

Mercyhurst College Civic Institute



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

December 2007

Mercyhurst Civic Institute

Kristen Burillo, MA
Research Analyst

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This report was prepared by the Mercyhurst College Civic Institute and can be accessed at:
www.civicinstitute.org or by calling Shelley Thayer at (814) 824-2327.

Funding for the Mercyhurst College Civic Institute comes from a variety of public and private sources including the Pennsylvania Department of Public Welfare, the Pennsylvania Commission on Crime and Delinquency, The Erie Community Foundation, the Erie County Department of Human Services, Private Donors and Mercyhurst College.

The Mental Health Court Approach

Statement of Need

People with severe mental illness are frequently arrested for minor, non-violent offenses, and are often incarcerated for these offenses without the option of mental health treatment. (NAMI, 2001). The Bureau of Justice Statistics reports that 49% of state prison inmates, 40% of federal inmates, and 60% of local jail populations endorsed symptoms consistent with a mental disorder. Nearly a quarter of state prison inmates, 14% of federal prison inmates, and 21% of local jail populations have a recent history of identified mental problems. A recent history was defined as having a clinical diagnosis or treatment by a mental health professional in the year before arrest or since admission (James & Glaze, 2006). Statistics indicate that inmates with mental illness are often repeat offenders; about a quarter of the inmates with a mental problem had been incarcerated on a least three prior occasions (James and Glaze, 2006). Other reports indicate that 75% of offenders have served time in a federal, state, or local jail or a probation system at least once before. Even more notable, 40% of adults who suffer from a mental illness come in contact with the criminal justice system at least once in their lifetime (Berg, 2005).

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 concerns, family problems, and financial difficulties. Due to these additional factors, a collaboration of enhanced services is necessary to successfully treat each individual. To address the increased number of mentally ill offenders and their wide range of needs, Congress authorized the federal Mental Health Courts program as part of legislation passed in the year 2000 (NAMI, 2001). Mental Health Courts provide community treatment and supervision as opposed to incarceration in an attempt to treat the underlying cause of the crime.

Common Features of Mental Health Courts

The common features of Mental Health Courts listed below are taken from Goldkamp and Irons-Guynn's monograph (2000), which examined 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:** The 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.

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. Another problem arises when one considers the timeline for identifying issues and making treatment decisions. 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. The need to quickly identify and assess the conditions of candidates, however, may conflict with the time needed to conduct a thorough clinical assessment and establish a reliable diagnosis (Goldkamp & Irons-Guynn, 2000). An additional 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). The court's range of responses, such as sanctions and rewards, coupled to a participant's behavior must therefore 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 treatment resources and facilities available for the court to place offenders (Goldkamp and Irons-Guynn, 2000).

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* which 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 in 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; Erie County Department of Human Services, Office of Drug and Alcohol Abuse and Office of Mental Health/Mental Retardation; Case Management Support Services; 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 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 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 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 breaking the cycle of re-offending by untreated mentally ill people. Through coordination between courts and community services, the model offers services and treatment as an alternative for mentally ill offenders.

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 following 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, Schizoaffective Disorder, Psychotic Disorder Not Otherwise Specified (NOS), Mood Disorder Not Otherwise Specified (NOS), or 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 and 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 are not only excellent referral sources, but swift and effective identifiers of seriously mentally ill detainees or prisoners. The Court, however, 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. The funding period was therefore based on a calendar year adjustment of March 1, 2002 to February 28, 2003. This report covers offenders who participated in the program during the fifth year of operations, from July 2006 through June 2007.

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. 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 his or her actions. Sanctions may include a warning by the Judge, increased supervision and treatment, demotion to a previous phase, community service, fines, and/or jail.

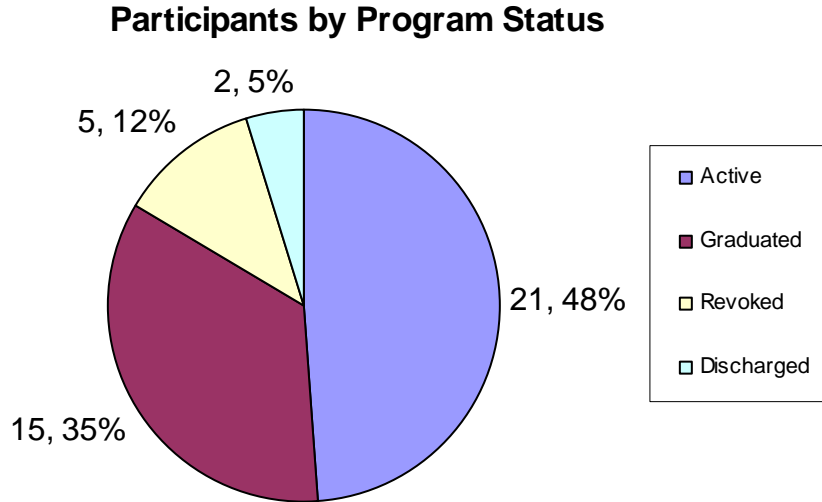
In order to reward good behavior, certain incentives may be granted by the Judge. These include verbal appraisal and acknowledgement in court, advancement to the next phase of the program, YMCA passes, gift certificates, decreased supervision, or decreased treatment requirements.

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. With input from the treatment team, the Treatment Court Judge determines termination. It is also possible for a participant to be discharged from the program due to a lack of program fit with his or her needs.

During the course of the fifth year, there were 43 offenders who participated. Of these individuals, 21 remained active at the end of the reporting period whereas five were revoked from the program. Of the five offenders who were revoked during the reporting period, two had progressed to Phase II before being revoked. There were 15 individuals who graduated from the program during this reporting period. Additionally, two offenders were discharged from the program (Figure 1).

Figure 1:



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; certain requirements must be met in order to move onto the next phase. When making a decision about phase progression for an individual, the Judge takes into consideration recommendations from the case manager. Program goals, treatment methods, and court supervision during each of the three Mental Health Court phases are described below.

Phase I: Targeted Average Duration - 2 To 3 Months

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

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 noncompliance.

Phase III: Targeted Average Duration - 3 To 5 Months

- Goals: Remain drug free, secure GED or higher, accept drug free lifestyle.

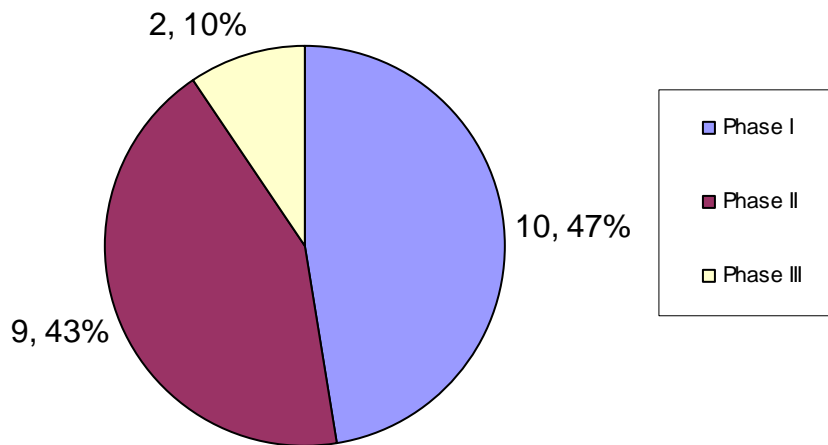
Methods: Urinalysis two times per week, continued group and individual counseling, update treatment plan, needs assessment, support groups and payment of current court fees and fines.

Court: Progress hearing monthly with possible sanctions for noncompliance.

At the end of the fifth year of Mental Health Court operations, 21 offenders (48%) were still active in the program. Of these offenders, 47% remained in Phase I, while 43% had progressed into Phase II and 10% had progressed into Phase III (Figure 2).

Figure 2:

Participants Active in the Program by Phase



The offenders also spent various lengths of time in each phase. Figure 3 below illustrates the average number of days, as well as the minimum and maximum number of days, that individuals spent in each phase. On average, participants who remain active in Phase I have spent more time in that phase (318 days) compared to individuals who have moved onto other phases. The average amount of time it took for individuals to complete a phase was 232 days for phase I (n = 26), 242 days for phase II (n = 17), and 224 days for phase III (n = 14).

Figure 3:

	Mean, (Min, Max) Days in..			
	Phase I	Phase 2	Phase 3	Total
Current Phase I Participants	318, (10, 1635)			
Current Phase II Participants	247, (140, 455)	318, (24, 835)		
Current Phase III Participants	156, (134, 177)	232, (197, 266)	328, (65, 591)	
Graduates	233, (113, 542)	244, (63, 834)	224, (98, 413)	656, (463, 1151)
Completed Phase	232	242	224	

Population Profile

Demographics

Basic demographic information collected from offenders is depicted in the figures below. As Figure 4 indicates, more men (56%) than women (44%) participated during the reporting period. Shown in Figure 5, the largest racial group was Caucasian (53%), while Native American was the smallest group (5%). Participants were likely to be either between the ages of 26-35 (n =12), 36-45 (n = 10), or 46-55 (n = 10). Only three of the program participants were 56 years of age or older, while eight were 25 years of age or younger (Figure 6).

Figure 4:

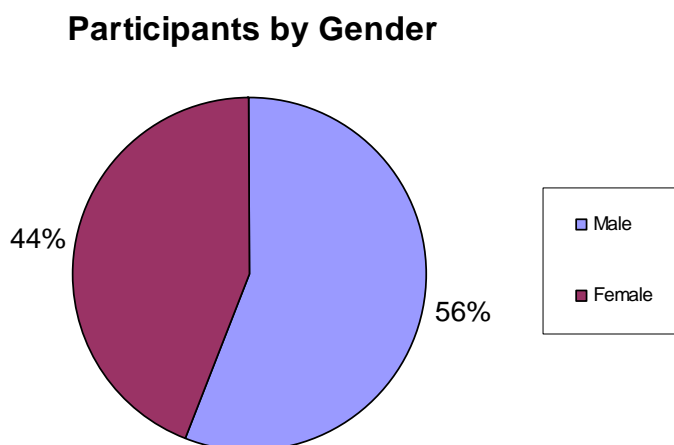


Figure 5:

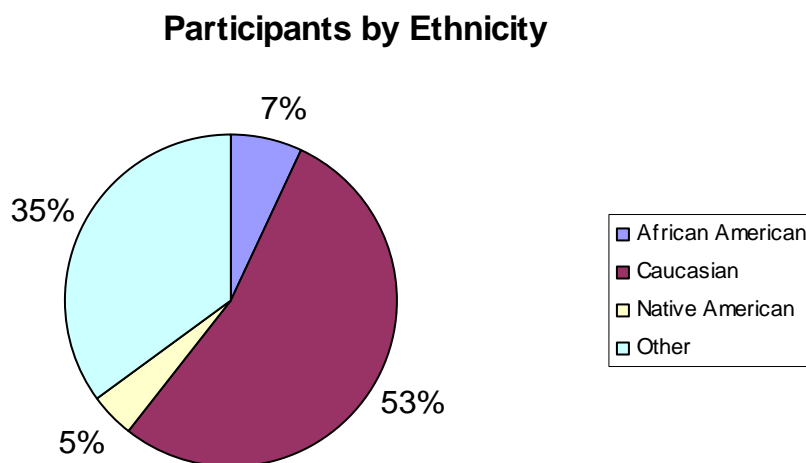
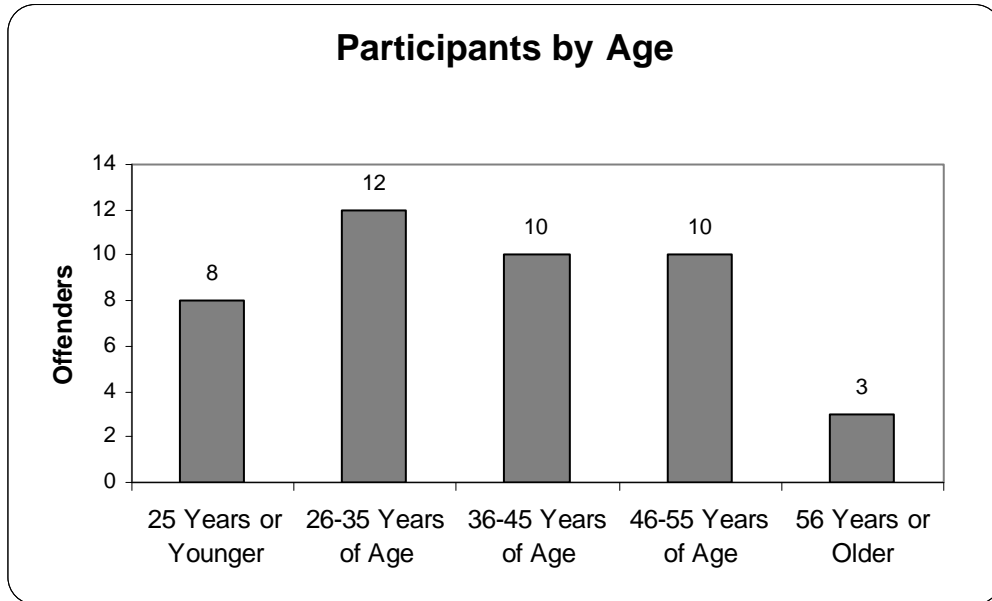


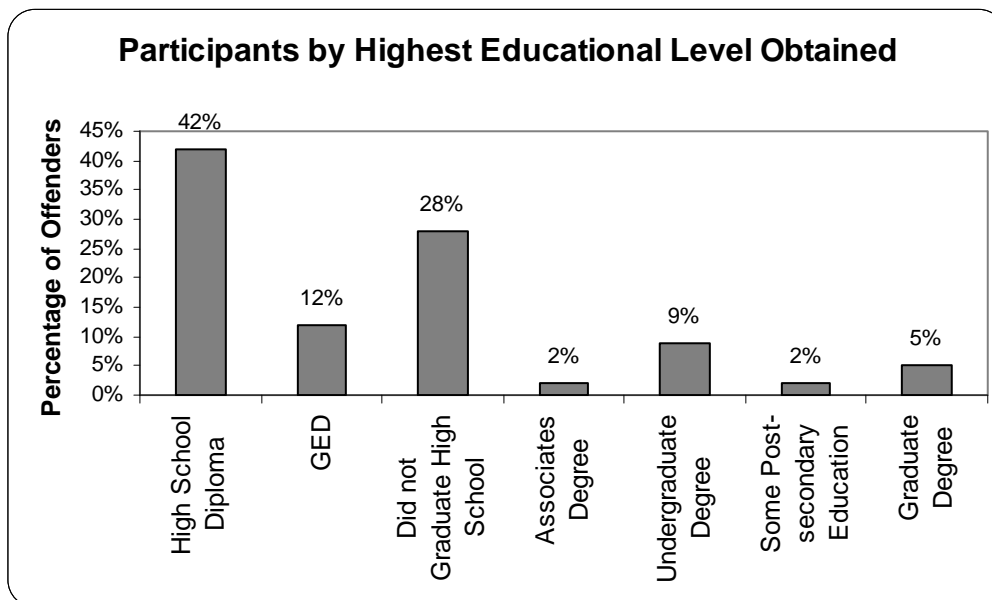
Figure 6:



Psychosocial

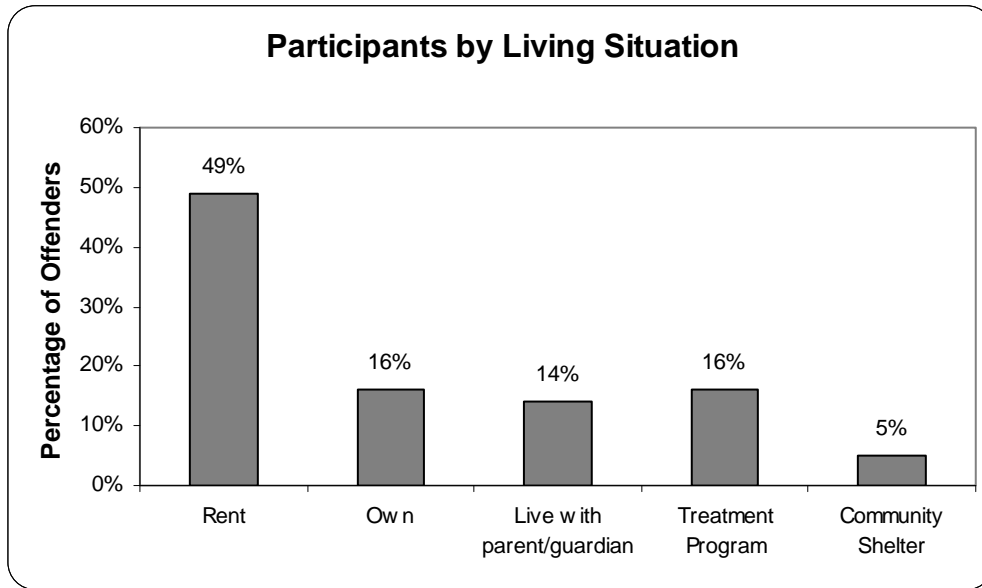
Areas of psychosocial evaluation included the education level, living situation, and marital status of program participants. Concerning the highest educational level obtained by participants, nearly three-quarters of participants obtained at least a high school diploma or GED (Figure 7). Twenty-eight percent of the program participants had not obtained a high school diploma by the end of the reporting period. Only 18% had pursued some level of education beyond high school.

Figure 7:



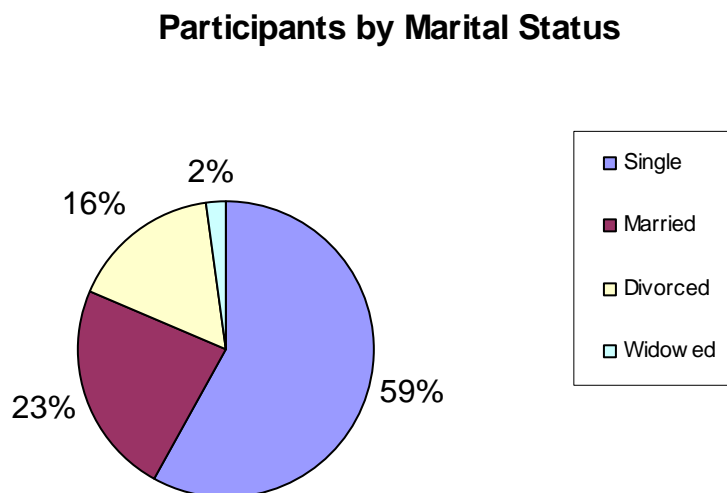
In terms of participant residency (Figure 8), most participants (49%) reported renting, while 16% reported living in a treatment program, 14% reported living with a parent or guardian, 16% reported owning their property, and 5% reported living in a community shelter.

Figure 8:



As shown in Figure 9, more than half (59%) of program participants were single. Twenty-three percent reported being married, 16% reported being divorced, and 2% reported being widowed.

Figure 9:



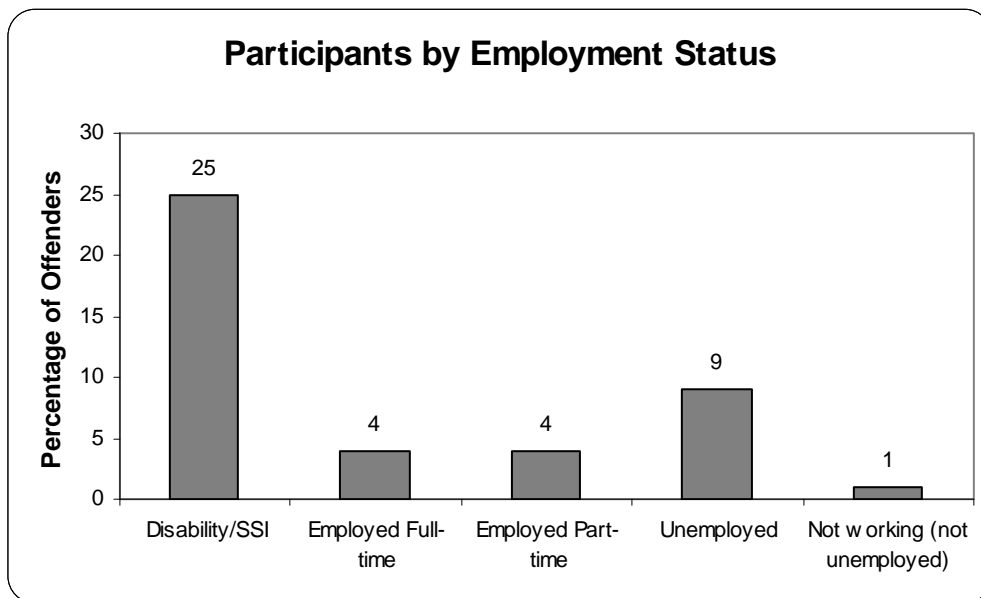
As shown in Figure 10, The majority of single men and women in the program did not have any children; however, five single participants did account for seven of the total children. The biggest proportion of children came from the married participants; the ten participants in this category accounted for about half of the children. The other half of the children, therefore, came from homes that do not have two biological parents in the household.

Figure 10:

	0 Children	1 Child	2 Children	3 Children	4 Children	Total # Children
Single	20	3	2	0	0	7
Married	0	2	5	2	1	22
Divorced	0	3	3	0	1	13
Widowed	0	1	0	0	0	1
Total # Children	0	9	20	6	8	43

An overwhelming majority (81%) of this year’s participants are not employed. Only four work full-time and another four work part-time. The largest group of participants was on disability. Figure 11 illustrates the categorization of participant employment status.

Figure 11:



Treatment History

A severe mental illness (SMI) diagnosis is a requirement for program eligibility. The majority of the offenders (43%) had a diagnosis of Major Depression (Figure 12). Other frequently diagnosed mental illnesses were Schizophrenia (26%) and Bipolar Disorder (21%). Diagnoses that occurred to a lesser degree included Schizoaffective Disorder and Borderline Personality Disorder. The majority of participants had received prior mental health treatment (Figure 13). Treatment can be on a group, family, or individual basis and may address counseling, medication, or drug and alcohol abuse. Please note that some participants received services with more than one agency.

Figure 12:

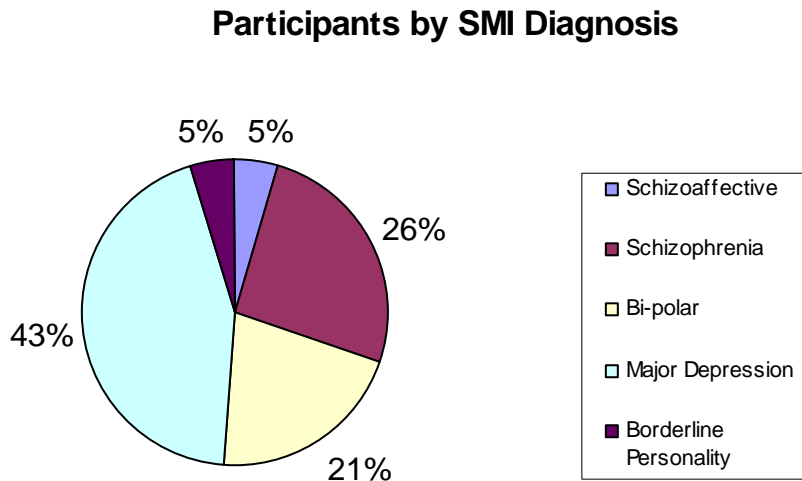


Figure 13:

Treatment Center	# Receiving Treatment
Stairways Behavioral Health	40
Deerfield	5
Gaudenzia	2
Private Practice	2
Safe Harbor	1
Cove Forge	1
Millcreek Community Hospital	1
Community House	1
Other	2

Criminal History & Drug/Alcohol Use

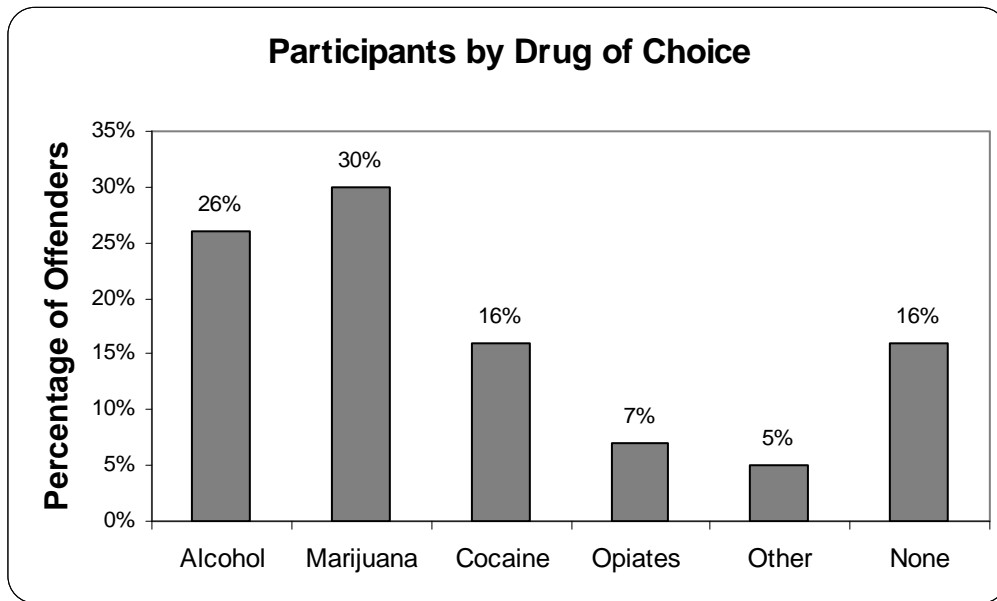
As shown in Figure 14, program participants have faced a wide range of criminal charges against them. The most common charges, which account for nearly half of the participants, were retail theft, theft, aggravated assault, or DUI.

Figure 14:

Charge	# with Charge
Retail Theft	8
Theft	5
Aggravated Assault	4
DUI	4
Criminal Trespassing	2
Resisting Arrest	2
Bad Checks	1
Burglary	1
Disorderly Conduct	1
Driving Violation	1
Endangering the Welfare of a Child	1
False Reports	1
Harassment	1
Identity Theft	1
Illegal Firearms	1
Impersonating Law Enforcement	1
Reckless Endangerment	1
Risking a Catastrophe	1
RSP, Possession of Marijuana, Criminal Mischief	1
Simple Assault	1
Stalking	1
Terroristic Threats	1
Unauthorized Use of a Motor Vehicle	1
Violation Drug, Device	1

While the vast majority of offenders (84%) did not enter into the program on a drug related charge, most participants identified drug abuse as being a part of their history (Figure 15). Many participants identified marijuana as their drug of choice (30%), with alcohol also being a popular choice (26%). 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 12 years old, with 15.5 years being the median age of first drug use.

Figure 15:



Conclusions

As the fifth year of the Erie County Mental Health Treatment Court concluded, the data suggests that many individuals have benefited from the provided services. Many of those in need of treatment, medical assistance, supervision, and life-skill development were able to receive assistance in their reintegration with their families and society. During this reporting period, fifteen people successfully graduated from the program while only five participants were revoked and two were discharged without achieving program completion.

Similar to past years, data collected during the fifth year of program operations suggests that the estimated time that participants are expected to spend in each phase is not consistent with the actual amount of time needed by most participants to complete the goals of the phase. The average amount of time it took for a participant to complete Phase I was nearly eight months as opposed to the expected two to three months. Similarly, it took the average participant just over eight months to complete Phase II rather than the expected three to six month time frame. Phase II was completed within an average of seven and a half months, which was longer than the proposed three to five months. Ongoing success of participants requires Treatment Court administrators to continue allowing participants to not be 'locked in' to a time frame for completion.

The data suggests that those individuals who are making progress through the phases are able to do so, albeit at a slower pace than first estimated; however, participants that are still active in the program seem to be having difficulty making it past Phase I and somewhat past Phase II. Those participants who have moved onto Phase III during this fifth year spent considerably less time in Phase I and Phase II than those participants who are still active in Phase I or II. Similarly, graduates of the program generally spent less time in Phase I and II than current active members of those phases. Phase I, in which the majority of significant lifestyle changes usually occur, requires a lot of dedication on behalf of the participants. Participants may struggle with the goals of this phase, and as the data suggest, may not be able to reach the goals very easily or at all. Sixty percent of the revoked participants did not complete Phase I.

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