

2017

Professionals' Perspective on Mental Health Courts

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Walden University

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Martha Amos

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Walden University

2017

Abstract

Professionals' Perspective on Mental Health Courts

by

Martha Amos

M.S., Adams University 2012

B.A., Colorado Christian College 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the degree of

Doctor of Philosophy

Psychology

Walden University

July 2017

Abstract

In recent years, the percentage of incarcerated individuals with mental illness has dramatically increased. It is very hard to provide treatment and care for these defendants in jails or prisons. Currently, there are more mentally ill individuals incarcerated than in psychiatric hospitals. Furthermore, as budget cuts are being decided, urban and rural communities in America are looking at ways to help the mentally ill by initiating a mental health court (MHC) or continuing to fund an already existing MHC. Guided by the therapeutic jurisprudence theory, the purpose of this study was to elicit the opinions from MHC professionals regarding the strengths and weaknesses of MHCs in addressing the needs of defendants, their victims, and the communities in which they live, in order to gain the recommendations for program improvement from the professionals who have knowledge of the impact of public safety, recidivism rates, and quality of life for mentally ill defendants. Study participants answered questions about several aspects of MHCs, such as length of incarceration, application of the therapeutic jurisprudence theory, treatment planning, and institutional budget constraints. The interviews were coded using NVivo, looking for common words, statements, and themes across responses. Mental health courts have been shown to save thousands of dollars to local community budgets, provide professional support and complete the judicial system requirements. This study furthers social change by supporting the rationale for MHCs: to help prevent defendants with mental illness involved in the criminal justice system from reoffending, thereby improving community safety and reducing justice system costs over the long term.

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Dedication

This is dedicated to all the people in my life who told me I could do this, and to the ones who told me to stop wasting money and don't go back to school they pushed me to succeed. To my dad who is looking down from heaven, he was always proud of me no matter what I did in my life. I strive to be that parent to my kids. My step dad who would encourage me every time I would see him, he is also looking down from heaven. This goes to the two men who made it all ok. This dedication goes to the amazing woman in my life who showed me that hard work pays off, and not to give up on my dreams, she worked at time 3 jobs to make sure we had food on the table and never complained about her life. My mom is an amazing lady and showed me to work hard and not give up.

Acknowledgments

I would like to take the opportunity to thank GOD; he has always guided me, I just never took the path he wanted me on, I would stray, and then find my way back. My family members for being so patient throughout the process. My wife Amy for taking care of our child, doing all the house work, and not getting upset when I would say “I don’t have time to do that right now.” She sat and listened for hours as I read and re-read my dissertation to her, making changes and then re-reading it. She never complained or ask me to find someone else to read it too. I want to thank my children Jamie for running the office every day while I did school work and therapy and never complained. She would greet me with a smile every day and tell me what issues the office had and assured me they were fixed. She talked to probation and clients and kept the counseling center running smooth. She made my schedule so that I could always have an hour or two to focus on the research and not worry about the office. I want to thank Austin for being so encouraging, we would sit and talk for hours about mental health courts, and he was always as interested as I was or at least he pretended to be, so it kept me motivated. I want to remind Amber something that she once said to me “if it's important then it is worth working for.” There have been times when things did not feel like this was ever going to happen and I would just remember what you said. I also want to thank my youngest RyAnn for all the hugs that I needed during those long weekends. She would help to clean the house and never get upset when I couldn't make a soccer game or play dolls with her.

A special THANKS to my best friend, Larry Amos who has been in my life for over 26 years and has encouraged me and reminded me when I was down to keep going.

He loves to joke a lot with me to keep me smiling. He would tell me that I could do this and encouraged me to stick with it.

To Traci who edited this book for free, chapter after chapter. Amanda Eckhart who listened to tape after tape and then help to make sure the data was correct. Richard Ott a research professor who helped me through the quantitative research in my PhD classes.

I want to thank my chair Dr. Palomino de Velasco, she has been amazing, and every time we talked, I would feel better about the direction she provided. She wasn't afraid to ask the tough questions and make me think about this research and the impact it could have on others' lives. I had the opportunity to meet her in person and was full of questions that she had no problem answering all of them. My methodologist Dr. Xuereb for all the hard work she did via Skype, we worked on my Chapter 3 for hours on the weekends until it was ready to go. She let me know I could do this, and when I felt internal doubt, she would just give me encouraging words. Both amazing women walked this entire journey with me and never gave up on me. I would also like to thank Dr, Tracy Mallett for all of her help with such an important step in this process, without these three women this would not have been possible.

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Chapter 1: Introduction to the study

Introduction

In the early 21st century, states responded to the mental health crisis that had begun to grip the nation by developing mental health courts (MHC; Lurigio & Snowden, 2009). The intent was to divert defendants away from the criminal courts and into a court designed specifically to handle the needs of the mentally ill (Lurigio & Snowden, 2009). An MHC is a problem-solving court that looks at defendants, their mental health issues, and the crimes they are accused of committing. It uses a specialized team of professionals to develop a treatment plan and sanctions that fit with the parameters of an individual's mental illness and the crime (Lurigio & Snowden, 2009). MHCs are a hybrid between the criminal justice system and the mental health treatment world. The purpose of the MHCs is to bridge the gap between punishment and treatment. This reflects an attempt to reduce the number of arrests, help defendants access the correct treatment, and try to decrease costs to the community for jail placement. The MHC can also eliminate the need to place defendants with mental illnesses automatically in jails or prisons (Kaplan, 2007). Steadman et al. (2014) assessed the overall cost of savings to the communities by utilizing MHCs. The discussion focused on the millions that will be saved by utilizing other means of treating the mentally ill instead of jails. The Vera Institute looked at the data and cost saving measures in 2015 and reported that treatment options have saved millions instead of incarceration (Subramanian, Delaney, Roberts, Fishman, & McGarry, 2015). MHCs have several different professionals who work with the defendants as a treatment team. This criminal justice team can include judges, district attorneys, public defenders, case workers, probation officers, and a wellness court coordinator. The community resource team can consist of case managers,

therapists, and group facilitators. Some courts have other professionals who will work with the defendants.

The first MHC I studied was started in 2012, designing roles and positions to deal with the mentally ill offenders in its district. The idea was to provide them with treatment options instead of jail. A second court that was used, because the first court did not produce enough participants for this study, was created building on other MHC models from around the nation that could provide evidence-based data on the courts' successes. MHCs were created to address the revolving door of mentally ill offenders (Auge, 2011).

There are many professionals involved in MHCs that are tasked with helping defendants successfully complete all the requirements set by the treatment team. Husman (2013) cited limitations, suggesting that interviewing more professionals may give a well-rounded perception of the mental health courts. The data from professionals helped me to understand where a gap existed either in the treatment planning, the resources, or access to treatment. All professionals were interviewed for this study because some professionals could potentially impact budgets for their MHCs in the future using the results of this research. Finding from research into MHCs can potentially be applicable to other MHCs, as discussed by Trupin and Richards (2003). Understanding the struggles and barriers the professionals have encountered and either overcome or identified as areas in need further assistance could help MHCs reduce the recidivism of defendants. Turpin and Richards cited how understanding the effectiveness of MHCs can help future courts gain knowledge from what worked and what failed so the new courts can avoid costly mistakes made in the past. Professionals have information that can help new courts from conception to success. In this chapter, I review the background of MHCs and discuss in depth the

purpose of this study and the theoretical framework used. I also present potential limitations to using a qualitative method and discuss the scope of the study.

Background of the study

More communities and individuals are requesting answers as to why the mentally ill are being housed in jails or prisons when it costs billions of dollars to the taxpayers to house them. In our current economic environment, the mental health community is experiencing a continuous and drastic reduction in financial aid, while the criminal justice system is demanding more funding than ever before (Honberg, Diehl, Kimbell, Gruttadaro, & Fitzpatrick, 2011). There must be a balance found between housing mentally ill individuals in state hospitals and housing them in jails or prisons. A study conducted by Bloom (2010) looked at the failure of the state institutions and how counties and states have begun a large-scale criminalization of the mentally ill. Bloom (2010) stated that without proper interventions, the mentally ill continue to go in and out of jails and prisons. Constantine (2010) looked at data from a Florida jail comparing the episodes of mental illness to incarceration. Constantine (2010) found that over 57% of defendants in jail had at least one felony on their record and multiple arrests leaving the communities vulnerable to criminal acts from the mentally ill. The crimes ranged from minor misdemeanors to felonies. The professionals could potentially know why some defendants are placed in jails instead of treatment facilities or the state hospitals.

Past studies have shown 64% of people incarcerated self-reported having a mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). A study conducted by McNeil, Binder, and Robinson (2014) found a large number of the homeless population with a diagnosed mental illness are being incarcerated and remain in jails for longer amounts of time than the general population. The professionals who work with the mentally ill in the mental health courts would

be aware how addressing the homelessness issue would reduce the amount of time spent in jails, according to Castellano (2011). Cummings (2010) stated that the money that is being spent on defendants who continue to frequent the jails or prisons continues to increase yearly. Nelson, Deess, and Allen (2011) looked at how long it takes to access treatment without interventions from the criminal justice system. Mental health courts shorten the time a defendant must wait before affordable treatment is available. Nelson et al. (2011) stated on average, a person released from jail may have to wait longer than 30 days to get into treatment. According to Constantine (2010), when the severely mentally ill go without treatment in the communities, they are more likely to commit serious felony offenses and put the community at risk. The severely mentally ill burden the criminal justice system as well as local jails that are unequipped to deal with these types of illnesses. The professional team working in the mental health courts would be involved in accessing treatment for the defendants.

Lamb and Weinberger (2011) conducted a study that demonstrated why mental health courts were necessary. One of the areas discussed was the importance of supportive services. The professionals knew the strengths and weaknesses of the services that were available to the defendants. Lamb and Weinberger (2011) also stated 82% of directors of parole and probation indicated that one weakness was a lack of mental health services for the defendants. Trupin and Richards (2003) looked at the data that was collected from the research and discussed how the professionals were able to suggest some organizational changes for the MHCs. This research was conducted 13 years ago and many changes have occurred since that time. Past studies revealed that initiatives had begun across the county to help defendants' access appropriate treatment instead of being placed in jails or prisons (Lamb & Weinberger, 2011). Steadman (2014) stated that mental health issues can be exacerbated by jail incarcerations. The longer a defendant with a

severe mental illness (SMI) is incarcerated, the more their mental health may decompensate. This can result in further behavioral issues, which can lead to new charges being filed. The American Psychiatric Association (2010) reported that jails need to have some form of adequate mental health treatment in the facility citing the cases of *Estelle v. Gamble* 429 U.S. 97, 103 (1976) and *Farmer v. Brennan*, 511 U.S. 825 (1994). These cases state that a defendant is entitled to adequate medical care under the eight amendments. According to Steadman (2014) jails should not be seen as treatment facilities but rather should keep detainees safe while incarcerated. Treatment should be overseen by the professionals in the community. The professionals working in the MHCs had working knowledge of the strengths and weaknesses of the current courts in existence. This provided insight into strengthening the process and improving internal procedures in order to help the defendants, the communities, and the professionals. Studies exist looking at one or two professionals, but they do not cover the entire professional team. Furthermore, Castellano (2011) reported on a disconnect between case manager and other professionals working within the mental health courts and the impact the working relationship had on the defendants. There were many professionals who deal with the defendants on a day to day basis who had knowledge of what is a strength or weakness of the current MHC. The professionals' insights to the strengths and weaknesses helped the defendant and the community in very different ways (Castellano 2011; Husman 2013).

Probation officers who monitor the treatment plan and the case managers who monitor the defendants have not been studied together. There is also research lacking concerning what the lawyers on both sides feel would better help their clients in these types of situations. The social workers and case managers who monitor and find resources for the defendants once the treatment team has developed a plan for the defendants can speak to whether this is a weakness

that needs to be addressed or if other alternatives have been found despite to the extreme funding cuts, which would demonstrate a strength of the MHC.

Law enforcement has discussed the growing need to address individuals with mental illnesses. The cost of housing these individuals strains the already tight budgets (Torry, Kennard, Slinger, Lamb, & Pavle, 2010). Jails have become the new asylums for these offenders. While communities are trying to address the budget constraints, the number of offenders continues to increase (Cotter, 2011). Fuller (2015) looked at the cost of housing the mentally ill in Los Angeles and discovered that it cost \$10 million for one year just for psychiatric medications. Ohio spent \$175,000 dollars a year for Zyprexa alone. Fuller (2015) reported the general population cost \$78.00 per day to be housed in jail or prison on average. Treatment of care of the mentally ill cost tax payers \$125.00 dollars a day on average. Additionally, a cost associated with the SMI and incarceration is the high price of medications. For example, an Invega shot can cost \$4,000.00 a month for one inmate.

A weakness exists in the beginning of the MHC process if treatment resources in the community or access to mental health medications or therapy did not exist. Defendants may not have the money or resources to bond out of jail even if their crimes have low bond amounts, which can mean longer incarcerations. According to Lurigio and Snowden (2009) MHC was a new idea when introduced into the criminal justice system in the 21st century. It was started to help defendants who had mental health issues not get trapped in the traditional court system and remain in jails or prisons longer than necessary. Research shows that before the creation of MHC, defendants with mental illness were housed in jails and prisons at an alarming rate. A study conducted by Watson, Hanrahan, Luchins, and Lurigio (2001) examined the access to treatment for defendants as well as the longer stays in jail because of bonding issues. The study

looked at the reasons for MHCs and discussed that the mentally ill being housed in jails and prisons has grown 154% over the past decade. This is a financial cost to the communities and an emotional cost to the defendants. Research done by Steadman (2014) and Steadman, Redlich, Callahan, Robbins, and Vesselinov (2011) looked at the length of jail days for defendants with SMI who qualified for an MHC. The study revealed that MHCs can reduce the time a defendant spends in jail by 100%. The study demonstrated a difference between 9 days versus 78 days for someone with an SMI According to McNiel, et al. (2014), inmates with SMIs can often become behavioral problems for jail staff because of their distorted and impaired thinking.

MHCs began out of a necessity to address the growing number of mentally ill individuals housed in jails or prisons who have put a strain on judicial system budgets across the nation (Prins & Daper, 2009). Past studies have demonstrated that defendants who were arrested remain incarcerated based on the inability to access the resources necessary to obtain release (McNiel & Robinson, 2014). Lamb and Weinberger (2011) discussed the importance of bridging the gap between treatment and punishment. The National Institute of Justice NIJ (“Specialized Courts,” 2017) looked at the link between therapeutic and interdisciplinary approaches to address mental health and addictions without jeopardizing public safety.

Problem Statement

Very little research has focused on the professionals who work in the mental health courts and how they view the success or failures of these courts. Several studies have been conducted discussing the effectiveness of mental health courts from a quantitative view-point, such as the studies conducted by Sarteschi, Vaughn, and Kim (2011) and Aldigé Hiday, Ray, and Wales (2014). There were two studies that examined mental health courts from the perspective

of the professionals from a qualitative case study view point. The first study was conducted by Cintron (2015), and the second was by Husman (2013). Husman (2013) argued that there is a dearth of research examining the strengths and weaknesses of MHCs from the professional sector's point of view. There is a need for further research being conducted on the impact of treatment provisions using open-ended questions as to whether the courts do justice well. (Redlich, Steadman, Monahan, Robins & Petrila, 2006). The present study explored the strengths and weaknesses of the MHCs with the professionals involved in the day- to-day operations. This can help new courts avoid the same errors that past courts have made, saving time and money to counties and helping defendants with successful outcomes. Furthermore, the effect of interprofessional dynamics was included. Data from multiple sources added trustworthiness to this study. Looking at the overall strengths and weaknesses of the MHC gave a truer picture of the MHCs and helped to determine the best course of action for a startup MHC. There have been studies conducted addressing other specialized courts and perspectives on their effectiveness from judges and case managers, but I could locate no study that looked at the strengths and weaknesses of the program from viewpoints of the entire treatment team (Tyuse & Linhorst, 2005; Wales, Hiday, & Ray, 2010). The study discussed by Tyuse and Linhorst (2005) showed that further research is needed on MHCs to evaluate the court progress and outcomes. Tyuse and Linhorst (2005) examined the roles of social workers and MHCs. Wales, et al. (2010) looked at MHCs' effectiveness, and discussed the limitation of the study, and one professional group limited the generalization of the data. Other MHCs were looked at from the judge's perspectives, but limitations were also cited (Redlich, et al., 2006). Helping the mentally ill maneuver the criminal justice system without long stays or failures at the requirements of the courts can help the community and the mentally ill. Fuller (2015) stated that there is a liability for the jails,

judicial system, and community mental health providers if the mentally ill are not being cared for. The liabilities exist in an increase in suicide risk in jails, inadequate care while confined, housing after incarceration, and the need to provide mental health treatment in and out of jails. Both the judicial team and community mental health team were asked about the incarceration of the defendants, housing for the defendants, and treatment options for the defendants currently in the MHCs. Identifying the strengths or weaknesses in the beginning of the process with length of jail stays or resources availability at the end of the process will help the defendant as shown by Auge (2011).

Purpose of the study

The research paradigm is anti-positivism, which states that individuals interpret and view situations based on their own experiences instead of what others believe or attempt to impose on them. Cohen et al. (2000) stated that reality is multi-layered and complex. The professional team as a whole has different experiences and understandings of how the MHC is failing or succeeding. This study examined the experiences of the professionals working in the MHCs to develop a clear picture of the strengths and weaknesses of MHCs. This research looked at the professionals' interpretations of the MHCs strengths and weaknesses, which included different views on the same experiences and situations.

The purpose of the study was to determine the strengths and weaknesses of the MHC from the point of view of the entire professional team. Husman (2013) discussed the limitation of using only one profession; that study consisted of probation officers. Castellano (2011) interviewed several professionals to gain in-depth knowledge of the influence that case managers had in MHC with helping the defendants to succeed. Castellano (2011) cited that it is important to understand the limitations of mental health professionals doing a dual job for both treatment

and judicial balance and their involvement with defendants and the court and other professionals. Offenders are assessed for appropriate placement in the MHC by the core treatment team. They look at available treatment, severity of the crime, and whether the defendants are willing to volunteer for the MHC program (Cotter, 2011). Determining the strengths and weakness of the courts may help other jurisdictions reproduce a mental health court. This study was done using a case study method.

The study looked at current mental health courts in the Rocky Mountains, and the professionals who worked with the defendants. Information on the strengths and weakness of the current courts will help future courts develop best practices and maintain success. This study filled that gap with the professional sector and their viewpoints on the successes and failures of the MHC to address the defendants, victims, and communities. It is important to understand which aspects of the process lead to the change, so that strengths can be further developed. All the professionals were asked questions about incarceration of the defendants and what they saw as the strengths of getting them off the streets or the weaknesses of the length of jail stay for these defendants.

Research Question

The research question aligns with the problem and purpose to take a deeper look at the perceptions of the entire professional team of the MHCs. The purpose of this qualitative research was to uncover the strengths and weaknesses of the MHC from the professionals' viewpoints. The research could assist with helping other MHCs in startup not make the same mistakes, thus saving time and money and better serving defendants.

RQ1. What do professionals who work in mental courts perceive as the strengths and weakness of the courts in their ability to meet the needs for the defendants, the victims, and the community they serve?

Conceptual Framework

The conceptual framework that was used is therapeutic jurisprudence theory, Wexler (2000) which will be discussed in detail in Chapter 2. Simply stated it is “the study of law as a therapeutic agent” (Wexler, 2000, p 125). Its focuses on how the law can and does impact the emotional and psychological well-being of the defendants who are forced to face a judge for a crime they committed. The theory explains how the law operates in action and not just the laws that are in the books or what is defined by the rules and procedures of the judges and attorneys (Wexler, 2000). Redlich (2014) stated that applying the therapeutic jurisprudence to the justice system will help the mentally ill successfully complete the requirements of the court system and not recidivate.

The theory enables judges, attorneys, and other court personnel to apply psychosocial insights to the sentencing and day to day practice of the law. Therapeutic jurisprudence has another important dimension that can be addressed, and that is how the law can be applied more therapeutically. To allow psychological insights to the day to day operations of the MHCs is the framework for Therapeutic jurisprudence theory. The elements of the Therapeutic Jurisprudence as stated by Redlich (2014) are how the law and the legal professionals can apply sanctions to defendants with a therapeutic approach. The Judge can look at defendants and apply individual treatment plans and address individual needs of defendants to help with recidivism (Redlich, 2014). The Therapeutic Jurisprudence is applied to specialized courts for the last 15 years

according to Redlich and Han (2014). Therapeutic Jurisprudence will be discussed in Chapter 2 dealing with the literature review of past studies involving this therapeutic framework. Looking at the strengths and weaknesses from the judicial professionals' view will help understand where barriers can exist between applying the theory and providing community treatment for the defendants.

A study conducted by Lamb, Weinberger, and DeCuir (2014) talked about applying the therapeutic jurisprudence in the beginning of the process and determining if a defendant should go to jail or other treatment options. The study concluded that it is critical that law enforcement and mental health workers collaborate on defendants and determine if jail or release is necessary. Applying the therapeutic Jurisprudence in the beginning is the only way to manage a mental health crisis according to Lamb, Weinberger, & Gross (2014). The community mental health treatment facilities would be involved in this process from the beginning using the MHC model. Understanding this theory will help determine the success or weakness of the mental health courts.

Nature of the study

A case study approach was used for this research. Case study was chosen over other methods because of the framework of real life experiences of the professionals. According to Thomas (2015) the basis for doing a case study is to understand the details of what is happening and what is related to what.

The case study will allow individual professionals to give an insight as to the strengths and weaknesses of the MHC from their own experiences and understanding of the design of how the MHC is supposed to work. Using a case study allowed an examination of MHCs from many

different angles and perspectives of multiple professionals looking at the same issues. This type of study will help provide a framework to analyze the data for patterns in relations to internal and external gaps in the beginning of the process of the MHC to the treatment availability for the defendants and the resources available to help with the basic needs. Case Studies as described by Thomas (2015) looks at one thing in detail trying to understand the how and why of a phenomenon. Thomas also stated that looking at a case from several directions will help give a rounder, richer, picture of the data creating more balance in the overall case study. Per Yin (2014) conducting a case study will require several skills. The first skill is to have good knowledge of the phenomenon, be a good listener ask good questions and finally be flexible and adaptable. During individual interviews, professionals were asked about the multiple aspects of the MHC from their own viewpoints. This type of study helped to show the strengths and weaknesses of mental health courts from the perspective of the entire professional team, not just one profession. The questions were designed to obtain information on the success or weakness of different areas of the MHCs. The whole team approach can bring different insights to the same MHCs, it is important to remember that using one subject with multiple viewpoints and experiences will help to identify the strengths and weaknesses of the MHCs for the defendants, the victims, and the community (Husman, 2013). Multiple professionals were interviewed with questions that were designed using past MHC professional experiences. The questions are designed to explore the strengths and weaknesses of the MHCs from the professional's perspectives. For assistance in pattern analysis and coding NVIVO will be used looking for themes to emerge.

Definition of Terms

Court staff: Court staff can vary depending on the MHC.

The consistent staff is comprised of the judge, a representative from the district attorney's office, public defenders, probation or parole officers, a case manager, and someone from the mental health team. (Almquist & Dodd, 2009)

Co-occurring disorders: The presence of two disorders together, usually mental illness and substance abuse. (Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2012)

Criminalization hypothesis: Criminal hypothesis states that individuals who would have been sent to psychiatric hospitalizations are now being sent to jail or prisons due to mental health deinstitutionalization. (Gu, 2014)

Civil commitments: Holding and treating a person who has not initiated any treatment for a mental health issue against their will. There are criteria that must be met such as the inability to keep themselves or others safe. (Mares, 2013)

Deinstitutionalization: President Kennedy outlined a plan in 1963 to reduce the number of mentally ill people in custody by half. They were released to communities where mental health was to be provided. (Harcourt, 2011)

Due process: Found in the fifth and fourteen amendments, due process is designed to ensure that a defendant is not stripped of their life, liberty, and property without their legal right respected. (Williams, 2010).

Dusky standards: Defendants must be able to understand the charges against them and the proceeding; also, they can aid in their defense with attorneys. (Redlich, Hoover, Summers, & Steadman, 2010).

Jurisdictional limits: The acceptance into a mental health court depends on the limitation of the court and if they accept individuals for a misdemeanor or felony charge. (Almquist & Dodd, 2009)

Intellectual disabilities: Significantly sub average general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance. (APA, 2010)

Mental health court: A specialized court that deals with defendants with mental illness; this is a specialized docket within a traditional courthouse. (Almquist, & Dodd 2009)

National Alliance on Mental Illness (NAMI): An organization founded in 1979 to help people with mental illnesses better their lives. Today they are the nation's leading voice for mental illness (NAMI, 2012).

Psychological mechanism: A defense mechanism that plays out in a work place, with different factors that can contribute to the environment of the work place. Those can be denial, repression, regression, displacement, projection, or the most common Rationalization. (Walsh, Crisp, & Moss, 2011).

Psychiatric symptoms: Signs and symptoms associated with mental illnesses. Can range from depression to schizophrenia. (Community Psychiatric Clinic, 2011).

Restorative practice: Approach to justice that strives to repair harm to all parties affected by an offense or wrongdoing. (Cook, Drennan, & Callanan, 2015)

Retributivism: The punishment of offenders by the courts based on the crimes they committed. (Johnston, 2011)

Therapeutic jurisprudence: “The study of law as a therapeutic agent” (Wexler, 2000, p. 125).

Therapeutic rehabilitation: Individualized treatment to reform delinquent behavior using sociological and psychological practices. (Johnston, 2011)

Voluntary participation: A defendant chooses to enter a specialized court where treatment is offered instead of going to a traditional court (Redlich, Hoover, Summers & Steadman, 2010).

Assumptions

Since this project utilizes a case study, it is likely that not enough data will be collected to identify different themes in the strengths and weaknesses of the mental health courts. This will be addressed by using the entire professional team who deals with the defendants and the mental health courts.

The second assumption will be that the participants will answer the semistructured interview questions frankly. As stated by Revell (2013), the concept of conversational partnership refers to the importance of building trust with a participant to get reliable data. This

was addressed in the structure of the interview and the initial invitation letter to be part of this research.

The third assumption is that professionals are used to being interviewed and can easily take over the interview, guiding it in the direction they wish it to go (Marshall, 2014). This was dealt with by having a set of standard questions that were asked to elicit data on that particular topic.

The final assumption is that one profession can blame another profession for any negative issues that may arise (Levi, 2016). There is a defense mechanism that can exist within a work place that can also affect professionals (Walsh, Crisp, & Marsh 2011). This was addressed during the semistructured interviews paying attention to the responses and keeping the participants on topic of what they see as a strength and weaknesses within the court.

Scope and Delimitations

The scope of the case study was the MHC professionals who work on a day to day basis within the MHCs. Identifying the professionals were accomplished by sending out e-mails to each mental health coordinator/liaison. The mental health coordinator/liaison was contacted to obtain a list of all the treatment team professionals' contacts. Once the contact information was obtained, an introductory e-mail was sent out asking for participation for the research. The interviews were conducted either on site or off depending on the participant's requests. If the interview will be conducted on site, I asked for the participant to obtain the meeting place. The study was restricted to the MHCs that currently exist in the Rocky Mountains. The study started with an MHC court that was in existence but was in the process of closing. Due to the first court closing, I determined that adding an additional court was necessary that was not closing. The

study included all professionals who work with defendants within an MHC in the judicial branch or community mental health resources. Due to the specific focus of the professionals' and the process of an MHC, all professionals were invited to participate to understand each role and responsibilities.

Husman (2013) found that one of the issues with this type of study was the sampling size. Husman (2013) stated that only using only one court and only seven participants for the study limited the opportunity to duplicate the results to other MHCs. Another study conducted by Castellano (2014) showed that one of the limitations was the number of participants in the study; more professionals will need to be added to eliminate biases and sampling size errors. It is estimated that there will be 12-15 participants involved with the interview and data collection of this research project. The entire professional team who is involved with the offenders were asked to be part of this project.

The professionals of the MHC were the focus of the study looking at the process for the defendants and the impact to the community. This helped to understand the strengths and weaknesses from a different angle. This study provided a rich picture and insight to MHCs. Looking at the defendant's outcomes, and the professionals involved in this day to day operations of the courts. The MHC defendants have been excluded in this study because the professionals have differing viewpoints of treatment accessibility, funding sources, and a working knowledge of what is a success and what is a weakness. The professionals have views that encompass multiple areas from many participants, such as treatment and jobs and housing for the defendants, whereas the defendants would only have a personal view of process and treatment availability (Husman, 2013).

Several theories were considered for this project such as the restorative justice theory, which was pioneered by Zehr, Claassen, and Umbreit in the late 1970's and early 1980s. The theory was later validated in multiple research projects. The theory looks at the crime, the acts of the criminal and the restoring the victim to pre-crime state (Ness & Strong, 2013). The victim can be a person, a community or society as a whole. This would be in direct conflict with the MHCs view point. A study conducted by Cook et al. (2015) looked at the restorative justice in a forensic mental health setting to determine if this was the best course of action when dealing with the criminal justice piece, and the mental health of a defendant. This study talked about how with Restorative interventions with the mentally ill population "they have a better chance of processing emotions, developing thinking and coherent narratives" per Cook et al. (2015). The second component is that this theory looks at repairing harm to all the parties affected by the defendant. The harm that a victim suffers is the corner stone of this theory, but what if the victim is the transient life style of the defendant. This theory would not help the defendant get out of jail sooner and back to the streets, because that just creates more charges. The restorative justice theory looks at restoring the community not the defendant. The issue with this theory is that this piece is during or after conviction and is not designed to look at getting a person with a mental illness out of jail and to treatment sooner. It looks at the crime, the defendant and the community excluding the mental health piece per Cook et al. (2015).

The next theory that was considered was the General Responsivity Principle of the Risk – Need Response Model (RNR). This was discussed by Andrews, Bonta, and Wormith (2011) and it looked at how offenders were assessed and treatment provided. There were three levels to this theory in assessing the offender for treatment. The three levels were designed to look at the offender and make a determination based on the three criteria, 1. Match the level of treatment to

the offender risk level. 2. Target the treatment to the criminogenic needs based on the criminal behavior. 3. Match the style of intervention to the offenders e.g. learning styles. The theory states that if the offender had a mental illness that was criminogenic then treatment was warranted. This theory would not be a strong theory by excluding the mental health of the offender where the mental illness was not a part of their criminal activity. Both theories were excluded from the scope of this project because they did not meet the needs of the research.

Limitations

The MHCs have limited professionals in each court, so finding enough participants who are willing to take part was a limitation. This limitation was addressed in the initial e-mail inviting participants to take part of this study, explaining the benefits of the study with participation.

Another limitation was selection bias; not having a large sample size may cause the data to be limited. I asked for all the professionals to participate, so an adequate sampling can be achieved of the different aspects of the process. If a profession is not represented, then it may limit the actual data that can speak to the interactions of the team for the benefit of the community and the victims and the defendants for the MHC. The target population was the entire professional team who work within the MHC. There are two subgroups in each MHC to try to obtain data saturation from. The sub groups need to consist of at least 3 professionals from the judicial group and 3 from the community mental health treatment group. Ensuring wide diverse sections of participants will need to be a priority. Selection bias needs to be considered or some conclusions may not be accurate. Selection bias can be avoided if an adequate number of professionals participate in the study. The number professionals working in the MHCs can range from 15-30 with an average of 20 depending on the size of the courts. No study exists to show

the exact number of professionals who work in the MHCs. I spoke to a specific MHC and they have on average 15 people who work daily within the court system to help the defendants.

The sampling started with the MHC located in Rocky Mountains. They were contacted to obtain an adequate sampling size of all the professionals. The first MHC did produce enough participants, but was in the process of closing, so I sent an invite e-mail to other MHCs in the Rocky Mountains. This was only done after the relevant MHCs have given their ethical approval. I asked for information on their views of the strengths and weaknesses of the mental health courts. The questions were made generic to the project so that anyone reading the final study cannot pinpoint one profession or court. Demonstrating how their identities will be kept confidential will be a hurdle that must be met in order to gain their trust. Gaining the trust of the professionals without a violation of the confidentiality of their positions or who they are the only way this research project can be successful. APA Code (8.03) states that precaution must be taken to guard the identity of the participants.

Significance of the Study

This study looked at the viewpoints from the professional sector. I assessed what professionals consider to be the strengths and weaknesses of the MHC in addressing the offenders, the victims, and the community. This study can help future MHCs in their conception to avoid financially crippling mistakes by looking at the strengths and weaknesses of what the professionals are reporting. The professionals are tasked with monitoring and supervising the defendants and if they encounter barriers, they help the defendants to overcome those barriers. Professionals also help the defendants complete the requirements set up by mental health courts. The significance of the study is to show any strengths and weaknesses as determined by the

MHC treatment team. The MHCs may vary in design but they should have common themes of treatment rather than punishment.

Past studies have demonstrated a social positive change by implementing an MHC. A study conducted by Hiday and Ray (2010) demonstrated that the recidivism rate was reduced by 88% for inmates who completed an MHC program. Redlich, Hoover, Summers, and Steadman (2010) also found similar outcomes when an inmate successfully completing an MHC. MHCs have a positive social change by reducing the lengths of incarcerations for defendants, and the access to services for the inmates, which can reduce costs to the community's (Hiday, & Ray, 2010). The current study led to MHCs being strengthened, through recommendations at the end of the study, and then this study enhanced the positive social change already offered by MHCs.

Summary

This chapter has defined the scope of the study, the purpose and the problem that was discussed. The problem statement explained why there is a need for this type of study and why examining the strengths and weaknesses of the mental health courts, from a professional point of view will benefit the community. Both the judicial system and the local mental health treatment facilities were a part of this study to show how addressing the strengths and weaknesses can benefit the system as a whole. An in-depth look at how studying the courts, and focusing on their strengths and weaknesses will help to duplicate courts in other counties. The social impact of the information gathered can be used to initiate and correctly maintain other mental health courts. Using a problem-solving approach to help the mentally ill defendants by adopting policy change in the local jails and courts, can help the communities save thousands of dollars with incarcerations. The professionals' viewpoints can aid in the development of strong MHCs.

The literature review will cover the history of the mental health courts, as well as the current state of the courts. It will define the MHC and the rationale for developing such courts. This will help give a comprehensive understanding of how the current courts operate and how past courts dealt with issues. Understanding the past can help with the strengths that exist from their point of view. In chapter 3 the qualitative case study will be discussed. It will explain the methodology and the study design in depth

Chapter 2: Literature review

Introduction to the Mental Health Courts

MHCs began out of necessity to address the growing need for mental health treatment in jails and prisons. The justification for the creation and funding of MHC programs was because the jails had become the new SMI asylums of the 21st century (Fields, & Phillips, 2013). The deinstitutionalization of the mentally ill was designed to release SMIs from psychiatric hospitals and back to the communities (Fields, & Phillips 2013). What developed, however was a revolving door with the mentally ill population and recommitment to our jails and prisons. Fields and Phillips (2013) noted that the highest recidivism rates are with the mentally ill population in jails and prisons.

According to Kundo (2000), the history of the MHC's began in the 1900s in Florida. The country was trying to figure out how to address the criminalization of its mentally ill citizens because the state-run psychiatric hospitals were closing or reducing the number of beds available. Early MHCs focused on redirecting their defendants with mental illnesses into a diversion program, allowing defendants to seek the treatment necessary to prevent them from reoffending and returning to jail or prison. The professionals on the judicial side dealt with these offenders for new charges or failure to appear warrants. The community dealt with these defendants because of the treatment plan that was implemented by the treatment team. The community team dealt with no-show appointments and failure to pay for services.

This literature review will look at many different aspects of the MHC from many various angles. The literature review will cover the different positions held by the professionals and how their roles impact the MHC, the defendants, and the community. The first section describes the

MHC and provides brief history of the MHC and the rationale for creating them. Next, I discuss the defining characteristics of the MHC. I present the conflicts between the MHCs and the traditional courts. Following that is a section on the strengths and weaknesses of the MHCs, and the professional roles with the defendants in the MHC setting. In addition, I discuss the professionals and their roles with the MHCs and the defendants. I review treatment aftercare which determines the success or failure of the defendants. The review then covers co-occurring disorders to determine their impact on the MHC and the professionals. In the final section I describe the MHCs that will participated in this research. The goal of this study was to look at the strengths and weaknesses of the MHCs from all the professionals' points of view, for which there is a gap in the research. Gaining the insight of the strengths and weaknesses of the courts can help future courts from conception to established practices. This may assist the mentally ill in finding treatment instead of long stays in jails or prisons.

Search Strategy

The following key words were used in this study to identify literature from the last five years: *mental health courts, jail inmates with mental illnesses, prisons and the mentally ill, jails and mental health medication, professionals and mental health courts, judges in courts, probations officer and their roles in mental health courts, courts as therapeutic agents, therapeutic jurisprudence, mental health court outcomes, how mental health courts function, assessing the effectiveness of mental health courts, serious mental illnesses in jails or prisons, traditional courts and mental health courts, closing psychiatric hospitals, drug courts and mental health courts, criminal justice system and mental health, health care programs for the mentally ill, involuntary commitments, Colorado mental health courts, specialty courts in our nation, civil commitment laws of Colorado, revolving door of the mentally ill, recidivism of the*

mentally ill, enrollment in the mental health courts, mental health diagnosis and the criminal population, history of the mental health courts, how mental health courts effect the recidivism rates, who benefits from mental health courts, volunteering in mental health courts, police and mental health courts, and judges and therapeutic jurisprudence. The following databases were used: Google Scholar, Walden library, Walden Dissertations, APA PsycNet, PsycINFO, Nih.gov, VERA.org, SAMSHA.gov Substance Abuse and Mental Health Administration. The official website of the Department of Corrections also contained valuable information to help guide this dissertation, as did that of the National Commission on Correctional Health Care.

There exist very few dissertations on the professionals who work in the MHC. For this study, I broke each professional role in traditional courts and MHCs in order to provide insight into what is expected of each of the professionals and their roles in helping defendants in the MHCs.

Theoretical Foundation

The theory that constituted the framework of this study was the therapeutic jurisprudence theory. This theory was first discussed by Wexler and Winick in 1987, at the National Institute of Mental Health. The reason for the term was to examine the way that the judicial system interacted with the mentally ill criminal. A concept called “psycholegal soft spots and strategies,” which was also developed by Wexler, precede the therapeutic jurisprudence. The psycholegal soft spot was used by attorneys to anticipate and deal with potential issues before they arose, that is if the case could be challenged later due to a mental illness. A second component seen from the attorneys’ prospective was if they could take advantage of a situation to help the case and client (Wexler, 2000). The psycholegal soft spot would help attorneys have a framework for applying the law.

Therapeutic jurisprudence described how the law could be seen to function as a therapist. It was soon hypothesized that judges and lawyers could set consequences and limits within the law and produce therapeutic outcomes in the drug and mental health communities (Wexler, & Winick 1991). Wexler (1991) described how the therapeutic jurisprudence was intended to work in mental health courts. The judges of these courts began taking an active approach to help defendants connect to services in the community. The judges looked at the defendants and tried to understand the issues that hindered them from successfully completing the court process. By targeting reoccurring issues for the defendants, the therapeutic model was designed to produce successful outcomes.

In the past, therapeutic jurisprudence has been applied in many different areas of the legal system and in communities. According to a study conducted by Fisher and Geiselman (2010), police officers can apply therapeutic jurisprudence to their everyday interactions with the victims and criminals they encounter. When defendants need to be transported to an inpatient facility such as a state hospital, they need to be treated with dignity and respect. When that is present, there is less chance of outbursts and problems. If defendants are given the opportunity to have their voices heard, and their stories told, no matter their mental health issues, then the outcome is better (Hiday, Wales & Ray, 2013). In addition, if law enforcement agencies follow the therapeutic jurisprudence theory, it could result in defendants responding more appropriately resulting in fewer charges being filed and the defendants getting the help they need. A study conducted by Hiday et al. (2013) showed that if law enforcement officers applied therapeutic jurisprudence to all the interactions with the mentally ill, it could significantly reduce the amount of time they spend in jail due to resisting arrest and failures to appear.

Perlin (2010) looked at the role of defense attorneys concerning how they could apply the therapeutic jurisprudence with their clients and the impact they could have on those defendants. Perlin (2010) wrote that if defense attorneys embraced this theory, then criminal lawyers could reduce the number of incarcerations, “salvage lives,” and work with other community entities to help the defendants get the correct treatment rather than punishment. This research looked at the attorneys and whether applying this theory had a real impact.

Monahan et al. (2014) helped define how the community can be involved in the therapeutic jurisprudence. The model looks at how the judicial system, mental health treatment facilities, and social welfare system must all work together to have a favorable outcome for the defendant. The social welfare system could have an impact on the defendants in MHCs by using subsidies as leverage for the defendant to follow all the mandated rules set by the courts (Monahan et al., 2014). The community mental health facilities are impacted by treatment being a requirement of the successful completion of the MHC (Monahan et al., 2014).

Past research demonstrates that applying therapeutic jurisprudence theory to all aspects of the criminal justice system as well as the community mental health facilities could produce better outcomes for defendants, jails, prisons, and the community.

History of Mental Health Courts

The first MCH was established in the 1900s in Florida as stated by Kundo (2000). According to Watson, et. al. (2001) the goal of the Broward court was to reduce the number of jail inmates that had mental illnesses and could be better served in other programs. A specialized docket was created to facilitate a quicker time for the defendants to be reviewed and placed into treatment instead of jail (Watson et al., 2001). Judges, probations officers and judicial staff were tasked with creating specialized treatment plans for each defendant. According to Watson et al.

(2001), by 2001 more than 1,200 defendants had passed through the mental health court. One of the weaknesses of the court that this study revealed was that there were not enough treatment options for the defendants that were accessible or financially obtainable. Another weakness was that the court was voluntary and that a defendant could feel coerced into the court without understanding all the facts (Watson et al., 2014).

The first court was designed to address the criminalization of people with mental illnesses who continued to be frequent flyers of the criminal justice system or first - time offenders who struggled with the sanctions set by the courts. Florida responded to a crisis that was affecting their state when it became apparent that jails and prisons were becoming the new mental hospital (Kundo, 2000). Past studies according to Watson et al. (2014) revealed that 10% to 15% of jail inmates had a serious mental illness. By comparison, that was the case for only 2% of the general population. It has also been shown that the mentally ill could encounter the police and maybe more likely to be arrested and spend more time in jail than the individuals without any mental health issues (Watson et al., 2014). Another factor that is contributing to the issue of more mentally ill in our local jails is the changing in the mental health laws and declining state hospitals to house the mentally ill. California soon followed by establishing their MHCs in 1999, to address similar issues the rest of the country was facing (Kundo, 2000).

Mental health courts became problem-solving courts to address the needs of criminal defendants with mental illnesses and co-occurring disorders or substance abuse issues. Addressing the concern for a more individualized jurisprudential approach to these defendants instead of just locking them up was the direction and intentions of these courts (Case, Steadman, Dupuis, and Morris, 2009). There is a criminalization hypothesis that states that many factors can lead to the mentally ill being arrested and placed in the criminal justice system

(Morabito, 2007). The first factor was the deinstitutionalization of the state mental hospitals. Many people with mental illnesses were put on the streets and vulnerable to getting arrested for behavior that was allowed in the hospitals (Morabito, 2007). The hypothesis also stated that officers are the first line of defense for the citizens and keeping the community safe. When criminal violations occur, then the officers would arrest the offenders and place them in jail. Morabito (2007) also stated that officers have the discretion to detain a person even if they exhibit a mental illness. The sole basis for the arrest could be to incarcerate the person. They would be easier to deal with in jail, then someone on the streets causing issues.

A reason that was cited by Morabito (2007) for the criminalization of mentally ill people was when the civil commitment laws changed. Fisher and Grisso (2010) looked at civil commitments statutes in many different states and compared them to each other. As stated by Fisher and Grisso (2010) the civil commitment statutes were allowed to take a person's civil liberties away from them, depriving them of freedom and the right to make decisions for themselves. In the 1960's the ease at which a person could be committed and lose their personal freedoms was widely abused across the nation. The Judges could be convinced to commit someone if the family deemed it necessary. The admission and discharge of these patients became skewed in favor of the family and less for the person with a mental illness (Fisher & Grisso, 2010). Fisher and Grisso (2010) stated that the civil commitments laws changed beginning in California in 1969, and it was in response to how loosely the commitment laws were being used. The Laterman-Petris-Short Act in 1969 addressed those issues and state by state reform began (Warren, 1977). Today the civil commitments laws address the dangers to self or others or a person with a grave disability due to mental illness. A Judge must convict a person to an institution with overwhelming evidence that they need to be deprived of their

freedoms for the safety of the community and themselves. Closing a majority of the state hospitals, limited the number of beds that were available to house the defendants, so alternative methods had to be found. Placing them in our jails or prisons as stated by Jones (2014) became the answer. A bill was introduced in Congress by president John F Kennedy in 1963 to reduce the number of mentally ill housed in state run facilities (Bloom 2010). According to Bloom (2010) President Kennedy stated that over 800,000 people were being housed in such facilities and he wanted the United States to respond with closing the hospitals and opening more community based mental health centers. The reality of the closures is that more and more mentally ill are being placed in jails or prisons because no community based mental health center exists for a short-term stay, helping the mentally ill get back on their feet. As reported by Schleisner in 2012 the tragedy in Sandy Hook was a result of an inadequate mental health system. Schleisner stated that if adequate mental health services would have been available then this tragedy could have been avoided (Schleisner, 2012). Colorado has seen a mental health tragedy with James Homes. It has been reported that Mr. Homes sought mental health treatment over and over as reported by Fox News in 2015. His psychiatrist tried to notify the police when she started receiving threatening text from Mr. Homes (Fox News 2015).

The final reason cited by Morabito (2007) for the criminalization of the mentally ill, was they were trying to control people's behavior that was once controlled by a psychiatric institution and overseen by trained professionals. Police officers have little to no training in dealing with the mentally ill offender. Police officers have the burden to determine if an offender is truly a danger to themselves or others and if treatment is a better option instead of jail (Morabito, 2007).

Definition of Mental Health Courts

Mental health courts are problem-solving courts that address a defendant who has committed a crime, and has a mental illness. As stated by Redlich, Steadman, Monahan, Robbins, and Petrila (2010) these courts are used to divert a defendant away from a traditional court and place them in a specialized court that looks at treatment and monitoring. The treatment is designed to address their mental illnesses. It also helps the participant with any outside stressors that may exist, helping them become successful while being monitored by the judges and court personnel. As cited by Bartol and Bartol, (2012) mental health courts are designed to address the problem of defendants serving time in jail or even prison for minor crimes. Mental health courts are voluntary in design and the defendant typically is screened by a therapist or counselor and treatment recommendations are made. Ultimately the Judge, who presides over the case, will determine the course of action for each defendant (Bartol & Bartol, 2012). This type of court is not the standard court procedures, where the punishment fits every person who has committed the same crime. Instead, it is on an individual case by case basis. The mental health courts are on different dockets and usually only one judge is assigned to hear the mental health cases. A treatment team will help the defendant to meet all the court ordered requirements set by the Judge. For a mental health court this team will be made up of the Judge, probation officers, case managers, defense attorneys, public defenders, and court coordinators (Wales, Hiday, & Ray, 2010).

One of the aspects of mental health courts per Redlich, Steadman, Monahan, Robbins, and Petrila (2010) is that they are supposed to be voluntary. According to Redlich et al, (2010) a person is accepted into the MHC by a team of professionals determining their eligibility. Once accepted the defendant has the option to have their case transferred to an MHC

or to keep the case in the traditional court. Redlich, Steadman, Monahan, Robbins, and Petrila (2010) went on to state that a defendant could be under extreme stress and not fully understand what it means to voluntarily move their case to an MHC. They are in most cases pleading guilty and agreeing to treatment and sometimes medications in order to fulfill the requirements of the courts. One of the main concerns is that a person must volunteer and if they enter the MHC they cannot get released until all the recommendations are followed. If a person cannot find adequate treatment or afford the treatment then they can be discharged from the MHC as unsuccessful and their case will be sent back to regular court with a guilty plea already in place (Redlich, Steadman, Monahan, Robbins, & Petrila 2010). If a person has a severe mental illness, can they really understand what they are agreeing to and can they truly volunteer for a specialized court is one issue that has arisen? What if the defendant has delusions or hallucinations how can they volunteer for the mental health court (Watson et al., 2001)? A study conducted by Frailing (2010) looked at how the participants were chosen for the mental health court. The study looked at the mental health issues of the participants of an MHC and if it was truly a voluntary court. The outcome showed that the participants who are accepted into the MHC are likely to be successful, so severe mental illnesses may not be considered if un-medicated. Does a person with a severe mental illness or intellectual disability hinder the success of the mental health court from the professionals' point of view?

The first factor to consider is the adjudication of the accused using the Dusky standard. The Dusky standard mandates a defendant know the proceeding against them and can aid in their defense (Dusky v. U.S., 1960). The issues are how a person can consent to a mental health court if they do not have a rational or functional understanding of how a court works, and aid in their defense. The second factor that was discussed in many articles was the procedures of the mental

health courts and how they work. What are the requirements of the defendants and the treatment team? How does confidentiality exist and who will receive the information? Finally, what were the consequences for compliance and not complying with the Judge's requirements (Redlich, Hoover, Summers, & Steadman, 2010).

A study conducted by Burke, Griggs, Dykens, and Hodapp (2012) looked at defendants with an intellectual disability and the mental health courts. They looked for defendants who had been placed in the mental health courts, and found that out of 230 records 11% had an intellectual disability. An intellectual disability was defined by Burke et al. (2012) as a person with a low-socioeconomic background limited education and most likely unemployed. Another important factor to consider is that when a defendant enters a mental health court with intellectual disabilities they tend to have less support to navigate the system correctly. They have limited finances to pay for the court costs and treatment that has been ordered (Burke et al., 2012). One important factor cited by Burke et al. (2012), is defendants with intellectual disabilities can have a higher rate of fighting, temper tantrums breaking the rules and lying and cheating. The question asked by Bruke et al. (2012) could a person with an intellectual disability really volunteer for a mental health court. A study conducted by Carney (2013), looked at how person with disabilities needs additional support when it comes to the laws and services but also retain autonomy. In the past, the laws have sided with family guardians, state run institutions mandating what was best for the ID person instead of letting them make decisions on their own (Carney, 2013). Professionals working within the MHC must have a working knowledge on Intellectual disabilities and how to deal with these inmates.

According to Carney (2013) there should be a fine line drawn between autonomy and guidance. Currently we have several gentlemen who were arrested on misdemeanor charges. In

the community, they were in group homes where they had case managers help guide their decisions. Once incarcerated the state-run facilities stopped helping to guide them. One of the gentlemen agreed to sign a plea agreement without understanding what he was doing. I called his public defender and let him know he did not understand what was happening and the PD stated that it was not his job to help him understand but rather to get the case resolved. I notified the Center for disabilities, just one example of a person with ID not fully understanding the requirements of a court.

Conflict between Mental Health Courts and Traditional Criminal Courts

The professionals of the MHCs will have a working understanding of both the traditional court and the MHC, so they can determine the success and weaknesses of the MHC, based on their experiences of both courts. Criminal courts have a long history of too many cases and limited resources. An issue to discuss is the courts are not equipped to deal with complex issues which defendants may present with (Frailing, 2010). Some of those issues are substance abuse and mental illnesses, domestic violence, and homelessness. Hueston and Burke (2016), compared traditional courts to specialty courts finding that in a traditional court the judge would order the defendant to stop doing whatever behaviors brought him to court for repeat offenses, and the defendant would say whatever he had to in order to gain release and propel him back into the community, so he could continue the behaviors again. In a specialty court, per Hueston and Burke (2016) the judge and defendant would talk about the behavior and the defendant's potential future, they collaborate with each other and are not adversarial.

To demonstrate the need for a mental health court, a study must first analyze the amount of money spent on incarceration versus the money spent on treatment. It would need to demonstrate the cost saving to the community to reduce the number of jail incarcerations.

Limited studies exist to compare dollar to dollar for treatment to the cost of jail or prison. The demand for mental health treatment across the country keeps increasing. In 2009 according to Keyes, and Lopez, (2009) it was estimated that the US spent 160 billion on direct and indirect costs of mental illnesses. The professionals who work within the MHC will know the funding issues and supports in place for these defendants. In 2011, it was reported by NAMI that one in 17 people live with a serious mental illness (Honberg, et al., 2011). Honberg et al. (2011) reported that states cut billions of dollars from their budgets leaving the court system to pick up the burdens of these clients. Giliberti (2015) reported that 1-5 people suffer from some kind of mental illness serious or otherwise, and unfortunately, often those people end up in jail or prison is they don't get effective treatment. Priester et al. (2016) discussed the kind of treatment that a defendant with a co-occurring illness needs, that would not be available in jails. Those defendants according to Priester et al. (2016) are at a higher risk of issues in the jail because they lack social skills and have lower energy and a low motivation to make changes. They usually have family or friends to help them navigate their day to day lives. In jail, they do not have anyone to navigate the issues that might arise. Priester et al. (2016) also reported that individuals in crisis will have a hard time navigating the laws and what they need because they are psychologically vulnerable. If you look at this from a family standpoint that means that a loved one could end up in jail with no one to help them, this is an outrage and should shock America, per Giliberti (2015). In 2015, NAMI also reported that over 2 million people are booked into a local jail, with the vast majority of them with non-violent crimes. "Once in jail the individuals do not receive the treatment that they need and end up getting worse." Misra (2016) wrote about the medications in jails and prisons for the defendants, and how they were the "formulary" medications which is lower in cost for the jails providing the medications. Most jails do not have

psychiatry to do proper evaluations. One area that the article talked about was that without proper treatment these defendants could end up in solitary confinement (the hole) which is cruel, inhumane, and degrading (Misra, 2016). Americans should be ashamed about the treatment of the mental ill in our jails and prisons according to Misra (2016). These are our mothers and fathers and sisters and brothers, yet they are placed in the “the hole”, and their mental illness might not be addressed correctly. An article published by the MacArthur Foundation looked at the mentally ill and jail population. The report written by Steadman (2015) discussed how jails were inappropriately used in housing the mentally ill. It is estimated that out of 12 million admissions to the jails in our country each year, that about 17% (2 million) have an active diagnosis and symptoms of a serious mental illness. Steadman (2015) also reported that between 75%-80% of these defendants also had a co-occurring disorder. Another factor that Steadman (2015) discussed was that nearly all the defendants with SMI’s both men and women have had lifelong histories of either sexual or physical abuse or in some cases have both.

Currently in the United States the National Institute of Mental Health reported that tens of millions of people have a mental illness and only about half will seek treatment. According to the Treatment Advocacy Center there are 4 million adults with a severe mental illness, it is estimated that forty-four thousand have schizophrenia and eighty-seven thousand has sever bipolar disorder (Treatment Advocacy Center, 2015).

The conflict between the two courts is how and when to punish the offenders. Retributivism is the oldest most popular way to punish, it simply says that the state will punish the offender based on the crime that was committed (Johnston, 2011). The two theories that govern both courts are in conflict with each other according to Johnston (2011). MHCs work from the theory of rehabilitation and criminal courts work on the theory of punishment and

deterrence for the offenders (Johnston, 2011). MHCs have a singular concern with treatment instead of punishments making a conflict with the two courts. MHCs in the past have given the offenders rewards for following the Judges orders and completing the tasks that were asked of them. Johnston (2011) reported that this may potentially give offenders the ok to repeat their crimes in order to have future gains. Discounting the reason for the mental health court and putting doubt in the minds of the community.

An issue seen by Johnston (2011) is that MHCs do not find eligible defendants as “insane” but still excuses them from their criminal behavior due to mental illnesses and inadequate mental health treatment. The second factor to consider is that MHCs do not require proof that a mental illness contributed to the criminal act. Instead, they assume that a person with a mental illness would not choose to commit a crime but under the circumstances have no choice. The facts exist that criminal justice courts are designed to punish offenders, so they do not repeat their offenses (Johnston, 2011). The public knows that if they commit a crime they will be punished by the courts, and sanctions will happen (Johnston, 2011). The Treatment Advocacy Center (2015) listed the mandatory law that exists in Colorado defining the inpatient or outpatient care of people with mental illnesses. The law states:

COLO. REV. STAT 27-65-111(1)

The court or jury shall determine that the respondent is in need of care and treatment only if the court or jury finds by clear and convincing evidence that the person has a mental illness and, as a result of such mental illness, is a danger to others or to himself or herself or is gravely disabled.

According to Lamb, Weinberger, and Gross (2014), the persistently mentally ill can be resistant to treatment. There exists a large population of SMIs who have a criminal history and resist psychiatric treatment. They are usually not compliant with medications, housing, jobs, or

treatment (Lamb et al., 2014). The next issues they discussed were that in some states defendants can be acquitted as not guilty by reason of insanity and placed in an outpatient treatment program as part of their condition of release. How would this impact the MHC? The defendant is required to plead guilty and follow all the treatment requirements? In the United States, it was reported that about 1% of all court cases use the insanity defense and out of those only 26% of them are found to be not guilty by reason of insanity (Law Info 2015). Some states sentence the defendant to a state hospital until which time they are deemed not a threat to society (Law Info 2015).

MHCs message to the public is that there are three overlapping issues that must be considered. The first is that the offenders are not appropriate for traditional court because they have a mental illness, and the offenders lack autonomy, rationality, and the ability to control their behaviors. The second issue is that MHC looks at the mental ill as the entity to treat and not a criminal behavior (Johnston, 2011). Third the offenders with mental illnesses are a protected class and therefore cannot truly be held accountable for their behavior, that offenders do not have the ability to control their behavior without interventions. Reinforcing the stigma of mental illness and the way the public sees a mentally ill offender (Johnston, 2011). From the victims of James Homes, they recant their horror of their ordeal in court room testimony but also in everyday life (O'Neil, 2015). The Defense Attorney acknowledged the pain and suffering that the victims had to endure but stated that her client suffers from a mental illness himself and that is what caused the massacre in the theater in Aurora (O'Neil, 2015).

One of the positives for the MHC is that the participants reported feeling high levels of choice, control, and the ability to make decisions. They also felt freedom as well as the ability to really speak to the judge and not just be a number on a docket (Frailing, 2010). One of the issues with MHCs' according to Canada and Watson (2013) is that the defendants what to be treated

fair and just. In an MHC, the participants must plead guilty to participate. In a traditional court, they have the option to have a trial by their peers or the Judge.

A conflict also exists between traditional courts and mental health courts in the time it takes from arrest to completion of the program. It was reported by Redlich, Liu, Steadman, Callahan, and Robbins (2012) that for traditional courts it takes an estimated 30 days from arrest to processing for about 25% of felony defendants and all were processed within one year from arrest. For an MHC, little is known about the length of the diversion process and when the defendant gets referred into the MHC. Time from referral to acceptance is an area where little knowledge is known (Redlich et al., 2012). For traditional courts, studies exist from the start to finish for a defendant. MHC there is no study that captures the time frames from arrest, to referral, to acceptance to completion. Some studies look at the time from arrest to referral, some from the time of referral to acceptance and finally from acceptance to completion, but none exists for all the steps together (Redlich et al., 2012). Professionals who work with defendants will work with them for 12-24 months and have a clear understanding of the strengths and weaknesses.

Inter-agency Communication in Mental Health Courts

According to Canada and Watson (2013) MHCs rely on the collaboration of community providers to fulfill the treatment requirements set by the treatment team. Inter-agency communication takes the form of a staff meeting with all partners at the table to discuss cases before every court session. The members of the team who are present in these staffing according to Canada and Watson (2013) are the court administrator, Judges, probation officers, case workers and attorneys.

Mental Health Court Outcomes

Predicting Success of Mental Health Courts

The goal of the mental health courts is to reduce the number of incarcerated inmates with mental health issues. Helping them to learn new tools and stop them from reoffending on people and the communities as discussed by Hawthorne et al (2012). In 2007, it was estimated that there were over 2.1 million inmates who were in jails and prisons. Hawthorne et al. (2012) also discussed the annual cost of incarcerating the mental health inmates is 14 billion dollars. The literature that exists for the short-term and long-term effects for inmates with mental illnesses has a root in the correctional system.

A study conducted by Hiday, Ray, and Wales (2014) looked at the predictors in determining the success of a defendant in a mental health court. The first factor that was discovered by Hiday, et al., (2014) was, if a defendant successfully graduated from a mental health court they showed a lower reoffending rate than defendants who were negatively discharged from the program. The measures that were used to determine success or failure was if the defendants were rearrested, the number of the rearrests, the severity of the crime, time of rearrests and if the crime resulted in incarcerated. The graduation rate showed an increase if the participant was female. The study revealed that males were likely to be terminated from the program due to non-compliance (Dirks-Linhorst et al., 2011). Professionals working within the MHC will have working knowledge of why defendants recidivate and the strengths and weaknesses of the MHC.

Another factor discussed by Hiday et al., (2014) was the best predictor of new offending was prior criminal behavior. A major predictor of failure of the program was if substance abuse

was involved or if the defendant had a co-occurring disorder. One study conducted by Burns, et al. (2012) discussed that one way to predict success was if the defendant had complied with all the mental health mandates.

Short - term success of the mental health courts was researched by Hiday et al. (2013). They reported that one year after graduation the defendants who participated in MHCs had a higher success rate than defendants who did not participate in MHCs or were terminated due to non-compliance. Exploring why the professionals believe the participants are successful or fail the program was discussed. The study conducted by Hiday et al. (2013) did not terminate defendants who struggled and slipped back into old ways or drug use. Instead, they found treatment programs that were effective and continued to support positive behavior. The way that defendants would be terminated as unsuccessful was if they were unwilling to cooperate with the Judge's mandates or treatment teams' requirements. In a county in the Rocky Mountains the sanctions for non-compliance are spelled out in detail to the defendant. The Judge determines the sanctions for non-compliance and they can range from a stern warning, work crew, required to sit in court for a certain amount of time, up to time in jail. Sanctions are assessed based on the severity of the non-compliance. If a person is dismissed from the MHC they are sent back to regular court with a guilty or no contest plea. The Judge in the traditional court will determine if the deferment will be eliminated and go straight to sentencing.

The long-term successes of the MHCs was discussed by Burns, Ray and Hiday (2012), looking at participants two years after post-exit. The criteria were that the defendants were no longer involved with any courts, had supervision of treatment facilities or any services that were provided while in the MHC setting. Several studies suggest that participating in MHCs have lower recidivism rates. They also have lower involvement in the judicial system. One of the

standards at which recidivism is measured is if the defendant is rearrested within a two-year period. The study done by Burns, Ray and Hiday (2010) suggests that recidivism rates do drop. One factor that is notable for the study is that people who complete the requirements have lower arrest rates than defendants who did not complete the program or did not ever enter in the MHC. The study concluded that over 3/4ths of the defendants who graduated from the MHC were not rearrested. The participants did not have any negative dealings with the criminal justice system, demonstrating that MHCs can prove to be successful for the defendants and public safety.

According to a study conducted by Hiday et al. (2014) an important factor to determine the short-term and long-term success of the defendants is if they successfully graduated from the program. Having their behavior monitored and redirected in a positive manner is a factor for success. Negative test results for drugs and alcohol, appearing at court mandated appointments and following mental health or drug treatment programs help participants successfully graduate from the MHCs. A study conducted by Gilmer, Stefancic, Ettner, Manning, and Tsemberis (2010) showed that there is a strong correlation between homelessness, mental illness and over utilization of the justice system. The study looked at other ways to dealing with these issues of incarceration and homelessness and discovered that if treatment, housing, and employment are available to the participants then the rate of return to incarceration is lowered. This concept is used in successful mental health courts as discussed by Watson et al. (2001)

Mental Health Court Weaknesses

Literature exists stating why mental health courts may not be as effective as they are believed to be. Johnston (2011) noted that no articles exist that analyze the theoretical framework for mental health courts, using the two justifications. The first justification as identified by Johnston (2011) is the therapeutic jurisprudence. Johnston (2011) argued that mental health

courts cannot be justified adequately because of their inability to resolve the conflict that exists between a person's criminal behavior and their mental illness. Yamada (2010) discussed how Therapeutic Jurisprudence looks at the psychological aspects of the person, crime and punishments taking all aspects into consideration. This helps to redefine the law and the legal system. The second statement made by Johnston (2011) was that the therapeutic rehabilitation depends on the link between the mental illness and the crime. The mental health courts view defendants with mental illness as the primary factor in their behavior and that if left untreated they will continue to break the law and have high rates of recidivism. Treatment teams from MHCs decide the best course of actions and treatment for the defendants. In some cases, this can have a longer compliance time than if they had gone to the traditional court, costing the taxpayer more money.

As stated by Seltzer (2005) one of the drawbacks to the mental health court is that so many people being funneled into the courts it is next to impossible to generate political concern to address the root of the problem. As stated by Rossman, Willison, Malik-Kane, Kim, and Sherrill (2012) mental illness is assessed by an eligibility scale and determined what, if any services a person shall receive. If a person has a SMI they usually have a harder time with school, treatment, education or follow through with the justice requirements (Rossman, Willison, Malik-Kane, Kim & Sherrill, 2012). According to Steltzer (2005) the courts should focus on defendants who are not eligible for any other traditional treatment or services. However, those defendants are more reluctant to receive treatment or ask for treatment. Mental illness is continuing to rise in our nation without any adequate funding to address it except in the criminal justice system. A study conducted by Frank and McGuire (2012) showed that a person with a DSM diagnosis has a higher rate of return to jail or incarceration.

Treatment Aftercare

One of the factors that have an impact on the mental health courts is if the treatment is provided once the defendant has completed the program (Hawthorne et al., 2012). One of the issues is that the treatment stops once they are discharged from the mental health courts. Mental health courts are designed to connect defendants with the appropriate treatment to help them instead of incarcerating the inmates (Lamb & Weinberger, 2011). Although jails and prisons are legally mandated to provide some type of mental health care for its inmates, the waiting lists are long, and their main concern is public safety (Hawthorne et al., 2012). For the professionals who work in the mental health courts, would this been seen as a barrier to the success of the program if a defendant cannot find or pay for adequate care. Does that jeopardize their other basic needs that the treatment team helps the defendant find such as housing, food, and appropriate medications?

When a mentally ill offender leaves incarceration either from jail or prison the literatures shows that they do not receive the services, they need (Held, Brown, Frost, Hickey, & Buck, 2012). There is an urgent need to address the challenges that face offenders who are released from jails if they are homeless or mentally- ill. One of the barriers is finding community-based services that will meet their needs at a cost they can afford (Held, Brown, Frost, Hickey, & Buck, 2012). The study conducted by Held, Brown, Frost, Hickey, and Buck (2012) found that if services are not provided then it can impact the high rearrests rate and the revolving door of these offenders. There has been an argument about the lack of services when inmate's transition to outpatient setting, this can result in the criminalization of inmates with mental illnesses (Peterson, Skeem, Hart, Vidal and Keith, 2010).

Upon release, the inmates have a large range of issues that need to be addressed to avoid any further interactions with the criminal justice system. One of those issues is housing or employment. Other factors include but not limited to adequate medications and mental health services. As stated by Lehman et al. (2012) these barriers can be detrimental to the inmates, and they can deteriorate quickly in the community causing rearrests or a visit to the emergency room. The community cannot wait for a crisis to occur before the inmate receives adequate medical treatment or mental health treatment. Without adequate aftercare, the defendant can deteriorate and end up back in jail, perpetuating the revolving door per (Held, Brown, Frost, Hickey, & Buck, 2012). This was one of the questions that was asked of the professionals of the MHCs.

Co-occurring Disorders and Mental Health Courts

One of the issues that were discussed by Adams and Fernando (2008) is if the defendant is diagnosed with a Co-occurring disorder. It is more difficult to treat the illnesses because they interact with each other, and the treatment strategies must be looked at closely. During the data collection process, these issues were explored to determine if this is a strength or weakness of the defendants. Does the treatment team deal with the substance abuse issues first or the mental health issues? Most programs deal with one before the other. According to an article located on SAMHSA website (2014), over 72% of the 1.1 million inmates who are currently residing in some type of a correctional facility have a co-occurring disorder. Another factor that was documented on SAMHSA (2014) is that the recidivism rates are higher for these inmates without proper treatment.

Therapeutic jurisprudence looks at the defendant from a holistic approach dealing with multiple issues that the treatment team must address. A notable fact is a type of disorder and the drug of choice for these inmates. SAMHSA (2014) documented that for males with

schizophrenia the alcohol abuse or dependence rate was 59% and 42% for drug abuse. For females with schizophrenia, they had 56% alcohol abuse and 60% drug abuse or dependence. Looking at just the mental health diagnosis, the literature shows that correctional facilities are untrained to deal with such issues (Adams & Ferrandino, 2008). The other disorders as cited by SAMHSA (2014) were major depression, mania and any severe disorder showing that 72% of the inmate's self-medicate to deal with their mental health issues. Once incarcerated the inmates need treatment to deal with these issues instead of substances (Adams & Ferrandino, 2008). The professionals must consider all the mental issues that a defendant has, to determine the success or weakness of the MHC.

Professional Role With Defendant's Requirements

Mental health courts across the country have different requirements for the defendants, such as getting a job or finding stable housing. But they all seem to follow a similar system when it comes to the treatment requirements (Hiday et al., 2014). One of those similar requirements is that the defendant must follow the Judge's mandates and the treatment team requirements. The defendants must adhere to a treatment plan that is individualized to their mental health issues and personal needs. The defendants will meet with the treatments team on a set schedule and with the Judge for mandatory status hearings. The defendant will also be held accountable for their actions and could face sanctions from the judge if requirements are not meet (Hiday et al., 2014). When defendants do not comply with the requirements of the treatment team or the Judges requirements, there are sanctions that can happen. One of those sanctions according to Redlich, Hoover, Summers, and Steadman (2010) is a warrant out for their arrest. Another is being placed in jail for a period of time or discharge from the MHC and sent back to the criminal courts for sentencing. These sanctions affect the entire system as a whole.

A study conducted by Almquist and Dodd (2009) showed that MHCs employ many different sanctions and incentives but that they are individualized to each defendant and it is not a cookie cutter method. There are many different professionals that interact with the defendants and sanctions. The set of professionals that help the defendant follow the treatment plan is the case managers and therapeutic team. They are designed to help the defendant to become successful with the requirements of the MHCs and show the defendant new behaviors. One of the issues with using sanctions as described by Almquist and Dodd (2009) was that some Judges use leniency on defendants when it comes to harsh sanctions such as jail for long periods of time, due to the defendant having a misdemeanor and a mental illness.

One of the treatment requirements that are necessary and at times mandated for these clients is mental health treatment. Some are even ordered to attend a substance abuse treatment program if they struggle with a co-occurring issue (Almquist, & Dodd, 2009). If a treatment requirement is to attend a substance abuse treatment program, are those providers also part of the treatment team. The Case managers and probation officers are the professionals responsible for helping the defendants locate adequate treatment. As discussed by Almquist and Dodd (2009) the popular direction from the treatment team is to emerge the defendant in community-based services instead of them going to jails or prison. It was discussed that jails and prisons are ill-equipped to address the mental illness of its inmates, and therefore inadequate treatment is provided. One of the issues that were discussed by Steadman, Scott, Osher, Agnese, and Robbins (2014) is that there is an influx of mentally ill entering jails or prisons and the correctional officers have little to no training to understand how to deal with these inmates, let alone help them in a time of crisis. The study also revealed that correctional officers have confidence in identifying psychosis in an inmate, but not certain how to identify or completely

understand the other major mental health issues with this population (Steadman, Scott, Osher, Agnese, & Robbins, 2014). Pandya, Bresee, Duckworth, Gay, and Fitzpatrick (2011) conducted a survey where they discovered that people with schizophrenia reported with overwhelming numbers that law enforcement and correctional officers had poorly treated them. The study concluded that people with schizophrenia are aware of the social stigma that the community has about their mental illnesses (Pandya et al., 2011). Policy makers and communities have begun to address treatment issues with the mentally ill defendants to try to reduce the cost to prosecute and sentence these offenders as well as eliminate the revolving door of these defendants (Almquist, & Dodd, 2009). The entire treatment team needs to have an idea of the different aspects of the defendants they are dealing with and some type of training to understand these mental health issues. Police offices and correctional staff are part of these treatment teams.

Diversion Programs and the Professionals

The professionals who work in the diversion programs will be the mental health community centers. The professionals are tasked with adhering to the requirements of the courts and ordering a defendant to treatment. A study conducted by Dirks-Linhorst, and Linhorst (2012) demonstrated that defendants who are court ordered into treatment has a lower rate of re-arrest post MHC completion than someone who volunteers to be there. A study conducted by Steadman and Naples (2005) looked at how long a defendant can stay in jail. The study revealed that a defendant who was sent to a diversion program remained in the community longer than a defendant who did not go to a diversion program. Another study conducted by Case et al. (2009) looked at pre-sentencing and post-sentencing and the arrest of defendants. The study showed that if a defendant were enrolled in a diversion program it would have an impact on the safety of the community and success rate of the defendant. The defendant had lower recidivism rates than

those who were not part of any diversion program (Case et al., 2009). Recent studies have questioned the hypothesis that few inmates fit the criminalization model and have a mental illness (Peterson, Skeem, Hart, Vidal & Keith, 2010). The professionals of the diversion programs will be included in the study of the strengths and weaknesses of the mental health court from the community mental health treatment team.

Professional Roles in Mental Health Courts

Judges

Judges in traditional courts were tasked with deciding the sentence of a case once the lawyers had come to a resolution with plea bargaining, or a jury had determined the guilt or innocence of the criminal defendant. The third role as described by Wales, Hiday and Ray (2010) was if the Judge determined the guilt or innocence. The Judge then passed the sentence down depending on the guilty verdict. According to Wales, Hiday and Ray (2010) the roles in the Mental health courts somewhat vary, because the defendant pleads guilty, the judge then orders them to whatever sanctions the treatment team have deemed necessary. One of the differences that were described by Wales, Hiday and Ray (2010) was that the Judge holds all the members of the team, including the defendant accountable for the resolution of the legal problems.

One of the aspects of a Judge's role as discussed by Frailing (2010) is that a Judge needs to apply the Therapeutic jurisprudence to every case when dealing with the mentally ill defendants. Frailing (2010) stated that the judge has been tasked with showing warmth, dignity, and respect to the defendants, which could be a motivating factor in the defendant staying engaged in the MHC process to successful completion.

A study conducted by Tsai, and Chan (2010) reported that burnout can happen with Judges because of the environment they work in. The stress and burnout can happen because they work in psychological demanding occupations. The Judges are tasked with upholding justice and finding answers from the conflicting stories heard in their court rooms. The Judges must make determination on people's guilt and innocence, and sanction them.

Attorneys

Attorneys play a key role in the mental health courts across our country according to a study conducted by Watson et al. (2001). The study that was conducted looked at several mental health courts across the county and one of the areas that an attorney is involved is the referral process is some of the MHC. An attorney can make a referral to the MHC team if they feel their clients would be appropriate for the MHC. Attorneys are responsible to their clients at every aspect of the MHC according to Wales, Hiday and Ray (2010). If a defendant fails they are still represented by the same attorney when they return to traditional court (Wales, Hiday, & Ray, 2010). Attorneys must always follow a defendant's due process and not violate their rights according to Williams (2010). The next piece that Attorneys must always consider is the Dusky Standards, a defendant must be able to aid in their own defense according to Redlich, Hoover, Summers, and Steadman (2010).

Probation Officers

According to a study conducted by Griffin, Steadman and Petrila (2014) the roles of a probation officer can vary from court to court. There were two separate models that involved the probation officers as supervisors of the defendants and the treatment requirements. The first model according to Griffin et al. (2014) was done in several mental health courts in the county.

The model used the probation officer to monitor the progress of the defendants while in the mental health courts. The second model according to Griffin et al. (2014) was a team effort by the probation officer and the mental health community, collaborating about the treatment progress of the defendant. Both models made the probations officers responsible for the treatment outcomes.

Police Officers

Police Officers are on the frontlines of the mental health crisis according to a study conducted by Lamb, Weinberger and DeCuir (2014). The study looked at how the Police officers respond to the criminal population when they also have a mental illness. The officers according to Lamb et al. (2014) have a responsibility to protect the community and the safety and welfare of the mentally ill. The officers must decide to arrest and detain the defendant within moments of arriving on scene. The officers have been asked to decide whether to transport the person to jail or local mental health treatment facilities or to ticket and release (Lamb et al., 2014). If an officer detains a defendant and transports to jail they are being asked to relay any information that is important to the booking officers so a decision can be made to determine if this defendant would be appropriate for MHC. Depending on the charges the defendant can be excluded and would not be eligible for MHC (Lamb et al., 2014).

Mental Health Courts Liaison

According to Griffin, Quintenz, Jenuwine, and Shasha, (2014) a mental health court liaison is not an agent of the courts but rather informs the court that there is a juvenile in detention that would better served in treatment in the community instead of remaining behind bars. The adult mental health courts have the same parameter; a mental health liaison may get a

referral to screen the inmate for potential acceptance in the mental health court (Wolff, Fabrikant & Belenko, 2011). It must also be noted that there is not cut and dry ruling on the acceptance into the mental health courts and the courts vary in what role the mental health liaison will have. In a job description that was put out by the Third Judicial District Court (2015) it spelled out the responsibilities and duties of the liaison/coordinator for the mental health courts. One of the duties was to gather all relevant information to present to the mental health team for admission into the court. Another job duty is to coordinate services with other agencies that are being ordered in their treatment plan and secure funding for the defendant. The list was extensive of the requirements of the mental health court coordinator.

Mental Health Professionals

Mental health professionals have multiple roles within the mental health courts according to a study conducted by Schneider (2010). One of the first interactions a mental health professional could have with a criminal with a mental illness is at time of arrest. Schneider (2010) reported that when a defendant is booked into a jail a mental health professional could be asked to do an assessment to determine if they are appropriate for the diversion track or remain in jail. The next set of roles a mental health professional may have according to Castellano (2011) is evaluating new court referrals. The professional may be responsible for developing and maintaining files on the mentally ill in the court systems. They have been tasked with overseeing the dispensing of medication and helping offenders find housing and jobs (Castellano, 2011). The mental health professional must also maintain the client – patient relationship while reporting back to the courts any violations that may happen, this according to Castellano (2011) is where issues may arise for the mental health professional. Castellano (2011) stated that the mental

health professionals participate in a “web of problem-solving activities with criminal justice, community personnel and their clients.”

Most of the research that has been conducted, shows traditional courts follow a pattern that the judges and attorneys are the central players. The judges and attorneys have been involved with the proceeding and how the disposition of the case is handled (Castellano, 2011). The new models according to Castellano (2011) has many different judicial players as well as mental health professionals working together to determine the best course of action for the mentally ill criminal.

Nurses and Psychiatric Providers

In some county jails in American an inmate is booked into the detention facility and seen within minutes by a registered nurse according to a study conducted by McNiel et al. (2014). The medical screening performed by the nurse asked questions regarding someone’s mental health problems at the time of the arrest. These questions can include but not limited to suicide ideations, depression, anxiety, and any medications the inmate may be on (McNiel et al., 2014). According to the study once an inmate has been identified as having potential issues then they are referred to a mental health professional for further evaluation. A book written by Stuart (2014) described that a nurse has little training in dealing with psychiatric issues in community setting. They have little training in identifying mental health issues and ways of dealing with those issues (Stuart, 2014). There is a need for Psychiatric nurses in both community and criminal justice settings.

Mental Health Courts Used for this Study

The courts used for this study were in the Rocky Mountains, the first Mental Health court was established in 2012, other counties soon followed suit. The second court was established in 2009. The premise was for a problem-solving court to deal with the mentally ill instead of sending them to jail or prison. The founders were hoping to stop the cycle of incarceration and get the defendants the treatment they needed. They cited the benefits of the MHC and how it would work to benefit the defendants and the community. One of the special features of the MHC is that they stated that they are the first of their kind to deal not only with defendants with misdemeanors, but they also are screening for non-violent felony offenses. No studies have been conducted with this MHC to see the strengths and weaknesses so other courts may use the same approach.

The next court was established in 2012, and is a blend between the first two MHCs established. It is like other MHCs in the nation addressing the revolving door of defendants returning to the criminal justice system (Auge, 2011). The mission and the goals it to take a defendant and help with treatment and any issues they have. The Rocky Mountain courts are set up on a 14- month program, meeting with Judges, probation officers and case managers weekly.

Case Study Approach

A study conducted by Cintron (2015) looked at the mentally ill in two Florida jails. The study looked at the problems that the mentally ill face once they are incarcerated. Cintron (2015) designed the case study to explore the perceptions of the admissions team and the mental health staff. The participants were interviewed and recorded, and open-ended questions were used.

Using multiple professionals enabled data triangulation. The study showed necessary change to the treatment of the mentally ill incarcerated in jails in Florida.

A study conducted by Pepper, Kirshner and Rylewicz (2014) looked at young adults and chronic mental health issues. The study found that treatment must be specific to each individual for a chance at a successful outcome. The case study concluded that the right treatment intervention that they youth could end up in jails or prison and homeless, the outcome of this study showed a need for treatment and specialized care in order to help these chronic young adults not burden the communities.

Summary of Literature

The literature varied in the studies but one issues that was evident in the literature about the history of the mental health courts was the safety of the community and treatment of the defendants instead of just throwing them in jail and locking them up. The history of the mentally ill defendants in this county shows a correlation between the mental illness and the crime that was committed. The MHCs were designed to address the mental illness to help the defendants (Morabito, 2007).

The literature review showed an in-depth look at the mental health courts and the roles of the professionals. Each section provided a look at the responsibilities of the professionals as well as applying the Therapeutic jurisprudence theory to each department could potentially help the defendant and the community as a whole.

Many studies exist on the recidivism rates of defendants of an MHC from a quantitative perspective. Few studies exist from a professional point of view on what the MHCs and what needs to be improved. Based on the previous research that has been conducted it is necessary to

gain the knowledge of the MHCs from the people on the front lines helping make MHCs successful, from the day to day operations to the long-time success of these programs. It has become critical to determine how successful programs work, and to fix the issues that arise so other counties and states can also develop MHCs in their areas helping to reduce the number of inmates in our jails and ultimately our prisons.

Chapter 3: Methodology

Introduction

The purpose of this research was to examine the strengths and weaknesses of the MHCs from the perspectives of the professionals involved in them, in order to help determine how MHCs could meet the needs of the defendants, victims, and the community more effectively. In this chapter I discuss the research design and the rationale for using the design, the role of the researcher, and how I dealt with any barriers and potential ethical issues. I also discuss the methodology and the rationale for its use, as well as the research strategies, how participants were selected, and the data that was collected and analyzed. I also account for the validity and reliability of the study and discuss any ethical concerns that arose from this study and how those concerns were addressed.

Research Design and Rationale

The research question for this study was:

RQ. What do professionals who work in mental courts perceive as the strengths and weaknesses of the courts in their ability to meet the needs for the defendants, the victims, and the community they serve?

A case study methodology was used for this research to determine the professionals' point of view on the process of addressing the needs of mental health defendants in the MHCs. I used this method to explore real-life situations by looking at the treatment team as a whole unit, thereby investigating the phenomenon via insight from multiple professions. Using a case study that involved the entire professional team uncovered data that could answer the *why* and *how* questions of the MHCs. As discussed by Thomas (2015), a case study should be used when an

in-depth exploration from multiple sources and perspectives is needed to look at a complex institution or a program. Brown (2008) also discussed that case studies can be used when the researcher prefers to investigate the *how* or *why* or *what* questions and focus was on a real-life phenomenon. This research considered MHCs from several perspectives.

The purpose of this case study was to examine the strengths and weaknesses of the MHCs from the perspectives of the professionals who are involved with them in order to help meet the needs of defendants, victims, and the community. The case study was done by using the explanatory style. According to Thomas (2015), the explanatory style should be used if the researcher wants to see how well something is working.

The case study approach was chosen because it allowed me to look at different parts of the phenomenon under study (Thomas, 2015). An MHC has many different professionals who work with one defendant for one outcome, which is a successful completion of the requirements of the MHC treatment team.

A historical qualitative design was considered but ruled out. The first reason was that the historical design looks at events from the past. As discussed by Cronon (2008), historical research looks at a subject from the past to determine the benefits that may accrue in the future. Looking at just the past was only one part of this study; this research considered the present as well in order to obtain clear data as to the strengths and weaknesses of the MHCs.

A phenomenological qualitative study was considered, but I ruled it out as well. According to Charmaz and McMullen (2011) a phenomenological study in a meaning-oriented approach. As described by Creswell (2014). A phenomenological study describes the lived experiences of individuals with things they have in common and interprets those experiences. This study was not concerned with the professionals lived experiences, it was concerned with

understanding how a group of professionals' work to make MHCs work in regard to the defendants' progress.

Role of Researcher

The researcher's role is an important point to discuss. As stated by Creswell (2014), the researcher needs to look at the natural setting of the research location. Interview subjects could be more comfortable and open up more in a familiar setting rather than a place where they may feel uncomfortable. The interviews were conducted in the participants' offices or at a public location chosen by the participant. I obtained information prior to the interview about the location to ensure that the participant would be comfortable. If a participant was requesting that interviews be conducted at the office, then permission was obtained from the appropriate people to do so.

The researcher is considered a key instrument in the study. I collected the data and interpreted what was discussed, as well as any documents from the participants or the courts. I looked at the patterns, categories, and themes that emerged and built the research from the bottom up by organizing the data as discussed by Creswell (2014). One important aspect is that the researcher must not lose focus on the meaning that the participants describe as their experiences. One way I avoided losing focus was to code one interview at a time and let there be at least 24 to 48 hours between coding so the information was fresh and not tainted by the previous interview.

Researchers must be aware of their own biases. The biases for this research may have been that I have studied MHCs and believe that they are a positive addition to the judicial system, which could have biased how I asked questions and the way I interpreted data. I have

never worked in an MHC, so no biases existed in terms of expectations of the strengths and weaknesses of the court from any professionals' point of view. Once the transcripts had been coded, a one to two-page summarized copy of key findings was to be sent to the participants for review to ensure that their responses to the interview questions were not taken out of context or changed in anyway. This helped eliminate research biases, ensuring the findings matched what the participant communicated and described during the semi-structured interviews. I avoided specific personal or professional relationships with any of the participants so that potential biases for that were avoided.

Methodology

The data for this research was gathered by conducting semi-structured interviews with the participants I looked for patterns and themes regarding MHCs from the professionals' perspective. As discussed by Thomas (2015), there are ways that interviews need to be conducted for a successful case study. One way is for semi-structured interviews presented in an interview schedule with the list of issues that will be addressed during that time frame. The primary goal for these interviews was be to obtain feedback on program operations and the participants' expectations. The interviews used open-ended questions about the current roles of the professionals, the expectations of the professionals and their views on the defendants and court outcomes. The interview structure gave an opportunity for participants to share openly and more completely then with just yes and no questions, per Thomas (2015).

Participant Selection Logic

The participants' selection was accomplished by sending an e-mail to the MHC liaisons asking permission for the contact information for the professionals at the MHCs in the Rocky Mountains. Purposive sampling was used, specifically for maximum variation sampling for this research. According to Suri (2011), this helps the researcher identify common themes that are relevant to gain a greater insight into the phenomenon. According to Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood (2015) this type of sampling can be used when the study seeks to use participants but the group size from which information is to be obtained is much smaller than would be needed for random sampling. This sampling strategy helped to provide rich data because every professional in the MHC had the opportunity to be part of the study. I asked for participation from all court personnel affiliated with the MHCs as well as, any law enforcements personnel or civilians who have contact with defendants who are potentially candidates for enrollment in the MHC.

The participants for the study also included professionals who worked in the mental health facilities or therapists in the communities. The main participants were the judge, a representative from the district attorney's office, a defense attorney; case managers, mental health team (community partner), court clerks, mental health coordinators, and probation or parole officers currently involved with MHC clients or who will be assigned to such clients.

The participants sampling size varied depending on the response from the initial e-mail. It is estimated that there could potentially have been between 12-15 participants for this study from all the professional areas. There was a total of 9 participants between two separate courts in the Rocky Mountains. Currently, there are six MHCs with approximately 12-15 professionals who work with MHC defendants on a day- to- day basis. The number of individuals in each

profession varied. There was at least one professional from every profession was represented except law enforcement.

Participants were chosen based on specific criteria. The first requirement was that participants must have worked in the MHC setting for at least 6 months. This was because they needed to have a working knowledge of the MHC expectations and understanding of their specific roles in helping defendants.

For the purpose of this study, all court personnel as well as clinical practitioners who were currently part of the MHC, were contacted for participation. An e-mail offer to join the study was sent to all potential participants. Permission was obtained from the individual MHC liaisons as well as from the IRB board prior to the e-mail being sent. An e-mail was sent to each MHC with an introduction letter establishing contact in an effort to begin building rapport with each MHC. An e-mail created a paper trail of any correspondence between the participant and myself. A thorough search was performed to determine if any new MHCs had started since 2011. Colorado lists their courts on the Colorado Judicial Branch website.

The court liaison was identified as the point of contact to obtain permission to conduct research with the treatment team personnel. I sent an e-mail introducing myself and the purpose for the research once the key personnel had been identified. The interview questions were attached to the original e-mail for the court personnel and clinical practitioners. This gave them the opportunity to review the questions before agreeing to participate. The questionnaire consisted of open-ended questions that each participant could choose to answer. A second court was chosen because the first MHC was in the process of closing. An e-mail was send out to the court liaison asking for permission to conduct research with the treatment team personnel.

Instrumentation

Several sources were utilized for this study, consisting of semistructured interviews and data collected from current MHCs. The interview questions were designed by the researcher based on past research of other mental health courts. No research has been done on the entire professional looking at the process of the MHC as well as the interactions of the entire team. So, it was necessary to design a set of questions that could capture the data. Other questions were designed by speaking to past employees working in mental health courts in another state, using their suggestions to develop questions that would help to gain the data that was necessary to answer the research question. The open-ended questions were designed to be unbiased and non-leading.

The first set of questions is designed for the professional experience. The job they are asked to perform can help to determine if they have working knowledge of the procedures of the entire MHC process. The second grouping is for input on the strength and weakness of the mental health courts from the professional experiences.

1. How has the interagency communication and collaboration been with your position?
2. What are the weaknesses and strengths of this communication? How does it affect the clients of the MHC?
3. How does a multi-disciplinary approach help the defendants, community, and the victims?
4. What are the challenges and benefits of developing an individualized treatment plan?
5. What are the strengths and weaknesses in using an MHC on reducing recidivism rates?

6. What are the strengths and weaknesses of addressing the housing issues, employment issues and treatment issues for the MHCs?
7. What type of monitoring of the defendants is ordered by the courts?
8. What are the strengths and weaknesses of this monitoring for community safety and victim safety?
9. What other information would you like to add to the successes and weaknesses of the MHCs?

Questions one through five, are designed to obtain professional information regarding the strengths and weaknesses of the MHCs. The questions are designed to look at the process of the professionals' working together and how it can benefit the defendants with successfully completing the requirements of the MHC.

The next questions six through eight were designed to speak directly about the process as seen from the professionals' point of view of the MHC. The questions are designed to look at the therapeutic element of the MHCS and if it aids in the success or weaknesses of the MHCs.

Procedure for Data Collection

Data was collected by face to face interviews using open ended questions to identify potential themes that may exist no matter the positions of the participant. Husman (2013) stated that each interview took between 1 to 1.5 hours for the interview; this is the same guideline that will be adopted for this research. The questions were asked and recorded on a tablet and notes taken for clarifying questions. Once the data had been transcribed and recorded in the research all interview paperwork will be destroyed using a document destruction company. The semi-structured interviews took place at the locations designated by the participants. If follow-up

clarification interviews are necessary, the participant will be notified by phone and e-mail of the necessity to follow-up. These clarification questions will not be conducted in person.

The recruitment was performed by sending an e-mail to the MHCs located in the Rocky Mountains. The participant's e-mails will be identified by a court liaison. All professionals will have an e-mail invitation sent to them individually, asking for participation in the study. The liaison had the contact information for the professionals in the MHC. A letter of cooperation will be obtained from the MHC liaison prior to any e-mails being sent out. An e-mail will be sent to potential participants introducing the study and information relevant to the study. If the sampling strategy produces too many participants' then a random selection will be done. The first court that was contacted was established in 2010. This random selection was done by separating the MHC into categories by oldest to youngest drawing a sampling of each court at least two per court will participate from each profession, more participants will not be ruled out as it may develop more in-depth data. The first court that was contacted is the MHC in the Rocky Mountains. I contacted that liaison once I have IBR approval and then an e-mail will be sent to the professionals of that court. If not enough participants' take part from the first MHC, then a second court will be contacted through the court liaison. Permission was obtained to contact the professionals of the second court to take part in the research. I sought approval from the IRB board for all 5 MHCs that could be part of the study. The participants were chosen from the MHC by order of when they responded to the original e-mail to participate.

The participants will exit the study by a phone call from the researcher letting them know the research is complete and to debrief them on the study and that the information that was obtained will be destroyed, once the data has been confirmed as accurate from each participant.

Data Analysis Plan

According to Yin (2009) there are five different ways to look at data. This case study was use the explanation building analysis. This was chosen because of the how or why something happened. Yin (2009) stated that to use this data analysis it must have some theoretically significant proposition. The proposition for the research will be the opinions of the professionals of the MHCs. The specific research question was;

RQ. What do professionals who work in mental courts perceive as the strengths and weakness of the courts in their ability to meet the needs for the defendants, the victims, and the community they serve?

All recorded interviews were transcribed and recordings will be destroyed. Transcripts were put into NVIVO to look for patterns and themes in the interview questions that were asked. The themes were identified in several ways. Themes are patterns of data that help to describe the phenomenon of this research (Thomas, 2015). The first way that a theme can emerge will be word repetition once the data has been coded. Looking at repetition can generate a list of unique words that can show a consensus from all the participants no matter the location known as building blocks (Thomas, 2015). The interviews that were conducted produced evidence of social conflict or contradictions, by their body language and non-verbal communications. The NVIVO program will be purchased for the purpose of this research project.

The instrument is also the researcher and they need to be aware their biases and pre-conceived perception of the problem (Seidman, 2013). The researchers ask the “why” to comprehend and learn about a phenomenon. Researchers need to pay particular attention when conducting interview to not lead participates to answer a question a certain way (Seidman, 2013).

Data was analyzed looking for patterns in the material collected; any discrepant cases was carefully coded to add to the trustworthiness of the research. The research is looking for the procedures that relate to recidivism rates from the professionals point of view. Any information that is considered negative toward the MHC from the participants will just add rich data to the study. Data that contradicts each other will add to the trustworthiness of the research. For this case study, semistructured interviews were conducted looking for any themes that may emerge.

My study looked at the data that has been collected by the current MHC in Colorado looking for treatment requirements that might have contributed to the recidivism rates of the defendants.

Issues of Trustworthiness

In order to demonstrate trustworthiness of this research project I addressed transferability, confirmability, dependability, and credibility. Research was done on the treatment aftercare of participants and statistics exist to show the recidivism rates of participants of the MHC. I asked participants about aftercare and the strengths and weaknesses. The research question will be discussed throughout the project to ensure that the study is answering the original question. The researcher will also discuss the background of the researcher that has shaped the interpretation of the findings per Thomas and Magilvy (2011). The final piece of trustworthiness will be for me to clarify any biases to ensure that no data was altered due to those biases.

Credibility

Credibility will be addressed by the triangulation of data from multiple sources. The sources will be the professionals from both the judicial branch and community mental health

partners. The questions were all the same for all the participants. The data was collected by face to face interviews.

As stated by Carlson (2010), one area to pay attention to is member checking, because of the nature of working with humans there is a dynamic that needs to be addressed. Research can inadvertently omit pieces of data that can damage the credibility of the research. Member checking is one way to avoid such a trap by inviting participants to check particular aspects of the data they provided, addressing the trustworthiness of the data and the outcome.

Transferability

Transferability for this study was achieved by showing how the data was obtained and the questions that were used. Thick description was accomplished by observing the participant while answering the questions, such as a nod to a question, a pause before answering or even a word or phrase interjected into the interview. Thomas (2015) addressed transferability of the research, by adding a thick, rich description of the research. This was done by showing what the research will be measuring, and what is intended for the study to provide, so the reader can feel as if they are part of the experience. Thomas (2015) also described a thick description as analyzing the scene, putting yourself in the other person's shoes or interpreting what the other person is doing. Carlson (2010) summarized a thick rich description as an "investigation of uniqueness" (p1104). Qualitative research is not interested in sustaining findings over similar situations; researchers are concerned with substantiating the finding over time. Thick description can help researchers address the credibility of the research by providing details of settings, participants' data and how it was collected and how the data was analyzed.

Transferability can also be obtained by a description of the process for obtaining the data, the participating selection, and the data outcome (Carlson, 2010). The detail about the methodology for this study can convey to other readers how this study can be transferred. According to Shenton (2004), there are several points that must be discussed in the research findings. The first point is that some of the MHCs and professionals who were involved in the research were imperative to show how this can be transferred to other jurisdictions. This was done by labeling the professionals who took part in the study such as Judges or probation officers and the mental health community. The finding can be transferred to their jurisdictions because the professionals are the same in their districts as well. I included a section in the data detailing the professionals and their job descriptions to show how other MHCs can apply the process to their MHCs. The thick rich description will be discussed further in the finding of this dissertation.

Dependability

Dependability refers to how the researcher arrived at data and the path at which it took (Shaw, 2013). The dependability for this study will be measured by using an inquiry audit. The auditor looked at the field notes, any reports, and transcripts to ensure that the researcher had not been careless or made mistakes in collecting the data, interrupting the information, and not misrepresenting the data to show favor to one side or another. I sent e-mails to several colleges in the area to ask for assistance in an auditor for this project. If the auditor finds errors in the data collection or interpretation, then I will relook at the information and amend the data accordingly. The auditor looked at the finding to ensure accuracy. The participants were notified of this third-party auditor. The auditor can be found by using research gate or any local colleges, and asked for assistance with this project.

Confirmability

Confirmability can be obtained by the researcher looking at self-biases and ensuring that all biases are reported and addressed (Shaw, 2013). Shaw (2010) also cited the importance of understanding that when data is gathered with the human experience that a researcher needs to make sense of the stories and experiences in a meaningful way. Shaw (2010) described reflexivity as the impact a researcher can have on the gathering and analyzing data. One way to achieve reflexivity is to declare in a different section of the research my position in relation to the research questions and the participants. Reflexivity was achieved by keeping a diary of my experience in identifying participants, collecting the data, and analyzing it. This diary was done to analyze any biases, and be reported on in the dissertation.

Shaw (2013) stated that using a tool such as NVivo can help guard against research biases to look for rare findings and enhance their own research. I had no personal interest in the strengths or weaknesses of the MHC. An MHC does not exist within a 200-mile radius. I do believe in the benefits of an MHC and that biases need to be addressed. One way this confirmability was accomplished and proved is by an audit trail showing all data and the triangulation between the sources.

Ethical Procedures

According to the American Psychological Association (2010) there are several rules that must be adhered to in order to produce ethical research. The first rule is to have institutional approval. This was done before the research began; from both Walden University and MHC liaison. One ethical issue that needs to be addressed is the informed consent of the participants. This was addressed by a scripted letter sent to each participant that they had to sign and discuss

before the interview was conducted to ensure they fully understand what they were consenting to.

The next ethical issue that was looked at was how the researcher will recruit participants. This is an ethical issue because researchers cannot hand pick participants as this may skew the data in one way or another. I recruited participants by sending out an e-mail to the MHCs asking for individual contact information for the personnel who work within the MHC. How the I dealt with confidentiality is another ethical issue. I ensured participants' names are not placed on any paperwork that others had access to. I meet with participants in a location they are comfortable with and will not share any information with anyone. I maintained my role as a research with each participant and not become emotionally involved in their lives. I maintained appropriate boundaries and not problem solve their issues. There was a disclosure statement on the original participation letter that stated if I suspected they were going to hurt themselves or others I would have acted accordingly.

The form that was used for the consent was sent to the IRB board for final approval. Please see attached APPENDIX A. A sentence was added to the consent form letting participants know that they can refuse to participate in the study with no repercussions to the participant. The participants were informed that they can withdraw at any time from the research with not future issues.

An important ethical rule that must be followed is reporting accuracy on the entire research findings. The interruption of the data as it is being coded can also be where an ethical violation can occur. This was addressed by sending a summary of the research to the participants to ensure that nothing was taken out of context or misunderstood so accuracy can be verified.

Another ethical issue is how the data will be destroyed once the research is complete. According to McLellan, MacQueen, and Neidig (2003) and Creswell (2014) unless a time frame is specified in the research disclosure statement then all audio and written transcriptions need to be destroyed once the information has been verified. All material was locked in a cabinet that only I have access to. Once all data has been verified for accuracy and the final research project has been accepted the data will be destroyed. Finally, according to the APA (2010) all publication will be given credit throughout the entire process, giving credit to authors and journalists.

Summary

Chapter 3 focused on the phenomenon for this study. It looked at why case study was chosen over other research designs and the rationale for using it. The Chapter talked about the researcher and how biases would be dealt with.

The population was identified and how they were selected and what biases may arise and how the selection biases would be addressed. Chapter 3 discussed where the data would be collected from and who would be part of the study. It looked at how the data was recorded and how the data would be destroyed. The instrumentation was discussed and how the participants received the questions and the semistructured interviews were conducted.

The chapter discussed the ethical issues that may arise in the interview process and ethical issues that could hinder the data collection. Chapter 3 looked about how the ethical issues surrounding the role of the researcher and the IRB boards' involvement was addressed.

Chapter 3 also talked about the trustworthiness and how dependability and confirmability was addressed. Transferability was discussed in chapter three as well a potential auditor to look at the data and ensure there was reliability in the results.

Chapter 4 will conduct the actual study looking at setting and the participants and the demographics that were used for the study. Chapter 4 will also look at the data and the results of the study after the data had been analyze.

Chapter 4: Results

The purpose of this qualitative study was to understand the strengths and weaknesses of the MCHs in the Rocky Mountains. As more jails and prisons become de facto mental health asylums, more states and counties are trying to find solutions for the overcrowding and financial drains this causes on the communities. Defendants can spend longer stays in jail if they suffer from a mental illness, costing the community thousands of dollars to adequately house and maintain their medical and mental health issues. An example of an increase in cost and a burden to already strained budgets is the cost of mental health medications. Once a defendant enters jail or prison, the individual communities are required to supply a defendant with the medications required to help stabilize/maintain their mental health. Specialty courts are being created to help alleviate the burden this place on the staff, defendants, and communities. The current study sought to understand the strengths and weaknesses of these courts in order to determine what was working and what could be improved up on. Starting an MHC is a costly enterprise and with the data from this study, communities could potentially avoid mistakes made by other courts and save time and money. This could ultimately help defendants avoid lengthy jail or prison sentencing, and help them access treatment, housing, and employment. The research question that guided this study was:

RQ: What do professionals who work in mental courts perceive as the strengths and weaknesses of the courts in their ability to meet the needs for the defendants. Victims, and the community they serve?

Research Setting

A total of eight face-to-face interviews were conducted across two MHCs. The interviews were semistructured, and follow up questions were asked and answered in line with research

purpose of examining the strengths and weaknesses of the court. For the ninth participant, interview questions were sent via e-mail because the participant could not fit a face-to-face into his schedule. The organization's conditions that could affect the interviews and participants varied from court to court. The first MHC was in the process of completely reorganizing their roles and the responsibilities of the defendants and the community. The court was closing due to funding issues, and one of the case managers was no longer going to have employment within the court. Other participants felt as if the MHC was closing due to not helping enough defendants. Case Manager G stated that "there was a lot of money spent on a few number of defendants." One of the professionals stated that there was a breakdown in the treatment team, and when it was time to reapply for the grant, the support did not exist for the grant application.

The second court had merged its two specialty courts under one umbrella. They took the mental health court and moved it under the drug court so more funding would be available to the defendants and more resources could be found.

Background on Courts

The first court began their quest for an MHC in 2010. A team of professionals went to other existing MHCs in the country to determine the best course of action to start an MHC in their community. At times, 3-4 professionals traveled the nation in search of best practices with lowest cost to communities and highest success rates for defendants. The first court that was interviewed started the court because the judge continued to see repeat offenders who did not successfully complete the requirements of the traditional court demands. The judge decided that a further consideration of these defendants might uncover an issue that the courts could solve in order to help the defendants. Four of the team members started the court in addition to their existing workload, adding the new defendants.

A grant was written to hire additional professionals to support the defendants. Once the \$350,000 grant was received in 2012, the first defendant was seen under the MHC structure. The court professionals believed that the court was ready, but they understood the growing pains that the court would experience. The first court closed in September of 2016 due to various reasons. The professionals in the court gave their account of why the court closed. There were professionals who had negative attitudes toward other professionals. The negative comments were removed from the coding.

The second court is currently in existence, and the treatment team and judicial team seem to operate independently of each other. This needed to be considered when coding the interviews. The second court merged the MHC with a drug court when they realized that the defendants with substance abuse issues also had mental health issues. The judge and professionals of the court noticed an overlapping charge for defendants with both substance abuse and mental health issues and wanted to deal with both under one judge and professional group. The second MHC had very strict rules to enter the secondary court instead of the drug court. The second court has been in operation since 2006.

Demographics

The demographics varied from court to court as can be seen in Table 1. The first court consisted of male and female professionals. Education level also varied with the professionals and the courts. In the first MHC, there were three professionals who had passed the bar and worked in the justice system. One professional has a master's in social sciences and addiction counseling. Two professionals had bachelors in psychology and worked in the treatment area of the court. One professional had held an addiction license for over 15 years and worked in the treatment field. The ages of the participants from the first court were from 30s to 60s.

In the terms of the demographics of the second court, the education ranged for the professionals. One had passed the bar and was practicing law in the state, and the other professional had a master in community psychology and worked in the justice system. The ages of the participants from the second court was 20s to 50s.

Table 1

MHC Demographics of Participants in the Study

Professionals	Gender	Ethnicity	Location
Court 1			
Judge (A)	Female	Caucasian	Court house
MH Coordinator (C)	Male	African American	Court house
Probation Officer (E)	Female	Caucasian	Therapist office
Therapist (F)	Female	Caucasian	Therapist office
Case Manager (G)	Female	Caucasian	Community Corrections
Case Manger (H)	Female	Caucasian	Community Corrections
Public Defender (J)	Female	Caucasian	Coffee Shop
Court 2			
Judge (B)	Male	Unknown	e-mail
MH Coordinator (D)	Female	Caucasian	Court House

Data Collection

For the first MHC, the interviews were conducted at four different locations, the court house, private offices, public offices, and a coffee shop. For the interviews that were conducted at the court house, I had to go through the scanner and wait for the professional to come escort me to the floor where the interview would be conducted. One of the professional's offices was off the judge's chambers and was not private enough for an interview. Therefore, we used an alternative room, a judge's chamber that was open, and the interview was conducted behind closed doors.

A first set of interviews were conducted at Community Corrections, which is a program designed to supervise probation and parole clients. Both professionals worked at this location and wanted the interview conducted there. I was asked to wait in the waiting room until the professionals were ready. There were two people present and the room was small and tight and the door had to be propped open because the room was very warm. This created an atmosphere of lower tones so it was difficult to hear the answers. These professionals worked in both sectors, the judicial sector and the treatment division. The participants were interviewed together at their request because they both had the same job title and could help each other identify the strengths and weaknesses of the MHC. Even though both had the same title, they had different jobs. The interviews lasted over 90 minutes.

The next interview was conducted in the court house. The professional's office was not private, so a judge's chamber was used, which was private and the door could be closed. During the interview, anonymized documents were obtained on the statistics of the success of the court, how defendants were monitored, how communication takes place, and e-mails between team members. The interview lasted for over an hour.

One set of interviews was conducted in a private office in a therapist business. The office was in a back house and the only access was through the main building, out back and into a new building. Both professionals were present when I arrived. The room was set up with an odd shape. The first chair was set next to the door and faced the wall and not the other two chairs; the next chair was 6-7 feet away. I had to turn my body side ways to ask the questions and balance my notebook on my lap. The next chair was face-to-face with the third chair and against the desk. The professionals asked to be together and do the interview at one time. They refused to allow their voices to be recorded but agreed to have the answers written down. One of the

professionals talked about trust and how important it was, but that participant was the one who refused to allow the interview to be recorded. The professional with the trust issues said that she was not comfortable with her answers being out there where anyone could hear them. Probation officer E stated, "I have a master degree and understand what these defendants needed and what the court requires." The interview lasted for an hour.

The final interview for that day was back at the court house. I once again had to go through security and up to a judge's chambers for the interview. This chamber was set up differently than the first judge's chamber. There were windows that faced a busy street and Christmas lights. The judge looked out the windows several times to the street below and the sun set before answering some of the questions. It appeared as if the judge was trying not to say anything that could be interrupted as degrading or critical to the professionals while trying to explain the weaknesses of the MHC, which was noted in the nonverbal journal.

The last interview for the first court was conducted in a coffee shop in an open area. No one approached the table and talked to the professional, and the setting did not seem to hinder the participants' responses. The request was made for a public place, not at the court house or office so no one could hear the interview and there could be no repercussions of this research. The professional stated that she still worked with all the professionals and some had issues with her stance on the MHC closure. The interview lasted over two hours even though the interview was scheduled for one hour. The professional asked if we could continue, and I agreed.

The second court also had a male and female, and the age range were the same as the first court. The interview was conducted in the court house, and I had to go through a security station and down a hall-way to offices and then into a waiting room to wait for the professional. Once the professional was notified I was there, I was escorted back through a series of hallways and

offices. I passed a conference room that had approximately 8-10 court professionals sitting around a table. I continued to the mental health coordinators office, which was semiprivate. The door remained open but no one left the conference room, so privacy did not seem to be an issue. However, I cannot be completely sure whether this impacted the participant's response.

The second judge in the research could not make the interview due to a busy work schedule, and so the questions were sent via e-mail and were answered and sent back to the e-mail listed on the consent form. The e-mail stated that if any clarifying questions were needed a phone call could be arranged.

There were two mental health coordinators who took part in this research. Both coordinators had information that was important to the strengths and weaknesses of the MHC. Coordinator C provided clarification on the roles of the professionals and how they impacted the defendants, community, and victims. Coordinator C also specified the stages of the MHC and how the defendants could progress on or go back to stage one. No other professional had such insight in regard to the MHC. Coordinator D provided information on the process of the court and how the multi-disciplinary team working together impacted the defendants and the court. The interview lasted for over an hour.

All participants consented to me making notes during the interview. Only two participants did not consent to the interview being audio-recorded as explained above. In all the interviews, I asked several follow-up questions to seek clarification on what participants had just said.

Data Analysis

NVivo was used to identify themes and patterns in the answers of the participants. Once the interviews were completed, I had to type all the questions and the answers I had written

during the interview in NVivo and then download all the audio recording. With the audio portion, it must be listened to in sections and then highlighted and coded under each question. Once the interviews were coded it was necessary to place a heading 1 in NVivo, before each question so the program would eliminate them and would just report on the participants' responses. The audio was then coded, listening to the audio tapes, and writing only the words that were verbalized excluding the words "the", "and", "but", "a", words of that nature. Then they were put into NVivo. The coding was done using auto coding for both the audio and interviews. The coding looked for themes identified the words most used to the least used. The coding also revealed the percentage based on the overall coding of the interviews. The most used word that NVivo identified was the word "defendant". The research participants said the word over 184 times, the next used word was community at 104, the coding showed over 100 words used during the interview process, the least word that was said was the word "wrong", only used one time.

Before starting the coding in NVivo I examined the therapeutic framework at which the research was based on and the research questions itself and predetermined that any word that was said by the participants' over 10 times based on the literature review in chapter 2 must be important. The themes started off with over 100 themes. Once NVivo was run there were over 100 words said over 10 times and words that were said 9 times or less for the entire coding process. I grouped the themes into categories. The themes were reduced to over 50 at that point, just looking for words being said the most. Some themes that emerged were defendants, community, court, help, treatment, and strength. The themes were then grouped into smaller categories, after re-listening to the interviews and listening to the key words and how they were used and in what context. An example of reducing the themes to smaller categories was the

judicial team talking about the communication with the treatment team members, the community and the defendants could be placed into a category of communication. It was necessary to reduce the themes from 50 to fewer but more comprehensive ones. There were 25 themes that emerged, by continuing to group them into more comprehensive overarching themes. Finally, data analysis stopped at four themes described below.

Communication was the first theme. Both judges talked about the defendants and how strong communication would either help or hinder their progress. Judge A talked about the relationship between the professionals' and the defendants, and how the defendants felt as if the judge was really listening to their concerns and really cared. Judge B talked about the defendants and how strong communication could help them be successful "the courts have a unique power to get the defendants who are unwilling or unable to cooperate to do what they are supposed to do."

The second theme that emerged was resources. All the professionals talked about the interactions with the community and how important it was for the success of the MHC. Case Manager G talked about how the neighborhoods did not want anyone with a mental illness living by their homes or their kids. Case Manager H talked about the stigma around someone who has a mental illness and a charge with the court. Coordinator C talked about how the community needed to collaborate with the MHC so that work could be found for the defendants and the requirements from the treatment team could be fulfilled.

The next theme was defendants. That word was mentioned 92 times. All professionals discussed the court requirements, the defendants, and how the court played a role in the success or weaknesses to the MHC, by monitoring treatment, monitoring court requirements, and monitoring needs for both the community and victims.

The final theme that appeared was treatment. Therapist F discussed how critical treatment was to a defendant's success of the MHC. Coordinator D talked about how treatment was usually the area where defendants would start failing the requirements of the MHC and this could be a weakness to the MHC. If a defendant failed the treatment part of the plan then it would have a negative effect on the defendant, the community, and the victims. The community would be affected if the defendant started reoffending with no one monitoring them in the treatment process.

The final step in the data analysis was removing any words that were not related to the success or weakness of the MHC, which were a personal attack on another profession. An example of this was a professional who said, "I have been in this field over 20 years and the other professionals should just listen to me, and not ask questions" per Probation Officer E. The word that appeared was "years" but a review showed it was related to this one professional and she said this word multiple times when referring to the questions of the research. This had nothing to do with the success or failure of the MHC but a statement from one professional about another.

Evidence of Trustworthiness

Credibility

The credibility of this project was ensured by inviting multiple mental health courts to participate in the interview process and asking the same question of each participant. There were nine questions that were developed to discuss the strengths and weaknesses of the mental health court. The questions were not leading or trying to elicit a response to lead this researcher in either direction. Participates were invited to answer the questions without interruption and questions were kept open. Participants said that they were glad to be part of this study because

they were hoping to get a clear picture of the strengths to take back to the stake holders and get their court back up and running.

Transferability

Adding a thick description to research is critical to demonstrate the credibility of the research (Thomas, 2015). In the current study, this was done by describing the research setting (see relevant section in this chapter). Furthermore, notes were taken about body posture, non-verbal statements and answering of the questions. There were eight interviews in total and verbal and non-verbal cues were recorded. When interviews were conducted together non-verbal cues were recorded such as a nod of a head to agree with what the other participant was saying. Shaking their heads and interjecting statements were also noted in the notes when a question, was being answered. When the interview was conducted alone, nonverbal cues were noted such as a participant started to cry when talking about the MHC closing. The Judicial team was all dressed as professionals in suits and skirts. When I interviewed a therapist and judicial member together one dressed casual and the other very professional, their body language and way they spoke matched their dress. Questions were asked the same to each professional with no inflections in my voice or different body language.

In addition, to ensure transferability, I have described the participants that took part, including their profession. The process by which I collected and analyzed the data, thus other researchers can transfer this process to study other MHCs.

Dependability

The interview questions and answers that were hand written were given to a third unbiased party to make sure that what was recorded in NVivo was what was written on the questionnaires. The coding was done via auto coding, so no words were missed or intentionally

left out looking for words that were frequently used; a word cloud is attached in Appendix D. The audio tapes were also given to the third party to listen to, to ensure that the words were recorded correctly, avoiding any biases from the researcher. Furthermore, the data collection strategy was developed through consulting the current literature base as outlined in chapter 3.

Confirmability

I kept a diary throughout the data collection and analysis process, and ensured I was reflexive. In my diary, I noted non-verbal for both professionals and myself to ensure no biases from my part affected or influenced the outcome of the responses. During the first day of interviews, I noticed a lot of head nodding and making comments about the response and had to look at my own biases and not give approval or disapproval for any responses that were being given. I took a deep breath before each interview and did a mental check during each question and before asking the next question. I had to not react when one of the participants started to cry, even though as a therapist I wanted to get some tissues and offer support. Checking my own personal biases was important when I was conducting an interview and got triggered by the responses of bashing other professionals. I did a quick mental check of my own body language and facial expression, so that it did not interfere with the responses.

Study Results

There were a total of four themes that emerged from the interviewing. A word cloud was developed to help demonstrate the themes presented in Appendix D. A word cloud is a representation of the most used words from the professional's interviews.

The themes that emerged are as follows, communication, resources, defendants, and treatment. Each theme comprises subthemes, as can be seen in figure 1, all linking to strengths and weaknesses of the MHC based on the professional's experiences.

Table 2 *Themes and Subthemes; Emerging From the Interviews*

Communication	Resources	Defendants	Treatment
Quality of communication	Housing	Relationship with MHC personnel	Aftercare
Comm. on reward/sanctions	Medication	Receiving Support	Realistic Goals
Comm. Style- Comm. at meeting Comm. within the team	Work Financial benefits	MH issues	Individual treatment

Communication

Throughout the interviews communication was discussed as a weakness or a strength, depending on the context. The communication with the defendants was a strength to the success of the MHC. The quality of communication among the judicial team and treatment team in both courts was considered influencing to the success of the court. Therapist F stated that “with that many strong personalities there are bound to be communication issues.” Highlighting how communication style could be a weakness.

Quality of Communication

Poor Communication

Judge A spoke of the struggles with communication within the mental health court. The judge spoke about the probation officers, the defense attorneys, and the prosecution attorneys disagreeing on the defendant’s treatment plan and taking up a lot of valuable time arguing over simple issues. Therapist F wanted full control of the treatment plan with no input from the other professionals. The team tried to solve the communication issue that had arisen by asking for a

mediator to be brought in to help them. Judge B also spoke about the communication between the professionals and how it impacted the defendants, community, and victims. An example given by the judge was not getting updates on the defendants' compliance to treatment, and that would either hinder the judge's ruling to progress a defendant to the next phase, or the defendants would not get sanctions for missing important requirements and "getting away with everything."

Mental health coordinator C spoke about communication between the two teams, the judicial team, and the mental health team. The coordinator reported that communication could be terrible between the teams and it affected the defendants in their treatment and progress, which was a weakness to the MHC.

Mental health coordinator D provided information on the communication between the judicial team and mental health team. The coordinator revealed that the mental health team does not communicate with the judicial team about the progress of the defendants in therapy or following the treatment team plan, "the lack of communication hinders the defendants and makes it harder for them to complete the treatment team's requirements because the judge does not have all the information." The coordinator talked about how living in a place with multiple mental health providers makes it difficult to get all the communications "when there are over 100 places a defendant can get their treatment from trying to track each defendant to each provider is nearly impossible and if the providers do not communicate with the courts then the defendants, community and victims can suffer." If the defendants are not held accountable for their treatment failure it affects the community by putting them at risk of new crimes being committed.

Probation officer E talked about how difficult it was to communicate with the other judicial team members and how it affected the defendants "If we're missing an element in a

defendant's treatment plan because of communication, it hurts the client, community and victims." Case manager H reported that they had a hard time with following the treatment plan when they were not included in the revising of the plan. Therapist F said, "I should be the one who makes changes and should not have to consult with the others." Coordinator C talked about how the team working together would either help or sometimes hinder the progress of the defendants, "when we talk or e-mail things work great for the defendants, but lately there has been one professional who refuses to be part of the team and make decisions for the defendants."

Participants from the first court talked about how important communication was and it was a weakness in their court, "we have a member of the team who feels that they should not have to talk to the other members and it hurts the defendants with their progress" was said by case manager G. The second court felt that the communication is an important part of the success or failure of the defendants. Judge B said that "when we can't get our treatment providers to communicate with the judicial side we don't know if the client can move to the next phase."

Good Communication

Both courts discussed that when communication was strong the defendants, community, and victims all benefited. Coordinator C discussed how the defendant was successful when they understood the requirements and the expectations of the team, "helping the defendant with the court requirements by disclosing how to succeed and what was considered a failure can help the defendants." It also helped the community to fully understand what was expected of each defendant." Case manager G said, "The victims were also communicated with so they understood what the defendant had to do, which is a strength of the MHC." Case manager H

said that “One of the successes of the MHC was helping the community understand mental illness so they would be more receptive to allowing them to live and work in their communities.”

Communication about Rewards and Sanctions

Another subtheme under communication was the rewards and the sanctions that were imposed on the defendants. The professionals from court 1 talked about how communicating with the defendants up front, from the application process on how to be successful in the program helped the defendants navigate the unknown of the MHC. Coordinator C discussed that the MHC was a volunteer program and people with mental health issues would need to fully understand what was required of them to be successful. Public defender J would spend a great deal of time with the defendants letting them know the benefits of the program and the sanctions if they failed at the MHC requirements. Once accepted into the program Case Manager H discussed with the defendants if they had a hot Urinary Analysis what the sanctions would be and how those would be imposed. The professionals of Court 1 spoke about communication up front with the defendants, letting them know the expectation of the program, how to advance to higher levels and what the phase system was about was reported as one of the strengths of the MHC. Judge A said, “in a traditional court the defendant is told what to do and expected to do it, in an MHC a defendant is told what to do, how to do it and exactly what will happen if they fail, they are given the necessary tools to help them succeed.”

Therapist F and Public Defender J both spoke about a rewards system and how the defendants responded in a positive way when they knew that they could earn prizes for doing what was expected of them in the treatment plan. Case Manager H stated that “without communication among the team some of the participants were not allowed to draw a prize even when they had

made their appointment, this frustrated the defendants, and some would start missing appointment, UA and other requirements.”

Participants from the second court also talked about the strengths of the MHC being clear communication with the defendants from the beginning of the process. Judge B talked about the rewards and sanctions being critical in the progression of the defendants, “without communication from the treatment team the defendants would have to stay on the same level they were on, and not get the benefits of the next level, this made the defendants resentful and some stopped trying.” One of the strengths described by coordinator D was that the judge would give clear and precise directions to the defendants of the MHC so they understood what the expectation of the court was.

Communication Style

The interviews highlighted the strengths and weaknesses to how the judicial team and the mental health team communicate and the effects it has on the defendants, victims, and the community. The two mental health courts monitored the defendants differently. In the first court the mental health coordinator set up an e-mail grouping to remind the team about upcoming meetings and updates that were necessary. For the first court, coordinator C said that “communication was critical to the defendants’ success of the court.” The communication would result in no lag time for the defendants and they could progress onto the next phase if they were successful. “Communication among the professionals would mean the defendants could show successes.” According to case manager G, the weaknesses of court one, is that if a professional does not want all the team members to have input then a professional would send out a private e-mail.

The second court had a different monitoring system, each professional would contact the coordinator of the court to update them on the treatment plan requirements, and the coordinator would then let the judge know. Coordinator D stated that “Monitoring the defendants was difficult if the professionals did not send in their updates, and it could put up barriers in the success or failure of the MHC.”

Meetings

Communication was critical in the weekly meeting of the first court. Case manager H stated that “There were professionals who would dominate the conversations and nothing would get done for the defendants and the treatment plans.” The first court had weekly meeting for 90 minutes where they discussed any issues that had arisen with the defendants, process, or professionals. This meeting was important for the MHC so that any problems could be discussed. All the professionals spoke about this meeting being a necessary part of the success of the MHC.

The second court did not have weekly meetings and case manager D discussed the need for such a meeting, even if it was done once a month so everyone could discuss the defendants. Case Manager D stated that “not having a weekly or monthly meeting hurt the premise of the MHC and can affect the defendants and the community.”

Communication Within the Team

One of the strengths of the MHC that was discussed in the first court interviews was a meeting that took place with all the professionals, and they were required to attend. The members would discuss each new application looking at the criminal history so the judicial team member had to be present. The professionals would present the presentence report so the case manager had to be present and finally the behavioral report so the therapist had to be present.

The professionals talked about the communication at the meeting as being critical. A weakness of the first court was if team members did not communicate during the week, “if a defendant misses a therapy meeting all the members need to know so that defendants does not slip through the cracks and endanger the community.” The professionals of the first court had stronger communication about the defendants. The team would know if the defendant was missing the requirements and take immediate actions to keep the community and the defendant safe. If the defendant completed all the requirements for the week the defendant would receive rewards at the court meeting. “The only way to have a strong MHC is to have strong communication between the team members, or the court would fail.”

The second court had the same team players but the communication was lacking. There was no weekly or monthly meeting between all the professionals, the only communication was via e-mail or phone calls. The judge wrote that, “collaboration is poor and the mental health agencies are bureaucracies that do not respond well to other agencies, causing the MHC to have weaknesses.” The second court reported issues with the mental health professionals, “the mental health agencies do not want to cooperate with the Justice system. Instead of seeing the courts as an ally to aid their clients, they see the courts as an adversary.” Without cohesion with the team members it effects the defendants in a negative way, they may not progress up levels, they may miss treatment requirements and that can put the community at risk as well as the victims. Coordinator D stated “if a defendant starts missing treatment, failing urinary analysis, or failing at the requirements and the courts are not notified then the community is at risk for the defendant reoffending.” Communication was talked about by every professional in both courts; there were areas that each professional talked about as a weakness to the MCH. Judge A discussed “when

team members don't get along or want to control the meeting and treatment plan it creates a negative atmosphere for all the professionals.”

Resources

The resource as a success or failure of the MHC was discussed by both courts with equal weight. Probation officer E stated that “without the correct resources the defendants were set up to fail.” Coordinator C showed statistics, that when the resources are addressed then it results in less jail days saving thousands of dollars to the community. Many different resources were discussed as a success for the MHC and the defendants and the community. Coordinator C talked about helping the defendants make their court dates, having a case manager who could teach the defendants how to ride the bus, showing the defendants how to grocery shop and manager their money was some of the successes from the MHC model. Coordinator D talked about a weakness of the mental health court was the lack of quality intensive outpatient treatment for the defendants. “We have groups here or there but it does not meet the requirements of the court, so defendants need to go to multiple centers for treatment and transportation is difficult and sometimes impossible.” Every professional discussed housing and medication, and work as an essential part of the success of the defendants and successful completion of the MHC.

Housing

Every professional discussed housing as an essential part of the success of the defendants and successful completion of the MHC. Case manager G stated, “The number one goal for the defendants is housing, it plays a huge part in success of the defendants and the MHC.” The cost of housing for the defendants and the courts was a barrier for both courts. The first court had a budget for housing for the defendants built into the grant. The housing grant allowed for \$400.00 for each defendant to help with housing, case manager G stated, “housing was a weakness for the

MHC because the cost was too high to continue to help all the defendants.” Coordinator C talked about an arrangement with the community to get housing for the defendants at a rundown motel for \$400.00 a week instead of a month draining the budget quickly. If housing was not available them it was hard for the defendants to complete the requirements of the MHC, “if they are living under the bridge or on a park bench, they do not care about medication or court dates or therapy.” Coordinator C said that “housing bleed us out, it was our largest expense and biggest barrier.”

The second court professional talked about housing as being a weakness also, “it is hard to find adequate housing for the mentally ill, and without it they do not care about court or medications,” per coordinator D. The housing crisis exists all over the state of Colorado per the coordinator D, “if a defendant cannot find a safe place to sleep at night then why would they care about the requirements of the treatment team.” In the second court, the defendant would have to stay in jail until housing was found. Case manager H talked about how having nine different people working on the housing issue so the defendant could get out of jail is a success for the defendants, community, and the MHC.

Medication

All participants discussed medication equally as important. The participants of the first court discussed that if a defendant was in jail and medication was started or changed it was difficult to get the defendant to see a doctor to continue that medication. “A defendant would get out of jail and stop going to get their medication because they couldn’t find a doctor, or they did not want to take it and they would end up back in jail due to decompensating,” per probation officer E. Another issue was lack of providers who took Medicaid and so the defendants would use the emergency rooms to get their prescriptions filled. Coordinator C spoke about the cost of a

defendant going to the emergency room on the community. A strength of the MHC was discussed from case manager H that Community Corrections have doctors who are available for the defendants and they would get into to see the doctor within 3 days of getting out of jail. When a mental health defendant went off their medication they would start to fail at the requirements of the court putting them at risk of being let go from the program and committing new crimes, which affects the safety of the community.

Work

The treatment plans for the MHCs stated that the defendants would need to find or keep their current jobs to be considered a success of the MHC. The professionals discussed this as a disadvantage to the defendants, stated case manager G “some of the defendants have low IQs and demanding they get a job sets them up for failure.” Using a cookie cutter approach to work with the defendants is viewed by the professionals as a weakness of the MHC, “a large percentage of the MH clients are not capable of obtaining and keeping a job, without support” (coordinator C). When work was successfully obtained, finding a job that would allow the defendants to do all the requirements of the treatment plan could be an issue. Probation officer E said, “there are a lot of requirements from the court, such going to court appointments, probation officer meeting, treatment meeting, going to do random Urinary Analysis and Case manager meeting that any typical job would get upset about, these meeting are usually during the day.” Case manager H reported that “if a defendant could find and keep a job it could be a success for the MHC, this could help our clients gain self-esteem that could help them in other areas.” Coordinator C stated “if the defendants have jobs then they contribute to the community and everyone wins.”

Financial Benefits

Starting an MHC can be expensive to the community; Public Defender J stated that “the frontend cost for startup runs into the hundreds of thousands.” Coordinator C said, “The long term social return for the community can save thousands for each defendant.” The social savings could be, lower ER visits, fewer ambulance trips, and fewer 911 calls which can save thousands, for the community. The defendants who are high utilizers of resources may be helped in an MHC to get support and reduce costs to the community per coordinator C and public defender J. Coordinator C disclosed that “it costs \$37,000 a year to house a MH defendant in jail, with treatment and medications.” Public defender J talked about how one defendant before entering an MHC program called 911 and had over 36 ambulance rides to the ER for “chest pains” in one year costing the community thousands. The same defendant only had one ER visit for an illness in the last 6 months saving the community time, and money. This is strength for the MHC per public defender J.

Defendants

All the participants of the courts discussed the defendants, they talked about how not helping the defendants could be a weakness of the MHC. Coordinator D talked about how the defendants with mental health issues need to have support from all areas to be successful in the MHC programs. Judge A talked about how important it was to apply therapeutic jurisprudence theory to every encounter with the defendants.

Relationship With MHC personnel

One of the benefits of the MHC as discussed by the judge A is that they get to know the defendants personally and their stories so the defendants feel a sense of personal stake with the judge, “the defendant responds positively to the judge when they know them by name.” The

second benefit of the MHC discussed by the coordinator C was “that a MHC allows defendants to get out of jail sooner under judicial oversight, probation monitoring, and a therapeutic control.” One of the successes for an MHC is “keeping people from re-offending while they are in the MHC program, and reducing the jail bed days” per coordinator C. A positive relationship with the defendants helps them reach out for help when they need it, per coordinator C.

Receiving Support

Case manager G stated that “as the defendants move from phase to phase they will need intensive support in the beginning and less as they become more successful.” An example of this support is that the MHC provides funding in the beginning when a defendant is on phase one per coordinator C. The defendants are responsible for the finances when they hit the third phase of the first MHC, “if a defendant does not pay for urinary analysis and they refuse to take them they are considered a failure requirements of the MHC” (Case manager H). The defendants are also responsible for many other aspects of the treatment plan. Case manager H said, “one of the costs to the defendants is restitution, an MHC success is providing support to the defendants to make sure that they learn to manage their money, and to pay for their court requirements.” When a defendant contributes to their treatment, cost of living, medications, and other court requirements there is a long-term benefit to the community and themselves, which was discussed by many professionals. One of the strengths of the MHC is helping defendants obtain their social security disability if they can’t work per case manager H, “making appointments and taking the defendants to get their social security can be a challenge, the application is long and can discourage someone with a mental illness.” Therapist F stated that “when a person can be responsible for them and be considered a productive member of society they are happier; their families acknowledge their success and everyone win.”

One of the strengths of the MHC discussed by case manager H, “helping a defendant understand their mental illnesses and manage it in a healthy way.” “Helping the defendant get engaged and stay engaged in treatment can help them understand they have a mental illness,” therapist F stated. Coordinator C discussed a conversation that he had with a defendant, “the defendant always felt different and was afraid of saying that he had a mental illness and what his family or friends might think. Once he was in the MHC he was successful in completing the requirements of the court.” Coordinator C talked about how many defendants had a mental illness in jail. “The jail in this community reported that 60% of the jail population had a mental illness that needed to be addressed.” “If the mental illness was addressed then it would benefit the community and the defendants but also the victims of the crime, by helping the defendant with the requirements of the court” per case manager G.

A mental health issues creates problems for the defendants if they are in and out of jail. A defendant with a mental illness, can be a drain on the system, emergency rooms, detox locations and homeless shelters. “A defendant with a mental illness can lose everything when they go to jail, an MHC team can help the defendant with the needs that they have, that is one of the success of the MHC” according to probation officer E. As defendants are being support in finances, treatment and other resources can help them take control of their lives.

Mental Health Treatment

Aftercare

One of the most important aspects of the MHC success is having a strong aftercare, all the participants of both courts talked about how this is important. “When we support a defendant for over two years just saying their done and leaving them can be a weakness for the defendants’ long term success per case manager D.” The first court did not have an aftercare program, they

no longer paid for housing, medication, or any other resource when the defendants finished all the requirements, this was identified by a case manager G as a weakness. “How can we be there to support someone with a mental illness for 2-3 years and just drop them after court is complete and expect them to continue their success. Usually they fail within a year or two” per coordinator C. The professionals of the second court also talked about not having an aftercare program as being a weakness, “recidivism rates are a lot higher for the mentally ill than other court defendants, if we don’t continue to support them how can they succeed” coordinator D said. All the participants talked about aftercare being a weakness of their MHC. Coordinator D said, “the defendants suffer and the community suffers because the recidivism rate is high once the MHC is done.” Case manager G stated that “in order to have a successful court there has to be an aftercare and our court did not have one, once they are done, we are done.”

Realistic Goals

Looking at the treatment goals can be a success or failure of an MHC. The defendants are included in the treatment planning process so they have a buy in for the court success. Judge A said that “individualizing treatment will benefit the defendant, community and the victims.” One of the barriers and weakness to the treatment plan per coordinator C is that resources may not be available, such as housing. One of the goals of the first court was to track sober days, “know where each defendant was in treatment, if they are progressing based on their goals of the team” reported coordinator C would be a success of the MHC. “A failure of the court would be, if the defendant is not completing their treatment this could put the community at risk” per case manager G. One of the goals is to help the community feel safe while a defendant is under court supervision. There were other goals that each defendant had to complete like treatment groups or individual therapy, restitution, and finally useful public service hours, “having a team of

professionals find locations for a defendant to do their community service hours was a strength of the MHC” per coordinator C.

Individualized Treatment

“Meeting the defendants where they are and ensuring their needs were met, is critical for the success of the MHC,” is a statement made by a judge A. Case manager H reported that “the treatment plan must be individualized for the individual to be successful, in a traditional court there are no treatment plans and success or failures are based on meeting the court requirements.” Judge A stated that “there is a list of requirements that gets reported to the entire team and the defendants are monitored weekly.” See Appendix E for the list. “Showing the defendants and reminding them of their requirements can help them be successful,” according to case manager G. One of the strengths discussed by the legal team is that defendants are allowed multiple mistakes before going to jail. “In a traditional court jail is usually a punishment that is used right way,” per probation officer E. Coordinator C discussed that before the MHC “a defendant would stay in jail on average 5-6 times longer costing money to the community.” Now with the sanction system the judge reported the longest stay in jail is 2-3 days. The MHC looks at the individual and works with their limitations, jail is not the first option. The strength from the treatment side is that with realistic goals and sanctions as a last resort the defendant could succeed. Without realistic goals the defendant could fail and go back to jail. “The defendant benefits by the treatment team helping them complete their requirements, the community benefits by knowing these defendants are being tracked and held accountable for their actions, and the victims benefit by knowing that the defendants are being monitored and if they start to fail they will go back to jail” is what coordinator C said.

Summary

There were nine participants from two different MHCs. Four themes emerged describing the strengths and weaknesses of the court; they were communication, resources, defendants, and treatment.

Communication was the first theme, and the participants talked about the benefits of using an MHC with defendants who have a mental illness, and the disadvantage of using a traditional court. How the community would be impacted in a positive way if/when the court runs smooth and how communication is key to the success or failures of an MHC. Participants spoke about communication among team members as being a weakness, and could have caused the MHC to fail. Without strong communication things get dropped or lost causing issues for the defendants. Both courts struggled with positive communication among team members. A strength of the MHC was communication was with the defendants, and helping them understand their requirements and supporting them created a positive outcome from them in both MHCs.

The next theme was resources and how the community can be impacted in a positive way when adequate housing is available and affordable. One of the challenges that all participants discussed as a weakness of the MHC was not having enough resources. Housing was a challenge in both courts and according to the participants not meeting that basic need can have a negative outcome for the defendants, the courts, and the community. The professionals of the first court tried to address the housing concerns by providing temporary housing while the team worked on permanent housing for its defendants using the housing first model. One of the weaknesses of court 1, was that funding ran out quickly, taking away from other areas that needed help such as paying for treatment.

The next theme was defendants. According to Wexler (2000) following the therapeutic jurisprudence model has a positive impact on the defendants and the MHCs. Judge A and B stated that they see a difference in the defendants when they address them by name and know what they have been going through. The next strength of the MHC is when the court helps the defendants pay for their requirements in the beginning of the process and as they move phases the defendants become more responsible for their finances and responsibilities setting them up for success.

The final theme was treatment; A weakness for the MHC with the defendants is there was no aftercare set up. Having support and guidance for two years and then just opening the door and saying goodbye was identified by all participants as an issue. Individualized treatment was a strength of the MHC, allowing the defendant to understand their mental illness and finding groups and therapy that were individualized to their specific needs was positive for the defendants and the community. Another strength that emerged through the research was that realistic goals that are obtainable for the defendants helps them succeed in the court requirements keeping the community safe and the defendants out of jail.

The participants of both courts talked about how a smooth court could impact the community but making sure the defendants were following the court requirements and helping the defendants locate necessary resources would benefit the community by keeping them off the streets, and committing new crimes. "The victims would benefit by knowing that the defendants were being punished but also getting help to not commit new crimes" public defender J said. Participants talked about a strong MHC could benefit everyone with less crime, less jail days; saving the community in emergency resources and helping people with a mental illness get the necessary resources and tools to live in the community without further incidents in the public.

This chapter demonstrated the strengths and weaknesses of the MHC in the Rocky Mountains and how other courts can benefit from this study. Chapter 5 will discuss the recommendations for further study and the conclusions of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to discover the strengths and weaknesses of the MHC from the perspective of the professionals who work day -to- day with the defendants, and court requirements. These professionals were tasked with community safety, ensuring that victims were not retraumatized, and working with defendants on their treatment plans. This study was conducted to determine if a community can benefit from starting an MHC or continuing to fund an existing MHC. Steadman et al. (2015) assessed the cost savings to the community of MHCs. Kaplan (2007) stated that MHCs can reduce jail stays for defendants, and help with their mental health treatment.

I identified four main themes from this study. They were: communication, resources, defendants, and treatment. Most of the professionals emphasized communication as a key component to an MHC. Another key finding to this research is resources. The study showed how, according to the participants, communities could lower jail bed days and identify what resources were needed for the mental health population, thus saving the tax payers thousands of dollars. This brought about social change for the defendants and communities by reducing the number of defendants involved in a revolving door of offense, arrest, incarceration, release and reoffence that currently exists. Treatment was another key theme to this study. This study helped to show the gap in treatment and the strengths of the MHC when addressing the treatment options. The final key finding was the defendants and how the MHCs would be a benefit to them in the judicial system. The defendants could benefit from an MHC by fewer jail days and finding the appropriate help in the community.

The results from this study demonstrated that starting an MHC or funding an existing court can bring about social change for defendants with mental illnesses when they are involved in the criminal justice system. It revealed that benefits to the community as well as the stakeholders and the victims could increase when the weaknesses were addressed. A key conclusion of this study was that if any county in America is considering starting an MHC it will need to consider the strengths and weaknesses of other MHCs so the community does not strain limited budgets. Helping communities start an MHC can bring about social change by aiding defendants with mental illness and their families by helping to find treatment resources and saving communities tax payer dollars.

Interpretation of the Findings

This study extended the knowledge base of MHCs: and how they are run and how they impact the defendants, victims, community, and the cost to the community. The findings should not be generalized to all MHCs across the country but should be limited in applicability to those in the Rocky Mountains, because other MHCs may not encounter the same barriers, such as a housing shortage or inadequate team communication. Additionally, the research was designed to examine the strength and weaknesses from the professionals' perspective. Looking at the multilayered reality of each professional and their own view of the MHCs must be considered, as discussed by Cohen et al. (2000).

The data produced four major themes with several sub themes. These findings were consistent with the literature review of the strengths and weaknesses of other MHCs in the nation. Communication was discussed by Canada and Watson (2013) as an integral part of an MHC because of the responsibilities of fulfilling the treatment requirements of the court. The

professionals in the current study discussed good communication as a necessity of the MHCs. Poor communication according to the data negatively affects the MHC, the defendants, and the community. Communication was a key theme for this research, and the professionals discussed how upfront communication with the defendants could help them be successful in the MHC. The second aspect of communication was among the professionals themselves; with good communication, the defendants received the necessary help and resources that they needed to complete the treatment plan and fulfill the requirements of the MHC.

Existing literature suggested that MHCs may not be as effective as they are believed to be because of the inability to resolve the criminal behavior and mental health issues. (Johnston, 2011). There were many differing opinions in the literature regarding the MHCs' ability to address defendants' criminal activities, and the mental illness. Yamada (2010) and Johnston (2011) talked about giving similar priorities to both the criminal behavior and the mental illness. This study indicated that while a defendant was engaged in the MHC, the recidivism rate was lower; the defendants were less likely to continue to commit new crimes. The issues were that once a defendant was released from the MHC with no aftercare, their recidivism rates go up, supporting the concerns about MHC and criminal behavior as stated by Johnston (2011). This study suggests that with good aftercare, the defendant would go on and not commit new crimes, and an MHC could provide the defendants with the necessary tools to obtain their own aftercare programs.

According to Lamb, Weinberger & Gross (2014), mentally ill offenders can be resistant to treatment and they usually are not compliant with medications, housing, or jobs, failing the requirements set by the courts. In a traditional court, there is no accountability in these areas; defendants are just sentenced to complete treatment and community service and pay fines and

fees. One of the strengths of the MHC per the professionals in the study was that with the support from the treatment team, a defendant is more likely to remain in treatment, get proper medication, stay in stable housing, and find a job or social security benefits to meet their basic needs. In MHCs the defendants have a team of professionals who help to secure the resources they need, ensuring they are completing the requirements of the courts. Therefore, it appears that, rather than the problem being that mentally ill offenders are not compliant, it is that they need the right support, and a professional team can offer that through an MHC.

This research demonstrated that there is a distinct difference between an MHC and traditional courts in terms of how the defendants, community and victims are impacted. Hueston and Burke (2016) wrote about the defendants of a traditional court learning to say whatever the judge wanted to hear to get out of jail and back to the streets. In a traditional court, the judge has no contact with the defendant once sentencing happens unless they have a probation-revocation (Hueston & Burke, 2016). In an MHC, however the judge is concerned with helping the defendant be successful in all areas of their lives. The judge is involved weekly in the defendant's progress and treatment plan.

The professionals interviewed for this study talked about the therapeutic jurisprudence theory and how it applied to the defendants with mental illnesses and the requirements of the court. The findings of this study agreed with previous literature from Wexler (2000) in regard to viewing a defendant in a therapeutic model and using goals that must be accomplished in conjunction with their mental illness diagnosis. Case et al. (2009) discussed using the jurisprudential approach instead of jail, thereby helping defendants meet the requirements of the courts and keeping them from reoffending. In an MHC, professionals look at a person's mental illness and address it while the offender is supported in complying with the court requirements.

MHCs in the Rocky Mountains use the therapeutic jurisprudence model to work with their defendants to gain trust and instill the desire to complete all the court requirements. Traditional courts look only at punishment and not treatment for the mental illness. Traditional courts according to Hueston and Burke (2016) have a high number of cases, and the judges do not have the time to spend with each defendant working through their issues. The judges hand down sentencing without the defendants having a voice in the matter, which creates an atmosphere of unfairness for the defendants (Hueston, & Burke, 2016). The current study supported the literature showing the defendants did better if they felt as if they had a voice with the judge.

One finding of this study is the benefit of an MHC over a traditional court in regard to how mentally ill defendants and the community are impacted. In an MHC, the treatment team monitors the defendants, ensuring they are following all the requirements of the courts. The defendants, community, and victims benefit from this. The findings of this study showed that there is a large positive impact on defendant behavior and community safety from defendants being held accountable by multiple professionals. Per the professionals from this study, when a defendant is engaged in an MHC, they have professionals there to help guide them through the justice process and help them to understand what is expected of them. According to Cook et al. (2015), restorative justice is used in traditional courts and is meant to restore the defendant to precrime status, the community back to being whole again, and the victim restored. In the restorative practice the lawyer explains the process or the judge discusses the charge and the defendant is expected to understand what is happening and what is the right course of action for themselves. If the attorney or judge feels the defendant does not fully understand they can be remanded to a state facility until competency can be restored and the case can proceed, costing thousands of dollars to the individual communities or state budgets. In an MHC, per the

professionals interviewed for this study, those same requirements apply but they have professionals to help. In an MHC, the defendant's mental illness is considered and the professionals would be with them to help them fully understand the process and provide support to the defendants from the beginning of the process until they complete the MHC. Some defendants may also be required to stay on medications, find housing, and apply for social security or some form of disability or a job. Professionals' help defendants meet their basic needs in every area while addressing their mental illness. The defendants benefit from an MHC by having nine professionals help to find the resources they need to be successful. The victims benefit by having defendants monitored to ensure that they are fulfilling the court requirements. The community benefits by knowing that the defendants are receiving the treatment that they need and are less likely to reoffend.

This research discovered that some MHCs have changed the way they operate, or closed the MHC, due to funding issues and tried to address the mentally ill in other programs. This study indicates that traditional courts can negatively impact the defendants, communities and at times the victims in the view of the professionals. The literature showed that traditional courts have too many cases and are not equipped to deal with complex mental health issues (Frailing, 2010). This study highlighted how the upfront cost to the community in starting an MHC or continuing to fund an MHC was minimal compared to the long term social return on investment in the lives of these mentally ill, saving the tax payers thousands of dollars in community services, and strengthening the family units so they could also help the mentally ill, once they successfully complete the MHC, taking over where the professionals left off.

Steadman (2015) talked about a defendant in jail staying longer and their mental health declining. This study is in line with the literature that a defendant can stay in jail in the beginning

of the process for longer times and their mental health can decline. Closing the MHC according to the professionals can set the defendants back, costing thousands to the community.

Hawthorne et al. (2012) discussed the goal of the MHC was to reduce number of inmates incarcerated with mental health issues. In 2007, Hawthorn et al. reported that 2.1 million inmates were incarcerated costing 14 billion dollars. This research showed that an MHC can reduce the days that defendants stay in jail helping to save money for the community. If the defendant agrees to volunteer in the MHC they get out of jail sooner and onto the requirements set by the treatment plan saving their communities money and lowering the number of defendants in jail.

Seltzer (2005) showed that one of the drawbacks of the MHC is that the number of defendants that are being funneled into the courts exceeds the amount of funding available for the MHCs. Defendants are not accepted in the MHCs based solely on them having a mental health diagnosis, they are accepted based on space and available resources. The current study supports that premise that defendants are denied based on available resources. The professionals identified lack of housing resources as an issue. The first MHC went through many different revisions on the application trying to streamline the process and capturing the defendants who were SMI and qualified for the court. Restricting the number based on qualifications and resources.

A study conducted by Carney (2013) spoke about the MHC, and defendants with lower IQ as needing additional support. This concept was also discussed by several professionals in this research and needing additional support or they would fail at the requirements of the MHC. Traditional courts are concerned with competency issues not IQ issues. When the MHC closed, the judicial team tried to find a solution to help the mentally ill. Multiple issues have risen because of this, the first is that, the program does not start until after sentencing and the

defendant is released from jail. One of the strengths of the MHC was the team of professionals who helped the defendants. The court closed per the professionals for two reasons, the first was lack of funding and the second was inadequate communication.

There were several distinctions between traditional courts and MHC in the literature review and confirmed by the participants of this research. One of the first distinctions between the courts was the professionals who worked in each court. Both courts have judges, and probation officers, defense attorneys and public defenders, but their job responsibilities are different. In a traditional court the judges can see hundreds of defendants a week (Hueston, & Burke, 2016). In the MHC, the judge sees a set number of defendants usually around 20-40, getting to know their stories, what their mental health issues are, how they are progressing and what they need additional support around. The probation officers also have different roles, they are involved in a deeper level, weekly with the defendants, knowing how they are doing, and progressing, and areas of concern for them (Griffin et al., 2014). The probation officers are tasked with keeping track of all the defendants progress as well as areas where they put the community at risk. This is a strength to the MHC holding the defendants accountable for their actions and fulfilling the requirements of the MHC, per the professionals' point of view.

Tsai and Chan (2010) talked about how in traditional courts the judges and lawyers are the key professionals who decide what the sentence will be, the punishment that must be enforced and any other court requirements that must be followed. In an MHC, the key professionals are the probation officers and the therapists, utilizing the other professionals for the input on the treatment plan and resources from the community. Moving the responsibility to outside providers for their knowledge of the defendant and what the treatment should look like. One of the issues in the research was lack of support from the therapeutic community for the

treatment plans and communication with the judicial team. The therapeutic community was asked to provide updates for the defendants on a weekly basis and without this the defendants, community and victims could suffer. Court two stated that the outside professionals are key to the success of the defendants and they must have good communication.

According to Redlich et al. (2010) a traditional court takes less time to completion than an MHC. A traditional court it is estimated 30 days from arrest to processing per Redlich et al. (2012) but for MHCs according to the research can take longer to get them screened for acceptance into the program. The beginning process can take 30-45 days. This study showed that even though it takes longer to get through the process, the long-term benefit is worth the wait. The professionals talked about the time frame but stated that with support from the professional team the defendants' chance of success in the program goes up. The defendants have help to stay out of jail and on their meds and off the streets while they are involved in the MHCs. The professionals spoke about the time, but added that if the defendant is successful, it reduces future jail stays and thousands of dollars from the community budgets.

Watson et al. (2001) discussed one of the weaknesses of the MHC as it being voluntary. According to Frailing (2010) a defendant who is accepted into an MHC can be successful. This is consistent to what this research discovered. One of the strengths was how the program and process were discussed at length with the defendants up front. What was expected of the defendants, and if they could follow the requirements or they were not placed into the program. The support that was given from the professionals during the process helped a defendant with a mental health issue be more successful than a traditional court. In a traditional court the participation is not voluntary, the defendant does not get the opportunity to be involved in their treatment and what the requirements are. The defendants according to Hueston and

Burke (2016) do not work with the judges throughout the process, they have a probation officer to monitor them and no resources are found to support their success.

The therapeutic jurisprudence theory was discussed by Wexler (2000) and looked at applying a more therapeutic approach that could potentially help defendants complete the requirements of the courts by connecting with the judge and judicial team in a more personal manner. The theory was also discussed by the professionals in this research, and they supported the idea of applying a more therapeutic approach to the defendants to help them with the requirements set by the judge. The professionals discussed how they have seen an improvement in the compliance with the defendants since acceptance into the MHC program and less incidents of defendants going back to jail which was also discussed by Redlich (2014).

Limitations of the Study

With all studies, there are limitations. This study was no exception to having several limitations. This study examined the strengths and weaknesses of an MHC from the professionals' perspective. The research was designed in such a way that the data pool was limited to only the professionals who work day to day with the defendants in the MHC. A limitation that affected the outcome data is a judicial member answered only the question that was asked. Two professionals said that they needed to answer the questions "politically correct". The professionals said that they were worried that they could be risking their jobs if someone found out that they were being negative about the MHC closing, so they were cautious about how they answered. The professionals mentioned that members involved in the MHC did not want to see it continue because of work load. The hesitation to answer the questions without thinking could hinder the true response from the professionals. This could be a limitation

because not knowing what information that they were withholding could weaken the finding of this study.

For one of the courts that did participate in the study, an e-mail was sent out to all 10 professionals and then follow-up calls were made to engage them in a conversation about the research and why their participation was important. Only two professionals agreed to participate, this could potentially change the outcome of this research by changing the strengths and weaknesses. Both members were from the judicial team and the therapeutic team was not part of this study. The study discussed the strengths and weaknesses from the point of view of both the judicial team and therapeutic team. Therefore in this MHC not all professionals were represented, which may have led to some issues not being discussed.

Another court participated but not all members agreed to be recorded during the interview so some important information about the strengths and weaknesses might have been missed. The reasoning was that one of the professionals did not want to be recorded was because she said, "I don't trust some of these professionals and I don't want my answers to be listened to by the wrong person." I assured the participant that the recording would not be heard by anyone but myself and a third party for coding, and the professional stated no again. These professionals as a team struggled with trust and communication. This can be seen as a limitation because there was no way to re-listen to the interview. Important information may have been missed while I was writing down answers to the questions.

Recommendations

The goal of the research was to identify any strength or weakness an MHC had from the perspective of the professionals who worked day to day with the defendants. This study was in response to the communities who look at starting a new MHC or strengthening their existing

programs. The professionals would have knowledge of what was working and what areas needed assessed and improved on. The goal was accomplished with this study, which leads to implications of future research.

One recommendation for future studies is how the data is coded; the data went from over 100 themes to four, taking time. In the future taking the questions that I developed and using the strengths and weaknesses already discovered to create more in depth questions given more information at which to draw from. Future research could look at the strengths such as defendant communication, and use that as a starting point to find out how the communication was accomplished and what exactly was done and said, so other MHCs would not have to start from the beginning with no guidance.

Another avenue for further research is looking specifically at the jails and how MHCs in the country could help to reduce the amount of mentally ill in the jails and how long they would remain in jail. According to Giliberti (2015), jails are becoming the new mental health asylums. The deputies and staff are not trained on how to deal with the mentally ill causing problems with the defendants. The professionals spoke about the mentally ill staying in jail for longer period of times causing thousands to the already strained budgets.

The knowledge that housing and medication are a weakness of the mentally ill defendants, gives communities an advantage when trying to work with them to get them out of jail. The professionals spoke about helping the defendants with their basic needs, such as housing and food, will help them to complete the requirements of the MHC, and help them in the future not commit crimes. Some communities have begun to build apartments specifically to house the mentally ill. Future research could be conducted on the amount of recidivism from the mentally ill based on housing needs with the mentally ill and the cost to the community.

The literature review revealed strengths and weaknesses from a quantitative perspective; only two past studies looked at an MHC from a qualitative method. Due to differing personalities, world views, politics and emotions, implementations of MHCs across the United States in general, there is a reasonable assumption that other MHCs could produce different strengths and weaknesses using the same nine questions that were created. Adding additional professionals, such as law enforcement and court personnel, could lead to additional insights about the strengths and weaknesses of the MHC.

Implications for Social Change

As the county responds to the mental health crisis gripping this nation, MHCs were started to address the needs of the mentally ill in jails and prisons. The jails and prisons have become the new mental health asylums of the United States leaving individual communities to try to pick up the pieces of managing these mentally ill in jail while trying to ensure community safety. After working at the jail for a year I was compelled to conduct this study. I work with the mentally ill and having no avenue for them to address their mental illness except in jail leaves the defendant vulnerable, deputies at risk and the community responsible for expensive mental health medications. The jails may be at risk for suicides and potential law suits because jail deputies and staff do not have the same mental health training that therapist have according to the professionals in this study.

Communities who consider funding an MHC can give defendants an alternative in the process, than just a traditional court or they could remain in jail for months and sometimes years with little to no help with their mental illness. MHCs can address the revolving doors for the mental ill according to Auge (2011). The highest recidivism rates for jails and prisons are with

the mentally ill (Fields, & Phillips, 2013). The mentally ill staying in jails and prisons for longer times per Steadman (2014) can exacerbate their mental illness creating additional issue for the defendants and the jails and the communities. Giliberti (2015) wrote an article that discussed that the mental ill and jails; it discussed that the longer a person with a mental illness stays in jail the more they decompensate. The finding from this study was that the counties who have an MHC help the defendants with jail stays and access to resources. The professionals stated that an MHC could help with this revolving door and reduce the time that a person with a mental illness is in jail.

The human component needs to be discussed with this research, a person with a mental illness can be locked up for months even years. The professionals discussed some defendants in the jail refusing medications and thinking the deputies were poisoning them, so they stopped eating and drinking. Professionals also discussed how families would call and plead to help their loved ones get the necessary medication and help that they needed while they were in jail. These types of stories are what the professionals discussed during the interview process. A book written by a father Pete Earley *Crazy: A Father's search through Americans Mental Health Madness (2007)*, depicts this type of issue in the jails with the mentally ill. The professionals discussed that most of the crimes are misdemeanor such as trespassing in a park after dark or stealing small items from grocery stores. The revolving door can be as simple as a defendant being in and out of jail because he received a summons to appear and missed his court dates, then he would receive a failure to appear warrant and the cycle would begin. Helping a person with a mental illness get out of jail sooner and getting treatment that they need and could be lifesaving.

Political advisors or committees could use these findings, to make a case for the community to start or continue to fund an existing MHC in those communities. This could help

to reduce the days a defendant spends in jail reducing the cost to the community. This study revealed that a strength of MHC, is helping to reduce the time and money spent on resources such as 911 calls, ambulance rides, and ER visits, helping defendants receive and stabilize on their mental health medications. Other strengths were lower recidivism rates in defendants while they were engaged in services and less repeated crimes from the defendants. An MHC per this study could save the community thousands of dollars in medications while housing a defendant, by reducing the number defendants with mental health issues in beds that a jail has, which could reduce overcrowding.

This study revealed a strength with the judges and judicial team using the therapeutic jurisprudence theory. The professionals discussed how well the defendants responded to the judges when they called them by name and listened to their stories and how the defendants felt as if someone really cared about them, and they were not just a number. This helped the defendants with accountability and following the treatment plan that the professionals put in place helping to reduce the revolving door that currently exists. Other judicial members of courts could use this research and apply the therapeutic jurisprudence theory in their court rooms changing the outcomes for the defendants, helping to reduce the recidivism rates. This theory and finding from the current study could also be taught in law school so the lawyers could learn to use this theory with their clients.

This study can bring about social change in many areas communities could use this research to avoid the same pitfalls that the other MHCs in this study had to deal with. The professionals talked about the application process going through four revisions losing valuable time for the defendants before acceptance into the MHC. Leaving the defendants in jail for longer than necessary. Shorter applications can get defendants into the MHC program sooner.

The biggest impact would be the defendants would get out of jail sooner and into the necessary treatment that they needed. The literature shows the longer the defendants stay in jail the sicker they can become, causing issues for the defendants, the deputies, and ultimately the community.

The second point of a social change would be a defendant receiving the necessary help with resources to help stabilize their mental illness. If a defendant continues to commit crimes it will be harder for them to get housing, jobs, and other necessary resources. This study showed that the professionals can help a defendant with the resources and stabilization, helping reduce the recidivism rates for these defendants. A community working together to find available resources to help the mental ill benefit the defendant, community, and victims.

The third area for social change is the media, in areas where an MHC exists the community is involved in finding resources and helping the mentally ill, reducing the stigma that the mentally ill are violent and need to be locked away forever. During the research of the MHCs the professionals talked about all community resources coming together for the benefit of the defendants, community, and victims. Other communities could use this research to look at the strengths of funding an MHC vs a traditional court, helping to change the stigma around mental illness and locating adequate resources.

The final and most important social change from this study is the defendants, their families, and the community as a whole. When defendants are arrested and they suffer from a mental illness there is not a lot of help for them behind bars and their mental health will continue to decline. They can remain in jail for months and even years without any support from friends and family. Families are impacted because someone with a mental illness may not understand the requirements of getting someone on a visitation list, how to work the complicated phone system, and deputies and jail staff do not have the time or resources to support this defendant every time,

cutting the defendants off from their family. I have had families call begging to get the necessary help for their loved ones, helping them to put their visitation lists together and how to use the phones so they can talk to their loved ones to ensure they are ok. An MHC could get the defendants back into the community quicker and back to their loved ones. The community will benefit if a team of professionals are helping the defendants get stable on their meds and become productive members of society.

Conclusions

This study was designed to look at the strengths and weaknesses of an MHC to determine if other communities could benefit by starting their own MHC, or continue to fund existing MHCs. There are many benefits to a community having an MHC or specialty court vs a traditional court. The strengths that this research discovered, was that the defendants with mental illnesses, have the potential to get out of jail sooner. Helping the defendants stay out of jail and obtain permeate housing and off the streets and out of the parks helps both the defendants, but also the community by providing stable living places, and help in securing money to buy food.

This research demonstrated that the cost over time is minimal compared to the long-term return on investment in the lives of these defendants and families and will save money overall to communities. This research demonstrated the strengths to the defendants, the community, and the victims if MHCs are funded fully. Without an MHC, there could potentially be an increase in emergency calls and visits to the ER, which could increase the cost to the community. There were four themes that were discovered during this research, they are communication, resources, treatment, and defendants. The professionals discussed the four themes, showing the strengths of an MHC and if areas are not addressed could be a weakness.

A successful MHC impacts defendants and families, because their loved ones receive the treatment and support they need, keeping them out of jail, lowering the recidivism rates.

Consider if this was your loved one and they needed support and the correct resources to help stabilize with their mental illness and the only place to house them was in jail. Giliberti (2015) wrote that jails are the new mental health asylums, is that where you would want your loved one to go?

This research demonstrated the long term social benefit of funding an MHC to help the defendants get out of jail, stay out of jail and stabilize with their mental illness. A traditional court is not equipped to deal with the mentally ill and they do not provide a team of professionals to help. Traditional courts look at the crime and punishment, an MHC look at the defendants, the mental illness the crime and finally the punishment, helping the defendants, the community, and the victims equally.

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Appendix A: Interview questions

RQ. What do professionals who work in mental courts perceive as the strengths and weakness of the courts in their ability to meet the needs of the defendants, the victims, and the community they serve?

1. How has the inter-agency communication and collaboration been with your position?
2. What are the weaknesses and strengths of this communication? How does it affect the clients of the MHC?
3. How does a multi-disciplinary approach help the defendants, community, and the victims?
4. What are the challenges and benefits of developing an individualized treatment plan?
5. What are the strengths and weaknesses in using an MHC on reducing recidivism rates?
6. What are the strengths and weaknesses of addressing the housing issues, employment issues and treatment issues for the MHCs?
7. What type of monitoring of the defendants is ordered by the courts?
8. What are the strengths and weaknesses of this monitoring for community safety and victim safety?
9. What other information would you like to add to the successes and weaknesses of the MHCs?

Appendix B: Cover Letter

Analysis of the mental health court
Questions for the professionals on the strengths and weakness of the mental health courts
Martha Amos, Graduate student
Walden University at Minnesota

To participants

My name is Martha Amos, and I would like to take a moment to introduce myself and discuss the research I am conducting. I am a doctoral student at Walden University. To complete the requirements for my Ph.D., I am conducting a study on the strengths and weaknesses of the mental health courts from the professionals' point of view. The questions are designed to look at the strengths and weaknesses from the beginning of the process to the completion of a defendant in the court. I am asking for a one on one interview with the participant to gain further knowledge about the mental health courts and any information that you feel is relevant to the study. The interview should be approximately 45 minutes, and can be done in a place of your choosing. This study is anonymous, and only your position will be reported. Participation is completely voluntary and in no way expected to cause adverse effects. Participation is confidential, and you may choose to return the questions via e-mail or mail them back. My address is Amos Counseling 1105 Ute Ave Grand Junction Co 81501. Your participation is greatly appreciated; please contact me to set up a time for a face to face interview no later than July 20th. Should you have any questions regarding this study, you can contact me via my personal e-mail, marthaamos29@yahoo.com. You may also contact Barbara Delevlasco Ph.D., the faculty chair at barbara.develasco@waldenu.edu. Should you have any questions regarding the validity of this study, you can contact the Institutional Review Board at the Walden University, via email, irb@waldenu.edu.

Thank you
Martha Amos
Graduate student at Walden University

Appendix C: Written Interview Results



Audit interview results



Appendix D: Phase System for Successful Completion of MHC

Phase	Minimum Duration	Court Appearance	Drug and alcohol testing	Probation meeting	Case Management meeting	Treatment contrast	Strikes allowed
Orientation	1 month	once/week	random	once/week	once/week	3-4/week	6
1	2 month	once/week	random	once/week	once/week	3-4/week	5
2	4 month	Twice/month	random	once/week	once/week	3-4/week	4
3	3 month	Every 3 wks	random	Twice/month	Twice/month	3-4/week	2
4	3 month	Once/month	random	Twice/month	once/week	3-4/week	1