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# Arizona's HB 2310: Mental Health Courts and Statewide Standards

*Final Report*

*Prepared for the Arizona Administrative Office of the Courts*

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**PROJECT DIRECTOR**

*Nicole L. Waters, Ph.D.*

**PROJECT STAFF**

*Jennifer K. Elek, Ph.D.*

*Tara Kunkel, M.S.W.*

*Tracey Johnson, B.A.*

**RESEARCH DIVISION | NATIONAL CENTER FOR STATE COURTS**

*October 2014*



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## NATIONAL CENTER FOR STATE COURTS

*October 2014*

## PRESIDENT

*Mary Campbell McQueen*

## VICE PRESIDENT, RESEARCH AND TECHNOLOGY

*Thomas M. Clarke*



To promote the rule of law and to improve the administration of justice in the state courts and courts around the world.

300 Newport Avenue  
Williamsburg, VA 23185  
(800) 616-6164

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We at the National Center for State Courts (NCSC) have had the pleasure of collaborating with the various people and organizations involved with Mental Health Courts (MHCs) in Arizona. It has been a gratifying experience for the NCSC to evaluate the MHCs in Arizona and prepare this report of the findings.

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NCSC staff members conducted onsite reviews with the following MHCs in Arizona:

- *Maricopa Superior Court: Seriously Mentally Ill Specialized Probation Caseload*
- *Pima County Consolidated Justice Court: Mental Health Court*
- *Pima County Superior Court: Mental Health Court*
- *Tempe Municipal Court: Mental Health Court*
- *Tucson City Court Mental Health Division: Mental Health Court*

NCSC staff members conducted phone interviews with the following MHCs in Arizona:

- *Flagstaff Justice Court: The Coconino County Mental Health Court Program*
- *Flagstaff Municipal Court: Mental Health Court*
- *Glendale Municipal Court: Mental Health Court*
- *Phoenix Municipal Court: Pre-screen Competency Program and Mental Health Diversion Program*
- *Sierra Vista Justice Court: Cochise County Provisional Rehabilitation Accountability (PRA) Program*
- *Yavapai County Superior Court: Seriously Mentally Ill Specialized Probation Caseload*
- *Yuma County Superior Court: Mental Health Court*

As a requirement of Arizona's HB 2310, the NCSC was responsible for developing statewide standards to establish and implement efficient, effective, and accountable performance measures for all mental health courts and seriously mentally ill specialized probation caseloads in Arizona. Meetings of a working group composed of key representatives of mental health court teams, facilitated by the AOC, were held January 29 and February 28, 2014. We at the NCSC greatly appreciate the efforts of the following Working Group Attendees:

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## Introduction

The National Center for State Courts (NCSC) prepared this report for the Arizona Supreme Court, Administrative Office of the Courts (AOC) pursuant to House Bill 2310 ([HB 2310](#)). Following approval by the AOC and the Arizona Judicial Council (AJC), this report will be presented to the Arizona Legislature and Governor.

This report presents a statewide evaluation on the effectiveness, efficiency, and accountability of 13 mental health court programs currently operating in Arizona. This report proposes standards for the design and operation of effective mental health courts (MHCs). The purpose of the MHC standards is to create accountability and enable performance monitoring, inform training and technical assistance efforts, increase public confidence in MHCs, and promote shared collaboration and communication across justice partners, treatment providers, and community service entities.

The NCSC gathered site-specific information for all identified MHCs in Arizona. Following a meeting on September 13, 2013, of 20 court representatives, including nine judicial officers, from twelve (4 Superior, 3 Justice, and 5 Municipal) of Arizona's MHCs, the NCSC, with the support of the AOC, selected 5 courts to conduct onsite reviews. The five courts were selected based on inception date (established prior to 2011), court structure (representative of all MHC types statewide), caseload (range in volume), and, for travel and cost considerations, proximity to one another.

In January and February of 2014, the NCSC visited the five selected MHCs. In total, the NCSC conducted in-person interviews with 67 team members, observed 8 dockets (including one video docket), observed 5 pre-docket team meetings, gathered feedback from 7 participants, and toured 3 treatment facilities (including an observation of one group session). The NCSC also conducted on-line surveys of the MHCs in Arizona.

This report is based on the findings from the data gathering activities and is divided into four sections, starting with an overview of the current practices in MHCs, followed by proposed model statewide standards, a third section summarizing the findings, and a fourth section with recommendations for overcoming barriers and challenges for optimal operations. Contained within the Appendix of this report are court-specific profiles of each of the MHCs. The Appendix is divided into two sections: the five MHCs selected

## Methodology

During the onsite visits to 5 of Arizona's MHCs, the NCSC interviewed individual team members, observed team meetings and status review hearings using semi-structured protocol, visited treatment provider sites, and conducted interviews/focus groups with select participants. NCSC staff also reviewed data capabilities and compiled data maintained by the courts, as available.

The NCSC also conducted an online survey of all 12 of Arizona's MHCs. The survey requested descriptive information about the court's participants, types of services participants are engaged in, the assignment/term of judicial officers, team and advisory board representatives, data collection capabilities, performance (program and treatment) monitoring activities, training usage and needs, funding needs, and priority areas for standards to address. The NCSC received 7 complete surveys, 4 partially complete surveys, and 1 court did not respond. All 12 courts provided additional documents to describe their programs. The materials included statistics, contracts and forms for participants, program policies and procedures, external agency reporting documents, screening checklists, and/or training materials.

for site visits appear in the first section while the other MHCs, involving telephone interviews with the teams, are described in the second section.

## Overview of Current Practices in Arizona MHCs

The Arizona judicial branch has made a commitment to problem-solving courts. In particular, the current Supreme Court strategic agenda has called for the expansion of problem-solving courts, evidence-based program evaluation, and community connections. The 2014-2019 Arizona Supreme Court Strategic Agenda includes several goals to protect children, families, communities, and vulnerable populations. Specific to MHCs is Goal 2, which calls for expansion of problem-solving courts through the enhancement of collaboration with partners and the development of evidence-based practices for problem-solving courts.<sup>1</sup>

Aligned with the strategic goals of the judiciary, Arizona currently has over 70 problem-solving courts in operation, including drug courts, DWI/drug hybrid courts, mental health courts, domestic violence courts, Veterans courts, and homelessness courts.<sup>2</sup> Recent legislation, [HB 2457](#), provides for the establishment of regional mental health and veteran courts that draw on regional resources, such as the Department of Veterans Affairs, and enables courts to transfer of cases to other court jurisdictions within the region.

This report is the result of House Bill 2310 that called for the AOC to:

- 1) Evaluate the effectiveness, efficiency, and accountability for MHCs and specialized SMI probation caseloads;
- 2) Develop standards for MHCs; and
- 3) Identify training needs for MHC judges and staff.

Therefore, the overview presented in this section reflects a description of how Arizona MHCs operate within the context of the criminal justice system and the state and regional mental health systems. It also identifies overarching themes in the objectives of the MHCs and the interagency collaboration required for a team-based approach in MHCs.

Within this report, the term *mental health court* (MHC) is applied broadly to both courts with specialized dockets for defendants who have serious mental illnesses as well as to specialized probation caseloads (SPCs) that are designed to work with seriously mentally ill (SMI) probationers in conjunction with a court. Nationally, this term is used to describe a team-based approach to providing ongoing judicial supervision and treatment coordination to address the mental health needs of defendants and reduce recidivism among mentally ill offenders. In the MHC model, the court uses its authority to link defendants with serious mental illnesses to targeted therapeutic interventions. A MHC

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<sup>1</sup> Advancing Justice Together: Courts and Communities.  
<http://www.azcourts.gov/portals/0/AdvancingJusticeTogetherSA.pdf>.

<sup>2</sup> The NCSC conducted a national *Census of Problem-Solving Courts* and identified 78 problem-solving courts and an additional 15 youth/teen courts in operation in Arizona during 2012.

team has specialized knowledge about mental illnesses and, with the guidance of clinical team members, can develop individualized case management and treatment plans for these defendants.

In Arizona, the MHCs represent a wide array of diverse models. Most importantly, the variations include limited jurisdiction courts (municipal and justice of the peace courts) and general jurisdiction courts (superior courts). Another important distinction is the point at which the defendant enters the MHC. Understanding this is important to fully appreciate each program's design and its operating policies. Some of the MHCs are diversion programs operated by the city or county attorney's office, others operate post-plea with a deferred sentence conditional upon the successful completion of the program, while still others are post-sentence with MHC terms, or terms of probation that operate with specialized probation officers and units designed for persons designated as SMI.

Jurisdiction type and program entry point are important distinctions for many reasons, but three variants are most pertinent to Arizona MHCs. First, limited jurisdiction courts typically hear misdemeanor cases, whereas general jurisdiction courts have exclusive jurisdiction over felony cases. General jurisdiction courts typically have more resources at their disposal, for example, to establish more sophisticated MHC screening and assessment protocols. Jurisdiction type may also dictate aspects of program design, such as whether the program uses a diversionary, post-conviction, post-plea, or hybrid model as the point of entry. Second, sentence length varies by offense type. Defendants may face, for probation-eligible felonies, a maximum sentence of seven years as compared to facing six months for misdemeanor charges. This may dictate, for example, the length of participant involvement with the MHC, the amount of progress that may be made in establishing mental health stability or addressing defendant needs, and the nature of legal consequences for graduation or termination from the MHC program. Finally, public defenders or court-appointed attorneys play different roles across the MHC models, as the point of entry (e.g., pre-plea, post-plea, post-sentence) varies. Defendants may not be routinely assigned legal representation for lower-level offenses.

As expected, the Arizona MHC programs do not operate in isolation of the larger criminal justice system or the operations of the state and regional mental health systems. Rather, each MHC works within the constraints and opportunities of these systems. It is precisely through the collaborative efforts of representatives of these systems that MHCs may:

- Facilitate timely access to community treatment services by defendants in need;

One MHC team member described the positive results of the MHC as: "The program is great because people do learn accountability. [The MHC] gives an incentive to maintain contact with the treatment agency. It helps keep people from recidivating because they keep going to treatment... Some people may not have sought out help on their own, or were in denial and didn't realize they needed help. It's great to have the [treatment provider] agencies available to provide free or low-cost treatment. MHC gives them the motivation they need to help themselves."



- Improve public safety through reduced recidivism and increased compliance with supervision terms;
- Improve the mental health, stability, social functioning, and overall quality of life of defendants with mental illnesses; and
- More effectively allocate state resources through more judicious use of incarceration and hospitalization, informed by the early identification of persons with mental illness.

Several features of this broader context clearly influence MHC program design features and merit further discussion. The following sections detail the relationship of how MHCs operate within the criminal justice system and the behavioral health system.

## Criminal Justice System

The criminal justice system intercepts include, among others, interactions with law enforcement, information exchange with the local jails, and court intervention. The sequential intercept model<sup>3</sup> suggests that early and frequent interventions at each intercept will avoid the revolving door contacts that persons with mental illnesses have with the criminal justice system. Training and other efforts to develop or enable proactive responses at the first point of contact, during incarceration, and upon release can have a positive impact on persons with mental illnesses.

The first point of contact for defendants in the criminal justice system is most often with law enforcement. In Arizona, some jurisdictions have equipped law enforcement teams with specialized training on how to appropriately respond to and assist individuals with mental health issues. Programs such as Crisis Intervention Team (CIT) training help officers learn techniques to enhance safety (of the individual in crisis, of responding officers, and of public citizens in the community) and to facilitate a more effective resolution to crisis incidents. Participating officers are trained in de-escalation strategies when engaging with persons who are mentally ill, resulting in fewer injuries, increased diversion rates into the behavioral health care system, and reduced rates of mentally ill in the jails.<sup>4</sup> Members of Arizona MHC teams note the value of these trainings and resulting positive community impact. Officers knowledgeable about mental health and the programs designed to serve this population (such as MHCs and psychiatric crisis units) protect the community and streamline the processes for linking the defendant to treatment.

A MHC team member remarked: “Law enforcement...we have excellent CIT trained officers. They make a tremendous difference in our community. Not every officer understands or knows about it, but with training in crisis intervention, the tradeoff is remarkably different.”

<sup>3</sup> Roisin Doyle et al., *First-Episode Psychosis and Disengagement from Treatment: A Systematic Review*, 65 PSYCHIATRIC SERVICES, no. 5, 603-11 (2014).

<sup>4</sup> Vincent Beasley, *Crisis Intervention Team*, MEMPHIS POLICE DEPARTMENT, <http://memphispolice.org/crisis%20intervention.htm> (last visited May 21, 2014).



Likewise, expansion of mental health training for law enforcement in Arizona may help to further reduce the incidence of mentally ill persons in jails. Nationally, jails house an alarming percentage of mentally ill (17% of the jail population is mentally ill).<sup>5</sup> Arizona, second to Nevada, has the next highest odds for mentally ill persons being jailed versus hospitalized (odds are 9.3 to 1).<sup>6</sup> Jails are often ill-equipped to effectively manage persons with mental health issues. Jail staff are often not trained on appropriate behavioral responses with the mental health population and also do not often have sufficient access to clinical assessment/diagnosis, treatment, and medication management resources. MHCs in Arizona report that psychological evaluations and Arizona Health Care Cost Containment System (AHCCCS) eligibility applications are typically not pursued while defendants are in custody. Many mentally ill persons enter the jail without prescription information and may require a more comprehensive clinical assessment to identify a response strategy. For mentally ill persons who enter the jail on a regimen of psychotropic medication(s), this regimen often cannot be sustained because of inadequate access to prescription medications in the jail. Often inmates experience a delay between entry to the jail and provision of medication. Interruptions in the continuity of a medication regimen is detrimental to establishing stability.

Upon release from incarceration, mentally ill persons may reenter the community without treatment or support services in place. As a result, such individuals may again encounter law enforcement or end up in the emergency room.<sup>7</sup> As a workaround solution, Arizona MHCs commonly use third party release plans to transport an individual directly from jail to an affiliated treatment provider. Additionally, some MHC team members admitted that jail was used as a safe holding place for a participant in crisis or in need of services while awaiting availability of a residential treatment bed. Using jail in this situation “is inconsistent with best practices, unduly costly, and unlikely to produce lasting benefits.”<sup>8</sup> One solution to this problem is to ensure that communities have safe and sober living options for individuals with mental illness.

One MHC team member asserted: “Jail is rarely, if ever used as a sanction in [our] MHC... jail is considered by the team to be a costly alternative.”

Of the 13 MHCs in Arizona, five use jail time as a sanction for participants. Jail time is more typically used as a sanction in the superior court programs. The time participants are sent to jail ranges from no more than 2 days to as many as 3 weeks for not complying with conditions of probation or non-compliance with program requirements.

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<sup>5</sup> Henry J. Steadman et al., *Prevalence of serious mental illness among jail inmates*, 60 PSYCHIATRIC SERVICES, no. 6, 761–65 (2009).

<sup>6</sup> E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAIL AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 8 (2010).

<sup>7</sup> Emergency rooms, like jails, play a role in filling gaps in the current mental health system by serving the seriously mentally ill immediately following a crisis situation. As a result, the mentally ill receive a poor level of reactive rather than proactive service, with a high cost to taxpayers.

<sup>8</sup> NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, ADULT DRUG COURT BEST PRACTICE STANDARDS, VOLUME I 41 (2013).

## Behavioral Health System

To understand the culture and context within which MHCs operate and address defendants' treatment needs, one must also understand the behavioral health system administering the services. The Arizona Department of Health Services, Division of Behavioral Health Services ([ADHS/DBHS](#)) designates four regional behavioral health authorities ([RBHAs](#)) that are managed care corporations to administer publicly funded behavioral health services. The four RBHAs currently providing services to the MHCs in Arizona include: Cenpatico, Northern Arizona RBHA, Mercy Maricopa Integrated Care (which replaced Magellan in this capacity as of April 1, 2014), and Community Partnership of Southern Arizona.<sup>9</sup>

Each RBHA subcontracts with direct behavioral health treatment providers in the region. Most MHC participants receive behavioral health care services through these RBHA network providers. The state Medicaid insurance program, the Arizona Health Care Cost Containment System ([AHCCCS](#)), covers the cost of services provided by these agencies, allowing mentally ill persons access to treatment at no additional cost to themselves or to the MHC program. As a large proportion of defendants referred to MHC in Arizona are indigent and because MHCs are not funded to provide for participants' behavioral health care costs, determining AHCCCS eligibility becomes an important factor in identifying the range of treatment and case management services available to MHC participants.<sup>10</sup> An authorized ADHS/DBHS representative conducts an SMI determination, which is strictly an administrative (not clinical) review of records to establish SMI status.<sup>11</sup> Without personal financial resources or an SMI designation to secure AHCCCS coverage, MHC participants are unable to access the full range of services.

In the referral and admissions process, MHCs make a determination as to who is clinically eligible for the program. SMI status is one way to make this determination. Many Arizona MHCs require an active SMI designation for program admission, except in rare circumstances when the applicant demonstrates that s/he possesses the financial means or private insurance coverage to secure treatment, and/or utilizes a treatment provider who agrees to share status updates on the applicant with the MHC during the participation period.

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<sup>9</sup> The RBHA in geographic service area #5, the Community Partnership of Southern Arizona (CPSA), has started to provide direct care services. CPSA's direct-care arm is called Community Partnership Care Coordination (CPCC).

<sup>10</sup> Case managers are assigned to all participants who receive an SMI designation, are eligible for AHCCCS, and receive treatment through a RBHA-contracted treatment provider agency.

<sup>11</sup> To inform the SMI designation determination, the assessor reviews records regarding the applicant's diagnosis, assessment of functional impairment (inability to live independently, risk of serious harm to self or others, and/or dysfunction in role performance), and risk of deterioration (e.g., through contributing chronic factors or comorbid substance dependence issues). An example of a form used to make this type of determination can be found here: <http://www.narbha.org/includes/media/docs/3.10.1-Form-DBHS-NARBHA-SMI-Determination.pdf>.

The process by which individuals are assigned an SMI designation is not well understood by many of the MHCs' team members. As discovered through the interviews of the team and collaborating agencies, the SMI determination process appears to be closely guarded by the agencies conducting the reviews, resulting in conflicting and, at times, inaccurate knowledge by MHC team members of the process and/or criteria used in the review. This lack of transparency sometimes fueled perceptions among MHC team members that the designation process is unreliable, with authorized representatives sometimes failing to assign the SMI designation when MHC team members believed SMI status was appropriate.

As one MHC team member suggests: "Mental Health Court should be open to everyone. But [they say] you have to have an SMI designation. Private psychiatrists will not want to submit information to the court on a regular basis, but all [RBHA providers] have agreed to do that as part of the arrangement. But the arrangement is not equitable for all [defendants] who need help... I think there are ways to incorporate the views of private MH providers into the MHC system and not overburden them. [If] a judge asks a doctor to provide information to support his care, [that doctor] will comply with that request."

For many courts, the agency assigning this designation serves as the gatekeeper of clinical eligibility for admission into the MHC; however, some MHC teams sought ways to serve the mentally ill defendants who were perceived to have fallen through these administrative cracks.

## Purpose and Target Population

In Arizona, MHCs emerged to address a wide array of interrelated criminal justice and mental health issues. The Arizona MHCs seek to reduce costs borne by the court, the criminal justice system, and the health system associated with mentally ill defendants. Punitive approaches in the traditional criminal justice system have not successfully deterred defendants with serious mental illnesses from reoffending nor have those approaches adequately addressed the underlying mental health issues, criminogenic risk factors, or other needs. Less common purposes for MHCs in Arizona were also observed. One MHC used the authority of the court to hold providers accountable for providing quality mental health services; another MHC was developed to uniquely address the inefficiencies and costs associated with Rule 11 competency hearings through a pre-screening program.<sup>12</sup> From a macro-economic perspective, the most compelling long-

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<sup>12</sup> In a Rule 11 petition, the Forensics Services Division of the Superior Court receives criminal cases which have defendants who may need to be evaluated for competency. The court will order that two doctors will conduct a psychological evaluation of the defendant to determine whether the defendant is competent to be adjudicated. In the event that a defendant is considered as incompetent and not restorable within the statutory time limits, he/she may qualify for civil commitment and criminal charges may be dismissed.

term benefit of MHCs is the goal of improving their stability and quality of life. In all, these MHCs seek to address any or all of the following issues:

- Improved coordination, communication, and linkages with treatment services;
- Improved public safety through reduced recidivism and compliance with conditions of probation;
- More cost-effective utilization of resources through reductions in use of jail, hospitalization, and failure to appear rates;
- Improved mental health and stability for participants; and
- Improved processes by providing timely and effective responses to mental health needs.

As most of Arizona's MHC programs use the SMI designation as the primary clinical eligibility criterion, program entry in some cases may be almost entirely dependent on whether the defendant can secure an SMI designation. This eligibility criterion may help to ensure that all costs associated with treatment services are covered, but shifts control over admissions away from the MHC team to the agency making the SMI designation. As a case in point, some interviewees referred to the court as the "[RBHA's name] court." Using the SMI designation as the clinical eligibility criteria has an additional layer of complexity with participants presenting co-occurring substance dependence disorders. The SMI determination is delayed for MHC applicants who present with co-occurring disorders. Depending on drug type, there is a resolution period of 30 to 120 days before an SMI determination can be made, thereby delaying MHC clinical eligibility determinations.

Arizona MHCs have responded to the impact that SMI determinations can have on admission decisions through three basic approaches:

1. ***Expanded clinical eligibility criteria for MHCs.*** In response to the perception that some defendants who could benefit from MHC participation were being denied SMI status, some MHC teams have reconsidered their clinical eligibility requirements and now look for ways to include defendants who are ineligible for AHCCCS funding. Typically, this involves accepting participants to whom ADHS/DBHS assigns a *general mental health* (GMH) designation (defined by DBHS as a "classification of diagnoses... that are not so severe that people cannot function without intense services and medications," i.e., not SMI) and who thereby can access only a restricted menu of free behavioral health care services, or by accepting individuals with the means to self-pay (with private insurance or other financial resources). To implement these solutions, MHC teams face some challenges. In these programs, MHCs must develop "creative" treatment plans for non-SMI status participants using only free resources and/or for self-pay designees who use private providers outside of the RBHA network of collaborating agencies, in which case the MHC must determine how to secure regular status reports from the private clinician.

2. ***Allowed admission into the program while awaiting SMI designation or an appeal of a denied SMI designation.*** MHC team members described several reasons for time delays in the SMI determination process, including a lack of historical reports and conflicting historical information, in addition to indications of co-occurring substance dependency. A complication for the court due to this potential delay is whether to admit, and later retain, a participant who is denied the SMI designation after a delay or appeal.
3. ***Developed a separate track within the MHC to accommodate individuals who do not receive the SMI designation*** (including those designated as GMH, or those with clinical diagnoses from private providers). The separate track allows the court to accept participants who are denied diversion due to legal eligibility criteria or for those without SMI designations. The downside to this track is that those who do not are not in the SMI track (e.g., receive diversion) may not have the opportunity to have their charges dismissed upon successful completion of the program.

Legal eligibility for MHC is dependent upon the stage of adjudication in which the participants can enter the program. For example, in pretrial diversion programs, the prosecutors must screen the extant charges before offering dismissal of those charges upon successful completion of the program. Some types of legal charges precluded defendants from program entry. Charges such as sex offenses, weapons charges, and violent offenses were commonly excluded offenses. Prior convictions and lack of victim consent were also reasons for exclusion.

## Team Members and Collaborating Agencies

Mental health courts provide judicially supervised, community-based treatment plans for participants, which are designed and implemented by a team of court staff and mental health professionals. The local and statewide culture in Arizona affords the MHCs both opportunities and challenges when working with this type of team-based approach. Collaborating agencies must demonstrate support for the program through active participation and dedicated resources.

Across the Arizona MHCs, processes vary not only between limited and general jurisdiction courts or between diversion and post-adjudication models, but also within similar jurisdiction types and program models. These differences dictate the role of particular team members, their involvement on the MHC team, and their degree of control over MHC eligibility decisions.

Based on observations, surveys, and interviews with team members, involvement of the prosecutor's office ranges from complete control over the eligibility decision in diversion models to a more limited role in post-adjudication models, in which the prosecutor may only attend court hearings when a potential violation of probation motion is filed on a probationer on a SPC. In some MHCs special terms are attached to a sentence which enables flash incarceration as a sanction, whereas in other MHCs the SMI Unit probation officers and/or prosecutors must file a violation of probation resulting in a termination in the program to sanction a probationer with jail time.

Similarly, the involvement of the probation department in MHC operations ranges from none (or a minor surveillance capacity), to an essential, if not primary, team role. In some MHC programs, the probation department determines the appropriateness of admission to the program or decides whether or not a probationer on the SPC should appear on the MHC docket. For example, in one post-adjudication model, the participant is not required to appear before the court for regular status hearings. In this model, the SMI Unit officer decides who should appear in court and how frequently. This accommodates an SMI Unit that serves a high volume of probationers (~600 active on the unit), where approximately 20 percent (~120) are active and appear in court on an as-needed basis. Probationers on a SPC in one county have MHC terms attached to their sentence which enable flash incarceration as a sanction, whereas, another SPC must file a formal violation of probation resulting in a termination to impose subsequent jail time. These differences dictate the role probation officers play on the MHC team.

The role of the RBHA with each MHC team also varies widely and could involve a number of different responsibilities. As interviews and observations revealed, in some MHCs, the RBHA provides a dedicated court liaison to serve a quality control function, ensuring that treatment providers and case managers' report to the court with accurate and timely information. This liaison may also provide training to the case managers on the protocols of the MHC, which was an ongoing task in some MHCs due to high turnover of the case manager position. In other MHC programs, the RBHA liaison has data access to the jail system, allowing them to identify potential MHC referral candidates (by identifying defendants who already receive or have received services through the RBHA network), identify when active MHC participants are taken into custody, and determine when MHC candidates and participants are released from custody. In addition, RBHA liaisons on the MHC team serve as a resource for identifying viable treatment programs and other service options. Maintaining current information on services available by the various treatment providers has proven difficult in some jurisdictions due to the constantly changing landscape. For MHCs that operate without involvement of the RBHA, but instead work directly with treatment providers, the MHC team is more likely to have a team member with a clinical background, operate with a coordinator role, and maintain its own data.

Regardless of the RBHA's involvement, all MHCs are potentially impacted by changes in the agency holding the current RBHA contract with ADHS/DBHS. When ADHS/DBHS contracts with a new agency to operate as the RBHA, this transition may adversely affect several aspects of the MHC, including the quality of treatment provider data to which the MHC team has access, the degree to which the RBHA and affiliated direct providers may wish to cooperate with the MHC, and the degree to which an appropriate institutional structure exists within the RBHA to support ongoing MHC operations. A noteworthy example is that one MHC was forced to cease operations for approximately 18 months due to a transition in the RBHA agency, which discontinued the contract with the MHC's behavioral health treatment provider. In another region, when a new agency recently assumed its role as the RBHA, the former RBHA agency retained all rights to its client database infrastructure. The new RBHA was forced to

piece together data from each of the local direct care providers to reconstruct the client database upon which regional MHC operations rely heavily.

Behavioral health treatment providers play a critical role in the MHC, and as expected, the MHCs employed a variety of models for their participation. The two basic models are to: 1) have a clinical team report to a dedicated liaison from each agency who participates in the MHC team discussions and appears at the status hearings to report on the agency's clients; or 2) have all case managers who have been assigned to represent MHC participants provide reports to the MHC team during MHC staffing meetings and/or court status hearings, but not operate as dedicated MHC team members.

**Table 1. Treatment Representatives Present at Court Hearings**

<i>Court</i>	<i>Representative</i>	
	<i>RBHA</i>	<i>Treatment</i>
Maricopa County Superior Court	Yes	Case Managers
Pima County Consolidated Justice Court	Yes	Case Managers
Pima County Superior Court	No	Provider Liaison
Tempe Municipal Court	Yes	Case Managers
Tucson Municipal Court	Yes	Provider Liaison
Flagstaff Justice Court	No	Provider Liaison
Flagstaff Municipal Court	No	Provider Liaison
Glendale Municipal Court	Yes	Case Managers
Sierra Vista County Justice Court	No	Provider Liaison
Yavapai County Superior Court	No	None
Yuma County Superior Court	No	Case Managers

Source: NCSC interviews with team members.

Note: The general team model is reflected in the table; exceptions occurred, especially for private providers.

Each model has value in the effort to maintain a functional balance between limiting the number of individuals present to inform MHC team decisions on adjustments to participants' treatment plans and allowing the MHC team to obtain accurate information about individual participants regarding treatment compliance and personal circumstances. This balance is especially challenging for higher volume MHCs; one MHC had over 20 case managers reporting to the court weekly. MHC teams that benefit from the insights of a clinically-trained MHC team member reported a better understanding of the participants' mental health needs. Additionally, this clinically trained MHC team member is not affiliated with a provider agency which advocacy issues exhibited by some agency representatives. Furthermore, this role enhances the treatment planning process, which is, at times, assumed by other team members (e.g., case managers, judges, attorneys, probation officers) in the absence of a clinically trained team member.



On the whole, the MHC team members are notably dedicated to the participants and to the broader mission of the mental health court program. In particular, MHCs with the resources to have dedicated team members from each office, department, or agency involved in the collaborative effort seemed better able to implement program rules and policies consistently across cases. In general, the team members demonstrate effective collaborative efforts to find innovative and effective solutions to improve the criminal justice and behavioral health systems in which these MHCs operate.

## Proposed Standards

**Utility of Standards.** Standards for the development and administration of MHCs provide the following potential benefits:

- Provide guidance to: existing MHCs seeking to enhance their performance; new programs seeking to design programs to achieve the best possible results; and MHCs undergoing a transition (e.g., changing judges or treatment providers) that desire to avoid any deterioration in performance.
- Provide a valid basis for: holding MHCs accountable; structure efforts to monitor their performance; and offer a framework for program evaluations.
- Permit MHCs to realize economies of scale that will enable them to confidently increase the number of participants they serve by providing a uniform set of empirically informed processes that are highly reliable and replicable.
- Inform training and technical assistance efforts for MHC staff and collaborators.
- Increase public confidence in MHCs by demonstrating that mental health courts have a sound basis for self-regulation.

If standards are developed by professionals and others intimately familiar with the operations of the MHCs and rest on the basis of sound empirical research, they can pre-empt efforts by other less well-informed bodies to provide such standards. It is also worth noting that mental health courts are “loosely-coupled organizations.”<sup>13</sup> In such organizations, accountability and autonomy are often competing values and a source of tension. However, court leaders and collaborative agencies can take this as an opportunity to proactively define the terms by which accountability and other performance measurements preserve independence.

The real value in MHC standards comes from the interactions among all collaborators of the interconnected systems. The standards should promote communication among MHC components by clearly establishing common expectations and providing guidance for mutually beneficial outcomes.

**Process for Development.** The NCSC conducted an environmental scan of all 50 states to identify standards for drug courts, problem-solving courts generally, and those specific

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<sup>10</sup> MARY CAMPBELL MCQUEEN, GOVERNANCE: THE FINAL FRONTIER 1 (2013), available at [http://www.hks.harvard.edu/var/ezp\\_site/storage/fckeditor/file/pdfs/centers-programs/programs/criminal-justice/ExecSessionStateCourts/ES-StateCourts-GovernanceFinalFrontier.pdf](http://www.hks.harvard.edu/var/ezp_site/storage/fckeditor/file/pdfs/centers-programs/programs/criminal-justice/ExecSessionStateCourts/ES-StateCourts-GovernanceFinalFrontier.pdf)

to MHCs to inform the proposed MHC standards for Arizona.<sup>14</sup> Nationally, drug courts have a large basis of empirically-based research to draw on to develop best practices and standards, whereas MHC research is limited.<sup>15</sup> At the time of the NCSC's scan, only three states had standards that specifically applied to MHCs (Georgia, Wisconsin, and New York) and a handful of other states had developed more general guidelines.<sup>16</sup> Since January of 2014, three additional states began developing statewide MHC standards. Kansas sought recommendations as to whether they should implement statewide standards or guidelines, which is currently pending approval. March of 2014 proved to be an active month, with a standards bill in session in New Hampshire and Idaho issuing a draft proposal of MHC standards. Although there are current efforts underway to develop statewide standards specific to MHCs, Arizona is among the leaders in the nation.

The NCSC prepared an initial draft of proposed mental health court standards for the Arizona Administrative Office of the Courts. This initial draft was informed by: 1) the three sets of standards in place in other states at the time this project commenced (fall of 2013), 2) the Essential Elements of a Mental Health Court, and 3) the National Drug Court Standards.<sup>17</sup> This initial draft was shared with the MHC Standards Working Group prior to its first meeting. The discussions and insights provided by this project's invaluable Working Group were the driving force behind a revised draft of the proposed standards. The Working Group, comprised of 26 individuals, met in January and February of 2014. The Group included representatives of the court (judicial officers, coordinators, and a clinician), probation officers, prosecutors and defense attorneys, and representatives from RBHA and DHBS.<sup>18</sup>

In April of 2014, the Chief Justice issued an administrative order ([AO 2014-43](#)) to establish a Mental Health Court Advisory Committee. This committee, chaired by Marcus Reinkensmeyer of the AOC, met four times between June and September of 2014

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<sup>14</sup> A total of 21 states have developed state-specific drug court standards (GA, CO, NM, TX, UT, WY, MN, VT, DE, NC, VA, AR, ID, IL, MD, MS, PA, AL, MO, LA, NJ). An additional 5 states follow the 10 Key Components as guidelines or standards (AZ, CT, CA, SD, WV). Three states have developed "Recommended Practices" (NY, FL, KY). Wisconsin, Nebraska, and Washington are in the process of developing statewide drug court standards.

<sup>15</sup> The National Association of Drug Court Professionals released the first set of national standards for drug courts in 2013 (NADCP, *supra* note 6) and it is expected that a second set of standards will be released in 2015. Prior to the release of national standards, many states relied upon the 10 key components for drug courts as a basis for developing statewide standards (NADCP, *supra* note 6, at 1).

<sup>16</sup> Oregon developed standards that apply broadly to all "specialty courts" including mental health courts. Utah developed a checklist for certification of problem-solving courts and effective January 1, 2014, Ohio established certification standards. Minnesota adopted the "Essential Elements for Mental Health Courts" as a broad-based guide. Texas has a statutorily created Council to recommend best practice guidelines to the Governor's Criminal Justice Division. Legislation in Texas requires all specialty courts to provide performance measure data upon request, regardless of funding source.

<sup>17</sup> See COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2007). See also NADCP *supra* note 6.

<sup>18</sup> For a complete list of Working Group members, see page iii.

to review the proposed Working Group standards and make recommendations to the AOC on a final set of standards.<sup>19</sup>

**Proposed Standards.** The final set of proposed standards, presented in a separate document, are intended to provide guidance for the design of new and enhancement of existing MHCs in Arizona. As indicated in Table 2 below, Arizona has addressed many of the same issues in their final set of proposed standards as the other four states with MHC standards. The standards apply to general and limited jurisdiction courts (municipal, justice, and superior courts) and include programs that employ diversionary and non-diversionary models. The standards include procedures to establish and implement efficient and effective MHCs that are accountable to the public, judiciary, and as established in HB 2310, the legislature; and propose guidance on how such concepts are measured.

**Table 2.** *Comparison of the Content Areas Covered by State MHC Standards*

Content Areas		Arizona	Georgia	Idaho	New York	Wisconsin
<b>Addressed in the Arizona Standards</b>	Development, Planning, and Administration	X	X		X	X
	Mental Health Court Team	X	X	X	X	X
	Eligibility, Screening, and Assessment	X	X	X	X	X
	Roles and Responsibilities of the Judge	X		X		X
	Sanctions and Incentives	X	X	X	X	X
	Treatment	X	X	X	X	X
	Confidentiality of Records	X	X	X	X	X
	Sustainability	X	X	X	X	X
	Training	X				X
<b>Not Addressed in the Arizona Standards</b>	Use of Evidence-Based Practices					X
	Equal Treatment of Historically Disadvantaged Groups					X
	Due Process Concerns and Community Safety					X
	Community Outreach					X
	Rule Compliance/Oversight and Accountability			X		

Discussions during both the Working Group and Advisory Committee meetings routinely focused on how to balance the need for representing the wide array of current practices across Arizona’s MHCs with the need for reflecting best practices in the field. Best practices are defined as aspirational goals that are aligned with evidence-based practices that courts could practically comply with in a five-year time frame, assuming the infrastructure and human resources capacity were in place. A major source of disagreement on whether to endorse some of the proposed standards was conflicting opinions regarding constrained resources.

<sup>19</sup> Members of the project team from the National Center for State Courts were not official members of the MHC Advisory Council. The NCSC was invited by teleconference as a guest to the Advisory Council meetings.

One of the key proposed standards addresses sustainability, which requires data collection and performance measurements that directly measure effectiveness, efficiency, and accountability. However, the courts do not have a case management system designed to accommodate the inter-agency collaboration required of a MHC nor do the courts have adequate staff to gather, monitor, and manage with these measures. One MHC was able to implement the full set of 14 national performance measures, but has concerns about a sustaining this effort due to the loss of a temporary, volunteer position to manage the dataset.

As several MHC team members remarked about the current data tracking and reporting capabilities and the impact for the implementation of the standards:

- *“The major concern is that a statewide mandate will be imposed to collect data and incorporate additional elements to the program that we don’t currently do [without additional funding]... The lack of resources is a big problem.”*
- *“[Our court’s current case management system] is about 15 years old. We’ve been waiting a long time, about 7 years, for a replacement case management system. [The existing one] doesn’t have the tools, and it’s not worth it to write reports against [it] when a new case management system keeps being promised and it could change.”*

To support the implementation of the best practices, will require the establishment of a robust data infrastructure, staff to gather, enter, and monitor the data, development of data sharing protocols, and support from multiple collaborating agencies. Currently these requirements are not in place.

## Findings and Conclusions

An underlying theme throughout this report is the recognition that statewide standards must be inclusive of the vast differences in MHC models operating across the state and be mindful of the constraints by the larger criminal justice and mental health systems within which they operate. Members of both the MHC teams and the Working Group expressed concerns that a goal of developing statewide standards was to “standardize” MHCs into one model. Clearly, this is not possible nor advisable. Approval of these proposed standards should not imply or direct standardization, while enhancing accountability.

It is also important to reflect on why MHCs are established. MHCs in Arizona serve to increase public safety and reduce recidivism, help individuals in crisis achieve stability through participation in effective mental health and substance abuse treatment, improve the quality of life for people with mental illnesses charged with crimes, and more effectively employ limited criminal justice and mental health resources.

Based upon its observations, interviews, surveys, and document reviews, the NCSC offers a series of conclusions regarding the operational strengths and challenges of MHCs in Arizona.

## Arizona's MHCs demonstrate numerous strengths:

### The teams were:

- *Dedicated*, working with limited resources, and at times, drawing on the dedication of volunteers to serve as core team members;
- *Innovative*, implementing creative and effective workarounds in response to barriers and complex institutional challenges; and
- *Collaborative*, working together for the betterment of the defendants and drawing on collective resources to find solutions.
  - *"I feel that our team communicates very effectively. Everyone on the team is genuinely interested in working with the seriously mentally ill. All of us jumped at the opportunity to be involved with the program."*

"If I had unlimited resources, I would love for professionals to be involved with the MHC program who possess expertise in the areas of housing and disability benefits. A number of our participants lack stable housing. An even larger number of our participants have been denied disability benefits. In my view, both stable housing and disability benefits can play a significant role in participants' ability to maintain long term stability. The addition of professionals in these areas would be of great assistance to our participants and lead to better outcomes."

### The treatment agencies and service providers working with the MHCs:

- *Capitalized on mental health treatment expertise* to inform treatment plan development and effective responses to participant progress or decline,
- *Incorporated peer support specialists* to further cultivate a network of prosocial support for clients,
- *Offered a wide array of programs* in large metropolitan areas from a wide array of providers, and
- *Incorporated housing specialists* in some courts to provide individualized housing solutions for the defendants, which was mentioned as a gap in available services in virtually every MHC.

## The operation of the MHCs in Arizona also reflects the following challenges:

### Most MHCs collected minimal data.

- Data are necessary to conduct program evaluations, make programmatic improvements, and document MHC practices for sustainability.
- Without the benefit of automated reporting capabilities, the MHCs that collected data resorted to manually created spreadsheets.
- Inefficiencies resulted from a lack of an integrated data system. Each agency represented on the team tracked its own data in its own system. This process resulted in duplicate efforts, cost inefficiencies in tracking the same information

across agencies, and added potential risk in reduced data quality due to human error.

According to the results of NCSC's survey of the MHCs, approximately two-thirds of the courts were able to report the total number of participants served by their courts. Most were operating near capacity.

**Table 3. Capacity and Number Served in 2013**

<i>Court</i>	<i>Capacity</i>	<i>Served</i>
Maricopa County Superior Court	120	120
Pima County Consolidated Justice Court	--	--
Pima County Superior Court	50	60
Tempe Municipal Court	100	136
Tucson Municipal Court	--	--
Flagstaff Justice Court	20	25
Flagstaff Municipal Court	--	--
Glendale Municipal Court	80	122
Phoenix Municipal Court	--	--
Sierra Vista County Justice Court	--	20
Yavapai County Superior Court	40	10
Yuma County Superior Court	50	16

Source: NCSC Survey administered in April 2014.

Note: "--" indicates that the court did not respond to the survey or was unable to provide the data.

Most MHCs did not assess whether the program addressed the intended purpose.

- Primarily MHCs indicated the goals were to reduce recidivism and connect (or re-connect) criminal justice-involved defendants with mental illnesses with appropriate mental health services. Without assessing if the court addressed this primary purpose, MHCs struggle with which policies and procedures are best suited for fulfilling their mission. As an example, if the purpose is to reduce recidivism, the MHCs should employ current best practices for reducing recidivism by using risk/need/responsivity (RNR) assessments and matching those assessment results to treatment plans. MHCs must collect and monitor recidivism data to know whether the MHC is, in fact, reducing recidivism.

Only three courts track post-program recidivism. One court indicated that probation can identify new felonies statewide through its electronic case management system (APETS), but was unable to track new limited jurisdiction offenses. All programs individually monitor participants for new offenses while they are in the program, but only three MHCs track this information in a database.



**Table 4. Whether the MHC Tracks Recidivism**

<i>Court</i>	<i>Recidivism</i>	
	<i>In-program</i>	<i>Post-program</i>
Maricopa County Superior Court	No	Yes
Pima County Consolidated Justice Court	No	No
Pima County Superior Court	Yes	No
Tempe Municipal Court	Yes	Yes
Tucson Municipal Court	No	No
Flagstaff Justice Court	No	-- <sup>a</sup>
Flagstaff Municipal Court	No	No
Glendale Municipal Court	No	No
Phoenix Municipal Court	No	No
Sierra Vista County Justice Court	No	No
Yavapai County Superior Court	No	-- <sup>a</sup>
Yuma County Superior Court	Yes	Yes

Sources: Responses to NCSC survey, NCSC interviews, and records shared with NCSC.

Note: In-program recidivism is monitored by the courts as a component of program compliance or terms of probation. This table indicates "Yes" under in-program recidivism only if the court explicitly tracks this information in a database.

--<sup>a</sup> Indicates the program was implemented in 2012 or more recently and recidivism data is not yet available; court indicated it has plans to begin tracking recidivism.

- Some MHCs indicated the purpose of the program was to improve the defendant's mental health and stability. MHCs would need to track outcome data (mental health indicators) or programmatic data to evaluate the effectiveness. One example is to track total time in the program to identify ideal timeframes to receive a maximum benefit for stabilizing mental health symptoms. The ideal time, from MHC team members' perspectives, was a longer duration than some programs were designed to accommodate or as compared to an alternative sentence without the program. Two MHCs tracked participant diagnosis information and examine those data in conjunction with time in the program and success rates to inform program performance.

Some MHCs do not have clearly defined target populations.

- As the court often does not set the clinical or legal eligibility criteria used to make admission decisions, there were several procedural mechanisms developed by the court as a workaround to accommodate differing perspectives on who should be served by the MHCs.
- There was a significant lack of understanding by the MHC teams about how SMI designations are made and what information informed AHCCCS eligibility. These designations determine what services are available to the participants and need to be understood to ensure efficient and effective treatment and to ensure adequate coverage of the defined target population.



- Co-occurring mental health and substance abuse disorders reportedly occurred at a high rate among MHC participants.<sup>20</sup> The MHCs, through limited drug testing requirements and limited use of validated assessment tools to identify a co-occurring population, addressed co-occurring diagnoses as an exception, not an expectation.

Some MHCs did not operate with full support from all representatives.

- A collaborative approach to problem-solving requires representatives who are dedicated to the team, understand their role, and understand the purpose of the court. Some team members, in addition to identifying ambiguity about their own role, did not clearly understand the role of others on the team. A memorandum of understanding or other shared document that describes all team member roles was available in only a small majority of the MHCs. Two examples of MHCs that share clear definitions of team member roles are listed below.
  - Pima County Superior Court MHC clearly describes roles of the team members through its website.<sup>21</sup>
  - Yuma County Superior Court MHC provides a brochure to participants and team members that clearly describe each member's role. This is an excerpt describing the role of the treatment agency representative:

*“Treatment Agencies: Provide comprehensive mental health and/or substance abuse evaluations and intakes in a timely manner, provides rehabilitative therapy sessions, drug screening, case management and monitoring for MHC participants. Each treatment agency provides ongoing verbal and/or written treatment compliance/progress reports on participants to assist the team in any decisions. Attends all staffing and compliance hearings and makes recommendations for rewards, sanctions, graduation, and termination decisions for each of their MHC participant. Assists with housing, transportation, volunteer work and vocational training.”*

- Greater variation across courts seemed, in part, due to differences in knowledge and experience regarding the purpose of the court program and the components of the MHC process (e.g., lack of understanding about each office or agency's role in the MHC process; poor or undeveloped working chemistry with other team members), as well as personality or other individual differences associated with the interpretation of those policies and with discretionary aspects of MHC program operations (e.g., differences in style between individual case managers of MHC participants that may result in inconsistent treatment recommendations across cases; differences in priorities across individual prosecutors may result in inconsistencies in how cases are referred and/or evaluated). These issues were

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<sup>20</sup> Interviewees reported rates of co-occurring substance abuse and mental health issues as high as 80-90% of participants.

<sup>21</sup> See, for example: <http://www.sc.pima.gov/?tabid=94>.

raised by team members from several different MHC programs across the state in a number of ways, as illustrated below:

- *“When you have a dedicated prosecutor, [the MHC] runs so much better. You can provide a better legal service for clients when the prosecutor is on board and communicative and organized.”*
- *“I would like to see more stability on the prosecutor’s side – they change every 6 months. ...It causes a lot of delays in court because the prosecutor isn’t familiar with the issues and doesn’t know what is going on in the case. The MHC is used as a training ground for prosecutors.”*
- *“It took a while but they have a very good team now. The jail is involved to work together and make things easy for MHC cases. Everybody knows each other and works well together.”*

Some MHCs were fortunate to have support from all team members, but more commonly, there was a lack of support from one of the core team members. When there was a lack of support, team dynamics suffered as a result of incomplete buy-in from all team members and this tension threatened the continuity of operations. Continuity among dedicated members was critical for effective team collaboration.

#### Training was limited across all team members.

- Most MHC judges received mental health training; however, team members were less likely to have participated in training on mental health issues. Most frequently, judges attended the Arizona Problem-Solving Court Conference and received training on mental illness diagnoses. Several judges also received presentations about MHCs in other jurisdictions in the state from visiting MHC team members. When asked, MHC team members requested a wide range of training topics to fill their needs, if resources were available. Most often, MHC team members requested training on medications (psychopharmacology), on current trends (e.g., DSM-V, trauma-informed treatment), to better understand specific classes of disorders (e.g., Axis 1) and mental illness more generally, and on communication strategies for and effective responses to individuals with mental illness (e.g., motivational interviewing, therapeutic judging). Some MHCs also requested training on performance measures, housing options, and government benefits processes.

One MHC team member stated: “Providing access to justice requires our courts to continually strive to maintain and improve upon existing processes and systems which ensure effective and efficient case management and use of information and resources. Judges and court staff need the appropriate resources and training to ensure all cases are heard in a timely manner and processed efficiently. Also, our justice system partners and the public should be able to access courts and court information in the most efficient ways possible. While implementing planned technology improvements, we must also find ways to improve existing practices and policies to further ensure that public resources are used effectively, efficiently, and accountably.”

## Recommendations

To address these findings, the NCSC recommends the following actions.

### **1. MHCs should prioritize continuity and sustainability through standards on data collection and implementation of a data infrastructure.**

Clearly, implementation of the proposed standards requires additional resources to acquire an integrated case management system designed for interagency data sharing commonly required by problem-solving courts. Such a system should be maintained by the court. A suggested action plan to enable data tracking and reporting includes the following.

- Establish a state-wide multidisciplinary task force to inventory sources of available program data, data standards, and possible means of electronic data exchange.
- Establish a plan for development of systems and staff support for ongoing program data sharing and reporting.
- Identify funding requirements for such a system(s) and prospective funding sources.

Problem-solving courts nationwide have been successful in maintaining effective electronic data exchange efforts. Additionally, integrated criminal justice projects with a collaborative consortium governance and multi-source funding have valuable experience to lend to the design and implementation task force. Goal 3 of the Arizona Supreme Court, Administrative Office of the Courts' 2014-2019 Strategic Plan provides explicit support for improvements in court processes through case management and information sharing technologies.<sup>22</sup>

### **2. MHCs should revisit the court's purpose.**

MHCs should gather data elements to directly assess and evaluate compliance to its stated purpose. Evaluation will inform MHC mission statements and guide the court to identify data elements necessary to capture measureable effects to determine if the court is serving its intended population and accomplishing its intended goals. Evaluation results will also inform court leaders to make policy decisions regarding the terms of MHC participation to better achieve stated MHC goals. For example, one MHC coordinator conducted an internal evaluation to discover that a longer period of sustained compliance with treatment was necessary to routinize the treatment regimen and better enable MHC participants to maintain stability beyond program completion. These findings informed the decision by the MHC team to extend the program from a one-year commitment for participants to 18 months.

In addition, many courts stated the purpose of the MHC was to improve mental health stability and quality of life for defendants. Others suggested the court's purpose was to

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<sup>22</sup> Advancing Justice Together: Courts and Communities,  
<http://www.azcourts.gov/portals/0/AdvancingJusticeTogetherSA.pdf>.

act as a more cost-effective utilization of resources through reductions in use of jail, hospitalization, and failure to appear rates. These MHCs should consider early intervention models per the system intercept model, when possible. Early diversion is an effective approach for addressing the mental health needs of defendants and serves as a cost-effective solution.<sup>23</sup>

**3. Due to resource constraints, MHCs should consider who is best served with a team-based approach as compared to a more traditional approach without regular judicial supervision.**

Courts should consider empirically based reasons for developing specialized tracks within MHCs, such as to accommodate different treatment service management structures (e.g., has a case manager or not, receives the maximum array of free treatment services covered by AHCCCS or not), for defendants with co-occurring mental health and substance abuse disorders, and for offenders with high/low criminogenic risk of recidivism. For example, MHCs that accept non-SMI defendants without AHCCCS coverage and who cannot afford the full array of treatment services available in the community should establish relationships with other community agencies and providers to secure or facilitate access to otherwise limited community housing and other programs for these participants who would otherwise “fall through the administrative cracks.” Alternatively, defendants with co-occurring mental health and substance abuse disorders may not be adequately served by traditional, one-dimensional mental health or substance abuse programming and should receive specialized treatment programming designed to address co-occurring disorders simultaneously.

Importantly, whereas some defendants with mental illnesses may be best served using a combination of intensive supervision and intensive treatment conditions, others may be adequately served with minimal supervision or oversight by the court simply by connecting them to the appropriate community-based mental health services. Over-supervising low-risk individuals can have a detrimental effect of increasing recidivism by, for example, interfering with positive pro-social activities such as employment or education.<sup>24</sup> To achieve goals of reducing recidivism, MHCs should use offender RNR assessments to inform decisions about appropriate treatment interventions and services designed to target the offender’s criminogenic risk factors. Note that mental illness does not cause criminal behavior; offenders with mental illness are no more likely to recidivate than mentally healthy offenders. Instead, mental illness, like physical illness, operates as a responsivity factor; stability must be achieved before criminogenic risk factors can be addressed.<sup>25</sup> RNR assessment tools can provide information to judges and probation

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<sup>23</sup> Doyle et al *supra* note 1.

<sup>24</sup> See Christopher T. Lowenkamp & Edward J. Latessa, *Understanding the risk principle: How and why correctional interventions can harm low-risk offenders*, TOPICS IN COMMUNITY CORRECTIONS: ASSESSMENT ISSUES FOR MANAGERS, 3-8 (2004). See also discussion in Christopher T. Lowenkamp, Edward J. Latessa, & Alexander M. Holsinger, *The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs?*, 52 CRIME & DELINQUENCY, no. 1, 77-93 (2006).

<sup>25</sup> See J. L. Skeem et al., *Offenders with Mental Illness have Criminogenic Needs, too: Toward Recidivism Reduction*, L. & HUM. BEHAV. (forthcoming Dec. 2013). See also J. Bonta, M. Law & K. Hanson, *The Predictions of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOLOGICAL BULLETIN, no. 2, 123-42 (1998).

officers about the level of supervision necessary to manage an offender in the community and the level and type of services needed. However, without data available to determine which offenders are best served in the various Arizona MHC models, the MHCs are not currently able to make responsive modifications to their procedures.

**4. MHCs should formalize commitment from key stakeholder agencies or offices and secure dedicated team members with clearly defined roles.**

Court leadership should secure a formal, written commitment from stakeholder agencies or offices whose ongoing cooperation is required to support MHC operations. A memorandum of understanding (MOU) would specify the roles, responsibilities, and relationship to other team members. Securing the long-term support and commitment of these collaborating entities in this way is essential to ensure the continuity and sustainability of the MHC program and prevent the possible discontinuation of a program in the face of, for example, turnover in leadership or staff from the prosecutor's office or a RBHA agency transition.

There is a clear benefit to collaborating with team members who are dedicated to work with the MHC; such participation further contributes to the stability and sustainability of a MHC program. All team members should have policies and procedures that clearly define roles. Such documents should be specified in writing and available to the entire team. Specifically, the roles of case managers, treatment provider representatives, and RBHA liaisons should be clarified. The RBHA role should be used as a resource for identifying appropriate services in the community. The MHCs should prioritize establishment of a coordinator to manage data collection, monitor performance, and coordinate training opportunities. The MHCs should have a team member who has clinical training to serve as a neutral advocate for treatment services and to guide criminal justice responses that are most effective for the seriously mentally ill population.

**5. MHC teams should seek appropriate training.**

Training should focus on two key areas. First, the MHC team members would greatly benefit from a training on AHCCCS eligibility processes and the impact the Affordable Care Act will have on connecting defendants who are and are not covered under AHCCCS to appropriate services. Second, the teams would benefit greatly from training on mental health diagnoses, psychopharmacology, and effective responses to individuals with serious mental illnesses.

Overall, dedicated MHC team members should stay current with the recent developments in the field, understanding mental health in the criminal justice system. Team members, including judges, should visit clinical treatment and social service facilities and seek training on communicating and interacting with defendants in the program. Judges should attend current training events on judicial ethics, evidence-based mental health treatment, and co-occurring substance abuse treatment.

Training opportunities includes the National Association of Drug Court Professionals annual conference, with a specialized track on mental health courts; national Justice

Center trainings on mental health courts offered through Council of State Governments;<sup>26</sup> statewide initiatives such the Mental Health Conference offered through the Education Services Division in conjunction with the Judicial College of Arizona; or through a local university such as Arizona State University's Mental Health America of Arizona Annual SEEDS Conference, whose 2014 conference was on the Intersection of Behavioral Health and Criminal Justice.<sup>27</sup>

Upon approval of a final set of statewide standards for mental health courts in Arizona, it will be necessary to also include training for the courts on implementation of and compliance with the standards. Training will also be necessary for courts that do not yet operate within the scope of the approved statewide standards.

## Summary

Arizona MHCs represent a vast array of models at all stages of adjudication. The MHCs must work within the constraints of the local and state criminal justice and behavioral health systems to effectively process and serve defendants with mental illnesses. Undoubtedly, all MHCs would benefit from data to assess efficiency and adequately evaluate effectiveness. The data will ensure continuity of operations for MHCs operating within the state. This report should be used as a blueprint to capitalize on the synergy of the current evaluation efforts and standards development efforts for implementing evidence-based standards and performance measures so that MHCs can operate efficiently, effectively serve the defendants and the public, and hold defendants accountable to protect the community.

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<sup>26</sup> See for example, <http://csgjusticecenter.org/courts/mhc-curriculum/> on Developing a Mental Health Court.

<sup>27</sup> 2014 Conference: <http://cabhp.asu.edu/events/seeds-2014-conference-the-intersection-of-behavioral-health-and-criminal-justice>.

## Resources

COUNCIL FOR STATE GOVERNMENTS JUSTICE CENTER, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2007).

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# Appendix:

## Arizona Mental Health Court Profiles

### *Site Visits*

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*This Appendix is divided into two sections. Listed in this first section, the NCSC conducted site visits to the MHCs listed below. To inform these profiles, the NCSC observed team staff meetings and status review hearings, interviewed team members, participants, and stakeholders, toured court, probation, and treatment facilities, and reviewed program policies, procedures, and data on participants.*

*The profiles reflect program descriptions of these five MHCs:*

- *Maricopa Superior Court: Specialized Probation Caseload for Seriously Mentally Ill*
  - *Pima County Consolidated Justice Court: Mental Health Court*
  - *Pima County Superior Court: Mental Health Court*
  - *Tempe Municipal: Mental Health Court*
  - *Tucson City Court Mental Health Division: Mental Health Court*
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## Maricopa County Superior Court

### Maricopa Superior Court: Seriously Mentally Ill (SMI) Specialized Probation Caseload<sup>1</sup>

#### **History**

Maricopa Superior Court's operations with the SMI Specialized Probation Caseload began in 2004.<sup>2</sup> This caseload operates within a larger context of the Maricopa Consolidated Mental Health Court. A clear benefit of this "Consolidated" Mental Health Court is that the dockets operating within this court are interrelated, covering a range of mental health issues (e.g., guardianship, competency). The mental health court (MHC) operates a docket to provide judicial support and oversight for probationers on specialized caseloads who have serious mental illnesses. During the NCSC's visit, Commissioner Barbara Spencer and Commissioner Patricia Starr presided over the MHC.

#### **Program Design**

*Purpose.* The purpose of the SMI unit of the specialized probation caseload is to improve probationers' opportunities for success on probation through close supervision, timely case management, education and training, advocacy, and effective collaboration with community agencies. The MHC operates as a post-sentence model under specialized probation caseloads designed for individuals with mental illness. The most notable feature of the program is that probation officers can schedule court appearances on an "as needed basis" for the offenders they supervise. Not all SMI probationers will appear before a judge in MHC. Court appearances are scheduled for SMI probationers on either end of the compliance spectrum—those doing well and those doing poorly. Probation views this model as a useful tool for SMI probation officers to solicit input from a multi-disciplinary team on potential solutions. The court status hearings serve as a sanction to reinforce and/or encourage compliance or as an incentive to receive judicial recognition. Court hearings also enable the court's authority to be used as leverage to gain treatment provider compliance to meet participants' needs. The court is generally responsive to probation requests and will typically docket a matter within two to three days. Probationers receive mental health terms attached to their sentence to enable probation officers to request "flash incarceration" (or interim deferred jail time up to 120 days) without the need to file a petition to revoke probation.

*Target population.* The target population is Maricopa County adult felony probationers who have qualified serious mental illnesses, including Axis I diagnoses or evidence of functional impairment.

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<sup>1</sup> The National Center for State Courts would like to acknowledge the following members of the Maricopa Superior Court for their time and involvement with this project: Jessica Ethington (SMI Probation Supervisor), Frankie Jones (Prosecuting Attorney), Kim McCurtain (SMI Probation Officer), Rodney Mitchell (Public Defender), Douglas Murray (SMI Probation Officer), Catherine Soileau (Comprehensive Mental Health Coordinator), Commissioner Barbara Spencer, Commissioner Patricia Starr, Cathryn Whalen, (Public Defender), Fred Wilhalme (SMI Probation Officer), and Tammy Wray (Public Defender).

<sup>2</sup> For additional information see: <http://www.maricopa.gov/opa/mhc.aspx>. See also <http://www.superiorcourt.maricopa.gov/SuperiorCourt/ProbateAndMentalHealth/Index.asp>.

## **Eligibility**

*Legal eligibility.* All probation eligible charges are screened for the SMI specialized caseload, including transferred youth, sex offenders, and all populations of offenders that have been verified through the RBHA as an SMI. SMI unit probation officers determine who makes a MHC appearance and when.

*Clinical eligibility.* To be eligible for the SMI specialized caseload, probationers must be designated as SMI by the local RBHA. SMI unit probation officers will consider accepting probationers with traumatic brain injury, development disability, and/or dementia diagnoses.

*Screening and assessment tools.* Probation officers assess the general recidivism risk and criminogenic needs of all participants using the OST (Offender Screening Tool) and reassess on the FROST (Field Reassessment Offender Screening Tool). This information is used to inform case planning. All defendants also undergo a presentence investigation, of which the OST assessment is a part. The presentence report is used in part to inform the judge's decision for assigning mental health terms to the sentence.

## **Program Description**

### Efficiency

*Referrals.* Referrals arrive along two primary routes. Most frequently, if RBHA has previously evaluated the defendant and offered a designation as SMI prior to sentencing, then the pre-sentencing officer recommends a mental health addendum on the pre-sentencing report. The judge has the discretion to add the mental health court addendum, but it is generally discouraged unless the probationer is verified with an SMI designation. The second path is that probation officers outside the SMI unit can call for a judge to add an addendum retroactively to place participants on the SMI unit after sentencing to probation. The team indicated that ideally sentencing judges should have more information about the SMI designation during sentencing so that the mental health terms are added to the sentence early in the process.

*Staffing and docket.* On average, the court calendars 30 participants each week; the majority of those on the SMI caseload are not set on the calendar. Court is primarily used for situations in which the participant decompensates or faces compliance issues. Court is used as a way to trouble-shoot with a multi-disciplinary team to solve any treatment concerns. Probation officers expressed the benefit of not waiting until a probationer is petitioned to revoke to receive judicial support. As of the time of NCSC's visit, the staffing meetings lasted approximately an hour and a half, followed by a 45 minute break to enable public defenders to discuss updates with their clients. The court status hearing lasted approximately 45 minutes. There were approximately 12 participants on the calendar for the NCSC's observed docket. Typically, there are 12-20 scheduled participants appearing for each docket. The current model creatively sustains the resources necessary to supervise and process the large volume of participants. Thus, any change to the "as needed" calendaring model would require significantly more resources to accommodate additional staffing and status hearings as well as a significant increase in probation officers overseeing specialized caseloads to handle an already large caseload.

SMI probation officers use various tactics to streamline the court processes and spend less time in court. For example, one probation officer schedules all court appearances on the same day every two weeks to streamline the time she spends in the courtroom.

### Accountability

*Program structure.* The SMI probation officers require probationers to maintain minimum contacts and comply with probation requirements. However, participants face various individualized terms of probation; many probation officers report that this population often requires more contacts than the minimum requirements. The average caseload of specialized SMI unit is 610 probationers with caseloads capped at 40 per officer. The average time in the MHC program is one and a half to three years.

The team employs a range of incentives including gift cards, certificates, fewer appearances, and public recognition. On the other end of the spectrum, the court employs sanctions including more frequent appearances in court, verbal admonishments, threat of jail time, and flash incarceration. The team universally recognizes that jail time disrupts a participant's stability and results in a lack of continuity in prescription medication. Thus, the court uses jail time sparingly and for short terms (typically less than 7 days). However, jail is used as a way to place a participant in a safe, sober environment or while awaiting treatment availability in the community.

### Effectiveness

*Team members.* The team operates in a problem-solving capacity to overcome barriers to participant success. The team consists of two commissioners, a court coordinator, SMI probation officers, regularly assigned public defenders, a peer mentor representative, a RBHA representative, and a host of case managers. A prosecutor was typically not present unless there was a filing for a petition to revoke probation. This absence was clearly understood by the team to be an issue of funding, not an indication of a lack of cooperation or support for the program.

The presiding judge determines rotation, which occurs approximately every three years. During our visit in March of 2014, two judges (Commissioner Starr and Commissioner Spencer)<sup>3</sup> oversaw the mental health court docket that reviews the SMI specialized probation cases. The MHC team meets quarterly to make programmatic decisions about the program and discuss potential improvements.

Training requirements for SMI probation officers is extraordinary and commendable. SMI officers receive training in the first year on the job that addresses the following topics: co-occurring disorders, psychological disorders, crisis overview, and psychopharmacology. SMI officers can also opt to take recommended training on topics such as: housing, suicide, RBHA orientation, and AHCCCS Universal Application.

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<sup>3</sup> The assignment to the MHC was Commissioner Spencer's second assignment on the MHC; the first was in 2007. Commissioner Starr took over for one of the founding judges (Judge Michael Hintze) when he retired; recently Commissioner Spencer has been appointed as Superior Court Judge and will no longer preside over the MHC, as of June 30, 2014.

*Services provided.* The MHC team suggested that Maricopa County has a wealth of services as compared to other regions of Arizona. Yet, the team also identified that housing and substance abuse services were inadequate to serve the population. In particular, identifying housing for individuals with co-occurring, substance abuse, and/or functional impairments was particularly difficult. The co-occurring population was estimated at over 90 percent of those on the SMI specialized caseload. To adequately serve this population, the program requires both validated assessment tools for detecting co-occurring disorders at an early stage in treatment development and a need to connect the participants with existing co-occurring treatment in the county. Additionally, the team reports that drug testing processes could be improved, such as identifying a better response for a missed drug test than considering it positive, particularly for a low-functioning population. Functional impairment is reportedly high among this population, which at times, requires a designated payee or guardian ad litem to administer their funds and navigate the benefits system.

*Data and evaluation.* The probation department gathers most of the data on the specialized caseload and reported a 73 percent success rate for FY 2013. This figure includes probationers with early terminations, those who expired out of the program, those who complete probation with earned time credit, and those who exit probation on successful completion. In FY 2013, 351 probationers exited probation.

Admirably, the SMI units in the probation department have recently expanded the data elements it tracks to better understand the effectiveness of sanctions/incentives for MHC participants and is poised to make programming changes in response to the data results. The court collects limited data on participants; currently the court collects data manually in Excel.

### **Program Exit**

There is no formal graduation for the SMI specialized probationers. Probation officers can request an early probation termination; optionally, the probation officer can place the case on record and the team will congratulate the participant in open court. After graduation, some participants engage in alumni support groups and are encouraged to seek peer support training opportunities. Aftercare and access to services post-program is available for those who are AHCCCS-eligible.

## Pima County Copnsolidated Justice Court

### Pima County Consolidated Justice Court: Mental Health Court<sup>4</sup>

#### History

The Pima County Consolidated Justice Court (PCCJC) began operating an informal mental health court in 2000 under Judge Carmen Dolny as an effort to respond in a new way to the volume of mentally ill offenders circulating through the criminal justice system. Several tragedies in the Tucson area – crimes borne of mental illness – heightened awareness of the link between mental health and criminal justice in the community consciousness. The PCCJC community viewed early identification and efforts to connect mentally ill offenders with treatment services as a partial solution to reduce recidivism driven by mental illness and provide these individuals with a chance for a better life. In 2009, Judge Susan Bacal became the current presiding judge of this docket and transformed the initiative into a formal PCCJC MHC program, modeled after the longstanding MHC program at the local Tucson City Court.

#### Program Design

*Purpose.* The PCCJC MHC does not currently have a formal mission statement or statement of program goals, although several team members indicated that this could be helpful moving forward. Interviews with team members indicated that the MHC operates primarily as a mechanism for (re)connecting mentally ill defendants with behavioral health services through the RBHA. It also operates to reduce failure-to-appear rates with this population: The judge and other MHC team members provide a supportive environment for mentally ill offenders to see their legal matters resolved, and will consolidate court appearance dates into a single appearance date when a defendant has several outstanding cases.

*Target population.* The PCCJC MHC program targets mentally ill defendants at two points. The pre-plea diversion track, overseen by the county attorney's office, targets first-time offenders. The post-conviction (i.e., "non-diversion" or "general MHC") track targets mentally ill defendants deemed ineligible for diversion by the county attorney's office, admitting these defendants as MHC participants following a guilty plea.

#### Eligibility

*Legal eligibility.* The PCCJC MHC program accepts all referrals of defendants with behavioral health needs to one of the two MHC program tracks. The post-conviction track does not have rigid legal eligibility criteria. Participation in the diversion track must be approved by the county attorney. Defendants with prior convictions and/or who face certain types of charges (such as for criminal traffic offenses or offenses involving weapons) are typically ineligible for diversion. Several MHC team members expressed a

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<sup>4</sup> The National Center for State Courts would like to acknowledge the following member of the Pima County Consolidated Justice Court for their time and involvement with this project: Janet Altschuler (Private Attorney), Hon. Susan Bacal, Megan Bright (COPE Court Services Specialist), Diana Carino (CPCC Criminal Justice Liaison), Elizabeth Cirillo (Public Defender), Gabrielle Danaher (CODAC Criminal Justice Care Manager) Yvonne Hendrix (Courtroom Clerk), Lisa A. Kumiega (Deputy County Attorney), Kate K.V. Lawson (CPCC Criminal Justice Manager), Patrick Alan Moran (Private Attorney), Victor da Rosa (La Frontera Criminal Justice Case Manager), Terry Staten (Sheriff's Department Detective Sergeant), and Joe Valenti (Public Defender).

desire to see diversion expanded to defendants who have prior convictions, as the possibility of case dismissal is understood to be a powerful motivator for MHC participants to comply with treatment.

*Clinical eligibility.* The defendant must consent to the terms of the PCCJC MHC program, which includes the receipt of behavioral health treatment services as prescribed by a treatment provider. Team members indicated that an SMI designation, along with the defendant's financial status and proof of legal residency, are used to inform a determination of defendant eligibility for the state Medicaid insurance program ([AHCCCS](#)), which covers behavioral health care costs associated with MHC participation. The PCCJC MHC program does not require an SMI designation for admission; however, interviewees expressed a concern that the MHC program is unable to serve defendants with clear mental health needs who are not SMI- or AHCCCS-eligible and who do not otherwise have the means to self-pay for treatment.

*Screening and assessment tools used.* All clinical assessments used to establish AHCCCS insurance eligibility and/or inform treatment planning are conducted by behavioral health providers in the RBHA network. No other standardized screening or assessment tools inform the eligibility determination.

## **Program Description**

### Efficiency

*Referrals.* Candidates for referral to the PCCJC MHC may be identified at any point in the criminal justice process. Local law enforcement undergo specialized training on how to respond to mental health-related incidents in the community; the Pima County Sheriff's Department has a dedicated Mental Health Investigative Support Team ([MHST](#)), which works closely with the RBHA criminal justice team to proactively identify mentally ill offenders and connect them with appropriate services. Treatment provider liaisons also review information on new arrests from the jail. At arraignment, any offender identified as mentally ill by a local treatment provider agency under the RBHA is automatically referred to the MHC. In addition, defense attorneys, judges, and others who note mental health-related concerns with a defendant may ask to have the defendant's case referred for possible admission to MHC.

Although some defendants would not be provided with court-appointed defense counsel in traditional court given the nature of their charges, the PCCJC MHC appoints defense counsel for every referred case.<sup>5</sup> To maintain continuity in the MHC program, the MHC judge will select counsel from a short list of pre-approved defense attorneys under contract with the court who have demonstrated expertise or affinity to working with mentally ill defendants.

*Staffing and docket.* The PCCJC MHC hears cases on a dedicated docket, convened twice a week (on Wednesday and Thursday afternoons).<sup>6</sup> The calendar includes a mix of

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<sup>5</sup> Interviewees indicated that PCCJC is not supported by a public defender's office.

<sup>6</sup> NCSC researchers observed the Thursday afternoon docket on January 30<sup>th</sup>, 2014, which ran approximately 1 hour and heard cases for 16 defendants (some of whom appeared for multiple cases). One



arraignments, status hearings, and trials for defendants in and out of custody. Defendants in custody are typically heard first, followed by out-of-custody defendants in the order in which they arrive to court and sign in with the courtroom clerk. Participants may leave court after their case has been heard. Witnesses and victims may attend court proceedings and are asked to notify the judge or county attorney upon arrival. Several court-appointed defense attorneys voiced appreciation for the effort to coordinate their cases when possible (i.e., to schedule the attorney's clients for status review hearings on the same day).

The MHC operates without routine staffing meetings; however, team members exchange information at the start of each docket and in between cases. To inform proceedings, the RBHA liaison and the criminal justice liaisons from each participating behavioral health provider agency operating under the auspices of the RBHA have access to computerized database information about MHC participants. Information shared includes participant compliance with treatment during the prescribed monitoring period (e.g., attendance at appointments, behavior toward treatment team) and knowledge of circumstances surrounding any client misbehavior (e.g., in conjunction with re-arrests identified through a data sharing collaboration between RBHA and the jail). Criminal justice liaisons from provider agencies typically do not operate in the case manager role for MHC clients, but access status information and notes provided by the client's individual case manager to represent the provider agency in communications with the court. Interviewees from the court expressed satisfaction with the quality and timeliness of information shared by the criminal justice liaisons.

#### Accountability

*Program structure.* To successfully complete the diversion track of the MHC program, participants must fulfill a 9 to 12-month term of compliance with a treatment plan, as defined by the participant's treatment provider. They must maintain a clean record during this period (i.e., no new arrests). Participants are also required to attend judicial status hearings for progress reviews every three months, complete five hours of community service, and complete any other terms of diversion customized for the participant in the diversion agreement. Although the county attorney's office charges fees of participants who go through traditional (i.e., non-MHC) diversion, participants in the diversion track of the MHC program are not required to pay fees.

Similar terms are required of participants in the post-conviction track of the MHC program. Post-conviction MHC participants must fulfill a 6 to 12-month term of compliance with a treatment plan, as defined by the participant's treatment provider, and maintain a clean record during that time. These participants are also required to attend periodic judicial status hearings for progress reviews; the frequency of these hearings is contingent on the participant's demonstrated compliance with program terms, with less compliant individuals scheduled to appear more frequently before the judge over the monitoring period. Participants must also comply with any individual terms specific to his or her plea agreement, such as a fine and/or a period of supervised probation.

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interviewee indicated that docket volume on any given day may range from only one to as many as 30-40 cases.

Participants are given several opportunities to demonstrate compliance and receive verbal praise when successful, but some interviewees indicated a desire to see the MHC implement a wider array of sanctions and incentives in response to participant behaviors. The county attorney has full discretion to terminate from the MHC program a participant who incurs a new arrest. If a diversion-track participant is permitted to continue in the MHC program, new charges may be combined with the original charges in the diversion agreement. Participants who do not comply with their diversion or plea agreement may be taken into custody as a last resort, which typically precedes formal termination from the MHC program.

Since April of 2009, nearly 500 cases have been entered into the MHC program. Currently, about 150-200 cases are actively enrolled.

### Effectiveness

*Team members.* Team members present for the MHC docket include the judge, courtroom clerk, prosecutor from the county attorney's office, court-appointed defense counsel (those representing MHC participants scheduled to appear that day), a RBHA liaison, and criminal justice liaisons from the following behavioral health provider agencies under the RBHA: [COPE](#) Community Services, Inc.; [CODAC](#); and [La Frontera Center, Inc.](#) Team members do not receive specialized training for the PCCJC MHC program but several expressed a desire for opportunities such as funding/resources permit.

Team members demonstrated strong support for the MHC program but also expressed some concerns. All team members participate in MHC on a part-time basis, and several communicated the time-management challenges associated with additional non-MHC responsibilities. Most indicated a desire for more dedicated staff time (e.g., in the form of two full-time dedicated defense attorney positions, one full-time dedicated courtroom clerk position or two part-time clerk positions, more of the judge's time on an expanded MHC calendar). Team members also wished to see more visible support from the county attorney's office through leadership participation in semiannual MHC team potluck meetings and an investment in continuity by assigning a dedicated county attorney to the MHC for a sustained period of time. Most team members expressed frustration that the MHC appeared to be a "training ground" for new prosecutors, who typically rotate through the position every three months.<sup>7</sup>

*Services provided.* Participants typically receive services from the RBHA network of behavioral health treatment providers, such as COPE, CODAC, La Frontera, or the direct care arm of CPSA (called Community Partnership Care Coordination or CPCC). However, participants may receive services from private providers or other provider agencies without a dedicated PCCJC MHC criminal justice liaison. Services commonly include mental health, trauma, and substance abuse treatment via individual counseling, group treatment sessions (including gender-specific treatment groups), medication

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<sup>7</sup> NCSC researchers requested but were unable to secure an interview with the MHC prosecutor.

management, and recovery support services/peer mentoring. Some providers offer financial assistance to help clients secure benefits and assistance in locating housing.

A few interviewees expressed some doubt in the efficacy of group treatment options for offenders with mental health needs, and one indicated that a more structured approach designed specifically for the criminal justice population (separate from those who are not justice-system involved) may benefit MHC participants.

*Data and evaluation.* The PCCJC MHC has not been previously evaluated. The PCCJC uses the AGAVE case management system, which tracks the number of cases and participants entered into MHC, basic demographic information about MHC participants (e.g., age, race, gender, basic information about the types of charges faced by MHC participants, and how each MHC case is resolved (adjudication type and, if applicable, reason for termination). It does not currently track post-program outcome data on participants.

### **Program Exit**

Participants who successfully complete the MHC diversion track have their charges dismissed; supervision is terminated. Interviewees estimated that approximately 90 percent of participants successfully complete the program. For participants who are terminated from MHC diversion for noncompliance, prosecution is reinstated.

Participants who successfully complete the MHC post-conviction track may have suspended jail time expunged from their record; however, program involvement offers other benefits to these participants, who may feel more comfortable about appearing in a specialized court with the support of a knowledgeable court-appointed attorney and treatment provider representatives than in a traditional court with potentially no or less-qualified representation. Graduations occur once every three months; participants receive a certificate of completion. No formal court aftercare program is offered, but AHCCCS-insured participants may continue to receive treatment services through their preferred provider.

## Pima County Superior Court

### Pima County Superior Court: Mental Health Court<sup>8</sup>

#### **History**

In July 2004, Judge Nanette Warner of the Arizona Superior Court in Pima County assembled a committee of local criminal justice stakeholders to direct the development and implementation of a specialized court program for mentally ill offenders. Judge Warner noted the high rate at which petitions to revoke probation were being filed against community-supervised offenders with serious mental illnesses (SMI) and called for a program that could better meet the needs of these individuals to help them successfully complete probation. Since inception, three judges have presided over the Pima County Superior Court's Mental Health Court (MHC). The current MHC judge is Judge Deborah Bernini.

#### **Program Design**

*Purpose.* The goals of the MHC program are to: improve communication and collaboration between the court, community supervision agencies, law enforcement, and behavioral health providers in partnership with program participants; increase the efficiency of criminal case processing; improve the likelihood of success of treatment interventions, agency placement, and community supervision for program participants; increase compliance with conditions of release and probation for program participants; and reinforce positive, pro-social choices for program participants.<sup>9</sup>

*Target population.* The MHC program serves adult community-supervised felony offenders who have been designated as SMI by the RBHA.<sup>10</sup> The MHC is not a diversion program. Participants enter the program as part of a specialized probation caseload for SMI-designated defendants.

#### **Eligibility**

*Legal eligibility.* A defendant must be convicted of probation-eligible felony charges. Defendants charged with serious crimes (murder, sexual assault, child molestation, some domestic violence crimes) are typically ineligible for MHC.

*Clinical eligibility.* The defendant must have an active SMI designation and must receive or be willing to receive behavioral health treatment services through the RBHA network. For defendants who have not yet been evaluated for the SMI designation, an authorized

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<sup>8</sup> The National Center for State Courts would like to acknowledge the following members of the Pima County Superior Court for their time and involvement with this project: Peggy Averett (Administrative Assistant), K. Kent Batty (Court Administrator), Anne-Marie Braswell (Community Relations Coordinator), Nancy Coomer (Public Defender), John Delgadillo (CODAC), Amanda Guerrero (Jail Medical Provider), Sally Hueston (HOPE Peer Support), Sam Nagy (CPCC Criminal Justice Peer Mentor), Ronald G. Overholt (Deputy Court Administrator), Kelly Pesano (Senior Probation Officer), Terri A. Rahner (Criminal Justice Clinical Coordinator), Richard Walitshek (Probation Officer, SMI Caseload), and Steven R. Wenzel (Veterans Justice Outreach Coordinator).

<sup>9</sup> The mission of the MHC program, along with other information including the application for admission, may be found on the Superior Court website at: <http://www.sc.pima.gov/?tabid=94>.

<sup>10</sup> The RBHA for the Superior Court of Pima County in geographic service area #5 is the Community Partnership of Southern Arizona (CPSA).

RBHA professional will conduct an SMI evaluation.<sup>11</sup> The SMI determination is informed by the individual's psychiatric diagnosis (which must be established before the SMI evaluation can take place) and a global assessment of functioning (GAF) score at or below 50. Those designated as SMI are eligible for coverage through AHCCCS, which pays for a greater array of services in the RBHA network.<sup>12</sup>

The MHC program does not typically accept SMI-designated defendants with a co-occurring substance abuse disorder. These defendants are instructed to address any substance abuse issues before they will be considered for admission to MHC.

*Screening and assessment tools used.* All clinical assessments are conducted externally from the court by an authorized RBHA representative. In addition, the adult probation department conducts several standard assessments of the defendant for inclusion in the presentence report and to inform probation case planning. Written by a presentence investigation officer, the presentence report includes results from the Offender Screening Tool (OST) and a supplementary substance abuse assessment called the Adult Substance Use Survey (ASUS). To inform updates of the probationer's supervision and treatment plan, the supervising probation officer conducts a field reassessment version of the OST (called the FROST) with the offender. The FROST is designed for administration at six-month intervals for as long as the offender remains on probation.

## **Program Description**

### Efficiency

*Referrals.* The MHC accepts referrals from Superior Court judges, attorneys, specialized SMI probation officers, the Southern Arizona Veterans Affairs (VA) Health Care System, and the clinical coordinator. Referrals may occur: (a) post-plea, if the defendant appears to have a mental illness and is likely to be sentenced to probation; (b) presentence, as part of preparations to dispose of a probation-presumptive case against a defendant who appears to have a mental illness; (c) post-sentence with SMI-designated probationers on a specialized probation caseload; (d) pre-release, for those in custody who may have a mental illness and who will be serving a probation term. Referred candidates in the community who have been previously enrolled in the RBHA network often have an active SMI designation and may immediately access these treatment services while a MHC admission decision is pending. Those referred by the probation department from the SMI probation caseload often already receive treatment services in the community; all such referrals are accepted into the MHC, even if the defendant has a co-occurring substance abuse disorder that would, through other referral sources, disqualify him or her from consideration. Referral candidates not already connected with the RBHA network and who require an SMI determination often experience a significant time delay between referral and enrollment in treatment services.

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<sup>11</sup> In Tucson, the CPSA criminal justice team typically submits SMI evaluation requests, along with preliminary information about the defendant, to the Southern Arizona Mental Health Corporation ([SAMHC](#)), who will dispatch a representative to conduct the evaluation with the defendant.

<sup>12</sup> Those with the less severe general mental health designation (GMH) are not eligible for AHCCCS enrollment.

Admission decisions are made on a case-by-case basis. Upon acceptance into the MHC program, the defendant's case is transferred to the presiding MHC judge to set the conditions of probation, to ensure that appropriate mental health terms are defined.

*Staffing and docket.* Organizational practices support an efficient court calendar. All MHC team members attend a 30-minute staffing every Monday immediately prior to the MHC docket. The supervising probation officer and case manager from the treatment provider agency complete a standardized progress report (called a Behavioral Health Tracking Form) on all participants whose cases appear on the MHC calendar that week. This report is shared with the MHC team via email prior to staffing to inform court decisions about the case. This process allows for the review of 10-12 cases in a speedy 30-minute docket. Wait times are minimal and participants are permitted to leave court as soon as their case has been heard.

#### Accountability

*Program structure.* The MHC program is designed for completion within 18 months and features a general MHC track as well as a specialized track for military veterans. All participants are required to attend routine judicial status hearings for a progress review with the MHC judge. The entire MHC team is present, including the participant's probation officer and liaison from the behavioral health provider from which the participant receives services. Intervals between hearings vary: Defendants who demonstrate compliance with the conditions set by the MHC are required to attend court less frequently, whereas those who demonstrate noncompliance are required to appear before the judge more often. In addition to verbal encouragement and praise for demonstrated compliance, certificates of accomplishment are awarded to participants at each status hearing and as they progress through the program. Probation officers are authorized to administer any sanction (e.g., write a letter, complete community service time) in response to noncompliant participant behavior. The MHC judge may also order a participant into custody at the status hearing as a sanction. In these cases, the probationer typically spends three weeks in jail until a petition to revoke probation is heard and decided on by the court. If jail time was issued as a sanction only, the participant is then reinstated to MHC.

The MHC team strives to maintain a manageable caseload not exceeding 50 active participants at any one time. At the time the court was surveyed, the MHC program had 34 active participants.

#### Effectiveness

*Team members.* A team of dedicated criminal justice and behavioral health professionals support and monitor all participants for the duration of their involvement in the MHC program. Team members include: a judge; a criminal justice mental health clinical coordinator; attorneys from the County Attorney's Office, Public Defender's Office, and Legal Defender's Office; specialized probation officers who supervise SMI caseloads; a jail-based medical provider; a liaison and peer recovery support specialist from the RBHA; liaisons from local behavioral health agencies in the RBHA network charged with providing mental health treatment and additional peer recovery support services to

MHC participants; a liaison from the VA; and an administrative assistant.<sup>13</sup> As of February 2014, provider agencies represented by liaisons on the MHC team include: [COPE](#) Community Services, Inc.; [CODAC](#) Behavioral Health Services; [La Frontera Center](#), Inc.; and [HOPE](#), Inc. Team members also have additional responsibilities outside of the MHC program. Based on interviews and direct observation, team members appear to share a collaborative mindset and have an effective communication system.

*Services provided.* All services are provided through the RBHA network of behavioral health providers. Common services include group treatment, individual counseling, peer support groups, and medication management. Housing, financial, and transportation services may also be available if the participant is enrolled in AHCCCS. MHC team members and affiliates generally considered the range of services offered through the RBHA network to be comprehensive, but expressed a desire to see improvements in participant access to intensive residential treatment beds and stable housing. Others expressed concerns about the use of a group treatment session requirement in some case plans, as group settings may not be appropriate for some SMI-designated participants.

*Data and evaluation.* The clinical coordinator conducted a five-year review of the 252 cases heard by the MHC from July 2004 to October 2009. The effort to collect and clean the necessary data to inform this evaluation reportedly took almost a year. Of the 252 cases analyzed, 191 involved clients with co-occurring mental illness and substance abuse diagnoses. The percentage of participants with co-occurring disorders who successfully graduated from the program was 33 percent, while the overall graduation rate was around 40 percent. The clinical coordinator also found that participants benefited from longer periods of MHC involvement.<sup>14</sup> The MHC team established several of the current program parameters in response to this information (by restricting the admission of defendants with co-occurring disorders, by lowering program capacity from 90 to 50 active participants, and by retaining participants in the MHC program for a target time frame of 18 months instead of 12 months). Since these changes, graduation rates have reportedly risen by more than 10 percent.

### **Program Exit**

With a probation sentence, MHC participants often have suspended jail time. Upon graduation from the MHC program, remaining jail time is dismissed. Those who unsuccessfully exit the program (i.e., terminations) return to jail or prison. In 2013, the MHC program produced 13 graduates.

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<sup>13</sup> In Pima County, offenders who have an SMI designation are placed on a dedicated SMI probation caseload. Probation officers assigned to an SMI probation caseload receive specialized training, such as crisis intervention, in addition to standard probation training requirements. Although other MHC team members have completed informal and elective training opportunities, no standard MHC training curriculum has been developed. New presiding MHC judges are trained primarily via a mentoring approach.

<sup>14</sup> The five-year review also showed differences in MHC participant graduation rates between the three primary behavioral health providers. Team members attributed this to the financial resources of clients served in particular geographic areas.



Former participants may continue accessing available treatment and peer support services in the community through the RBHA network free of charge as long as they maintain AHCCCS coverage. Interviewees indicated that an MHC alumni peer support group is convened by the RBHA liaison, and HOPE and other peer support providers serve in an aftercare capacity by providing alumni with pro-social opportunities.

## Tempe Municipal Court

### Tempe Municipal: Mental Health Court<sup>15</sup>

#### History

The first participant entered the Tempe Mental Health Court (MHC) program in June of 2003. A development committee identified the objectives of the program, which were to provide early identification of mentally ill offenders and provide them with a diversion option that identifies appropriate treatment and support services. Defendants' lack of knowledge about benefits and a lack of access to treatment was part of the impetus for the project. Judge MaryAnn Majestic currently presides over the MHC.

#### Program Design

*Purpose.* The MHC is a specialized docket designed to address the unique needs of seriously mentally ill offenders and provide services that reduce the possibility of recidivism and reduce jail days.<sup>16</sup> People who gain access to effective mental health services can rebuild their lives and become productive members of the community.

*Target population.* The MHC program operates as a voluntary, pre-plea diversion program for individuals with serious mental health issues who are typically charged with misdemeanor offenses.

#### Eligibility

*Legal eligibility.* All charges are eligible for diversion into the MHC with the exception of DUI. If the offense involved a victim, victim consent is required.

*Clinical eligibility.* The clinical eligibility is an SMI designation. However, the prosecutor offers a diversion option for those who do not receive an SMI designation from RBHA (i.e., those who are designated as GMH or undergoing an appeal of a denied SMI designation). All participants must be either case managed through a RBHA provider or receive care from a private provider who provides regular reporting on progress to the MHC team.

*Screening and assessment tools used.* All clinical assessments are conducted by behavioral health providers in the RBHA network.<sup>17</sup> No other screening or assessment tools are used by the court to inform a determination of eligibility.

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<sup>15</sup> The National Center for State Courts would like to acknowledge the following member of the Tempe Municipal Court for their time and involvement with this project: Stanley Alexander (Magellan Health Services Court Advocacy Liaison), Erin Cain (Choices Network Case Manager), Annaluisa Castro (HOPE Lives), Stacey Clay (Magellan Court Liaison), Andrew Davidson (Prosecutor), Christopher Gonzalez (Hope Lives Chief Executive Officer), Scott McAlister (Court Appointed Attorney), Hon. MaryAnne Majestic, Raymond Mathis (HOPE Lives), Gerri Mattern (Mental Health Advocate/Defense Council), and Kimberly Sotelo (Executive Assistant).

<sup>16</sup> Tempe Mun. Ct. P. 252.001, (for Mental Health Courts, dated 8/3/2011).

<sup>17</sup> At the time of the NCSC site visit, Magellan held the RBHA contract, as of April 1<sup>st</sup> 2014, Mercy Care took over RBHA contract.

## **Program Description**

### Efficiency

*Referrals.* Referrals may come from jail staff, judges, attorneys, the RBHA liaison, or family members. Local law enforcement is also trained in CIT and offers another source of referrals. This training enables law enforcement to better respond to calls and effectively de-escalate crisis situations involving citizens with mental illnesses. Following arrest, those in custody will typically be admitted into the MHC within a week or two; out of custody, typically within a month.

*Staffing and docket.* Two 30-minute dockets take place on Tuesday mornings.<sup>18</sup> Status reports are distributed to the team members prior to the docket. Each docket is preceded by a 30-minute staff meeting during which the core MHC team reviews and discusses reports on the calendared cases, including consideration for any new participants. In each docket, Judge Majestic reviews approximately 8-10 cases; participants are permitted to exit court after their case has been heard. The judge orchestrates a very efficient process for team members and participants across both staff meetings and status review hearings.

### Accountability

*Program structure.* The MHC is a pre-plea, deferred prosecution program. Participants are expected to adhere to the requirements set by the court: maintain contact with a case manager, adhere to their treatment plan, take medication as directed, and avoid re-arrest. At every status review hearing, participants receive an individualized contract with specific short-term goals identified by the team. Participants, depending on determined needs, appear on a schedule that ranges from weekly to every couple of months. The duration of the program is typically 11-12 months. Upon successful completion of the program, the pending charges are dismissed.

### Effectiveness

*Team members.* The team consists of a judge, prosecutor, voluntary defense counsel, RBHA liaison, and individual case managers from treatment provider agencies. The team exhibits a rare but extremely valuable culture—complete buy-in from all team members. Dedicated team members demonstrate longevity and support to the program through unpaid, volunteer participation. Specifically, although court-appointed defense attorneys are paid a flat rate by the court to represent up to 400 cases per year and receive a bonus of \$132/case thereafter, the MHC cases, which are more time intensive to represent, do not qualify towards this case total. High turnover among case managers contributes to the high degree of variation in level of engagement, quality of information reported to the team, and knowledge about the criminal justice system. At the time of NCSC's visit in February of 2014, a local housing representative had recently joined the team to address housing needs of participants.

*Services provided.* Treatment providers contracted through RBHA or through private providers offer a wide array of services, including individual therapy, group counseling, and ancillary services such as life skills. The team identified housing as a critical, but

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<sup>18</sup> An additional docket was added to accommodate an increasing caseload. The dockets are divided between the two assigned public defenders.

unmet, need for participants, often complicated by AHCCCS eligibility and coverage restrictions. As a result, the team invited a local housing representative to join the team staffing. The MHC serves a large volume of participants with co-occurring substance abuse issues. However, treatment agencies do not reliably provide drug testing services. Additionally, medication continuity while in custody was reportedly unreliable.

*Data and evaluation.* The MHC documents its data collection process to ensure sustainability. The court manually tracks statistics on its participants.<sup>19</sup> In 2013, the MHC served a total of 136 participants representing 213 cases. Projections for 2014 indicate an increase in the number of participants; the number of total served as of February 2014 was 81 representing 121 cases. The number of active participants as of February 2014 is 73.

### **Program Exit**

Upon successful completion of the program, the participant receives a certificate at graduation and the charges are dismissed. If the participant fails to complete the program, the case is set for a pretrial conference and set back on the regular court docket. The court does not oversee a formal aftercare program, but graduation requirements prepare participants for transition into the community. All participants qualifying for AHCCCS may opt to continue services after exiting the program. Since the program's inception, the court has had 195 graduates out of 484, a rate of 40% overall.

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<sup>19</sup> Data elements tracked include: new participants, active participants, suspended prosecution, current warrants, graduations, transfers to the regular track, length of case, cases per participant, motion to dismiss without graduation, and incidents of reoffending.

## Tucson Municipal Court

### Tucson City Court Mental Health Division: Mental Health Court<sup>20</sup>

#### History

The Tucson City Court [Mental Health Division](#) manages the oldest continuously operational mental health court (MHC) in Arizona. Representatives from the prosecutor's office, the public defender's office, and the RBHA engaged in preliminary discussions about the possibility of creating a mental health court program after local pretrial services and jail representatives identified inefficient and costly practices in the system's response to individuals with mental illness.<sup>21</sup> Specifically, they recognized that multiple Rule 11 motions for an evaluation of competency were being filed for the same person at the same time in different courts. The MHC emerged from these discussions in January of 2000 as a two-pronged response for reducing criminal justice costs associated with mentally ill offenders. First, it streamlined existing processes by establishing a centralized court docket with a specialized team to manage cases with mentally ill defendants. Second, the MHC took additional steps to connect mentally ill offenders with the treatment and resources needed to help them become better functioning members of the community, to improve their quality of life, and, ultimately, to increase their periods of mental stability between crisis episodes. Judge Michael Lex conducted the MHC for approximately 10 years and was succeeded by Judge Susan Shetter, who currently presides.

#### Program Design

*Purpose.* The mission of the Tucson City Court MHC is to “enhance public safety, to guarantee equal justice for criminal defendants with mental illnesses and to effectively incorporate the continuity of care available in our community into judicial decisions.”<sup>22</sup>

*Target population.* The MHC primarily targets defendants who have been designated as SMI, with a traumatic brain injury (TBI), or with a developmental disability (DD) by the RBHA and who face City Court misdemeanor charges. The MHC also accepts defendants with a mental health diagnosis who do not have a formal ADHS designation but who have personal means to self-pay for treatment services.<sup>23</sup>

#### Eligibility

*Legal eligibility.* Defendants may be admitted to the program on a pre-plea, deferred prosecution basis (MHC diversion track); those found ineligible for MHC diversion may be accepted to the general MHC track following a plea to charges. Defendants charged

<sup>20</sup> The National Center for State Courts would like to acknowledge the following members of the Tucson City Court for their time and involvement with this project: Allen Chapman (Probation Officer), Brenda Cook (Prosecutor), Nancy M. Coomer (Public Defender), Andrea Craig (COPE Court Services Specialist), Dawn Q. Darkes (Supervising Attorney), Baird Greene (Prosecutor), Sherilynn Griffiths (Public Defender), Christopher Hale (Court Administrator), Christine L. Makielski (Public Defender), Marie Patino (La Frontera Center Recovery Facilitator), Caitlin Glass Tevis (Public Defender), Mary C. Trejo (Supervising Public Defender), Mary-Carol Wagner (Public Defender), and Arthur Zaragoza (Public Defender).

<sup>21</sup> As of this report, the RBHA in this geographic region is the Community Partnership of Southern Arizona (CPSA).

<sup>22</sup> The mission of the Tucson City Court MHC is explained on their [website](#).

<sup>23</sup> Self-paying participants account for only ~2% of admissions, according to team members.

with prostitution, DUI, sex offenses, or assault with injuries and repeat offenders with extensive criminal histories are typically ineligible for MHC diversion. Defendants who previously participated in MHC diversion are typically not readmitted.

*Clinical eligibility.* For both MHC diversion and general MHC tracks, the defendant must have an active SMI designation and must currently receive or be willing to receive services through the RBHA network, *or* must self-pay for services from a private provider who is willing to report regularly to the RBHA regarding their client's compliance with treatment. For defendants who have not yet been evaluated for the SMI designation, an authorized RBHA professional will conduct an evaluation.<sup>24</sup> The SMI determination is informed by the individual's psychiatric diagnosis (which must be established before the SMI evaluation can take place) and a global assessment of functioning (GAF) score at or below 50. Those designated as SMI are eligible for coverage through AHCCCS, which pays for a greater array of services in the RBHA network.<sup>25</sup>

*Screening and assessment tools used.* All clinical assessments are conducted externally from the court by an authorized RBHA representative. No other standardized screening or assessment tools inform the eligibility determination.

## **Program Description**

### Efficiency

*Referrals.* Law enforcement personnel with specialized behavioral health training and treatment provider liaisons on the MHC team often identify defendants for assignment to the MHC docket based on the defendant's behavior at arrest or, if jailed, based on a prior history of enrollment with a treatment provider agency. In addition, a case may be reassigned to the MHC docket for an eligibility determination from another City Court docket. Referrals typically occur pre-plea for admission to the MHC diversion track.

Once referred, the MHC team conducts an eligibility review. A dedicated prosecutor makes the final decision regarding legal eligibility for MHC diversion. Interviews and observations on-site in early February 2014 revealed a lack of agreement or mutual understanding between team members regarding legal eligibility criteria, which has generated team perceptions of a lack of predictability in the admissions process and reflects a lack of clarity about the intended target population of the MHC program.

Referred defendants who have been previously enrolled in the RBHA network often have an active SMI designation; these individuals may immediately access treatment services while awaiting an admission decision. Alternatively, defendants who do not already have an active SMI designation and who do not have the means to self-pay for program participation require an SMI evaluation by a RBHA representative. Although strict state requirements dictate the timeframe during which a requested SMI evaluation must be

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<sup>24</sup> In Tucson, the CPSA criminal justice team typically submits SMI evaluation requests, along with preliminary information about the defendant, to the Southern Arizona Mental Health Corporation ([SAMHC](#)), who will dispatch a representative to conduct the evaluation with the defendant.

<sup>25</sup> Those with the less severe general mental health designation (GMH) are not eligible for AHCCCS enrollment.

completed, defendants may experience a significant time delay between referral and enrollment in treatment services. MHC attorneys typically request a 30-day continuance to allow for the SMI evaluation process to take place. Additional delays may occur, for example, if the request for an SMI evaluation was not formally submitted, reflecting a lack of clarity regarding who may be appropriately responsible for ensuring that an SMI evaluation request is submitted to the RBHA.<sup>26</sup> In addition, interviewees indicated that RBHA representatives do not conduct SMI evaluations with defendants who have an active substance abuse problem; the substance abuse issue must be addressed before an SMI determination can be made. This incurs additional delays in establishing clinical eligibility.

Acceptance to MHC is formalized by a written contract between the court and participant, who is typically assigned defense counsel. The contract describes the terms of participation, to which a participant must agree as a condition of admission.<sup>27</sup> If the participant is found ineligible for MHC diversion or chooses not to participate in the program, the case may be transferred to a standard docket for traditional case processing. The MHC transfers participants who require a competency evaluation to the Superior Court for evaluation; the case will return to the MHC if the participant is found competent or upon restoration, if found incompetent but restorable.

*Staffing and docket.* A dedicated MHC docket convenes on Tuesday mornings, Wednesday mornings and afternoons, and Thursday mornings. Participants in custody are typically scheduled first, followed by out-of-custody defendants who are scheduled in 15-minute blocks. Once their case is heard, participants may leave court. Video review hearings with in-custody participants are held on Tuesday and Thursday afternoons.<sup>28</sup> Some interviewees indicated that the demand for MHC was high, and expressed a desire to expand the MHC calendar.

The MHC operates without routine staffing meetings. Team members exchange information in between cases to inform proceedings. The RBHA and treatment provider liaisons access computerized client databases to obtain information about participant compliance with treatment during the prescribed monitoring period and about known circumstances surrounding any participant misbehavior.<sup>29</sup> Interviewees supported the creation of a dedicated staffing period before the MHC docket, which would allow for advance team discussion and decision-making. Team members acknowledged that routine staffings could reduce participant wait times in court and speculated that gained efficiencies would be most helpful with lower-functioning participants.

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<sup>26</sup> Some team members indicated that the defendant is typically responsible for formally requesting an SMI determination; however, other team members expressed the concern that this may not be a reasonable expectation of referred defendants. The MHC team is permitted to assist the defendant in submitting the request for an SMI evaluation.

<sup>27</sup> The MHC credits defendants for compliance with treatment following arrest but prior to program admission.

<sup>28</sup> NCSC researchers observed the Wednesday morning docket on February 5<sup>th</sup>, 2014, which began at 8:30 am and ran approximately 3.5 hours. Ninety-seven cases were scheduled, although many defendants appeared for multiple cases, which were consolidated on the docket.

<sup>29</sup> Liaisons typically did not operate as the participant's case manager, but accessed the case manager's notes on the participant to share with the MHC team.



## Accountability

*Program structure.* The MHC serves about 200 participants at any given time in one of two MHC tracks: MHC diversion (pre-plea on a deferred prosecution basis) and general MHC (post-conviction for those ineligible for MHC diversion). The program is currently designed to be completed in six months, although team members indicated that a longer period of involvement, such as 18 months, may help reduce post-program relapse. All participants are required to comply with a treatment plan, as defined collaboratively by the MHC team, and attend routine judicial status hearings.<sup>30</sup> Intervals between hearings vary: Participants who demonstrate compliance with the conditions set by the MHC are required to attend court less frequently, and may be rewarded with verbal praise, certificates, or gift cards. Noncompliant participants are required to appear in court more often and may receive verbal admonishments or warnings regarding possible termination from the program.

## Effectiveness

*Team members.* A team of dedicated criminal justice and behavioral health professionals assist and monitor all MHC participants for the duration of their involvement in the MHC program. Team members include: a judge; an attorney from the city prosecutor's office; court-appointed attorneys from the public defender's office and private practice; a liaison from the RBHA; liaisons from treatment provider agencies; and a court clerk.<sup>31</sup> As of February 2014, the MHC team included liaisons from the following treatment provider agencies: [COPE](#) Community Services, Inc.; [CODAC](#) Behavioral Health Services; [La Frontera Center](#), Inc.; and [HOPE](#), Inc. Team members also have additional responsibilities outside of the MHC.

Based on interviews and observation, most team members work well together and share a collaborative mindset. However, there was clear tension between the MHC and the prosecutor's office regarding issues such as the purpose of the program, resource allocation needs, and MHC diversion eligibility criteria. Moreover, during the February 2014 site visit, considerable financial cut-backs were pending for all criminal justice team member agencies in prioritizing financial resources, including support for the MHC. These decisions could potentially alter team composition and MHC resources in the near future.

*Services provided.* Participants may obtain treatment from private providers but typically use a RBHA network provider. The services in the RBHA network are generally comprehensive and include mental health, trauma, and substance abuse treatment via individual counseling, group treatment sessions (including gender-specific treatment groups), medication management, and recovery support services/peer mentoring. Some providers offer financial assistance to help clients secure benefits and assistance in locating housing. Team members expressed a desire for greater availability of housing, inpatient treatment beds, and transportation for participants. Although MHC diversion

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<sup>30</sup> As of the February 2014 site visit, general MHC also required a period of supervision by city probation; however, the probation monitor position has since been terminated.

<sup>31</sup> The dedicated city probation monitor supervised a heavy caseload of about 200 active probationers, 60% of which participated in the general MHC program.

terms include mandatory group treatment sessions, interviewees also voiced concerns about the appropriateness of group treatment settings for all participants.

*Data and evaluation.* The MHC program has not been previously evaluated and does not currently track most of the data elements necessary for evaluation. With the promise of a new case management system on the horizon, it may not be cost effective to finance a local effort to adapt and generate reports from the current system. To address this issue, interviewees expressed a clear preference for the creation of a state data collection and reporting system.

### **Program Exit**

For participants who are removed from the program for noncompliance, prosecution is reinstated. Participants who successfully complete MHC diversion have charges dismissed. No legal benefits are awarded to general MHC graduates, although they may benefit from MHC team support through the legal process and to secure treatment services, housing, and disability benefits. Former participants may continue accessing available treatment and peer support services in the community through the RBHA network if they maintain AHCCCS enrollment. Interviewees indicated that an MHC alumni peer support group is convened by the RBHA, and HOPE and other peer support providers serve in an aftercare capacity by providing alumni with pro-social opportunities. The MHC typically graduates about 15-20 participants per month.<sup>32</sup>

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<sup>32</sup> Graduations are typically convened on the third Friday of each month.

## *Phone Interviews*

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*The NCSC conducted phone interviews with the following MHCs. The NCSC contacted several key team members in each of the following courts to inform the following profiles:*

- *Flagstaff Justice Court: The Coconino County Mental Health Court Program*
  - *Flagstaff Municipal Court: Mental Health Court Program*
  - *Glendale Municipal Court: Mental Health Court,*
  - *Phoenix Municipal Court (Pre-screen Competency Program & Mental Health Diversion Program)*
  - *Sierra Vista Justice Court: Cochise County Provisional Rehabilitation Accountability (PRA) Program*
  - *Yavapai County Superior Court MHC: Specialized Probation Caseload for Seriously Mentally Ill, and*
  - *Yuma County Superior Court: Mental Health Court*
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## Flagstaff Justice

### Flagstaff Justice Court: The Coconino County Mental Health Court Program<sup>33</sup>

#### History

In 2012, Judge Howard Grodman approached the county attorney's office, public defender's office, and [The Guidance Center](#), a local treatment provider agency, to ascertain the degree of interest in a new mental health court program. With the support of these agencies, as well as Coconino County Superior Court, adult probation department, police department, Northern Arizona Regional Behavioral Health Authority ([NARBHA](#)), and the Coconino County Criminal Justice Coordinating Council, the Coconino County Mental Health Court (MHC) Program was established in May 2012. Flagstaff Justice Court adopted Flagstaff Municipal Court's Mental Health Court program model with a few amendments: The Justice Court program adopted an expanded admissions policy to include not only misdemeanors but also felony-level cases and to accept defendants not only pre-plea on a deferred prosecution basis but also post-conviction. The Coconino County MHC Program accepts defendants transferred to Flagstaff Justice Court from Coconino County Superior Court to be judicially supervised in the MHC program as a mandatory term of their adjudicated felony probation sentence.

#### Program Design

*Purpose.* The official description of the Coconino County MHC Program identifies the following program goals: (a) increase treatment engagement (to reduce criminal involvement and [improve] quality of life); (b) improve public safety (by decreasing criminal involvement); (c) increase the effective use of resources (by shifting response from criminal justice to mental health treatment for defendants with mental illness); and (d) stabilize the mental health of participants (by improving mental health).<sup>34,35</sup>

*Target population.* The MHC program accepts adult SMI-designated defendants with misdemeanor charges, felony charges, or cases pending in the Superior Court's Probation Revocation Court.

#### Eligibility

*Legal eligibility.* All cases transferred from Coconino County Superior Court are accepted into the MHC Program. However, Justice Court diversion referrals must be approved by the dedicated representative of the county attorney's office. Defendants with misdemeanor or felony charges are eligible. Criminal history does not preclude program eligibility, but the county attorney may exercise his discretion to reject a candidate (e.g., on the basis of public safety considerations) if a serious or violent criminal history is

<sup>33</sup>The National Center for State Courts would like to acknowledge the following member of the Flagstaff Justice Court for their time and involvement with this project: Hon. Howard Grodman, Russell Marsitto (Adult Probation), and Fanny Steinlage (Deputy Public Defender).

<sup>34</sup> The official MHC Program description referenced in this report is the May 30, 2013 revision of the document originally created in April 2013.

<sup>35</sup> Supplementary documentation summarized the goal of the MHC program as "...to identify individuals whose involvement in the criminal justice system is largely related to their serious mental illness and to offer therapeutically appropriate supervision to achieve and maintain stability and prevent recidivism."

noted. The county attorney will consult with any victims in a case (if applicable) before approving a referral. Former MHC Program participants are not specifically precluded.

*Clinical eligibility.* For diversion, the county attorney must believe that a main driver of the defendant's criminal behavior is mental illness and that a defendant can benefit from participation in the MHC Program. Defendants must have an active SMI designation *or* meet ADHS criteria for an SMI designation and be willing to undergo an evaluation. The public defender's office has limited funding to pay for SMI evaluations, which are conducted externally by an authorized RHBA behavioral health professional. Defendants designated as SMI who also have co-occurring substance abuse disorders are eligible for the program; those with developmental disabilities are ineligible. The defendant must receive Title 19 funding to cover the costs of treatment services while in the MHC Program.

In addition to the above legal and clinical requirements, candidates must reside in Flagstaff or have transportation to attend all required appointments and hearings in Flagstaff. Homeless defendants are not excluded, but must establish a reliable method for communication with the court; case managers will assist accepted MHC participants as needed to locate housing and other appropriate resources.

*Screening and assessment tools used.* The SMI evaluation informs the determination of clinical eligibility. Legal eligibility is ascertained via two distinct processes depending on the origin of the case. A defendant's legal eligibility is determined by the county attorney on a case-by-case basis. For Superior Court probation transfers, however, presentence reports developed by the adult probation department help inform judicial sentencing decisions regarding mandatory MHC Program participation. In addition to general information about the defendant and the offense, presentence reports provide standardized assessment information from the Offender Screening Tool (OST) and the Adult Substance Use Survey (ASUS), which probation administers to defendants with suspected substance abuse problems.

## **Program Description**

### Efficiency

*Referrals.* Anyone may refer a Justice Court case for MHC diversion at any stage of a criminal proceeding. A public defender is typically appointed for SMI-designated defendants. Once identified, the county attorney, public defender, and treatment provider liaison discuss the referred candidate to determine eligibility and acceptance into the MHC Program. Participation is considered voluntary: If the defendant opts in, the public defender will obtain a signed Waiver of Confidentiality from the defendant to authorize treatment providers to provide records and discuss treatment issues with the court during active program participation and through a two-year post-program follow-up period. In addition, the court will set the matter for a status hearing on the MHC docket to approve the agreed-upon terms and formally admit the defendant to the program. A defendant who declines the acceptance offer will be removed from the MHC docket and placed on a standard court docket for case processing.

For cases transferred from Superior Court, however, participation is a mandatory term of the defendant's felony probation sentence. When the sentencing judge orders a defendant to MHC Program terms, the case file is duplicated and transferred to Flagstaff Justice Court to appear on the MHC docket for formal admission. This process typically takes several weeks.

Admission to the MHC Program depends on availability. The MHC Program can serve up to 20 participants at a time and currently has 20 active participants.<sup>36</sup> Approximately half of this caseload is comprised of deferred prosecution cases from the Justice Court; the other half is comprised of case transfers from Superior Court. Interviewees discussed solutions to meet the increasing demand for slots in the program, including expansion to implement a dedicated Superior Court MHC program.

*Staffing and docket.* The MHC team convenes an 8:15 staffing meeting prior to the 9:15 MHC docket on Wednesday mornings, held every other week. Currently, most MHC participants are clients of The Guidance Center, whose MHC liaison provides a one-page status report to inform discussion on each participant scheduled to appear that day. Case managers of other treatment provider agencies who do not attend staffing may provide status updates to the public defender via voice mail. The probation officer and public defender provide updates and associated recommendations for felony probation participants.

#### Accountability

*Program structure.* To successfully complete the MHC Program, Justice Court diversion participants must fulfill the agreed upon program terms. Similarly, Superior Court probation participants must complete the terms of their adjudicated sentence. MHC Program terms typically require demonstrated compliance with a treatment plan. On average, participation lasts for 6-12 months but may extend for a longer period of time based on the individual participant's need and as agreed upon by the MHC team. Participants are also required to attend routine judicial status hearings for progress reviews during this time. In addition to the above requirements, all Superior Court probation participants must comply with the terms of probation.

As a sanction for positive drug tests, failure to appear in court, or other noncompliant behavior, 24-48 hour jail stays may be ordered for MHC Program participants. A decision to order jail time as a sanction is made only after the MHC team discusses the behavior at staffing to weigh the costs and benefits; a significant cost is that participants are unable to receive their prescribed psychotropic medications while in custody. Other sanctions may include verbal admonishments, community service hours, writing assignments, and house arrest. Sanctions are typically scheduled first on the MHC calendar as an example to other program participants. Incentives are commonly used and may include verbal encouragement or praise, special recognition, being heard first on the calendar (all participants may leave after their case is heard), and a reduction in frequency of required court appearances. Graduates receive a certificate of completion and special rewards (e.g., gift cards or movie passes from donated funds).

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<sup>36</sup>The caseload of active participants was reported in a March 27, 2014 interview.

### Effectiveness

*Team members.* A dedicated judge staffs the MHC Program along with dedicated representatives from the county attorney's office, public defender's office, and adult probation department and a dedicated liaison from The Guidance Center treatment provider agency.<sup>37</sup> Case managers from other treatment provider agencies with clients on the MHC docket may also attend. A representative from a newly established peer support agency has also started to attend the biweekly staffing meetings. Team members appeared to be highly collaborative and supportive of participants. Interviewees indicated that the services of a guardian ad litem could benefit some MHC Program participants; the judge is currently exploring grant funding opportunities to secure these appointments.

*Services provided.* All participants have an active SMI designation and are eligible for Title 19 funding, which pays for a greater array of services in the NARBHA network. Services are primarily provided through The Guidance Center, but participants may elect to obtain treatment from a private provider. Services available to MHC participants include but are not limited to individual counseling, vocational counseling, dialectical behavior therapy, co-occurring mental health and substance abuse and other group treatment sessions, medication management, and peer support.

Denial of disability benefits by external state agencies and limited local housing options can pose challenges for participants in the MHC Program. Local area shelters close during summertime months; homeless participants must resort to a camping lifestyle at local parks, which regulate the hours at which individuals may come and go from campsites for safety reasons. This can sometimes interfere with participant attendance at group treatment sessions, peer support sessions, or other meetings.

*Data and evaluation.* The MHC has not undergone a formal evaluation. However, the official program description indicates that the court collects data to compute court-specific performance measures for inclusion in MHC program annual reports.<sup>38</sup>

### **Program Exit**

Exit outcomes depend on the individualized terms of MHC Program participation. For deferred prosecution cases, successful completion typically results in case dismissal; prosecution is typically reinstated if the participant is removed from the program for noncompliance. For Superior Court transfers, participants who successfully complete the MHC Program terms may still be required to complete a defined period of supervised probation. The MHC judge may not formally revoke probation for these participants; rather, any revocation hearings are convened in Probation Revocation Court before a dedicated Superior Court judge. If the participant is revoked from probation and sent to prison, he or she is typically terminated from the MHC Program as well.

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<sup>37</sup> The dedicated public defender staffs the Coconino County MHC Program on a volunteer basis; this position is not funded.

<sup>38</sup> The document defines measurements of increased treatment engagement, public safety, and effective use of resources. It also calls for the MHC program to report on process measures but does not define the full scope of information to be included in the annual report.



As of this report, six participants have graduated and six have been unsuccessfully terminated from the MHC Program since inception. Interviewees reported no recidivism to date among program graduates. Currently, the MHC Program does not offer a formal court aftercare program for graduates, but AHCCCS-insured participants may continue to receive treatment services through their preferred provider. The judge expressed interest in developing a discharge planning component as a future MHC Program improvement.

## Flagstaff Municipal Court

### Flagstaff Municipal Court: Mental Health Court<sup>39</sup>

#### History

Flagstaff Municipal Court's Mental Health Court (MHC) program began in November of 2006. Following the Tucson Municipal and Tempe Mental Health Court models, the initiative to establish the Flagstaff Municipal MHC resulted from a desire to improve the process for managing the high volume of and to produce better criminal justice outcomes for mentally ill defendants. The official MHC program description indicates that "the initial procedures, protocols and terms of participation were developed over a 12-month period of time through the cooperation of the Flagstaff City Court, Prosecutor, Public Defender, [The Guidance Center](#), [NARBHA](#), Flagstaff Police Department, and Coconino County's [Criminal Justice Coordinating Council](#) (CJCC) – Mental Health Substance Abuse Subcommittee."<sup>40</sup>

#### Program Design

*Purpose.* The stated goals of the program are to increase treatment engagement, improve public safety, and increase the effective use of resources.

*Target population.* The MHC program targets defendants facing misdemeanor charges at the Flagstaff Municipal Court who currently have or are eligible for an SMI designation by the RBHA.

#### Eligibility

*Legal eligibility.* Cases that involve mandatory fines, such as DUI and marijuana possession, are ineligible for MHC diversion. Cases involving a misdemeanor-level violent offense are typically not eligible, but may be accepted at the prosecutor's discretion and informed by a consultation with any victim(s). Former MHC program participants are not specifically precluded from readmission.

*Clinical eligibility.* For MHC diversion, defendants must have an active SMI designation or meet ADHS criteria for an SMI designation and be willing to undergo an evaluation. The defendant must receive Title 19 funding to cover the costs of treatment services while in the MHC program. Defendants designated as SMI who have co-occurring substance abuse disorders are eligible; those designated as having a developmental disability by the RBHA, are found incompetent to stand trial, or who otherwise are unable to enter the program of their own volition are excluded.

*Screening and assessment tools used.* The SMI evaluation, along with supplementary clinical assessments like the GAF, is conducted by an authorized RBHA representative and used to inform the MHC eligibility determination. The court does not administer any additional screening or assessment instruments to inform MHC admission decisions.

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<sup>39</sup>The National Center for State Courts would like to acknowledge the following member of the Flagstaff Municipal Court for his time and involvement with this project: Hon Thomas Chotena.

<sup>40</sup> The mission of the CJCC is "to address issues and needs arising within the criminal justice system in Coconino County." The CJCC is comprised of professionals from the court, law enforcement, treatment agencies, city government and county government, as well as public citizens.

## **Program Description**

### Efficiency

*Referrals.* Defendants may be referred to MHC at a number of points in the criminal justice process. Law enforcement, judges, attorneys, or others who have a reason to believe the defendant may be mentally ill may refer the defendant to MHC at any time prior to plea.

For every defendant referred to MHC, a public defender is appointed. The public defender will consult with the defendant to file a formal Request to Enter with the MHC and obtain a signed Waiver of Confidentiality, in which the defendant authorizes the court to gather data on the his or her compliance with treatment services and contacts with the criminal justice system through a two-year post-program follow up period if accepted into the MHC program. If the defendant wishes to pursue MHC diversion, the court will set the matter on the MHC docket for a pretrial conference to render an admission determination. If the defendant does not wish to pursue MHC diversion, the public defender will request that the matter be removed from the MHC docket and transferred to a standard docket for traditional case processing.

Typically, defendants seeking admission to the MHC already have an active SMI designation. The admissions process for those who require an SMI evaluation to establish eligibility may take a few additional weeks or longer, depending on the nature of the charges and whether or not the defendant has been released from custody.<sup>41</sup>

As a condition of acceptance, homeless participants are required to establish a reliable method for communication with the court. Case managers will assist accepted MHC participants as needed to locate housing and other appropriate resources.

*Staffing and docket.* The MHC docket is held every other week on Thursday afternoons. Approximately 11-20 cases are heard in each two-hour session. In addition, the MHC team convenes for a staffing immediately before the MHC docket, which typically runs one to one and a half hours. The MHC team will review cases in preparation for the docket and discuss any program issues that may arise. Case managers share status updates on participant progress with the team to determine the most appropriate court response in each case. The team may also receive reports from the local Flagstaff hospital on the status of clients who are MHC participants. The public defender may require time to meet with his or her client following the staffing but before the case is heard on the MHC docket.

### Accountability

*Program structure.* The MHC program accepts cases on a deferred prosecution basis and is designed to be completed by participants in six months, but involvement may last up to one year. Once accepted, participants must attend judicial status hearings twice a month for the first two months and once a month thereafter until program completion or termination; the court may amend this schedule as needed on a case-by-case basis.

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<sup>41</sup> SMI evaluations are not presently conducted for defendants in custody.

Participants must also comply with a treatment plan developed by their preferred treatment provider.

Participants in good standing may receive incentives such as verbal encouragement or praise, certificates, less frequent court appearances, or treats such as gift cards. Graduation ceremonies are held at the beginning of the calendar to receive public recognition/praise and to serve as a positive example to other program participants. Non-compliant participants may be sanctioned, for example, with verbal admonishments, writing assignments, community service hours, or extended time in the program (usually an additional one to four months; no more than an additional four to six months in total may be added to program terms). In addition, participants who fail to appear for a scheduled status review hearing more than once may have a warrant issued. Jail is rarely used without a warrant and is never used as a sanction for non-compliance with treatment. Jail sanctions are typically short stays of about two days.

Participants who pick up new charges while in the MHC may be sanctioned with jail time, or they may be terminated from the program. For those who are retained in the program, new charges may be consolidated with their existing MHC agreement. The modified agreement typically extends the period of program participation required for successful completion and dismissal of all charges.

As of September 2013, the MHC served 44 active participants.

### Effectiveness

*Team members.* The mental health court team consists of a dedicated judge, prosecutor, public defender, and case worker representatives from The Guidance Center and [Southwest Behavioral Health Services](#). The team appears to have a healthy communication process and a collaborative mindset. An interest in more specialized training to facilitate greater shared understanding of mental health concepts, treatment approaches, and treatment goals was noted.

*Services provided.* Provided services include but are not limited to individual counseling, group treatment sessions, medication management, and emergency psychiatric services; CBT (cognitive behavioral therapy) and integrated substance abuse and mental health treatment options are available. The local community recently communicated to the RBHA a concern about the inadequacy of services given available state funding; since then, the RBHA has introduced several service improvements, such as a mobile crisis provider outfit and peer support group services.<sup>42</sup> However, housing was identified as a major need for MHC participants that existing services do not adequately address. Participants forced to adopt camping lifestyles face significant challenges that interfere with their ability to meet basic attendance requirements of MHC program participation. Inpatient/residential treatment was identified as another service need area.

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<sup>42</sup>The interviewee explained that NARBHA must service a large, primarily rural geographic region, which may pose unique challenges in the provision of appropriate services.

*Data and evaluation.* The official program description indicates that the court collects data to compute court-specific performance measures for annual reporting purposes.<sup>43</sup> The MHC has reportedly undergone a process evaluation and an outcome evaluation.

**Program Exit**

Upon successful completion of MHC program terms, participants' charges are dismissed. For participants who unsuccessfully exit the program, prosecution is reinstated.

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<sup>43</sup> The document defines measurements of increased treatment engagement, public safety, and effective use of resources. It also calls for the MHC program to report on process measures but does not define the full scope of information to be included in the annual report.

## Glendale Municipal Court

### Glendale Municipal Court: Mental Health Court<sup>44</sup>

#### History

The Glendale City MHC was implemented by Judge Finn on January 2, 2013. Until that point, the court was unable to adequately address the needs of defendants with mental illnesses, causing a significant financial strain on the system. The court was founded to cut costs by streamlining the process for defendants with mental health issues and connecting them to services. Reductions in failure to appear costs (\$150/defendant) and reductions in jail costs (reducing time in jail and by integrating third-party release from jail directly to services) have significantly reduced the court's budget. A planning committee conducted a need assessment for the program prior to implementation. The court matched four years of RBHA clients with the court's list of defendants and found significant crossover, justifying the need for this program.

#### Program Design

*Purpose.* The pre-plea diversion program benefits from the court's supervision and leverage to connect people who are in need of mental health services with community resources. "The purpose of this program is to provide judicial supervision to ensure defendants diagnosed with major mental illnesses maintain case management services, take medication as prescribed, and attend requirement treatment programs."<sup>45</sup> The court connects people with necessary services to maintain psychiatric stability, provides support to navigate the medical and behavioral health system, and reduces the costs (e.g., failure to appear, jail days) borne by the court.

*Target population.* The program's target population includes all defendants charged with misdemeanors who are diagnosed with serious mental illnesses.

#### Eligibility

*Legal eligibility.* The prosecutor reviews the charges and prior criminal history to determine eligibility. All defendants charged with misdemeanors or violations are eligible for the program.

*Clinical eligibility.* Defendants are eligible for the mental health court if their mental health treatment is case managed. Original eligibility required an SMI designation, but as the court identified that this overlooked some defendants, it opted to expand the criteria. The critical eligibility criterion is whether the treatment provider will provide regular up-to-date status reports to the court team.

#### Program Description

##### Efficiency

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<sup>44</sup>The National Center for State Courts would like to acknowledge the following members of the Glendale Municipal Court for their time and involvement with this project: Stanley Alexander (Magellan Court Advocacy Liaison), Jennifer Dalton (Public Defender), and Hon. Elizabeth Finn.

<sup>45</sup> GLENDALE CITY COURT ANNUAL REPORT (2013), available at <http://www.glendaleaz.com/court/documents/CourtAnnualReport.pdf>.

*Referrals.* The Glendale MHC is a pre-plea diversion program for defendants with mental illnesses. Referrals come from multiple sources including case managers, judges, attorneys, jail staff, and RBHA court liaisons. During arraignment, the prosecutor may notice possible mental illness through details included in police reports. The MHC also has access to the RBHA database and can determine if someone is case managed. The team will also cross-reference the Superior Court data system to identify additional charges and Rule 11 outcomes prior to making contact with the defendant. Defendants may voluntarily agree to enter the program, at which time, the case is set on the calendar.

#### *Staffing and docket.*

Typically, on a docket with 30-35 defendants, there are ~20 case managers present for court status hearings that last one hour. The team meets to discuss the cases scheduled for the docket for approximately an hour and a half prior to court. Court proceedings last one and a half to two hours. Recently, the Glendale MHC staffing process was featured in a local [news segment](#). The court holds staffing and status review hearings every other week on Wednesdays. On the Friday before court, the court clerk compiles court information that is subsequently reviewed by the judge. Staffing discussions are led by the judge.

#### Accountability

*Program structure.* Participants progress through three phases as a function of their needs. The first phase requires attendance in court every two weeks. This is reduced to every four weeks in the second phase and every six weeks in the third phase. At court, participants receive a copy of a contract that specifies conditions for compliance, including contacts with case manager, treatment sessions, and if applicable, drug testing and probation contacts. The contract also denotes the date and time of the next appearance.

When participants struggle with the program requirements, the team will redirect the participant to focus compliance on one or two critical requirements. When participants are consistently non-compliant, the court may impose sanctions like essay writing, community service, and increased treatment or supervision contacts. Jail is rarely, if ever used as a sanction, as the program operates pre-plea; jail is also considered by the team to be a costly alternative.

The court has approximately 90 currently active participants, with a capacity for 80. The total number served in 2013 was 122 participants.

#### Effectiveness

*Team members.* The mental health court team includes the judge, a public defender, a prosecutor, a RBHA-liaison, a representative of a peer support agency, and case managers representing the treatment provider agencies. The dedicated team operates cohesively. Case managers experience high turnover, and combined with the volume of representatives, the team relies on the RBHA representative to ensure receipt of complete and timely communication about the participants. The judge makes the final decision in court, but the entire team participates in making recommendations.



*Services provided.* The team reports that participant services are fairly comprehensive, but identify several gaps including housing (especially for women, children, and families) and services for non-Title 19 participants. Non-title 19 participants do not receive a full array of counseling or inpatient services. Overall, co-occurring treatment for participants who face both substance abuse and mental illness disorders is lacking. Although group counseling is more widely available, team members report that participants with mental illnesses often respond better to individual counseling, though individual counseling is not as readily available. One team member reflected on the location of treatment facilities; it is important to provide access in the neighborhood in which the participant resides, but that neighborhood is often an area prone to homelessness, drug usage, and is not conducive to recovery or establishing stability. Finally, the team reported a need to distinguish program and treatment requirements for participants who may have similar clinical diagnoses, but very different levels of functioning.

*Data and evaluation.* The Glendale MHC is to be commended as it is among the few programs in Arizona that gathers participant feedback upon exit. The court surveys participants about the fairness of the program and the participants' level of satisfaction and uses those data to improve future outcomes.

### **Program Exit**

Participants successfully complete the program when they remain compliant for a minimum of six months. Twenty-four participants graduated last year and another two as of March 2014. The program does not have a maximum duration but the longest time in program reported thus far has been approximately 14 months. Average time in the program is six to nine months. Successful completion of the program results in a prosecutorial dismissal of the charges against the participant. Participants who fail to successfully complete the program are returned to court to enter a plea agreement or to set the case for trial on the original charges. The court is currently investigating the creation of an alumni association to connect current participants with graduates.

## Phoenix Municipal Court<sup>46</sup>

The Phoenix Municipal Court operates two related, but distinct programs that address mental health needs of defendants. The first is a program to reduce the use of unnecessary Rule 11 proceedings and to streamline the processing of necessary Rule 11 proceedings through a specialized docket to pre-screen for competency. The second is a diversion program through the prosecutor's office that results in a dismissal of charges if the defendant complies with the program's treatment requirements. Neither program operates under the traditional mental health court model, but both are described here as programs designed for defendants with mental illnesses.

### Pre-screen Competency Program

#### History

A planning committee consisting of the associate presiding judge, court administrator, criminal division administrators, public defender's office, and city prosecutor's office founded this specialized mental health docket in May 2012. The court was experiencing recurring problems with large numbers of people requesting unnecessary competency evaluations or failing to attend their screening appointment which, coupled with changes in billing, resulted in a financial strain for the court. This docket was implemented to address these issues in particular.

#### Program Design

*Purpose.* The goal of this program is to centralize and streamline the screening process to determine whether defendants should undergo full Rule 11 proceedings or remain within the jurisdiction of the court. This docket focuses on the criminal competency evaluation process. The public defender's office created a position for a coordinator with mental health expertise to work with the defendants and court appointed attorneys to reduce the number of unnecessary competency evaluations. The program further streamlined the evaluation process by having the doctors performing the pre-screen evaluations come to the courthouse, thereby reducing the number of defendants who fail to attend their appointments. The competency cases are also now consolidated on a single judge's docket.

*Target population.* The program aims to serve individuals who have mental health needs and need assistance in navigating the criminal justice system.

#### Eligibility

*Legal eligibility.* Eligible participants have been charged with any misdemeanor or violation (no charges are categorically excluded).

*Clinical eligibility.* All participants have a question of competency; some are already clients of RBHA, others are new to the behavioral health system or operate under a private treatment provider.

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<sup>46</sup>The National Center for State Courts would like to acknowledge the following members of the Phoenix Municipal Court for their time and involvement with this project: Martha Perez Loubert (Prosecutor) and Don Taylor (Executive Court Administrator)

## **Program Description**

### Efficiency

*Referrals.* As previously stated, the primary purpose of the program is to efficiently process cases without the delay of an unnecessary Rule 11 hearing or defendants failing to appear for their prescreening appointments. Cases are usually identified by the public defender's office but may also be referred by the defendant's case worker (RBHA or private provider), law enforcement or jail staff. The public defender has designated a staff member who has been especially helpful in filtering out potential cases that are unlikely to have competence issues. The cases are then reviewed to determine whether there has been a previous competence evaluation. If the client has mental health issues but no previous psychological evaluation, the client is usually evaluated by a provider, when possible, on-site. This docket is designed to handle 10 participants at a time, but there are 10 dockets held per month, totaling approximately 100 defendants a month.

*Staffing and docket.* The docket is held every Friday at 8am and 10am and, twice a month, at 1:30pm as well. A RBHA representative is sometimes in attendance. The court does not hold a staffing. The process involves Judge Robert Doyle who relies heavily upon a public defender with mental health experience as an early filter. This position is especially important to the docket and interviewees noted that if the public defender's office had extra funding, it would be used to support this position.

### Accountability

*Program structure.* The program capitalizes on the defendant's presence in the courthouse and conducts the interview and case review onsite. This reduces the failure to appear rates experienced prior to the program's implementation.

### Effectiveness

*Team members.* There is no formal team, but collaborating members include a court administrator, the public defender, the judge, a treatment provider representative, an evaluator, and the prosecuting attorney.

*Services provided.* The court does not impose requirements, monitor compliance with, or evaluate treatment services provided to participants.

*Data and evaluation.* The program has not been evaluated, but initial reviews suggest the program succeeds at the mission, reducing Rule 11 hearing requests, reducing FTAs and subsequent bench warrants for defendants, and ultimately, saving the court money. The court has considered a second phase of the program, which would implement a model that aligns with other MHCs. Once a person is deemed competent, but with mental health issues, the court, through this second phase, could process the case using a team-based, problem-solving approach. However, this phase would require additional funding which is currently unavailable.

## **Program Exit**

Participants assessed as needing a full competency determination will be sent to the Superior Court for a Rule 11 hearing. Participants who are assessed as competent remain on the docket with one judge until the resolution of the case.

## **Mental Health Diversion Program**

### **History**

The mental health diversion program has been operating since 1996. Last year, the court dedicated one courtroom and one judge, Robert Judge Doyle, to exclusively process the cases for this diversion program. As a whole, Phoenix Municipal Court operates nine diversion programs, including the mental health program.

### **Program Design**

*Purpose.* The MH Diversion Program provides defendants with an opportunity to resolve the criminal charge against them and have the charge(s) dismissed. The program will link defendants to professional mental health support. The court signs a motion to continue arraignment for 120 days to allow the defendant to complete the program. The judge does not hold intermittent status review hearings during those 120 days.

*Target population.* The MH Diversion Program is a pre-plea model designed to help individuals who have mental health needs and come into contact with the criminal justice system.

### **Eligibility**

*Clinical eligibility.* At a pre-trial disposition conference the prosecutor may determine, through conversation or a review of police reports, that the defendant has some mental health issues and request the case be set to the mental health court. The local RBHA<sup>47</sup> reviews the case to determine whether they will accept the defendant in their program. The eligibility determination is related to financial and health status with AHCCCS.

*Legal eligibility.* Legal eligibility is determined after the RBHA review. All charges, except DUI and traffic violations, are accepted. Defendants who have already had charges dismissed as a result of a previous diversion agreement are not eligible for admission into the program.

## **Program Description**

### Efficiency

*Referrals.* Referrals most often originate from a prosecutor at a pre-trial disposition conference. Then, once RBHA determines eligibility, the participant is assigned to a case manager through a contracted treatment provider. The defendant signs a motion to continue and the case is set for an SMI hearing 120 days out.

*Staffing and docket.* Although the team does not meet regularly for status review hearings or staffing, the defendant meets with a public defender and a social worker through the same office. The docket for mental health court is held weekly on Fridays before Judge

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<sup>47</sup> RBHA contract was with Magellan, but as of April 1, 2014, is now Mercy Maricopa Mental Health.

Doyle, the dedicated mental health court judge. At the SMI hearing, the court hears a recommended report from the case manager at the end of the 120 days. If the defendant is compliant with all diversion requirements, the charges are dismissed.

#### Accountability

*Program structure.* Participants are required to comply with all clinical team requirements, meet with a nurse or psychiatrist once a month, attend two groups a week, and take all prescriptions as prescribed. Participants must submit to drug testing, per clinical requests, and attend substance abuse treatment, as needed. All participants must meet with a case manager from the treatment provider at least once a week. Additionally, participants must pay any outstanding restitution. These requirements are expected for a minimum, four-month period.

If the participant is progressing well, but has not completed all of the program requirements, some defendants require more time to complete the program and may be given an extension up to an additional 120 days. The team indicated that 120 days is not enough time, across all cases, for successful resolution. There has been a desire to follow a more traditional mental health court team model, by bringing together a problem-solving team who could meet regularly and conduct a staffing on the active participants.

#### Effectiveness

*Team members.* Team members include a prosecuting attorney, a public defender, the judge, and a case manager from the treatment agency.

*Services provided.* Services are, at times, not available for the referred defendants (e.g., those who do not qualify for AHCCCS), leading to an exclusionary determination by the provider. Medication costs and housing options are among the most needed services. Jail houses many mentally ill defendants who cannot afford to bond out and the services provided in the jail are reportedly inadequate.

*Data and evaluation.* The diversion program has not been formally evaluated and does not track referrals denied for admittance by RBHA. However, the number of participants who have met the eligibility requirements included 84 people from fiscal year 2012-2013. The projected volume for the current fiscal year is 72.

#### **Program Exit**

If a participant successfully engages in the treatment requirements set by the case manager during the four-month period, the defendant appears in court for an SMI hearing to have his or her charges dismissed. As previously stated, some participants are granted an extension of an additional 120 days to complete the requirements if he or she demonstrates progress. Defendants who are not in compliance are reset on the calendar for an arraignment hearing and enter a plea or for adjudication by the court.

## Sierra Vista County Justice Court

### Sierra Vista Justice Court: Cochise County Provisional Rehabilitation Accountability (PRA) Program<sup>48</sup>

#### **History**

In 2005, Judge Timothy Dickerson was approached by representatives of Southeastern Arizona Behavioral Health Services (SEABHS) with a proposal to create a mental health court program in Sierra Vista, the population center of Cochise County.<sup>49</sup> SEABHS, a behavioral health treatment provider agency, had a contractual agreement at the time to operate under the auspices of RBHA. The Sierra Vista Justice Court conducted the Provisional Rehabilitation Accountability (PRA) Program from 2005 until 2009, when the Arizona Department of Health Services awarded a new RBHA contract to [Cenpatico](#) of Arizona. This transition disrupted the operation of the PRA Program for approximately 18 months. Operations resumed in 2011 after representatives from Arizona Counseling & Treatment Services ([ACTS](#)), a behavioral health treatment provider agency subcontracting with Cenpatico, approached the former PRA Program judge and prosecutor with interest in operating the treatment component of the program to support reinstatement.

#### **Program Design**

*Purpose.* ACTS created a written description of the PRA Program, which identifies the following program goals: “(a) Help insure [sic] public safety by addressing underlying behavioral disorders of criminal defendants; (b) Reduce participant days incarcerated (resulting in less jail overcrowding); (c) Reduce participant recidivism; (d) Reduce participant psychiatric hospitalizations (and concomitant county costs); (e) Increase continued treatment compliance through therapeutically-supported criminal justice experience; (f) Stabilize participants as community residents.”

*Target population.* The PRA Program is an extended pretrial diversion program of the county attorney’s office, serving adult misdemeanor defendants with signs of mental illness.

#### **Eligibility**

*Legal eligibility.* An adult defendant must face misdemeanor charges and be willing to sign a contractual agreement with the court to participate in the PRA Program. Any victim(s) in the case must also consent to the defendant’s participation in the program.

*Clinical eligibility.* Currently, the PRA Program accepts primarily those defendants who already have an active SMI designation. From 2005-2009, an SMI designation was required to establish eligibility. Since reinstatement of the PRA Program, however, the

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<sup>48</sup> The National Center for State Courts would like to acknowledge the following members of the Sierra Vista Justice Court for their time and involvement with this project: Thomas Bennett (Deputy Cochise County Attorney) and Hon. Timothy Dickerson.

<sup>49</sup> SEABHS representatives originally proposed the idea of establishing a specialized mental health court in Bisbee, the county seat, which did not have the population size sufficient to support the ongoing operation of a specialty court.

prosecutor has exercised greater discretion to admit non-SMI candidates. The prosecutor currently accepts defendants who show signs of mental illness but who do not have an active SMI designation, and who are also enrolled in an intensive outpatient treatment program for a co-occurring substance abuse problem. The prosecutor may also exercise discretion to preclude individuals from the program who have a history of noncompliance with behavioral health treatment providers.

*Screening and assessment tools used.* Currently, the county attorney's office determines candidate eligibility on a case-by-case basis. The treatment provider may conduct relevant assessments upon intake to inform case planning; however, this information is not submitted to the court.

## **Program Description**

### Efficiency

*Referrals.* Candidates for the PRA Program are primarily identified by the prosecutor. Cases may also be referred to the prosecutor by defense counsel, behavioral health case managers, the local homeless shelter, law enforcement, or other criminal justice professionals for consideration. However, because misdemeanor-level charges heard at the Sierra Vista Justice Court do not always result in the appointment of defense counsel and because the PRA Program does not receive additional funding to secure special appointments for potential participants, defendants typically appear without legal representation.

The prosecutor will discuss in a pretrial conference with the defendant, the defendant's family, and any victims whether to take the case to trial or seek admission to the PRA Program. This discussion includes a description of the purpose and participation requirements of the PRA program. Any victims in the case must consent to the referral and the candidate must voluntarily seek admission to the program. If the candidate is eligible for diversion, the prosecutor then schedules a hearing with the PRA Program judge for formal admission. At this hearing, the judge again reviews the general program expectations with the defendant, who must sign a contract in court to confirm his or her agreement with the terms of participation in order to begin the program.

*Staffing and docket.* The PRA Program operates without a formal staffing meeting or dedicated court calendar. Cases are scheduled before the judge as needed on the traditional Wednesday calendar; when possible, PRA Program cases may be clustered together on the calendar, but are typically heard between traditional cases. The prosecutor works closely with the ACTS recovery coach/case manager liaison to secure status updates on client compliance with the prescribed treatment plan. A representative from Veterans Affairs (VA) often attends hearings for VA clients in the PRA Program and shares status updates directly with the prosecutor. Participants who receive treatment services from other external providers who do not submit regular reports to the PRA Program prosecutor, however, must bring to court some form of written documentation of their treatment compliance to inform the proceedings.

### Accountability

*Program structure.* To successfully complete the program, participants must fulfill a six-month term of compliance with a treatment plan, as defined by the participant's treatment provider. Participants are required to attend two or three judicial status hearings for a progress review during a typical six-month period. Participants who do not comply with their treatment plan, or who return to court on a warrant after failing to appear for their review hearing, may be given additional opportunities to demonstrate compliance before the decision is made to remove them from the program. Participants may be reinstated to the program on the same charges at a later date if they can demonstrate sustained compliance with treatment. Participants who pick up new charges are typically not reinstated. The Sierra Vista Justice Court has a capacity for serving five or six PRA Program participants at a time and, as of February 4, 2014, has five active participants. In the past three years, the program has served approximately 70 participants. Interviewees expressed a desire to serve more participants on a dedicated docket, but without dedicated funding are limited by the available resources.

### Effectiveness

*Team members.* A dedicated judge, prosecutor, and ACTS liaison operate the PRA Program. Others (such as private defense counsel, the VA liaison, or case manager from another treatment provider) may also attend court hearings and/or communicate participant status updates with the prosecutor, but are not dedicated team members. Participant status updates can be difficult to obtain from case managers with external treatment provider agencies.

*Services provided.* Most participants have an active SMI designation and are eligible for insurance coverage through AHCCCS, which pays for a greater array of services in the RBHA network. For the PRA Program, services are primarily provided through ACTS and include individual counseling, group treatment sessions, and medication management. Those ineligible for AHCCCS do not benefit from free treatment services but may choose to self-pay for services from ACTS or a private provider. This financial burden, however, often prohibits uninsured participants from securing adequate treatment. The team indicated concern regarding the limited array of treatment services available locally, and the need for other services such as inpatient treatment.

*Data and evaluation.* The PRA Program has not been previously evaluated and does not currently track program or participant data. The court does not receive additional funding to support staff time for data collection or reporting activities or the development or purchase of tools necessary to enable them. Interviewees expressed the concern that a statewide mandate to collect data and report on performance measures will be imposed without the provision of additional resources to enable the court to comply.

### **Program Exit**

Participants who successfully complete the PRA Program have their charges dismissed. For participants who are removed from the program for noncompliance, prosecution is reinstated. In the past three years, approximately 35 participants have successfully completed the program. No formal court aftercare program is offered, but AHCCCS-



insured participants may continue to receive treatment services through their preferred provider.

## Yavapai County Superior Court

### Yavapai County Superior Mental Health Court: Specialized Probation Caseload for Seriously Mentally Ill<sup>50</sup>

#### **History**

The Yavapai County Superior Court's SMI Unit of the Specialized Probation Caseload program accepted its first probationer in October of 2013, so the program is in its infancy. Approximately four years ago, stakeholders including law enforcement and members of probation discussed the need for a program for probationers with serious mental illnesses. The program is based on Maricopa's SMI Specialized Probation Caseload (SPC).

#### **Program Design**

*Purpose.* The goals of the SPC are to address the needs of supervised probationers who are seriously mentally ill and help them succeed with the requirements of probation.

*Target population.* The population served by this program includes probationers who are mentally ill and who are currently receiving psychotropic medication services. The program is a post-sentence probation program with the option of court hearings as determined by the probation officer and treatment provider.

#### **Eligibility**

*Legal eligibility.* The SPC for SMI probationers is open to those on probation for a felony. Most face a standard three-year probation term.

*Clinical eligibility.* Probationers must receive an SMI designation by the RBHA and be accepted by the Mental Health Probation Caseload Officer. The team also considers whether the probationer has current/recent psychotropic medication and a history of psychiatric hospitalization. The policy indicates probationers with low functioning scores or brain damage will be considered for admission, though none has been accepted to date.

*Screening and assessment tools used.* All probationers are screened by probation using the statewide general recidivism risk and criminogenic needs assessment tool, the OST, and reassessed with the field reassessment tool, the FROST. Participants are also screened for functional impairment using the Global Assessment Functioning scale (GAF scores less than 60 are accepted).

#### **Program Description**

##### Efficiency

*Referrals.* Referrals can originate with the standard probation officers (e.g., probationer is in crisis, struggling with medication or homelessness) who can recommend transfer to the SMI caseload. Some probationers may be placed on the specialized caseload through a judge recommendation prior to sentencing due to a recent psychotic episode and after

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<sup>50</sup>The National Center for State Courts would like to acknowledge the following members of the Yavapai County Superior Court for their time and involvement with this project: Debra Kendall (Probation, SMI Caseload) and Kathy Rhodes (Probation).

having court-ordered psychiatric evaluation while in custody. A pre-sentencing officer may also identify a candidate.

*Staffing and docket.* Those who are calendared on the MHC docket are typically those in crisis, facing non-compliance issues, substance abuse, or possible probation violation. New participants appear on the docket until medication and treatment is stabilized. Some participants are also brought to court for the judge to acknowledge their positive progress. The calendar is held every two weeks with approximately two to five defendants, though the calendar has been as high as 10; the docket lasts approximately 30-60 minutes.

### Accountability

*Program structure.* The court calendar is used specifically as leverage to gain compliance with probationers to meet conditions of probation. The team uses jail time frequently as a response to non-compliance behaviors by participants on a case-by-case basis. Typically jail terms are one to two weeks in length; rarely, jail is used for longer terms (up to 30 days) as a workaround solution to hold participants in a sober environment or to await an opening for a residential bed.

### Effectiveness

*Team members.* The team is primarily comprised of probation officers and the judge. Resource issues have prevented the county attorney and the public defender from participating as a dedicated member of the team. As of the date of this report, a peer mentor and the RBHA representative have discussed joining the team, including options for joining telephonically, but have not formally committed membership to the team. The team has also discussed the desire for a law enforcement (county and/or city) representative to be part of the team.

Probation has regular contact with the court through a staffing lasting 30-60 minutes held every two weeks. The judge and probation officer occasionally receive input from treatment providers and a National Association for the Mentally Ill (NAMI) peer support mentor. Regular information provided from the RBHA, the county attorney, or the public defender is limited and a lack of resources was consistently noted as a source of this shortcoming along with a lack of sufficient buy-in by some of the stakeholders.

*Services provided.* Treatment is provided by a RBHA direct services provider. In addition to mental health counseling services, participants may receive employment readiness training and life skills assistance. However, team members indicated that services for a nurse to fill medications and provide education on how to take medications would be helpful to improve stability for the participants. The team would like to see better access to medication and assistance in securing AHCCCS, when eligible, while in custody. Currently, no screening is conducted in the jail and participants are often released without services. Gaps in services are extensive and include low-income housing, sober living housing and day-programs, transportation, and random drug testing services. Transportation is especially difficult due to the geography of the county, with a mountain range literally dividing the county. Establishing housing is difficult as probationers often have a history of eviction and need assistance to re-establish credibility on housing

applications. Access to a wide array of services, particularly in the rural areas of the county, is limited.

*Data and evaluation.* Participant recidivism, defined as a revocation within Yavapai County, is currently tracked by probation. Probation can identify new felonies statewide through its electronic case management system (APETS), but is unable to track new limited jurisdiction offenses. Currently, probation identifies SMI through special attributes contained within APETS; probation manually tracks diagnosis, medications, sanctions in court, and number of events. Probation plans to track additional data, such as the number of times participants appear in court, transfers on/off the specialized caseload, new misdemeanor charges, and petitions to revoke for technical or new law violations.

### **Program Exit**

Participants complete the program after six stable months of compliance. Participants must also secure stable housing and demonstrate an ongoing aftercare plan. The legal benefits of graduation are a transfer to the standard probation caseload to complete probation terms.

## Yuma County Superior Court

### Yuma County Superior Court: Mental Health Court<sup>51</sup>

#### History

Yuma County MHC was created by a collaboration of attorneys, probation officers, mental health advisors, treatment providers, and leaders in the detention facility and the court. The court was created, upon the suggestion of Mary White, Assistant County Attorney and with the support of Presiding Judge John Nelson, to address a need to provide treatment options for felony offenders who are diagnosed as seriously mentally ill, rather than sentencing them to regular probation. The stakeholders met in August of 2012 and made the commitment to establish a Mental Health Court (MHC); the first court calendar was held on April 15, 2013.<sup>52</sup> Judge Lisa Bleich currently presides over the MHC. After a visit to the Pima County Superior Court's MHC, Yuma determined that a coordinator position was necessary for the success of the program. A senior probation officer was loaned to the program to serve this role. The MHC offers eligible participants the chance to enter both an alternative treatment and sentencing program for defendants with serious and persistent mental illness that are facing criminal charges and/or are having challenges managing their mental illnesses with traditional probation and treatment.

#### Program Design

*Purpose.* The goals of the MHC are to: 1) reduce risk to the community through reoffending and violations of probation for individuals with mental health needs, 2) improve the linkage of such probationers to needed services, 3) reduce cost to the criminal justice system as an effective alternative to jail, and 4) hold providers accountable to provide quality and effective mental health services. The MHC reports a current capacity of 50 to serve supervised probationers with mental illnesses.

*Target population.* Defendants who have a serious and persistent mental illness and the criminal behavior in the offense should be related to or caused by the individual's mental illness. As the number of active participants approaches the capacity of 50, the team expressed a need to revisit eligibility requirements to align with the target population and prioritize individuals whom the program can best serve.

#### Eligibility

*Legal eligibility.* Initially, the MHC did not accept probationers with weapon or violent charges, but in recognition of the lack of alternatives for such defendants, the team expanded the criteria and now only excludes those with sex offenses. The MHC only accepts those on supervised probation for a felony.

*Clinical eligibility.* Probationers are eligible if they have an Axis I or II clinical diagnosis. Originally, participants were required to receive an SMI designation by RBHA, but the

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<sup>51</sup>The National Center for State Courts would like to acknowledge the following members of the Yuma County Superior Court for their time and involvement with this project: Hon. Lisa Bleich, Cathy Dryer (Probation), and Lori Lashway (Clinical Social Worker).

<sup>52</sup>LISA W. BLEICH, YUMA COUNTY MENTAL HEALTH COURT, drafted for the National Association for Court Managers and nominated for the National Justice Achievement Award.

team has expanded the program for those designated as General Mental Health (GMH) with medication services.

*Screening and assessment tools used.* A treatment provider conducts a review for a co-occurring substance abuse diagnosis to identify if the probationer presents with a primary substance abuse diagnosis and who may be more suited for Drug Court. All probationers are screened by probation using the statewide general recidivism risk and criminogenic needs assessment tool, the OST and reassessed with the FROST.

## **Program Description**

### Efficiency

*Referrals.* Referrals are pre- and post-sentence and originate with a range of sources including, defense attorneys, judges, court commissioners, probation or law enforcement officers, jail representatives, and treatment providers. An application form along with mental health records, a pre-sentence investigation report (PSI) that provides a criminal history, a report on incarceration, current symptoms, and any GMH or SMI designation is presented to the coordinator for review. The team makes admittance decisions as needed in difficult cases, such as considering exceptions to the eligibility criteria (e.g., those involving violent history or those without jail time attached, due to time served, which eliminates the use of jail as a sanctioning option). There is a delay in receiving SMI designations, especially for co-occurring disorders which require 90-120 days of sobriety. However, the program accepts probationers without the SMI designation or while their review is in process, which allows the MHC team to expedite admission into the program and accelerates the linkage to treatment.

*Staffing and docket.* The team reviews approximately 20 cases weekly on Mondays for approximately one hour prior to the status hearing. The docket immediately follows and lasts approximately one hour. The coordinator and judge facilitate the staffing meetings and review reports provided by the probation officer, jail representative, and the treatment provider.

### Accountability

*Program structure.* Participants enter the program after sentencing or disposition. Participants appear based on “levels” that range from weekly appearances (initially during stability phase) to every six weeks (while on maintenance phase). On average, probationers move through the phases of the program within an 18-month period. Phases are designed to advance probationers based on status in treatment, compliance with probation terms, status of employment/furthering education, sobriety time, and current status of financial obligations. Yuma County MHC has a well-documented handbook that describes the program and its expectations for all participants. The MHC provides probationers with a written list of advisory sanctions and incentives, including a wide range of options for progressive responses (e.g., written assignments, community service, global positioning program, reduction in court appearances, judicial recognition, bus passes). The MHC also conducts random drug screening according to supervised probation protocol. Jail sanctions are used sparingly with this population and jail terms typically range from three to five days.

## Effectiveness

*Team members.* The team consists of the judge, a clinical advisor,<sup>53</sup> a probation officer, MHC coordinator, public defender, prosecutor, case manager from treatment provider, SMI housing representative, and a representative from a peer support agency. The court communicates effectively and uses progress reports from probation and treatment to review updates in the probationers' status. Initially, a liaison from each treatment agency attended the staff meetings. However, the liaisons had limited information about the participants, so the court implemented a change; the court requires the case manager for each participant to attend the staff meetings and provide accurate and up to date information. This change in policy has improved team members' direct knowledge about the case and improved communications. Currently, the MHC is working with five agencies.

*Services provided.* The MHC works with treatment providers contracting with the RBHA. In addition to more traditional mental health services, an SMI housing representative is part of the team along with a team member who can identify and provide peer support. The MHC also connects probationers to life skills, financial counseling, and benefits assistance. The team expressed concerns over the quality of clinical assessments, treatment planning, and services offered, which stems from funding concerns. Some services are provided by under-trained clinicians while others are reportedly not available due to a lack of funding. Service gaps in the community include the lack of a psychiatrist in Yuma County, inpatient/residential programs, and transitional housing options. Additional service needs include access to a psychiatrist who could prescribe medications and funding to conduct full psychiatric evaluations.

*Data and Evaluation.* Yuma County's MHC tracks extensive data on its participants. The MHC employs the NCSC's full set of 14 national performance measures designed specifically for MHCs. This includes tracking in-program and post-program recidivism and conducting exit surveys. The court also reports an average time from referral to admission of 25 days, which will reduce jail days. Additionally, there is an advisory board that meets on an ongoing basis to make programmatic changes in response to performance data reviews.

In the spring of 2014, the MHC team members met with the Yuma County Justice Court and the Yuma Municipal Court to explore funding options to implement a pre-adjudication diversion program for misdemeanor offenders with mental illnesses.

## **Program Exit**

The program is nearly a year old, without any graduates. Repeated non-compliance has, to date, resulted in four terminations (these result in a petition to revoke probation). The MHC defines graduation requirements as completion of all treatment plan tasks, fulfillment of probation and court conditions, and full payment of financial obligations. Probationers are also required to demonstrate a minimum of four months of compliant and pro-social behavior and 30 days without a sanction. As a requirement of the fifth and

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<sup>53</sup>The current clinical advisor is a temporary and unpaid position. While the team values this position, it will likely be discontinued due to a lack of resources and funding.

final level in the program, probationers develop a written aftercare and wellness document that details daily tasks to stay well, identifies triggers/events and coping strategies, identifies community resources, and creates an action plan for independent living. Legal benefits of participating in the MHC result in termination of probation.