Nebraska Mental Health Court Best Practice Standards

Nebraska Supreme Court

Administrative Office of the Courts and Probation

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Preamble

The standards in this document are intended to transfer scientific knowledge gained from validly-performed research to define professional practices for the operation of Mental Health Courts. The standards disseminate the knowledge from mental health practitioners and professionally qualified researchers on how best to assist persons with mental illness who are involved in the criminal justice system.

The underlying philosophy of these standards is to establish a process within the criminal justice system to stabilize the behavior and conditions of a person with mental illness, to engage or reengage such person with mental health treatment systems and programs outside the criminal justice system and to resolve pending criminal prosecutions fairly and justly.

The standards are designed to provide measurable criteria and objectives to facilitate the study of the efficacy of Mental Health Courts. The efficacy of Mental Health Courts and the practices employed thus far in other jurisdictions are in the early stage of research and evaluation. The standards proposed in this document are intended for use in small scale tests of the methods and procedures described in the standards in the district courts of the state. The goal of such small scale tests is to assess the implementation, feasibility and suitability of the practices, i.e., the goal of the small-scale tests is to gather information to help answer whether Mental Health Courts can be operated effectively in Nebraska in compliance with existing scientific knowledge of how best to reduce criminal recidivism of persons with mental illness. Ultimately, the small-scale tests of these courts will require experimental or quasi-experimental evaluations to determine if they are, in fact, evidence based practices and an effective treatment intervention as administered in Nebraska.

While the standards include two tracks of admission, one for high need individuals who are convicted of a serious crime (track 1) and a second one for high need repeat offenders (track 2), the standards are currently intended for use with high risk and high need offenders during the pilot test phase. The introduction of Mental Health Courts in Nebraska via the district courts with a conviction of a serious crime is intended to provide a smaller potential population to facilitate the proper study and evaluation of Mental Health Courts and these standards.

Acknowledgement

These standards were prepared after extensive examination of existing studies, assessments, evaluations, and research literature on Mental Health Courts. The examination, synthesization, and articulation of the evidence from such research materials were used to develop concepts which were formulated into standards. The standards were then subjected to further analysis and editing. This intensive process was potent by reason of the expertise of the examiners and the developers of the standards, Dr. Richard Wiener, Ph.D., M.LS, Bessey Professor of Psychology at the University of Nebraska of Lincoln; Dustin E. Bartley, M.S., LIMHP, LADC, Adult Behavioral Health Specialist, Administrative Office of the Courts and Probation; Jon Day, LIMHP, LCSW, Executive Director, Blue Valley Behavioral Health; Colin Holloway, Ph.D. (expected 7/2020), J.D.; Molly R. Deters, B.A.; Robert Denton, M.S., Deputy Administrator, Administrative Office of the Courts and Probation; Adam Jorgensen, B.A., Nebraska Statewide Problem-Solving Court Director, and James E. Doyle, IV, District Judge.

Introduction

In April 2016, the Nebraska Legislature passed, and the Governor signed, legislation broadening the definitions of problem-solving courts to include Reentry, Veterans, Mental Health, Driving Under the Influence (DUI) and other problem-solving courts. In response, the Nebraska Supreme Court's Problem-Solving Court Committee appointed a Mental Health Court Subcommittee to establish implementation plans that included the development of best-practice standards for Mental Health Courts. In turn, the subcommittee appointed a work group to conduct a comprehensive review of the research on the operation and effectiveness of Mental Health Courts in the United States. The workgroup found, and the Subcommittee concurred in the finding, that the *Nebraska Adult Drug Court and DUI Court Best Practice Standards* and the *Nebraska Veterans Treatment Courts Best Practice Standards* could not serve as the framework for the *Nebraska Mental Health Courts Best Practice Standards*.

At the time of the adoption of these standards, the research on Mental Health Courts was an ongoing enterprise without final conclusions, both in terms of the number of studies and their scope. The studies conducted to-date have measured and reported different outcomes, partly because Mental Health Courts vary in terms of who participates and how the courts operate and partly because of the limited methodologies the studies used. While existing research, including meta-analyses, shows tentative support for the proposition that Mental Health Courts produce positive outcomes for their participants and for the public, more data and further research are needed to secure a higher level of confidence in these conclusions. To advance the design of the most effective courts, more empirical evidence is required on all aspects of Mental Health Courts to determine which elements have the greatest positive effects, why, and for whom. It is therefore the committee's conclusion that, while establishing Mental Health Courts in Nebraska can produce positive outcomes, it is essential that, from the very beginning, Nebraska Mental Health Courts collect data to document implementation, measure fidelity to current standards and best practices, and show they are effective in addressing mental health problems in the short term and criminogenic risk in the long term.

The subcommittee reviewed relevant evaluations and other research conducted of existing Mental Health Courts in the supporting evidence sections of this document. The subcommittee refers to such material when relevant to the standards that follow. Despite continuing efforts to research and validate existing Mental Health Court practices, at the time of the completion of this introduction, no national standards for Mental Health Courts have been proposed or promulgated. Further, there is currently no entity or group pursuing the development of national standards for Mental Health Courts.

The subcommittee examined the research literature conducted on Mental Health Court programs, policies, practices and procedures to determine whether there was sufficient evidentiary support for the promulgation of evidence-based standards. The subcommittee's efforts led to the conclusion that most of the methods and programs employed to address mental illness in the context of the criminal justice system rely heavily on the integration of the professional judgments, assessments and treatment recommendations of properly qualified and credentialed medical providers and treatment specialists, who in turn relied on standards of care extant in their respective professions. While whenever possible, these standards rely on empirical research for their support, in the absence of applicable research, the committee turned to the professional judgments of the experts as integrated in the various programs. Second, the subcommittee determined sufficient evaluations and research had been accumulated to define inceptive standards for some, but not all, of the standards required for the implementation and governance of Mental Health Courts. Such standards are labeled as inceptive because they are in the early stages of study and development and, as a result, are in need of further evaluation, study and revision. Third, where the evidence was not strong, the subcommittee relied on the professional judgment of the workgroup members, based on the literature review, to recommend interim standards denominated as guidelines. The guidelines are recommended for adoption with a corresponding commitment to the collection and analyses of performance, fidelity and outcome data to assist in developing evidence-based standards to support or replace the existing guidelines.

As additional research produces evidence to support changes, the subcommittee will make recommendations for modifications to both the standards and guidelines.

I. General Requirements

A. Evidence-Based Practices

All Nebraska Mental Health Courts shall utilize evidence-based practices as identified by applicable social science research and literature.

B. Protection of the Rights of Persons with Mental Illness

1. All persons with mental illness accused of a crime have the qualified right to refuse a particular treatment, including a particular medication, and such right shall be protected in a manner at least as protective of a person in treatment under a civil commitment process. Each court shall establish a process to review treatment refusals of persons placed in Mental Health Courts from the criminal justice system so any decision to reinstate charges is made in an informed manner after all reasonable alternatives have been exhausted. The purpose of this review process is to assure that the due process rights of all person with mental illness are recognized and protected. Therefore, all legal protections that normally apply will attach as part of the review process.

2. All persons participating in a Mental Health Court shall be treated in the least-restrictive manner available, and all unnecessary institutionalization or the use of incarceration shall be avoided. The use of incarceration is generally inappropriate for persons waiting for admission into a Mental Health Court. Incarceration tends to exacerbate underlying symptoms of mental illnesses. Long jail stays should be avoided in all cases. Least-restrictive supervision conditions should be considered for all participants.

3. Participation in any Mental Health Court program should involve the same level of voluntary choice required of a criminal plea. Adequate notice and informed consent must be scrupulously honored when prospective participants are choosing between adjudication in a traditional court system and participation in Mental Health Court. No person shall be required to decide whether to accept participation in a Mental Health Court unless the terms and the nature of the proposed treatment have been fully discussed and documented. If the individual does not understand the terms and nature of the proposed treatment, then a mental health counselor will be appointed to assist the prospective participant in reaching an informed decision.

4. In addition to competent legal counsel in the underlying criminal case, an experienced, non-legal independent advisor shall be available to help the prospective participant reach an informed decision. Such non-legal advisor shall meet the qualifications of the Mental Health Court team. The independent non-legal advisor shall also serve as a support person to ensure necessary services mandated as part of a treatment plan are provided in a timely and appropriate

manner. If the prospective participant engages both a lawyer and a non-legal advisor, the two must confer to assist the prospective participant to make an informed decision. In the area of legal judgements, the advice of legal counsel controls.

5. At or before the entry of the plea, the prospective participants shall receive a clear statement of the behaviors which may elicit an incentive, or sanction, and the range of consequences that may be associated with those behaviors; the criteria for phase adjustment; the criteria for program termination; and the legal and collateral consequences that may ensue from termination. If, at or before the entry of the plea, the judge determines a participant with a mental disorder does not understand these rights and responsibilities, the judge will appoint an independent advisor to review the contract or handbook with the participant to assist her or him to understand her or his rights and responsibilities.

6. At or before the entry of the plea, prospective participants shall receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information shall be described in a participant contract or handbook. If, at or before the entry of the plea, the judge determines a participant with a mental disorder does not understand these rights and responsibilities, the judge will appoint an independent advisor to review the contract or handbook with the participant to assist her or him to understand her or his rights and responsibilities.

7. Persons with co-occurring disorders, and especially substance use disorders, must be treated in an integrated program. The court retains discretion to determine if the best fit for such an individual is in a Mental Health Court or a Drug Court depending upon (a) the nature of the nexus between the individual's substance use and mental health problems and (b) depending upon whether the treatment team determines that the substance use or mental illness are the precipitating events for the individual's engagement with the criminal justice system.

8. Pending cases and charges about to be filed shall be consolidated whenever possible to assure the participant receives centralized, coordinated case management and a single treatment plan.

9. Program completion should be tied to adherence to the participant's court-ordered conditions and the strength of his or her connection to community treatment. The progression plan that accompanies this document will guide the decision that a participant has or has not engaged with the program at any given stage during treatment.

10. Relapses are common during the behavioral health recovery process and, when considered alone, are not reason for termination. However, repeated relapses without engagement in recovery activities may be considered alone as sufficient grounds for termination.

Relapses are defined for the purpose of this standard as a return to a prior state of problematic conduct or state of mind.

11. The length of Mental Health Court participation should not extend beyond the maximum period of incarceration or probation, whichever is longer, a defendant could have received if found guilty in a more traditional court process. Without limiting the foregoing, program duration should vary depending on a defendant's program progress. Drug Court research suggests the program length in Problem-Solving Courts should reach a minimum of 12 months in order to stabilize the behavior and conditions of a person with mental illness, to engage or reengage such person with mental health treatment systems and programs outside the criminal justice system and to resolve pending criminal prosecutions fairly and justly.

12. Mental Health Courts shall be implemented and operated as means of integrating or reintegrating the participant with existing mental health programs and services. Mental Health Courts shall not be operated as replacements for or alternatives to existing or desired programs for the treatment and care of persons with mental illness.

13. All information acquired, collected, recorded concerning an individual's participation, eligibility or suitability for participation in a Mental Health Court program shall be maintained in compliance with state and federal laws, and Nebraska Supreme Court and Probation Administration rules and regulations governing confidential information.

II. The Mental Health Court Team

A. Program Planning and Oversight

A steering committee or advisory board composed of representatives from a wide range of agencies and disciplines shall conduct initial planning and implementation. The steering committee or advisory board shall represent all aspects of the criminal justice system, mental health and substance use treatment and ancillary service providers, appropriate medical professionals, funding entities and the community at large. All Mental Health Courts shall have a written plan for modifying local protocols, processes, and procedures.

B. Team Composition

The Mental Health Court team shall include a judge, prosecutor, defense counsel, problem-solving court coordinator, probation-based community supervision officer, community support worker[1] and treatment provider(s). The Mental Health Court team shall also include a licensed mental health practitioner, licensed psychologist, or psychiatrist. If the Mental Health Court team does not include a licensed medical prescriber, the team shall enlist an external licensed medical prescriber [e.g. physician, advanced practice registered nurse (APRN-NP) or physician's assistant) who is available at specific designated times for consultation and to review medications. It is highly recommended that each Mental Health Court team include a law enforcement representative, employment and housing specialists, and other ancillary service providers. Every effort shall be made to assign members to the team for significant periods of time in order to maximize adherence to program tenets and to promote stability of the team.

C. Pre-court Staffing Meetings

All team members shall attend pre-court staffing meetings and shall be afforded the opportunity to provide information and professional perspectives regarding program participants' progress and make recommendations for modifications to individual case plans, as well as recommend appropriate sanctions and incentives. The information regarding the participants' progress shall include a discussion of mental health treatment progress, co-occurring issues, the need for and adherence to changes in medication regimens and progress and concerns about criminogenic factors.

D. Court Status Hearings

All team members shall attend court status hearings to demonstrate the collaborative nature of the Mental Health Court. Importantly, appearance by all team members enables a swift response

[1] Where used in these standards, the term "community support worker" means specialists who assist with housing, occupational engagement, education, transportation, medication compliance and management, connection to financial resources, peer support and other ancillary service providers. The identification of the appropriate community support worker(s) shall be made by the Mental Health Court team based on local conditions.

when the court learns new information about the client. It shall be the responsibility of the Problem-Solving Court Coordinator to ensure all case management and collateral information is available to the Mental Health Court team for court status hearings.

E. Communication

Programs shall have written formal and informal procedures for communication among team members that outline the frequency, timeliness and accuracy of information dissemination. Team members shall regularly communicate with each other and the judge outside of pre-court staffing meetings. Team members shall follow all federal and state confidentiality laws when handling protected health information.

F. Initial and Continuing Education

All programs shall have a written orientation plan for new team members. All team members shall attend continuing education sessions addressing or concerning the use of evidence-based research, which is the foundation of cognitive behavioral techniques, motivation to change interventions and other techniques related to the successful operation of effective Problem-Solving Courts. All team members shall complete training on the use of incentives and sanctions. All Mental Health Court team members shall receive training for trauma-informed care.

G. Roles and Responsibilities

Formal written agreements (e.g. memoranda of agreement/understanding) between the court and partner agencies/organizations shall detail team member roles and responsibilities. Written protocols shall be in place to ensure the appropriate resolution of conflict among team members.

H. Supervision Caseloads

Court supervision officers will use current risk assessment instruments and caseload standards to guide officer caseloads. At the upper end, supervision caseloads shall not exceed twenty-four active participants per supervision officer.

III. Target Population, Eligibility, Referral, Entry, and Orientation

A. Objective Eligibility and Exclusion Criteria

Eligibility and exclusion criteria shall be defined objectively, specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals and community supervision officers. The Mental Health Court teams shall not apply personal, subjective criteria to determine participant suitability for the program. Only individuals diagnosed with a major mental disorder shall be eligible for the Mental Health Court programs. A diagnosis of a major mental disorder must be made by a medical or behavioral health professional whose Nebraska license allows the diagnosing of major mental disorders. Major mental disorders are those outlined in Nebraska Administrative Code Title 172, Chapter 94 of the Nebraska Department of Health and Human Services. The current offense or criminal history shall not presumptively exclude candidates from participation in a Mental Health Court.

B. Entry into Mental Health Court

The County Attorney or the defense counsel can request a mental health evaluation by a licensed behavioral health or medical professional for an individual who the attorney believes may be eligible for Mental Health Court. If the result of the evaluation is a diagnosis of a major mental disorder, then the county attorney may refer the client to the Mental Health Court team for determination of entry suitability for Mental Health Court participation. The Mental Health Court team can recommend the client for entry, another form of diversion, drug court or recommend that the individual stay on the regular court docket. Mental Health Court participation is available for individuals with (1) High criminogenic risk and a major mental disorder or (2) Medium criminogenic risk with a history of repeated lower-level offences and a major mental disorder. The Level of Service/Case Management Inventory (LS/CMI) shall determine criminogenic risk. The Mental Health Court team must determine that the potential participant currently lacks access to appropriate mental health treatment or the potential participant's recent symptoms have prevented treatment compliance and that participation in the Mental Health Court is likely to address these mental health needs. The Mental Health Court judge will consult with the Mental Health Court team, but the judge has final authority on the admission of an individual into the Mental Health Court. Nothing in this standard shall reduce or diminish the discretion held by the county attorney to withhold the referral of any defendant to any Mental Health Court program.

C. High Criminogenic Risk Individuals and a Major Mental Disorder

The Mental Health Court shall seek and accept participants for admission who are at high risk for reoffending as determined by validated risk assessment instruments, such as the Level of

Service/Case Management Inventory (LS/CMI), properly applied, and who have been diagnosed with a major mental disorder by a qualified professional (see section B above). The individual is eligible if s/he shows high criminogenic risk and the court determines that the client's mental health symptoms have a direct connection to his/her criminogenic risk and if participation in the Mental Health Court is likely to increase access to and compliance with appropriate treatment to address current mental health needs. The licensed behavioral or mental health professional who assesses the mental disorder must use one or more validated instruments and DSM-5 diagnostic criteria and record the findings in the report to verify that the potential participant meets the mental illness entry criterion (See section IIIE below for appropriate assessment tools and processes).

D. Medium Criminogenic Risk Individuals with Repeated Lower-Level Offenses and a Major Mental Disorder

The Mental Health Court team can also accept participants for admission who are at medium criminogenic risk and who have a history of repeated low-level offenses provided that a behavioral or mental health professional licensed to diagnose mental disorders finds that the individual has a major mental disorder (see section IIIA above for criteria of qualified diagnosing professionals). This second track allows for admittance of participants who repeatedly commit lower-level offenses, but who do so as a result of the mental illness symptoms that they experience. The Mental Health Court team may accept these individuals provided that they have a diagnosed major mental disorder as assessed by a qualified professional using one or more validated instruments and DSM-5 diagnostic criteria who records the findings in a report to verify that the potential participant meets the mental illness entry criterion (see section IIIE below for appropriate assessment tools and processes).

E. Validated Eligibility Assessments

Candidates for the Mental Health Court shall be assessed for eligibility using validated risk assessment instruments and mental illness assessment tools prior to program entry. The risk assessment tools shall be empirically demonstrated to predict criminal recidivism or the likelihood of failure on community supervision and that risk assessment tool shall show equivalent predictive validity for men, women, and racial or ethnic minority groups that are represented in the local population. The risk assessment tools shall include validated screening tools, which include symptoms of substance use and/or mental health disorders. Trained and qualified professionals proficient in the administration of the risk assessment tools and interpretation of the results shall conduct screenings and assessments.

Candidates must be diagnosed with a major mental disorder to be eligible for participation in a Mental Health Court. A qualified professional (see Section IIIA above) must make a diagnosis of

a major mental disorder using DSM-5 diagnostic criteria and validated screening/assessment tools as clinically appropriate. Three instruments that have sufficient psychometric properties for this purpose are the Brief Symptom Inventory, the Beck Depression Inventory and the Beck Anxiety Inventory. Other validated mental health assessment tools may also be used.

Candidates with substance use or co-occurring mental health indicators must be assessed by professionals trained and proficient in the Standardized Model for the Delivery of Substance Use Services, administration of the assessment tools and interpretation of the results.

IV. Program Structure

A. Program Capacity

All Mental Health Courts shall develop a plan to ensure that the Mental Health Court programs and services are provided to all participants consistent with evidence-based practices. Program capacity shall be in compliance with the caseload standard outlined in section IIH. Program capacity shall not exceed the availability of mental health services in the community, probation supervision resources and court resources (e.g., judicial, courtroom personnel and physical facilities) to administer the Mental Health Court.

B. Program Entry

Programs shall minimize the time between arrest or citation and entry into the Mental Health Court and the time between Mental Health Court entry and the time of the first treatment session.

C. Successful and Unsuccessful Program Termination, and Program Duration

1. **Benefits of Program Participation**- Benefits of program participation shall be clearly articulated in a written document and participants shall be made aware of these benefits prior to program entry. Efforts will be taken to ensure individuals understand the benefits of program participation.
2. **Consequences for Unsuccessful Program Exit**- Participants shall be given written notice of the potential consequence for failure to complete the Mental Health Court program prior to program entry. The judge shall determine via colloquy at the plea hearing that the individual understands the consequences of unsuccessful program termination before becoming a participant.
3. **Program Length**- Program length shall be long enough to allow participants to initiate and maintain recovery; mental health stability; develop coping and relapse prevention skills; transition to and maintain compliance with a continuing care plan; and obtain suitable housing.
4. **Program Progression Structure**- Programs shall adopt the Mental Health Court Progression Plan (Appendix I below), which defines the progress expected of individual participants dependent upon their criminogenic and mental health needs during the program. The Mental Health Court Progression Plan shall be predicated on the achievement of realistic and defined behavioral objectives. As participants advance through the program, supervision services may be reduced. Treatment reduction will occur only if a licensed professional determines that a reduction in treatment is clinically beneficial to maintain mental health stability and substance desistance (if appropriate).
5. **Successful Completion Requirements**- Participants shall meet specified requirements in order to "successfully complete" the Mental Health Court program. Programs shall define

completion requirements to include those that focus on long-term success. These requirements should be an extension of the participants' progress in the program and shall incorporate a written post-program plan that focuses on skills to maintain the behavioral changes each participant accomplished during program participation. The Mental Health Court team shall implement this plan prior to program exit to allow the participant to practice learned behaviors and skills during participation in the program.

a. **Period of Time Clean and Sober Prior to Program Exit-** For those participants with a diagnosed substance use disorder, a minimum of 90 days of continuous abstinence shall be required for successful completion; however, each Mental Health Court may establish its own minimum standard that exceeds the established minimum.

b. **Stable and Prosocial Activities and Environment-** Programs shall require participants to be involved in prosocial activities prior to completion. Programs shall require participants to have identified the elements of prosocial living environments prior to program completion. Participants who are not suffering from a documented disability that prevents them from working shall be required to be enrolled in vocational education, have gainful employment or be working towards gainful employment prior to program exit unless gainful employment jeopardizes their eligibility to receive benefits. Programs shall require participants to establish a stable living residence. A stable residence shall mean a dwelling place with little change in its location or occupants from day to day. Stable residences include licensed halfway houses, ¾-way housing, single-family apartments, condominiums, duplexes and single-family houses. Stable housing excludes homeless shelters, boarding rooms, hotels and motels.

c. **Written Sustained Success Plan-** Each participant shall develop an individualized, written, long-term plan that shall be implemented prior to program completion. Programs shall require participants to demonstrate the ability to comply with the sustained plan in preparation for transition out of the program. If the Mental Health Court team determines that a participant is unable to follow the sustained plan, the team shall modify the plan to ensure that the plan is one that the participant can follow after exiting the program.

6. **Benefits of Successful Program Completion –** Mental Health Courts shall dismiss charges or motions to revoke probation upon successful completion.

7. **Unsuccessful Termination –** Any time termination is recommended, the participants' due process right shall be honored. Participants who fail to meet the program requirements shall be terminated from the program by the Mental Health Court judge and immediately remanded to the sheriff in the county of the Mental Health Court for delivery to the sentencing court.

V. Treatment

A. Continuum of Care

The Mental Health Court shall offer a continuum of care for treatment consistent with mental health disorders as found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 or updated editions) and consistent with current evidence-based practices for mental health treatment. Treatment for individuals with co-occurring disorders will apply standards and criteria from both the *Standardized Model for the Delivery of Substance Use Services* and the DSM-5, and will be consistent with current evidence-based practices for mental health treatment. Adjustments to the level of care shall be predicated on each participant's needs and response to treatment.

B. In-Custody Treatment

Participants shall not be incarcerated to achieve clinical or social service objectives. The Mental Health Court may utilize incarceration for reasons of public safety or preventing the participant from harming her or himself or others.

C. Team Representation

One or two treatment agencies/representatives shall be primarily responsible for managing the delivery of treatment services to Mental Health Court participants. Licensed representatives from these agencies shall be core members of the Mental Health Court team and regularly attend team meetings and status hearings. In the event that a mental health professional is not present at a pre-court staffing, no change in treatment shall be imposed unless there is a written assessment specifically describing the change in treatment delivered to the team by the mental health professional or his or her designee.

D. Treatment Frequency, Duration and Intensity

Each Mental Health Court shall refer participants to services aimed at reducing the risk of recidivism; compliance with these services shall be incorporated into the Mental Health Court requirements. The Mental Health Court shall match the frequency, duration and intensity of services to the participant's mental health needs and criminogenic risk as determined by empirically validated assessment instruments.

Participants diagnosed with a substance use disorder shall participate in substance use treatment of sufficient frequency, duration, and intensity to achieve remission (long term abstinence and recovery from addiction). Treatment provided shall be consistent with the results of the substance use evaluation and in compliance with the *Standardized Model for the Delivery of Substance Use Services*. However, the Mental Health Court shall allow flexibility to accommodate individual differences in each participant's response to treatment.

The Mental Health Court shall offer a continuum of treatment services sufficient to treat mental health disorders found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Service providers shall use current evidence-based practices to deliver mental health treatment. Evidence-based treatment for individuals with co-occurring disorders will apply standards and criteria from both the *Standardized Model for the Delivery of Substance Use Services* and the DSM-5. Adjustments to the level of care shall be predicated on each participant's needs and response to treatment.

E. Treatment Modalities

For participants with a mental health disorder and for participants with a mental health disorder and a substance use disorder diagnosed using DSM-5 criteria, the Mental Health Court shall offer a continuum of care for treatment consistent with current evidence-based practices for mental health and for participants with a co-occurring substance use disorder, substance use treatment. Initially, participants shall meet with a treatment provider or clinical case manager for at least one individual treatment session per week. Frequency of treatment shall only be modified based the recommendations of a licensed treatment provider. Treatment for individuals with co-occurring disorders will apply standards and criteria from both the *Standardized Model for the Delivery of Substance Use Services* and the DSM-5, and be consistent with current evidence-based practices for mental health and substance use treatment.

Adjustments to the level of care shall be predicated on each participant's needs and response to treatment. The frequency of individual sessions may be reduced if doing so would be unlikely to precipitate a setback or relapse. Caseloads for treating clinicians shall be small enough to provide them sufficient opportunities to assess participant needs and deliver adequate and effective dosages of evidence-based mental health and substance use treatment as needed.

Group participation for mental health and substance use treatment shall be guided by evidence-based selection criteria, including participants' gender, trauma history and co-occurring psychiatric symptoms. Program operations shall be monitored carefully for fidelity to the treatment model to ensure adequate services are delivered for all caseloads. When there is evidence that practice has deviated from an evidence-based model, efforts shall be made to return to the use of evidence-based practices.

F. Evidence-Based Treatment

Treatment providers shall administer behavioral or cognitive-behavioral treatment programs that are documented and have been demonstrated to improve outcomes for persons whose mental health and/or substance use disorders have contributed to the participants' involvement in the criminal justice system. Treatment providers shall be proficient in delivering the

interventions and shall be monitored regularly to ensure continuous fidelity to the evidence-based treatment models and effective programming outcomes.

G. Identify Services in the Community to Target Participant Needs

Each Mental Health Court shall develop a continuum of ancillary services to target the criminogenic needs and responsivity factors of Mental Health Court participants. Ancillary services may include, but are not limited to, job skills training, educational training and housing assistance.

H. Assess Changes in Participants' Needs and Responsivity Factors

Each Mental Health Court shall regularly assess and document changes in needs in conjunction with responsivity factors using a validated assessment tool (e.g. LS/CMI). The Mental Health Court shall revise case plans to respond to changes in participants' needs and responsivity factors.

I. Medication

Participants may use prescribed psychotropic or addiction medications, based on medical necessity, when prescribed by a licensed, registered, treating medical provider [e.g. physician, advanced practice registered nurse (APRN-NP) or physician's assistant] with expertise in mental illness or addiction medicine, in collaboration with the Mental Health Court team. Such collaboration shall not vest the power in the Mental Health Court team to terminate, decline, or refuse to permit the use of medication prescribed by a properly qualified and informed licensed prescriber.

J. Provider Training and Credentials

Treatment providers shall be registered service providers with the Administrative Office of the Courts and Probation. Providers shall have substantial experience working with criminal justice populations and be able to provide relevant outcome data and other treatment results demonstrating continuous fidelity to evidence-based practices. Providers shall be subject to the monitoring and evaluations criteria in section X.

K. Self-Help/Peer Support Groups

Participants shall attend self-help or peer support groups in addition to professional counseling if recommended by the treatment provider. Additionally, Mental Health Court participants shall have access to community support workers, mentors and other similar resources to assist with participation in court, treatment, finding housing and securing employment.

L. Treatment for Trauma-Based Disorders

Participants diagnosed with PTSD or a related trauma-based mental disorder shall receive an evidence-based intervention designed to help participants manage distress without resorting to substance use or other avoidance behaviors. Participants with PTSD or another trauma-based mental disorder shall be evaluated for suitability for group interventions and shall be treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety.

M. Criminal Thinking Interventions

Participants shall receive an evidence-based criminal-thinking intervention as part of their participation in the Mental Health Court. Staff members shall be trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention such as, but not limited to, Moral Reconation Therapy (MRT), Thinking for a Change or the Reasoning and Rehabilitation program.

N. Overdose Prevention and Referral

All participants shall complete a brief, evidence-based educational intervention describing specific and definite measures they can take to prevent or reverse drug overdose (c.f., Appendix V note N).

VI. Court Sessions/Judicial Monitoring/Status Hearings

A. Professional Training

Prior to assuming the role of Mental Health Court judge, or as soon thereafter as practical, the judge shall attend a Mental Health Court-specific judicial training program such as those administered by the National Drug Court Institute or the National Judicial College. The judge shall attend training events at least every three years on topics such as legal and constitutional issues in Mental Health Court, judicial ethics, evidence-based substance use and mental health treatment, cognitive behavioral treatments, behavior modification techniques, use of incentives and graduated sanctions, and community supervision. In addition, the Mental Health Court judge shall attend nine hours of mental health education every three years pertaining to the diagnosis and treatment of mental health disorders and conditions.

B. Length of Term

The judge or judges shall preside over the Mental Health Court for no less than three consecutive years to maintain the continuity of the program and ensure knowledge of the Mental Health Court policies and procedures.

C. Consistent Docket

Participants shall appear before the same judge or judges throughout their participation in Mental Health Court. If more than one judge serves as a primary judge, the judges shall maintain consistency and accountability through frequent communication and status updates regarding participants.

D. Frequency of Status Hearings

Participants shall initially appear before the judge(s) for status hearings no less frequently than every two weeks, with the preferred frequency being weekly. The frequency of status hearings may be reduced gradually after participants demonstrate sustained adherence to program requirements, such as mental health maintenance, regular treatment engagement and abstinence from alcohol and illicit drug use. The frequency of status hearing may be increased in the event the client departs from program requirements. In the event status hearings are gradually reduced, status hearing shall be scheduled no less frequently then than once every four weeks for such participants.

E. Length of Court Interactions

The judge shall spend sufficient time during status hearings to review each participant's progress in the program. A minimum of three to seven minutes is recommended, but more time may be necessary to adequately deal with individual case issues.

F. Judicial Demeanor

The judge shall offer supportive comments to participants, stress the importance of their commitment to treatment and other program requirements, and express optimism about their abilities to improve their health and behavior. The judge shall not humiliate participants or subject them to foul or abusive language. The judge shall allow participants the opportunity to explain their perspectives concerning factual controversies and the imposition of sanctions, incentives and therapeutic adjustments.

G. Judicial Decision Making

The judge shall be the ultimate arbiter of factual controversies and shall make the final decision concerning the administration of incentives or imposition of sanctions that affect a participant's legal status or liberty. The judge shall make such decisions after taking into consideration the input of other Mental Health Court team members and shall discuss the decision in court with the participant. With respect to treatment-related conditions, the judge shall give substantial weight to the input of appropriately licensed, qualified and trained treatment professionals and licensed medical prescribers.

VII. Drug and Alcohol Testing

A. Policy and Procedures

All programs shall have written drug and alcohol testing policies and procedures that address the following: chain of custody protocols (including direct observation of sample collection); protocols for determination of sample validity addressing dilution, tampering and adulteration; the process of contesting a sample; and measures to ensure that all testing is scientifically reliable and valid. Programs shall use scientifically valid and reliable testing procedures and establish a chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen shall be subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Programs shall have a policy that addresses training requirements for all staff administering drug and alcohol testing.

B. Frequency of Testing

Random drug and alcohol testing shall occur at least twice weekly at the beginning of the program. The frequency of testing can only be reduced at the request of the Mental Health Court team and with the approval of the Mental Health Court judge. For those individuals without a substance use diagnosis, testing may be reduced or eliminated with the approval of the Mental Health Court team and the judge. Testing may occur at any time, including non-traditional work hours, evenings, weekends and holidays. Participants shall be required to provide a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens shall be provided no more than four hours after being notified that a urine test has been scheduled. For tests with shorter detection windows, such as oral fluid tests, specimens shall be delivered no more than four hours after being notified that a test has been scheduled.

C. Random Testing

Drug and alcohol tests shall be administered randomly. Participants shall be required to provide samples within an appropriate time frame to detect drug and/or alcohol consumption.

D. Scope of Drugs Tested

Testing shall include a panel of substances in order to detect a broad array of possible substances known to be commonly used in the local Mental Health Court population and/or in the population of all users in the area. Testing for the detection of alcohol consumption shall be a part of all drug testing programs.

E. Availability of Results

Initial drug and alcohol screening results shall be available to the team and to the court within 48 hours of test administration. Confirmation results shall be available within 48 hours after the receipt of results.

F. Licit Addictive or Intoxicating Substances

Sanctions may be imposed for the non-medical use of intoxicating or potentially-addictive substances, including, but not limited to, alcohol, cannabis (marijuana), and prescription medications, regardless of the licit or illicit status of the substance. The Mental Health Court team shall consider expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether non-addictive, non-intoxicating, and medically safe alternative treatments are available. The Mental Health Court judge may request additional information from a licensed medical prescriber based upon a showing of reasonable, articulable suspicion of substance use or misuse.

VIII. Incentives, Sanctions, and Therapeutic Adjustments

A. Advance Notice

The Mental Health Court team shall develop written policies and procedures to communicate to Mental Health Court participants a clear statement of which behaviors may elicit an incentive, sanction or therapeutic adjustment; the range of consequences that may be associated with those behaviors; the criteria for phase adjustment; program termination; and the legal and collateral consequences that may ensue from termination from the Mental Health Court. These policies will be provided to all prospective participants prior to their entry into the Mental Health Court. All Mental Health Court decisions, including sanctions and incentives, shall be based upon the individualized progression plan for the participant.

B. Opportunity to Respond

Prior to the imposition of any non-custodial sanction or therapeutic adjustment, participants shall have an opportunity to explain their perspective concerning factual controversies and the imposition of sanctions and therapeutic adjustments. In the case of a custodial sanction, the participant shall have the right to request an evidentiary hearing with all the rights and protections that normally attach in order to resolve any factual controversy concerning the reason for the sanction.

C. Professional Demeanor

Interactions with participants from all service providers and team members shall always be professional and respectful in nature. Sanctions shall be delivered in a dignified and respectful manner. Participants shall not be shamed or subjected to foul or abusive language.

D. Incentivizing Prosocial Behaviors

Empirical research demonstrates that the use of incentives motivates behavior change more effectively than use of sanctions; specifically, four incentives should be applied for every one sanction. The Mental Health Court shall place more emphasis on swiftly rewarding productive and prosocial behaviors than it does on imposing sanctions. Criteria for phase advancement and successful program completion shall include objective evidence that participants are engaged in productive activities, including, but not be limited to, employment, education, or attendance in peer support groups. The reward shall be delivered as soon as possible after the observation of the desired behavior.

E. Therapeutic Adjustments

Participants shall not receive sanctions for not responding to treatment interventions if they are otherwise compliant with their individualized treatment plan and supervision requirements. Under such circumstances, the appropriate course of action shall be to reassess the individual

and adjust the treatment plan accordingly. Adjustments to treatment plans shall be made by duly-trained treatment professionals (such that participants are placed in the appropriate level of care or adjustments are made individually within a level of care).

F. Progressive Sanctions

The Mental Health Court shall apply a range of sanctions of varying magnitudes that may be invoked in response to program infractions. The sanctions shall increase progressively in magnitude over successive violations, if the individual participant is not deterred from additional violations. All sanctions shall be administered swiftly and with certainty. The Mental Health Court team shall exercise a reasonable degree of discretion to modify a presumptive sanction in light of the circumstances presented in each case. The sanctions shall be tailored to the responsiveness of individual participants.

G. Jail Sanctions and Public Safety

Jail sanctions shall be imposed judiciously, as a last resort, and only after the opportunity for an evidentiary hearing with counsel present. Jail sanctions shall only be administered for acts or behaviors which are not the product of the mental illness that precipitated the participant's admission to Mental Health Court. Jail sanctions shall be definite in duration and typically last no more than two to five days.

IX. Cultural Competence

A. Equivalent Access

Eligibility criteria for the Mental Health Court are non-discriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a historically disadvantaged group[2], the requirement shall be adjusted to increase the representation of such persons unless doing so would jeopardize public safety. The assessment tools used to determine participants' eligibility for the Mental Health Court shall be empirically validated for use with members of historically disadvantaged groups represented in the respective arrestee population.

B. Equivalent Retention

The Mental Health Court shall regularly monitor whether members of historically disadvantaged groups complete the program at rates equivalent to other participants. If completion rates are significantly lower for members of a historically disadvantaged group, the Mental Health Court team shall investigate the reasons for the disparity, develop a remedial action plan, if warranted, and evaluate the success of the remedial actions.

C. Equivalent Treatment

The Mental Health Court team will provide members of historically disadvantaged groups the same levels of care and quality of treatment as other participants with comparable clinical needs. The Mental Health Court shall administer evidence-based practices that are effective for use with members of historically disadvantaged groups represented in the Mental Health Court population.

D. Equivalent Incentives and Sanctions

Members of historically disadvantaged groups shall receive the same incentives and sanctions as other participants for comparable achievements or infractions. The Mental Health Court shall regularly monitor the delivery of incentives and sanctions to ensure they are administered equivalently to all participants. This data will be collected, reviewed and analyzed for evidence of disparate administration of incentives and sanctions on an ongoing basis by the internal evaluation team and analyzed as part of the external evaluation.

E. Equivalent Dispositions

Members of historically disadvantaged groups should not receive a disparate legal disposition or sentence for completing or failing to complete the Mental Health Court program based on

[2] Members of historically disadvantaged groups are defined as, those "who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status (The National Adult Drug Court Standards, Vol. 1)."

membership in a historically disadvantaged group. Data pertaining to the treatment of historically disadvantaged groups will be collected and reviewed on an ongoing basis by the internal evaluation team, and analyzed as part of the external evaluation.

X. Data and Evaluation

A. Electronic Case Management

Program operators and treatment providers shall regularly enter data into the designated Problem-Solving Court data management system for use in case and program management. Programs shall review statistics relevant to program performance and implement policy adjustments and training as the data require. To ensure that the data are accurate, the program shall utilize an independent research assistant or identify a Mental Health Court team member who is responsible for data quality assurance.

B. Timely and Reliable Data Entry

Staff members shall record information concerning the provision of services and in-program outcomes as soon as possible, but in any event no later than 48 hours of the respective events. Timely and reliable data entry shall be required of each staff member.

C. Recursive Evaluation

Programs, treatment providers and the Mental Health Courts themselves will engage in ongoing data analysis and program evaluation. Ongoing program evaluation shall consist of recursive (i.e. repeating) stages of evaluability assessment, process evaluation, outcome evaluation and feedback provision/utilization with the objectives of rigorously collecting and analyzing data to answer questions about how the court functions, whether the court is effective, and how the court procedures can change to improve functioning.

Evaluability Analysis (assessing the ability to complete a program evaluation). In this context, an evaluability analysis begins with the development of a logic model or program theory which ascertains the resources available to the court and how the court will utilize those resources to attain its objectives. Logic models are commonly represented as flowcharts that list program activities, mechanisms of change, internal changes in program participants, intended outcomes and unintended effects. The logic model connects the program components with causal links showing how activities activate mechanisms of change, which in turn lead to internal changes in participants and finally to program outcomes. The court, with the aid of an evaluator, will engage in discussions with staff, interview staff and stakeholders, review program materials, and review the literature pertaining to Problem-Solving Courts and especially Mental Health Courts to develop a logic model describing how the program ought to function (an example of a logic model of a typical Problem-Solving Court can be found in appendix 10). Mental Health Court logic models in Nebraska must be consistent with the Nebraska Mental Health Court Standards

and include the required activities and procedures described in the standards. The outcome of the evaluability analysis is a logic model that describes how the court intends to operate its program and that provides the court with a plan to evaluate the program.

Process Evaluation. A process analysis makes use of the logic model to identify the variables that the court must measure in order to determine whether the program is functioning in the manner that the logic model purports. As part of the process analysis, the evaluator or evaluation team must determine what data are needed to describe the program activities, mechanisms, internal changes and outcomes, and if those data are accessible through the Problem-Solving Court data management system or if additional data not included in that system must be collected to assess the components of the program logic model. After identifying the requisite data that the court needs to assess its functioning, the process evaluation gathers data on an ongoing basis to describe how the court staff implement the program and to determine the fidelity of the program as the staff enact it, comparing the descriptive data to both the logic model and the Nebraska Mental Health Court Standards. The goal of the process evaluation shall be to produce a statistical report that summarizes the manner in which the court actually functions and with that report the evaluator or evaluation team shall present an implementation analysis that tests whether the court procedures and processes show fidelity to the logic model and to the Nebraska Mental Health Court Standards.

Outcome Evaluation. Determining whether Mental Health Courts are effective requires the evaluator to compare outcomes for Mental Health Court participants to those of an unbiased and equivalent comparison group. Thus, outcome evaluations shall be an experimental or quasi-experimental test that include relevant outcome measures. The outcome measures shall consist of, but not be limited to, performance measures including successful graduations, new arrests, new convictions, new incarcerations, recidivism rates, and indicators of quality of life (e.g., successful employment, abstinence and overall wellbeing). The evaluator will use the program logic model to assist in selecting relevant outcomes measures. The method to choose an equivalent comparison group shall be state-of–the-science at the time the comparison group is chosen. At the present time, choosing an equivalent comparison group in the absence of random assignment to treatment conditions, involves carefully matching the treatment group and comparison group on selection factors. If a large data base is available, then the best method of matching involves a propensity modeling process. Individuals in the comparison group should meet legal and clinical eligibility criteria for participation in the Mental Health Court, but should not have entered the program for reasons having no relationship to their outcomes. Comparison groups shall not include individuals who were denied entry to the program because of their legal charges, criminal history, or clinical assessment results. Participants in the Mental Health Court and comparison groups shall have an equivalent opportunity to engage in the positive and negative performance indicators such as criminal activity, substance use, employment,

education, and any other activities contributing to quality of life. Ideally, outcomes for both groups shall be examined over an equivalent time period beginning from a comparable start date. However, if participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than participants in the other group, the length of time participants were incarcerated or detained shall be statistically accounted for in outcome comparisons using survival analysis or another suitable statistical control procedure involving an appropriate statistical regression technique. Outcomes shall be examined for all eligible participants who entered the Mental Health Court regardless of whether they were successfully or unsuccessfully terminated from the program. The goal of the outcome analysis is to determine if participation in the program is responsible for positive outcomes for the participants; that is, whether the Mental Health Court brought about the change. The evaluator will conduct the outcome analyses in the most rigorous manner possible using state-of-the-science measures and methods for all aspects of the evaluation. Once an outcome analysis is completed, the evaluator can move on to measure the cost of participation in the Mental Health Court and compare it to the cost of participating in the comparison group and present the results in a benefit-to-cost ratio, which will measure the efficiency of participating in the Mental Health Court.

Feedback Provision and Utilization. Mental Health Courts shall use the results of the evaluability analyses, process evaluations and outcome evaluations on a regular basis to make evidence-based decisions about the need for program change. Whenever the court or other stakeholders make policy changes to alter a component of the program, the evaluator or evaluation team shall continue to conduct implementation, fidelity and outcome analyses to examine the effectiveness of the policy changes and make further adjustments as necessary. In this manner, program evaluation in Mental Health Courts will consist of a recursive cycle of evaluability analyses, process analyses (i.e. implementation and fidelity studies), outcome evaluations and feedback utilization. The enactment of this cycle will result in evidence-based policy making for all Nebraska Mental Health Courts.

D. Ongoing Evaluations

Programs and treatment providers shall undergo process evaluations on an ongoing basis and shall submit reports on these evaluations, on such schedules as established by the Administrative Office of the Courts and Probation. Outcome evaluations shall be an experimental or quasi-experimental test and will be conducted by an independent evaluator. The evaluation methodology shall be state-of-the-science at the time the evaluation is conducted. Programs shall work closely with the evaluator to ensure that the Mental Health Court team can utilize evaluation results to examine program effectiveness and cost-efficiency, make improvements to program practices, and inform data collection processes in preparation for future evaluations.

E. Internal Evaluations

Internal evaluation of programs and treatment providers shall be ongoing. Implementation, fidelity and outcome analyses shall be examined for all Mental Health Court participants regardless of whether they successfully completed or were terminated from the program. Programs shall regularly examine and test standard compliance, program effectiveness and cost-efficiency, program practices, data collection processes, and case management quality assurance.

Appendix I

Nebraska Mental Health Courts Progression Plan

The goal of a Mental Health Court is to assist justice-involved individuals and their families in addressing behavioral health needs and reestablishing law-abiding, productive lives within the community. This Progression Plan follows the Nebraska Supreme Court's Mental Health Court Best Practice Standards and was designed to provide objective, measurable and consistent progression through any Nebraska Mental Health Court program.

All Mental Health Courts shall ensure each participant adheres to the core requirements of the progression plan. Specific details including, but not limited to, program structure, delivery of services and programming details shall be determined by each individual Mental Health Court. Mental Health Courts shall ensure the core requirements of the progression plan are completed in compliance with the Nebraska Mental Health Court Standards. Any individual progression plan may be modified based on the individual's circumstances and progress through the program. Therefore, the progression plan is a set of guideposts that specific Mental Health Court teams may need to modify for individual cases. The Mental Health Court team must develop an individualized treatment plan for each participant based upon this progression plan.

Each Mental Health Court shall complete the Screening Requirements for each potential participant before a decision is made on program entry, as follows:

Screening Requirements[3]

Goals: The major goal of the screening process is to ensure the admission of participants is in compliance with the Nebraska Best Practice Standards.[4]

- Evaluation(s) completed following the Nebraska Supreme Court's Standardized Model for the Delivery of Substance Use Services.[5]
- Validated screening and assessment instruments completed (LS/CMI, SSI, SRARF, Mental Health Screening Form III and the approved financial eligibility screening tool).[6]
- A mental health evaluation completed by a licensed behavioral health or medical professional relying on some set of standardized and validated assessment tools.
- Baseline drug test.[7]

Note: Collateral information and baseline drug testing results obtained during the Screening Requirements shall be used to determine eligibility for probation financial assistance ("vouchers") and

[3] This guideline and other time requirements are based upon experience of treatment providers in Nebraska Drug Courts.
[4] Mental Health Court Standards III(C), III(D)
[5] Mental Health Court Standards VI(D)
[6] Mental Health Court Standards II(E)
[7] Mental Health Court Standards VII

utilized to determine if there is a need for additional assessment(s) or evaluation(s). Information obtained during this process can be utilized to access adult behavioral health services.

Phase 1

Goals: The major goals for treatment during Phase 1 are to establish a foundation of support through treatment, to initialize stabilization and to begin ancillary services.

- Creation of individualized program plan[8]
- Approved residence[9]
- Drug testing, as determined necessary[10]
- Referral for unmet medical needs [11]
- Begin or continue treatment [12]
- Creation of peer support group plan in consultation with treatment provider[13]
- Educate and inform about community-based ancillary services and incorporate into individualized program plan, as needed[14]
- Status hearings[15]

Criteria for advancement

Participants shall complete objectives above as determined by the Mental Health Court team, display program compliance, demonstrate meaningful progress with their individual treatment plan and the individual program plan. Based upon professional judgment and experience, it is recommended that participants shall have a minimum of 14 days of continuous program compliance and attend a minimum of four weeks of status hearings to be eligible for advancement.[16] This standard shall hold until additional empirical evidence indicates otherwise.

[8] Mental Health Court Standards IV(C, 5c), V(D), V(G)
[9] Mental Health Court Standards IV(C, 5b), V(G)
[10] Mental Health Court Standards VII
[11] Mental Health Court Standards V(G)
[12] Mental Health Court Standards V
[13] Mental Health Court Standards V(K)
[14] Mental Health Court Standards V(G), V(I), V(K), V(L), V(M), V(N)
[15] Mental Health Court Standards VI(D)
[16] Mental Health Court Standards VI(D)

Phase 2

Goal: The major goals for treatment during Phase 2 are to demonstrate continued efforts at treatment compliance, symptom management, and abstinence. The participant must show continued progress with completing his or her individualized treatment plan.

Continued expectations from Phase 1:

- Approved residence
- Drug testing, as determined necessary
- Continuing treatment, as necessary
- Creation of peer support group plan in consultation with treatment provider
- Utilization of ancillary services
- Status hearings
- Update individualized program plan

Additional expectations for the participant include:

- Psychoeducational classes, as needed[17]
- Completion of or engaged in primary treatment services[18]
- Referral to life skills programming, as needed (such as hygiene, budgeting, vocational rehab)[19]
- Continuing to address unmet medical needs
- Obtain employment and/or further education[20]
- Establish program fee schedule
- Obtain valid driver's license or begin process of obtaining a valid driver's license or secure use of another form of reliable transportation
- Begin creation of written sustained success plan[21]

Participants shall complete objectives, display program compliance, demonstrate meaningful progress with the individual treatment plan and the individual program plan as assessed by the Mental Health Court team over the period of 120 days. During such 120 day period, the participant shall have 90 days of

[17] Mental Health Court Standards IV(C, 5b), VIII(D)
[18] Mental Health Court Standards V
[19] Mental Health Court Standards IV(C, 5b), V(G)
[20] Mental Health Court Standards IV(C, 5b), VIII(D)
[21] Mental Health Court Standards IV(C, 5c)

sustained abstinence and shall have substantially complied with program requirements in the judgment of the members of the Mental Health Court team.

Phase 3

Goals: The major goals for treatment during Phase 3 are to demonstrate progress on treatment goals, increased engagement with community support, and to make progress in addressing cognitive-behavioral needs and criminogenic needs.

Continued expectations from Phase 1:

- Approved residence
- Drug testing, as determined necessary
- Continuing treatment, as necessary
- Creation of peer support group plan in consultation with treatment provider
- Utilization of ancillary services
- Status hearings
- Update individualized program plan

Continued expectations from Phase 2:

- Psychoeducational classes, as needed
- Continuing treatment, as necessary
- Utilization of life skills programming, as needed (such as hygiene, budgeting, vocational rehab)
- Make progress on fulfilling program fee schedule
- Obtain valid driver's license or secure use of another form of reliable transportation

Additional expectations for the participant include:

- Demonstrating progress toward treatment goals, as applicable[22]
- Addressing financial obligations
- Gainful employment and/or education[23]

[22] Mental Health Court Standards V

[23] Mental Health Court Standards IV(C, 5b), VIII(D)

- Cognitive programming[24]
- Finalize written sustained success plan[25]

Participants shall complete objectives, display program compliance, demonstrate meaningful progress with the individual treatment plan and the individual program plan as assessed by the Mental Health Court team over the period of 120 days. During such 120 day period, the participant shall have 90 days of sustained abstinence and shall have substantially complied with program requirements in the judgment of the members of the Mental Health Court team.

Phase 4

Goals: The major goals for treatment during Phase 4 are to demonstrate internalized recovery skills, exhibit the ability to identify relapse issues and be able to effectively respond as assessed by the Mental Health Court Team. In addition, participants must comply with the individualized treatment plan, continue engagement in community support systems, and show progress toward symptom management.

Continued expectations from Phase 1:

- Approved residence
- Drug testing, as determined necessary
- Continuing treatment, as necessary
- Creation of peer support group plan in consultation with treatment provider
- Utilization of ancillary services
- Status hearings
- Update individualized program plan

Continued expectations from Phase 2:

- Psychoeducational classes, as needed
- Continuing treatment, as necessary
- Utilization of life skills programming, as needed (such as hygiene, budgeting, vocational rehab)
- Continue to address unmet medical needs, as necessary
- Make progress on fulfilling program fee schedule

[24] Mental Health Court Standards V

[25] Mental Health Court Standards IV(C, 5c)

• Obtain valid driver's license or continue process of obtaining a valid driver's license or secure use of another form of reliable transportation

Continued expectations from Phase 3 include:

• Completing outpatient treatment and/or demonstrating progress toward treatment goals

• Addressing financial obligations

• Gainful employment and/or education

• Cognitive programming

Participants shall complete objectives, display program compliance, demonstrate meaningful progress with the individual treatment plan and the individual supervision plan as assessed by the Mental Health Court team. Those participants having a co-occurring substance use disorder shall have 90 days of sustained abstinence[26] to be eligible for advancement or program completion. Participants without a co-occurring substance use disorder shall demonstrate 90 days of program compliance or, after the passage of 90 days, the participant has substantially complied with program requirements in the judgement of the members of the Mental Health Court team.

Program Completion Requirements

In addition to completion of all elements of the individual treatment program, Mental Health Court completion shall also require each of the following as assessed by the Mental Health Court team:

• 180 days of continuous substantial treatment plan compliance[27]

• 180 days of continuous employment or engagement in prosocial activities[28]

• Development of long-term recovery/behavioral health maintenance plan[29]

• Program fees paid in full

• Completion of all Mental Health Court programming requirements[30]

• Implementation of written sustained success plan[31]

[26] Mental Health Court Standards IV(C, 5a)
[27] Mental Health Court Standards IV(C, 5)
[28] Mental Health Court Standards IV(C, 5b), VIII(D)
[29] Mental Health Court Standards IV(C, 5c), V
[30] Mental Health Court Standards IV(C, 5)
[31] Mental Health Court Standards IV(C, 5c)

Appendix II

Supporting Evidence for the Mental Health Court Team

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.38-58.

A. Program Planning and Oversight

Engaging the community in the planning and implementation of a new program such as a Mental Health Court has been consistently identified as essential to successful implementation (Fixsen, et al., 2005). Implementation literature across different domains (including business, education and criminal justice) consistently cites the importance of "stakeholder involvement" and "buy-in" throughout the implementation process (Fixsen, et. al., 2005). Rogers (2002) identified communication, a clear theory of change that makes the case for the intended changes (in this case, implementing the Mental Health Court model), and the development of champions who can consistently advocate as key to implementation. Adelman and Taylor (2003), in the context of education, described some early stages of preparation for adopting innovations that include developing a "big picture" context for the planned program or intervention (How is the problem currently addressed? How will the planned intervention add value to current efforts?), mobilizing interest, consensus, and support among key stakeholders, identifying champions, and clarifying how the functions of the intervention (Mental Health Court) can be institutionalized through existing, modified, or new resources. A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found that focusing on procedures and consistently monitoring fidelity to the drug court model can prevent team and program drift (Van Wormer, 2010).

A localized study of a Mental Health Court in Brooklyn, New York, found that when the team, consisting of professionals, judges, defendants, prosecutors, defense attorneys, clinical staff, and community providers, worked closely, it allowed the court to take on difficult cases and work together more efficiently to provide stability and well-rounded assistance for their clients (Fisler, 2005). The close working proximity of these team members also allows for the team and the program to maintain a consistent plan for the clients.

B. Team Composition

Many Mental Health Courts have found success when involving many different team members that aid in the diverse needs of the clients in these courts; these members could include: judges, public defenders, state attorneys, prosecutors, treatment providers, clinical staff, law enforcement officers, probation or parole officers, and community support staff, among others (Carey et al., 2005; Carey et al., 2008; Fisler, 2005; Hiday, et al., 2014; Redlich, et al., 2005; Rossman, et al., 2012; Watson, et al., 2001). A national study that examined 69 drug courts found that when law enforcement officers were included on the team, there was an 87% reduction in recidivism and a 44% increase in cost savings when compared to courts that did not include these personnel (Carey et al., 2012).

Additional benefits of diverse team compositions are covered in sections C and D below.

C. Pre-court Staffing Meetings

Collaboration among team members is crucial for the success of the program and its participants. MaGaha et al. (2002) found that with systematic collaboration by the Mental Health Court team, participant attrition was significantly reduced. This level of collective effort can only be successful if all team members are regularly attending pre-court staffing meetings.

Recidivism and cost savings have also resulted from regular staff meeting attendance. Carey et al., (2012) found reduced recidivism and increased cost savings in a study of 69 drug courts; this study included key informant interviews, site visits, focus groups and document reviews. Compared to courts that did not have regular staff attendance at pre-court meetings by the defense attorney, there was a 20% reduction in recidivism in courts that did have a defense attorney present. In the same study, a 93% increase in cost savings was found when a defense attorney was present, compared to courts in which such persons did not attend pre-court staffing meetings. When a coordinator was present in the meetings, there was a 58% reduction in recidivism and a 41% increase in cost savings compared to courts that did not have a coordinator present. As for law enforcement attending the same drug court staffing meetings, there was a 67% reduction in recidivism and an increase in cost savings of 42% compared to courts that did not have law enforcement present. When these meetings included treatment providers, there was a reduction in recidivism by 105% compared to drug courts that did not have treatment providers present in these meetings. In courts where the judge, attorneys, treatment representative, coordinator, and probation officer, all attended staff meetings, cost savings was increased by 20% and recidivism was reduced by 50% more than in drug courts where all of these individuals did not collectively attend.

D. Court Status Hearings

Collaboration among team members is crucial for the success of the program and its participants. MaGaha et al. (2002) found that with systematic collaboration by the Mental Health Court team during court procedures, participant attrition was significantly reduced. This level of collective effort can only be successful if all team members are regularly attending court status hearings.

When members of the Mental Health Court team work collaboratively during status hearings, concerns about participants and their progress in the court or treatment can be addressed and rectified promptly. In a study of four Mental Health Courts across the United States, the quick responses and actions by the team (judges, public defenders, attorneys, family members, and treatment providers) allowed the team to collaborate more efficiently and for the team members and participants to feel greater satisfaction with the Mental Health Court (Watson et al., 2001). In this same study, one court was able to address the lack of certain types of services and was therefore able to add additional services to address this need. The same issues of lacking services was an issue that another court in this study was made aware of due to the collaborative work of the Mental Health Court team during hearings with their clients. These concerns might not have been addressed as quickly, or at all, if all members of the Mental Health Court team were not present.

Additionally, Carey et al., (2012) looked at the impact of team member attendance in drug court status hearings and found that drug court hearings where treatment representatives were present had a

reduction in recidivism of 105% more than courts where these individuals were not present; there was also 81% more cost savings in the courts that had treatment representatives present. The same study found that when law enforcement were present during status hearings, there was an 83% reduction in recidivism and 64% increase in cost savings compared to drug courts that did not have these individuals present. Additionally, when the judge, both attorneys, treatment representatives, probation officers, and a coordinator were all present for the status hearings, there was a 35% reduction in recidivism and a 36% increase in cost savings compared to drug courts where all of these individuals were not present.

E. Communication

An important part of the effective and efficient processes of a Mental Health Court is the communication between members of the team. Fisler (2005) assessed the communication within a Mental Health Court in Brooklyn, New York and found that when the communication was detailed, timely and candid, the treatment for participants was ultimately more effective.

Other problem-solving courts have emphasized the importance of communication in many aspects of the courts (Carey et al., 2008; Wolfe et al., 2004). Carey et al. (2012) assessed the impact of email communication in their study of 69 drug courts. In this study, recidivism was reduced by 119% and cost savings was increased by 39% when communication protocols (email, for example) were put in place. Additionally, research in interdisciplinary collaboration highlights the role of communication in enhancing collaboration on interdisciplinary teams (Stokols et al., 2008).

One study of team members in a drug court found the highest levels of collaboration between case managers, drug and alcohol providers, judges and mental health treatment providers; because of this collaboration, respondents strongly believed that they were able to engage in creative problem solving, understanding and incorporating diverse views, obtaining mutually-established goals, responding to client needs and matching services to program needs (Van Wormer, 2010).

F. Initial and Continuing Education

Epperson and Lurigio (2016) assessed how specialized mental health training would affect the relationships between probation officers and their clients. These researchers conducted interviews with the probation officers, staff and probationers, and collected data for 5-6 years on 864 clients involved in programs in a Chicago, Illinois county. This study found that the probation officers were significantly more sensitive to the role that mental health plays in criminal behavior. Additionally, these officers with mental health training were more focused on building their relationships with their clients and ensuring that those with mental health issues received the treatments they needed. Also, the officers with mental health training used greater discretion and strategic deployment of sanctions and violations compared to the officers who had not had the training. Additionally, in the same study, the clients viewed their experience in probation more favorably with officers who had had the specialized mental health training than the officers who did not have the training. Overall, this study did not find significantly different outcomes for probationers in terms of post-probation arrest or recidivism when their officers did or did not have the mental health training, but the results did suggest that the officers with the specialized training cultivated better relationships with probationers and focused more heavily on treatment.

It is important to assess participants who might exhibit trauma-related symptoms who might require trauma-specific services (Bath, 2008). This study focused on participants in drug court who required trauma services. This treatment began in the first phase of the drug court and continued, as necessary, throughout the client's time in drug court. Although not all participants with trauma histories require formal post-traumatic stress disorder (PTSD) treatment, all staff, including court personnel and criminal justice professionals, should be trauma-informed for all participants (Bath, 2008).

Carey et al. (2008) compared 18 different courts; business-as-usual courts, drug courts in which all staff were trained, and drug courts in which not all staff were trained. Drug courts that had the entirety of their staff trained had a 41% increase in cost savings compared to business-as-usual courts, and drug courts that did not have all of their staff trained had an 8% cost savings compared to business-as-usual courts. When comparing graduation rates in the same study, drug courts that had all staff trained had a 63% graduation rate compared to a 40% graduation rate for drug courts that did not have all staff trained.

Carey et al. (2012) assessed 69 drug courts and found that when these courts trained staff before program implementation, recidivism was reduced by 55%, and there was a 238% greater cost savings compared to courts that did not train their staff before implementing the program. Van Wormer (2010) surveyed 295 drug court staff and found that to combat "team drift," it is essential to continue education for the staff. Many researchers have also found that training can improve implementation (Latessa & Lowenkamp, 2006, Melde et al., 2006; Rhine et al., 2006; Murphy & Lutze 2009).

It is important that court team members have training on the use of sanctions and incentives (Lindquist et al. (2013); this process evaluation found that most team members had this type of training in NESCAARC (National Evaluation of Second Chance Act for Adult Reentry Courts) sites. Hamilton (2011) evaluated Harlem Parole Reentry Court and found that, with heightened supervision, participants of the reentry court had 28% fewer reconvictions after 2 years than those in normal parole supervision (34%). However, this study also found significantly higher rates of parole revocation due to technical violations (15% for heightened vs. 8% for normal). The researcher concluded that this was due to a surveillance effect from the increased supervision, which resulted in greater detection of minor violations. With this increased supervision, there were more frequent employment check-ins, home visits and urine analyses leading to greater detection of parole violations. Ayoub and Pooler (2015) conducted a true, randomized experiment on the Harlem Parole Reentry Court to evaluate its effectiveness. The results were positive: reconvictions during the first 18 months after release were significantly lower compared to the control group (29% vs. 37%); felony convictions were significantly lower after the first 18 months after release compared to the control group (4% vs. 10%); and, finally, parole revocations were significantly lower 18 months after release compared to the control group (12% vs. 22%). These successful results suggest that a design in which graduated sanctions are combined with adequate training and quality control measures of implementing sanctions can be very successful and beneficial for the clients.

G. Roles and Responsibilities

In their assessment of team decision-making across three sites, Crea et al. (2009) suggest that fidelity to the decision-making models is critical and that fidelity can be enhanced with clear role definitions. The team drift literature points to the need for clear definitions of roles and ongoing education to keep

programs focused on their mission (Van Wormer, 2010). In the same study, team members felt greater professional satisfaction when there was continued training and communication between team members. Continued collaboration allowed team members to recognize their role in the group and to contribute more to their team.

H. Supervision Caseloads

Many who find themselves in the criminal justice system also experience mental illness in some form. This population is a group with high levels of needs. A nation-wide study of 86 Mental Health Courts in the United States found that the median number of clients in the court was 36 (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). The same study found that as the number of clients increased, court appearances decreased, resulting in fewer interactions with the Mental Health Court team; therefore, clients might not be able to access or adjust their treatment as needed. Additionally, a localized study of two Mental Health Courts in New York stated that their case manager capacity ranges between 15 and 25 clients. These courts had experienced staffing cuts, which resulted in the higher range; these courts strive to keep their caseloads lower in order to assist clients more effectively.

The American Parole and Probation Association (APPA) introduced caseload guidelines in 2006, including guidelines regarding intensive supervised probation (ISP) (DeMichele, 2007). ISP is designed for high-risk, high-need probationers; these clients are at a higher risk of failing probation and having elevated social service and treatment needs (Petersilia, 1999). The APPA's recommendation for caseloads is 50:1 for moderate-risk and high-risk probationers without serious social-service or treatment needs, and caseloads of 20:1 for high risk, high-need probationers (Byrne, 2012; DeMichele, 2007). A randomized experiment confirmed that clients on a 50:1 caseload received more services (substance abuse and mental health treatment, probation office sessions, telephone check-ins, employer contacts and field visits) compared to clients who were supervised by officers with higher caseloads (Jalbert & Rhodes, 2012). In the same study, the researchers found better probation outcomes for clients on a 50:1 caseload because they were receiving more services. These clients had fewer positive drug tests and fewer technical violations. Probation officers with caseloads substantially above the 50:1 recommendation had difficulty monitoring probationers closely and reducing technical violations (Jalbert & Rhodes, 2012).

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Appendix III
Supporting Evidence for Target Population, Eligibility, Referral, Entry, and Orientation

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.6 – 10, 13; and (2015) p.59-73.

A. Objective Eligibility and Exclusion Criteria

Research shows that subjective eligibility criteria, including suitability determinations based on defendant motivation for change or readiness for treatment, have no impact on graduation or post-program recidivism rates (Carey & Perkins, 2008; Rossman et al., 2011). Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching participants to appropriate treatment and supervision services (Andrews et al., 2006; Bhati et al., 2008; Miller & Shutt, 2001; Sevigny et al., 2013; Shaffer, 2010; Wormith & Goldstone, 1984;). Adhering to this literature, Mental Health Courts in the United States and indeed throughout the world rely on two identification stages to determine eligibility for diversion programs: screening and assessment (Loong, Bonato, & Dewa, 2016). In the screening phase, criminal justice and/or legal professionals conduct preliminary investigations to determine the possibility that clients are suffering from some form of mental illness and in the assessment phase qualified mental health professionals administer standardized tests and interviews to confirm or disconfirm the existence of the condition (Loong et al., 2016; Steadman, Barbera, & Dennis, 1994). Nebraska Mental Health Courts follow this best practice approach to determine initial eligibility of clients.

B. Entry Into Mental Health Court

While there is no agreed-upon definition of what constitutes severe and persistent mental illness (SPMI), (Ruggeri, Leese, Thornicroft, Bisoffi & Tansella, 2000) there is agreement among mental health professionals that there are several characteristics that people with SPMI share. These include a diagnosis of a mental disorder from a qualified mental health professional such that the individual will require long term treatment (2 years or more) and because of that condition will show signs of severe behavioral and emotional dysfunction (Ruggeri et al., 2000). The illness requires supportive care for these individuals to lead successful community-integrated lives, to include successful daily living, positive interpersonal relationships, employment and successful self-care (Administration Samhss, 1999; Anthony, 1993). Without proper care, SPMI individuals suffer high risk for mental decompensation, emergency hospitalization, impaired social functioning and a general decrease in the quality of the lives that they are capable of living (Bellack, Bennett, Gearon, Brown, & Yang, 2006; Berren, Santiago, Zent, & Carbone, 1999). Nebraska Mental Health Courts provide SPMI individuals the opportunity to obtain the care that they need to function at the highest possible level in the community. Nebraska Administrative Code currently defines the following diagnoses as major mental disorders: schizophrenia, major depressive disorder, bipolar disorder, delusional disorder, psychotic disorder, panic disorder, and obsessive-

compulsive disorder (172 NAC). Lessor severity of these illnesses occur in individuals who do not require extensive long-term care. For example, with the aid of the Beck Depression Inventory II, a qualified mental health practitioner would label moderate depression as a score between 20 and 28 (Beck, Steer, & Brown, 1996). Similarly, licensed mental health professionals are able to differentiate between moderate and severely mentally ill individuals with the aid of standardized assessment tools as discussed in paragraph A above and C below.

C. High Criminogenic Risk with a Major Mental Disorder

The RNR (risk, need, responsivity) model of intervention in the criminal justice system states that interventions should match risk so that high-intensity interventions are suitable only for high-risk individuals (Dowden & Andrews, 1999; Dowden & Andrews, 2000; Dowden, Antonowicz, & Andrews, 2003). The need principle refers to the fact that interventions should target the criminogenic needs as assessed through a valid and reliable assessment instrument and the responsivity principle states that treatments should use evidence-based interventions such as cognitive-behavioral therapy. Therefore, the criminal justice system should retain high-intensity case management and interventions like Mental Health Courts for individuals who score high in risk and high in need on a validated instrument, such as the LS/CMI that Nebraska Probation uses.

Prior research shows this to be effective for drug courts and Mental Health Courts. A substantial body of research shows that drug courts that focus on high-risk/high-need defendants[32] reduce crime approximately twice as much as those serving less serious defendants (Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005) and return approximately 50% greater cost savings to their communities (Bhati et al., 2008; Carey et al., 2008, 2012; Downey & Roman, 2010). Lindquist et al., (2013) reviewed the entry criteria for the eight federally-funded reentry courts in the NESCAARC project to find that the default was to set eligibility criteria according to risk – most often including moderate- to high-risk clients. The eligibility criteria in the Nebraska standards are consistent with those in Lindquist et al.'s review. Similarly, Mental Health Courts often set eligibility criteria based upon risk and need. Campbell, Canales, Wei, Totten, Macaulay, & Wershler (2015) evaluated a Mental Health Court that did not follow the RNR model and demonstrated that it showed little in the reduction of criminogenic needs for those who completed the program. They concluded that Mental Health Courts ought to follow the RNR principles to maximize the likelihood of positive outcomes.

D. Medium Criminogenic Risk with Repeated Lower-Level Offenses and a Major Mental Disorder

Individuals with moderate criminogenic risk, but with severe mental health needs, return repeatedly to the criminal justice system unless evidence-based interventions address their underlying mental illness issues (James & Glaze, 2006). In fact, the number of problem-solving courts, including Mental Health Courts, has increased dramatically in the last decade to address the "revolving door" problem (Goodale, Callahan, & Steadman, 2013; Snedker, Beach & Corcoran, 2017). In one investigation, Snedker et al. (2017)

[32] Those who are (1) addicted to or dependent on illicit drugs or alcohol and (2) at high-risk for criminal recidivism or failure in less intensive rehabilitative dispositions.

studied 138 graduates of a Mental Health Court in a west coast city in the U.S. using statistical modelling techniques. They found that the odds that graduates with mental illness issues picked up new criminal charges was lower than it was prior to these individuals entering the court and that when they did pick up new charges, the time between charges was longer (Snedker et. al., 2017). Most importantly, Anestis and Carbell (2014) used a rigorous quasi-experiment with state-of-the-science propensity analysis to compare 198 offenders from a Mental Health Court with 198 offenders from a traditional court matched on criminogenic risk and mental illness seriousness. They found that the Mental Health Court participants showed a lower overall rate of recidivism and when they did recidivate, they took longer to pick up a new offense (Anestis and Carbell, 2014). This was true for the mentally ill offenders who had committed either serious offenses or lower-level misdemeanors.

E. Validated Eligibility Assessments

Problem-Solving Courts should use validated assessment tools to assess risk and need. Research suggests that standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching defendants to appropriate treatment and supervision services (Andrews et al., 2006; Miller & Shutt, 2001; Wormith & Goldstone, 1984). Drug courts that employ standardized assessment tools to determine candidates' eligibility for the program have significantly better outcomes than drug courts that do not use standardized tools (Shaffer, 2010).

Eligibility assessments should be performed along the dimensions of both risk and need to match defendants to appropriate levels of criminal justice supervision and treatment services, respectively (Andrews & Bonta, 2010; Casey et al., 2011; Marlowe, 2009). Most substance abuse screening tools are not sufficient for this purpose because they do not accurately differentiate substance dependence or addiction from lesser degrees of substance abuse or substance involvement (Greenfield & Hennessy, 2008; Stewart, 2009) nor do they assess risk for reoffending. Assessment tools used to determine candidates' eligibility for programs—which are often validated on samples of predominantly Caucasian males—should not be assumed to be valid for use with minorities, females or members of other demographic subgroups (Burlew et al., 2011). Studies have found that women and racial or ethnic minorities interpreted assessment items differently than other test respondents, making the test items less valid for these groups (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

While there is an extensive literature on the reliability and validity of some risk instruments (e.g., the LSI family of risk and need assessments), more generally, there is a need to verify that risk and need tools are valid in the populations in which professionals use them (Desmarais, Johnson, & Singh, 2016). That is, in order to verify that instruments are empirically valid and that they show no evidence of bias, researchers need to test them separately for specific populations. It is most important that validated instruments produce similar predictive results for minority and nonminority samples. Perhaps most importantly, practitioners should determine whether existing risk instruments give rise to minority disparities in predicting risk because of actual differences in participating populations, or alternatively, because of bias in the instruments, or bias in the ways practitioners utilize them (Monahan & Skeem, 2016). Furthermore,

instruments should not confuse the concepts of risk (predicting future criminogenic behavior) and blame (explaining past criminogenic behavior) (Monahan & Skeem, 2016).

There is a specific literature that examines the use of risk tools for specific purposes. For example, in their evaluation of the eight NESCAARC reentry courts, Lindquist et al. (2013, 2014) point out the importance of utilizing risk and need as eligibility criteria for clients. They report each of the 8 federally funded reentry courts made use of one of several validated risk assessment instruments including the Level of Service Inventory- Revised (LSI-R), Level of Service/Case Management Inventory (LS/CMI), Risk and Needs Triage (RANT), Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), Ohio Risk Assessment System (ORAS), and the Wisconsin Risk Assessment tool.

Jimenez, Delgado, Vardsveen and Wiener (2018) studied the validity of the LS/CMI as probation officers in the state of Nebraska use it to evaluate risk and need in community corrections. The first study found the predictive validity of the LS/CMI in 19,344 probationers over a 5.5-year period (January 2007-July 2013) indicated that it was a valid predictor of recidivism (return to probation). However, the instrument did show some significant, but very small, differences (very small effect sizes) for non-minorities as compared to minorities. Minorities did show higher risk than did non-minorities on seven of the eight criminogenic factors. Study 2 employed a true randomized experiment to determine if these slight prediction differences were due to greater risk in the population or bias in the application of the instrument. The results of this experiment showed very little bias in the instrument and no evidence that officers demonstrated racial bias in how they administered the LS/CMI. Jimenez et al. (2018) verified that the LS/CMI was a valid and unbiased instrument for use with Nebraska probationers. The Nebraska Mental Health Courts will utilize LS/CMI for its inclusion eligibility criteria.

In the state of Nebraska, psychiatrists, clinical psychologists and licensed independent mental health practitioners are qualified to officially diagnose mental illness, including severe mental illness (SMI – e.g. Schizophrenia, Major Depressive Disorder, and Bipolar Disorder). The State does not endorse specific tools for diagnosis of these illnesses, but instead relies upon the professional training and experience of qualified individuals to render a diagnosis. Qualified individuals typically interview clients, sometimes administer tests, collect collateral information, review existing records and then make their professional judgments to classify those with Schizophrenia, Depression or Bipolar Disorder, or other disorders, as SMI.

That said, there are instruments that psychologists and others who are qualified to diagnose can use to inform their judgments. When clinicians use these instruments, the results act to constrain and guide their judgments, making them more objective. Those instruments that diagnosticians commonly use include three highly recommended assessment tools, which qualified professionals can use to estimate cutoff boundaries for Mental Health Court: Brief Symptom Inventory (BSI), Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI). Other validated instruments are also available.

Brief Symptom Inventory (BSI)

The BSI (Derogatis, 1993) is a well-validated, self-report, 53-item inventory with 5-point Likert-like scales, which a client can complete in less than 10 minutes. Diagnostic interpretation requires clinical training,

but other professionals use it for research and evaluation. The BSI assesses psychological symptoms and distress, while yielding standardized indicators of commonly used psychological constructs (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism) and generally accepted global indices of mental illness (Global Severity Index - overall psychological distress level, Positive Symptom Distress Index - the intensity of symptoms, and Positive Symptom Total - total number of self-reported symptoms). The BSI correlates strongly with the parent instrument, the Symptom Check List (CSL-90) (Derogatis, 1974) – a 90-item longer version of the BSI. Citations for internal reliability of the BSI are Coefficient Alpha = .70 on average for all its scales and it has a test-retest reliability of *r* = .90. While there have been some complaints about the stability of its factor structure, mental health practitioners from all over the world commonly rely on it to assist in their diagnoses.

Beck Depression Inventory (BDI-II)

The BDI is a self-report, 21-item inventory with close-ended, 4-level anchors, which a client can complete in less than 10 minutes. Diagnostic interpretation requires clinical training, but other professionals, researchers and evaluators commonly use it for group-level data. The BDI-II is a revision of the BDI, which shows improved psychometric status through application of highly sophisticated statistical technology, i.e., Item Response Theory (Santor & Ramsay, 1998). Research has shown the instrument to have good sensitivity and moderate specificity. The BDI-II has very high internal reliability, Coefficient Alpha = .92, for outpatients and .93 for a non-clinical sample. There are numerous studies of its stable factor structure. Diagnostic interpretation requires clinical training, but other professionals use it for research and evaluation studies.

Beck Anxiety Inventory (BAI)

The BAI is a self-report, 21-item inventory with close-ended, 4-level anchors, which a client can complete in less than 10 minutes. Diagnostic interpretation requires clinical training, but other professionals, researchers and evaluators commonly use it for group-level data. Research has shown the instrument to possess high internal consistency (α = .92) and test–retest reliability over 1-week period *r* = .75 (Beck, et al., 1988). The BAI successfully discriminated between anxious diagnostic groups (panic disorder, generalized anxiety disorder, etc.) and non-anxious diagnostic groups (major depression, dysthymic disorder, and so on) (Beck et al., 1988).

Description of LS/CMI

The Level of Service/Case Management Inventory (LS/CMI) is an assessment that measures the risk and need factors of late-adolescent and adult offenders (Andrews, Bonta, & Wormith, 2006). The LS/CMI is also a fully-functioning case management tool. This single application provides all the essential tools needed to aid professionals in the treatment planning and management of offenders in justice, forensic, correctional, prevention and related agencies. The inventory consists of a commonly used set of scales with over 1 million administrations (internationally) in 2010 alone (Andrews, Bonta, & Wormith, 2010). Each scale includes a series of binary items that together measure one of the "Big Four" predictors of

criminal behavior (i.e., criminal history, antisocial attitudes, antisocial associates, and antisocial personality) or one of the remaining four scales that make up the "Central Eight" criminogenic factors (i.e., education/employment, family/marital status, leisure recreation and substance abuse). Most recently, Olver, Stockdale, and Wormith conducted a large-scale meta-analysis of all LSI scales, which included 128 studies and 130,833 offenders and found a moderate effect size (r = .30) using a random effects model to predict general (not violent) community recidivism. In the U.S., the effect size was slightly lower, but still significant (r = .22). Wiener found the validity coefficient of the LS/CMI in Nebraska to be similar to the rest of the United States with an r-value of .21.

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Appendix IV

Supporting Evidence for Program Structure

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.19-24, 40-51; and (2015), p.51-58.

A. Program Capacity

As the number of participants increases, supervision availability decreases. A nationwide study of 86 operating Mental Health Courts in the United States found that the median number of clients was 36 (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). Redlich et al. (2006) found that as the number of clients increased, the frequency of their court appearances decreased, which resulted in fewer interactions with the Mental Health Court, and thus, less supervision by the Mental Health Court team. A localized study of two Mental Health Courts in Bronx and Brooklyn, NY, stated that their court capacity ranged between 15 and 25 participants. Staffing cuts had resulted in the increased number of cases per manager (Rossman et al., 2012).

Carey et al. (2012) compared recidivism rates of 69 drug courts and found that the programs with fewer than 125 participants had recidivism reduced over five times more than the reduction of recidivism in courts with over 125 participants. Problem-solving courts may find difficulty in continuing to provide services and resources needed by their participants as the capacity of the court increases. A study of 70 drug courts found a significant inverse relationship between drug court size and recidivism rates (Carey et al., 2008, 2012). Staff should monitor Mental Health Court operations, and if some operations are drifting away from best practices, a remedial action plan should be implemented to rectify the deficiencies, such as hiring additional staff, purchasing more drug and alcohol tests, providing continuing education for staff, or scheduling status hearings on more days of the week.

The American Parole and Probation Association (APPA) introduced caseload guidelines in 2006, including guidelines regarding intensive supervised probation (ISP) (DeMichele, 2007). ISP is designed for probationers that are both high-risk and high-need, and as such are at higher risk of failing probation and having serious social service and treatment needs (Petersilia, 1999). Mental Health Courts are comparable to ISP because they are intended for high-risk and high-need or moderate risk and severe need individuals. APPA recommends caseloads of 50:1 for moderate-risk and high-risk probationers without serious social service or treatment needs, and caseloads of 20:1 for high-risk, high-need probationers (Byrne, 2012; DeMichele, 2007). A randomized experiment confirmed that probationers on a 50:1 caseload received more services, including substance abuse and mental health treatment, probation office sessions, telephone check-ins, employer contacts, and field visits than probationers supervised by officers with higher caseloads (Jalbert & Rhodes, 2012). As a result of receiving more services, probationers on a 50:1 caseload had better probation outcomes, including fewer positive drug tests as well of fewer technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above the 50:1 recommendation had difficulty monitoring probationers closely and reducing technical violations.

B. Program Entry

It is important for participants to receive treatment as quickly as possible. Lowder, Demarais, & Baucom (2016) found that each additional day between referral to the Mental Health Court and receipt of mental health services was associated with 1.03 fewer post-program jail days served.

Identifying participants who may be good candidates for a problem solving court, and getting them into a program promptly, is crucial to the individual's success in the program. A nationwide study found that programs that had 50 days or fewer between arrest and program entry were associated with a 63% greater reduction in recidivism when they were compared to programs with a greater number of days between arrest and program entry (Carey et al., 2012). Additionally, Carey et al., (2008) looked at 18 drug courts and found that shorter periods of time between arrest and entry into the program was associated with lower recidivism rates as well as greater cost savings.

C. Successful and Unsuccessful Program Termination, and Program Duration

1. Benefits of Program Participation AND 2. Consequences for Unsuccessful Program Exit

It is important for participants to know the details of the program because it will allow them to make educated decisions and be aware of progress requirements. Redlich & Summers (2010) examined two Mental Health Courts in New York and Nevada and found that 9-27% of participants demonstrated clinically significant impairments in their understanding of legal terms and concepts. Mild impairments were seen in 5-25% of participants. With deficits like these, it is imperative that participants understand the workings of the problem-solving court and what will be expected of them.

It is also important that participants understand that the Mental Health Court is a voluntary program. More than half of the participants surveyed in Redlich and Summers' (2010) study claimed to have not been told that the decision to enroll in the court was voluntary and were not told of the requirements of the court prior to enrollment. More than half also did not know that the final enrollment decision was theirs to make, they did not know they could leave the court program if they decided, and they could not name one disadvantage to being in the court (Redlich and Summers, 2010). Keeping participants in the dark about the happenings of the court program is detrimental to the operations of the court and the success of the participant.

Rossman et al., (2011) examined twenty-three adult drug courts, also known as the NIJ-Multisite Adult Drug Court Evaluation (MADCE), found that when participants are provided with a written schedule of rewards for participation and sanctions for non-compliance prior to beginning participation, courts see better outcomes from the participants. In the same study, programs in which participants perceived that the court had a higher degree of leverage over them (e.g. that they were being closely monitored and that the consequences of noncompliance would be negative) prevented more crimes than those with a low degree of leverage (Rossman et al., 2011).

A meta-analysis of approximately sixty studies including seventy drug courts examined the relationship between recidivism and the type of reward associated with graduation (Shaffer,

2006). Shaffer (2006) found that drug courts are more effective at reducing recidivism when graduation leads to charges and/or motions to revoke probation being dismissed than when it is linked to avoiding a sanction.

3. Program Length

The amount of time each participant spends under court supervision and treatment should be based on the needs and treatment plan for that individual, but should not exceed the typical sentence and probationary period for the criminal charge. There is no established "model" of a Mental Health Court; most courts operate on their own guided, but often unwritten, rules and procedures (Berstein & Seltzer, 2003).

Hughes and Peak (2012) found that Mental Health Courts have demonstrated short-term improvement in reducing recidivism for participants; however, the long-term results are unknown. Additional involvement and time with the court and the court team members can affect a participant with a mental illness positively. This study claims that Mental Health Courts should be designed for specific populations that need specific treatment without always involving the court. These researchers stressed the importance of agreement amongst the participants and the team members, in terms of goals for the court and goals for the participants, for growth to continue.

Rossman et al., (2011) looked at twenty-three adult drug courts, also known as the NIJ-Multisite Adult Drug Court Evaluation (MADCE), and found that providing substance abuse treatment of sufficient duration is crucial in order to allow participants to alter their behavior and attitudes appropriately for continued sobriety. A meta-analysis including 60 studies, covering 76 distinct drug courts and 6 aggregated drug court programs, looked at duration of the court. This study found that the programs that lasted 8-16 months were significantly more effective at reducing recidivism than shorter or longer programs (Shaffer, 2006). Carey et al., (2012) looked at 69 drug court programs that were 12 months or longer and found a 57% greater reduction in recidivism than shorter programs. Marlowe, Dematteo, and Festinger (2003) make a point in saying that 12 months in substance abuse treatment is required to reduce the probability of relapse by 50 percent. They also claim that 12 months of drug treatment is the "median point" on the dose-response curve; meaning that approximately 50% of participants who complete 12 months of more of drug abuse treatment are able to remain abstinent for an additional year following the completion of their treatment.

4. Program Progression Structure

Several studies have found that using a written schedule of graduated sanctions and incentives is most effective in producing positive outcomes (Cissner & Rempel, 2005; Harrell et al., 2000; Rossman et al., 2011). In a meta-analysis of adult drug courts including 92 studies, Mitchell et al. (2012) specifically examined multi-phase programs and found that programs with more than three phases had a larger reduction in drug recidivism than programs with fewer phases.

5. Successful Completion Requirements

It is important for participants to have access to the services that they may need in order to be successful while participating in the Mental Health Court, as well as after graduating from the court. Hughes and Peak (2012) looked at the short- and long-term implications for criminal activity of those involved in Mental Health Courts and found that those who had participated in a Mental Health Court had demonstrated short-term improvement in reducing criminal activity; however, they were unsure of the long-term results. The researchers also emphasized that additional involvement and time with the court and the court team members could have a positive effect on a participant with mental illness.

a. Period of time clean and sober prior to program exit

Carey et al. (2012) examined 69 drug courts and found that programs that required participants to have at least 90 days of negative drug tests prior to successfully graduating from the program had a 164% greater reduction in recidivism and 50% greater cost savings than programs that required participants to have fewer days of negative drug tests.

b. Stable and Pro-social Activities and Environment

It is important to have participants be making progress in other areas of their lives in order to be successful outside of the Mental Health Court. The Mental Health Court team is there to support the participants and help find resources where they are needed. A nationwide study found a 48% greater cost savings when a program requires participants to have sober housing prior to graduation compared to programs that did not (Carey et al., 2012). From the same study, an 83% greater cost savings was found when programs required participants to have a job or be enrolled in school prior to graduation, compared to programs who did not. Andrews and Bonta (2010) noticed an association, although weak, between prosocial recreational activities and criminogenic need; that is, if the participant is not engaging in prosocial activities, their risk of recidivism increases.

c. Written Sustained Success Plan

Aftercare services are important for the participants' success after completing the program; such services are also associated with reducing recidivism (Van Voorhis & Hurst, 2000). Seigal et al. (2002) found that in a random-assignment study of 453 veterans who were receiving substance abuse treatment, aftercare services, including continued supervision and case management, resulted in significantly reduced negative behavior.

In practice, Lindquist et al. (2013) observed that 3 of 8 NESCAARC reentry courts provided post-program aftercare services, including extending community supervision, continued drug testing, and some limited program services.

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Appendix V

Supportive Evidence for Treatment

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.38 – 49; and (2015) p.5-25.

A. Continuum of Care

Mental Health Courts have been successful in increasing access of services to clients (Boothroyd, et al., 2005). Outcomes are significantly better in Mental Health Courts that offer a continuum of care, including housing, employment, outpatient and inpatient services, medication management and crisis services, among others (Gonzales & McNiel, 2018; Herinckx, et al., 2005; Luskin, 2013). Other problem-solving courts have also found significantly better outcomes in courts that offer a continuum of care including a variety of services (Carey et al., 2012; Koob et al., 2011; McKee, 2010). Participants who are placed initially in residential treatment should be stepped down gradually to day treatment or intensive outpatient treatment and subsequently to outpatient treatment[33] (Krebs et al., 2009). Moving participants directly from residential treatment to a low frequency of standard outpatient treatment has been associated with poor outcomes in substance abuse treatment studies (McKay, 2009a; Weiss et al., 2008).

Significantly better results are achieved when substance abuse treatment participants are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). Studies have confirmed that participants who received the indicated level of care according to the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*[34] (ASAM-PPC) had significantly higher treatment completion rates and fewer instances of relapse to substance use than participants who received a lower level of care than was indicated (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008) and had equivalent or worse outcomes than those receiving a higher level of care that what was indicated (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Magura et al., 2003; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for participants below the age of twenty-five (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010).

PTSD may also co-occur with substance abuse and anxiety disorders, further complicating treatment decisions (Friedman, 2014). The National Survey on Drug Use and Health found that "7.0 percent of participants aged 18 or older experienced past-year serious psychological distress (SPD), 7.1 percent met the criteria for a past-year substance use disorder (SUD), and 1.5 percent had co-occurring SPD and SUD (based on combined 2004-2006 data, SAMHSA, 2007)." The more recent 2009 National Post-Deployment

[32] Broadly speaking, standard outpatient treatment is typically less than nine hours per week of services, intensive outpatient treatment is typically between nine and nineteen hours, and day treatment is typically over twenty hours but does not include overnight stays (Mee-Lee & Gastfriend, 2008).

[34] The *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC) is the most commonly used placement criteria (Mee-Lee et al., 2001).

Adjustment Survey yielded a 20 percent PTSD rate occurrence and a 27 percent alcohol misuse occurrence rate for those participants that had been deployed (Elbogen, Johnson, Newton, et al., 2012). The physical and psychological conditions participants face as a result of their military service may also relate or lead to secondary social issues. It should also be noted that these issues may co-occur. For example, homeless veterans are more likely to have chronic medical conditions and mental health needs than other homeless adults (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).

Evidence suggests racial and ethnic minority participants may be more likely than non-minorities to receive a lower level of care than is warranted from their assessment results (Integrated Substance Abuse Programs, 2007; Janku & Yan, 2009).

B. In-Custody Treatment

Costs and involvement in the criminal justice system (arrests) are reduced significantly when individuals with serious mental illnesses are given stable supervised housing and effective treatment (Clark, Ricketts, & McHugo, 1999). The same study found that the cost of an arrest and processing through the legal system was far greater than the treatment needed by these individuals, and when these individuals were compliant in their treatment, they were able to avoid involvement with the criminal justice system (Clark, Ricketts, & McHugo, 1999).

Studies looking at other problem solving courts have found similar results. Relying on in-custody substance abuse treatment can reduce the cost-effectiveness of a drug court by as much as 45% (Carey et al., 2012). Also, research shows that substance abuse treatment provided in jails or prisons is not particularly effective (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs, such as therapeutic communities (TCs), have been shown to improve outcomes for jail or prison inmates (Mitchell et al., 2007), most of the benefits of those programs were attributable to the fact that they increased the likelihood participants would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 2004).

C. Team Representation

One assessment of a Mental Health Court in a Florida county found that the court utilized the state mental health agency and the largest mental health provider in the county to represent and manage treatment for participants. Having representatives from these agencies present during staff meetings and hearings allowed for quick responses during hearings and eased the processing through the court for participants; thus, participants had more effective treatment (Petrila, et al., 2001).

Research on other problem-solving courts has found better outcomes when the number of treatment agencies used are limited. Outcomes are significantly better in drug courts that rely on one or two primary treatment agencies to manage the provision of treatment services for participants (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). In a study of 69 drug court programs, recidivism was reduced as much as twofold in programs where representatives from these primary agencies are core members of the drug court team and regularly attend staff meetings and court hearings (Carey et al., 2012). This arrangement helps to ensure that timely information about participants' progress in treatment is communicated to the drug court team and treatment-related issues are taken into consideration when

decisions are reached in staff meetings and status hearings. When drug courts are affiliated with large numbers of treatment providers, outcomes were enhanced for programs in which the treatment providers communicated frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

D. Treatment Dosage and Duration

The longer participants remain in treatment and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Gottfredson et al., 2008; Peters et al., 2002; Shaffer, 2010; Taxman & Bouffard, 2005). A study of several Mental Health Courts found great variation between courts and even within each court. This allowed for treatment to be decided on a case-by-case basis, but treatment generally lasted between one and two years (Bernstein & Seltzer, 2003). The same study also made a point to limit the length of supervision as not to exceed the typical sentence and probationary period for the charge (Bernstein & Seltzer, 2003).

The best outcomes are achieved when addicted participants complete a course of treatment extending over approximately nine to twelve months (270 to 360 days; Peters et al., 2002; Huebner & Cobbina, 2007). On average, for drug courts treating those addicted to drugs and at high risk of recidivism or treatment failure, participants will require approximately six to ten hours of counseling per week during the first phase of the program (Landenberger & Lipsey, 2005) and 200 hours of counseling over the course of treatment (Bourgon & Armstrong, 2005; Sperber et al., 2013). The most effective drug courts publish general guidelines concerning the anticipated length and dosage of treatment, but retain sufficient flexibility to accommodate individual differences in responses to treatment (Carey et al., 2012). Significantly better results are achieved when substance abuse participants are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). Studies have confirmed that participants who received the indicated level of care according to the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*[35] (ASAM-PPC) had significantly higher treatment completion rates and fewer instances of relapse to substance use than participants who received a lower level of care than was indicated (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008) and had equivalent or worse outcomes than those receiving a higher level of care than what was indicated (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Magura et al., 2003; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for participants below the age of twenty-five (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010).

E. Treatment Modalities

Mental health and drug treatment can be provided in individual and group settings. Research shows that outcomes are significantly better in drug courts that require participants to attend individual sessions with

[35] The *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC) is the most commonly used placement criteria (Mee-Lee et al., 2001).

a treatment provider or clinical case manager at least once per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011). Studies have shown that Mental Health Courts have significantly increased access to treatment needed by their participants (Boothroyd, et al., 2005; Luskin, 2013).

Group counseling can improve outcomes for problem-solving court participants, but only under certain conditions. It is especially important that the groups apply evidence-based practices and that participants are screened for their suitability for group-based services (Andrews et al., 1990; Gendreau, 1996; Hollins, 1999; Lowenkamp et al., 2006). The size of the group also has implications for its effectiveness. Research indicates counseling groups are most effective with six to twelve participants and two facilitators (Brabender, 2002; Sobell & Sobell, 2011; Velasquez et al., 2001; Yalom, 2005). Groups with more than twelve members have fewer verbal interactions, spend insufficient time addressing individual members' concerns, are more likely to fragment into disruptive cliques or subgroups, and are more likely to be dominated by antisocial, forceful or aggressive members (Brabender, 2002; Yalom, 2005). Groups with fewer than four members commonly experience excessive attrition and instability (Yalom, 2005).

Evidence reveals group interventions may be contraindicated for certain types of participants, such as those suffering from serious brain injury, paranoia, sociopathy, major depression or trauma disorders (Yalom, 2005). Individuals with these characteristics may need to be treated on an individual basis or in specialized groups that can focus on their unique needs and vulnerabilities (Drake et al., 2008; Ross, 2008). Researchers have identified substantial percentages of Mental Health Court participants who may require specialized group services for co-occurring substance use disorders (Mendoza et al., 2013; Peters, 2008; Peters et al., 2002) or trauma histories (Sartor et al., 2012). Better outcomes have been achieved, for example, in drug courts (Messina et al., 2012; Liang & Long, 2013) and other substance abuse treatment programs (Grella, 2008; Mills et al., 2012) that developed specialized groups for women with trauma histories.

Mental Health Courts must identify a range of complementary services for their participants, refer them to indicated services, and ensure that the services are delivered in an effective sequence. This complex task must be informed by a professionally-trained clinician or clinical case manager who can perform clinical and social service assessments, who understands how the services should be sequenced and matched to the participant, and who can monitor and report on participant progress (Monchick et al., 2006; Rodriguez, 2011). Generally, clinical case managers are social workers, psychologists, or addiction counselors who have special training in identifying participant needs, referrals for indicated services, coordinating care between agencies, and reporting on participant progress in the program (Monchick et al., 2006; Rodriguez, 2011). Court case managers will generally administer a brief screening designed to identify participants who may require more substantial clinical assessments. Participants who score above a certain threshold on the screening instrument should be referred to a clinically-trained treatment professional for additional assessment.

F. Evidence-Based Treatments

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) individuals receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3)

treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al., 1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009).

Adherence to these principles has been associated with significantly better outcomes in drug courts (Gutierrez & Bourgon, 2012), Mental Health Courts (Erickson, et al., 2006; Lowder, et al., 2016) and in other drug abuse treatment programs (Prendergast et al., 2013). Fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Lutze & Van Wormer, 2007; Smith et al., 2009).

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among prisoners include Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R), Thinking for a Change (T4C), Relapse Prevention Therapy (RPT) and the Matrix Model (Cullen et al., 2012; Dowden et al., 2003; Ferguson & Wormith, 2012; Landenberger & Lipsey, 2005; Lipsey et al., 2001; Lowenkamp et al., 2009; Marinelli-Casey et al., 2008; Milkman & Wanberg, 2007; Pearson et al., 2002; Wilson et al., 2005). The Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing prisoners (Bahr et al., 2012; Wanberg & Milkman, 2006) and problem-solving court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007).

G. Identify Services in Community to Target Participant Needs

Many successful Mental Health Courts have provided various ancillary services for their participants, such as parenting classes; individual, group and couples counseling (Luskin, 2013), trauma services; employment assistance (Herinckx, et al., 2005); and housing assistance (Gonzales & McNiel, 2018).

In a study of 69 drug court programs, Carey et al. (2012) found that programs that offered ancillary services had better outcomes than those that did not. Programs that offered mental health treatment had 80% greater recidivism reduction; those that offered parenting classes had a 65% greater recidivism reduction; and those that offered family/domestic relations counseling had 65% greater recidivism reduction compared to programs that did not offer these services. Programs offering parenting classes reported a 52% increase in cost savings and those offering anger management had a 43% increase in cost savings compared to programs that did not offer these services.

I. Medications

Psychotropic medications have been found to provide significant short-term relief from distressing symptoms relating to mental health conditions (Hughes and Peak, 2013). A study by Hughes and Peak (2013) assessed the criminal justice system's reliance on psychotropic medications to treat those with mental illness in Mental Health Courts. These researchers stressed that clients can benefit from psychotropic medications, but this is not something that can be heavily relied on; other treatments and therapies can have better success in long-term contexts. This assessment suggests that psychotropic medications be available as a resource for clients, but not be the only resource available (Hughes and Peak, 2013).

Medication-assisted treatment (MAT) can significantly improve outcomes for addicted persons (Chandler et al., 2009; National Center on Addiction and Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opioid-addicted inmates' engagement in treatment; reduce illicit opioid use; reduce rearrests, technical parole violations, and re-incarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are non-addictive and non-intoxicating. Studies have reported significant reductions in heroin use and re-arrest rates for opioid-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI drug courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

J. Provider Training and Credentials

Studies have found that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005) and to deliver culturally competent treatments (Howard, 2003). A large-scale study found that clinically certified professionals significantly outperformed noncertified staff members in conducting standardized clinical assessments (Titus et al., 2012). Clinicians are also more likely to endorse treatment philosophies favorable to participant outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012). Providers are better able to administer evidence-based practices when they receive three days of pre-implementation training, periodic booster trainings, and monthly individualized supervision and feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience working with populations in criminal justice settings and are accustomed to functioning in a criminal justice environment (Lutze & Van Wormer, 2007).

K. Peer Support Groups

Research has found that individuals are very successful when they are involved in organizational environments (in this case, peer support groups in mental health settings) that provide clear roles and expectations, professional autonomy and respect (Cronise et al., 2016; Davis 2013; Kuhn et al., 2015; Mancini, 2018; Moran et al., 2013; Myrick and del Vecchio, 2016).

Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a substance abuse treatment episode (Kelly et al., 2006; Moos & Timko, 2008; Witbrodt et al., 2012). Individuals who are court-mandated to attend self-help groups perform as well or better than non-mandated individuals (Humphreys et al., 1998). The critical variable appears to be how long the participants were exposed to the self-help interventions and not their original level of intrinsic motivation (Moos & Timko, 2008).

Successful outcomes for those with substance use disorders are more likely if participants attend self-help groups and also engage in recovery-relevant activities like developing a sober-support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011) and learning effective coping skills from fellow group members (Kelly et al., 2009). Research has demonstrated that interventions can improve participant engagement in self-help groups and recovery activities. Examples include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, intensive referrals improve outcomes by assertively linking participants with support-group volunteers who may escort them to the groups, answer any questions they might have and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

L. Trauma-Informed Services

Participants in Mental Health Court that exhibit trauma-related symptoms require specific, trauma-informed services beginning in the first phase of Mental Health Court and continuing, as necessary, throughout the participant's enrollment in the program. Individuals in the criminal justice system with PTSD are nearly one and half times more likely to reoffend than individuals without PTSD (Sadeh & McNiel, 2015). Additionally, participants with PTSD are at a much greater risk of being discharged prematurely or dropping out of substance abuse treatment than participants without PTSD (Mills et al., 2012; Read et al., 2004; Saladin et al., 2014). Even though all participants with trauma histories may not require formal PTSD treatment, each staff member, including court personnel and criminal justice professionals, should receive trauma-informed training (Bath, 2008).

M. Criminal Thinking Interventions

Problem-solving court participants frequently exhibit criminal thinking patterns that may lead to program failure and criminal recidivism (Gendreau et al., 1996; Helmond et al., 2015; Knight et al., 2006; Walters, 2003). Some Mental Health Court participants may hold counter-productive attitudes or values, have difficulty understanding their role in interpersonal conflict, as well as have difficulty anticipating consequences before they act. These anti-social sentiments can cause participants to be viewed as suspicious or manipulative and may lead to frequent conflict. There are several evidence-based cognitive-behavioral interventions to address criminal thinking patterns. Evidence-based programs that demonstrate improved outcomes for participants include Moral Reconation Therapy (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Thinking for a Change (Lowenkamp et al., 2009), and Reasoning & Rehabilitation (Cullen et al., 2012; Tong & Farrington, 2006). Studies suggest that the most beneficial time to introduce these interventions is after participants are stabilized in treatment and are no longer experiencing acute symptoms of withdrawal (Milkman & Wanberg, 2007).

N. Overdose Prevention and Referral

Unintentional overdose deaths from illicit and prescribed opioids has tripled over the last fifteen years (Meyer et al., 2014), and individuals addicted to opioids are at a high risk for overdose immediately following their release from jail or prison because their tolerance of opioids reduces significantly during incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014). Mental Health Courts should educate

participants and their family members about simple overdose prevention and reversal strategies. Mental Health Court personnel and other criminal justice professionals should be trained on the administration of overdose reversal medications such as naloxone, a non-addictive, non-intoxicating medication that poses a minimal risk of medical side-effects (Barton et al., 2002; Kim et al., 2009). Studies in Scotland and the United States have demonstrated that educating at-risk persons and their significant others about how to prevent or reverse an overdose significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

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Appendix VI

Supporting Evidence for Court Sessions/Judicial Monitoring/Status Hearings

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.20 – 25; and (2015) p.38-50.

A. Professional Training

Mental health-specific training for judges is vital to the success of the Mental Health Court and its clients. Epperson and Lurigio (2016) assessed the success of clients when working with team members that had received specialized training for offenders with serious mental illness (SMI). These researchers found that when these team members had undergone this training, they were significantly more sensitive to the role of mental health in criminal behavior. This training also encouraged team members to be more focused on their relationships with clients and getting their clients the mental health treatment services needed compared to team members who had not had this kind of specialized training.

Seck, Tsagaris, and Rowe's (2017) study on offenders with developmental disabilities and co-occurring diagnoses in a Mental Health Court found that when judges and other court personnel received additional training in developmental disabilities and mental health, the Mental Health Court was better able to assess offenders' mental health and judicial needs. This additional training resulted in improved court outcomes when compared to courts that did not have such training.

Research on drug courts has found that the judge has a very unique and significant impact on the outcomes of the court (Carey et al., 2012; Jones, 2013; Jones & Kemp, 2013; Marlowe, 2006; Zweig et al., 2012). A national study of 23 adult drug courts found significantly greater reductions in crime and substance abuse when the judges were observed by independent entities to be knowledgeable about substance abuse treatment (Zweig et al., 2012). A statewide study of New York's drug courts found significantly better outcomes when participants perceived the judges as being open to learning about addiction as a disease (Farole & Cissner, 2007). Focusing on training, in particular, research shows that outcomes are significantly better when drug court judges attend annual training conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010).

B. Length of Term

Research on length of term for Mental Health Court judges is lacking, thus additional research is needed to support this standard in a Mental Health Court. However, research dealing with other problem-solving courts is available.

Research on judges in drug courts suggest that many of the judges are significantly less effective in reducing crime during their first year on the bench in the drug court than subsequent years (Finigan et al., 2007). A study of 69 drug courts found almost three times greater cost savings and significantly lower recidivism when judges presided over the drug courts for at least two consecutive years (Carey et al.,

2008, 2012). Carey et al. (2012) found significantly greater reductions in crime when judges participated in drug courts on a voluntary basis and when their term in the drug court was indefinite in duration.

C. Consistent Docket

Research on consistency of the judge in Mental Health Courts is lacking; therefore, additional research is needed to support this standard in a Mental Health Court. However, research dealing with other problem-solving courts is available.

The poorest outcomes for drug courts were found in several studies where the courts rotated their judicial assignments or required participants to appear before alternating judges (Finigan et al., 2007; National Institute of Justice, 2006).

D. Frequency of Status Hearings

A national study of 86 Mental Health Courts reported better outcomes in almost all of the courts in which clients were required to report weekly or bimonthly for judicial hearings in the beginning of the program. As the program continued, the courts required less frequent judicial hearings. This same study found that the courts that did not require clients to return more frequently were also the courts that were more likely to use jail as a sanction (Redlich, et al., 2006). Another study of several Mental Health Courts in the United States reported that in six of the eight courts surveyed, clients are attending status hearings at least weekly until less supervision is required (Griffin, Steadman, & Petrila, 2002).

Other problem-solving courts have experienced better outcomes when clients were appearing for status hearings every week or every two weeks. In a series of experiments, researchers randomly assigned drug court participants to appear before the judge every two weeks for status hearings or only to appear before the judge in response to repetitive rule violations. These studies showed that high-risk participants had significantly better outcomes (better counseling attendance, drug abstinence, and graduation rates) when they were required to appear before the judge every two weeks (Festinger, et al., 2002). These findings were replicated in misdemeanor and felony drug courts in urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was also confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

A meta-analysis including 92 adult drug courts (Mitchell et al., 2012) and an additional study of 69 adult drug courts (Carey et al., 2012) found significantly better outcomes for courts that held status hearings for their clients every two weeks during the first phase of the program. Additionally, better outcomes and greater cost savings were present in courts that scheduled status hearing at least once per month until the last phase of the program (Carey et al., 2008, 2012).

E. Length of Court Interactions

One study assessed a Mental Health Court in Broward County, Florida, and reported that clients will spend between several minutes to a half-hour before the judge during status hearings (Petrila, et al., 2001).

In a study of 69 adult drug courts, the researchers found that when judges spent an average of at least three minutes, and up to seven minutes, interacting with clients during court sessions, outcomes were significantly better (Carey et al., 2008, 2012).

F. Judicial Demeanor

Fisler (2005) assessed a Mental Health Court in Brooklyn, New York, and found successful outcomes when trust and respect were established between the judge and other team members and their clients. This was done by encouraging the judge to take the time during court sessions to encourage the participant to honor the agreements made to stay in treatment and refrain from committing any new offenses. This court found that the trust-building approach expected that the participants would feel that the court is fundamentally fair, and that they will be listened to and treated with respect (Fisler, 2005).

Studies of other problem solving courts have consistently found that participants reported the quality of interactions with the judge are the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The NIJ Multi-site Adult Drug Court Evaluation (MADCE) found significantly greater reductions in crime and substance use when judges were observed as being more respectful, fair, attentive, enthusiastic, consistent and caring during their interactions with the participants in court (Zweig et al., 2012). In addition, a statewide study in New York found significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about addition as a disease (Farole & Cissner, 2007). In contrast, judges who were perceived as being arbitrary, jumping to conclusions, or not allowing participants the opportunity to explain their side of controversies were found to have significantly poorer outcomes (Farole & Cissner, 2007; Zweig et al., 2012).

Program evaluations have also reported that supportive comments from judges were associated with significantly better outcomes in drug courts (Senjo & Leip, 2001) and stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

These findings are consistent with a body of research on procedural fairness or procedural justice. Successful outcomes and favorable attitudes towards the court system were more likely when the participants were treated with respect by the judge, perceived the judge to be unbiased and benevolent in intent, and were given an opportunity to explain their side of controversies (Burke, 2010; Burke & Leben, 2007; Frazer, 2006).

G. Judicial Decision Making

Research on the impact of a team approach to decision making is limited; however, research suggests that a collaborative team effort is beneficial for the court and for effective court processes (MaGaha, et al., 2002; Watson, et al., 2001). Mental Health Courts have found success when members of the team work collectively and collaboratively in order to aid in the progress of the participants. MaGaha et al. (2002) found that collaboration by the Mental Health Court team during court procedures significantly reduced participant attrition. A study of four Mental Health Courts in the United States found that quick responses and actions by the team (judges, public defenders, attorneys, family members, and treatment providers)

allowed the team to collaborate more efficiently and for the team members and participants to feel greater satisfaction with the Mental Health Court (Watson, et al., 2001).

An evaluation of the Staten Island Treatment court found that respondents (judge, prosecutor, and defense attorney) stressed the importance of strong relationships among the team members of the drug court when overcoming implementation challenges (O'Keefe & Rempel, 2006). Additionally, in focus groups, experienced treatment court judges from California and New York reported that a team approach was one of the most important factors to success (Farole, et al., 2005). A national study of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers, and others) found supportive evidence that collaborative efforts of drug courts provide benefits to the justice, public health, and education systems (Van Wormer, 2010).

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Appendix VII
Supporting Evidence for Drug and Alcohol Testing

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.52-66; and (2015), p.26-37.

A. Policy and Procedures

Cary (2011) and McIntire and Lessenger (2007) describe techniques participants use to falsify samples, including dilution, adulteration, substitution and tampering. Policies and procedures should focus on limiting opportunities to falsify samples (ASAM 2013, Cary 2011, Katz et al., 2007, Tsai et al, 1998). Chain-of-custody and reporting of results should also be focused on ensuring valid and reliable results (Meyer 2011). Drug and alcohol test results must be derived from scientifically valid and reliable methods in order to be admissible as evidence in legal proceedings (Meyer, 2011). Appellate courts have confirmed the scientific validity of several methods for analyzing urine, such as the enzyme multiple immunoassay technique (EMIT), gas chromatography/ mass spectrometry (GC/MS), liquid chromatography/mass spectrometry (LC/MS), as well as tests for sweat, oral fluid, and ankle-monitors (Meyer, 2011). Drug courts must follow customary chain-of-custody procedures for test specimens, including establishing a paper trail identifying each individual in custody of the testing specimen, and have adequate labeling and security measures to maintain the integrity of the testing specimen. Drug court outcomes are significantly better when policies and procedures are clearly outlined in a participant handbook or manual (Carey et al., 2012). Criminal defendants were much more likely to react favorably to an adverse judgement if given advance notice regarding how the judgement would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug courts can improve participants' perceptions of fairness by detailing policies and procedures in a manual or handbook and frequently reminding participants of testing procedures and participant requirements located in the contract or handbook.

B. Frequency of Testing

In a study of 69 drug courts, Carey et al. (2012) found that programs that tested at least two times per week in phase one increased cost savings by 61% compared to programs that tested less frequently. Research has also shown the importance of testing on weekends and holidays because these are high-risk times for drug and alcohol abuse (Kirby et al, 1995; Marlatt & Gordon, 1985). Drug courts that perform urine drug testing more frequently experience better outcomes in terms of higher graduation rates, lower drug use, and lower criminal recidivism amongst participants (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2006). Drug court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for successful completion of the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006). For the first several months of the program, the most effective drug courts administer urine drug testing at least twice a week (Carey et al., 2008). A study of seventy drug courts demonstrated that programs that performed urine drug testing at least twice a week produced a 38% greater reduction in crime and were 61% more

cost-effective than programs that performed urine drug testing less often (Carey et al., 2012). The metabolites of most drugs are detectable in urine for approximately two-to-four days, so testing less frequently could leave an unacceptable gap of time when participants can use drugs and avoid detection, leading to poorer outcomes (Stitzer & Kellogg, 2008). Auerbach (2007) and Cary (2011) suggest providing no more than an 8-hour notice that the test will be performed.

C. Random Testing

Research shows that drug testing is most effective when it is performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). Auerbach (2007) and Cary (2011) suggest providing no more than an 8-hour notice that the test will be performed.

D. Scope of Drugs Tested

Research suggests that it is important to test for a broad array of drug types (Carey, 2011). Cary (2010) describes SPICE and K2, two synthetic cannabinoids that can be difficult to detect with standard drug testing. In a study including over 300 surveys and 25 interviews, Perrone et al. (2013) demonstrated that people switch from using marijuana to using synthetic cannabinoids to avoid detection during testing duration and switch back after the testing period.

E. Availability of Testing Results

In a study of 69 drug courts, Carey et al. (2012) found that programs in which drug test results were available in two days or less had 73% greater reduction in recidivism and 68% increase in cost savings compared to programs that took longer to receive results.

F. Licit Addictive or Intoxicating Substances

Research has shown that the ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of drug court (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in drug courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012).

If addiction medications may be helpful, their use should be authorized only if a physician with training in addiction psychiatry or medicine carefully monitors the participant. There is a serious risk of morbidity, mortality, or illegal diversion of medications when general medical practitioners prescribe addiction medications to this population (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

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Appendix VIII
Supporting Evidence for Incentives, Sanctions, and Therapeutic Adjustments

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.26 - 37; and (2015) p.59 - 74.

A. Advance Notice

A nationwide study of four Mental Health Courts conducted as part of the MacArthur MHC Project suggests that Mental Health Court participant perceptions of voluntariness, procedural justice, and knowledge of Mental Health Court processes significantly predicted program performance, recidivism, and Mental Health Court graduation (Redlich & Han, 2014). Redlich and Han (2014) conclude that the relationship between these procedural justice elements of therapeutic jurisprudence and Mental Health Court outcomes suggests that, to the extent Mental Health Court participants are given advanced notice of Court policies, the less likely they are to re-offend or be removed from the program. Similarly, Wales, Hiday, & Ray (2010) conducted a study of 8 Mental Health Court's which found evidence that elements of procedural justice, including full transparency of court practices, sanctions, and policies was linked to positive outcomes. Wales et al. (2010) noted that judges play a particularly important role in improving participant perceptions of fairness by providing notice of court policies and full transparency on court decisions.

Additional research on Mental Health Court participation and termination suggests that participants who received clear instruction regarding court policies, notice of expectations, and knowledge about sanctions and rewards perceived a greater degree of procedural justice, reported less coercion, and felt more respected during the process (Canada & Hiday, 2014; Canada & Watson, 2013; O'Keefe, 2006; Munetz, Ritter, Teller, & Bonfine, 2014; Redlich & Han, 2014). Findings in these studies also suggests that perceptions of respect and procedural justice are linked to higher rates of completion and lower rates of recidivism or other negative outcomes (Canada & Hiday, 2014; Munetz et al., 2014; Redlich and Han, 2014; Wales et al., 2010). Observations of established Mental Health Courts across the country regularly note that the standard practice is consistent with the principles of therapeutic jurisprudence, which demand that participants receive adequate notice of court policies, including information regarding incentives, sanctions and therapeutic adjustments (Epperson & Lurigio, 2016; Petrila, Poythress, McGaha, & Boothroyd, 2001; Watson, Hanrahan, Luchins, & Lurigio, 2001)

This research on Mental Health Court outcomes is consistent with established research on best practices in other problem-solving courts, notably, drug courts. National studies of drug courts across the country have found significantly better outcomes when participants were provided with notice of what to expect, including a schedule of predictable sanctions, reminders about treatment responsibilities, information about incentives, and guidelines for court policies and procedures (Burdon et al., 2001; Stitzer, 2008;

Carey et al., 2008a, 2012; Cheesman & Kunkel, 2012; Cissner et al., 2013; Shaffer, 2010; Young & Belenko, 2002; Zweig et al., 2012).

B. Opportunity to Respond AND C. Professional Demeanor

Mental Health Courts are guided by principles of therapeutic jurisprudence and, as such, place special importance on providing participants with the opportunity to respond and treating them with a professional demeanor (Watson et al., 2001; Wiener, Winick, Georges, & Castro, 2010). Research on Mental Health Court participation and outcomes suggests that providing clients with the opportunity to be heard and respecting their role in the process reduces perceptions of coercion and encourages participation in treatment (Canada & Hiday, 2014; Canada & Watson, 2013; Poythress, Petrila, McGaha, & Boothroyd, 2002). Studies which review and compare Mental Health Courts across the country have found that, although courts operate under different rules and do not perfectly mirror each other, successful courts recognize the importance of treating Mental Health Court participants with respect and provide them with the opportunity to be heard and respond (Canada & Hiday, 2014; Petrila et al., 2001; Redlich 2005; Redlich & Han, 2014; Watson et al., 2001).

Two separate outcome analyses conducted by Canada and Hiday (2014) and Redlich and Han (2014) concluded that program success and reduced recidivism were most prevalent when legal actors (judges, probation officers, attorneys, etc.) incorporated the principles of therapeutic jurisprudence by building a relationship with the participants, which includes providing participants with the opportunity to be heard and treating them with respect. Each study connected higher levels of procedural justice with greater levels of participant engagement, increased levels of program success, and lower rates of recidivism (Canada & Hiday, 2014; Redlich and Han, 2014).

Additional research on Mental Health Court participants suggests that perceptions of procedural justice can also have a positive impact on mental health outcomes (Kopelovich, Yanos, Pratt, & Koerner, 2013; Ray and Dollar, 2014). Kopelovich et al. (2013) reviewed four New York City Mental Health Courts and found that, to the extent participants reported higher perceptions of procedural justice from interactions with the judge and other officers of the court, they showed a greater reduction in mental health symptoms. Additional research has found that providing mentally ill offenders the opportunity to participate in a Mental Health Court setting provides greater access to mental health services and reduces Mental Health Court participant perceptions of negative stigma against them (Ray & Dollar, 2014).

D. Incentivizing Prosocial Behaviors

Judges in American Mental Health Courts are called upon to implement the principles of therapeutic jurisprudence by treating participants with respect, establishing trust, encouraging voluntary engagement with treatment plans, and focusing on incentives rather than punitive sanctions (Kopelovich et al., 2013; Munetz et al., 2014; Petrila et al., 2001; Redlich et al., 2005). Research suggests that it is standard practice for Mental Health Court judges to foster positive relationships with participants by congratulating and praising positive behavioral and treatment outcomes in order to encourage participation in program,

curate a therapeutic relationship with the court, and motivate adherence to program treatment requirements (Canada & Watson, 2013; Fisler, 2005; Frailing, 2010; Redlich, 2005; Redlich et al., 2006).

Empirical study of the effect of incentives is limited, but research concerning Mental Health Courts suggests that participant perceptions of engagement with the program, adherence to the principles of therapeutic jurisprudence and positive life changes are linked to program participation, positive treatment outcomes and reduced recidivism (Canada & Hiday, 2014; Han, 2019; Kopelovich et al., 2013; Redlich & Han, 2014). Further, research conducted in drug courts supports the use of a 4:1 incentive to sanction ratio which is associated with better program outcomes for drug users[36] (Gendreau, 1996; Senjo & Leip, 2001; Wodahl, Garland, Culhane, & McCarty, 2011).

E. Therapeutic Adjustments

Research shows that Mental Health Court success, recidivism reduction, and mental health symptom management are linked to therapeutic practices such as building relationships between legal actors and Mental Health Court participants, incentivizing prosocial behavior, and strategic use of sanctions as a response to Mental Health Court program non-compliance (Canada & Hiday, 2014; Han, 2019; Kopelovich et al., 2013; Munetz et al., 2014; Petrila et al., 2001; Redlich et al., 2005; Redlich & Han, 2014). Research also shows that clinical outcomes can be improved when Mental Health Courts establish individualized treatment plans that focus on administering appropriate medication, providing a continuum of care and using standardized instruments to assess and respond to each participant's treatment needs (Campbell, Canales, Wei, Totten, Macaulay, & Wershler, 2015; Carey et al., 2012; Gonzales & McNiel, 2018; Koob et al., 2011; McKee, 2010). Finally, research also suggests that feelings of guilt or anxiety among participants were connected to higher rates of Mental Health Court failure and recidivism (Canada, Markway, & Albright, 2016).

Taken together, this research shows the importance of developing and adjusting individualized treatment plans rather than using sanctions when faced with participants who are not responding to treatment interventions. Mental Health Court success is improved by therapeutic relationships designed to treat psychiatric symptoms and address criminogenic needs, with the use of sanctions limited to violations of, or non-compliance with, Mental Health Court programming and rules (Campbell et al., 2015; Canada & Hiday, 2014; Canada, Markway, & Albright, 2016; Kopelovich et al., 2013; Redlich et al., 2005; Redlich & Han, 2014).

F. Progressive Sanctions

Research on Mental Health Courts suggests that the nature of mentally ill participants gives judges and court officials pause when issuing sanctions, choosing instead to focus on treatment outcomes (Griffin et

[36] Research which suggests the 4:1 ratio is correlational and collected post hoc (after the fact). The greater proportion of incentives to sanctions could encourage positive behavior, or it could be the result of positive behavior. Further, this research was conducted in drug courts rather than Mental Health Courts. Nevertheless, this research suggests that problem solving courts are more likely to encourage successful outcomes with incentives rewarding positive behavior rather than sanctions.

al., 2002; Redlich et al., 2005). Although research on newer Mental Health Courts which admit more participants charged with felony offenses suggests an increased willingness to use severe sanctions, reviews of existing Mental Health Courts still demonstrate a tendency for judges to utilize less severe sanctions until a participant demonstrates the need for more punitive action by repeated non-compliance (Redlich et al., 2005). Progressive sanctions emphasizing treatment rather than punishment are also consistent with therapeutic jurisprudence, the underlying theory of Mental Health Court operation, adherence to which has been linked to positive program, treatment, and recidivism outcomes (Canada & Hiday, 2014; Han, 2019; Kopelovich et al., 2013; Munetz et al., 2014; Petrila et al., 2001; Redlich & Han, 2014).

Empirical research supporting the use of progressive sanctions comes from drug court analysis which suggests that intermediate magnitude sanctions which are tailored to match treatment and program goals, gradually increase in magnitude as infractions increase, and focus on treatment produce the best program and recidivism results (Harrell & Roman, 2001; Hawken & Kleiman, 2009; Marlowe & Kirby, 1999; Marlowe & Wong, 2008; National Institute on Drug Abuse, 2006).

G. Jail Sanctions and Public Safety

Reviews of Mental Health Courts across the country suggests that the standard of practice in these courts is to resort to jail sanctions infrequently and only as a last resort (Griffin, Steadman, & Petrila, 2002; Redlich, Steadman, Monahan, Petrila, & Griffin, 2005; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). Redlich et al. (2005) conducted a comprehensive review of so-called "second generation Mental Health Courts" and found that as Mental Health Courts have evolved the use of jail sanctions has been limited to use as a last resort, particularly to encourage detoxification or provide a "wake-up call" to participants who repeatedly refuse to participate. Redlich et al. (2006) conducted a national survey of established Mental Health Courts and found that 33% of courts used jail as a sanction in 5% or fewer of cases, and an additional 39% use jail as a sanction in 5 – 20% of cases. Thus, the standard practice across 72% of Mental Health Courts in America is to use jail sparingly, having only resorted to doing so in less than 20% of cases (Redlich et al., 2006).

Using jail as a last resort sanction is also supported by literature reviewing drug courts, which suggests that the magnitude and severity of sanctions is less important than certainty and immediacy when considering long-term outcomes (Harrell & Roman, 2001; Marlowe, Festinger, Foltz, Lee, & Patapis, 2005; Nagin & Pogarsky, 2011). Research from drug courts suggests that drug courts which relied on jail sanctions, particularly sentences longer than 3 – 5 days, were less effective at promoting program success, less cost-effective, and less likely to reduce recidivism than courts which did not rely on jail as a sanction (Carey, Mackin, & Finigan, 2012; Hawken & Kleiman, 2009).

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Appendix IX

Supporting Evidence for Cultural Competence

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.11-19; and (2015) p.59-66.

A. Equivalent Access

Steadman et al. (2005) found that those who were more likely to be referred to the Mental Health Court were older, white, and female, as compared to offenders serving time in jail or prison. Additional research is needed to examine the representation of other historically disadvantaged groups in Mental Health Courts.

Evidence suggests that in drug courts, African-American and Hispanic or Latino individuals may be underrepresented by about 3% to 7%. Nationwide studies suggest that about 21% of drug court participants are African American and 10% are Hispanic or Latino, whereas about 28% of arrestees and probationers were African American and about 13% were Hispanic or Latino (Bureau of Justice Assistance, 2012; Huddleston & Marlowe, 2011).

Research suggests that the disparity between Caucasian and minority representation in drug courts might be due to disproportionately restrictive eligibility criteria (Belenko et al., 2011; O'Hear, 2009). For example, African Americans or Hispanics may be more likely to have prior felony convictions or other charges on their criminal records compared to Caucasians, which could disqualify them from participating in a drug court (National Association of Criminal Defense Lawyers [NACDL], 2009; O'Hear, 2009).

Drug and DUI courts often use assessment tools to determine an individual's eligibility; however, these tools are often validated on samples that consist predominately of Caucasian males. As a result, these tools may not be valid for use with minorities, females, or individuals of other demographic subgroups (Burlew et al., 2011; Huey & Polo, 2008). Research has shown that women and racial or ethnic minorities may interpret test items differently compared to other individuals, thus making the test items less valid for women or minorities (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

B. Equivalent Retention

Research is lacking on the retention rates of Mental Health Court participants from traditionally disadvantaged groups. Although research has found no difference between the completion rates of men and women in the Mental Health Courts (Ennis, McLeod, Watt, Campbell, & Adams-Quackenbush, 2016; Hiday, Ray, & Wales, 2014), it is still important to monitor the retention rates of all participants to ensure that there are not inequalities among historically disadvantaged groups.

In drug courts, studies have found that successful graduation rates have been significantly smaller for African-American or Hispanic participants when compared to non-Hispanic Caucasians (Finigan, 2009, Marlowe, 2013). Some studies found this discrepancy to be as high as 25% to 40% (Belenko, 2001, Sechrest & Shicor, 2001). However, the research is mixed; a small number of studies have found no differences,

and even some with better outcomes, for minorities as compared to Caucasians (Cissner et al., 2013; Saum et al., 2001; Vito & Tewksbury, 1998).

Some researchers have tried to explain these disparities within drug courts, suggesting that they might be explained by broader societal burdens that are often experienced more by minorities. These societal burdens could include lesser education or employment opportunities or an influx of drugs into minority communities (Belenko, 2001; Dannerbeck et al., 2006, Fosados, et al., 2007; Hartley & Phillips, 2001; Miller & Shutt, 2001). The racial disparities disappeared when the researchers controlled statistically for these societal factors (Dannerbeck et al., 2006).

It is also important that sufficient attention is being given to employment and education problems that minority participants are experiencing; focus groups and interviews with minority participants suggested that this was an area that needed more attention by the drug court teams (Cresswell & Deschenes, 2001; DeVall & Lanier, 2012; Gallagher, 2013; Leukefeld et al., 2007).

C. Equivalent Treatment

Of those who are involved in the criminal justice system, racial and ethnic minorities often receive treatment of lesser quality than non-minorities (Brocato, 2013; Janku & Yan, 2009; Fosados et al., 2007; Guerrero et al., 2013; Huey & Polo, 2008; Lawson & Lawson, 2013; Marsh et al., 2009; Schmidt et al., 2006). An example of this disparity is related to California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000; this is a statewide diversion initiative for nonviolent drug possession defendants. Researchers wanted to study the effects of Proposition 36 over several years and found that, for similar patterns of drug abuse, Hispanic participants were significantly less likely to be placed in residential treatment compared to Caucasians (Nicosia et al., 2012; Integrated Substance Abuse Programs, 2007). In the same study, medically-assisted treatment for addiction was less likely to be given to African-Americans.

Mental Health Courts aim to reduce these disparities seen in access to treatment among minorities. However, in some treatment settings, such as those for addiction, women and racial minorities are often under-represented in clinical trials, thus the treatments are often less beneficial for these groups of individuals (Burlew et al., 2011; Calsyn et al., 2009). To combat the lack of beneficial treatment for some individuals, there are a few treatment approaches, and a continuously growing number, specifically tailored to the needs of women and racial minorities. One study found that treatment outcomes increased significantly for young African-American male participants when the treatment program was delivered by an experienced African-American clinician, and when the treatment addressed issues these individuals faced, such as negative racial stereotypes (Vito & Tewksbury, 1998).

Studies have shown that women with histories of trauma have significantly more success in gender-specific substance abuse treatment groups (Dannerbeck et al., 2002; Grella, 2008; Liang & Long, 2013; Powell et al., 2012). In one randomized, controlled trial, a gender-specific approach was demonstrated to significantly improve outcomes for female drug court participants (Messina et al., 2012). A national study of about 70 drug courts also found that programs that offered gender-specific treatments significantly reduced recidivism compared to those that did not (Carey et al., 2012). In relation to culturally-specific

treatments, the success of the program ultimately depends on the training and skill of the treatment providers (Castro et al., 2010; Hwang, 2006).

D. Equivalent Incentives and Sanctions

Currently, empirical research is lacking to know if Mental Health Courts are distributing incentives and sanctions equally among their participants. Therefore, more research is needed in this area. However, there are anecdotal observations documented to support the concern of racial or ethnic minority participants receiving additional, or more severe sanctions (NACDL, 2009). One focus group of minority participants reported feeling more likely to be ridiculed or laughed at as a response to violations during court sessions (Gallagher, 2013).

However, according to the little research that has been done on problem-solving courts' use of sanctions, distribution of sanctions appears racially and ethnically equal (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferro & Daigle, 2012; Jeffries & Bond, 2012). Additional research is needed to study this matter in operating Mental Health Courts.

E. Equivalent Dispositions

There is not currently any research that looks into the disparities of sentencing and dispositions for minority participants in Mental Health Courts. Additional research is needed in order to see if minority participants are experiencing these harsher sentences unjustly.

In other problem-solving courts, there have been concerns about racial or ethnic minority participants being sentenced more harshly for failing to complete the court program when compared to non-minorities (Drug Policy Alliance, 2011; O'Hear, 2009). There is research from one study that suggests that those who were terminated from the drug court did receive harsher sentences compared to those who had been traditionally adjudicated with comparable offenses (Bowers, 2008). However, there is no evidence that would suggest that harsher sentences are impacting minorities and non-minorities differently. There is one study is Australia that suggests that indigenous minority participants of a drug court were less likely to be sentenced to prison than their non-minority counterparts (Jeffries & Bond, 2012).

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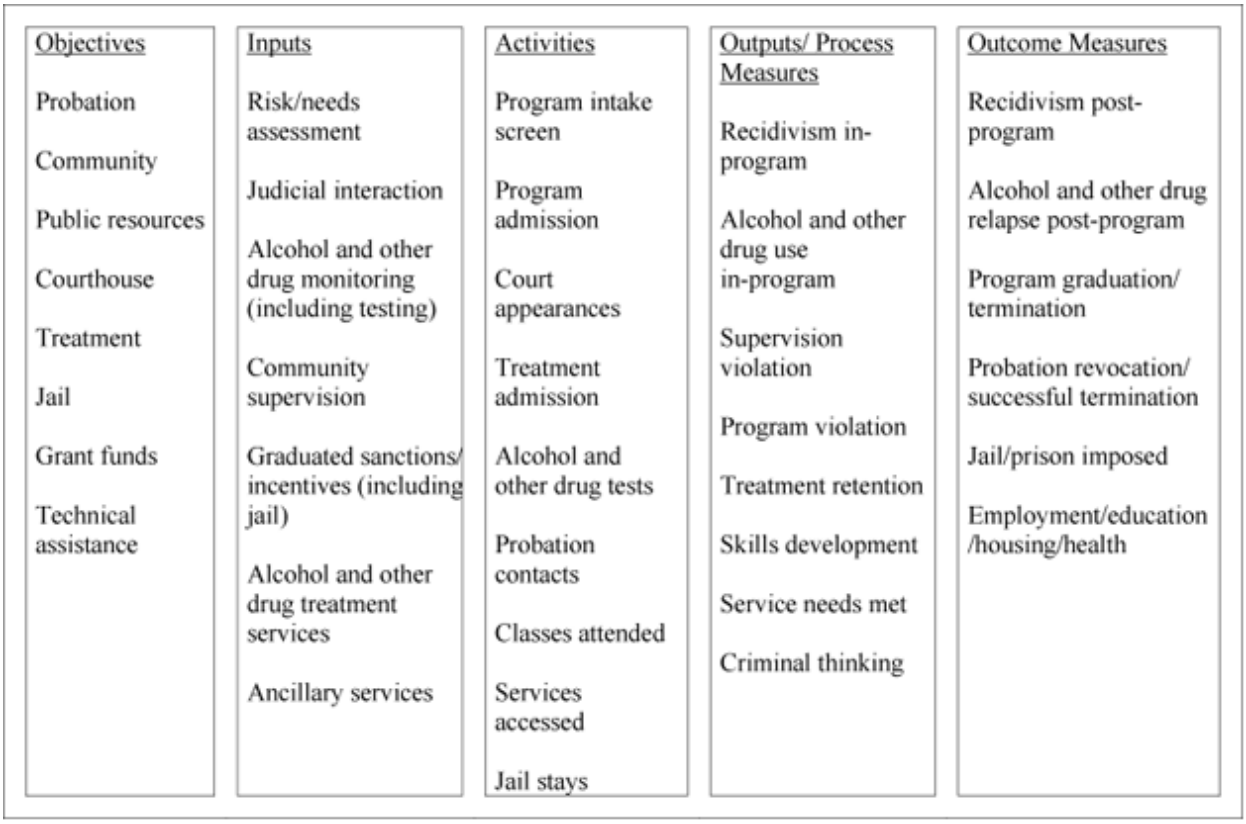
Appendix X
Supporting Evidence for Data and Evaluation

The supporting evidence is consistent with the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.66-74, as well as more general discussions of program evaluation methods.

At the center of the evaluation model described in these standards is the development of a Mental Health Court Logic Model or Program Model. Below is an example of a generic Logic Model for Problem-Solving Courts (Bureau of Justice Assistance, 2017):



A. Electronic Case Management (Fidelity and Implementation)

There is general agreement in the mental health field that a severe limitation on the use of existing evidence-based practices (EBP) is the lack of fidelity of service delivery (Williams, 2016). In other words, even the most successful EBP interventions are likely to fail if the delivery of the service fails to meet the standards developed when the program was first tested and shown to be effective (Linfield & Posavac, 2019). Implementation fidelity studies have as their goal to measure and document the degree to which a program adheres to the implementation practices that the program developers intended and, as such, those measures moderate the relationship between interventions and program outcomes (Carroll, Patterson, Wood, Booth, Rick & Balain, 2007). These implementation studies require ongoing and

sophisticated electronic databases that summarize the court's activities. Carroll et al. (2007) reviewed the existing implementation study literature and identified several measures that successful implementation studies include: 1) adherence – whether the program staff implement the program as it was originally intended, 2) dosage – the amount of intervention that the participants receive (e.g., duration and frequency), 3) quality – the manner in which the staff deliver the intervention, 4) participant responsiveness – the extent to which program participants are engaged in the services, and 5) program differentiation – establishing which parts of the program are necessary for successful outcomes.

Since Carroll et al.'s earlier work, program evaluators have generally agreed that implementation studies are essential to effective program functioning (Linfield & Posavac, 2019) and numerous published studies with the sole purpose of studying the implementation and fidelity of EBPs have continued to appear in the literature up until current times, continually growing ever more sophisticated (Bast, Andersen, Ersboll, Due, 2019). In fact, it has become standard operating procedure for programs to routinely collect implementation data and regularly review the ongoing fidelity of their interventions (Linfield & Posavac, 2019). Early on, researchers examining Mental Health Courts conducted implementation studies of the then-newly emerging programs (Griffin, Steadman, Petrila, 2002). Importantly, these researchers later returned to first generation Mental Health Courts to document changes in adherence, dosage, quality and participant responsiveness (Redlich, Steadman, Petrila, Monahan, and Griffin, 2005; Redlich, Steadman, Monahan, Robbins & Petrila, 2006). More recently, Canada, Barrenger and Ray (2019) reviewed the literature on the impact of Mental Health Courts and identified the need for more implementation scientists to develop instruments and checklists that document the components necessary for successful outcomes. These measures will be more successful to the extent to which researchers collect them electronically and store them in electronic databases.

While it is possible to conduct evaluations without electronic databases (Redlich et al., 2005; 2006), most implementation studies that evaluators conduct in current times rely heavily on electronic record keeping because of its accuracy and efficiency. Most other problem-solving courts also rely on electronic record keeping to assess implementation and fidelity. A study including 18 drug courts found that programs that used paper files to keep records necessary to perform evaluations had higher investment costs, lower graduation rates and less improvement in outcome costs than programs that used electronic records for these purposes (Carey et al., 2008). In a study of 69 drug courts, keeping electronic records, as opposed to paper case files, was a critical step to allowing programs to track their own statistics and to participate in evaluations conducted by independent evaluators (Carey et al., 2012).

B. Timely and Reliable Data Entry

Poor data entry by staff is a substantial threat to a valid program evaluation. The optimum time to record information about services and events is when they occur, otherwise known as real-time recording. Real-time recording prevents lapses in memory from causing gaps in recorded information, and with such a wide variety of services and events in need of recording, it is the most reliable method. Basic texts on program evaluation recommend collecting data through electronic means when possible and collecting information as soon as possible after the event has transpired (Linfield and Posavac, 2019; Rossi, Lipsey,

and Henry, 2019; Shadish, Cook, and Campell,2002). Rossi et al. (2019), as well as Linfield and Posavac (2019) advocate that evaluators gather information from institutional records (i.e., a Mental Health Court database and the Nebraska Probation database) as well as from system-wide records (i.e., Nebraska JUSTICE database) in addition to surveys and interviews. Mental Health Courts should consider affiliating with local university, psychology, sociology, political science and criminology or other social science departments for assistance in developing a timely and reliable data collection system.

True real-time recording is challenging to accomplish, but in all circumstances, data should be recorded within forty-eight hours of events. After forty-eight hours, errors in data recording have been shown to increase significantly; after one week, the data is likely to be inaccurate, so much so that it would be more prudent to leave the data as missing rather than try to fill in the gaps from faulty memory (Marlowe, 2010). Failure to record service, performance and event information in a reliable and timely manner jeopardizes the effectiveness of the program and the quality of participant care.

C. Independent Evaluation AND D. Internal Evaluation

Internal and independent program evaluators have different advantages and disadvantages in conducting implementation and outcome evaluations. Internal evaluators work for the agencies they evaluate and external evaluators work for research firms, universities or government agencies who conduct evaluations of programs other than their own (Linfield & Posavac, 2019). Internal evaluators have the disadvantage of limited expertise, whereas external evaluators generally have greater expertise either within their agencies or they can easily obtain that expertise from colleagues and other evaluators in other agencies (Linfield & Posavac, 2019). However, internal evaluators generally possess greater and more detailed knowledge of the program under study as compared to external evaluators (Linfield & Posavac, 2019). Furthermore, staff are often more willing to share sensitive information with an internal evaluator because the internal evaluator can more easily establish a trusting relationship with program staff who are their fellow workers. On the other hand, internal evaluators are likely to be less objective than external evaluators because they ultimately report back to the organization that oversees the program (i.e., the Mental Health Court). External evaluators have less to lose by reporting problem findings and may have more to offer to ameliorate problems they uncover. This is true because external evaluators do not rely on the organizations they evaluate for continued employment and because they have greater access to the general literature in program development outside the agency they are evaluating (Linfield & Posavac, 2019). In general, internal evaluators have some advantage in conducting implementation studies, but are at a disadvantage for conducting outcome evaluations; therefore, collaboration between internal and external evaluators may work to offset the advantages and disadvantages of each (Linfield & Posavac, 2019).

With regard to drug courts, where there has been a large number of evaluation efforts, the literature demonstrates that independent evaluations make a valuable contribution to the court's effectiveness. Carey et al. (2008) found that programs that participated in more than one evaluation conducted by an independent evaluator had improved outcome costs compared to those that did not (Carey et al., 2008). Drug courts that involved an independent evaluator and implemented at least some of their

recommendations were twice as cost-effective and twice as effective at reducing crime as drug courts that did not involve an independent evaluator (Carey et al., 2008, 2012). Participant perceptions of the program are often highly predictive of outcomes, particularly perceptions of the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005); the quality of treatment services provided (Turner et al., 1999); and the procedural fairness of the program (Burke, 2010; McIvor, 2009). Participants are much more likely to be forthright with an independent evaluator about their perceptions than with program staff, who control their fate in the criminal justice system. Insights from independent evaluators could provide valuable remedies for program deficiencies that can lead to improved participant perceptions and outcomes.

At the same time, there is a growing literature of implementation and outcome evaluations of Mental Health Courts that evaluators have completed. The internal evaluations often do not to find their way into the published literature, but they are sometimes available on state and problem-solving court websites. Section A above summarizes some of the most important points regarding the conduct of implementation studies, regardless of whether internal or external evaluators complete the work. As discussed above, external evaluators are more likely to conduct outcome evaluations and, indeed, there is also a growing literature on outcome evaluations. In fact, Lowder, Rade, and Desmaris (2016) conducted a meta-analysis of outcome studies of Mental Health Courts that included 17 experimental or quasi-experimental outcome studies of Mental Health Courts that mostly external evaluators completed between 2004 and 2015, which included over 16,000 court participants. Across these studies, Mental Health Courts reduced recidivism significantly (albeit with a small effect, a Cohen's d value of -.20) relative to traditional criminal courts. Across the 25 outcomes, there was significant heterogeneity of results, indicating that much more evaluation is necessary to specify differences in court implementation strategies, which are associated with differences in success. In fact, a qualitative review of 29 articles, each of which purported to conduct experimental or rigorous quasi-experimental outcome evaluations of Mental Health Courts (Canada, Barrenger, & Ray, 2019), found varying results depending upon the type of Mental Health Court studied. Canada et al. (2019) included only programs that met five central criteria of Thompson, Osher, and Tomasini-Joshi's (2007) essential elements of problem-solving courts. They are 1) the participants in the court were people with mental illness, 2) clients voluntarily chose to participate in the court after providing informed consent, 3) the court itself provided treatment services or arranged for other agencies to provide those services to the participants, 4) the court team included integrated criminal justice and mental health professionals, and 5) the court conducted ongoing monitoring of participants to assure that they were in compliance with court and treatment orders. Overall, Canada et al. (2019) concluded that Mental Health Courts relative to "business as usual" courts, reduce recidivism, but that outcomes depended upon the type of court and treatment provided. More specifically, those studies that were rigorously conducted showed stronger results for mixed Mental Health Courts (i.e., those that involved both misdemeanors and felonies – the type recommended in Nebraska) as compared to those that only served clients with misdemeanor charges. Results for felony-only courts were promising, but there were not enough of them to make conclusive comments. Canada et al. (2019) reiterate the need for continued implementation and outcome studies to determine which components are critical to successful outcomes and the authors advocate for evidence-based policy making in which Mental Health Court staff regularly engage in evaluation studies and modify their procedures based on the outcomes.

E. Comparison Groups

In order to measure the effectiveness of problem-solving court programs, it is important to address the question of whether the problem-solving court program is responsible for the favorable outcomes of some participants, or if those participants would have had equal success outside the program. The performance of problem-solving court participants must be compared to an unbiased and equivalent comparison group. Comparing the performance of the problem-solving courts to what most likely would have happened if the problem-solving court did not exist is referred to as testing the counterfactual hypothesis, and it helps determine whether the problem-solving court was effective (Shadish et al., 2002). There are acceptable and unacceptable methods of forming comparison groups and the validity of the results will vary depending on how the comparison group was formulated. The strongest inference of causality is reached with the random assignment method. Eligible participants are randomly assigned to either the problem-solving court program or to a comparison group. Random assignment provides the greatest likelihood that the groups started out with an equal chance of success, and is the best indicator of program effectiveness (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Reichardt, 2011; Shadish et al., 2002; Telep et al., 2015). Some problem-solving courts are reluctant to use the random assignment method as it denies potentially effective services to eligible participants. Nonetheless, random assignment is a strong choice for programs with insufficient capacity, and a number of courts with insufficient capacity have successfully used random assignment to form comparison groups (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999). Indeed, there is one study of a Mental Health Court in which researchers were able to randomly assign participants with felony or misdemeanor charges to either a Mental Health Treatment Court or to treatment as usual and then studied them for two years (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005). Results showed that, relative to the control participants, those in the Mental Health Court developed stronger independent living skills and reduced their substance problems. Although graduates of both groups were equally likely to spend additional time in jail, those in the Mental Health Court group did so for less serious offenses. There have been no other random control trials published in the literature.

A second acceptable method to form comparison groups is the quasi-experimental comparison group. This group is formulated from individuals who were eligible for the drug court program, but did not enter for reasons unlikely to be related to their outcomes. A third method is the matched comparison group, where staff construct a comparison group from a large and heterogeneous pool, such as a statewide probation database. There are also unacceptable methods to forming a comparison group (Reichart, 2011; Shadish et al., 2002). Comparison groups should not be formulated from individuals who refused to enter the problem-solving court, were denied access to the problem-solving court because of criminal or clinical histories, individuals who dropped out of problem-solving court, or individuals who were terminated prematurely from the problem-solving court program. It is likely these individuals were disadvantaged from the outset, and their inclusion in comparison groups will bias the results of any comparison.

Digging deeper, there are taxonomies that classify applied research designs, which researchers use to evaluate interventions in order to determine if they are evidence-based programs. One of the best classification systems, titled the Scientific Method Scale, developed at the National Institute of Justice,

dates back to 1997 (Sherman, Gottfredson, MacKenzie, Reuter & Bushway, 1997). It identifies five levels of research rigor ranging from simple correlations to randomized, controlled experiments. The levels are: Level 1) a simple correction between a crime intervention (i.e., across programs) and a measure of crime (i.e., recidivism); Level 2) a simple correlation between a crime intervention (i.e., across programs) and a measure of crime where the interventions occurred prior in time to the measure of crime; Level 3) comparing a group with the program to a group without the program on the measure of crime; Level 4) comparing a group with the program to a group without the program on the measure of crime where there is control over irrelevant factors usually demonstrated by showing that the non-equivalent comparison group is similar to the treatment group on all but minor factors that are not-likely to make a difference (i.e., by matching individuals in the treatment and comparison group on all of the relevant factors; Level 5) the use of random assignment of the treatment and control so that groups are comparable at the beginning of the experiment. Sherman et al. (1997) and others that followed this approach in the criminal justice arena adopted this or modified taxonomies and identified Level 4 and Level 5 as rigorous designs with the former called quasi-experiments and the latter randomized control trials (Friendship, Street, Cann, & Harper, 2005). As discussed above, Lowder et al. conducted a meta-analysis of outcome studies of Mental Health Courts that included 17 experimental or quasi-experimental outcome studies (Level 4 or Level 5 studies) completed between 2004 and 2015.

One way that researchers attempt to make non-equivalent comparison groups similar to each other is to measure the crime outcome before the program begins and then again when the intervention is over to control for initial differences between the treatment and comparison group. Campbell and Stanley (1963), Cook and Campbell (1979), and Shadish et al. (2002) refer to these types of Level 4 quasi-experiments as non-equivalent comparison studies with identical pretests and posttests. Another way that researchers make non-equivalent groups similar to each other is by matching participants in both groups on all relevant variables so that, on average, the groups are similar enough before the study begins to attribute differences between the groups to the treatment. Matching across a large number of variables can be difficult because it requires a large number of participants to be able to find matches on the critical factors. One way to create matches with large numbers of participants is to treat group membership as a dependent variable and predict the likelihood of every person ending up in each group (i.e., the selection process) using the factors that are likely to impact the crime measure. The resulting measures of selection likelihood (i.e., probabilities) are called propensities and the type of matching is called propensity matching (Austin, 2011; Rosenbaum & Rubin, 1983).

Propensity matching constructs a non-equivalent control group design by using sophisticated statistical analyses (i.e. logistic regression) to model the selection process differentiating those who were in the treatment condition from those who were not. Common matched selection factors in the criminal justice arena include demographics, risk assessments, type of index offense, criminal history and so on. In the end, each individual receives a probability score – the probability that he or she would end up in the treatment group. Researchers select those not in the treatment group who have an equal probability of ending up in the treatment group (as those who are actually in the treatment group) and make them the comparison sample. This process simulates a true randomized experiment in which participants have an

equal probability of assignment to the treatment and experimental groups – that is, the result of an unbiased coin toss.

One example of a propensity matching outcome study of Mental Health Courts is Anestis and Carbonell's (2014) comparison of 198 offenders participating in a mental health problem-solving court in the Southern United States to 198 matched offenders in the traditional court system. The matching variables included age, severity of the index offense, mental diagnosis, homeless status, type of index offense, level of index offense (e.g., misdemeanor vs. felony) and 26 other possible confounds. After matching, the two groups equivalent on these factors were significantly different on outcome measures of recidivism and time until new arrest showing that the Mental Health Court participants were less likely to recidivate, and when they did, it took them longer to do so compared to those in the traditional courts. This is an example of a Level 4 outcome study (Sherman et al., 1997).

F. Using Data and Evaluation Results to Manage Programs

The final step in the evaluation process is using results from data analysis and evaluation to adjust program practices. Carey et al. (2008) found that drug court programs that reported program statistics and used evaluation data to modify court operations had higher graduation rates (60% vs. 39%) and better results in terms of outcome costs (34% vs. 13%) compared to programs that did not. In their 2012 study, Carey et al. found that programs benefited substantially from using both their own program statistics to modify court operations and from using the results of independent evaluations to modify court operations. Programs that made modifications based on regular reporting of program statistics experienced 105% reduction in recidivism and 131% increase in cost savings, while those that used results of independent evaluations showed an 85% reduction in recidivism and 100% increase in cost savings. (Carey et al., 2012).

Because Mental Health Courts are a relatively new addition to the problem-solving court family, studies that directly show the advantage of evidence-based policy making in this area are lacking. Nonetheless, the program evaluation literature is not silent on this issue. Instead, it recommends a recursive approach in which data are collected to modify decisions that have policy implications (Linfield & Posavac, 2018; Rossi, Lipsey, and Henry, 2019). In fact, an area of program evaluation, referred to as implementation science is concerned with studying the conditions that promote the use of research findings and the results of evidence-based practice studies into the daily practice of program interventions in order to increase both the quality and the effectiveness of services (Bauer, Damschroder, Hagedorn & Kilbourne, 2015). Implementation science focuses on four areas of measurement: a) fidelity - adherence to the program protocol as developed, b) dose delivered - the number of program units, hours or sessions provided, c) dose received – the extent to which the recipients were receptive or engaged in the program, and d) program quality - how well the staff executed the various program components (Durlak & DuPre, 2008; Fixsen, Naoom, Blase, Friedman, & Wallace, 2009; Glasgow, Vogt, & Boles,1999; Morrel-Samuels et al. 2018). Implementation studies begin with a well-developed and researched program theory or logic model, which is necessary to identify pertinent variables and test relationships among them. Efforts at evidence-based decision making for Mental Health Courts in Nebraska should make use of implementation science as it is the current standard in the program evaluation field.

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