IDAHO MENTAL HEALTH COURTS EVALUATION REPORT

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INTRODUCTION

Mental Health Courts

In general, mental health courts (MHCs) are specialized courts for defendants with mental illness. Nationally, MHCs vary considerably in practice, but most include treatment and community support, the use of sanctions and incentives to encourage adherence to rules, and a team of court staff and mental health professionals led by the MHC judge (Almquist & Dodd, 2009). Many MHCs reduce or dismiss charges for participants who successfully complete all requirements (Boothroyd et al., 2003).

Research demonstrates that MHCs reduce recidivism compared to treatment as usual, but findings regarding other outcomes have been mixed (Edgely, 2014; Honegar, 2015, Cross, 2011; Sarteschi, Vaughn, and Kim, 2011). Although a considerable amount of research has focused on the practices and components of MHCs that lead to reduced recidivism, no clear consensus has emerged (Honegger, 2015; Edgely, 2014; Cross, 2011; Wales, Hilday, & Ray, 2010; Frailing, 2010).

Pursuant to the Idaho Drug and Mental Health Court Act, Idaho MHCs seek "to reduce the overcrowding of jails and prisons, to reduce alcohol and drug abuse and dependency among criminal...offenders, to hold offenders accountable, and to reduce recidivism." The first MHC in Idaho commenced in Bonneville County in 2002. Currently, there are eleven MHCs in Idaho—one or more operating in each of the seven judicial districts.

This Evaluation

This first statewide evaluation of Idaho MHCs used data from **MHC participants** (n = 715) and a **comparison group** (n = 128). This report includes felony and misdemeanor recidivism outcomes for both groups including an analysis of types of re-offenses and recidivism by criminogenic risk. The report also presents analyses of graduation for MHC participants, descriptive information about MHC participants and comparison group members, and information about MHC practices from interviews, observations, and results of a MHC team-member survey. Finally, included are some exploratory analyses linking MHC processes to outcomes. The following paragraphs summarize conceptualization and measurement of key outcomes and indicators and give a brief explanation of the analyses performed for each section of the report.

MHC Participants

The sample of MHC participants (n = 715) included all individuals who began participation in an Idaho MHC between January 1, 2010 and December 31, 2014.

Comparison Group

The comparison sample (n = 128) consisted of all individuals who received any Assertive Community Treatment (ACT) services any time between January 1, 2010 and December 31, 2014, had ever been in the custody of the Idaho Department of Correction (IDOC), had an LSI-R score of 18 or higher, and had not participated in a MHC.

1. Recidivism

Recidivism data came from court records from the legacy Idaho Statewide Trial-court Administrative Records System (ISTARS) and Odyssey, which is Idaho's new case management system. A filing during the follow-up period that resulted in a misdemeanor or felony conviction counted as recidivism.

Exclusions. To be consistent with other statewide evaluations of problem-solving courts, a number of low-level misdemeanors did not count as recidivism (see Appendix A). Filings in the first 60 days after MHC start date also did not count as recidivism, because these charges likely resulted from the incident that led to participation in MHC.

Follow-up Period. Length of the follow-up period ranged from one to six years. The follow-up period began with intake into court for MHC participants. The follow-up period started January 1, 2010 for comparison group members who were already enrolled in Assertive Community Treatment (ACT) prior to that date. The follow-up period began on the day ACT services began for comparison group members who started ACT services after January 1, 2010. The follow-up period ended December 31, 2016 for all individuals.

Analyses and Results. Results include the recidivism rate for MHC participants and comparison group members and the breakdown of felony and misdemeanor recidivism for each group. Results also include the types of recidivism offenses for each group. MHC participants had a lower overall rate and a lower felony rate of recidivism than the comparison group. This report also included average time to re-offense, average number of re-offenses, and recidivism rates by criminogenic risk (Level of Service Inventory-Revised or LSI-R scores). Finally, Cox regression analyses tested how MHC participation and other characteristics relate to the probability of felony and misdemeanor recidivism. Results suggested MHC participants were less likely than comparison group members to have felony recidivism, and older participants were less likely to have felony or misdemeanor recidivism.

2. Graduation (MHC Only)

When participants successfully complete all requirements, they graduate from MHC. Participants who do not graduate from MHC may terminate unsuccessfully or neutrally. Participants are unsuccessful if they drop out of court or the MHC team terminates their participation. Unsuccessful terminations often result in incarceration. Neutrally terminated participants typically transferred to another problem-solving court or another jurisdiction, their sentence may have expired, or their participation ended due to some reason other than non-compliance or undesired behavior.

Analyses and Results. An analysis of graduation by risk revealed that graduation related strongly to risk; lower risk participants were far more likely to graduate than higher risk participants. Logistic regression results suggested males, older participants, lower risk participants, and those who needed fewer medical and planning, assessment, and reporting services were more likely to graduate. An examination of recidivism by graduation revealed that individuals who graduate were less likely to recidivate (both felony and misdemeanor recidivism).

3. MHC Participants and Comparison Group Members

Differences in outcomes between MHC and the comparison group could result from preexisting differences between the two groups. To better understand both groups and to examine preexisting differences, the evaluation includes an examination of group-member demographics, including age, gender breakdown, risk, diagnosis, and services received.

Analyses and Results. Both groups had more males than females, but females made up a significantly smaller percentage of the comparison group compared to MHC participants. Both groups were a little over 80% white/non-minority. The average age for both groups was 35. MHC participants had slightly higher risk (average 32) than the comparison group (average 28). There were no significant differences in the rates of diagnoses between the two groups, but the sample size for some of the diagnosis in the comparison group was quite small. On average, MHC participants and comparison group members received about the same amount of medical, recovery support, and planning/assessment/reporting services. However, on average, MHC participants received more than three times as much drug and mental health treatment services.

4. MHC Processes and Operations

This section reports on MHC processes and operations that are based on the results of a review of research, review of state and national standards, a team member survey, interviews with judges, interviews with coordinators, and participant focus groups. Observations of court staffings and hearings also informed process and operations analyses. The following paragraphs briefly describe the method for each component of the process evaluation.

Literature and Standards Review. This evaluation included a literature search and review of articles, studies, and reports on MHCs. A total of 39 documents were reviewed, the majority of them published in peer-review journals. Some themes emerging from the literature included the history and development of MHCs, theory driving MHCs, outcomes, key processes, and limitations of current research. In addition to the review of articles, both Idaho Standards and Guidelines for MHCs and the NADCP Adult Drug Court Best Practice Standards (Volume I, 2013 and Volume II, 2015) were reviewed.

MHC Team Member Survey. 107 MHC team members from across the state completed a survey about their court's process and operations. The survey included items about MHC staffings and hearings, judicial leadership, team functioning, and the respondent's role on the MHC team. The survey included open-ended items and many team members provided comments and details about MHC operations.

Site Visits, Interviews, and Observations. A major component of the process evaluation was a site visit to each court by an evaluator. Site visits included an observation of a court staffing, an observation of a court hearing, an interview with the court coordinator, a brief interview with the judge, and a focus group with court participants.

Process and Operations Analysis and Synthesis. Evaluators analyzed the team member survey, observations, coordinator and judge interviews, and participant focus groups separately for themes and findings. It is beyond the scope of this report to include outcomes of each process analysis.

Instead, evaluators identified major themes supported by multiple process analyses. Major themes included:

- Adherence to entrance criteria
- Orienting new participants to MHC
- Team communication
- The importance of the judge
- Team-member training, knowledge and buy-in,
- ACT and other services

Emphasizing incentives while minimizing sanctions.

Literature review results and information from state and national standards supplement findings from the process evaluation.

5. MHC Processes Related to Outcomes

The final section of the report connects findings from the process and outcome evaluations. For these exploratory analyses, courts were divided into groups based on process findings (low, medium, and high). This section reports recidivism and graduation rates for the low, medium, and high groups for processes that appear related. These analyses revealed team functioning, judicial leadership, and staffing quality appear related to recidivism outcomes, and staffing quality and communication in staffings appear related to graduation.

1. RECIDIVISM

MHC Participants had a lower rate of overall recidivism than the comparison group

34% MHC Recidivism Rate

43% Comparison Recidivism Rate

Recidivism- A filing during the follow-up period, that resulted in a misdemeanor or felony conviction. Some statutes and filings were excluded from counts of recidivism (See Appendix A).
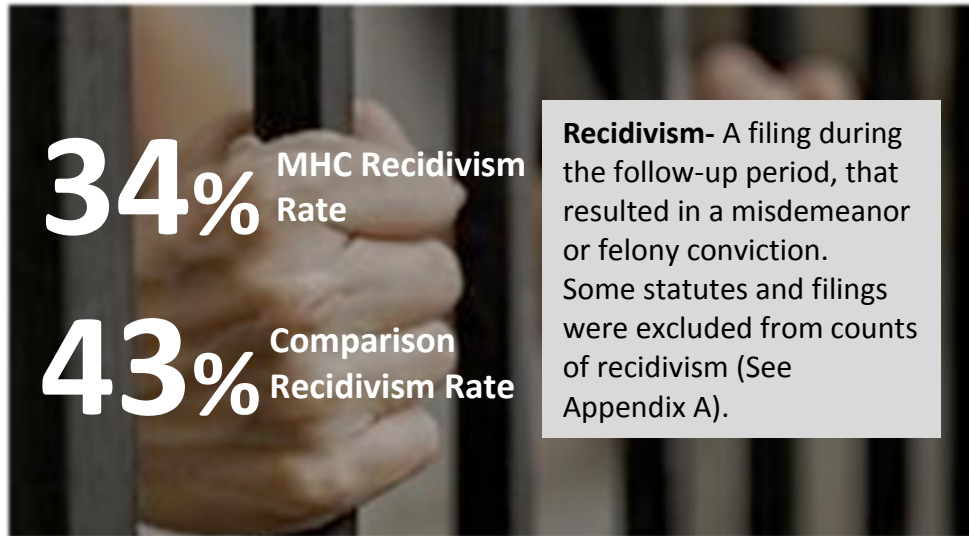
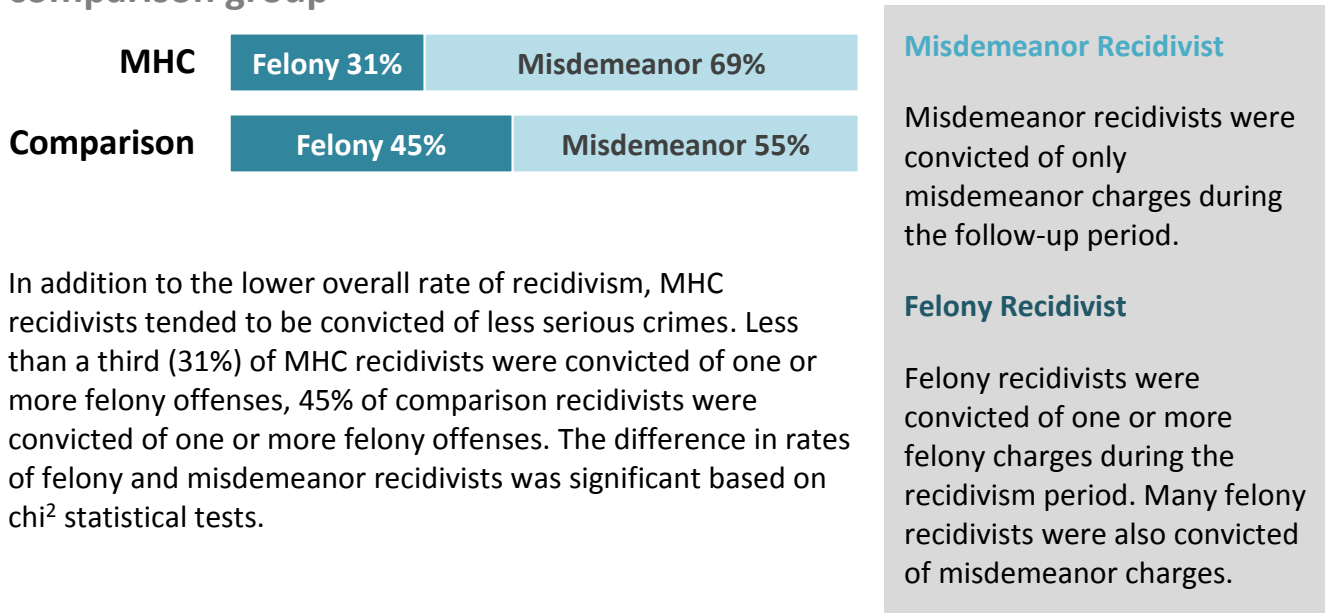MHC recidivism was 9% lower than comparison recidivism. The difference was significant based on chi^2 analyses. Appendix B reports the felony and misdemeanor recidivism rates for each MHC.

MHC participants had a lower rate of felony recidivism than the comparison group

MHC	Felony 31%	Misdemeanor 69%
Comparison	Felony 45%	Misdemeanor 55%

In addition to the lower overall rate of recidivism, MHC recidivists tended to be convicted of less serious crimes. Less than a third (31%) of MHC recidivists were convicted of one or more felony offenses, 45% of comparison recidivists were convicted of one or more felony offenses. The difference in rates of felony and misdemeanor recidivists was significant based on chi^2 statistical tests.

Misdemeanor Recidivist

Misdemeanor recidivists were convicted of only misdemeanor charges during the follow-up period.

Felony Recidivist

Felony recidivists were convicted of one or more felony charges during the recidivism period. Many felony recidivists were also convicted of misdemeanor charges.

Felony recidivism often included convictions of property, drug, and crimes against persons

83%

Mental Health Court		Comparison Group
35%	Property	31%
33%	Drug	26%
15%	Person	24%
11%	DUI	5%
6%	Other	14%

81%

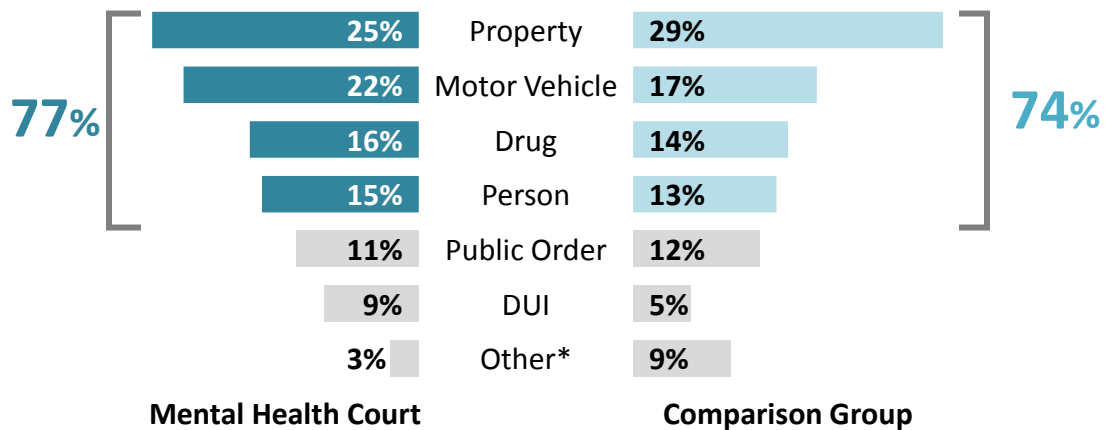**Mental Health Court** **Comparison Group**
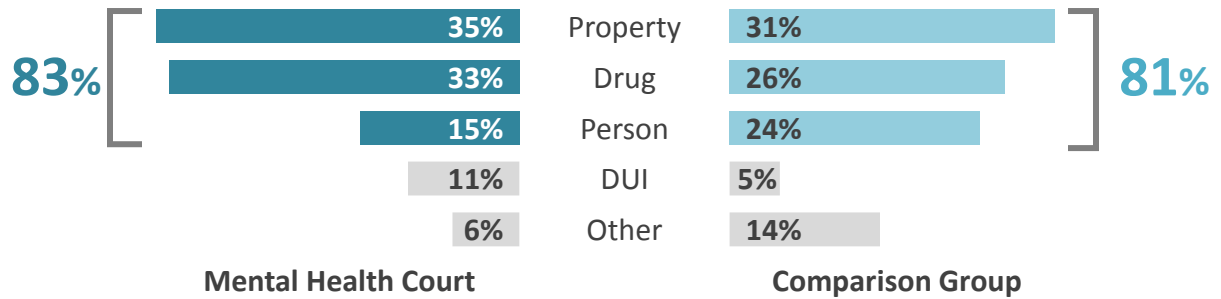
MHC participants and comparison-group members recidivated with similar types of felony crimes. In both groups, property, drug, and crimes against persons accounted for over 80% of felony recidivism.

Number of Charges Convicted and Sample Size

Percentages in this report are typically based on the number of individuals. Percentages of types of recidivism crimes are based on the total number of charges convicted rather than the total number of recidivists. Individual recidivists often had multiple convictions.

Misdemeanor recidivism often include property, motor vehicle, drug, and crimes against persons

77%

Mental Health Court		Comparison Group
25%	Property	29%
22%	Motor Vehicle	17%
16%	Drug	14%
15%	Person	13%
11%	Public Order	12%
9%	DUI	5%
3%	Other*	9%

74%

Mental Health Court **Comparison Group**

MHC participants and comparison-group members had similar types of misdemeanor convictions. Property, motor vehicle, drug, and crimes against persons accounted for around 75% of misdemeanor recidivism convictions in both groups. The comparison group had significantly more other convictions.

In both groups, the average time to recidivism was about 600 days

	MHC	Comparison
Average	624	577
Standard Deviation	482	570
Range	70 - 1971	13 - 1712

On average, it appears MHC participants went longer before recidivating; however, an independent samples *t* test indicated that the difference was not significant. Note the large range of days to recidivism and the large standard deviation. High variability decreases the statistical power to detect significant differences in *t* tests.

MHC participants with the lowest risk scores had the highest rate of felony recidivism of all MHC participants
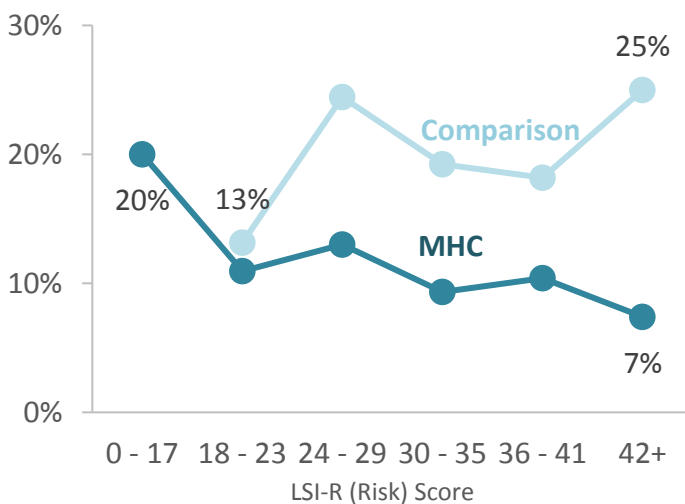
Problem-Solving Courts and Risk

Two previous statewide evaluations also found the lowest-risk problem-solving court participants had poorer outcomes than higher-risk participants did. Increasing evidence confirms that problem-solving courts are most effective for high-risk individuals and not appropriate for those with low criminogenic risk. See the reports here: https://isc.idaho.gov/solve-court/rd

Level of Service Inventory-Revised (LSI-R)

The LSI-R is a quantitative assessment of offender characteristics and other contextual factors used to make sentencing, supervision, and treatment decisions. The score is an indication of criminogenic risk or risk of future criminal behavior. Trained professionals administer the 54-item survey by interview. Numerous studies demonstrated the reliability and validity of the LSI-R.

The lowest criminogenic risk (LSI-R score) MHC participants had the highest rate of felony recidivism (20%). Recidivism rates in MHC participants decreased as risk scores increased; the highest risk MHC participants had the lowest rate of felony recidivism (7%).

The criminogenic risk of individuals in the comparison group appeared unrelated to rates of felony recidivism.

Misdemeanor recidivism was highest for MHC participants with LSI-R scores between 30 and 35
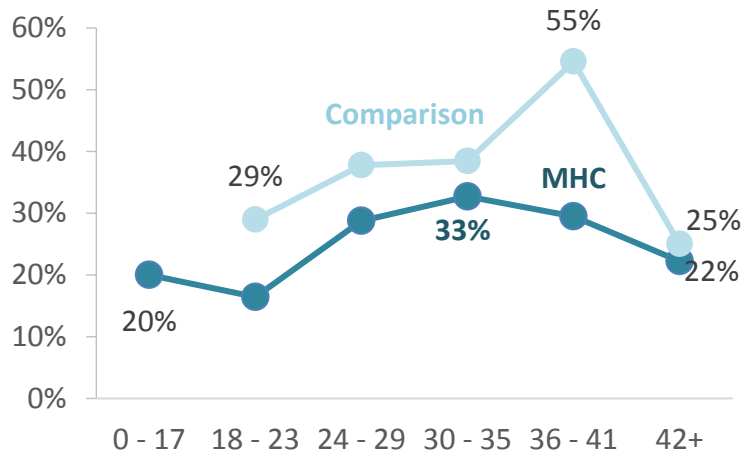
In contrast to felony recidivism, lower-criminogenic risk MHC participants had lower rates of misdemeanor recidivism (20% and 16% in the two lowest risk groups). The misdemeanor recidivism rate was 33% for MHC participants with risk scores between 30 and 35. For both MHC and the comparison group, misdemeanor recidivism was highest in the mid to upper risk scores and lower in low and high risk scores.

Comparison group members and younger individuals were more likely to have felony recidivism
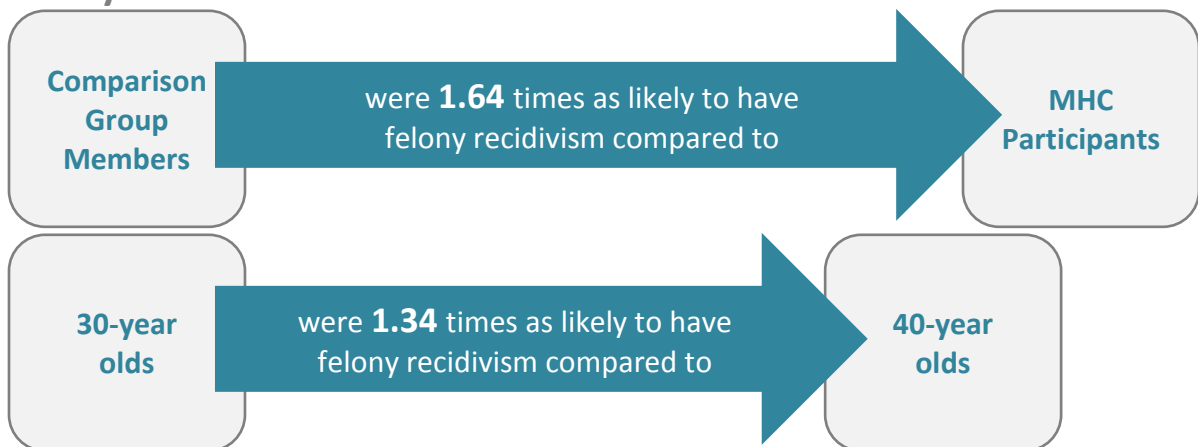
Cox Regression (time-sensitive regression analysis) identified variables related to felony and misdemeanor recidivism. The figure above reports the hazard ratios for MHC participation and age. Analyses suggest comparison group members were more likely to have felony recidivism than MHC participants, and younger individuals (in either group) were more likely to have felony recidivism than older individuals.

Interpreting Hazard Ratios

A hazard ratio compares the risk of a certain outcome (recidivism) at two levels of a predictor variable (such as age or MHC participation). A hazard ratio of 1 indicates that the risk is no different at one level of the predictor than the other. A hazard ratio greater than one indicates the risk of the outcome is greater at the one level of the predictor. For example, the figure on the previous page indicates that the risk of felony recidivism for comparison group members is 1.64 as much as the risk for MHC participants, or in other words, if 10% of MHC participants have felony recidivism, it is likely that 16 % of the comparison group will have felony recidivism.

Younger individuals were more likely to have misdemeanor recidivism

30-year olds → were **1.25** times as likely to have misdemeanor recidivism compared to → **40-year olds**

MHC Participation and Age

MHC participants had a lower risk of felony recidivism than comparison group members. Despite the affect MHC participation had on risk of felony recidivism, results of the Cox regression indicated that participation in MHC did not influence the risk of misdemeanor recidivism.

Younger individuals in both groups had higher risk of felony and misdemeanor recidivism. The effect of age was greater for felony recidivism (1.64) than misdemeanor recidivism (1.25).

2. GRADUATION (MHC ONLY)

Low-risk participants graduated at high rates and high-risk participants graduated at low rates
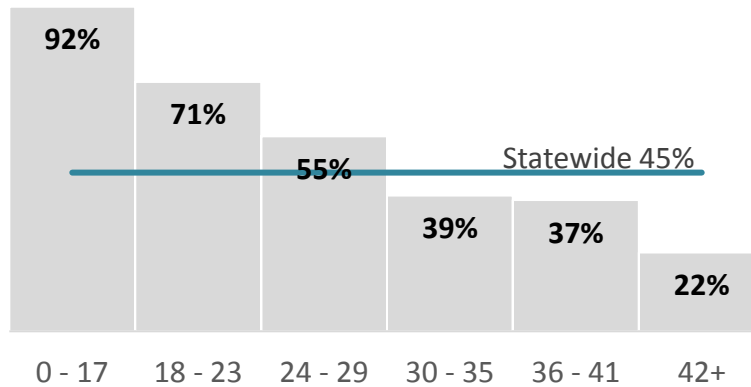

The overall MHC graduation rate was 45%. See Appendix B for the graduation rates of each MHC. There was a clear inverse relationship between criminogenic risk and graduation rate. Low-risk participants graduated at much higher rates than high-risk participants. 92% of the lowest-risk MHC participants graduated. Only 22% of the highest risk MHC participants graduated.

Older participants, males, low risk, and those who received less medical or planning, assessment, and reporting services were more likely to graduate
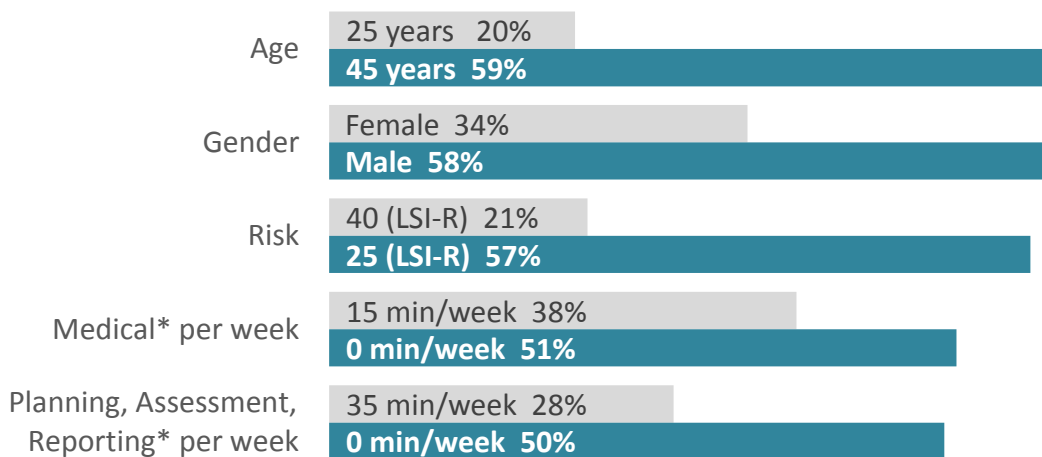
Note this chart shows logistic regression model predictions of graduation rates, not observed findings.
*See Appendix A for examples of Medical Services and Planning, Assessment, Reporting Services.

Logistic regression revealed participant characteristics that influence graduation rates for MHC participants. The chart on the previous page shows model-predicted graduation rates for participants at different levels of variables that influence graduation rate. Results indicate MHC participants graduate at higher rates if they:

- Are older
- Are male
- Have lower risk scores
- Received less medical service
- Received less planning, assessment, and reporting services

Age and Outcomes

Age was the only variable found significantly related to all three outcomes in the MHC evaluation. Older individuals were less likely to have felony and misdemeanor recidivism and older MHC participants were more likely to graduate.

Criminality peaks in early adulthood and declines with age (Ulmer & Steffensmeier, 2014). Which specific factors drive the age-related decline in criminality is an unsettled question.

Findings of this evaluation suggest older participants have better outcomes in MHC. Judges, coordinators, treatment providers and other team members should understand that compared to older participants, younger participants may have additional needs, different motivations, require additional resources and alternative strategies in order to be successful in MHC. Differences in older and younger participants should be studied further.
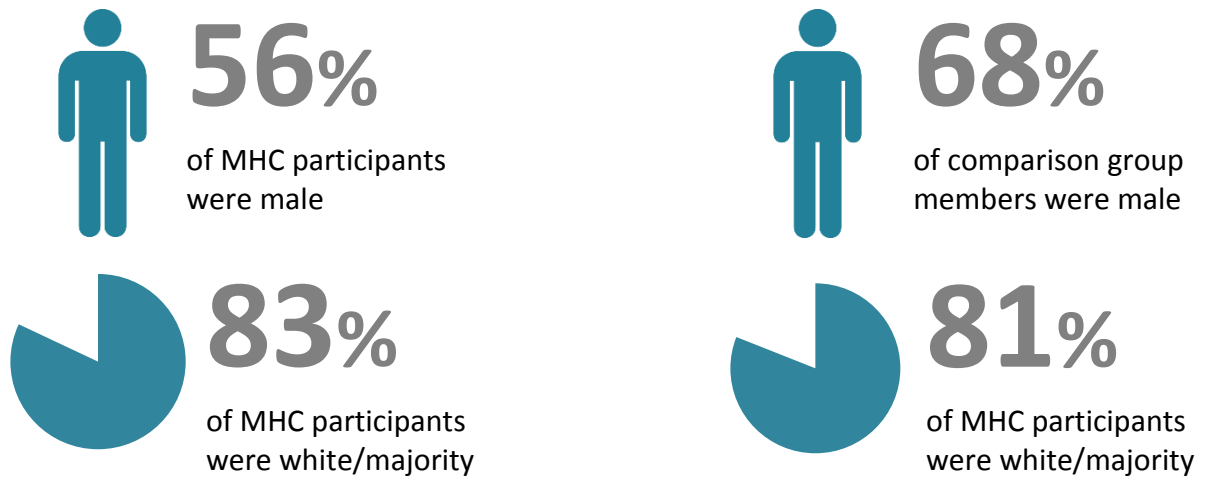
Graduates had lower rates of felony and misdemeanor recidivism than non-graduates
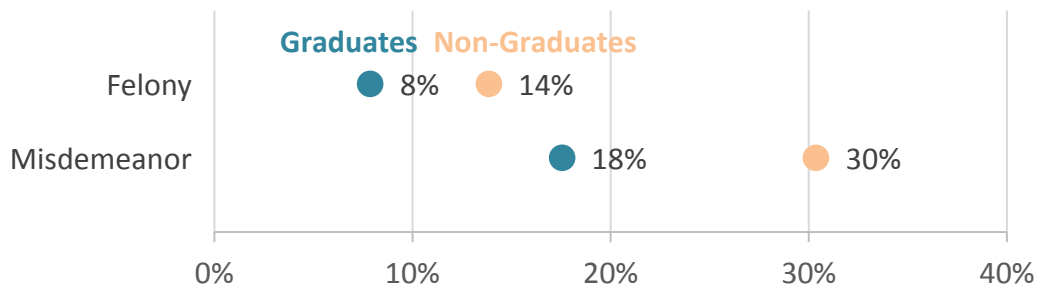
Compared to non-graduates, MHC graduates had lower rates of felony and misdemeanor recidivism. The differences in recidivism rates for graduates and non-graduates were significant based on chi^2 statistical tests.

3. MHC AND COMPARISON DEMOGRAPHIC AND SERVICE INFORMATION

MHC and Comparison Group were Similar in Gender and Race

56%
of MHC participants were male

68%
of comparison group members were male

83%
of MHC participants were white/majority

81%
of MHC participants were white/majority

Males made up over half of both groups, but the comparison group had a significantly higher percent of males than MHC (based on a chi^2 test). MHC participants and the comparison group were over 80% white/non-minority. There were no significant differences in minority status between the MHC participants and members of the comparison group.

MHC and Comparison Group were Similar in Age, but MHC had Higher Risk

Measure	MHC		Comparison	
	Average	SD	Average	SD
Age (years)	35	10	35	10
Risk (LSI-R)	32	7	28	7

Matching

Evaluations often match treatment and comparison groups on key variables and risk factors. Due to limited number of comparison group individuals, the evaluation did not attempt to match MHC and comparison individuals. However, the groups were similar in terms of white/minority breakdown and age. MHCs had a higher average risk and a higher percent of females.

Both MHC participants and the comparison group members had an average age of 35 years old. MHC participants had an average risk score of 32, significantly higher (based on *t*-test) than 28, the average risk for members of the comparison group.

MHC participants and comparison group members looked similar in terms of mental health diagnosis

MHC **Comparison**

|	MHC	Comparison
Bipolar	42%	37%
Major Depressive	25%	9%
Schizoaffective	18%	31%
Schizophrenia	12%	20%
Psychotic NOS	2%	3%
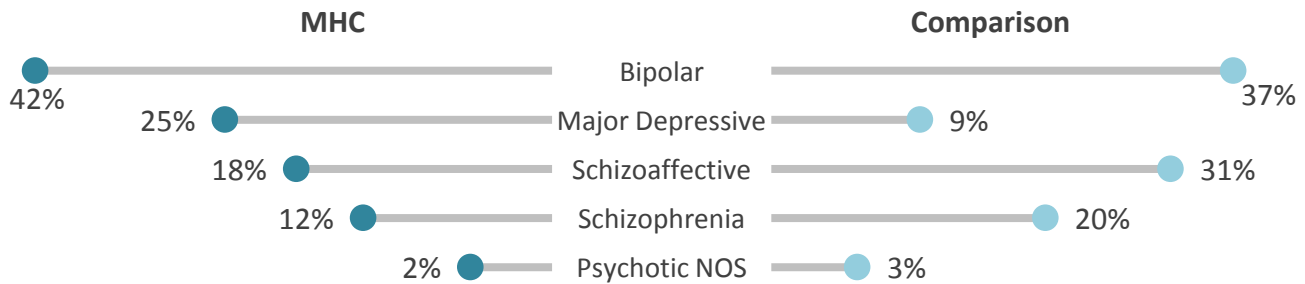
Based on information from the Department of Health and Welfare, MHC participants and comparison group members had similar rates of mental health diagnoses. MHC participants had a higher rate of bipolar and major depressive and lower rates of schizoaffective and schizophrenia, but these differences were not significant according to results of chi^2 statistical tests. The low sample size of the comparison group decreases statistical power to detect significant differences.

MHC participants had a significantly higher average treatment minutes per week than comparison group members
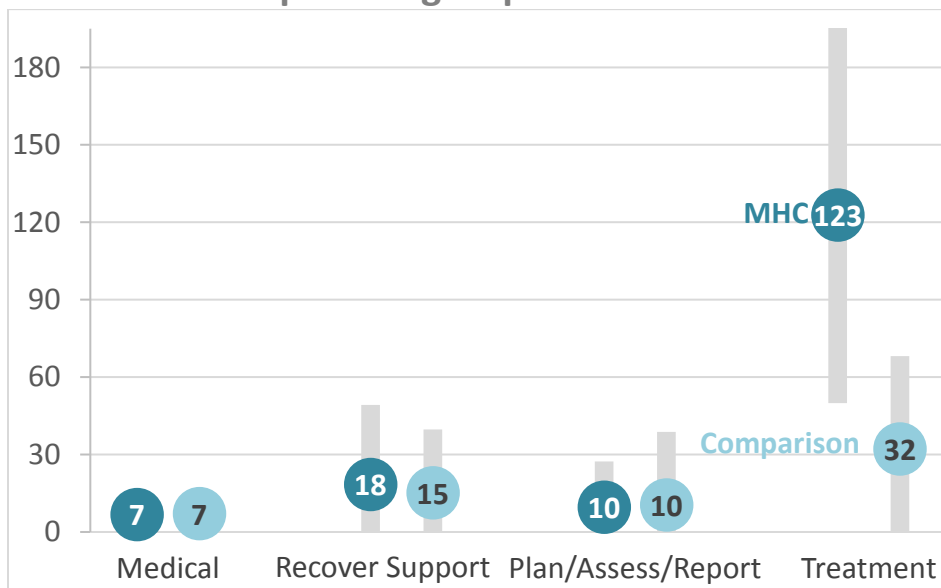
Standard Deviation

Standard deviation (SD) is a measure of the spread of the data. The gray bar indicates the range from one SD below the average to one SD above it. In general, the average minutes per week for about 68% of individuals will fall within the range indicated by the gray bars.

On average, MHC participants received 123 minutes per week of treatment services, significantly higher (based on *t*-test) than the comparison group average of 32 minutes per week. There were no significant differences in average medical, recovery support, or planning/assessment/reporting services between the two groups. Clearly, a benefit of MHC participation is increased access to mental health and substance abuse treatment. Interestingly, regression analyses did not find treatment minutes per week significantly related to any of the three outcomes.

Treatment Received and Recidivism

MHC participants received significantly more substance abuse and mental health treatment than comparison group members. Intuitively, it appears MHC participants benefited from additional treatment and those benefits may have contributed to lower rates of felony and overall recidivism, but the importance of the role treatment amount played in decreased recidivism is not clear based on evaluation results.

Cox regression analyses did not find treatment minutes per week related to the likelihood of felony or misdemeanor recidivism, suggesting other elements of MHC are driving lower recidivism rates. On the other hand, treatment may have important influences on recidivism, but regression analyses missed the relationship due to complex interactions or high variability.

Treatment amount may vary considerably from individual to individual based on risk and need and may vary considerably based on time in treatment or time in court. The effect of treatment on outcomes could vary depending on individual criminogenic risk, severity of need, or time in treatment or court. It was beyond the scope of this evaluation to test for complex interactions.

The standard deviation for treatment was large, particularly for MHC participants, indicating a lot of variability in the amount of treatment individuals received. Regression analyses are less able to detect significant relationships in variables with very high variability.

Future research and evaluation should focus on treatment, how it varies between individuals and over time, and how it affects outcomes such as recidivism and graduation.

4. MHC PROCESS AND OPERATIONS

Adherence to Entrance Criteria is Necessary

State and national standards, research on drug courts, judges' comments, and team-member survey responses underscore the importance of admitting appropriate participants to MHC.

According to the National Association of Drug Court Professionals (NADCP) standards, courts who admit participants with low criminogenic risk and low service needs into a problem solving court intended for high-risk and high-need participants may waste resources and increase rates of recidivism.

Two Idaho MHC judges reported improvement in retention and graduation as their courts improved screening practices to ensure that participants had high criminogenic risk, high service needs, and qualifying diagnoses.

MHC team members acknowledged room for improvement in adhering to target population in the intake process:

> **38%** said **all** participants match entrance criteria
>
> **58%** said **most** participants match entrance criteria
>
> **4%** said only **some** participants match entrance criteria

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Standards & Guidelines: Target Population

To qualify for MHC an applicant must have:
- a serious and persistent mental illness
- two or more functional deficits
- one or more indicators of high service needs

In addition, MHCs are intended for individuals whose mental illness relates to his or her current charge(s) and who has moderate-high or high criminogenic risk, and does not pose a safety risk to the community, other participants, or MHC and treatment staff.
Quick referral and placement into MHC can increase participant motivation to enter and remain in treatment.

(Standards and Guidelines 1.3, 1.7, 1.8, 1.10)

Handbooks and Orientations Prepare Participants for MHC

State and national standards and research underscore the importance of preparing participants for drug court. Many participants found handbooks and orientations or pre-phases important during the difficult adjustment to participation in MHC.

Research suggests individuals who are fully aware of requirements are more likely to graduate (Almquist & Dodd, 2009, p. 18). MHC participants reported a difficult adjustment period during their first month in MHC. During this time, they felt anxious and unsure. To help with the transition, some courts have orientations and one court has a "pre-phase." Participants who experienced an orientation or pre-phase reported better understanding of the rules upon entry, and a shorter adjustment period.

Standards: Participant Handbook and Preparing Participants

Each MHC participant shall receive a handbook setting forth:

- Expectations and requirements for participants
- The general nature of incentives and sanctions
- The potentiality of noncompliance leading to termination

(Standards and Guidelines 4.14, 3.14, 4.13, 3.19)

MHC Team Communication is Key to Success

Both national and state standards make clear that open communication between members of the drug court team is essential for court functioning. MHC judges, coordinators, and team members expressed the importance of open communication. Participants in focus groups also noted the stress and anxiety they had felt when there was a breakdown or failure of communication between team members.

The Importance of Communication

Judges and coordinators expressed the importance of communication between team members. When teams function well there is frequent, relevant, and respectful communication, teams feel free to disagree, and disagreements are resolved through honest and respectful communication. In contrast, coordinators discussed current or past problems that resulted from breakdowns in communication.

Communication and consistency in staffings is essential to MHC success (Trupin et al., 2001, p. 33).

"If probation and treatment and everybody's not on the same page…that makes it more challenging for the judge, for the participant, for everything."

--Coordinator

The Central Role of the Judge in MHC

Evidence of the important role the judge plays was found in state and national standards, research, and from judges, coordinators, participants, and team members.

Researchers have described the judge's role as central to the success of MHC (Thompson et al., 2007). Researchers have hypothesized and theorized the role of the judge and particularly the judge-participant relationship has important influence on outcomes (Edgely, 2014; Wales, et al., 2010; Gottfried, et al., 2014).

In interviews, many coordinators described judges' interactions with participants as warm, engaging, genuine, positive, thoughtful, and respectful. They perceived judges as stern when needed, holding participants accountable, but also positive, motivating, and focused on participant strength.

In focus groups, most participants held positive opinions of their judge. They often described judges as the first authority figure to show genuine interest in them. Most participants felt the judge truly cared about their success. They reported the judge makes a point to build up their self-esteem, even when they had violated rules. Participants viewed judges as a source of support, and expressed desire to excel in MHC so they did not disappoint the judge. In contrast, some participants expressed dissatisfaction with their judge. Some participants felt their judge was not knowledgeable or understanding of mental health and substance abuse issues. Some participants felt the judge imposed incentives and sanctions that were inconsistent, unfair, or overly harsh.

One coordinator suggested that participants know when a judge is not sincere when interacting with participants. According to the coordinator, both judge and participant struggle when their relationship is not genuine.

Team member ratings and comments of judges were mostly positive. Many team members felt their judge was knowledgeable about the MHC model and displayed effective leadership in staffings and hearings. On the survey, a few MHC team members felt their judge was biased, did not foster open communication, or needed additional education and training on mental health and substance use issues and the MHC model.

Standards and Guidelines: Judge's Role

The judge serves as leader of the MHC team and plays an active role in:
- MHC staffings
- Conducting status hearings
- Imposing rewards, incentives, and sanctions
- Seeking consensus-based problem solving and planning

(Standards and Guidelines 4.6)

Importance of MHC Team-Member Training, Knowledge, and Buy-In

State and national standards, drug court research, and judge and coordinator interviews provided evidence of the importance of team member knowledge and buy-in.

Both the NADCP Standards and Idaho's MHC Guidelines highlight the importance of team member knowledge by specifying minimum training requirements for them. The NADCP Standards also cite research on the importance of team member training, some of which demonstrates the relation between team member training and desirable outcomes (Carey et al., 2008, 2012). Coordinators and Judges also emphasized the importance of training and team member knowledge. However, they also suggested that in addition to knowledge, team members needed high buy-in to the MHC model in order for courts to function successfully. One judge stated that stronger and more committed team members make for better outcomes for participants. Many judges, coordinators and team members indicated that MHCs do not hold the minimum recommended number of trainings (two per year) and meetings for addressing court issues (two per year).

Assertive Community Treatment (ACT) and Other Services

MHC participants, most coordinators, and most judges were very positive in their comments regarding ACT teams and the services they provide. Some participants suggested that ACT teams succeeded where previous treatment attempts failed because the ACT team addressed mental health and substance abuse simultaneously. According to coordinators, effective ACT teams understand the MHC model, communicate well—sharing pertinent information while protecting participant privacy, and keep participants' wellbeing and improvement the priority.

Standards and Guidelines: Mental Health Court Treatment

MHC treatment consists of ACT and should:
- Address criminogenic needs identified using the LSI-R
- Address functional deficits identified using the Idaho Standardized Behavioral Health Assessment
- Be trauma informed
- Include the use of evidence-based cognitive behavioral interventions
- Address participant motivation and engagement
- Include peer support as an integral part
- Include referrals of family members to services as needed
- Address family and parenting issues, and needs of children of participants
- Apply evidence-based services for co-occurring disorders including, but not limited to, medication
- Be responsive to individual needs and characteristics

(Standards and Guidelines 3.1 - 3.9, 3.16, 3.17)

Despite the mostly positive feedback, judges and coordinators expressed some concern about ACT teams. Some ACT teams lack personnel to adequately serve MHC participants, particularly in areas with growing need. Some coordinators had current or prior issues with poor communication with the ACT team. According to judges and coordinators, a poor relationship between the ACT team and the MHC adversely impacts participants, and court functioning and outcomes suffer.

Emphasizing Incentives and Minimizing Sanctions

All six data sources for the process evaluation support the idea that emphasizing incentives and minimizing the use of sanctions improve court functioning and lead to better outcomes.

Many judges, coordinators, team members and participants expressed concerns about overuse of sanctions and insufficient use of incentives.

In addition, the Standards and Guidelines state that incentives are more important than sanctions for changing behavior. Further, research suggests that a four to one incentives to sanctions ratio is ideal (Kubiak et al., 2001), and that sanctions for behavior that is not willfully defiant may be counterproductive (Edgely, 2014).

> According to participants, a candy bar is a sign of approval from the court - encouragement to keep going until the next hearing. Several participants reported the symbolism is more valuable than the reward itself.
>
> "Sanctions are not nearly as effective as we think they are…People overvalue the importance of sanctions."
> --Coordinator

Strategies to Minimize Sanctions

1. **Reducing or eliminating sanctions for behaviors related to distal goals**
2. **Using graduated sanctions and starting with very low-level sanctions**
3. **When appropriate, making treatment or program adjustments, or using contingency management instead of sanctions**

Instead of These Common Sanctions:

- **Jail**
- **Community service**
- **Essay writing**

Try These Alternative Responses:

- **Skill building**
- **Treatment adjustments**
- **Contingency management**

5. MHC PROCESSES RELATED TO OUTCOMES

MHCs with high team member ratings of staffing quality had lower rates of recidivism

MHCs whose team members gave high ratings of staffing quality had low rates of felony recidivism (5% compared to 14%) in teams with low ratings of staffing quality. Similarly, courts with high team member ratings of judicial leadership and team functioning had the lowest rates of felony recidivism.

Felony Recidivism by Team-Member Ratings

	Low	High
Judicial leadership	14%	6%
Team functioning	14%	7%

Courts with high team-member ratings of staffing quality, judicial leadership, and team functioning had low rates of misdemeanor recidivism.

Similar to felony recidivism, higher MHC team-member perceptions of team functioning, judicial leadership, and staffing quality were associated with lower rates of misdemeanor recidivism. Judicial leadership had the highest disparity between high and low ratings. Courts with low ratings of judicial leadership had 23% higher misdemeanor recidivism.

Misdemeanor Recidivism by Team-Member Ratings

	Low	High
Staffing Quality	34%	19%
Judicial leadership	37%	14%
Team functioning	36%	16%

Courts with high team-members ratings of staffing quality and communication in staffings had high graduation rates

MHCs had higher graduation rates when team members perceived staffings and communication in staffings as high quality. Communication had the largest disparity between courts with high and low ratings. Courts with high ratings of communication in staffings had a 12% higher graduation rate than courts with low ratings.

Graduation by Team-Member Ratings

	Low	High
Staffing Quality	44%	52%
Communication	38%	50%

Findings connecting MHC processes to outcomes are exploratory and tentative

The analyses used to produce the findings connecting team-member ratings to outcomes were less rigorous than other analyses completed in this evaluation and these findings are tentative. Although the findings make intuitive sense, please keep in mind the following:
- The unit of analyses was court and the sample size was small (n = 11).
- There were no tests of significance or controlling for possible confounding variables (for example, courts with poor communication may have also had higher-risk participants).
- There is no temporal precedence of process. Team-member ratings come from a survey implemented well after the outcomes of recidivism and graduation had taken place.

In spite of these cautions, the process portion of this evaluation clearly demonstrated that stakeholders and researchers recognize the importance of staffing quality, judicial leadership, team function, and communication in MHC. Any improvements in these areas are likely to have positive impact on MHC functioning and outcomes.

LIMITATIONS AND CONCLUSION

Notable Outcomes

Results of this first statewide evaluation of MHC in Idaho have important implications for policy decisions and the implementation of MHCs. Some notable findings of the evaluation include recidivism differences in MHC participants and comparison group members, the relation of risk to felony recidivism, and the influence of age on recidivism and outcomes. These findings are summarized briefly below.

MHC Participants Recidivated at Lower Rates

The overall rate of recidivism for MHC participants was 34%, significantly lower than the comparison group rate of 43%. In addition, MHC participants had a significantly lower rate of felony recidivism. Results of the Cox regression estimated that comparison group members were 1.64 times as likely to have felony recidivism.

Criminogenic Risk and Felony Recidivism

MHC participants with the lowest criminogenic risk had the highest rate of felony recidivism (20%) and participants with the highest risk had the lowest rate of felony recidivism (7%). In contrast, the rate of felony recidivism increased with criminogenic risk for comparison group members. This finding underscores the importance of admitting high risk and high need applicants and suggests that MHCs have the greatest benefit with higher risk participants.

Age and Recidivism and Graduation

Age was the only variable related to all three of the outcomes of interest. Older individuals were less likely to have felony and misdemeanor recidivism, and more likely to graduate compared to younger individuals. Future research and evaluation could focus on the relation of age to outcomes and strive to identify practices and supports which improve outcomes for younger participants.

How Valid are Findings?

Every evaluation has limitations. Some limitations affect the validity of evaluation findings and conclusions. The following paragraphs discuss two limitations that threaten the validity of the findings of this evaluation: The suitability of the comparison group, and the absence of information on probation violations and incarceration.

Comparison Group Suitability

For this evaluation, the only meaningful difference between the comparison group and MHC participants *should* have been participation in MHC. Otherwise, the lower recidivism rate in MHC participants could be attributable to other differences. In general, the best way to overcome this threat to validity is to randomly assign individuals to MHC or to the comparison group. Random assignment in

this case is neither feasible nor ethical. Commonly, researchers overcome this threat to validity by matching participants on key characteristics. Unfortunately, the sample size of identified individuals in Idaho with criminal-justice involvement, severe and persistent mental health issues, who had not participated in MHC, was not sufficient to employ effective matching techniques. Regression analyses is a third method to address preexisting differences between groups and was employed in this evaluation. Regression analyses control for between group differences on variables of interest.

In addition to using regression analyses, similarities between the MHC participants and the comparison group mitigated the threat of preexisting differences. In terms of age, minority status, and mental health diagnoses the comparison group appeared no different from MHC participants. The comparison group had a higher percentage of males and a lower average risk score compared to MHC participants. Cox regression models reported on in this report controlled for gender and risk.

Despite the lack of random assignment or matching, the use of regression analyses and the similarities between the MHC participants and the comparison group support the argument that the lower felony recidivism rate in MHC participants was a result of participation in MHC and not due to preexisting differences between groups.

Absence of Probation Violation and Incarceration Outcomes

A complete picture of negative outcomes of interest would include new convictions, probation violations, and incarceration. This evaluation only includes the outcomes of felony and misdemeanor recidivism (convictions during the follow-up period). The Idaho Department of Correction provided incarceration data, but incarceration findings were mostly null, and difficult to interpret. Inclusion of probation violations in future evaluations will provide context for interpreting incarceration information.

Incarceration results are particularly difficult to interpret when individuals are incarcerated without corresponding convictions (recidivism). Information on probation violations is likely key to reconciling incongruent recidivism and incarceration data. Due to inconsistent practices for documenting probation violations in ISTARS, probation violations could not be included as an outcome.

The new case management system has a uniform statewide procedure for documenting probation violations. Future evaluations should include convictions, probation violations, and incarcerations in outcomes.

Important MHC Processes and Operations

This evaluation included collecting of interview, observation, focus group, and survey data regarding important practices in MHCs. In addition, an extensive review of MHC literature, state guidelines, and national standards supplement process findings reported herein. The literature review and process data collected highlighted the importance of the following in drug court operations:

- Adhering to entrance criteria
- Preparing participants for MHC

- MHC team communication
- Judicial leadership
- Team member training, knowledge, and buy-in
- Emphasizing incentives and minimizing sanctions

Judges, coordinators, MHC team members, participants, relevant research literature, and state and national standards suggest that these are key processes. MHC teams should consider these processes as they strive to improve their practices and update their policies and procedures.

Processes Related to Outcomes

Some MHC team-member survey responses correlated with outcomes. Specifically, team member ratings of staffing quality, judicial leadership, and team function related to felony and misdemeanor recidivism rates. The higher the ratings in these areas, the lower the recidivism rate. In addition, staffing quality and communication issues in staffings correlated with graduation rates. The higher the rating of staffing quality the higher the graduation rate. The more issues team members reported with communication in staffings the lower the graduation rate.

The relation of these processes and outcomes makes intuitive sense. However, these analyses were exploratory and findings are tentative and should be interpreted with caution for a few reasons. First, the participants whose outcomes are included in this evaluation terminated participation in MHC between 1 and 6 years before the processes for this evaluation were measured. The process-outcome relationships depend on the assumption that the practices measured for the evaluation are a proxy for the practices from previous years. This assumption does not hold up if MHC practices change drastically from year to year.

Second, the analyses consisted of a simple comparison of rates across score groupings of process variables. The comparison were far less rigorous than regression analyses. In contrast to regression analyses, these analyses did not attempt to control for other variables or to rule out the possibility that apparent relationships were coincidental. In addition, the unit of analyses was court, meaning the sample size was only eleven.

Despite the lack of rigor of the process-outcome analyses, the process-focused portion of this evaluation identified staffing quality and communication, team functioning, and judicial leadership as essential to MHC functioning. Coordinators and judges should evaluate their MHC teams in these areas and look for ways to improve.

Conclusion

Despite limitations in comparison group, scope of outcomes, and the rigor of some analyses, this evaluation provides useful information. Policy makers and practitioners should consider the results of this evaluation in policy and operational decisions, and as a reference for MHC improvement efforts.

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APPENDIX A: METHOD

Samples

Data for this evaluation came from three samples: mental health court participants, a comparison group of ACT recipients, and MHC team members. Each is described below.

MHC Participants. The treatment group for the quantitative evaluation consisted of 715 MHC participants with intake dates from January 1, 2010 to December 31, 2014. Another sample of MHC participants participated in focus-group interviews for the qualitative evaluation and included a selection of MHC participants in each court actively participating during the spring of 2016. Active participants of each MHC were also observed in a court hearing during the spring of 2016.

Comparison Group. The comparison group consisted of 128 individuals who received ACT services during the period of January 1, 2010 to December 31, 2014 (ACT services may have commenced prior to this period), had ever been in the custody of the Idaho Department of Correction, and had a Level of Service Inventory-Revised (LSI-R) score of 18 or greater.

MHC Team Members. Both the judge and the coordinator for each MHC were interviewed for the qualitative evaluation. In addition, all MHC team members were invited to complete a survey regarding court practices. The MHC team of each court was also observed in a staffing and a court hearing.

For descriptive statistics of the MHC and comparison groups used in the quantitative analysis see MHC Participants And Comparison Group Members on page 15.

Quantitative Data Sources

Data for the quantitative evaluation came from three sources, court records, Department of Health and Welfare (DHW) records, and IDOC records. Each is described below.

1. **Court Records.** Data from both the legacy ISTARS and the new Odyssey case management systems were used in this report. The ISTARS Parties on Diversion report was used to identify MHC participants and for participant and court information. The ISTARS filings by statute, for Twin Falls a custom Odyssey query provided data on criminal convictions for measuring recidivism.

2. **DHW Records.** DHW provided data for both the MHC and ACT recipients. DHW data included individual information for MHC participants and ACT recipients, intake and assessment information—including diagnosis, and information about the types and amounts of services received.

3. **IDOC Records.** IDOC matched ACT records to their records by name and birth date to identify the comparison group. IDOC provided demographic data and all status changes (start or end of probation, retained jurisdiction, or prison incarceration) for MHC participants and comparison group members.

Quantitative Procedure

Data Matching. Data were matched between the multiple data sources on name and birthdate. Efforts were made to confirm near matches (e.g. different name spellings or slight differences in birthdate) using other information such as residence, and race and ethnicity.

Recidivism Analyses. Recidivism was defined as any felony or misdemeanor conviction during the follow-up period. The follow-up period began 60 days post intake for MHC participants and at ACT intake or January 1, 2010 for individuals who were already receiving ACT services for the comparison group. The follow-up period ended December 31, 2015. The follow-up period ranged from 1-6 years, depending on when the individuals started MHC or ACT services. Certain low-level misdemeanor offenses were excluded from recidivism counts (see the table below). The 60-day lag period from the start date used for MHC participants is not necessary in the comparison group, because there is no arrest/conviction event associated with participation in ACT treatment.

Description of Charges and Statutes Excluded from Recidivism Counts
Alcoholic beverage-unlawful transportation
I23-505, I23-505(1), I23-505(2)(M) I18-1502(b), I23-1024, I23-604, I23-949
Animal at large
M245-10-3-10, M373-6.08.080--PF, M772-6.04.030C(1)
Animal nuisance
M660-6-2-22, M772-6.04.030C(4)
Defecate or urinate in public
M772-8.12.020H
Disorderly conduct
C1-5-4-4, M242-9.08.010 H, M325-4-12-4, M352-5-5-030, M354-6-3-2, M368-9-3-7, M388-9.04.010, M399-5-2-2(J), M422-5-3-7, M439-09.32.010, M611-8-1-27, M694-6-2-3(A), M772-9.16.090, M807-6-01-05
Disorderly premises
M465-745-6-1-25, M772-8.24.040A, M772-8.24.040B, M807-6-01-08
Dog at large
C28-5.1.6, M108-5.101, M139-6.08.100, M156-7.1, M295-110-10(B), M305-6-2-9, M368-9-2-20(A), M506-6-02-07, M506-6-02-07A, M694-8-108(A), M736-5-10-10(B)
Dog license required
M245-10-3-7, M439-06.08.040, M660-6-2-15(A), M736-5-10-4
Dog nuisance
C7-4-4-3, M807-6-07-23

Description of Charges and Statutes Excluded from Recidivism Counts (Cont.)
Dog-failure to provide for
M303-5-4-12(C)
Drivers license violation
I49-301
Fireworks violation
I39-2609, M648-24-8
Fish and Game violation
I36-105, I36-1401, I36-409
In park after dark
M807-13-03-05E
Liquor-fail to present identification
I23-943A
Littering
I18-3906, I18-7031, M807-6-16-02, M807-6-16-06
Open container
M199-3-2D-2, M245-1983.4, M325-3-2-2, M354-3-2-6(A), M354-3-2-6B2, M611-8-7-3, M648-6-2, M657-10-1-12, M660-6-1-3, M736-4-2-22, M736-4-2-26, M736-4-3-17, M772-9.12.035A, M807-13-03-05, M807-13-03-05A2, M807-6-01-15
Pedestrian-Under the Influence of Alcohol or Drugs
I49-1426
Public intoxication
M303-5-8-7, M379-City Ordinance 07-532, M483-9.04.030, M487-5-8-7, M506-6-01-21(D), M736-5-22-7, M807-6-01-06
Rabies vaccination-fail to vaccinate
M772-6.04.080A
Tobacco-possession, distribution or use by minor
I39-5703, M807-6-01-04
Urinating in public
M354-6-3-9, M422-5-3-4(3), M431-6-1-13, M657-10-1-10, M658-6-2-12 M807-6-01-18

Time-sensitive regression analyses were used to identify predictors associated with felony and misdemeanor recidivism. Regression variables included group (MHC or comparison), gender, risk, age, diagnosis, and services received.

Graduation Analyses

Graduation rates were calculated for the entire state, each court, and for LSI-R risk score ranges. Graduation was the outcome for a logistic regression testing the same predictors (excluding group) used for the time-sensitive recidivism regressions. To facilitate interpretation of results, significant predictor variables were reported as conditional probabilities at different levels of the predictor variables using the method described by Osborne (2012). Finally, the rates of felony and misdemeanor

recidivism were calculated for graduates and non-graduates. Chi^2 tests were used to identify significant group differences in the rate of each outcome.

Descriptive Analyses

MHC participants and comparison group members including descriptive statistics were reported including: gender, age, risk, diagnosis, and services received (see the table below). Average and standard deviation was reported for continuous variables with t-tests to check for group differences. Percentages were reported for categorical variables with chi^2 tests to check for group differences.

Categories of Services Received

Service Category	Examples of Services
Treatment	Group or individual: psychotherapy, counseling, skills training, and crisis intervention
Recovery Support	Community reintegration, community-based rehabilitation, case management, family support or therapy, transportation, occupational therapy, drug testing, and life skills
Planning/ Assessment/Records	Diagnostic interview, screening, individualized treatment plan, functional assessment, collateral consultation, intake assessment, individual assessment, report preparation, psychological testing, other evaluations
Medical	Nursing service, pharmacological management, medication injection, blood draw, medication supply, and medication administration.

Qualitative Data Sources

The qualitative evaluation focused on MHC practices and processes. Eight data collection procedures yielded data for the process evaluation including a survey, and a site visit consisting of observations, and interviews. One of two evaluators from the Data & Evaluation Department visited each court in the spring of 2016. Each procedure is described below.

1. **MHC Team Member Survey.** MHC team members completed a survey regarding practices in their MHCs. Coordinators provided names and email addresses of 129 individuals to be invited to participate. The survey included questions regarding MHC intake, staffings, hearings, judicial leadership, team functioning, and the team member's individual role. Altogether, 107 (83%) team members participated in the survey.

2. **Staffing Observations.** As part of site visits, an evaluator observed and took notes on a MHC team staffing.

3. **Hearing Observations.** As part of site visits, an evaluator observed and took notes on a MHC review hearing.

4. **Coordinator Interviews.** As part of site visits, an evaluator conducted a semi-structured interview with the MHC coordinator. Coordinator interviews typically lasted between 45

minutes and 2 hours, and included questions about referrals, screening, intake, court staffings, team communication, the judge, review hearings, peer support specialists, incentives and sanctions, termination procedures, training and improving practices, and treatment and the ACT team.

5. **Judge Interviews.** As part of site visits, an evaluator conducted a semi-structured interview with the MHC judge. The interview with the judges was much briefer than the coordinator interview and included questions about what is going well and what challenges the MHC has.

6. **Participant Focus Group Interviews.** As part of site visits, an evaluator conducted a semi-structured focus group interview with 4 – 9 participants. The evaluator invited participants to discuss communication of court requirements, accessibility of team members, probation, drug testing, treatment, incentives and sanctions, the judge, and progressing in drug court.

7. **Literature Review.** Literature on MHCs was reviewed, and research findings were incorporated into evaluation findings.
8. **Standards and Guidelines.** Idaho and National Standards were reviewed and incorporated into evaluation findings.
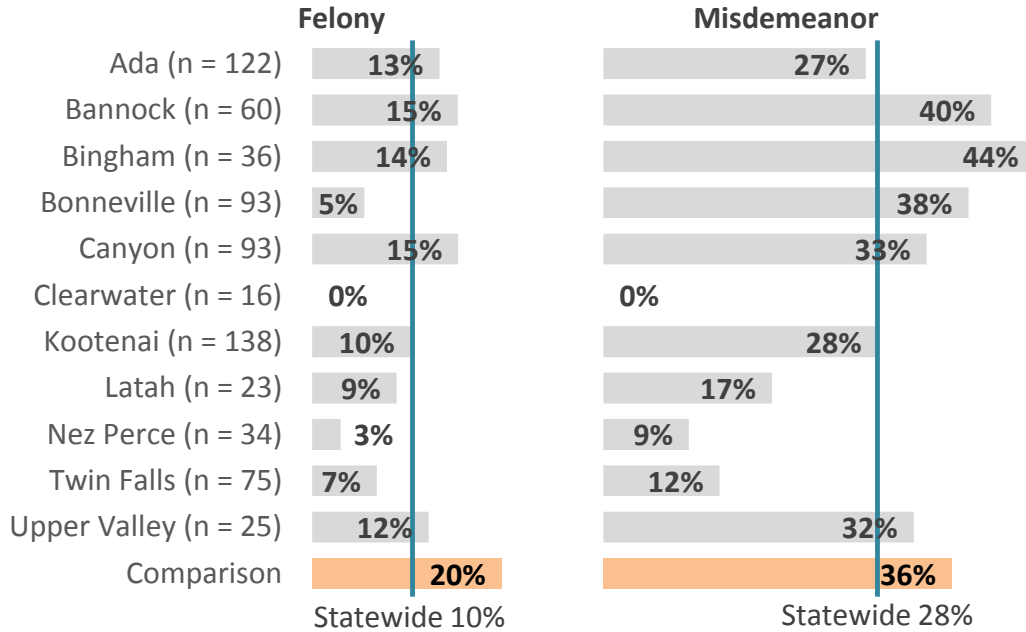
Qualitative Procedure

Site visits were conducted in the spring of 2016. Notes from observations, notes from coordinator and judge interviews, and transcriptions of focus group interviews were reviewed for common themes. Additional themes were gleaned from the results of the team survey and survey comments from team members. Themes from the qualitative evaluation were then supplemented with research findings and conclusions and references to state and national standards. The most salient themes supported by multiple data sources were reported.

Connecting Process and Outcome

Exploratory analyses were conducted to try to establish which processes are related to which outcomes. Outcomes were compared between groups of MHCs that looked similar on process measures. These analyses were exploratory and findings should be considered tenuous because of the small sample size (only 11 courts), and some issues of temporal precedence; the causal factor or the process was measured after the effect or the outcome.

APPENDIX B: OUTCOMES BY MHC

Felony and Misdemeanor Recidivism by MHC

	Felony	Misdemeanor
Ada (n = 122)	13%	27%
Bannock (n = 60)	15%	40%
Bingham (n = 36)	14%	44%
Bonneville (n = 93)	5%	38%
Canyon (n = 93)	15%	33%
Clearwater (n = 16)	0%	0%
Kootenai (n = 138)	10%	28%
Latah (n = 23)	9%	17%
Nez Perce (n = 34)	3%	9%
Twin Falls (n = 75)	7%	12%
Upper Valley (n = 25)	12%	32%
Comparison	20%	36%
	Statewide 10%	Statewide 28%

Graduation by MHC

Ada (n = 122)	35%
Bannock (n = 60)	40%
Bingham (n = 36)	59%
Bonneville (n = 93)	59%
Canyon (n = 93)	45%
Clearwater (n = 16)	50%
Kootenai (n = 138)	42%
Latah (n = 23)	52%
Nez Perce (n = 34)	56%
Twin Falls (n = 75)	32%
Upper Valley (n = 25)	57%
	Statewide 45%