of time a mentally ill offender would be incarcerated, which is the goal of the Broward County Mental Health Court (Petrila, 2002).

A major difference between the Jefferson County Mental Health Court and the Broward County Mental Health Court is the type of offense each court accepts. The Jefferson County Mental Health Court accepts only non-violent, felony offenders; the Broward County Mental Health Court accepts only misdemeanor offenses. From the perspective of the Jefferson County Mental Health Court, accepting misdemeanants criminalizes mental illness, as acts such as disturbing the peace, loitering, even public intoxication can be solely the result of the mental illness. The Broward County Mental Health seeks to connect misdemeanants with mental health treatment before a felonious act is committed (Petrila, Poythress, McGaha, & Boothroyd, 2001). This difference in the type of offense that each court accepts can help explain the many differences between each court.

The mental health criteria of these mental health courts vary greatly, presumably because of the type of offense each court accepts. For the Jefferson County Mental Health Court, clients must be diagnosed with a serious mental illness (an Axis I diagnosis according to the DSM-IV). Case managers must obtain medical documentation confirming the mental ill. However, in the Broward County Mental Health Court, the client must have a diagnosis of mental illness or mental retardation by a mental health expert or show symptoms of a mental illness or mental retardation at any point during arrest, confinement, or in court appearances (Petrila, Poythress, McGaha, & Boothroyd,

2001). One reason for this variation in the mental health criteria is that the Broward County Mental Health Court deals with less serious offenses. In addition, if a client did not enter into the mental health court in Broward County, the client would enter a different specialty court, the misdemeanor court (Petrila, 2002).

Table 2

Comparison of the Jefferson County MHC and the Broward County MHC

	Jefferson County MHC	Broward County MHC
goals	to aid mentally ill, felony offenders with specialized treatment and to expedite the cases of mentally ill, felony offenders	to aid mentally ill misdemeanants in getting mental health treatment and to reduce the amount of time spent in jail by mentally ill misdemeanants (Petrila, 2002)
type of offense	non-violent felonies	misdemeanors
mental health criteria	must have a previous medical diagnosis of an Axis I mental health condition according to the DSM-IV	must have a diagnosis of mental illness or mental retardation by a mental health expert or show symptoms of a mental illness or mental retardation at any point during arrest, confinement, or in court appearances (Petrila, Poythress, McGaha, & Boothroyd, 2001)
pre- versus post-adjudication	post-adjudication	pre-adjudication
length of time in MHC	at least one year	up to one year (Petrila, Poythress, McGaha, & Boothroyd, 2001)
use of sanctions	sanctions imposed by judge and/or case manager	no sanctions are used (Petrila, Poythress, McGaha, & Boothroyd, 2001)

Whether the case is handled pre- or post-adjudication is another difference. To enter the Jefferson County Mental Health Court, a client must plea guilty to the charges

presented at court. With few exceptions, a client will have the felony offense still on his or her criminal record. The Broward County Mental Health is pre-adjudication. However, as mentioned earlier, the offenses that are accepted in the Broward County Mental Health Court are not as serious.

The length of time a client is in each mental health court is proportionate to the offense in which the client is charged. In Broward County, it is a misdemeanor, which means the client is only in mental health court for up to one year (Petrila, Poythress, McGaha, & Boothroyd, 2001). In Jefferson County, it is a felony, so the client has a minimum of one year involvement with the mental health court. However, in both mental health courts, clients finish the program once they have completed all program requirements. For the Jefferson County Mental Health Court, clients must finish the three phases outlined in previous in this study. For the Broward County Mental Health, clients must get connected with community mental health resources (Petrila, Poythress, McGaha, & Boothroyd, 2001).

The most surprising difference in these two mental health courts is the use of sanctions. The Jefferson County Mental Health Court uses sanctions for non-compliance – which can include a positive urinalysis, not properly taking medications or attending appointments, and not contacting case managers as instructed. There are two types of sanctions: case manager imposed sanctions and judicially imposed sanctions. Case manager imposed sanctions include retention in mental health court, increased drug testing, and case manager disapproval. Judicially imposed sanctions include disapproval by the judge about the actions or inactions of the client, judicial review of the case, and failure of the mental health court program. However, the Broward County Mental Health

Court does not use sanctions. Much like the belief of the Jefferson County Health Court that allowing misdemeanants to plea into mental health court is criminalizing mental illness, Broward County believes that sanctioning clients would be punishing clients for having a mental illness. Instead, the judge encourages clients to take advantage of the opportunity the mental health court gives them to connect with mental health treatment in the community (Petrila, Poythress, McGaha, & Boothroyd, 2001).

The Jefferson County Mental Health Court and the Broward County Mental Health Court approach the issues of mentally ill offenders from opposite (but not necessarily opposing) directions. The Broward County Mental Health Court seeks to treat offenders with minor offenses before a more serious offense occurs. The Jefferson County Mental Health Court seeks to treat those offenders with the more serious offenses to keep these offenses from re-occurring. While much research has been completed on the successes of the Broward County Mental Health Court, the Jefferson County Mental Health Court has not been examined in as much detail. By studying the structure of the Jefferson County Mental Health Court, a model to help treat the felonious mentally ill offenders could be developed.

RESEARCH DESIGN AND METHODOLOGY

Study Population

The study is based on records of all Jefferson County Mental Health Court clients for the period March, 2000 through March, 2006. The present study will use all of the clients entering Mental Health Court during this period.

Source of Information and Data Collection

Data were extracted from case files of clients who have participated in Mental Health Court since its beginning. TASC has collected data on all mental health court clients throughout the entire mental health court process. The data used in this evaluation are divided into two categories: data gathered when clients entered mental health court and data gathered after clients have left mental health court. The data gathered when clients entered mental health court includes offender characteristics, mental health information, prior criminal history, and prior substance abuse history. This data describes who participates in the Jefferson County Mental Health Court. The data gathered after clients have left mental health court includes whether or not the client completed mental health court.

Variables Used in the Study

The variables generated from the case files fell within five major categories: offender variables, mental illness variables, substance abuse variables, criminal history variables, and whether or not the client completed mental health court.

Independent Variables

The independent variables associated with the offender are age, gender, race, educational level, income prior to entering mental health court, employment prior to entering mental health court, number of children, if the client ever lost custody of children, marital status, type of residence, whom does client live with, and the total number of days spent in mental health court. The independent variables associated with mental illness are the previous mental health diagnosis and prior hospitalizations due to mental illness. The independent variables associated with substance abuse are if the client admits to drug addition or alcohol addiction, prior drug treatment, and if anyone client resides with abuses drugs and/or alcohol. The independent variables associated with criminal history are total number of pending cases, total number of prior misdemeanor, felony, and violent convictions, prior failure to appears, total number of arrests, and total amount of time incarcerated.

Dependent Variables

The dependant variable of whether or not the client completed mental health court is the actual program outcomes. Program outcomes are either completion of mental

health court or failure of mental health court. A failure of mental health court includes being terminated for non-compliance or leaving the program prior to completing the specialized treatment plan.

Data Analysis

This study used descriptive statistics to determine how cases are distributed on each of the variables. Bivariate analysis helped identify significant relationships between independent variables and the dependent variable. The variables found to be most significant were used in a multivariate analysis using logistic regression. This method of multilevel analysis was used because the dependent variable is dichotomous.

Limitations

The main limitations of the present study are the use of secondary data and the generalizability of the findings. Secondary data analysis is "a form of research in which the data collected and processed by one researcher are reanalyzed – often for a different purpose – by another" (Maxfield & Babbie, 2001, 427). This dataset was collected by TASC and TASC employees, not the researcher. There is always the possibility that data can be misinterpreted. It is also possible that a variable that was not included in this dataset could prove to be significant.

In addition, the findings of this study may not be generalizable to other mental health courts. This mental health court only accepts felony offenders. This unique characteristic limits the generalizablility of the findings to other mental health courts that

accept only misdemeanants or misdemeanants along with felony offenders. However, the findings will be noteworthy as this is one of two mental health courts that only accept felony offenders. This court could prove to be a model for other courts to follow.

RESULTS AND ANALYSIS

General Findings

There were 145 cases (N=145) that were closed in the Jefferson County Mental Health Court by March, 2006 (see Table 3). The entire population was used in the present study. A breakdown of the *offender variables* showed 77 clients (64.7 percent) successfully completed mental health court; 38 clients (31.9 percent) unsuccessfully completed mental health court; and 4 clients (3.4 percent) left mental health court due to some external force making these outcomes neither successes nor failures. These clients either died while they were in mental health court or left because of extreme illness. Therefore, these cases were excluded from the analysis. Men made up the majority of the population (62.8 percent) as did clients who were never married (59.2 percent), clients that lived in a house or an apartment (85.6 percent), and clients that had no children in the home (87.2 percent). The population was 51.7 percent white and 46.2 percent black. The average age was 35. The majority of the population (52.8 percent) had at least a high school education, yet the majority had a yearly income of less than $5,999 (60 percent). Only 21 of the clients (14.8 percent) were employed upon entering mental health court. The *mental illness variables* revealed that the majority of clients had been hospitalized for mental health reasons (62.5 percent) and had been in drug treatment (69.8 percent) with 61.2 percent of clients entering mental health court admitting to a current drug addiction.

The *criminal history variables* show that the majority of clients had one or two pending cases (73.6 percent) and the majority had also never had a failure to appear (56.1 percent). In general, the mental health court clients did not have a long history of felonious acts. Fifty-nine clients (41.3 percent) did not have a previous felony conviction, while 65 clients (45.5 percent) had one or two previous felony convictions. However, the clients do have an extensive history of misdemeanor convictions; 33.6 percent had one or two; 16.8 percent had three or four; and 30.1 percent had five or more. The majority of clients spent 45 days or less incarcerated in the five years before entering mental health court (54.7 percent) with 29.5 percent spending no time incarcerated. The average number of arrests during this time period was four.

The dependent variable is whether or not a client completed mental health court. Almost 65 percent of the clients completed mental health court; 27.7 percent were terminated because of non-compliance with treatment.

Table 3

Study variables, definitions, and descriptives

Variables	Categories	Percentage	Mean	SD
Offender variables				
Age upon entering MHC			35	8.79
Years of education completed upon entering MHC				
	less than high school	47.2		
	high school or GED	33.1		
	more than high school	19.7		
Race of client				
	black	46.2		
	white	51.7		
	other	2.1		
Gender of client				
	male	62.8		
	female	37.2		

Client's income the year before entering MHC				
	$0 - 5,999	60		
	$6,000 - 10,999	24.2		
	$11,000 - 20,999	8.3		
	$21,000 - 29,999	2.5		
	More than $30,000	5		
Employment status upon entering MHC				
	unemployed	45.1		
	employed	14.8		
	disabled	40.1		
Number of children under the age of 18 living with client upon entering MHC				
	0	87.2		
	1 - 2	9.9		
	3 - 4	2.8		
Has client ever lost custody of children?				
	no	72.4		
	yes	27.6		
Martial status upon entering MHC				
	never married	59.2		
	married	9.2		
	separated/divorced	28.2		
	widowed	3.5		
Type of residence upon entering MHC				
	house/apartment	85.6		
	homeless/shelter	2.3		
	institution	8.3		
	Other group situation (recovery/half-way house)	3.8		
With whom does the client reside with upon entering MHC?				
	alone	7.9		
	spouse/significant other	10		
	spouse/significant other & children	2.9		
	parent/siblings	30.7		
	other relatives	7.9		
	shelter/street	11.4		
	institution	18.6		
	friends	10.7		
Total number of days client spent in MHC				
	0 - 180 days	17.2		
	181 - 270 days	14.5		
	271 - 360 days	9		
	361 - 450 days	22.1		
	451 - 540 days	15.9		
	541 - 630 days	10.3		
	631 - 720 days	2.8		
	721 days or more	8.3		

Mental illness variables				
Previous mental health diagnosis				
	Bipolar	30.4		
	Major Depressive Disorder	25.2		
	Schizophrenia	33.9		
	Psychotic Disorder	10.4		
Was client hospitalized for a mental illness in the previous 5 years upon entering MHC?				
	no	37.5		
	yes	62.5		
Substance abuse variables				
Does client admit to drug addiction?				
	denies use	10.1		
	admits use/denies addiction	28.8		
	admits addiction	61.2		
Does client admit to alcohol addiction?				
	denies use	15.1		
	admits use/denies addiction	59		
	admits addiction	25.9		
Has client ever been in drug treatment?				
	no	30.2		
	yes	69.8		
Number of times client has entered drug treatment			3	2.9
Does anyone living with client abuse drugs and/or alcohol?				
	no	91.5		
	yes	8.5		
Criminal history variables				
Total number of pending cases				
	0	13.6		
	1 - 2	73.6		
	3 - 4	10.7		
	5 or more	2.1		
Total number of misdemeanor convictions				
	0	19.6		
	1-2	33.6		
	3-4	16.8		
	5 or more	30.1		
Total number of felony convictions				
	0	41.3		
	1-2	45.5		
	3-4	11.9		
	5 or more	1.4		
Total number of violent offenses				
	0	88.9		
	1 - 2	10.4		
	3 - 4	0.7		

Has client ever had a failure to appear?				
	no	56.1		
	yes	43.9		
Total number of arrests in the previous 5 years upon entering MHC			4	4.34
Total amount of time client spent incarcerated in the past 5 years				
	0	29.5		
	up to 45 days	25.2		
	46 days - 6 months	20.9		
	7 - 12 months	10.8		
	more than 1 year	13.7		
Dependent variables				
Whether or not a client completed MHC				
	successfully completed MHC	64.7		
	failure to complete MHC	31.9		
	outside forces made client leave MHC	3.4		

Bivariate Analysis

Bivariate analysis was used to determine if the relationships between the individual independent variables and the dependent variable were significant. The variables that are significant at the bivariate analysis will be included in the multivariate level of analysis. All of the variables were included in the bivariate analysis (see Table 4). When examining the *offender variables*, the race of a client (0.025, $p \leq 0.05$), the employment status upon entering mental health court (0.085, $p \leq 0.1$), with whom a client resides upon entering mental health court (0.006, $p \leq 0.01$), and the total number of days a client was in mental health court (0.000, $p \leq 0.01$) proved significant.

The two *mental illness variables*, previous mental health diagnosis (0.440) and if client hospitalized for a mental illness in the previous 5 years upon entering MHC (0.723), were not significant at the bivariate level of analysis. This finding was surprising because the expectation was that these variables would be significant. According to these data, previous mental health history does not significantly impact outcome of the mental health court experience.

Table 4

Chi-square values for the independent variables

Independent variables	Chi-Square values	Significance
Offender variables		
Age upon entering MHC	75.955 (df=68)	.238
Years of education completed upon entering MHC	5.792 (df=4)	.215
Race of client	11.126 (df = 4)	.025**
Gender of client	.400 (df=2)	.819
Client's income the year before entering MHC	9.131 (df=8)	.331
Employment status upon entering MHC	8.189 (df = 4)	.085*
Number of children under the age of 18 living with client upon entering MHC	7.838 (df=6)	.250
Has client ever lost custody of children?	4.302 (df = 2)	.116
Martial status upon entering MHC	8.203 (df=6)	.224
Type of residence upon entering MHC	7.487 (df=6)	.278
With whom does the client reside with upon entering MHC?	47.451 (df = 26)	.006***
Total number of days client spent in MHC	51.928 (df = 20)	.000***
Mental illness variables		
Previous mental health diagnosis	5.849 (df=6)	.440
Was client hospitalized for a mental illness in the previous 5 years upon entering MHC?	.649 (df=2)	.723
Substance abuse variables		
Does client admit to drug addiction?	8.235 (df = 4)	.083*
Does client admit to alcohol addiction?	2.396 (df=4)	.663
Has client ever been in drug treatment?	1.961 (df=2)	.375
Number of times client has entered drug treatment	15.278 (df=22)	.850
Does anyone living with client abuse drugs and/or alcohol?	5.031 (df = 2)	.081*
Criminal history variables		
Total number of pending cases	9.466 (df = 6)	.149
Total number of misdemeanor convictions	2.657 (df=6)	.850
Total number of felony convictions	1.343 (df=6)	.969
Total number of violent offenses	6.927 (df = 4)	.140
Has client ever had a failure to appear?	8.065 (df = 2)	.018**
Total number of arrests in the previous 5 years upon entering MHC	12.559 (df = 8)	.128
Total amount of time client spent incarcerated in the past 5 years	18.153 (df = 8)	.020**
$p \leq 0.01$ ***statistically significant at the .01 probability level.		
$p \leq 0.05$ **statistically significant at the .05 probability level.		
$p \leq 0.1$ *statistically significant at the .1 probability level.		

The results in Table 4 also indicate that two of the *substance abuse variables*– the client admitting to drug addiction (0.083, $p \leq 0.1$) and the client living with a person that abuses drugs and/or alcohol (0.081, $p \leq 0.1$) are highly significant. (Those who admit to drug addiction are more likely to complete Mental Health Court successfully. Likewise, the results show that clients who lived with persons who abuses drugs are more likely to complete mental health court successfully.)

In addition, both a history of failure to appear (0.018, $p \leq 0.05$) and the amount of time a client spent incarcerated in the previous five years (0.020, $p \leq 0.05$) proved significant from the *criminal history variables*. The variables total number of pending cases (0.149), total number of violent offenses (0.140), and total number of arrests in the previous five years (0.128) were close to significance. Since these variables are close to significance, they will be included in the logistic regression analysis.

Multivariate Analysis

In the multivariate analysis, logistic regression was used to determine the "best" predictors of success in mental health court. The dependent variable *termination from mental health court* is dichotomous because the two possible outcomes are successful completion or failure. For this analysis, the 3.4 percent of clients that had neither successfully completed nor failed mental health court are excluded.

There are five models estimated at the multivariate level of analysis. The first model examines the *offender variables* only (see Table 5). This analysis includes all of the offender variables that were significant at the bivariate analysis, plus three additional variables – years of education completed, gender of client, and if the client ever lost

custody of children. Years of education completed and the gender of the client were included as basic demographic information. If a client ever lost custody of children (0.116) could show the possibility of commitment to completing mental health court in order to regain custody. However, loss of custody could be related to a loss of hope and subsequently a failure of mental health court. This variable was included since it was close to significance at the bivariate level.

In the first model, both the client's employment status (0.042, $p \leq 0.05$) and if the client ever lost custody of children (0.025, $p \leq 0.05$) are significant. Both of these variables were added to this analysis despite their insignificance at the bivariate level. It is also important to note that the person a client resides with (0.101) is close to significance at the 0.1 level. The Nagelkerke R^2 of 0.19 indicates that the model has very weak explanatory power; it only accounts for 19 percent of the dependent variable – success or failure.

Table 5

Model 1: Logistic regression with offender variables only

Offender variables	B	S.E.	Significance	Exp(B)
Years of education completed upon entering MHC	-0.432	0.331	0.192	0.649
Race of client	-0.614	0.529	0.246	0.541
Gender of client	0.444	0.551	0.420	1.559
Employment status upon entering MHC	-0.659	0.325	0.042**	0.517
Has client ever lost custody of children?	-1.593	0.709	0.025**	0.203
With whom does the client reside upon entering MHC?	0.223	0.136	0.101	1.249
Constant	1.150	1.209	0.341	3.159
Nagelkerke R^2	0.197			
$p \leq 0.01$ ***statistically significant at the .01 probability level.				
$p \leq 0.05$ **statistically significant at the .05 probability level.				
$p \leq 0.1$ *statistically significant at the .1 probability level.				

Model 2 includes the *mental illness variables* only (see Table 6). Neither of the mental illness variables were significant at the bivariate level, but both are used in this analysis. The importance of examining the significance of the type of mental health diagnosis will determine if this mental health court is capable of dealing with all Axis I diagnoses. In addition, if a client was hospitalized for mental illness, the client would have some experience in treatment. Perhaps having previous experience with treatment would make a client more comfortable in the treatment setting of the mental health court. However, the *mental illness variables* continue to be insignificant at the multivariate level indicating that previous mental health experiences have no impact on outcome of mental health court. Further, the Nagelkerke R^2 indicates that model has very little explanatory power in explaining program outcome. According to the Nagelkerke R^2 for this model, mental health variables account for less than five percent in the explanation of the dependent variable.

Table 6

Model 2: Logistic regression with mental illness variables only

Mental illness variables	B	S.E.	Significance	Exp(B)
Previous mental health diagnosis	0.29	0.208	0.163	1.336
Was client ever hospitalized for a mental illness in the previous 5 years upon entering MHC?	0.274	0.446	0.540	1.315
Constant	-1.233	0.439	0.005	0.291
Nagelkerke R^2	0.034			
$p \leq 0.01$ ***statistically significant at the .01 probability level.				
$p \leq 0.05$ **statistically significant at the .05 probability level.				
$p \leq 0.1$ *statistically significant at the .1 probability level.				

Both *substance abuse variables* that were significant at the bivariate analysis were used in Model 3 (see Table 7). This analysis also included the variable if the client has

ever been in drug treatment. Much like the mental illness hospitalization variable in Model 2, if a client was in drug treatment in the past, the client may be more comfortable in the treatment setting of the mental health court. None of the *substance abuse variables* show significance in this multivariate analysis.

Table 7

Model 3: Logistic regression with substance abuse variables only

Substance abuse variables	B	S.E.	Significance	Exp(B)
Does client admit to drug addiction?	0.118	0.35	0.736	1.125
Has client ever been in drug treatment?	0.416	0.540	0.441	1.516
Does anyone living with client abuse drugs and/or alcohol?	1.108	0.802	0.167	3.028
Constant	-1.361	0.579	0.019	0.256
Nagelkerke R^2	0.045			
$p \leq 0.01$ ***statistically significant at the .01 probability level.				
$p \leq 0.05$ **statistically significant at the .05 probability level.				
$p \leq 0.1$ *statistically significant at the .1 probability level.				

Model 4 examines the *criminal history variables* (see Table 8). While three variables were significant at the bivariate level, this analysis includes three addition variables that were close to significant – total number of pending cases (0.149), total number of felony offenses (0.140), and total number of arrest in previous five years (0.128). Surprisingly, the only two variables that are significant are total number of pending cases (0.073, $p \leq 0.1$) and total number of arrests in previous five years (0.067, $p \leq 0.1$). However, the total number of pending cases is almost significant (0.109).

Table 8

Model 4: Logistic regression with criminal history variables only

Criminal history variables	B	S.E.	Significance	Exp(B)
Total number of pending cases	0.613	0.383	0.109	1.845
Total number of violent offenses	-1.604	0.893	0.073*	0.201
Has client ever had a failure to appear?	0.360	0.530	0.497	1.433
Total number of arrests in the previous 5 years upon entering MHC	0.495	0.271	0.067*	1.641
Total amount of time client spent incarcerated in the past 5 years	0.052	0.182	0.774	1.054
Constant	-2.253	0.647	0.000	0.105
Nagelkerke R^2	0.198			
$p \leq 0.01$ ***statistically significant at the .01 probability level.				
$p \leq 0.05$ **statistically significant at the .05 probability level.				
$p \leq 0.1$ *statistically significant at the .1 probability level.				

The last model, Model 5, is a full model in which all of the variables used in the previous 4 models are combined (see Table 9). This model explains 55.6 percent of the variation in the data. Three of the *offender variables* are significant – gender of client (0.035, $p \leq 0.05$), losing custody of children (0.015, $p \leq 0.05$), and with whom a client resides (0.048, $p \leq 0.05$). This is the first analysis in which gender is significant. In fact, females are 11 times more likely to successfully complete mental health court than males. If a client ever lost custody of children, the client was significantly more likely to fail mental health court, perhaps because of a lack in stakes of conformity or, as previously mentioned, a loss of hope.

The *mental illness variables* remain insignificant. Since this is a mental health court study, these results may seem surprising. However, the fact that these variables are not significant shows the ability of the program to serve clients with any Axis I diagnosis, regardless of the type of mental health treatment in the past.

This is the first analysis of the *substance abuse variables* that living with someone that abuses drugs and/or alcohol is not significant. However, clients that admit to drug

addiction (0.022, $p \leq 0.05$) are significantly more likely to complete mental health court. In fact, clients who admit to drug addiction are five times more likely to complete mental health court.

Table 9

Model 5: Logistic regression with all independent variables

Variables	B	S.E.	Significance	Exp(B)
Offender variables				
Years of education completed upon entering MHC	-0.327	0.550	0.553	0.721
Race of client	0.206	0.972	0.832	1.229
Gender of client	2.427	1.150	0.035**	11.327
Employment status upon entering MHC	0.262	0.620	0.672	1.300
Has client ever lost custody of children?	-3.478	1.437	0.015**	0.031
With whom does the client reside upon entering MHC?	0.448	0.227	0.048**	1.565
Total number of days client spent in MHC	0.097	0.214	0.652	1.101
Mental illness variables				
Previous mental health diagnosis	0.937	0.716	0.190	2.553
Was client ever hospitalized for a mental illness in the previous 5 years upon entering MHC?	-0.129	0.916	0.888	0.879
Substance abuse variables				
Does client admit to drug addiction?	1.667	0.728	0.022**	5.294
Has client ever been in drug treatment?	1.495	1.157	0.196	4.459
Does anyone living with client abuse drugs and/or alcohol?	1.663	1.411	0.239	5.276
Criminal history variables				
Total number of pending cases	1.960	0.870	0.024**	7.098
Total number of violent offenses	0.797	1.283	0.535	2.218
Has client ever had a failure to appear?	1.934	1.280	0.131	6.914
Total number of arrests in the previous 5 years upon entering MHC	-0.316	0.575	0.583	0.729
Total amount of time client spent incarcerated in the past 5 years	1.257	0.565	0.026**	3.513
Constant	-12.040	4.787	0.012	0.000
Nagelkerke R^2	0.556			
$p \leq 0.01$ ***statistically significant at the .01 probability level.				
$p \leq 0.05$ **statistically significant at the .05 probability level.				
$p \leq 0.1$ *statistically significant at the .1 probability level.				

The analysis of the *criminal history variables* reveals two significant variables – total number of pending cases (0.024, $p \leq 0.05$) and total amount of time incarcerated in

previous five years (0.026, $p \leq 0.05$). Regarding the variable total number of pending cases, results indicate that as the number of pending cases increase, the probability of success increases by 1.9, and clients with more than one pending case are seven times more likely to be successful. It is no surprise that the total amount of time a client is incarcerated is significant because offenders with mental illness typically have very negative incarceration experiences because of their mental illness (Teplin, 1983). In fact, offenders that have been incarcerated the longest amount of time in the previous five years are over three times more likely to successfully complete mental health court.

CONCLUSION

The purpose of this study was to determine who participates in the Jefferson County Mental Health Court and what factors determine who successfully completes mental health court. By determining significant predictors of success, these factors can be targeted by mental health court to help improve outcomes of specific groups.

The majority of participants in the Jefferson County Mental Health Court are unmarried, unemployed, white males with at least a high school education, a yearly income of less than $5,999, and no children living in the home. Participants are most likely to be suffering from Schizophrenia or Bipolar Disorder and have been hospitalized for their mental illness prior to entering mental health court. An overwhelming majority of participants admit to both drug and alcohol use.

In addition, most participants are not new to the criminal justice system. They have both prior misdemeanor and felony convictions; however, these prior convictions are not from violent crimes. The average number of arrests of participants within the past five years is four, with the majority being incarcerated.

According to the final logistic regression model, which accounts for 55.6 percent of the dependent variable variation, females are significantly more likely to successfully complete mental health court than males. Participants who have never lost custody of their children are more likely to graduate than participants that have ever lost custody. These findings could suggest a more severe mental illness, a mental illness that is harder

to treat, or a willful participant that refuses to comply with treatment. Any of these factors might explain why a participant lost custody of his or her children and why the participant did not graduate mental health court.

Participants who live either with family members or alone are more successful than participants living in any other settings. Family members can offer a support structure to the participant while he or she is completing mental health court in addition to helping the participant follow mental health court rules and requirements.

As mentioned in the demographics, an overwhelming majority of clients admit to drug and alcohol use. However, clients that admit to drug addiction are more likely to successfully complete mental health court. It has been said that admitting to addiction is the first step to recovery. Also, admitting to addiction allows the case managers to better create a treatment plan for the participant to be successful.

The more pending cases a participant has when entering mental health court, the more likely a client will graduate. Also, the more time a participant has spent incarcerated in the previous five years, the more likely it is that the participant will complete mental health court. These two independent variables are related in that a participant with more pending cases and a participant that has spent more time incarcerated have more to lose by not completing mental health court. The stress from overcrowding, accompanied with abuse by other inmates, has a tendency to worsen the symptoms of mental illness, so participants that have been incarcerated probably fear being incarcerated again (Teplin, 1983). In addition, more pending cases can equal more incarceration time if the client does not graduate.

Policy Implications and Future Research

Since women do significantly better in the mental health court than men, case managers could try to determine if there is a difference in treatment models based on gender. An example might be that a community treatment center in which clients are very success is for women only. On the other hand, there might be a treatment facility for men only in which men are not as successful.

Finding a place for clients to live once they are released from jail is hard for case managers. However, since clients living alone or with family do better than clients living in institutional settings or with friends, it is crucial that case managers utilize all resources available to help place the client with family members. This is not always an easy task since there may not be any family in Jefferson County, Alabama, or the family residing within the county may not want the client moving in. However, the clients that are able to live with family have better program outcomes.

There is no "standard operating procedures" for mental health courts to operate. The general framework for mental health court is the drug court model. However, this poses many different options for the structure of mental health courts. As mentioned previously in this study, the Broward County Mental Health Court and the Jefferson County Mental Health Court differ greatly. It remains to be determined which framework will be adopted as a "best practices" model for mental health courts. Further research into the Jefferson County Mental Health Court is crucial, as it is only one of two mental health courts that accept only felony offenders.

This study is a snapshot of the participants of the Jefferson County Mental Health Court from its inception to March, 2006. March, 2006, was chosen as the end date

because the Jefferson County Mental Health Court implemented an aftercare program following the March, 2006, graduation. The aftercare program is expected to bridge the gap between offender supervision under the mental health court program and when offenders are expected to maintain their own mental health treatment within the community outside of the criminal justice system. It would be interesting to compare the clients who completed mental health court prior to March, 2006, with the clients who completed after March, 2006.

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