

# **Process Evaluation of Baltimore City Mental Health Court**



**Maryland Judiciary Research Consortium**

**Maryland Judiciary,  
Administrative Office of the Courts**

March 2010

# **Process Evaluation of Baltimore City Mental Health Court**

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Division of Parole and Probation  
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## **THE MARYLAND JUDICIARY RESEARCH CONSORTIUM**

This report is a product of the Maryland Judiciary Research Consortium (MJRC). The Consortium comprises units of Maryland's public universities, which collaborate under memoranda of understanding with the Maryland Judiciary, Administrative Office of the Courts. The institution responsible for the production of the current report, Morgan State University, School of Community Health and Policy, is a member of MJRC. The contact representative for the Consortium is C. David Crumpton, Administrative Office of the Courts, Court Research and Development Department. He can be reached at 410-260-1274 and [david.crumpton@mdcourts.gov](mailto:david.crumpton@mdcourts.gov).

## **Executive Summary**

The study presented in this report represents the initial application of a new methodological framework in a process evaluation of the Baltimore City Mental Health Court. This study of the Baltimore City Mental Health Court parallels a process evaluation of the Harford County Mental Health Diversion Program using the same methodological approach. Development of the process evaluation methodology by the Maryland Judiciary Research Consortium (MJRC) and the evaluations in Baltimore City and Harford County were funded by the Governor's Office of Crime Control and Prevention (GOCCP) and the Maryland Judiciary, Administrative Office of the Courts. These parallel current studies offer researchers and the Administrative Office of the Courts an opportunity to test and improve the methodology. The methodology consists of applying a systems and organizational perspective to the court evaluation process.

This process evaluation study of the Baltimore City Mental Health Court (BCMHC) was designed to meet the following purposes: (1) identify and describe the policies and procedures that govern the operation of BCMHC, (2) describe the interagency and collaborative linkages and resources that support the implementation of the mental health court in Baltimore City; (3) identify the methods and types of data that are collected by the various participating and supporting agencies involved in BCMHC, and (4) assess the extent to which BCMHC provides the intended intervention to its target population. The methods utilized for this study included (1) collecting and examining archival data and documents in the public domain on the Baltimore City Mental Health Court and the various agencies involved in the development and implementation of the court, (2) reviewing meeting minutes of the committees involved in the planning and operation of the BCMHC, as well as minutes of Maryland's Mental Health

Oversight Committee and its precursor entity; (3) surveying representatives from stakeholder agencies and organizations; and (4) conducting interviews with key informants representing stakeholder organizations who had specific knowledge of BCMHC's development and operations. The research involved the collection of qualitative data and quantitative measures. Qualitative data were sought upon which the context of the court's development and operation might be accurately portrayed. Sources of quantitative data were sought that would provide measures of the court's level of effort (i.e., service provision).

A review of the context within which BCMHC developed reveals that a significant portion of the individuals who were, or had been, processed through the criminal justice system had some form of mental illness. It was within this milieu that interested individuals, organizations and agencies impacted by this phenomenon began to meet, exploring strategies to coordinate efforts that would address this issue. Although a number of factors serve as the catalyst for the development of the mental health court in Baltimore City and a number of agencies were involved, ultimately an individual judge, the Honorable Charlotte Cooksey, provided the impetus for the creation of BCMHC and the development of its current operating procedures.

BCMHC serves as a mediating agent to assist offenders with mental illness in gaining access to needed programs and services. It operates in a collaborative team like manner with various agencies and entities involved in the process inclusive of representatives from the Office of State's Attorney, Office of the Public Defender, Department of Public Safety and Correctional Services, the Mental Hygiene Administration, Developmental Disabilities Administration, and Alcohol and Drug Abuse Administration of the Department of Health and Mental Hygiene, and

Baltimore Mental Health Systems. The court-based mental health intervention program in Baltimore was not designed to meet the needs of all defendants with mental health conditions. Only a select sub-population of offenders with mental illness is eligible to participate in BCMHC. Defendants must be eligible for services from the public mental health system, be at least 18 years of age and meet clinical and criminal charge criteria to be accepted into BCMHC. The defendant must have Axis I serious mental illnesses and/or trauma-related disorders and be charged with misdemeanors or felonies within the jurisdiction of the District Court (except domestic violence related offenses) and have never been convicted of a serious crime, such as rape, abduction, or murder. Two types of cases are heard in BCMHC: all cases in which an assessment of competency to stand trial has been ordered and cases of eligible persons who voluntarily agree to participate in BCMHC. BCMHC still functions as a court under the authority of the judge. However, there are notable differences in the manner in which the court oversees cases. The central difference between BCMHC and “business as usual” court settings is largely seen in the specialized and intense nature of the court’s oversight of cases and its collaboration with other public agencies to adjudicate and monitor those cases. This team approach with a focus on treatment and support services are among the essential elements distinguishing mental health courts (Council of State Governments Justice Center, 2007).

Research has shown that in efforts requiring a significant amount of collaboration, one of the factors predictive of success is the extent to which respective goals of the collaborating entities are congruent with the goals of the collaboration. The potential for success will be further strengthened if individual collaborating entities perceive that their distinct goals and objectives are considered in the mission of the collaborative effort (Wolff, 2001). Applying these criteria,

the qualitative evidence gathered in this study indicates that BCMHC possesses important building blocks for success yet faces a number of challenges. One such challenge lies in the nature of the collaborative effort that supports the operation of the court. The successful operation of BCMHC is highly dependent upon the support and participation of source organizations that provide clinical assessments, monitoring and supervision and actual clinical services.

Other related organizational challenges may also impact stability. The collection of performance and outcome data is a critical element in the implementation and sustainability of a mental health court program. Indicators of sustainability include having formal policies and procedures, long term funding or a funding plan, an operations plan to address staff turnover, an effective management information system and a community outreach strategy (Council of State Governments Justice Center, 2007). BCMHC has evidence of three of these five indicators of sustainability.

Formal Policies and Procedures. There are specific written policies and practices for BCMHC set forth in an operating manual, and this manual has been made available to other judges and court personnel outside of mental health court.

Plan to Address Staff Turnover. To promote the integrity of the BCMHC's operations during changes in leadership, training on the policies and procedures of BCMHC was conducted for all Administrative Judges of the District Court and was offered at the Judicial Conference and the District Court Educational Conference.

Outreach to Community and Media. Evidence of outreach to the media and community include articles about the court in local papers and professional journals, and references in a resource manual published by the local chapter of the National Alliance on Mental Illness (NAMI).

The two missing or weak indicators of sustainability were found to be funding and data. During the initial review of BCMHC there was no evidence of sustained funding support. As mentioned earlier, the financial resources made available for the court's operation are contingent upon the continued collaborative support of its source organizations. A place in the organizational chart and identification in the budget are typical indicators of a financial commitment to support a program or unit within a larger system. BCMHC has no formal presence in an organizational chart nor does it possess a line item in the District Court's budget. Though placement in an organizational chart may be a common indicator of institutionalization, the institutionalization of BCMHC within the Judiciary might be best assessed in an examination of the sustainability of its practices and procedures within the judicial system, whether centralized in a given problem-solving court (i.e., court docket) or integrated into the practices and procedures of the court. Such an assessment, however, is not possible without adequate data on the outputs of the court.

The systematic collection of performance measures (i.e., effort and effect) is vital to the sustainability of the court-based problem-solving intervention. Measures of effort include data on outputs as evidence of the process (e.g., number of defendants and profile data on those participating). Measures of effect are the evidence of the results of the intervention's efforts (e.g., compliance, re-arrests, etc.) Inadequacies in case data collection were a major challenge to assessing the efforts of BCMHC. The absence of systematic data collection and management



procedures specific to BCMHC prevented an accurate assessment of the workload of the court for this report and poses the greatest limitation to assessing the court's effectiveness as preparations are being made to conduct an outcome evaluation. BCMHC reported continual unsuccessful efforts to create and implement a data collection system, including a work group involving staff from the Judicial Information System (JIS) that identified key data elements. However, JIS lacked the resources to implement such a system. If assessment of the effectiveness of BCMHC is desired, two actions are recommended: further research should be undertaken to assess outcomes of the BCMHC and attention should be directed to assure a data collection and report system is developed that will both meet the needs of the court and have the capability to assist researchers in answering outcome research questions.

The report also highlights next steps in the evaluation of the BCMHC. These next steps are organized from a multi-level systems approach with potential questions:

*From the perspective of the judicial system:* What has been the impact of BCMHC on the court system?

*For the broader state and local criminal justice system:* Has BCMHC assisted other organizations in the criminal justice system – law enforcement agencies, prosecutors, public defenders and correctional agencies – become more efficient and effective?

*For the state/local mental health system:* Has BCMHC impacted the efficiency and effectiveness of mental health case management and service delivery?

*For BCMHC participants:* Has BCMHC improved the timeliness and effectiveness of the utilization of services by offenders with mental illness?

Consideration of these questions will serve to provide a focus to the outcome evaluation.

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## **Introduction**

The Maryland Administrative Office of the Courts (AOC) partnered with the University of Maryland Institute for Governmental Service and Research (IGSR) and the Morgan State University School of Community Health and Policy (SCHP) to conduct process evaluations of the state's court-based mental health interventions in Baltimore City, Harford County and Prince George's County. This report presents the process evaluation of Baltimore City Mental Health Court (BCMHC). The process evaluations of both Baltimore City Mental Health Court and Harford County Mental Health Diversion Program represent the initial applications of a new methodological framework and strategy for conducting a process evaluation of mental health courts. As preparation for this study and the development of the evaluation framework, IGSR conducted an in-depth review of the literature on mental health courts. The literature review, which supports both the evaluation of Baltimore City Mental Health Court and Harford County's Mental Health Diversion Program, may be found in the report on Harford County's Mental Health Diversion Program. Development of the process evaluation methodology by Maryland Judiciary Research Consortium (MJRC), which included a review of the literature, and the evaluations in Baltimore City and Harford County, were funded by the Governor's Office of Crime Control and Prevention (GOCCP) and the Maryland Judiciary, Administrative Office of the Courts. As one of the first attempts to apply this new methodology, the current study offers the researchers and the Administrative Office of the Courts an opportunity to test and improve it.

In addition to assessing the processes of BCMHC, this study will provide background information needed to conduct future outcome and cost evaluations of this court-based mental health intervention. The study has been conducted in light of cautionary advice offered by Wolff

and Pogorzelski (2005) and others regarding the need to understand the environment and “active ingredients” of court-based mental health interventions in order to completely describe them and evaluate their effectiveness. To this end, the systems and organizational perspectives that support the current study will assist the audiences of this report in understanding the context and operation of BCMHC and other mental health interventions in Maryland’s court system.

## **Study Overview**

### **Purpose of the Study**

The purposes of process evaluations are to document the essential elements and core actions/strategies of a program or system’s operations; describe the level of effort and the efficiency of the operations; identify beneficiaries and recipients of the system or program’s efforts; and assess the level of satisfaction among beneficiaries, recipients and stakeholders. This evaluation study, which is aimed at documenting and describing the operations of the mental health court in Baltimore City, is intended to serve as the foundational phase of a larger study; information represented in this report will be used to frame study of the outcomes and cost associated with BCMHC. This study was designed to collect data that will (1) identify and describe the policies and procedures that govern the operation of the mental health court, (2) describe the interagency and collaborative linkages and resources that support the implementation of the mental health court in Baltimore City, (3) identify the methods and types of data that are collected by the various participating and supporting agencies involved in BCMHC, and (4) assess the extent to which BCMHC provides the intended intervention to its target population.

## **Description of Methods**

The methods utilized for this study included collecting and examining data from a variety of sources: (1) available archival data and documents in the public domain on the Baltimore City Mental Health Court and the agencies involved in the development and implementation of the courts, (2) meeting minutes of the committees involved in the planning and operation of the BCMHC, as well as minutes of Maryland's Mental Health Oversight Committee and its precursor entity; (3) structured survey of representatives from stakeholder agencies and organizations; and (4) semi-structured interviews with key informants who had specific knowledge of BCMHC's development and operations. Public domain information included web site information for the source organizations and documents such as annual reports and brochures. A list of documents (web-based and paper versions) reviewed for this report may be found at the end of the document. Stakeholder organizations that were contacted for the survey included entities/groups participating in the planning and development of BCMHC as well as mental health service provider organizations that may have provided services for defendants in BCMHC. The key informants who were interviewed represented the public agencies and private organizations that are currently involved in the day-to-day operations of the court. Drafts of the report were also shared with key informants and stakeholders to confirm accuracy of information about their respective organizations, to identify possible gaps in information and to obtain updates to the information.

*The Essential Elements of Mental Health Courts*, a report of the Council of State Governments Justice Center (2007), provided the analytical framework for assessing the design and implementation of BCMHC. The Council's report distilled the literature relevant to mental

health courts and identified an emerging consensus around 10 guiding factors on how such courts should be planned and operated. The process evaluation data obtained using the methods described were collected with these ten essential elements in mind. Consistent with these elements the data and other performance indicators were examined to assess the extent to which BCMHC evidenced the following.

1. Multi-sector participation of criminal justice, mental health, substance abuse and other key stakeholders in the planning and administration of BCMHC;
2. Eligibility criteria that reflect an understanding of the relationship between the mental illness and the offense of the defendant, while preserving public safety as a priority;
3. Timely identification and linkage of participating defendants to services;
4. Individualized treatment plans with clear terms for participation in the mental health court program;
5. Policies and procedures that ensure defendants have access to legal counsel for their decisions to participate and procedures to address the defendant's competency when such concerns arise;
6. The utilization and promotion of evidence-based treatment and support services.
7. Policies and procedures that ensure that the confidentiality rights of the defendant are protected;
8. Ongoing training for criminal justice staff and mental health providers, as well as periodic assessment of training needs;
9. Policies and procedures governing monitoring of participants to support adherence to the conditions of participation in BCMHC; and



10. The collection and use of both performance and outcome data for purposes of program improvement as well as the identification of program impacts – both critical to promoting continued support for the court-based intervention.

Consistent with these identified essential elements, the process evaluation report describes the planning and administration of BCMHC, policies and procedures which govern eligibility criteria, participants access to services and the rights of defendants' participating in the court, available services and the process for accessing these services, the personnel which constitutes the mental health court team as well as the extent of training for both criminal justice and mental health service staff involved in the court. This report also describes and reports on the performance data that are available on the BCMHC.

### **History and Development of Mental Health Court**

In evaluating the Baltimore City Mental Health Court (BCMHC), it is important to first illuminate the circumstances that fostered its development. Such insight provides guidance in mapping the contextual factors that are relevant to assessing the court's process and impact. A driving force behind the development of a mental health court in Baltimore City was anecdotal and documented evidence that a significant portion of the individuals who were, or had been, processed through the criminal justice system had some form of mental illness. Estimates at the time placed the number at around 16% of those processed through the criminal justice system. This estimate of offenders was consistent with statistics at the national level and for the State of Maryland (Conly, 1999).

A second driving force was the treatment and management of the mentally ill who encountered the justice system. Prior to the establishment of BCMHC in 2003, cases involving offenders with mental illness were spread among nine different criminal courts in Baltimore City with multiple judges, prosecutors, public defenders, and service providers (Cooksey & Cooper, 2004). In addition to the court's adjudication of defendants with mental illness, two public agencies provided assessment and/or monitoring services to individuals with mental illness within the justice system – the Medical Services Division (MSD) of Baltimore's Circuit Court through its Forensic Alternative Services Team (FAST) (formerly Community Re-Entry Program – CREEP) and the State Department of Health and Mental Hygiene's Community Forensic Aftercare Program (CFAP). The State's Psychiatric Hospitals and numerous private providers also provided direct services to court-involved individuals, for both BCMHC participants and defendants in the City's other District Court locations. Since 1995, FAST has conducted psychosocial assessments and made recommendations at booking, bail hearings and trials.

In 1999, Maryland's Mental Hygiene Administration (MHA) attempted to gain a better understanding of the level of need among the population with mental illness by surveying nonviolent offenders with mental illness in Baltimore City. MHA conducted a survey of individuals within the criminal justice system who were housed in mental health facilities and shelters. The study included 536 individuals. Research showed that the non-violent offenders with mental illness differed from the general incarcerated population in a variety of ways; they were likely to spend greater time in jail, have greater difficulty in adhering to the rules, and often "acted out" in response to intensified levels of stress brought on by jail confinement. When arrested, these offenders frequently were not in compliance with their medication regimen and

frequently suffered from drug withdrawal (Conly, 1999). Other findings were that (1) detention facility personnel were not trained to treat mental health issues and (2) the services in detention facilities were inadequate to meet the level of need (Conly, 1999). Based on the study, MHA concluded that better coordination of mental health services for this population was needed in order to reduce re-offending, re-admission, and duplication of services. Two years later, the Baltimore Mental Health Systems (BMHS) annual report for 2001 made reference to initial meetings among court officials to discuss collaborating to address the problems that had been found by the 1999 MHA study. The BMHS report stated that:

*A significant change occurred in BMHS's design for collaboration for services and coordination in Forensic Services. In August, 2000 a combined meeting of a number of specialized groups was created and moved to Civil District Court to facilitate attendance of court officials including Judges, States' Attorneys and Public Defenders. Other interested groups in attendance included jail personnel, representatives of State Hospital Centers, Baltimore Substance Abuse Systems (BSAS), the Forensic Alternative Services Team (FAST) and community service providers. An ongoing agenda to share information and to problem solve was established. The meetings maintained their focus on the pre-trial processes (Baltimore Mental Health Systems, 2001, Goal #1, Objective A, Forensic Services).*

Members of an initial informal group of representatives of the criminal justice and public agency stakeholders, who later served as the planning committee for BCMHC, reported that mental health symptoms worsened during detention at central booking and Baltimore City Detention Center (BCDC or City Jail). The City Jail was often referred to in written documents and in interviews with various stakeholders as the largest provider of mental health services for

offenders, gaining this status by default through the observed pattern of repeated offenses and recidivism of offenders with mental illness. Both personnel and service issues were identified. The group determined that jail personnel were not trained to meet the mental health needs of the population of offenders with mental illness, and correctional facilities were inadequately staffed to effectively coordinate services for detainees with mental illness during detention and upon release. (Cooksey & Cooper, 2004; Conly, 1999; Laing, 2008)

The BCMHC planning group members came to a shared understanding that the existing system for dealing with offenders with mental illness was not adequately addressing their needs - it was failing in terms of public safety, diversion from incarceration, and treatment of mental illness. A consensus was reached that the solution lay beyond the traditional criminal justice approach (Laing, 2008). Ultimately an individual judge, the Honorable Charlotte Cooksey, provided the impetus for the creation of the BCMHC. The pivotal role of Judge Cooksey was supported in stakeholder interviews conducted for this study as well as in public information and promotional documents (i.e., newspaper articles and a BCMHC brochure). As a result, in 2003 BCMHC became Baltimore City's latest commitment to therapeutic jurisprudence. The concept of therapeutic jurisprudence refers to the extent to which substantive rules, legal procedures, and the role of legal actors (judges, lawyers, etc.) are applied to produce therapeutic or anti-therapeutic consequences or outcomes for individuals involved in the legal process.<sup>1</sup>

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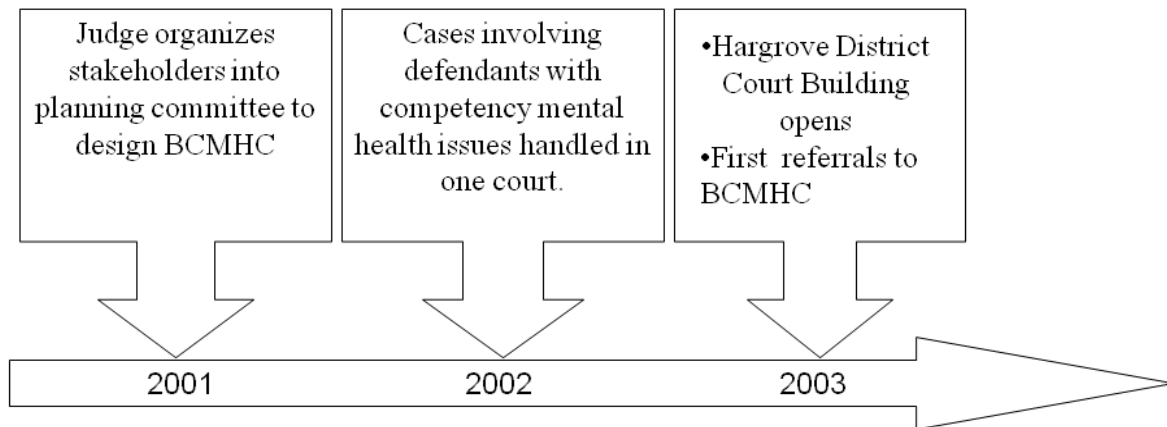
<sup>1</sup>The term therapeutic jurisprudence was first used by Professor David Wexler in a paper delivered to the National Institute of Mental Health in 1987. The conceptual framework has been the impetus for the creation of a number of specialty courts, such as drug courts.

In an effort to draw upon the experience of other mental health courts, members of the planning group reported visiting various courts around the country including mental health courts in Dade County, Florida; Seattle, Washington; New Orleans, Louisiana; Pittsburgh, Pennsylvania; and Brooklyn, New York. Evaluations, critiques, and resource material pertaining to mental health courts were read and considered. Planning group members attended national conferences in California and Pittsburgh in order to hear from experts in the field and engage in discussions with mental health court judges and team members from other states that had implemented or were planning to implement these court-based interventions.

### **Precipitating Events**

In addition to the contextual factors indicated in the preceding sub-section, several defining decisions and actions contributed to the formation of the BCMHC. Figure 1 represents a chronology of these events.

**Figure 1. BCMHC Development Timeline**



## **The Function of BCMHC**

BCMHC was established with two overarching goals: 1) to ensure the public safety; and, 2) to improve outcomes for nonviolent offenders with mental illness. The appellation of “mental health court” provides a somewhat limiting picture of BCMHC’s operation. It might be more aptly described as an amalgam of policies, practices and relationships among a variety of organizations that is orchestrated by the court with the intent of diverting individuals with specified mental health problems away from incarceration and into treatment. From its inception, BCMHC was designed to strike a balance between the goals of the justice system and those of the mental health treatment system. The intent was to effect a measurable decline in the number of episodes of re-offending and incarcerations among the target nonviolent offenders with mental illness.

Founded with a multidisciplinary treatment approach to addressing the needs of defendants, the BCMHC serves a discrete subset of the population of offenders with mental illness in the criminal justice system. All BCMHC cases are heard and participant case records are kept at the John R. Hargrove Sr. Courthouse in the Brooklyn community of south Baltimore City.

## **Contextual Analysis**

The preceding section described precipitating factors and circumstances surrounding the development of BCMHC. The contextual analysis represented in this section describes the organizational position of BCMHC within the local criminal justice and mental health treatment systems, as well as within Maryland’s judicial system. It also identifies jurisdictional/agency

entities involved in the development of BCMHC and discusses the ongoing role each plays to support the operations of the program.

### **Organizational Position in the Judicial System**

Maryland's system of local trial courts includes circuit courts and the district courts. Circuit courts are organized into four primary components: family, juvenile, criminal, and civil. The District Court of Maryland is responsible for handling cases that include criminal misdemeanors, some felonies, motor vehicle violations, and peace and protective orders, landlord and tenant issues, replevin actions (a remedy for the recovery of goods), small claims up to \$5,000, and civil actions under \$25,000 (Maryland Judiciary, 2006). Jury trials are not conducted in District Court.

The District Court of Maryland is organized into 12 geographic subdivisions. The Baltimore City District Court, including BCMHC, is located in District 1. Baltimore City is served by five District Court locations: Edward F Borgerding Courthouse, Civil Division Courthouse, Eastside Courthouse, John R. Hargrove, Sr. Courthouse, and Baltimore City Central Booking. Baltimore City's District Court judges hear over 66,000 cases per year (Maryland Judiciary, 2006).

BCMHC is part of the Baltimore City District Court's Criminal Division. To the general public, BCMHC is not easily discerned as a distinct operating entity within Maryland's judicial system. It does not appear on any official organizational chart nor is it referenced in the most recent edition of the Maryland General Assembly Legislative Handbook in its acknowledgement of other problem solving courts. It is referenced in the annual reports for the Maryland Judiciary as one of the "specialized dockets" also known as problem solving courts. For the public there is a

single pdf file brochure concerning BCMHC (Maryland Judiciary, Baltimore City District Courts, n.d.). The Judiciary’s intranet provides access to the procedures manuals and related forms used by BCMHC. Until just prior to the publication of this report, there were no specific funding allocations for the operations of the court. This changed with AOC funding of a staff position for the court.

### **Source Organizations**

A number of organizations were involved in the planning and development of the mental health court and continue to be involved in its operation. These organizations collaborate to support the operations of the BCMHC. Each organization provides distinct contributions to the support of BCMHC operations. We use the term “source organization” to refer to the organizations that make noteworthy resource contributions to this court-based mental health intervention. Eight organizations can be most clearly identified as source organizations for BCMHC:

- District Court of Maryland
- Office of the State’s Attorney for Baltimore City
- Maryland Office of the Public Defender (OPD)
- Maryland Department of Public Safety and Correctional Services (DPSCS), including:
  - Division of Parole and Probation (DPP)
  - Division of Pretrial Detention and Services (DPDS)
- Maryland Department of Health and Mental Hygiene (DHMH)
  - Mental Hygiene Administration (MHA)
  - Community Forensic Aftercare Program (CFAP)
  - Developmental Disabilities Administration (DDA)



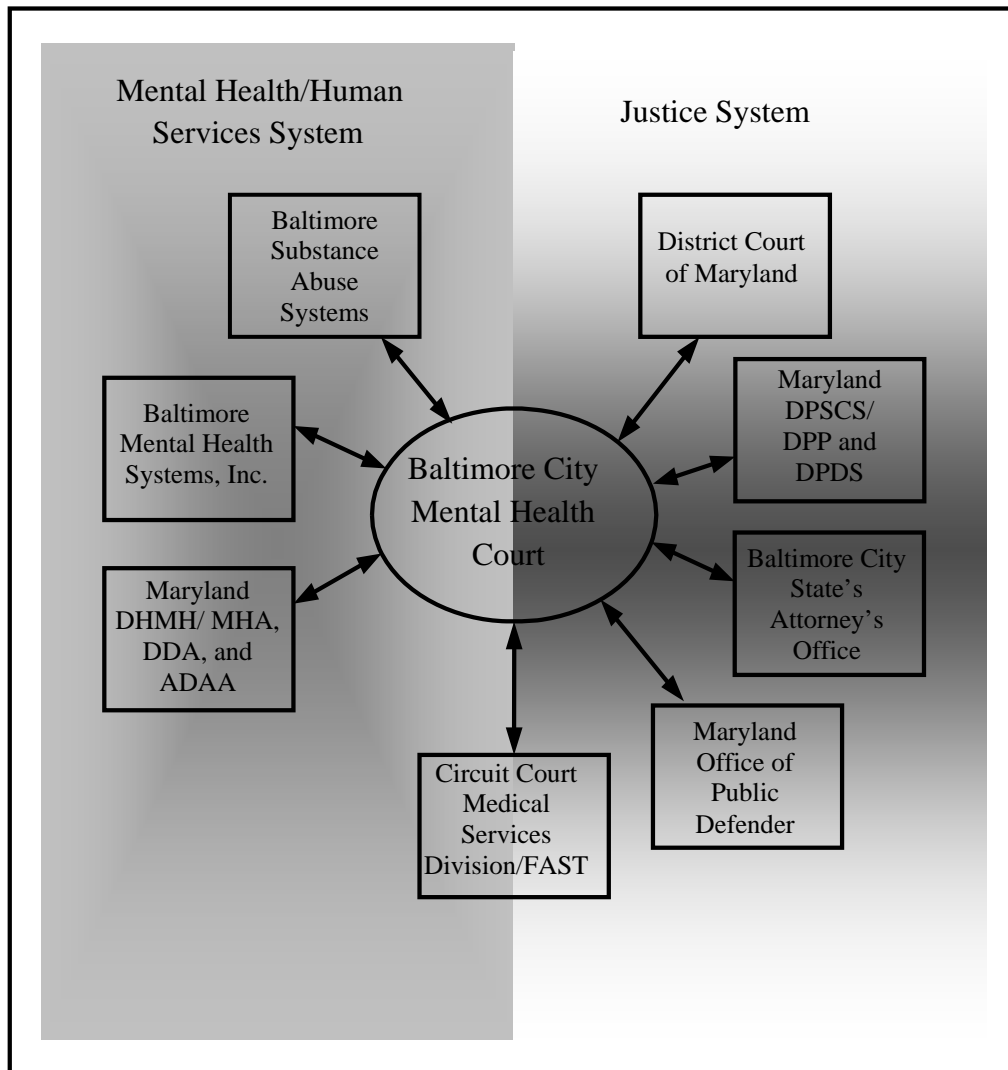
- Alcohol and Drug Abuse Administration (ADAA)
- Baltimore Mental Health Systems (BMHS)
- Baltimore Substance Abuse Systems (BSAS)
- Circuit Court for Baltimore City, Medical Services Division (MSD), including:
  - Forensic Alternative Services Team (FAST)

The operation of BCMHC represents linkage or blending of the purposes, structures, and organizational resources (primarily staff resources) of its source organizations. In addition, many other organizations contribute to the operation of the BCMHC. Their involvement in BCMHC is tangential as compared to the eight primary source organizations. For example, the Baltimore City and Baltimore County Police Departments contribute to the effectiveness and operation of the BCMHC by expediting warrants issued by the Court.

### **Design of the BCMHC**

At the heart of the design of BCMHC is the linkage of two local public systems: the justice system and the mental health/human services system. This is represented in the dual nature of BCMHC's mission. To make BCMHC function requires: (1) alignment and reciprocity of mission between each source organization and BCMHC and (2) operational interdependence among the source organizations.

**Figure 2. BCMHC and Its Source Organizations**



The following discussion includes detailed descriptions of BCMHC's source organizations and their relationships with the court-based mental health intervention, and introduces the functional concept of the BCMHC team.

### **Office of the State's Attorney for Baltimore City**

The Office of the State's Attorney for Baltimore City is an organizational unit of Baltimore City government. It represents the State of Maryland in all criminal prosecutions that result from

crimes charged by local law enforcement agencies occurring in Baltimore City. The mission of the Office of the State's Attorney for Baltimore City is to investigate and prosecute crimes occurring in Baltimore City without prejudice or bias, and to ensure that all citizens, victims, witnesses, and defendants alike, are treated fairly and respectfully and are accorded procedural justice.

The Office of the State's Attorney provides two dedicated full time Assistant State's Attorney positions and a three-quarter time administrative support position to try cases before the BCMHC. The Office of the State's Attorney is intimately involved in developing intervention plans for BCMHC participants. The designated Assistant State's Attorneys are considered part of the BCMHC team.

### **Maryland Office of the Public Defender**

The Office of the Public Defender (OPD) is an independent agency of the State of Maryland. It is the largest legal service organization in the State. Baltimore City is one of 12 districts in which OPD offices are located. The mission of the OPD is to provide legal representation to indigent defendants in the State of Maryland by safeguarding fundamental individual rights and ensuring access to the guaranteed protections afforded by the United States Constitution, the Bill of Rights, the Maryland Constitution and Declaration of Rights, and the laws of Maryland.

The Office of the Public Defender is charged with providing the best possible legal representation for its clients. Sometimes, this mission results in clients with mental illness choosing to not participate in BCMHC. In some circumstances, OPD might suggest to offenders

that they would benefit from BCMHC. According to interviewees, usually these are cases wherein offenders are “living life on the installment plan.” Individuals might be experiencing repeated and chronic periods of offending, serving short jail sentences, and re-offending. OPD might then suggest BCMHC as a way to break this cycle. OPD places priority on addressing clients’ legal needs. To do this within the context of BCMHC, OPD provides the services of two Assistant Public Defenders.

Within the Office of the Public Defender there is a Mental Health Division. The OPD Mental Health Division provides representation for individuals involuntarily confined to public and private mental health facilities across the state. This includes administrative hearings and may include cases in both the circuit courts and District Court, thus not all of these cases are heard by the BCMHC. The Chief of the Mental Health Division was a member of the planning committee for the BCMHC.

### **Maryland Department of Public Safety and Correctional Services (DPSCS)**

DPSCS is an executive department of the State of Maryland. Its mission is to protect the public, its employees, detainees and offenders under its supervision. The Department operates the state’s adult correctional facilities and provides probation and parole and pretrial monitoring services for adult offenders. DPSCS includes a Mental Health Division that oversees the delivery of mental health services for prisoners who are committed to the Division of Correction and who are in acute care, long term residential, step down, outpatient, and transitional care. This Division rarely interacts with BCMHC. The DPSCS organizational units that most frequently work with

BCMHC are the Division of Pretrial Detention and Services and the Division of Parole and Probation.

*Division of Pretrial Detention and Services (DPDS)*

DPDS oversees booking, processing, care management, custody and control of Baltimore City arrestees. These functions are performed by three subdivisions within the Division: Baltimore Central Booking and Intake Center (BCBIC), Baltimore City Detention Center (BCDC), and the Pretrial Release Service Program (PRSP). The Baltimore Central Booking and Intake Center (BCBIC) opened in November 1995 as the central location for booking and processing all arrestees in Baltimore City. Nearly 100,000 arrestees are processed yearly in this internationally recognized center. The Baltimore City Detention Center (BCDC) (commonly referred to as Baltimore Jail or City Jail) is one of the largest pretrial detention facilities in the United States and the largest in Maryland. More than 40,000 inmates are taken into custody at this Center each year (Maryland Department of Public Safety & Correctional Services, 2006). The Pretrial Release Service Program (PRSP) provides pretrial services to an average of 1,250 defendants yearly. These services are roughly divided into four functional areas: investigation, case management, case diversion, and detention. The program collects and assesses criminal history and personal data on Baltimore City arrestees, provides community supervision to defendants awaiting trial, and provides risk classification for bail review.

Defendants may be released by BCMHC on a pre-trial basis with supervision by this division. The Division has a Mental Health Pre-Trial Agent dedicated to BCMHC who monitors BCMHC participants who are released subject to PRSP supervision.

### *Division of Parole and Probation (DPP)*

DPP supervises and monitors offenders who are serving or completing sentences in the community. DPP operates 43 field offices with some 700 parole and probation agents and 95 drinking driver monitors. These employees supervise/monitor approximately 67,000 offenders at any given time in communities throughout Maryland. In addition, about 60 agents function as full time investigators conducting pre-sentencing, pre-parole, and other investigations for the Maryland Parole Commission, the courts, and other criminal justice agencies. DPP has one dedicated full-time probation agent assigned to BCMHC cases to monitor probationers according to their court ordered plan.

### **Department of Health and Mental Hygiene (DHMH)**

DHMH is an executive department of the State of Maryland responsible for pursuing the goals and policies of Maryland's health care system. DHMH is charged with the responsibility of providing competency to stand trial and criminal responsibility evaluations for the Judiciary, and to provide treatment or services for individuals found incompetent to stand trial or not criminally responsible. DHMH is also charged with conducting Health General 8-505 alcohol/substance abuse evaluations, and funding placements pursuant to those evaluations. In April 2008, the Department created the DHMH Office of Forensic Services to facilitate communication between the Judiciary, other criminal justice agencies and DHMH, and to improve services to the criminal justice system. Two administrations within DHMH work closely with BCMHC: the Mental Hygiene Administration (specifically the Hospitals and Community Forensic Aftercare Program) and the Developmental Disabilities Administration.

### *Mental Hygiene Administration*

The public mental health system is managed by the Mental Hygiene Administration (MHA) of DHMH and by Baltimore Mental Health Systems (BMHS). The public mental health system is comprised of psychiatric hospitals operated by MHA. It also includes funding of community mental health services. The hospitals that serve BCMHC are Walter P. Carter Center, located in the City, Spring Grove Hospital Center, located in Baltimore County, and Clifton T. Perkins Hospital Center, in Howard County. Perkins Hospital serves those individuals charged with the most serious offenses. The hospitals provide court ordered evaluations and treat those individuals found incompetent to stand trial or not criminally responsible due to a mental illness. The hospitals, through their Forensic Coordinators, work closely with BCMHC to present aftercare plans that are incorporated into release orders by the Court. The MHA also has an Office of Forensic Services. This office assists in coordinating evaluations. It also includes the Community Forensic Aftercare Program (CFAP), which monitors individuals on conditional release or certain Orders of Pretrial Release. The CFAP office may also assist in mediating differences in opinion regarding the implementation of a participant's treatment plan or addressing situations in which the court ordered plan is in conflict with the policies and procedures of service provider organizations. MHA is the primary funder for all mental health services in Baltimore City. It funds BMHS, which is the designated Core Service Agency (CSA) for Baltimore City. MHA also provides the funding for the FAST program and for part of the Medical Office.

*Developmental Disabilities Administration (DDA)*

DDA is responsible for funding programs and services for individuals with developmental disabilities. As such, DDA identifies resources for BCMHC participants, e.g. behavioral support services, vocational services, sheltered workshops, employment support, and transportation. In addition to these services, DDA offers residential placement through its licensed provider agencies. On-going case management, which is referred to as service coordination, is also provided for all court-involved individuals who are determined to be eligible for DDA services. DDA also operates two facilities for court-involved individuals with developmental disabilities. The facilities are the Secure Evaluation and Therapeutic Treatment units (also referred to as SETT) located in Sykesville and Jessup, Maryland. DDA provides a forensic liaison to the BCMHC to assist in developing community plans.

*Alcohol and Drug Abuse Administration (ADAA)*

While substance abuse is primarily dealt with via drug courts, there are co-occurring mental health and substance use issues where drug problems may need to be addressed. Within DHMH, ADAA is charged with promoting, establishing, monitoring and funding programs for prevention, treatment and rehabilitation related to the misuse or abuse of alcohol and drugs. ADAA is charged with the responsibility for court ordered substance abuse evaluations. ADAA delegates most of its authority for evaluations to the Baltimore Substance Abuse Systems (BSAS). In addition, ADAA provides funds to BSAS to purchase services.



### **Baltimore Mental Health Systems (BMHS)**

BMHS is a private non-profit that serves as the Core Service Agency, or local mental health authority, for Baltimore City. It is charged with developing a coordinated and comprehensive network of mental health services for the residents of Baltimore City. It develops Baltimore's mental health plan, identifies service needs, and identifies and pursues funding opportunities. It receives the majority of its funding through MHA. BMHS does not provide direct services. Rather, it purchases services through the Medical Services Division of Circuit Court (i.e., FAST evaluations) or purchases services that are not funded through the public mental health system (e.g., case management, medications, rent, etc.).

### **Baltimore Substance Abuse Systems (BSAS)**

BSAS is responsible for defining and meeting the City's need for alcohol and drug treatment and prevention services. It plans, develops, and implements a comprehensive and integrated service system, managing state, federal and local grant funds. BSAS coordinates and monitors the delivery of alcohol and drug abuse services provided by all grant-funded programs.

### **Circuit Court for Baltimore City, Medical Services Division (MSD)**

MSD was established in 1925 to provide psychiatric, psychological, and social work evaluations for the court system in Baltimore. The mission of MSD is to provide timely, high quality, unbiased court ordered evaluations and reports. The MSD may find a defendant competent to stand trial or criminally responsible, however if competency or criminal responsibility is in doubt, the defendant is referred to a DHMH facility for further evaluation. MSD has developed special programs and services reflecting the Court's commitment to therapeutic jurisprudence.

MSD's Forensic Alternative Services Team (FAST) program provides services and support to BCMHC. While operated by and under the funding of the Circuit Court, MSD receives funds from DHMH to conduct competency and criminal responsibility evaluations, pre-sentence psychiatric evaluations and to operate special programs such as FAST.

*Forensic Alternative Services Team (FAST)*

FAST is funded through a contract with BMHS and has been in operation for approximately 16 years. Its mission is to divert individuals with mental illness and relatively minor charges to appropriate mental health and other community services. In its relatively new role with the BCMHC, FAST has effectively become the clinical arm of the BCMHC. FAST clinical social workers serve adults who: (1) have been diagnosed with a major mental illness or illness associated with trauma; (2) are charged with a minor offense; and (3) who agree to community based treatment supervised by FAST. FAST's social workers are available to all District Courthouses in Baltimore City and all pre-trial detention facilities. FAST conducts psychosocial assessments and makes recommendations for pretrial diversion at bail hearings, which take place at the Central Booking and Intake Center. FAST works closely with the MSD, which provides court ordered psychiatric and psychological assessments in cases involving competency to stand trial and criminal responsibility. The FAST program can divert defendants to BCMHC at the booking/bail review phase. Defendants may be monitored by FAST without entering BCMHC. If defendants are eligible, treatment plans are offered at bail hearings. Defendants may be released under court order to comply with specified treatment or other plans indicated in release agreements. Though FAST's involvement primarily has been pre-trial, FAST clinicians also provide consultation during trials and at sentencing.

A partial picture of resource commitments made to BCMHC by source organizations can be seen in Table 1, which summarizes direct staff allocations assigned to the BCMHC, and in Table 2, which displays services provided. This does not fully capture the extent of financial and other resource commitments source organizations make to BCMHC.

Table 1. Source organization (other than District Court) resource commitments to BCMHC: Full-time equivalent (FTE) positions.

Organization	Position	FTE
Baltimore City Office of State's Attorney	Assistant State's Attorney	2.00
	Administrative Support	.75
Maryland Office of Public Defender	Assistant Public Defender	2.00
Maryland DPSCS, Division of Parole and Probation	Probation Agent	1.0
Maryland DPSCS, Division of Pretrial Detention and Services	Pretrial Agent	1.0
BMHS, Inc.	N/A	0
MSD/FAST	Licensed Clinical Social Worker	1.0*

\*The 1.0 FTE represents two social workers at 0.5 FTE.

Table 2. Summary of services provided by source organizations (excluding District Court) to BCMHC

Organization	Service Provided
Baltimore City Office of State's Attorney	Represents the State of Maryland in all criminal prosecutions that result from crimes charged by local law enforcement agencies occurring in Baltimore City.
Maryland Office of Public Defender	Provides legal representation to indigent defendants in the State of Maryland.
Maryland DPSCS, Division of Parole and Probation	Helps make communities safe by supervising/monitoring offenders who are serving or completing sentences in the community.
Maryland DPSCS, Division of Pretrial Detention and Services	Books, processes and manages the care, custody and control of Baltimore City arrestees.
BMHS, Inc.	Serves as the designated mental health authority for Baltimore City.
MSD/FAST	Conducts psychosocial assessments in order to divert defendants with mental illness from incarceration, treatment planning, monitoring, and consultation.
Maryland DHMH	Provides evaluations, inpatient treatment or habilitation services, aftercare planning, clinical and support services in the community and monitoring of conditional releases and some pretrial orders of release

## BCMHC Relationships with Source Organizations

### *Decision Making and Accountability*

The structure of BCMHC reflects a model of mutually dependent inter-organizational decision making and accountability. Each source organization follows its internal decision-making and accountability process. The source agencies frequently collaborate and communicate with each other on general and case-specific issues. This is a necessity because each organization has a

critical function required to process each case. Each organization's success in case processing is dependent on other organizations performing their function. For example, if monitoring agencies (FAST, DPDS, and DPP) and evaluating agencies (MHA, DDA, and ADAA) do not submit timely reports, the efficiency of court processing is negatively impacted. Collaborative decision-making occurs in semi-weekly case review meetings called before BCMHC sessions convene. Team members also communicate with each other outside of the case review meeting.

Each source organization is bound by law to exert decision making within its statutorily defined area of responsibility. FAST determines whether a defendant meets the legal and clinical criteria for mental health court; the State's Attorney decides whether the case has prosecutorial merit, the Public Defender consults with the defendant about participation in the program and the strength of the case, and the judge makes findings of competency, criminal responsibility, guilty or not guilty, and imposes sentences. Collaboration among source organizations is essential for each in performing its respective mandatory role associated within BCMHC.

### *Resources*

BCMHC has access to resources necessary to respond to the needs of its participants only through its source organizations. Each source agency has determined how to best fulfill its obligation to the BCMHC participants. For example, OPD has dedicated two attorneys to staff the MHC. DPP has provided a full time probation officer to serve the BCMHC caseload. DPP is also a part of crisis intervention teams that collaborate when offenders violate terms of their probation.

BCMHC does not have direct control over resources made available by its source organizations. Resources are provided at the discretion of source organizations. The mental health court does not have direct control over availability of mental health beds in either inpatient facilities or substance abuse treatment programs. Maryland law does allow judges to order competency and criminal responsibility evaluations and substance abuse evaluations, as well as commitment to DHMH for treatment.<sup>2</sup> In accordance with an agreement with DHMH, hospital beds must be made available promptly and residential substance abuse treatment beds within no more than 90 days.

#### *Interagency Agreement*

There is no written agreement that formalizes the collaboration among the source organizations. However, the agreement to collaborate is operationalized through the written policies and procedures manual for BCMHC. The manual articulates the role of and resources contributed by the source organizations. Additionally, each source organization participates in formal monthly meetings that focus on administrative and policy issues. During these monthly meetings, the operations of the BCMHC are considered. A more detailed description of these meetings appears in the next section of the report covering design and operation of the Mental Health Court.

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<sup>2</sup> By statute: Title 3 “Incompetency and Criminal Responsibility” of the Criminal Procedure Article, Crim. Pro. 3-101 through 3-123 is the comprehensive statutory scheme that details the various evaluation and treatment commitment provisions regarding mental disorders and “mental retardation”- competency and criminal responsibility. Health General 8-505 through 8-507 contains the substance abuse evaluation and commitment provisions.

### *Additional Resources*

The Mental Health Oversight Committee of the Maryland Judiciary’s Office of Problem Solving Courts monitors the operation of BCMHC and other court-based mental health interventions operating in the State of Maryland. Members of this committee include judges, representatives of state executive departments and private organizations interested in the work of mental health-related problem-solving courts. This committee considers statewide policy concerning court-based mental health interventions in Maryland and works with the Office of Problem Solving Courts to provide an annual training conference. Through its Office of Problem Solving Courts, the Maryland Judiciary provides additional resources in the form of grant opportunities.

### **Design and Operations of the Mental Health Court**

The previous section detailed linkages between BCMHC and its source organizations. This section describes how the source organizations function together to make BCMHC operate as a *hybrid organization* – a distinct organizational entity that blends characteristics of its source organizations. As indicated earlier, the appellation of “Mental Health Court” represents a somewhat limited understanding of BCMHC operation. A more accurate portrayal is to describe it as an amalgam of policies, practices and relationships among a variety of organizations that are orchestrated by the court with the intent of diverting individuals with specified mental health problems away from incarceration and into treatment. These processes do not encompass all of the mental health services provided to individuals within the criminal justice system.

### **Goals and Objectives**

According to BCMHC internal documents, goals for the intervention include:

- Reducing inappropriate incarceration of individuals with mental illness;
- Reducing repeat criminal activity by offenders with mental illness; and
- Reducing the length and frequency of hospitalizations of offenders with mental illness.

Ultimately, the aim of BCMHC is to preserve the public's safety while promoting the health and wellness of offenders with mental illness.

### **Staff, Team Members, and Others Associated with BCMHC**

The operation of BCMHC is supported by the team described earlier that includes a probation agent, a pre-trial agent, two state's attorneys, two assistant public defenders, and a FAST social worker who is also the Clinical Court Coordinator. These inter-organizational staff commitments are complemented by other characteristics of the organizational relationships developed to support the operation of BCMHC. For instance, the Division of Parole and Probation, Division of Pretrial Detention and Services, and DHMH Community Forensic Aftercare Program may also provide supervision in lieu of FAST. In addition, the treatment plan is part of the probation or pretrial services requirement, which is supervised by a probation or pretrial services agent. FAST provides clinical guidance to the probation and pretrial agents when needed. The Baltimore City Police Department has assisted the intervention by agreeing to expedite service of warrants issued for BCMHC participants and, in some instances, to transport defendants to the hospital.

### **Communication and Information Sharing**

There are two days per week set aside for BCMHC dockets - Mondays and Thursdays. Team meetings are held in the morning, and cases are heard in the afternoon, generally between 2:00



p.m. and 4:30 p.m. In the interest of efficiency, the court works to group the competency cases together and process them on one of the two scheduled court days. The team members present at the morning meetings vary but generally include the Judge, Assistant State's Attorney, and Assistant Public Defender. The Court Clerk is also present. Service providers and monitoring agencies are included in the meetings as the docket warrants. These docket meetings cover both voluntary and competency entrant cases. BCMHC participants are not present at the morning sessions, but all defendants are represented by counsel. Pre-hearing meetings among BCMHC team members are primarily conducted to share information, discuss facts, and ensure that everyone's questions can be answered before the formal BCMHC session. All cases on the docket for a given day are reviewed. Dates for future hearings are also set. The pre-hearing team sessions are also used to resolve problems or conflicts that have arisen regarding treatment plans for participants.

BCMHC team members receive court dockets to be considered via email. Progress and evaluation reports are distributed prior to the meeting to those team members involved with the case. Monthly dockets are provided to give team members time to plan and prepare. Two days prior to a scheduled docket, a final schedule is emailed with indication included of reports or other information that will be needed for the meeting. The clerk for the courtroom in which BCMHC cases are heard coordinates communications with members of the team regarding the docket. For competency hearings, annual review reports are provided to the court two weeks prior to a hearing date. Other reports are due in the two-day advance window.

### *Planning and Coordination of BCMHC*

Meetings of BCMHC organizational stakeholders are held monthly. These meetings have been ongoing since 2003, with the list of participants remaining stable over time. The monthly meetings are used to resolve issues and minimize conflicts that arise from interaction among the many agencies that have contact with BCMHC. The meetings serve as opportunities for the stakeholder agencies to voice concerns and seek collaborative solutions.

Some organizational representatives suggest that, although they are involved in a system that is normally adversarial, they seek to focus on the intervention's goals (Laing, 2008). The court makes determinations regarding the overall operation of the intervention and individual cases based on recommendations from the BCMHC team. All of the team members may not agree in every case. They are, however, given opportunities to make their individual positions known to the court (Laing, 2008).

### **Case Eligibility, Participant Flow, and Admission**

#### *Eligibility Criteria and Enrollment Process*

For an individual to be eligible for BCMHC he/she must be a Baltimore City resident, at least 18 years old and diagnosed with Axis I serious mental illness and/or trauma-related disorder. He/she must be eligible for public mental health services (see Table 3 for a list of eligibility criteria for public mental health services) and agree to comply with BCMHC requirements. He/she must be charged with a misdemeanor or felony within the jurisdiction of the District Court (except domestic violence related offenses) and have never been convicted of a serious crime, such as rape, abduction, or murder. Finally, the candidate offender must not have any detainers or

pending cases unless it is determined that the pending cases will not interfere with his/her treatment plan. (Cooksey, 2005).

Table 3. Eligibility criteria for access to Baltimore City public mental health services.

Published eligibility criteria for access to the Public Mental Health System
<ul style="list-style-type: none"><li>• The individual has a mental health disorder as defined in DSM IV TR</li><li>• Individual is a Medicaid recipient</li><li>• Individual is ‘dually eligible’ for Medicare but remains in the Medicaid fee-for-service system requirements.</li><li>• Individual is Medicaid ineligible and because of psychiatric and financial need may be eligible to have the cost of mental health services (in whole or in part) subsidized by the State and/or local funds.</li></ul>
Source: Mental Hygiene Administration. Service Eligibility 2008. Available at <a href="http://www.dhmd.state.md.us/mha/serviceeligibility.html">http://www.dhmd.state.md.us/mha/serviceeligibility.html</a>

While the Mental Health Court is understood to be a voluntary program, it is clear from interviews and other documents that the activities and personnel involved with the competency cases heard at Hargrove District Courthouse are linked to the Mental Health Court and can be described as part of the larger court-based mental health intervention. Consequently, the BCMHC participant recruitment/enrollment presented here is described in terms of two entry pathways – voluntary and competency.

### *Competency*

One method of entry into BCMHC occurs when offenders are referred for a competency evaluation. A competency evaluation hearing can be requested by a judge or by defense counsel.

Once an order for evaluation has been issued by the judge, DHMH assumes oversight and responsibility for the individual to insure that a psychiatric assessment of mental competency is conducted in a timely manner. Individual evaluations are performed by the clinicians in the MSD or at the DHMH facilities. The MSD provides competency evaluations at both the District Court and Circuit Court levels.

A court may order an evaluation of competency to stand trial or an evaluation of competency to stand trial/criminal responsibility. The majority of the evaluations deal with competency to stand trial. By statute, the issue of competency may be raised by the defendant, defense counsel, the Assistant State's Attorney or the judge. Upon a motion for competency, a hearing is convened where the defendant is given an opportunity to be heard, and the court may order a competency to stand trial evaluation. If the court orders the evaluation, the case is transferred to the Mental Health Court.

The defendant is screened by a psychiatrist or psychologist at the Court Medical Office. If the clinician conducting the screening opines that the individual may be incompetent to stand trial, the defendant is referred to the Mental Hygiene Administration or the Developmental Disabilities Administration for further evaluation. If the judge finds that the defendant would be at risk in the detention center, the judge may order that DHMH immediately conduct the evaluation in a hospital or residential center determined by the Department. Of those cases referred for additional evaluation, at least 90% are referred to MHA as he/she may have a mental disorder. If the defendant is incarcerated, the individual is admitted to an MHA psychiatric hospital for the evaluation. If the individual has been released on recognizance or bail, the individual is seen at

the MHA facility, but not admitted unless clinically indicated. If the individual has a diagnosis of mental retardation, the evaluation is completed at the Secure Evaluation and Therapeutic Treatment (SETT) unit in Jessup.

The facility not only evaluates the individual, but if the individual is accepting of treatment or services, the facility offers the treatment and services. Many individuals entering MHA inpatient psychiatric hospitals need mental health treatment to make them competent to stand trial, or they may be competent but require treatment to permit them to return to the community with their mental health stabilized.

The Department completes the evaluation and submits a report to the court. If DHMH opines that the individual is competent to stand trial or does not need inpatient or residential care, the report may include information regarding what services would be required to assist the defendant to maintain competency or be restored to competency in the community. The report may also indicate what services are necessary to keep the individual from being a danger to self or person or property of others as a result of mental illness or mental retardation. The services could include mental health treatment, vocational rehabilitation, housing case management, alcohol or substance abuse treatment, or other services. If services are recommended, proposed providers are included in the report.

If the court finds the individual is competent to stand trial and the defendant either does not meet the criteria for MHC or does not wish to participate in MHC, the defendant is released from the DHMH facility and either returned to jail to await trial or released on bail or recognizance. If the

court finds the defendant competent, and the defendant meets the criteria for MHC and wants to participate, the defendant is accepted and the treatment plan becomes part of the release conditions. If the defendant is found by the court to be incompetent but not dangerous the defendant is released from the DHMH facility with monitoring by CFAP. The service plan outlined in the report can be used by the MHC in the Pretrial Order and often is used by the MHC in disposition of the case. The State's Attorney may agree to stet a charge (hold charges for an undefined period), agree to nolle pros a charge (provide assurance of no legal proceeding going forward), or agree to a finding of guilt on a lesser charge, if the defendant agrees to comply with the conditions in the service plan. The plan is then incorporated into the court order, whether an Order of Pretrial Release or a Probation Order. The plan is thus used as a diversionary plan from incarceration. Each DHMH facility has a forensic coordinator that serves as an intermediary between the treatment team at the facility and the MHC team. The coordinator presents the service plan as a possible disposition plan for the defendant, attends the MHC hearings and pre-meetings to explain the plan to the MHC team, and works closely with the MHC to ensure that safety needs are appropriately addressed in the service plan. The plan is monitored by the DPDS, DPP, or CFAP.

Based upon the evaluation and other information presented at court, if the court finds a defendant incompetent to stand trial and dangerous to self or person or property of others, the individual is committed to DHMH for residential or inpatient care. He/she receives services at the facility, and is routinely re-evaluated to determine if the individual can be found competent, or incompetent but not dangerous, or to determine if an opinion of non-restorability is appropriate. The hospital provides updates to the court at least every six months through status reports and an

annual hearing report. The facilities' forensic coordinators provide the reports to the court and answer questions as necessary. On rare occasion, an evaluator (psychiatrist/psychologist) from the facility will attend court to answer questions.

### *Criminal Responsibility*

If the court orders an evaluation for criminal responsibility, the evaluation process is similar to the process for competency evaluations. If the court finds a defendant not criminally responsible, the individual is committed to DHMH unless the court finds that the person would not be a danger if released. The individual remains in a DHMH facility until such time as the court finds that the person may be returned to the community without being a danger to self, other persons, or property of others as a result of mental illness or mental retardation. The individual is released on conditions documented in a Conditional Release order. The conditions may include provisions for supervised housing, mental health treatment, alcohol or substance abuse treatment, and a day time activity, including therapy, education or employment. The defendant is monitored by the CFAP.

Once evaluations are completed the findings are presented to the judge presiding over the competency cases. All Baltimore City District Court competency hearings are heard at the Hargrove District Courthouse. There are six judges within the court who participate in BCMHC; however, one judge has the responsibility for hearing the majority of these cases. BCMHC judges receive and utilize competency evaluation reports in making final determinations of legal competency. Review by BCMHC judges may also include clinical consultation with FAST. All of the core BCMHC organizational stakeholders are represented at determinations of competency.

If an offender is determined to be incompetent to stand trial and dangerous (ISTD) due to a mental disorder or mental retardation, the individual remains under the responsibility of DHMH and a residential placement is mandated. The current options for placement in public treatment facilities include the Walter P. Carter Center, Clifton T. Perkins Hospital Center, Spring Grove Hospital Center, and facilities run by the DDA. If the offender is found incompetent but non dangerous (ISTN), he/she is not committed to DHMH but may be monitored by CFAP. A finding of not criminally responsible (NCR) can be established as a result of a plea being entered by the defendant. NCR cases and the determination of ISTD/ISTN follow a similar court supervised treatment process. The court continues responsibility for review of competency according to an established schedule and is apprised of changes in treatment or supervision status. So long as the individual remains designated as incompetent, he/she cannot opt out of court-mandated treatment. Competency status can change; incompetent individuals who become competent may be considered for voluntary inclusion in the BCMHC.

#### *Voluntary Entry*

The voluntary admission process applies to defendants for whom competency is not an issue and to individuals found to be competent to stand trial. The voluntary admission process requires that the candidate meet the criteria for participation in BCMHC described earlier. The pre-determination process includes discussion and, at times, negotiation among BCMHC organizational stakeholders. Key to the determination is the final charge that is entered; the charge must be appropriate for adjudication at the District Court level and must not include domestic violence. Consequently, negotiations between the Assistant State's Attorney and



Assistant Public Defender are important. The offender must be willing to be subject to the control of the court.

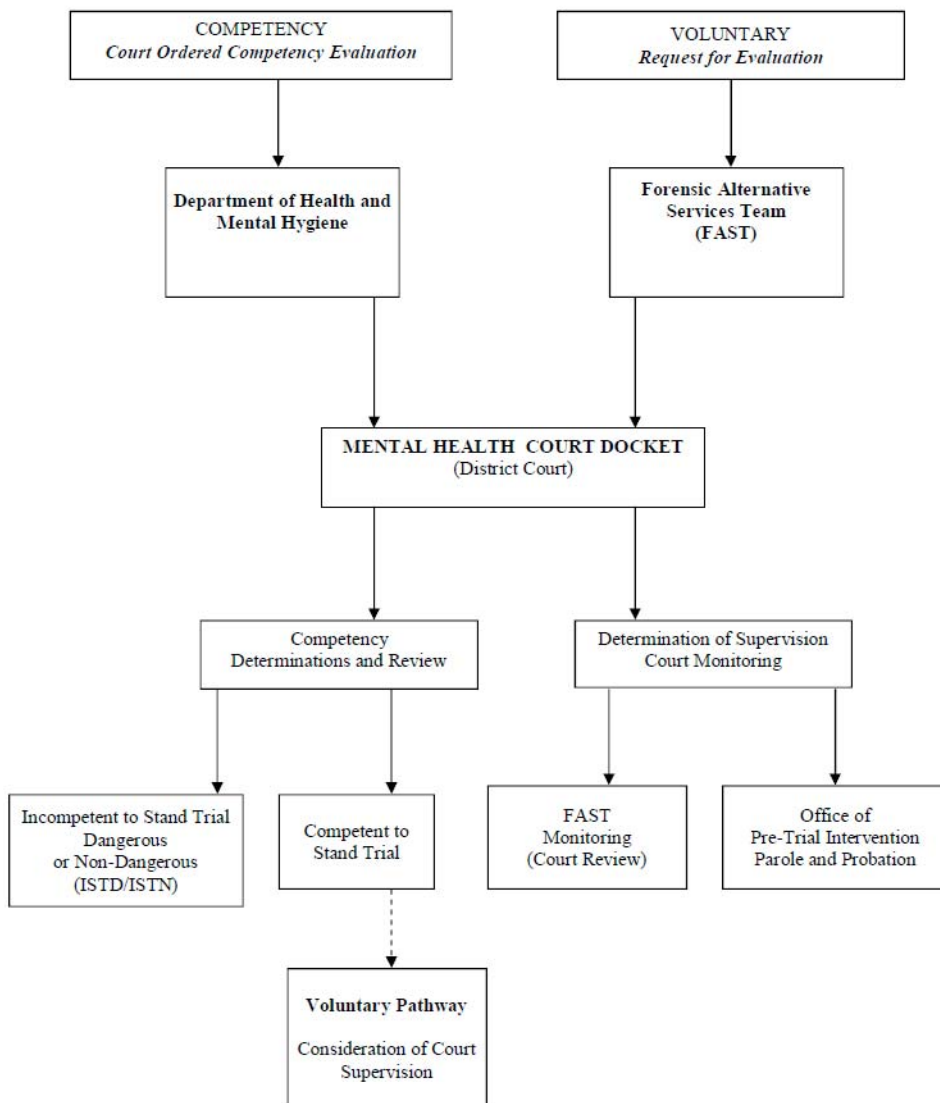
In addition to receipt of services, the potential benefits to the BCMHC participant who successfully completes the mandated treatment plan include assurance of no legal proceeding going forward (nolle pros), a hold on charges for an undefined period (stet), probation before judgment, probation versus incarceration, or early termination of probation.

FAST is generally brought into the admission process very early on, usually at the point of booking, to begin its assessment and determine if diversion is appropriate. FAST makes a determination as to whether it will provide monitoring of eligible defendants. If FAST is unwilling/unable to monitor, it can recommend that the BCMHC candidate become a participant in BCMHC (placed on the BCMHC docket) under the supervision of the court, with monitoring by either the DPP or the DPDS. FAST may also recommend competency evaluations or recommend that offenders not be supervised through the court intervention process.

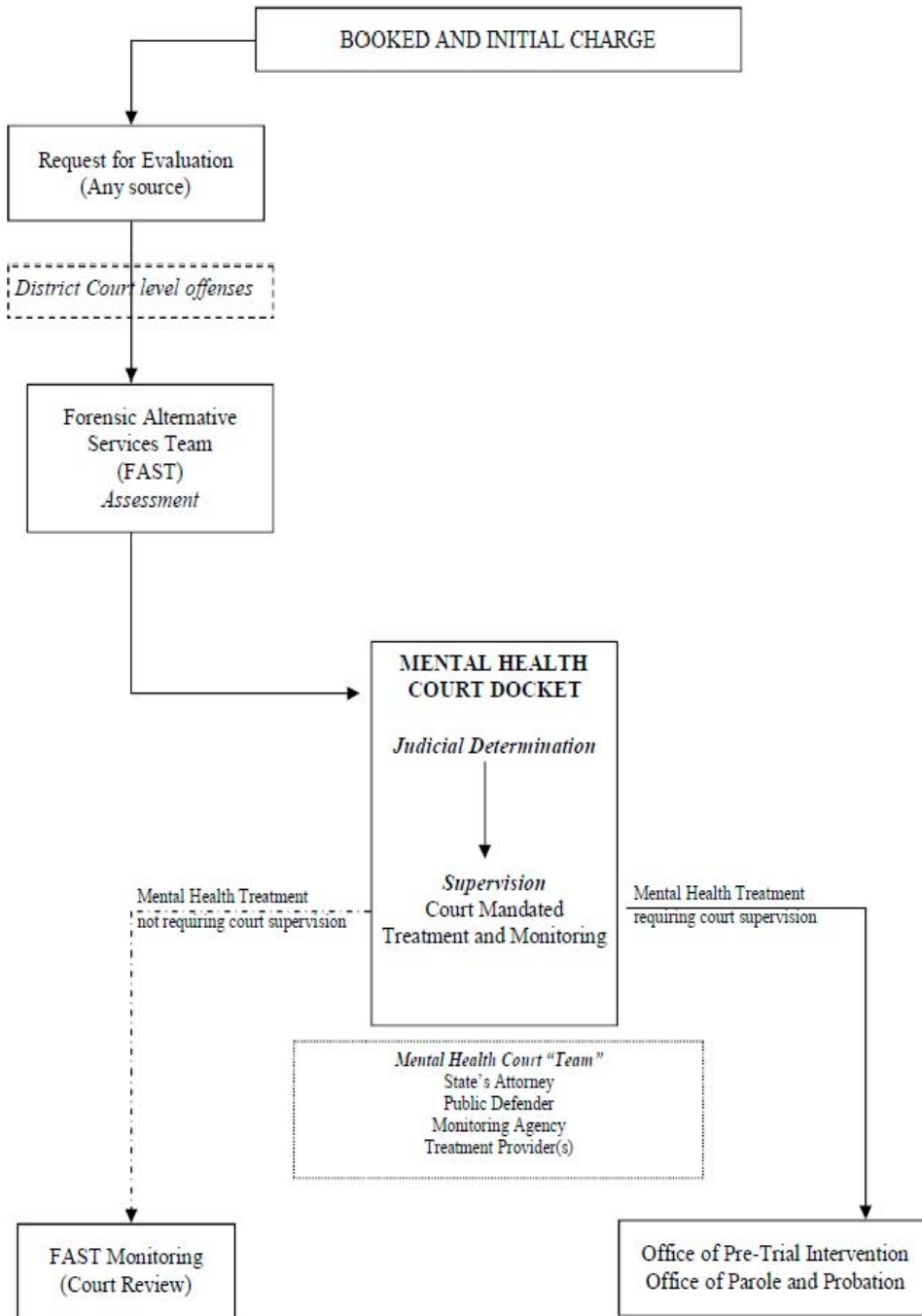
The judge utilizes input from FAST, the Office of the State's Attorney, and the Office of Public Defender in making the final determination of the offender's entry into the court-based intervention. If an offender enters BCMHC, he/she has a treatment and supervision plan mandated by the court. According to the terms of that plan, service providers are identified and remain in contact with responsible entity assigned to monitor the case. The monitoring agency might be Parole and Probation, Pretrial Services or FAST. The designation for monitoring the individual is dependent upon how the case entered and was initially handled by the court. Court

appearances for the BCMHC participant are scheduled to insure that he/she meets all requirements of BCMHC, that monitoring is taking place as indicated, and that services are being provided as ordered. In addition to enforcing compliance by the individual BCMHC participant, the judge possesses the authority to insure that court mandates are being followed by the agencies involved in BCMHC.

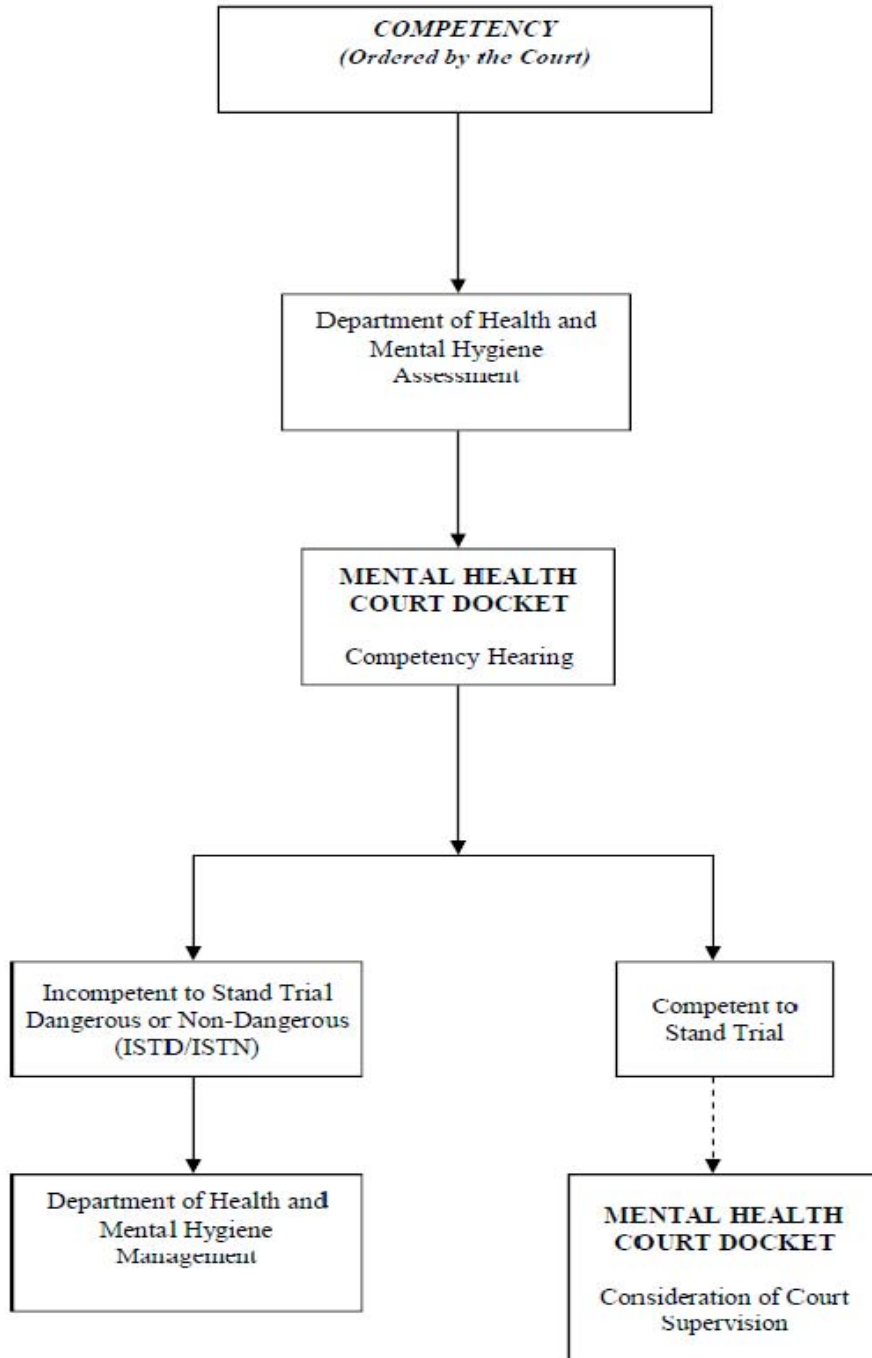
**Figure 3. Operating model of BCMHC: pathways and processes of the court-based mental health intervention**



**Figure 4. Voluntary Pathway into the BCMHC**



**Figure 5. Competency Pathway into BCMHC**



## **Process Evaluation Performance Measures**

The previous section described how the Baltimore City Mental Health Court operates. The current section uses process indicators to assess the adequacy and efficiency of BCMHC operations. The section seeks to answer:

- Whether there are clear and commonly understood goals, objectives, and policies and procedures for this court-based mental health intervention;
- Whether there is a functioning team working collaboratively to implement policies and procedures to achieve BCMHC goals and objectives; and,
- Who has been served and what has been the scope of services provided.

### **Goals and Objectives**

An indicator of the efficiency of an operation is how well its goals and objectives are conveyed to key operation position holders. The extent to which organizational goals and objectives are conveyed will be represented by the extent to which there is a common understanding of the goals and objectives among the organization's staff members.

The results indicate there is substantial agreement among those involved regarding BCMHC's goals and objectives. There are, however, predictable differences in team members' perspectives regarding the meaning of the goals and objectives and how they are accomplished. For example, consistent with their training, experience and agency affiliation, the clinical or service coordination team members tend to focus on the quality and appropriateness of treatment. Consistent with their legal experience, training, and organizational missions, the attorneys among the team members primarily focus on legal processes and outcomes.

The results of the study's interviews and survey indicate that BCMHC team members believe that their frequent interaction contributes to a shared understanding of the court's goals and objectives. This is reinforced by the inclusion of the intervention's goals and objectives in the operating manual. The manual was developed by the court's founding judge, with input from the stakeholders, to orient new members on the goals, objectives, and operations of BCMHC and as a guide for existing team members

Research has shown that in efforts requiring a significant amount of collaboration, one of the factors predictive of success is the extent to which respective goals of the collaborating entities are congruent with the goals of the collaboration. The potential for success will be further strengthened if collaborating entities perceive that their distinct goals and objectives are considered in the mission of the collaborative effort (Wolff, 2001). Applying these criteria, the qualitative evidence gathered in this study indicates that BCMHC possesses important building blocks for success.

## **Team Functioning**

### *Clarity of Roles and Responsibilities*

Although the BCMHC team operates as a cohesive group in processing cases through the intervention, it is quite clear that each member of the team has a distinct role to play. The team members recognize the interrelatedness of their roles. Each team member is well versed in his/her respective areas of responsibility and demonstrates understanding of the roles of other team members.

The roles played in BCMHC are consistent with the roles played by team members in other court settings. A difference is that, in the context of BCMHC, the team members pursue their roles in a collaborative manner – a distinct contrast to the often adversarial environment of their “business as usual” work in the judicial system. The collaborative nature of BCMHC does not appear to have changed the traditional role and authority of the judge. In BCMHC, the person in charge is clearly the judge. Without doubt all individual and organizational stakeholders recognize that the judge is in charge and should receive deference due to his/her position of authority.

### *Training and Development*

Based on information gathered, it is not known whether all of the members of the mental health court team have participated in training specifically for their work in mental health court. The majority did not respond to this question on the survey. Those who did respond indicated having received special training for working in mental health court. Training has been made available through both the Administrative Office of the Courts and BMHS on issues related to forensic services for offenders with mental illness. Several MHC judges have attended courses at the National Judicial College in Reno, Nevada as well as training provided by The Advanced Science and Technology Adjudication Resource Center, Inc. (ASTAR). ASTAR is a non-profit organization “...dedicated to enhancement of capacities of the courts via science and technology knowledge tools.” (Advanced Science and Technology Adjudication Resource Center, Inc., nd)

In addition, some BMHC team members have attended national conferences put on by National GAINS Center for People with Co-Occurring Disorders in the Justice System, an initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S.

Department of Health and Human Services. Interviews with team members suggest that a significant amount of training also happens “on the job.” While each member of the team is professionally trained in his/her respective discipline, on-the-job interaction provides team members with training regarding the work and the perspectives of their colleagues. Much of this experiential training occurs through the interaction during the BCMHC team’s semi-weekly morning meetings.

#### *Stability of staff*

Thus far BCMHC’s source organizations have honored their resource commitments. As a result, staffing for BCMHC has been stable. Staffing decisions are ultimately within the purview of the individual source organizations.

#### *Conflict Management*

The majority of persons responding to the study’s survey and in depth interviews indicated that team members handled conflicts by discussing issues until they are resolved. Results of the interviews suggest that, when differences are not resolved at the team level, agency heads get involved to resolve them. This most frequently occurs when actions required by BCMHC are not consistent with source agency policies and procedures. Occasional tensions and apparent differences inherent in sometimes conflicting and/or competing inter-agency interests appear not to have diminished the value that team members ascribe to their colleagues’ perspectives.

Despite the substantial level of cooperation exhibited among team members, in some situations, aligning individual agency interests with those of BCMHC is a product of coercion. Interview respondents reported incidents wherein the judge threatened issuance of contempt citations to



coerce agency action to assist BCMHC participants. These episodes indicate that, at times, BCMHC processes will reflect the adversarial tensions of “business as usual” judicial processes more than the collaborative approach reflected in the intervention’s goals and objectives and usual operation.

Beyond the judge’s occasional use of coercion to assure provision of services to BCMHC participants, respondents to the study’s interviews and survey indicate that the judge’s demands for inter-agency cooperation also force needed organizational change. Respondents reported that the judge’s actions make the system “more efficient.” The judge’s institutional role and the respect and deference associated with it allow him/her to imprint his/her approach to fair and just treatment on the manner in which cases are handled in BCMHC. Although BCMHC policies and procedures are clearly delineated in its manual, variations in their application to individual cases are seen as the judge exercises the discretion inherent in his/her position. While occasional *ad hoc* rulings by the judge allow BCMHC to meet the individual needs of its participants, these rulings may also challenge the understanding among the judge and team members needed to sustain the collaborative nature of the court-based mental health intervention.

### **Communication and Information Sharing**

Another indicator of operational efficiency is the timeliness of communication and adequacy of information sharing among BCMHC team members. The evidence gathered for this study indicates that there is frequent communication among the team members. Team members reported having access to all of the information from other team members necessary to perform their tasks for each case. The monthly administrative meetings and semi-weekly docket meetings

address information gaps that might emerge if inter-agency communication was not emphasized in BCMHC.

### **Case Eligibility, Participant Flow, and Admission**

Relevant process measures also include whether a specified target number of persons served or quantity and scope of services provided have been achieved and if there is compliance with eligibility criteria set forth in BCMHC policies and procedures.

#### *Eligibility Criteria*

Members of the BCMHC team directly involved in its day-to-day operations demonstrated to the researchers that they consistently understand the eligibility criteria. Team members expressed concerns, however, as to whether there is consistent application of the criteria. Respondents reported that exceptions are made to allow ineligible defendants to participate. Because confirmatory data were not available for this study, this assertion could not be verified. However, this tendency was expressed by both legal and clinical/service team members, increasing the credibility of the assertion.

During the final review process for this report, the judges involved acknowledged changes that had been made in the original eligibility criteria. The Court reported that it now accepts defendants who live in surrounding counties who can be monitored and has accepted defendants who have private insurance. Also reported was the decision to accept defendants with serious cognitive limitations due to mental retardation or brain injury. Available data on the various

jurisdictions in which defendants reside (see data tables in this section) are evidence of this change in policy.

### *Service Provision Targets*

When BCMHC was founded there were no specific target service goals established for the intervention other than an expectation among the organizers of handling an estimated 250 competency cases in District Court. BCMHC did not set specific caseload/capacity targets. A formal needs assessment was not conducted prior to establishment of BCMHC. The capacity of the public mental health system was not assessed before BCMHC was initiated.

The Office of States' Attorney and OPD team members interviewed tended to refer to BCMHC participants as defendants, while the service/clinical team members tended to refer to them as either participants or clients. This semantic distinction in labeling offenders with mental illness reflects the tension between the local criminal justice and community health systems that BCMHC seeks to ameliorate.

## **BCMHC Services**

### *Scope of Services*

The public mental health system (PMHS) pays for most services on a fee-for-service basis. This means they do not buy slots, but rather if the defendant has Medicaid eligibility or is otherwise eligible for services within the PMHS, the services are medically necessary, and there is a willing Medicaid provider, the service will be provided. One criterion for eligibility for services from the PMHS is a status of recently released from a State psychiatric hospital or from

incarceration, BCMHC provides for participants an additional means of access to public mental health services for which they would be eligible in the community. The evidence gathered in this study is not adequate to determine if BCMHC participants have greater access to mental health services or realize appropriate and continued utilization of these services. These dimensions of analysis are candidate measures for an outcome evaluation of BCMHC.

All team members with social work/clinical backgrounds surveyed, regardless of position, understand the variety of services provided through BCMHC. A majority of the team members with legal training could specify the array of available services. BCMHC policies do not, however, include guidelines concerning the array of available services, their intensity or length of treatment.

Team members rated coordination of services for offenders with mental illness as “poor” before the mental health court was established in Baltimore City. When asked to rate coordination of services under BCMHC, survey respondents with legal backgrounds tended to rate coordination as “good” or “excellent,” while clinically trained/service oriented team members tended to report a rating of “good” or “fair.” This suggests higher expectations regarding coordination among the clinical team members. None of the respondents rated mental health coordination within BCMHC as “poor.”

## **Intervention Compliance and Completion and Non-Completion**

Data were not available to assess rates of compliance and completion. Data from the survey of key informants, however, provided information on the strategies used to promote compliance and completion.

### *Rewards and Sanctions*

BCMHC team members described several strategies to promote compliance with the intervention's requirements: there are reward parties, graduation ceremonies and decreased monitoring as participants demonstrate continued evidence of compliance in their court appearances. When participants are non-compliant, sanctions levied by the judge include additional treatment or other services to address the reasons for non compliance. The judge also uses verbal warnings and jail time as sanctions.

### *Criteria for Completion*

Completion of the BCMHC intervention is based on determination by the judge that participants no longer require monitoring by BCMHC. This determination is not based solely on completion of mental health services. As a serious mental disorder is never "cured" one may never "complete" mental health services, but may require less intensive services overtime and may always require some clinical services. It represents an assessment by the judge, supported by information provided by BCMHC team members, that the subject participant no longer requires BCMHC monitoring to support their therapeutic progress and offending avoidance. A participant may also complete BCMHC intervention by virtue of the expiration of their probation.

## **BCMHC Outputs: Case and Service Utilization Data**

### *Data Challenges/Issues*

Individual case data on BCMHC participants have not been systematically collected. FAST collects and reports data to the BMHS as well as to the MSD. It does not, however, distinguish BCMHC cases from other case monitoring and assessments that it may perform. The Institute for Governmental Service and Research (IGSR), University of Maryland-College Park began a process of extracting data from current cases in mental health court in an effort to build individual participant profiles. Data were collected from cases before the court during the first calendar quarter of 2009. The demographic process outputs presented in this report (see below) represent the data extracted during that time period. Thus it represents a cross sectional descriptive profile of cases. Data were not available to examine trends over time.

Since BCMHC's inception, the District Court has maintained a hard copy filing system for its cases. This system is distinguished by the placement of an orange folder for BCMHC participants inside their original court case files. Unique identifying numbers assigned to the orange folders indicate in which courthouses BCMHC cases originated.

### *Reported data*

Prior to IGSR's initiation of BCMHC data entry, the researchers developed the following estimates of the intervention's activity from their interviews with individuals associated with the BCMHC and review of public records:

- 13 – 16 cases are reviewed per docket
- 200 – 250 competency cases are considered per year

- Approximately 4,000 cases have been processed through BCMHC since 2003 and about half of these cases (2,000) were in BCMHC between 2007 and 2008.
- FAST, the primary source organization conducting assessments of offenders with mental illness for BCMHC, screened 1,024 individuals for diversion services and monitored 49 defendants on court-ordered alternatives to incarceration for the fiscal year ending June 2008. However, these numbers include but are not limited to the mental health court. The 49 defendants monitored represent 25% of the referrals made to FAST (Baltimore Mental Health Systems, 2008). Data on the percentages referred were not available.
- As of the publication of this report, on average 30 new cases per month are referred to BCMHC.

In its 2008 annual report, BMHS made reference to the Forensic Assertive Community Treatment Team (FACTT) program funded by BMHS. This state-certified evidence-based program seeks to retain “*forensically involved clients* [offenders with mental illness] *in community settings.*” BMHS reported that between April 2006 and July 2008, 118 persons were enrolled in FACTT. However, the majority of these cases were not in mental health court.

### *Snapshot Profile of Cases*

The case data extracted by IGSR are used here to provide a snapshot profile of the cases. The following set of figures and tables offer a picture of demographic and other characteristics of BCMHC participants for the first calendar quarter of 2009.

Table 4. Demographic characteristics of BCMHC participants.

Race							
Black or African-American		White			Other		
85%		14%			1%		
Gender							
Female				Male			
34%				66%			
Place of residence by county							
Anne Arundel	Baltimore City	Baltimore County	Alexandria, VA	Missing	Total		
3	118	3	1	24	145		
Living Arrangements							
Transitional Housing	Private Residence	Shelter	Street/Outdoors	Unknown			
1%	72%	3%	7%	62%			
Most severe qualifying arrest charge							
Weapons related	Drug related	Assault	Burglary	Nuisance*	Theft	Indecent exposure	Other
3%	19%	32%	5%	12%	5%	3%	21%

\*Nuisance includes several different offenses (disturbing the peace, ungovernable, harassment, telephone misuse, failure to obey lawful order)



Figure 6. BCMHC Participants by Race

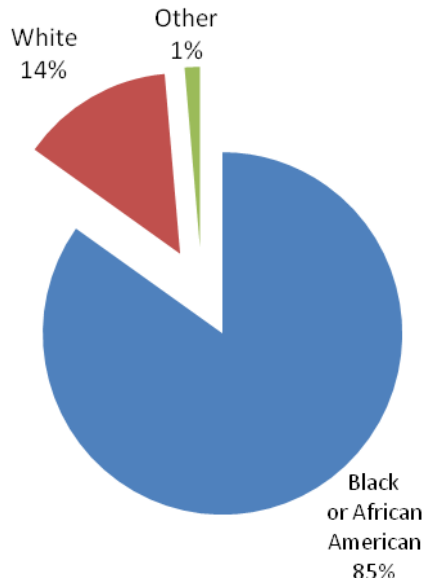


Figure 7. Gender Distribution of BCMHC Participants

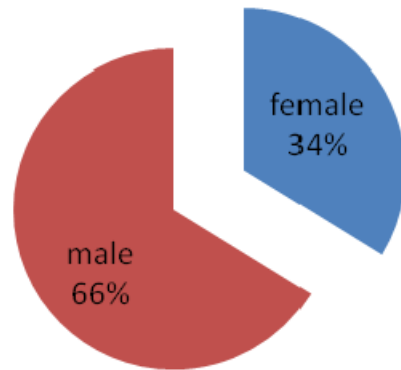


Figure 6. BCMHC Participants' Living Arrangements

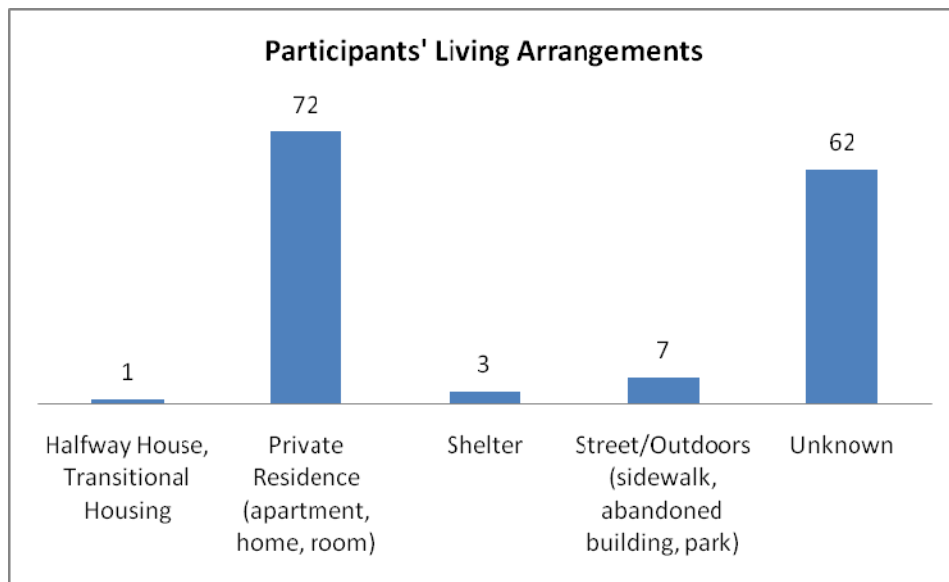
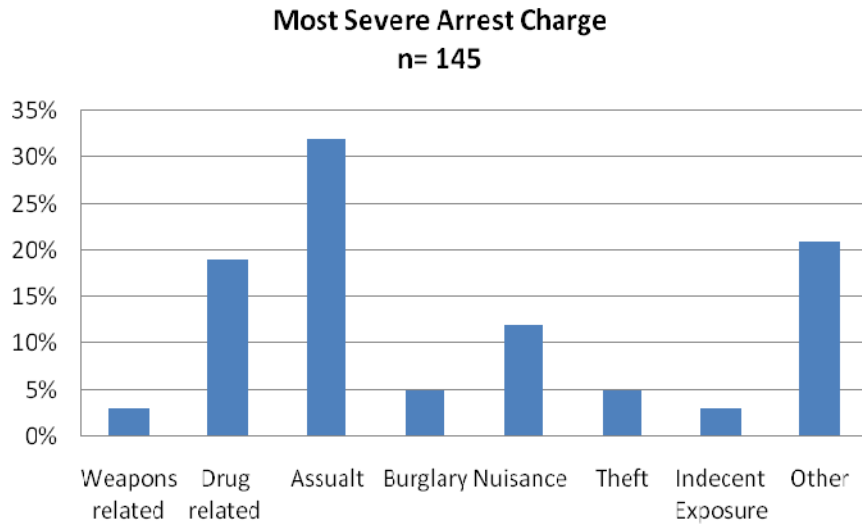


Figure 9. BCMHC Participants' Most Severe Arrest Charge



\* Nuisance includes several different offenses (disturbing the peace, ungovernable, harassment, telephone misuse, failure to obey lawful order)

## **Analysis and Discussion**

The findings from the process evaluation have highlighted several characteristics of BCMHC: Baltimore City's court-based mental health intervention is not a program. Though it serves as a mediating agent to assist offenders with mental illness in gaining access to needed programs and services and operates in a collaborative team like manner, BCMHC still functions as a court under the authority of the judge. The central difference between BCMHC and "business as usual" court settings is largely seen in the specialized and intense nature of its oversight of cases. Judges in other courts might also avail themselves of strategies to meet the needs of offenders with mental illness. BCMHC, however, applies a level of intensity in dealing with offenders with mental illness not seen in other courts.

A specific sub-population of offenders with mental illness is eligible to participate in BCMHC. Only defendants eligible for public mental health services, or services from DDA, and who meet clinical and charge criteria are referred to BCMHC. Defendants with mental illness with adequate financial resources may be ordered by non-BCMHC District Court judges to follow treatment plans that include similar practices and procedures as those found in BCMHC.

The successful operation of BCMHC to meet the needs of indigent offenders with mental illness is highly dependent upon the support and participation of the source organizations that provide clinical assessments, monitoring and supervision and actual clinical services. Despite differences in perspectives and organizational missions, there is a shared commitment among BCMHC's source organizations to serve the best interests of the population served by BCMHC whether they are referred to as "defendants," "clients" or "participants."

The complex inter-organizational pattern of resource provision required to support BCMHC presents it with continuous challenges. Allocation of resources by each source organization is constrained by the organization's willingness and ability to participate in the court-based mental health intervention. So long as the source organizations possess budgetary capacity to support resource provision to BCMHC, and the operation of the court-based intervention adequately aligns with source organization goals, support for BCMHC most likely will continue. Should these conditions change, the nature of BCMHC operation might be threatened.

The analysis also reveals a vulnerability for the sustainability of BCMHC as it currently functions and recognizes early efforts to address this area of vulnerability. The judge as "program champion" raises a challenge for sustainability and institutionalization of the set of collaborations and processes that are currently in place. The power and authority that each judge deems appropriate to assert and shape the direction and scope of their respective courts could leave the court open to modification as its judicial leadership changes. One of the activities implemented that may minimize the impact of change is the ongoing training efforts to include judges and other court officers who currently are not directly involved in mental health court.

Further, the usual indicators that would be evidence of institutionalization within an organization (i.e., a formal identity in organizational charts and a dedicated budget) were not found.

However, the institutionalization of BCMHC within the judiciary might be best assessed in an examination of the sustainability of its practices and procedures within the judicial system, whether centralized in a given problem-solving court (i.e., court docket) or integrated into the

practices and procedures of the court. Such an assessment, however, is not possible without adequate data on the outputs of the court.

A finding that ultimately impacts the ability of the researchers to assess the effectiveness of BCMHC operations involves the historic inadequacy of the intervention's collection and management of case data in a systematic manner. The importance of having adequate data to support policy and management decision-making is highlighted by the perception that ineligible defendants enter BCMHC. As discussed earlier in the report, because systematic data were not available, assessment could not be made of the frequency and reasons for variation from eligibility criteria. Systematically collected and archived data will be useful in discovering why and how often ineligible cases are allowed access to BCMHC and whether there is a need to change the eligibility criteria to include these cases. BCMHC reported continual unsuccessful efforts to create and implement a data collection system, including a work group involving staff from the Judicial Information System (JIS) that identified key data elements. However, JIS lacked the resources to implement such a system. Use of the Statewide Maryland Automated Record Tracking (SMART) system in the future may provide assistance in providing the evidence necessary to make such policy decisions.

Other critical management questions may also go unanswered without the availability of adequate data. For instance, neither the sources of referrals to BCMHC nor the number of requests to be heard by BCMHC denied based on the nature of charges or on mental health assessments have been heretofore tracked. Lack of tracked data prevented the current study from determining what proportion of applications to the BCMHC get accepted or what proportion of

those eligible for the intervention choose conventional adjudication rather than this alternative approach. Likewise, comparison of individuals who choose conventional adjudication versus those who volunteer for BCMHC cannot be made.

The collaborative nature of BCMHC and its variety of source organizations present interesting implications for moving forward to conduct an outcome evaluation. Process evaluation is often performed to identify the essential elements and core operations as a prelude to the assessment of a system or program's outcomes. Answering questions about operations and the level of effort involved in a program or system make it possible to draw inferences about outcomes and the impact of the subject program or system. The data systems that are needed to collect process measures are also needed in order to capture some outcome measures.

As the data management system is constructed to more accurately depict the operations of the court, outcome data elements must also be considered. Since, as was noted earlier, BCMHC essentially operates astride multiple local public service realms and organizational boundaries, outcome research questions should take into account multiple perspectives:

- *From the perspective of the judicial system:* What has been the impact of BCMHC on the court system? Has it contributed to the efficiency and effectiveness of court operations? Has it affected court caseloads? How much does it cost compared to conventional court? Has it improved access to justice and fairness of treatment by the courts for offenders with mental illness.
- *For the broader state and local criminal justice system:* Has BCMHC reduced recidivism? Has it assisted other organizations in the criminal justice system – law

enforcement agencies, prosecutors, public defenders and correctional agencies – become more efficient and effective

- *For the state/local mental health system:* Has BCMHC increased the availability, accessibility and/or quality of services? Has it impacted the efficiency and effectiveness of mental health case management and service delivery?

Beyond the organization and system level outcome questions that emerge from the process evaluation, questions regarding the individual level impact of BCMHC are inferred. *For BCMHC participants* these questions include: Has BCMHC contributed to reduce individual re-offending experience? Has it increased quality of life and daily functioning? Has BCMHC improved the timeliness and effectiveness of the utilization of services by offenders with mental illness?

As the SMART system is applied in BCMHC, attention should be directed to assure that the new system possesses data collection and report generation capability to assist researchers in answering these outcome research questions.

The project undertaken has provided insight into the workings of the multifaceted characteristics of the BCMHC. The research identified the development, structure and operations of BCMHC and within the framework of “essential elements” of mental health courts has revealed strengths and weaknesses. This work should serve as a solid foundation upon which action may be taken to construct an appropriate outcome evaluation for BCMHC, and may also serve a framework by which process evaluations of other mental health courts may be conducted.

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## **List of Acronyms**

ADAA	Alcohol and Drug Abuse Administration
BCBIC	Baltimore Central Booking and Intake Center
BCDC	Baltimore City Detention Center
BCMHC	Baltimore City Mental Health Court
BMHS	Baltimore Mental Health Systems
BSAS	Baltimore Substance Abuse Systems
CFAP	Community Forensic Aftercare Program
CFR	Code of Federal Regulations
CREEP	Community Re-Entry Program
CSA	Core Service Agency
DDA	Developmental Disabilities Administration
DHMH	Department of Health and Mental Hygiene
DPDS	Division of Pretrial Detention and Services
DPP	Division of Parole and Probation
DPSCS	Department of Public Safety and Correctional Services
FACTT	Forensic Assertive Community Treatment Team
FAST	Forensic Alternative Services Team
GOCCP	Governor's Office of Crime Control and Prevention
HCMHDP	Harford County Mental Health Diversion Program
HIPAA	Health Insurance Portability and Accountability Act
IGSR	Institute for Governmental Service and Research
ISTD	Incompetent to stand trial and dangerous
ISTN	Incompetent but non dangerous
MHA	Mental Hygiene Administration
MHP	Maryland Health Partners
MJRC	Maryland Judiciary Research Consortium
MSD	Medical Services Division
NAMI	National Alliance on Mental Illness
NCR	Not criminally responsible
OPD	Office of the Public Defender

PMHS	Public mental health system
PRSP	Pretrial Release Service Program
PTS	
SETT	Secure Evaluation and Therapeutic Treatment unit
SMART	Statewide Maryland Automated Record Tracking

## **Appendix 1**

**Morgan State University School of Community Health and Policy/  
University of Maryland Institute for Governmental Service Research**

### **MENTAL HEALTH COURT EVALUATION PROJECT**

#### **Service Provider Interview**

### General Instructions for Conducting Interview

- ✓ Read consent statement to interviewee before conducting interview
- ✓ Provide interviewee with copy of contact information for the evaluation project.
- ✓ Ask the respondents all applicable questions.
- ✓ If a question appears to have already been answered by the interviewee in a previous statement, you should preface the question with a statement such as
  - *“You may have answered this question in a previous statement, but I would like to confirm your response.”*
- ✓ Transition between sections of the interview using the scripted language provided as a guide. These transition statements provide the interviewee with a sense of the direction and purpose of each set of questions, facilitating the interview process. The transition language may be found in the text box at the beginning of each section of questions.
- ✓ Remind interviewees that they are always welcome to state that they do not know the answer if they do not in fact know the answer.

**Mental Health Court Evaluation**  
**Treatment Provider Questionnaire**

Date of Interview: \_\_\_\_\_ Name of Interviewer: \_\_\_\_\_

**Background Information**

**Interviewer Suggested Script:** *This first series of questions helps to build a relevant professional profile of the mental health court service providers with whom interviews are being conducted.*

1. What is your current position at the treatment program:  
 Director                       Clinical Director                       Supervisor  
 Case Manager                       Counselor/Therapist                       Assessor  
 Intake Coordinator  
 Other: \_\_\_\_\_
  
2. How many months have you worked with the Mental Health Court (MHC) Program?  
\_\_\_\_\_ (months)
  
3. How long have you worked in the Mental Health field? \_\_\_\_\_ (years)
  
4. Do you have any type of specialized degrees?  
 No  
 Yes – Type: \_\_\_\_\_  
\_\_\_\_\_
  
5. Do you have any type of professional certification?  
 No  
 Yes -- Type: \_\_\_\_\_  
\_\_\_\_\_

**Reasons for the MHC**

**Interviewer Suggested Script:** *With the next set of questions, we would like to know what you know about how the mental health court came into being in **Baltimore City**. If you do not know the answer to any of these questions you are always welcome to state that you do not know the answer to any of the questions.*

6. In your opinion, what precipitated the change in the court system to adopt a mental health court?  
\_\_\_\_\_  
\_\_\_\_\_



7. If you know, describe how the court dealt with mentally ill offenders prior to the MHC. Note if there have been changes with the offenders' ability to access treatment since the implementation of the mental health court.

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8. How would you rank the performance of the court in dealing with the mentally ill offender before the planning of the mental health court?

- Excellent  
 Good  
 Fair  
 Poor  
 Terrible  
 Don't know

### Planning of the MHC

**Interviewer Suggested Script:** *This next series of questions seeks information on the planning efforts to establish the mental health court in **Baltimore City**. If you do not know the answer to any of these questions you are always welcome to state that they do not know the answer to any of the questions.*

9. Was anyone from your agency involved in the development of the MHC?  
 No – a. Why do you believe that no one from your organization was involved? (skip to question 23 after an explanation is provided)

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- Yes Provide the position of the person involved in the planning process: \_\_\_\_\_

- Don't Know (SKIP TO QUESTION 23)

10. Were you involved in the creation of the Mental Health Court?

- No (SKIP TO QUESTION 23)  
 Yes

11. How many planning meetings took place? \_\_\_\_\_

12. How many did you attend? \_\_\_\_\_

13. In developing the MHC what were your agencies goals and objectives?

14. Were the goals of the MHC designed around the existing mental health system or was the goal to change the mental health system?

- No
- Yes
- Don't know

15. What population was the MHC designed to serve?

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16. How was the target population identified? \_\_\_\_\_

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17. Why was that population selected? \_\_\_\_\_

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18. Were population selection criteria driven by any of the following (check all that apply):

- Resource availability
- Fiscal conditions
- Political environment
- Other – List:

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19. Were designated treatment slots in the community identified as part of the planning process?

- No
- Yes
- Don't know

20. Were designated treatment slots in the community acquired as part of the planning process?

- No
- Yes
- Don't know

21. How was the issue of balancing the individual's treatment needs and public safety addressed?

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22. What was the process for developing MHC goals and objectives?

Explain:

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## Operations of the MHC

**Interviewer Suggested Script:** *While the previous questions focused on what you knew about the development of the mental health court in **Baltimore City**, for this part of the interview, I will now be asking questions on the current day to day operations of the mental health court in **Baltimore City**.*

23. Have you received written policies and procedures explaining the Mental Health Court?
- No  
 Yes

24. Were you trained on the policy and procedures?
- No  
 Yes -- a. Was the training voluntary or mandatory?
- Voluntary
  - Mandatory
- b. How helpful did you find the training?
- Very helpful
  - Helpful
  - Partially helpful
  - Not helpful

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- c. Do you think that the training covered all of the necessary information needed to perform your job within the rules of the MHC?
- No – Explain:  
\_\_\_\_\_  
\_\_\_\_\_
- Yes

25. Have you received training in any of the following (check all that apply):

- Social work and psychology techniques
- Clinical risk assessment instruments and procedures
- Working with the developmentally disabled
- Working with people with traumatic brain injury
- Working with people with psychiatric disabilities
- Offender Population
- Communication strategies (e.g. motivational enhancement techniques)
- Procedural justice techniques
- Other – Describe: \_\_\_\_\_

26. What are the criteria used to:

a. Include participants in MHC: (Describe)

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b. Exclude participants from MHC: (Describe)

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27. Is a **STANDARDIZED** mental health assessment used to determine eligibility and treatment planning?

No

Yes -- Describe:

Don't know

28. Are assessments for co-occurring disorders conducted?

No

Yes

Don't know

29. Are there any policies or guidelines for the type of services to be provided to mental health court participants?

No

Yes – Describe:

Don't know

30. Are there any policies or guidelines for the following:

	Yes	No	Don't Know
Intensity of treatment			
Length of Time			

31. Can you tell me the specific goals and objectives for the MHC's review hearings in the court. Describe:

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32. Do legal factors such as (see below) impact the treatment plan?

	Yes	No	Don't Know
Criminal History			
Probation/Parole status			
Type of charge			

33. Does victim input impact the treatment plan?

- No  
 Yes  
 Don't know

### Services and Resources

**Interviewer Suggested Script:**

*We are about half way through the interview. The aim of the next few questions is to learn more about the services and resources available to mental health court clients.*

34. Are there designated treatment slots in the community for program participants?

- No  
 Yes  
 Don't know

35. Which of the following do you provide to your MHC clients?

- Day treatment  
 Individual therapy  
 Intensive psychiatric rehabilitation  
 Psychosocial clubs (e.g., self help groups)  
 Assertive community treatment (ACT) teams  
 Community based case management services  
 Addiction counseling  
 Family counseling  
 Other: \_\_\_\_\_

36. Does your agency coordinate access for MHC participants to the following resources:

- No
- Yes -- a. Which of the following do you use?
  - Housing
  - Transportation
  - Vocational and Educational Services
  - Job Placement
  - Food banks
  - Medicaid/Other Healthcare
  - Other – List: \_\_\_\_\_
  - I am not aware of any.

a. How are the interactions with these systems and/or organizations developed and managed?

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37. Does your agency provide services for participants with co-occurring disorders?

- No
- Yes - Describe: \_\_\_\_\_
- Don't know

37a If no, does your agency coordinate access to substance abuse treatment?

- Yes
- No

### Consent and Confidentiality

#### Interviewer Suggested Script:

*It is important for the evaluation to understand how matters of consent and confidentiality are handled.*

38. Does the consent process allow you to share confidential information?

- No
- Yes-- a. Which of the following can you share treatment information with?
  - Judge
  - Prosecutor
  - Defense Attorney
  - Case Manager
  - Clinical Staff
  - Probation Officer
  - Coordinator
  - Other: \_\_\_\_\_
  - Don't know

39. In your opinion, what kinds of confidentiality protections are appropriate for the information that defendants reveal. (Types of information such as mental health diagnosis, details of the crime, length of treatment diagnosis, and history of illness)

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40. How would you compare the right to privacy and privilege of mental health court participants compared with persons in treatment who are not in mental health court?

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**Clients**

**Interviewer Suggested Script:**

*Without looking at individual case records, we would like to know more about the clients you serve in the MHC.*

41. Which of the following reasons appear to be influential in a defendant's decision to participate in the MHC?

- Avoid incarceration     Receive treatment for mental illness  
 Receive treatment for drug problem     Other: \_\_\_\_\_

a. Of these, which is the most important:

- Avoid incarceration     Receive treatment for mental illness  
 Receive treatment for drug problem     Other: \_\_\_\_\_

42. In your estimation, approximately what percentage of the offenders in the MHC have a history of mental illness prior to this arrest? (indicate percentage) \_\_\_\_\_

43. In your estimation, approximately what percentage of the offenders in the MHC have a history of encounters with the mental health system prior to this arrest? (indicate percentage)

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44. Have there been any exceptions to allow ineligible defendants to participate?  
 No  
 Yes --Explain: \_\_\_\_\_  
 Don't know

45. On average, how many contacts per month do you have with your MHC clients? (give number)

46. Are clients involved in the creation of their treatment plan?  
 No – Explain: \_\_\_\_\_  
 Yes -- Explain: \_\_\_\_\_  
 Don't know

### Sanctions & Incentives

47. Do your clients sign behavior contracts?  
 No  
 Yes -- How is compliance with behavior contracts tracked and monitored?  
\_\_\_\_\_  
 Don't know

48. Do you use sanctions when a client exhibits negative behavior?  
 No – What type of action do you take? \_\_\_\_\_  
\_\_\_\_\_  
 Yes a. What kind of sanctions do you use? \_\_\_\_\_  
b. Do you think the use of sanctions is effective with this population? \_\_\_\_\_  
c. How are the sanctions given? \_\_\_\_\_

49. Do you use incentives when a client exhibits positive behavior?  
 No  
 Yes – a. What types of incentives are used? \_\_\_\_\_  
b. Do you think the use of incentives is effective with this population?  
\_\_\_\_\_  
c. How are the incentives given? \_\_\_\_\_



## Teamwork

### Interviewer Suggested Script:

*The mental health court team consists of service providers and officers of the court (e.g., the judge, defendant's attorney, parole officer, State's attorney. In your role as one of the members of the MHC team, we would like to know your perspective on how the team operates.*

50. In your opinion, do some team members have more influence over final decisions regarding treatment planning?

- No  
 Yes -- a. Which team members? \_\_\_\_\_

51. Are there any team member conflicts?

- No  
 Yes -- a. How are these conflicts dealt with? \_\_\_\_\_  
 Don't know

52. How often is client progress and compliance shared?

- Daily  
 Weekly  
 Biweekly  
 Monthly  
 Only at court.  
 Never

53. How interrelated is your role to the roles of the other MHC team members?

- Highly interrelated  
 Somewhat interrelated  
 Not interrelated (Independent of one another)

54. Do you immediately notify the other MHC team members of changes in compliance such as failure to appear for treatment session, drug use, non-compliance with medication?

- No – a. Why not?  
 Yes –b. Which events do you notify other team members about immediately?

\_\_\_\_\_  
 Don't know

**Other Issues/Team Member Opinions**

**Interviewer Suggested Script:**

*We are near the end of the interview. This is the last set of questions.*

55. How would you rate the coordination of the services among treatment providers and the court when there is a problem?

- Excellent
- Good
- Fair
- Poor
- Terrible
- I do not communicate with other team members and/or the court.

56. In your opinion, is mental health court implemented without racial, ethnic, gender, or socioeconomic status bias?

- No – Explain:  
\_\_\_\_\_
- Yes
- Don't know

57. How would you describe the way participants are being treated in the program? Is it:

- Fairly                       Unfairly
- Justly                         Unjustly
- Respectfully                Disrespectfully
- With dignity                Without dignity
- Other: \_\_\_\_\_ ?

58. Do you trust the legal staff to balance the clinical needs with public safety concerns when creating a treatment plan for program participants?

- No – Explain:  
\_\_\_\_\_
- Yes -- Explain:  
\_\_\_\_\_
- Don't know

59. Do you think that all needed services are available?

- No – Explain:  
\_\_\_\_\_
- Yes -- Explain:  
\_\_\_\_\_
- Don't know

60. Do you think that clients are actually receiving all of the services that they need?

No – Explain:

\_\_\_\_\_

Yes -- Explain:

\_\_\_\_\_

Don't know

61. Do you think that everyone has the same goals for balancing treatment and public safety?

No – Explain:

\_\_\_\_\_

Yes-- Explain:

\_\_\_\_\_

Don't know

62. Do you think that the MHC is successful at reducing recidivism?

No – Explain:

\_\_\_\_\_

Yes-- Explain:

\_\_\_\_\_

Don't know

63. Do you think that the MHC is a successful program that should be retained?

No – Explain:

\_\_\_\_\_

Yes

Don't know

64. Please rate your agreement with this statement. The MHC helps to break down the stigma and misconceptions that keep many people with mental illness isolated and marginalized

Completely agree

Somewhat agree

Neither agree nor disagree

Somewhat disagree

Completely disagree

Explain: \_\_\_\_\_

65. What do you see as the limitations of what the MHC can achieve?

\_\_\_\_\_

\_\_\_\_\_

**Suggested Script:**

*We are at the end of the interview but before closing I would like some personal information from you which you may or may not wish to provide.*

66. What is your age? \_\_\_\_\_

67. Sex :  Male  
 Female

68. Race/Ethnicity:  Black (non-Hispanic)       White (non-Hispanic)       Hispanic  
 Asian     American Indian  
 Other \_\_\_\_\_

**Suggested Script for Closing Statement:**

*Thank you very much, Mr./Ms/Dr \_\_\_\_ for your willingness to participate in this survey and for the important information you have provided us about the role of your organization in the mental health court/diversion program. The information collected from all the providers will be summarized and shared with you and your organization. If you have any question for me I will be glad to answer, and if you need to follow up on the project please contact the PI at Morgan with the contact information provided earlier. Thank you for your time.*

## Appendix 2

Morgan State University School of Community Health and Policy/  
University of Maryland Institute for Governmental Service Research

### MENTAL HEALTH COURT EVALUATION PROJECT

#### Court Observation Form

Instructions: Complete one form each time you visit court.

Observer Name: \_\_\_\_\_

Date of Observation: \_\_\_\_\_

Observation Time Start: \_\_\_\_\_

Observation Time End: \_\_\_\_\_

Length of Docket: \_\_\_\_\_

Number of Cases: \_\_\_\_\_

County/City: \_\_\_\_\_

## MENTAL HEALTH COURT PROGRAM

### Court Observation Form

Date: \_\_\_\_\_  
 Court: \_\_\_\_\_  
 Case ID: \_\_\_\_\_  
 Observer: \_\_\_\_\_

*Instructions:* Complete this form for each case called. Circle the appropriate answer and write applicable notes.

1. Did the defendant appear?  
 No  
 Yes (if no, skip to Narrative Section)
  
2. What was the defendant's gender?  
 Male  
 Female
  
3. Which appearance was this?  
 Initial  
 Planning  
 Follow-up
  
4. How many service provider representatives were in court? \_\_\_\_\_
  
5. Who was present and in what number? (Please check all that apply)

Type	Present	Number
Case Manager		
Public Defender		
Probation officer/agent		
Treatment Provider		
Housing Manager		
Substance abuse		
Family		
Other (Describe)		

6. What do the service providers report (check all that apply)?  
 Positive Feedback/good report  
 Negative Feedback/negative report  
 Neutral Feedback/only update on status  
 Other (describe) \_\_\_\_\_  
 \_\_\_\_\_
  
7. Which of the following occurred during the court session? (check all that apply)  
 Warrant for the defendant's arrest Describe: \_\_\_\_\_  
 Incentive (Describe): \_\_\_\_\_  
 Sanction (Describe): \_\_\_\_\_

**Judge**

8. Does the judge appear to be supportive of the defendant?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_

9. Does the judge appear to be satisfied with the defendant's progress?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_

10. Rate the judge's level of familiarity with the case  
 Not familiar  
 Somewhat familiar  
 Knowledgeable

a. Approximately how long did the judge interact directly with the defendant? (Indicate time in minutes) \_\_\_\_\_

11. Which of the following occur during the interaction? (check all that apply)  
 Judge converses with the defendant  
 Judge makes eye contact with the defendant  
 Judge asks the defendant probing/in-depth questions  
 Defendant approaches the bench  
 Judge shakes the defendant's hand  
 Other parties present approach the bench without the defendant  
Describe: \_\_\_\_\_  
 Other (Describe): \_\_\_\_\_

**State's Attorney**

12. Does the State's Attorney appear to be supportive of the defendant?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_

13. Does the State's Attorney appear to be satisfied with the defendant's progress?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_

14. Which of the following occur during the interaction (check all that apply):  
 State's Attorney converses with the defendant  
 State's Attorney makes eye contact with the defendant  
 State's Attorney shakes the defendant's hand  
 Other (Describe): \_\_\_\_\_

15. Rate the State's Attorney's level of familiarity with the case  
 Not familiar  
 Somewhat familiar  
 Familiar

**Defense Counsel**

16. Does the Public Defender/Defense Attorney appear to be supportive of the defendant?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_
17. Does the Public Defender/Defense Attorney appear to be satisfied with the defendant's progress?  
 Yes (Describe): \_\_\_\_\_  
 No (Describe): \_\_\_\_\_
18. Rate the Public Defender/Defense Attorney's level of familiarity with the case  
 Not familiar  
 Somewhat familiar  
 Familiar  
a. Approximately how long did the Public Defender/Defense Attorney interact directly with the defendant? (Indicate time in minutes) \_\_\_\_\_
19. Which of the following occur during the interaction? (check all that apply)  
 Public Defender/Defense Attorney converses with the defendant  
 Public Defender/Defense Attorney makes eye contact with the defendant  
 Public Defender/Defense Attorney speaks to the defendant at length during session  
 Public Defender/Defense Attorney shakes the defendant's hand  
 Other (Describe): \_\_\_\_\_

**Narrative**

Provide a brief narrative of the case including information when defendant fails to appear (FTA) for scheduled court session.

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## **Appendix 3**

**University of Maryland Institute for Governmental Service Research/  
Morgan State University School of Community Health and Policy**

**MENTAL HEALTH COURT EVALUATION PROJECT**

**Baltimore City  
Criminal Justice Interview**

### General Instructions for Conducting Interview

- ✓ Read consent statement to interviewee before conducting interview
- ✓ Provide interviewee with copy of contact information for the evaluation project.
- ✓ Ask the respondents all applicable questions.
- ✓ If a question appears to have already been answered by the interviewee in a previous statement, you should preface the question with a statement such as
  - *“You may have answered this question in a previous statement, but I would like to confirm your response.”*
- ✓ Transition between sections of the interview using the scripted language provided as a guide. These transition statements provide the interviewee with a sense of the direction and purpose of each set of questions, facilitating the interview process. The transition language may be found in the text box at the beginning of each section of questions.
- ✓ Remind interviewees that they are always welcome to state that they do not know the answer if they do not in fact know the answer.

**Mental Health Court Evaluation  
Criminal Justice Questionnaire**

Date of Interview: \_\_\_\_\_

**Background Information**

**Interviewer Suggested Script:** *This first series of questions helps to build a relevant professional profile of the mental health court criminal justice team with whom interviews are being conducted.*

46. Age: \_\_\_\_\_

47. Sex :  Male  
 Female

48. Race/Ethnicity:  Black (non-Hispanic)     White (non-Hispanic)     Hispanic  
 Asian     American Indian  
 Other \_\_\_\_\_

49. How many months have you worked for MHC \_\_\_\_\_ (months)

50. What is your current position at the MHC :

Judge                                       State's Attorney     Supervisor  
 Case Manager                               Public Defender     Private Defense Attorney  
 Pre-Release Officer                       Parole/Probation Officer  
 Intake Coordinator                       Other: \_\_\_\_\_

51. How long have you worked with mentally ill offenders? \_\_\_\_\_

52. Do you have any type of professional certification?

No  
 Yes Type: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

53. Do you have any type of specialized degrees?

No  
 Yes Type: : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Reasons for the MHC

**Interviewer Suggested Script:** *With the next set of questions, we would like to know what you know about how the mental health court came into being in **Baltimore City**. If you do not know the answer to any of these questions you are always welcome to state that they do not know the answer to any of the questions.*

54. How would you rank the performance of the court in dealing with the mentally ill offender before the planning of the mental health court?

- Excellent
- Good
- Fair
- Poor
- Terrible
- Don't know

55. In your opinion, what precipitated the change in the court system to adopt a mental health court? \_\_\_\_\_

56. Describe how the court dealt with mentally ill offenders prior to the MHC. Note if there have been changes with the offenders' ability to access treatment since the implementation of the mental health court. \_\_\_\_\_

## Planning of the MHC

**Interviewer Suggested Script:** *This next series of questions seeks information on the planning efforts to establish the mental health court in **Baltimore City**. If you do not know the answer to any of these questions you are always welcome to state that you do not know the answer to any of the questions.*

57. Was anyone from your agency involved in the development of the MHC?

- No a. Why do you believe that no one from your organization was involved? (skip to question 27 after an explanation is provided)

Yes Provide the position of the person involved in the planning process: \_\_\_\_\_

- Don't Know (skip to question 27)

58. Were you involved in the development of the MHC?

- No (skip to question 27)
- Yes

59. How many planning meetings took place? \_\_\_\_\_

60. How many did you attend? \_\_\_\_\_

61. In developing the MHC what were your agencies goals and objectives?  
\_\_\_\_\_  
\_\_\_\_\_

62. Were the goals of the MHC designed around the existing mental health system or was the goal to change the mental health system?  
\_\_\_\_\_

63. What population was the MHC designed to serve?  
\_\_\_\_\_

64. How was the target population identified?  
\_\_\_\_\_

65. Why was that population selected?  
\_\_\_\_\_

66. Was the availability of resources taken into account before selecting a target population?  
 No  
 Yes  
 Don't know

67. Were population selection criteria driven by any of the following (check all that apply):  
 Resource availability  
 Fiscal conditions  
 Political environment  
 Other – List:  
\_\_\_\_\_

68. Were designated treatment slots in the community identified as part of the planning process?  
 No  
 Yes  
 Don't know

69. Were designated treatment slots in the community acquired as part of the planning process?  
 No  
 Yes  
 Don't know

70. How was the issue of balancing the individual's treatment needs and public safety addressed?

\_\_\_\_\_

71. What was the process for developing MHC goals and objectives?

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Operations of the MHC

**Interviewer Suggested Script:** *While the previous questions focused on what you knew about the development of the mental health court in **Baltimore City**, for this part of the interview, I will now be asking questions on the current day to day operations of the mental health court in **Baltimore City**.*

72. Did you receive written policies and procedures explaining the MHC upon your hire?

No

Yes

73. Were you trained on the policy and procedures upon your hire?

No

Yes a. Was the training voluntary or mandatory?

Voluntary

Mandatory

b. How helpful did you find the training?

Very helpful

Helpful

Partially helpful

Not helpful

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Do you think that the training covered all of the necessary information needed to perform your job within the rules of the MHC?

No Explain: \_\_\_\_\_

Yes \_\_\_\_\_

74. Have you received training in any of the following (check all that apply):

- Communication strategies (e.g. motivational enhancement techniques)
- Procedural justice techniques
- Social work and psychology techniques
- Clinical risk assessment instruments and procedures
- Working with the developmentally disabled
- Working with people with traumatic brain injury
- Working with people with psychiatric disabilities
- Offender population
- Other – Describe: What are the criteria used to:

a. Include participants in MHC:

Describe: \_\_\_\_\_

b. Exclude participants from MHC:

Describe: \_\_\_\_\_

75. Is a **STANDARDIZED** mental health assessment used to determine eligibility and treatment planning?

- No
- Yes Describe: \_\_\_\_\_
- Don't know

76. Are assessments for co-occurring disorders conducted?

- No
- Yes Describe: \_\_\_\_\_
- Don't know

77. Are there any policies or guidelines of the type of services to be provided?

- No
- Yes Describe: \_\_\_\_\_
- Don't know

78. Are there any policies or guidelines for the following:

	Yes	No	Don't Know
Intensity of treatment			
Length of Time			

79. State the specific goals and objectives for the MHC's review hearings. Describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

80. Do any of the following legal factors impact the treatment plan?

	Yes	No	Don't Know
Criminal History			
Probation/Parole status			
Type of charge			

81. Does victim input impact the treatment plan?

- No  
 Yes  
 Don't know

**Services and Resources**

**Interviewer Suggested Script:**

*We are about half way through the interview. The aim of the next few questions is to learn more about the services and resources available to mental health court clients.*

82. Are there designated treatment slots in the community for program participants?

- No  
 Yes  
 Don't know

83. Which of the following is provided to the MHC offenders?

- Day treatment     Individual therapy     Intensive psychiatric rehabilitation  
 Psychosocial clubs     Assertive community treatment (ACT) teams  
 Community based case management services     Addition counseling  
 Other: \_\_\_\_\_

84. Does your agency coordinate access for MHC participants to ancillary services:

- No  
 Yes a. If yes, which of the following do you coordinate? (Check all that apply)  
 Housing  
 Transportation  
 Vocational and Educational Services  
 Job Placement  
 Food banks  
 Medicaid/Other Healthcare  
 Other – List: \_\_\_\_\_

b. How are the interactions with these systems and/or organizations developed, managed, and maintained?

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85. Does your agency provide services for participants with co-occurring disorders?

No a. Does your agency coordinate access to co-occurring disorders?

No

Yes Describe: \_\_\_\_\_

Don't know

Yes Describe: \_\_\_\_\_

Don't know

### Consent and Confidentiality

#### Interviewer Suggested Script:

*It is important for the evaluation to understand how matters of consent and confidentiality are handled.*

86. Does the consent process allow you to share confidential information?

No

Yes a. Which of the following can you share treatment information with?

Judge

Prosecutor

Defense Attorney

Case Manager

Clinical Staff

Probation Officer

Coordinator

Other: \_\_\_\_\_

Don't know

87. In your opinion, what kinds of confidentiality protections are appropriate for the information that defendants reveal? (Types of information such as mental health diagnosis, details of the crime, length of treatment diagnosis, and history of illness)

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88. How would you compare the right to privacy and privilege of mental health court participants compared with persons in treatment who are not in mental health court?

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89. Did the MHC plan to develop, manage, and maintain interactions with other systems?

No a. Were there any specific obstacles that prevented this from happening?

No

Yes – Describe: \_\_\_\_\_

Don't know

Yes b. What were those other systems? (list): \_\_\_\_\_

Don't know

## Offenders

### Interviewer Suggested Script:

*Without looking at individual case records, we would like to know more about the offenders you serve in the MHC.*

90. Does the offender have the option to withdraw from the MHC after they have started the program?

No

Yes

Explain: \_\_\_\_\_

Don't know

91. Which of the following reasons appear to be most influential in an offender's decision to participate in the MHC? (Check all that apply)

\_\_\_ Avoid incarceration

\_\_\_ Receive treatment for mental illness

\_\_\_ Receive treatment for drug problem

\_\_\_ Other: \_\_\_\_\_

a. Of these, which is the most important?

\_\_\_ Avoid incarceration

\_\_\_ Receive treatment for mental illness

\_\_\_ Receive treatment for drug problem

\_\_\_ Other: \_\_\_\_\_

92. From your estimation, approximately what percentage of the offenders in the MHC have a history of mental illness prior to this arrest? (indicate percentage) \_\_\_\_\_

93. In your estimation, approximately what percentage of the offenders in the MHC have a history of encounters with the mental health system prior to this arrest? (indicate percentage) \_\_\_\_\_

94. What happens to defendants who opt into the MHC but have their case transferred to a conventional court?

\_\_\_\_\_  
\_\_\_\_\_

95. Have there been any exceptions to allow ineligible defendants to participate?

No

Yes Explain: \_\_\_\_\_

Don't know

96. On average, how many contacts do you have with your MHC offenders? (give number) \_\_\_\_\_

97. Are offenders involved in their treatment mandate?

- No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know

### Sanctions & Incentives

#### Interviewer Suggested Script:

*The next set of questions involve finding out information about how the court deals with non-compliant and compliant offenders.*

98. Do offenders sign behavior contracts?

- No  
 Yes How is compliance with behavior contracts tracked and monitored?  
\_\_\_\_\_  
 Don't know

99. Do you use sanctions when an offender exhibits negative behavior?

- No What type of action do you take? \_\_\_\_\_  
\_\_\_\_\_  
 Yes a. What kind of sanctions do you use? \_\_\_\_\_  
b. Do you think the use of sanctions is effective with this population?  
 No  
 Yes  
 Don't know  
c. How are the sanctions given? \_\_\_\_\_

100. Do you use incentives when an offender exhibits positive behavior?

- No  
 Yes a. What types of incentives are used? \_\_\_\_\_  
b. Do you think the use of incentives is effective with this population?  
 No  
 Yes  
 Don't know  
c. How are the incentives given? \_\_\_\_\_

### Court Process

#### Interviewer Suggested Script:

*We would like to know more about the MHC court process.*

101. Does the judge monitor all participants in the MHC?

- No  
 Yes Explain: \_\_\_\_\_  
 Don't know

102. How would you rate the judge's role in monitoring progress and compliance?

- Essential
- Somewhat helpful
- The judge does not have a role in this area.

103. How would you rate the judge's effectiveness at managing public safety?

- Highly effective
- Moderately effective
- Effective
- Highly ineffective
- Moderately Ineffective
- Ineffective

104. From your estimation, what percentage of eligible offenders opt to go through traditional court? (list percentage)\_\_\_\_\_

a. In your opinion, why would some offenders choose tradition court over the MHC? \_\_\_\_\_

105. Are offenders with co-occurring issues (e.g. substance abusers with mental illness) accepted into the MHC?

\_\_\_\_\_

### Teamwork

#### Interviewer Suggested Script:

*The mental health court team consists of service providers and officers of the court (e.g., the judge, defendant's attorney, parole officer, State's attorney. In your role as one of the members of the MHC team, we would like to know you perspective on how the team operates.*

106. In your opinion, do some team members have more influence over final decisions regarding treatment mandate?

- No
- Yes a. Which team members? \_\_\_\_\_

107. Are there any team member conflicts?

- No
- Yes a. How are these conflicts dealt with? \_\_\_\_\_
- Don't know

108. How often is offender progress and compliance shared?

- Daily
- Weekly
- Monthly
- Only at court
- Never

109. How interrelated is your role to the roles of the other MHC team members?
- Highly Interrelated  
 Somewhat Interrelated  
 Not Interrelated (Independent of one another)
110. Do you immediately notify the other MHC team members of changes in compliance such as failure to appear for treatment session, drug use, non-compliance with medication?
- No a. Why not?  
 Yes b. Which events do you notify other team members about immediately?
- 
- Don't know

**Other Issues/Team Member Opinions**

**Interviewer Suggested Script:**

*We are near the end of the interview. This is the last set of questions.*

111. How would you rate the coordination of the services among treatment providers and the court when there is a problem?
- Excellent  
 Good  
 Fair  
 Poor  
 Terrible  
 I do not communicate with other team members and/or the court.
112. In your opinion, is mental health court implemented without racial, ethnic, gender, or socioeconomic status bias?
- No Explain: \_\_\_\_\_  
 Yes  
 Don't know
113. How can you describe the way participants are being treated in the program? Is it:
- Fairly             Unfairly  
 Justly             Unjustly  
 Respectfully    Disrespectfully  
 With dignity    Without dignity
114. Do you trust the treatment staff to balance the public safety concerns when creating a treatment plan for program participants?
- No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know

115. Do you think that all needed services are available?  
 No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know
116. Do you think that offenders are actually receiving all of the services that they need?  
 No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know
117. Do you think that everyone has the same goals for balancing treatment and public safety?  
 No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know
118. Do you think that the MHC is successful at reducing recidivism?  
 No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know
119. Do you think that the MHC is a successful program that should be retained?  
 No Explain: \_\_\_\_\_  
 Yes Explain: \_\_\_\_\_  
 Don't know
120. Please rate your agreement with this statement. The MHC helps to break down the stigma and misconceptions that keep many people with mental illness isolated and marginalized.  
 Completely agree  
 Somewhat agree  
 Neither agree nor disagree  
 Somewhat disagree  
 Completely disagree  
 Explain: \_\_\_\_\_
121. What do you see as the limitations of what the MHC can achieve?  
 \_\_\_\_\_  
 \_\_\_\_\_

## Appendix 4

### Interview Questions for Representatives of Source Organizations

How was your organization been involved in the development of Baltimore City's Mental Health Court?

What is the nature of the relationship of your agency/office to the mental health court program and the agency/office's role in the operations of Baltimore's Mental Health Court? Are parameters of the relationship, inclusive of respective roles and responsibilities formalized through MOU/MOAs? Could we obtain a copy of or review the MOU

[Probe for methods of interacting and communicating (e.g., joint meetings, consultations, shared staff, shared reports, committees, etc) Seek to gather information on the agency/office engages in the day to day operations of the mental health court]

Who in your agency/office makes decisions that may have influence the work of the Mental Health Court? Describe. [Seek the name of the person and their position/title]  
What type of impact – e.g. case eligibility, case disposition, services offered, and etc.

Does your agency/office contribute resources to the operation of Baltimore's Mental Health Court? What type of resources – e.g., staff, mental health services, other operational supports, funds and etc.? Are there dedicated funds from the operating budget? Describe any resources provided and the mechanism for sharing such resources.

What data does your agency/office maintains which may document the work that the agency/office does for Mental Health Court (e.g., assessment and coordination meetings, referrals, participants, encounters, frequency of court sessions attended by staff, and etc)?

Do you know of any other agencies/offices would have data that would help in documenting the operations of the court?

*Ask the following if info was not offered or provided during an earlier part of the interview]*

As a representative of your agency/office, how are you involved in the implementation of mental health court in Baltimore City?

Is there anyone else in your organization with whom we should talk that is knowledgeable about the day to day operations of Mental Health Court in Baltimore?

*[Ask for name, title and contact information]*