

Mercyhurst College Civic Institute



ERIE COUNTY TREATMENT COURT Mental Health Court Status Report: Year Three

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The Mental Health Court Approach

Statement of Need

The Bureau of Justice Statistics reports that 16% of state prison inmates, 7% of federal inmates and 16% of those serving time in local jail and probation have either a mental condition or have experienced an inpatient stay in a mental hospital. Additionally, 75% of these offenders have served time in a federal, state or local jail or probation system at least once before. Even more notable, 40% of adults who suffer from a mental illness came in contact with the criminal justice system at least one time before (Berg, 2005). Over time this population began to account for an ever-expanding system workload. To address this growing problem, Congress first authorized the federal Mental Health Courts program as part of legislation passed in the year 2000; these courts were created in response to the large number of severely mentally ill people incarcerated in our nation's jails for non-violent offenses (NAMI, 2001). People with severe mental illness are frequently arrested for minor, non-violent offenses, some as a result of being homeless (NAMI, 2001). They are often incarcerated for these offenses without the option of mental health treatment.

The needs of mentally ill offenders are diverse. Upon release from prison, the inmate frequently does not receive aftercare and thus is recycled back into the criminal justice system (NAMI, 2001). This population often needs treatment not only for mental illnesses, but also for drug or alcohol problems, medical illnesses, family and financial problems. It has been reported that 60% of mentally ill state prison inmates were under the influence of alcohol or drugs at the time of their offense (Berg, 2005). Due to these additional factors, a collaboration of enhanced services is necessary to successfully treat each individual.

Issues Raised by Mental Health Courts

The issues that create the biggest challenge for the operation of Mental Health Courts arise because of the conflict between criminal justice and mental health treatment goals. It is widely acknowledged that criminal justice goals are punitive in nature, while treatment goals are more rehabilitative. For example, the most effective courts identify mentally ill candidates at the earliest stage of processing; this is to ensure that the candidate receives needed medical attention and to initiate the stabilization process (Goldkamp & Irons-Guynn, 2000). The need to quickly identify and assess the conditions of candidates may conflict with the time needed to conduct a thorough clinical assessment, which is required for a reliable diagnosis (Goldkamp & Irons-Guynn, 2000). Another challenge is defining program success. Goal measurement, tracking movement through various phases, and setting achievable milestones in mental health court is more complex than in other specialty courts. Success may differ from individual to individual, and most likely will not follow the court's model (Goldkamp & Irons-Guynn, 2000). Also, the court's range of responses, such as sanctions and rewards, coupled to a participant's behavior, must be wide-ranging. The court must sanction poor behavior in a manner that remains clinically appropriate. Finally, there is the disparity between the large number of mentally ill candidates and the lack of available treatment resources and facilities for the court to place offenders (Goldkamp & Irons-Guynn, 2000).

Common Features of Mental Health Courts

The common features of Mental Health Courts listed below are taken from Goldkamp and Irons-Guynn's (2000) monograph, which examined four Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.

1. **Voluntary:** The defendant must consent to participation before entering the program.
2. **Eligibility Requirement:** Only persons with demonstrable mental illness that was likely to have contributed to their involvement in the criminal justice system are eligible.
3. **Focus on Low-Level, Non-Violent Offenders:** This model places high priority on the public's concerns about safety in arranging for the care of mentally ill offenders in the community.
4. **Early Intervention:** Timely identification of candidates through screening and referral process.
5. **Team Approach:** Reliance on multidisciplinary team of professionals.
6. **Continuing Judicial Supervision:** Periodic review, required hearings, etc.



Erie County Mental Health Court

Introduction

Information contained within this report regarding the structure and operation of the Erie County Mental Health Court was taken from the *Erie County Treatment Court Policy and Procedures Manual*. This manual was developed by the Erie County Court of Common Pleas in March of 2002.

The Erie County Treatment Court was developed to handle cases involving non-violent, seriously mentally ill or drug-abusing offenders. The Treatment Program consists of a Drug Court as well as a Mental Health Court component. The two adult specialty courts, drug and mental health, exist and operate under the umbrella Treatment Court of Erie County.

The Erie County Treatment Court is a collaboration involving the Erie County Court of Common Pleas, Sixth Judicial District; the Erie County Public Defender's Office; the Erie County District Attorney's Office; the Erie County Department of Human Services, Office of Drug and Alcohol Abuse and Office of Mental Health/Mental Retardation; Case Management Support Services; the Erie County Adult Probation/Parole Department; the Erie County Prison; Mercyhurst College Civic Institute; and the Erie Area Drug and Alcohol and Mental Health Treatment Providers.

Funding is provided by the U.S. Department of Justice, Drug Court Program Office; the Pennsylvania Office of Mental Health and Substance Abuse Services; the Pennsylvania Commission on Crime and Delinquency; the Erie County Office of Drug and Alcohol Abuse; and the Erie County Office of Mental Health/Mental Retardation.

As stated in the *Erie County Treatment Court Policy and Procedures Manual* (2002), the Erie County Treatment Court supports and has adopted the 10 Key Treatment Court components as created by the National Association of Drug Court Professionals. These key components include:

1. Treatment Court integrates drug and alcohol, mental health, and other services with Justice System case processing.
2. Using a non-adversarial approach, prosecution and defense counsel to promote public safety while protecting participant's due process rights.
3. Eligible participants are identified early and promptly placed in the Treatment Court Program.
4. Treatment Court provides access to a continuum of alcohol/drug, mental health, and other related treatment and rehabilitative services.
5. Absences monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs Treatment Court responses to participant's compliance.
7. Ongoing judicial interaction with each Treatment Court participant is essential.
8. Monitoring and evaluation to measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective Treatment Court planning, implementation and operation.
10. Developing partnerships among Treatment Courts, public agencies, and community-based organizations generates local support and enhances Treatment Court effectiveness.

Treatment Model

The Erie County Mental Health Court program consists of intensive and comprehensive supervision, case management, and treatment. This holistic approach treats the severe mental illness as the causative factor in the candidate's criminal history. The court model is based on the philosophy of preventing or breaking the cycle of re-offending by untreated mentally ill people. The model offers services and treatment as an alternative for mentally ill offenders through coordination between courts and community services.

The ideal outcomes of the Treatment Court model are reaching the desired population; placing the offenders in the appropriate medical, behavior health, and related services treatment facilities; establishing stability and normalcy in the life of the offender; and continuing comprehensive care support and supervision throughout and after Treatment Court.



Program Eligibility

Eligible candidates for the Erie County Mental Health Court program are adult defendants who are pre-trial detainees or awaiting a preliminary hearing or criminal trial. There must be a strong indication of mental illness in the current offense or history of offenses. Certain offenses disqualify a defendant from admission into Treatment Court, for example, prior firearms convictions; more than two prior felony convictions or a significant history of misdemeanor convictions; or prior convictions, including previous juvenile adjudications, for any violent felonies.

The defendant must not only meet the legal criteria but also the clinical criteria in order to be accepted for admission. All defendants who are to be considered for the Mental Health Court must have a recent diagnosis of a Severe Mental Illness (SMI). These diagnoses may include: Schizophrenia, Bipolar Disorder, Major Depression, Paranoid Schizophrenia, Schizo/Affective Disorder, and Borderline Personality Disorder. All of the above diagnoses are Axis I with the exception of Borderline Personality Disorder, which is an Axis II diagnosis.

Referral & Admission

An essential part in reaching and admitting the most suitable participants for the Mental Health court program is establishing referral sources. The Erie County Treatment Court has developed an ongoing partnership with the Erie County Prison, mental health treatment specialists, and other mental health and criminal justice professionals. These agencies and professionals are not only excellent referral sources, but swift and effective identifiers of seriously mentally ill detainees or prisoners. The Court makes the final decision as to whether the defendant will be admitted into the program.

Status Report

Population Sample

The official start of the first year of funding for Erie County Mental Health Court was January 2002. However, the first offender was not admitted into the program until March 2002. Therefore, the funding period was based on a calendar year adjustment, March 1, 2002 to February 28, 2003. This report covers offenders who participated in the program during the third year of operations, from March 1, 2004 to February 28, 2005.

Criteria for Evaluation

This report is an analysis of the demographic, psychosocial, mental health and drug use patterns of the offenders. Program involvement and progress is studied based on phase progression and length of stay in each phase (description of phases to follow - see page 7). Outcomes of the program will be analyzed to the extent there is a sample of participants who have either graduated or have been revoked from the program.

Methodology

Program data is collected by the Adult Mental Health Probation Officer through intake interviews and information from the participant's treatment providers. Data is continually updated as participants either progress or fail to progress through the programmatic phases. Collected data is periodically sent to the Mercyhurst Civic Institute where it is analyzed and reports are produced on an annual basis.

Program Operations

Requirements

All participants are required to abide by the conditions stated in their individual case management plan, which include the requirements for compliance. In addition, defendants are required to:



1. Participate in a treatment program as often as required by the provider.
2. Report to the Mental Health Court Probation Officer and Case Manager as often as required.
3. Submit to urine samples and/or breathalyzer testing as often as required.
4. Attend the required support groups.
5. Appear in court for progress hearings as required.

Sanctions & Incentives

Offenders who fail to comply with program and treatment requirements are held accountable through sanctions handed down by the court. The use of sanctions emphasizes to the offender the consequences of non-compliance and requires the offender to be accountable for their actions. Sanctions may include a warning by the Judge, increased supervision and treatment, demotion to a previous phase, community service, or fines and/or jail.

In order to reward good behavior, participants are eligible to be entered into a drawing where prizes such as YMCA passes, gift certificates and other incentives are awarded. There is also the incentive of possible decreased supervision and/or treatment requirements, and promotion to the next phase and eventually graduation.

Graduation & Termination

The participants who have complied with their treatment plan and achieve the stated program goals are eligible to graduate. There is a graduation ceremony at which each graduate may speak about their time in the program and the changes that have taken place in their lives. In contrast, offenders who fail to comply with the treatment plan may be revoked from the program. Termination is determined by the Treatment Court Judge, with input from the treatment team.

During the course of the third year, there were 48 offenders who participated. Of these individuals, 40 remained active at the end of the reporting period, and 8 had been revoked from the program. Of the 8 offenders who were revoked during the reporting period, 2 had progressed to Phase II before being revoked. There were 10 individuals who graduated from the program.

Figure 1:

N = 48	#	% of Total	who were . . .
<i>Number Active at Conclusion</i>	40	83%	active as of 3/1/05.
<i>Number Revoked</i>	8	17%	revoked between March 1, 2004 and February 28, 2005.
<i>at phase I</i>	6	13%	revoked at phase I.
<i>at phase II</i>	2	4%	revoked at phase II.
<i>Number Graduated during Y3</i>	10	21%	graduated from the program.

Phase Movement

The expected length of the mental health court program is a minimum of twelve months. Length of program involvement depends on an individual's criminal offense, participation, and progress in each treatment phase. The Erie County Treatment Court Program consists of three phases. In the cases of mental health participants, there is extra emphasis on following the individual's treatment/medication plan. In order to move to the next phase of treatment, certain requirements must be met. It is then up to the Judge, considering recommendations from the case manager, whether or not the individual progresses to the next phase. Program goals, treatment methods, and court supervision during each of the three Mental Health Court phases are described on the next page.



Phase I: Targeted Average Duration - 2 To 3 Months

Goals: Discontinue use of drugs, stabilize physical health, begin job interview process and secure employment.
 Methods: Urinalysis two times per week, psychosocial and physical assessment, individual and group therapy, support groups, job and educational assessment, payment of current court fees and fines.
 Court: Progress hearings weekly with possible sanctions for non compliance.

Phase II: Targeted Average Duration - 3 To 6 Months

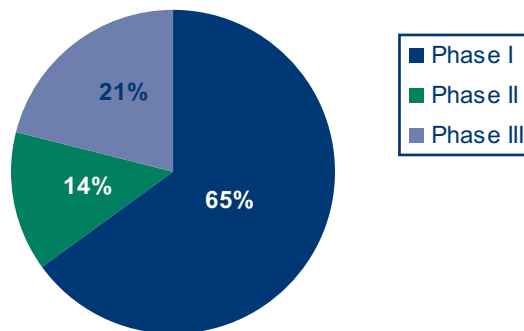
Goals: Remain drug free, maintain employment, and begin GED education if needed.
 Methods: Urinalysis two times per week, continued group and individual counseling, update treatment plan, needs assessment, support groups and payment of current court fees and fines.
 Court: Progress hearing bi-weekly with possible sanctions for non compliance.

Phase III: Targeted Average Duration - 3 To 5 Months

Goals: Remain drug free, secure GED or higher, accept drug free lifestyle.
 Methods: Urinalysis two times per week, continued group and individual counseling, update treatment plan, needs assessment, support groups and payment of current court fees and fines.
 Court: Progress hearing monthly with possible sanctions for non compliance.

At the end of the third year of Mental Health Court operations, 65% of the offenders were in Phase I, while 14% had progressed into Phase II and 21% had progressed into Phase III (Figure 2).

Figure 2: Offenders by Program Phase



The offenders also spent various lengths of time in each phase. Figure 3 below illustrates that those who are in Phase I have spent on average the most amount of time in that program (319 days). Current Phase II participants spent an average of 198 days in Phase I before being promoted, and have spent an average of 160 days in Phase II. The shortest time spent in any phase by any group was Phase III participants in Phase III (148 days).

Figure 3:

Current	Spent an average of ___ days in:		
	Phase I	Phase II	Phase III
Phase I participants	319		
Phase II participants	198	160	
Phase III participants	230	213	148

Population Profile

Demographics

Basic demographic information collected from offenders is depicted in the following figures. As Figure 4 indicates, more men than women participated in the program (58% versus 42%, respectively) during the reporting period. Shown in Figure 5, the largest racial group was Caucasian (81%), while Hispanic made up the smallest (2%). Sixteen (33% of participants) were between the ages of 26 and 35 (Figure 6).



Figure 4: Offenders by Gender

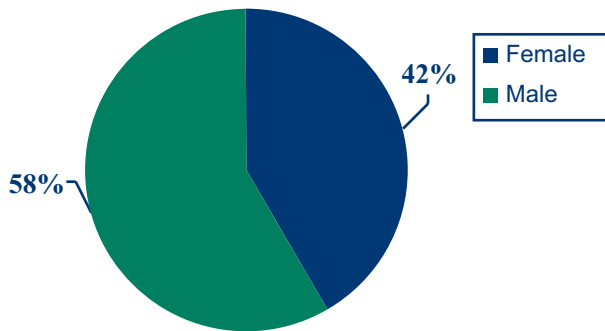


Figure 5: Offenders by Ethnicity

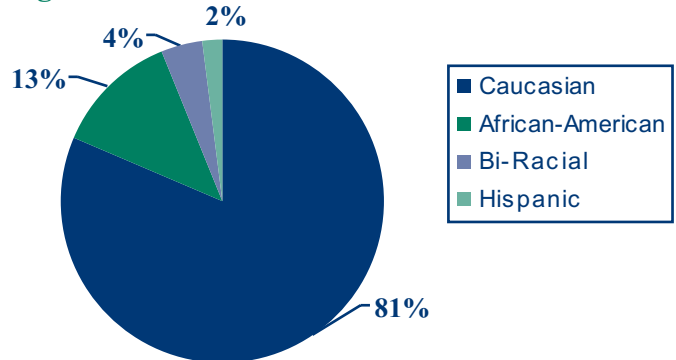
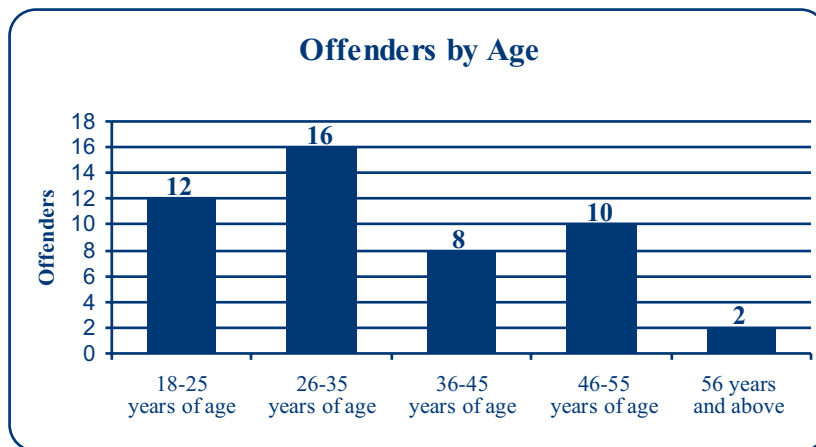


Figure 6:



Psychosocial

Areas of psychosocial evaluation included the education level, living situation, and marital status of program participants. Concerning the highest educational level obtained by participants, well over half (67%) obtained either a high school diploma or GED (Figure 7). Twenty-one percent of the program participants had not obtained a high school diploma by the end of the reporting period. Only 13% had obtained at least some post-secondary education.

Figure 7:

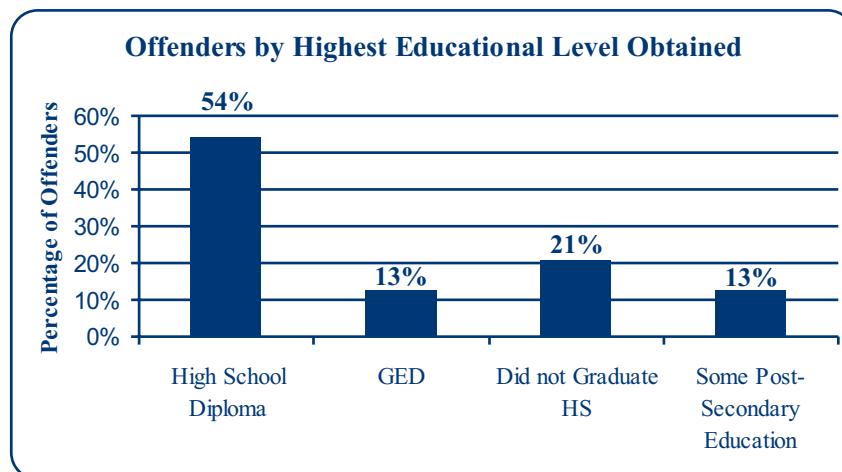




Figure 8:

In terms of participant residency, 44% reported living alone, while 18% reported both living with someone or treatment program (Figure 8). A smaller percentage of participants were either being detained in the Erie County Prison or residing in a housing facility (4% each).

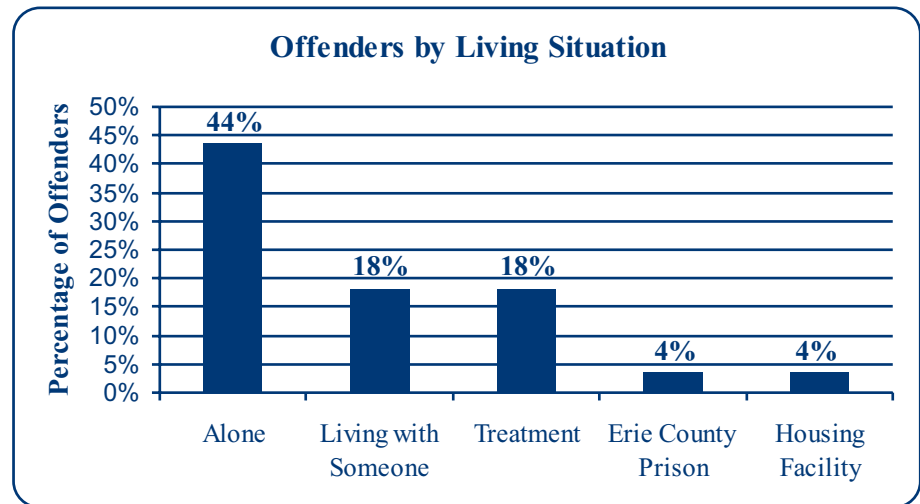
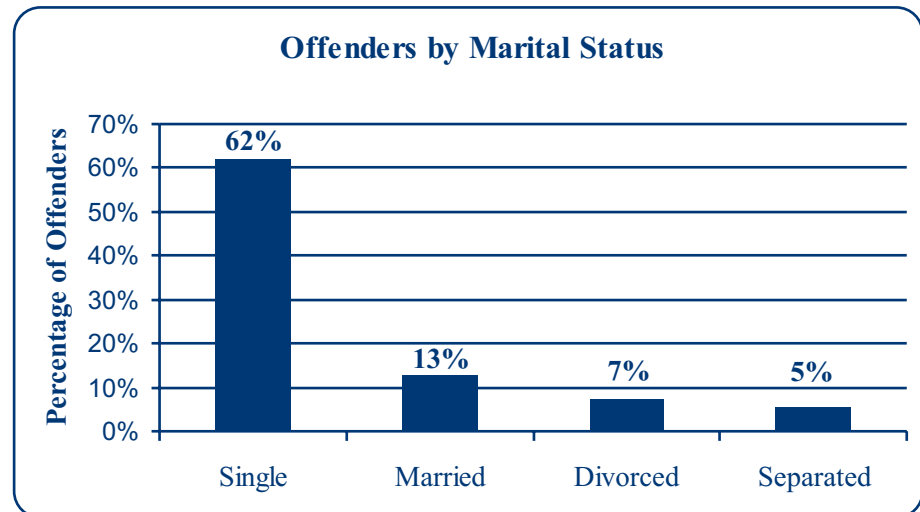


Figure 9:

As shown in Figure 9, more than half (62%) of program participants were single. Thirteen percent reported being married, and a nearly equal percentage indicated that they were either divorced (7%) or separated (5%).



Single participants also had the most children of any marital group. Figure 10 notes that this group cares for 28 children, or 54% of the total population of children involved. However, an additional 12 children are products of divorced or separated arrangements. Therefore, a total of 40 of the 51 children (78%) do not have two biological parents in the household.

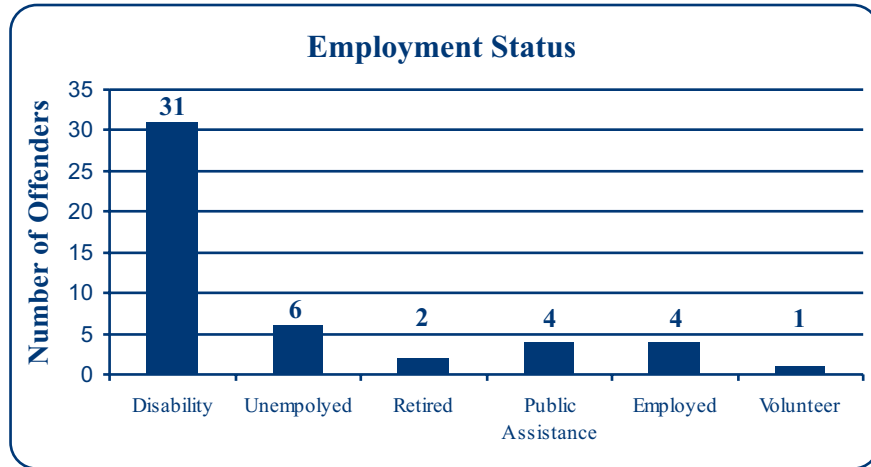
Figure 10:

Marital Status who have	0 Children	1 Child	2 Children	3 Children	5 Children	TOTAL # CHILDREN
Single	17	12	1	3	1	28
Married	2	2	2	0	1	11
Divorced	0	3	1	0	0	5
Separated	0	0	2	1	0	7
TOTAL # CHILDREN	0	17	12	12	10	51



In terms of working, an overwhelming majority (92%) are not employed. Only 4 of 48 participants work. Figure 11 demonstrates the categorization of participant employment status. The largest group of participants were on disability.

Figure 11:



Treatment History

A majority of mental health court participants had received prior mental health treatment. Nearly half of the offenders (42%) had a severe mental illness (SMI) diagnosis of Major Depression (Figure 12). Another frequently diagnosed mental illness was Bipolar Disorder. Diagnoses that occurred to a lesser degree included Schizophrenia, Paranoid Schizophrenia, and Affective Schizophrenia. The participants received either outpatient or inpatient treatment at a number of facilities. Treatment can be on a group, family, or individual basis, and may involve therapy, medication, health care, and treatment for drug and alcohol abuse. See Figure 13 below for a full allotment of where program participants received treatment.

Figure 12: Offenders by SMI Diagnosis

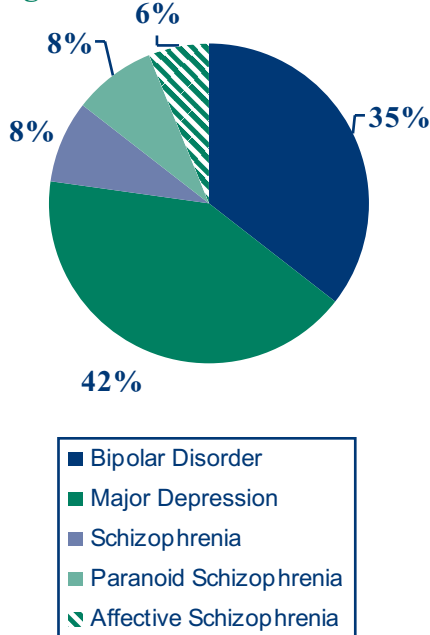


Figure 13:

Treatment Center	# receiving treatment
Stairways Behavioral Health	30
Hamot Medical Center	5
Millcreek Community Hospital	2
Safe Harbor (Community Integration, Inc.)	2
Saint Vincent Health Center	1
Deerfield	1
Corry Memorial Hospital	1
Glenbeigh	1
VA Hospital	1
Horizon	1
Other	3



Drug/Alcohol Use & Criminal History

While the vast majority of offenders did not enter into the program on a drug related charge, most participants identified drug abuse as being a variable in their criminal history. A majority of participants identified marijuana as their drug of choice (27%), followed by alcohol (25%) illustrated in Figure 14. However, 23% of the offenders claimed no drug use. A small percentage (8%) of participants had drug abuse problems involving cocaine, or all drugs.

Figure 14:

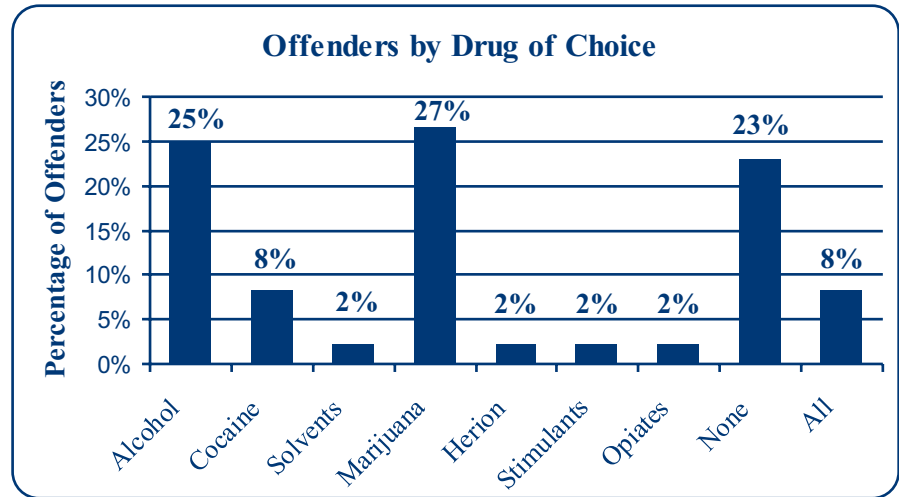


Figure 15 below demonstrates other age data. The offenders that did identify themselves as having a drug abuse problem began using drugs or alcohol at a young age. The minimum age at which drug use began was 13 years old, with 16 years being the median age of beginning drug use. The average current age of participants is 35.8 years old, the youngest being 18, the oldest being 63. Currently, the average stay in the program is 36.3 months; the shortest being 18 months, and the longest at 63 months.

Figure 15:

	Age Began Using	Current Age	Months In Program
Mean	16	35.8	36.3
Minimum	13	18	18
Maximum	23	63	63

In addition to their drug abuse, participants also have a criminal charge against them. Below in Figure 16, it is noted that over half of participants (26 of 48) have one of three charges against them: theft/retail theft, DUI, or assault/simple assault. The other 22 participants had widely varying charges. In fact, there were 15 charges among these 22, including burglary, resisting arrest, harassment and sex crimes, among others.

Figure 16:

Charge	# with charge	Charge	# with charge
Theft/Retail Theft	12	Sex Crimes	1
DUI	8	Corruption of Minors	1
Assault/Simple Assault	6	Bad Checks	1
Endangering a Child	3	Harassment	1
Burglary	2	Solvents	1
Defiant Trespass	2	Criminal Attempt	1
Arson	2	Habitual Offender	1
Resisting Arrest	2	Receiving Stolen Property	1
Terroristic Threats	2	Firearms	1



Conclusions

In order to ensure the continuing operation and success of the Erie County Mental Health Court, further analysis of program outcomes will be necessary. A larger sample size, as well as an analysis of future participants who graduate from the program versus those who are revoked, will provide a more accurate profile of success or failure. Long-term, trends could also be noted in terms of *why and when* individuals are being revoked (possible identification of stumbling blocks) so program administrators could better prepare for more difficult times. Additionally, post-program follow-up would be beneficial to measure the lasting effects of the program, especially for recidivism and relapse rates.

Data collected during the third year of program operations suggests that the estimated time that participants are expected to spend in Phase I is not consistent with the actual amount of time needed by most participants to complete the goals of this phase. Phase I seems to be the make or break portion of the program, which suggests that the ability to adjust to a new way of living proves to be difficult for many program participants. However, once this phase is completed, time spent in the following phases has a tendency to decrease. The number of program participants who are revoked decreases as well with the graduation to next phases. Though the time-frame goals to complete each phase outlined in the program guidelines are not being met, the 'flexibility' of allowing people as much time as needed seems to be beneficial in allowing the participants to complete the program.

Further conclusions based on the data show that employment is extremely low amongst the participants. With only four of the individuals holding jobs, it could be hypothesized that the lack of employment could lead to low self-esteem and worth issues, further complicating participants' mental health issues and leading them down the path of choosing to use drugs. In terms of employment, the number of children in single households is overwhelming. Take into cumulation these three factors (employment, children, drug-use), it is apparent that the problems being faced by individuals are widely felt. Without strong parental role-models, many of the participant's children may fall into the cycle. Further examination of children in the future could provide important information regarding how mental health issues affect future generations.

Though still in the early stages of development, and even with the issues being raised by its critics, the implementation of mental health courts have helped to deal with a vulnerable population in a more effective, costly method. With all the benefits that have been noted, perhaps one that many overlook is this: The establishment of mental health courts has resulted in a positive unintended outcome in many communities that have implemented them. The coalitions of diverse partners that often formed to create these courts have remained together in many cases to work on other issues and lobby for increased resources (Pettila, Poythress, McGahan, & Boothroyd, 2001). These continued efforts indicate that not only are the immediate clients served well by the mental health court system, but the community as a whole benefits as well.

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