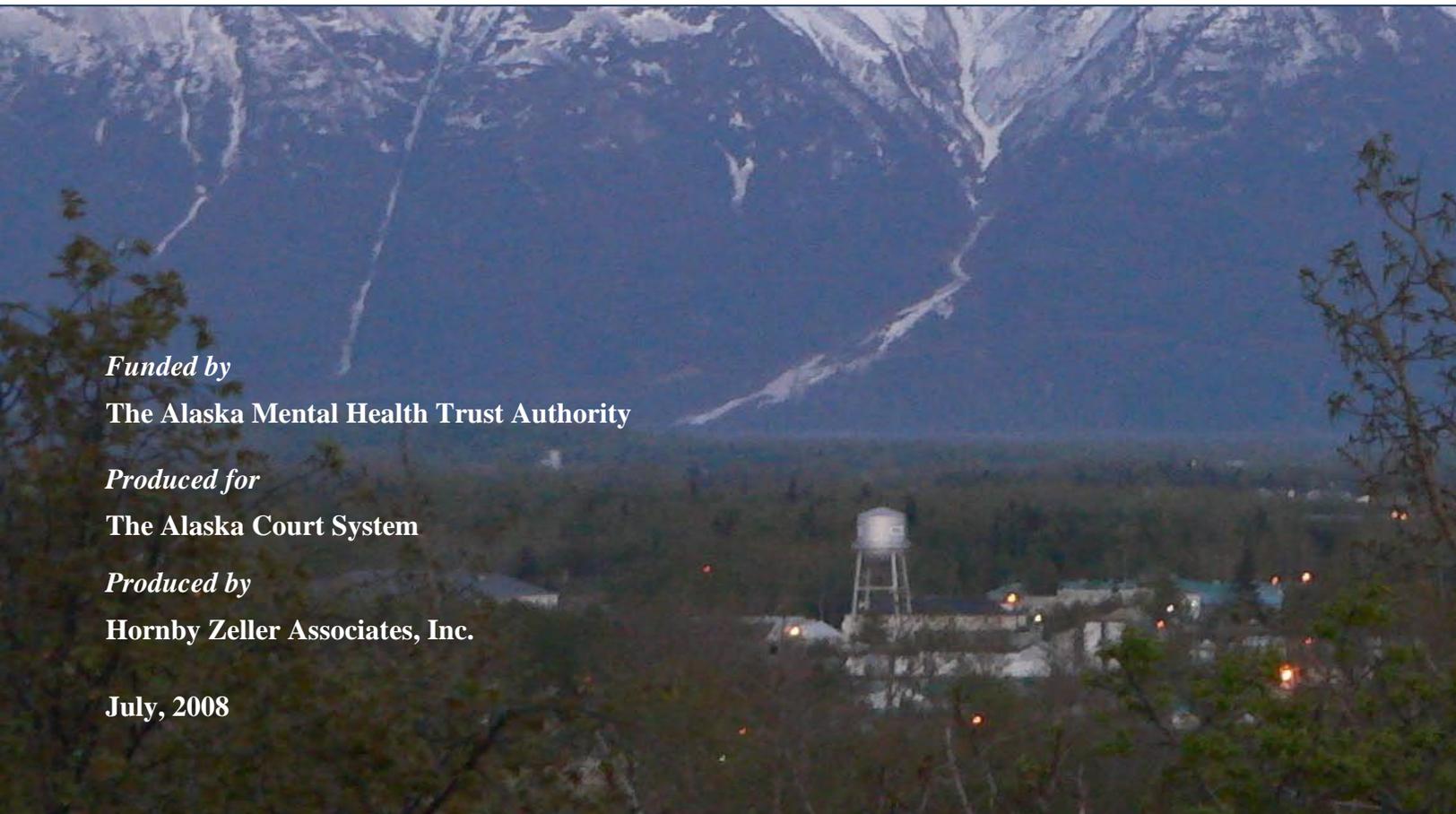




**Outcomes from the Last Frontier:
An Evaluation of the
Palmer Coordinated Resources Project
Palmer Mental Health Court**



Funded by
The Alaska Mental Health Trust Authority

Produced for
The Alaska Court System

Produced by
Hornby Zeller Associates, Inc.

July, 2008



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Funded by:

The Alaska Mental Health Trust Authority

Partners:

**Alaska Court System
Alaska Department of Corrections
Alaska Department of Health and Social Services,
Division of Behavioral Health &
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July, 2008

Acknowledgements

Hornby Zeller Associates would like to acknowledge the support received from the many agencies and individuals involved in this study. First and foremost, we would like to thank Kristin Hull, the Alaska Court System's Project Coordinator for the Palmer Coordinated Resources Project (PCRP). Ms. Hull provided us with immeasurable support throughout the course of the study. Whether it was assisting us in arranging primary or secondary data collection efforts, arranging site visits, providing technical assistance or helping us simply navigate the system, Ms. Hull proved to be an invaluable resource and deserves many special thanks.

We would also like to thank all the key officials within the Alaska Department of Corrections, the Alaska Department of Health and Social Services, the Alaska Court System and the Alaska Mental Health Trust Authority for allowing administrative data sharing privileges to take place in order to support the evaluation effort. In addition, we would like to thank the 22 key actors who, either directly or indirectly involved with the PCRP, took the time to lend us their thoughts about the program and its place in the provision of mental health care services in the community. Most importantly, special thanks go to the PCRP participants who took the time to share with us information about their experiences with the program. We believe that their opinions will heavily influence the recommendations ultimately adopted for program improvement. Had it not been for these collaborative efforts, this report would simply not have been possible.

This project is funded by the Alaska Mental Health Trust Authority under contract with the Alaska Court System. Kristin Hull, the Alaska Court System's Project Coordinator for the Palmer Coordinated Resources Project, and the Honorable Gregory Heath, District Court and Mental Health Court Judge, served as the primary officials involved in the study. The contents of the report are the sole responsibility of the authors and do not represent the opinions of the funding agency.

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Executive Summary

Alaska is one of the pioneering states in the implementation of therapeutic court programs dedicated to serving people with mental illness who are involved in the criminal justice system. Located in the Matanuska-Susitna Borough in South Central Alaska, the Palmer Coordinated Resources Project (PCRP), or Palmer Mental Health Court, became the second operational mental health court in the state upon receiving its first referral in January, 2005. Covering more than 23,000 square miles, the PCRP serves one of the largest and fastest-growing settlement areas in Alaska, including towns such as Palmer, Wasilla, Houston, Big Lake, Willow and Talkeetna.

What exactly does the PCRP do? In general, the PCRP is a specialized criminal court docket dedicated to diverting non-violent mentally ill defendants from incarceration into a regimen of court-monitored, community-based treatment and social services. The overarching goals of the PCRP are to improve both clinical and criminal justice system outcomes through:

- 1) improved identification of persons whose mental illness and lack of adequate treatment is a primary factor in their criminal justice system involvement;
- 2) development, implementation, and monitoring of a coordinated mental health treatment and criminal justice intervention plan;
- 3) improved coordination among criminal justice, mental health and related support systems;
- 4) increased judicial oversight and engagement with participants.

One of the underlying principles guiding the best practices of effective mental health court programming suggests that the planning and administration of a mental health court should include a broad-based group of stakeholders representing the criminal justice, behavioral health and service delivery systems. In this way, mental health courts work to facilitate wellness through a coordinated response designed to assist people with mental illness escape the revolving door of the criminal justice and mental health systems.

The PCRP is just one of the estimated 184 mental health courts that are in operation across the United States. Today, all but eleven states¹ have implemented at least one mental health court, although the majority (n=76) are located in Ohio (n=30), Idaho (n=25) and California (n=21). Indeed, mental health courts are fairly recent innovations; the first mental health court was established in 1997. The state of Alaska is a pioneer in the implementation of mental health courts, spearheaded by such programs as the Anchorage Coordinated Resources Project (ACRP), which has been in operation since 1998 and is one of the first mental health courts established in the United States.

Nationally, studies on mental health courts have consistently shown that they can successfully divert defendants from jail into treatment, provide more treatment, and faster linkages into treatment than traditional avenues afforded to those experiencing mental illness in the criminal justice system. However, the broader and sustained impact of these programs on the criminal justice system, and on the individuals participating in these programs is just starting to be explored. A recent companion study of the mental health court program in Anchorage revealed marked reductions in criminal recidivism and gains along clinical outcome measures, thereby generating institutional savings that far exceed the operational costs of the program. Similar questions posed of the Anchorage CRP will also be asked of the Palmer CRP. Does the PCRP also help in reducing crime? What is the impact of the PCRP on the quality of life of those

¹The eleven states that do not have a mental health court are North Dakota, South Dakota, Kansas, Michigan, Nebraska, New Jersey, Wyoming, Connecticut, Massachusetts, Arkansas and Mississippi (Raines & Laws, 2008).

who participate? Is the PCRCP also cost-effective? To answer these questions, the Alaska Mental Health Trust Authority (AMHTA), in conjunction with the Alaska Court System, commissioned a study to provide an in-depth analysis of the PCRCP on a variety of individual and system-level outcomes.

Performed by Hornby Zeller Associates, Inc. (HZA), the study examines the outcomes of the PCRCP using a wide variety of methods including an analysis of administrative data, interviews with former PCRCP participants, interviews with key stakeholders, and observations of PCRCP system processes and operations. Administrative data sources include information maintained by PCRCP program staff as well as the Alaska Court System (both electronic and hard copy form), Medicaid data from the Alaska Department of Health and Social Services, Division of Health Care Services (DHSS), psychiatric histories from the Alaska Psychiatric Institute (API) and correctional histories from the Alaska Department of Corrections (ADOC).

Major findings presented throughout the report reveal that the program is generating many positive outcomes for the State of Alaska and Beneficiaries of the AMHTA. The PCRCP has demonstrated reduction along both criminal and clinical recidivism measures, resulting in a net institutional savings greater than the annual operational costs of the program. The following provides a summary of highlights presented throughout the report:

- The combined institutional savings generated by the PCRCP (\$243,313) exceeds the estimated annual operational costs of the program.
- Diverting Trust Beneficiaries with severe mental illness from incarceration into the PCRCP poses less of a risk to public safety than traditional adjudication.
- The average daily cost to operate the PCRCP is estimated at \$16.98 per person, which is substantially less than the average daily cost of incarceration (\$121.60).
- Since its inception, a total of 223 people had been referred to the PCRCP. Of these referrals, more than half elected to sign up to participate in the program (n=131).
- As of December 31st, 2007, a total of 100 people had formally opted into the PCRCP. Of these, 40 people successfully completed the program and graduated, while 20 elected to discontinue their participation. Forty people were still active in the program.
- The PCRCP's retention rate (80%) and program completion rate (67%) compare favorably with the mental health court program in Anchorage, as well as other therapeutic court programs nationally.
- The PCRCP reached its targeted operational capacity of 40 participants relatively soon after enrolling its first participant. In the past year (2007), the PCRCP has been either at or above operational capacity, and has an ongoing waitlist of people desiring to participate in the program.
- PCRCP participants were less likely to engage in new criminal conduct after exiting the program (17%) than an equivalent group of people experiencing mental illness and also involved in the criminal justice system (40%). PCRCP graduates were the least likely overall to re-offend (5%).
- Among those who did engage in new criminal conduct, PCRCP participants were less likely than an equivalent group to commit new felonies, violent or drug-related crimes.

- Approximately one third of all PCRCP participants had a history of a psychiatric admission to the Alaska Psychiatric Institute (API). Within one year after being discharged from the PCRCP, not one individual had experienced a subsequent psychiatric hospitalization.
- The vast majority of former PCRCP participants self-reported improvements along all quality-of-life domains as a result of their participation in the program.

As a result of the major findings presented throughout this report, HZA would like to encourage the Alaska Court System and key stakeholders within the State of Alaska to consider the following recommendations to improve systems performance, which will likely generate improved outcomes for the PCRCP as well as the people it serves.

Recommendation 1: Re-examine the methods by which the PCRCP identifies its intended target population and consider implementing a therapeutic court targeting individuals whose primary problem is substance abuse as opposed to mental health.

An analysis of participant diagnostic criteria and interviews with participants and stakeholders revealed that many PCRCP participants may be more appropriately served by a therapeutic court specializing in addictions (e.g., drug court) as opposed to a mental health court. Ideally, a mental health court should target individuals experiencing moderate to severe mental illness and mild or no problems relating to substance abuse. The Alaska Court System should consider implementing such a program, given the rising demand and impact of substance abuse in the Matanuska-Susitna Borough. The introduction of integrated actuarial assessments to the admissions process (rather than relying solely on clinical judgment) will also help the PCRCP identify its intended targeted population.

Recommendation 2: Develop a more formalized system of graduated sanctions and incentives, and increase funding to expand the range of incentives available for PCRCP participants.

As part of the evaluation, the research team presented many key stakeholders with a hypothetical scenario about a fictional PCRCP participant. Key stakeholders had a wide variety of responses to the scenario, with some recommending the use of sanctions and others not. While everyone was in agreement that the participant's treatment plan should be reviewed, stakeholders were split as to whether a sanction should be imposed or not, as well as what type of sanction should be imposed. Of those recommending a sanction, one-third advocated for an increased level of supervision and monitoring (e.g., increased testing, attendance at treatment, more frequent court appearances), one-fifth recommend jail as a sanction, and one key stakeholder recommend the individual perform some kind of public service work.

A graduated system of sanctions and incentives is an *Essential Element* of effective mental health court programming, and while used by the PCRCP, the program has not yet developed a formalized, graduated system. Moreover, there is currently no dedicated funding stream to support the provision of tangible rewards. The PCRCP and its participants would benefit by developing a system of incentives and sanctions that is not fixed (in that if one does X, one must necessarily receive Y) but rather, one that is tailored to allow for a range of options, so as to be able to more appropriately respond to the individual while at the same time preserving a sense of fairness among PCRCP participants as a whole. How and in what way the PCRCP applies sanctions should also be carefully explained to participants prior to their admission to the program.

Recommendation 3: Review PCRCP Policies and Procedures and develop a contingency management plan for turnover among PCRCP staff.

The relative success or failure of any therapeutic court program can often boil down to the level of investment, commitment, and dedication among key staff and service delivery system providers. When turnover occurs, it can have a significant impact on therapeutic courts as well as the participants they serve. The PCRCP would benefit from revising its Policies and Procedures to include a set of clearly defined roles and responsibilities for project management staff; currently these are somewhat vague, particularly with respect to the role of the case coordinator and project manager. The PCRCP would also benefit from the implementation of a contingency management plan, to include specific trainings and resources for new team members.

Recommendation 4: Increase community recognition and support for ongoing programmatic sustainability.

Virtually all participants and key stakeholders interviewed expressed widespread, enthusiastic support for the PCRCP. At the same time, the overwhelming majority believed that the program is not well known in the community at large. The ultimate goal of any therapeutic court is to move along a continuum from basic implementation (requiring judicial leadership) to integration (forging partnerships) to institutionalization (being interwoven into the fabric of a community). Given the successful outcomes generated by the PCRCP, it would behoove the program to increase its public awareness profile. This can be accomplished by taking advantage of local media outlets, providing pamphlets for local agencies and organizations (both private and public), and development of a PCRCP advisory board as many key stakeholders indicated a desire to become more actively involved with the program.

Recommendation 5: Revise admissions-related procedures to reduce the time it takes to formally opt into the PCRCP.

The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. The reason for this principle is simple: it is well known throughout the literature that the sooner an individual, particularly one motivated by criminal justice involvement, is placed into treatment, the better his or her short and long-term outcomes will be in the future. The amount of time between the Initial Opt-In Hearing and the Formal Opt-In Hearing, where a formal intervention and treatment plan are adopted, averages 49 days. Although service plans are developed and service linkages are initiated during this interim period, the PCRCP should consider establishing earlier benchmarks (upon which all parties can agree) and try to work within these parameters to shorten the time it takes participants to be formally accepted into the program.

Recommendation 6: Provide resources to allow for a representative from the treatment community to be present at both pre-court meetings and status hearings.

Many treatment providers expressed the desire to be more actively involved in the PCRCP. However, the strain on available resources often limits the ability of providers to be present at either pre-court or PCRCP status hearings. It should be recognized that treatment professionals can provide important insights, as well as developing innovative strategies in the method by which the PCRCP responds to a wide variety of participant behaviors.

Recommendation 7: Revise existing methods by which PCRCP referrals and participant updates are reviewed by members of the PCRCP team.

Interviews with PCRCP team members and observations of PCRCP operations revealed inconsistencies in the content of the participant updates that are disseminated to team members at the pre-court meeting. The PCRCP should streamline the way in which participant updates are shared, so that information concerning the major life domains of each individual is presented more consistently. In addition, the PCRCP pre-court meeting often spends a great deal of time discussing new referrals to the program. These discussions typically involve whether or not the applicant is considered a “good fit” for the program, subjectively projecting out whether or not the individual will likely be successful. This is a common occurrence and ethical problem for many therapeutic court programs, as no one knows or can predict who will or will not ultimately succeed. As long as the defendant meets the program’s legal and clinical eligibility requirements, absent a veto from either the DA or PCRCP judge, that individual should be accepted into the PCRCP.

Recommendation 8: Provide additional support staff to streamline PCRCP operations.

Observations of PCRCP systems operations revealed the need to provide at least a part-time position to support the multitude of responsibilities of the one dedicated project manager. In light of the possibility of a future addictions court being created, there should be a reevaluation of the current project manager’s role and responsibilities. It would behoove the Alaska Court System to consider elevating the PCRCP project manager position to project coordinator responsible for supervising both therapeutic courts. Two project assistant positions could be added (one for each court) which would help streamline court systems processes by eliminating potential duplication of effort.

Recommendation 9: Consider reorganizing the PCRCP status hearing.

A common criticism among participants and key stakeholders interviewed concerned the order in which cases are heard during the PCRCP status hearing. Generally, graduates appear first, followed by in-custody cases, formal and initial opt-ins; active participants are heard last. Active participants and their support persons (e.g., family, service providers) are critical of having to wait one to two hours before they have a two or three minute dialogue with the PCRCP judge. The PCRCP may want to consider re-ordering the types of cases being heard (giving more priority to active participants) or create two separate PCRCP dockets that are shorter in duration. For example, one docket can be dedicated to in-custody cases, initial and formal opt-ins, and the other can be dedicated to graduates and active program participants.

Recommendation 10: Consider implementing the recommendations put forth by former participants of the program.

It is rare for individuals who participate in therapeutic court programs to have their input on a large scale when it comes to program evaluation and developing strategies for systems improvement. In this study, active and former PCRCP participants were asked about what recommendations they would make to improve the program. While some participants said they would not change anything, others provided recommendations that generally centered on the following five areas:

- 1) Develop more supports and activities for participants;
- 2) Develop a method by which participants can better understand their legal situation (how their legal case will be resolved) as well as what their expectations are from the program;
- 3) Develop a separate program for people who are in substance-related recovery;
- 4) Hire more treatment staff as many counselors are burnt out; and
- 5) Provide more resources, particularly with respect to transportation.

Background and Context

Despite modest fluctuations in crime rates over the years, it is estimated that on any given day there are 2.2 million people incarcerated in the United States. At mid-year 2006, among the 42 jurisdictions with jail and prison population increases, the State of Alaska experienced the highest rate of prison population growth (9.4 percent) of any state in the country (USDOJ, 2007; Sabol, Minton and Harrison, 2007).

One of the many contributing factors related to this growth involves the prevalence and high rate of recidivism among those with serious mental illness and co-occurring substance-related disorders; a population that has become more abundant in correctional populations both in terms their absolute numbers and proportionate representation (Lurigio & Swartz, 2006). In Alaska, a recent Department of Corrections (ADOC) study revealed that more than 42 percent of all inmates in custody of the ADOC are people with mental illness, or beneficiaries of the Alaska Mental Health Trust Authority (AMHTA)². The study also revealed that Trust Beneficiaries spend significantly more time in custody than other inmates, are more likely to recidivate, recidivate sooner, and many are not reconnected with community-based mental health service providers upon release (Ferguson, Hornby and Zeller, 2007).

The escalating number of people in the criminal justice system who experience mental illness has led many jurisdictions like the Matanuska-Susitna Borough to adopt new strategies in an attempt to divert appropriate populations away from incarceration into community-based treatment and social services. Established in 2005, the Palmer Coordinated Resources Project (PCRP), also known as the Palmer Mental Health Court, is a recent innovation implemented by the Alaska Court System (ACS). The project is dedicated to serving adults charged with misdemeanor crimes who are also beneficiaries of the AMHTA³. The overarching mission of the PCRP is to:

“...divert people with mental disabilities charged with misdemeanor offenses from incarceration and into community treatment and services and to prevent further contacts with the criminal justice system.” (Alaska Court System, 2006)

The impetus for the establishment of the PCRP can be largely attributed to the marked reductions in recidivism generated by its sister court program in Anchorage (the Anchorage Coordinated Resources Project, or ACRP), as well as the rapid population growth of the Matanuska-Susitna Borough and the commensurate rise in the number of Trust Beneficiaries involved in the Borough’s criminal justice system. Are mental health courts unique to the state of Alaska? No, in fact there are approximately 182 similar programs in operation across the United States. What do we know about mental health courts? Are they effective? Do they save money? These are some of the questions policymakers and community stakeholders are interested in having answered, however researchers have been hard-pressed to identify those outcomes.

Nationally, studies on mental health courts have consistently shown that they can successfully divert defendants from jail into treatment, provide more treatment, better treatment, and faster linkages to treatment than the traditional avenues afforded those experiencing mental illness in the criminal justice

² Beneficiaries of the AMHTA are people with: 1) mental illness; 2) developmental disabilities; 3) chronic alcoholism with psychosis; and, 4) Alzheimer’s disease, related dementias and other cognitive impairments. See Appendix B for a more complete definition of Beneficiaries that fall under the purview of the AMHTA.

³ Consistent with national trends, the State of Alaska has implemented a variety of therapeutic court programs numbering fourteen in total. At present, two (located in Anchorage and Palmer) are dedicated to exclusively serving adult populations who are Beneficiaries of the AMHTA.

system. However, definitive outcomes of mental health courts programs are just now emerging and remain relatively few and far between.

Generally, though, most studies compiled to date are encouraging, showing positive results in some areas and mixed results in others. For example, several studies show that mental health courts have demonstrated reductions in criminal justice system involvement (Ferguson, Hornby & Zeller, 2008; Moore & Hiday, 2006; Herinckx, Swart, Ama & Knutson, 2003; Trupin, Richards, Lucenko & Wood, n.d.), whereas other studies show mixed results when examining either clinical outcomes or quality-of-life measures (Ferguson, Hornby & Zeller, 2008; Boothroyd, Mercado, Poythress, Christy & Petrila, 2005; Cosden, Merith, Jeffrey Ellens, Jeffrey Schnell & Yasmeen Yamini-Diouf, 2004).

In terms of cost-effectiveness, two studies conducted by RAND and Hornby Zeller Associates revealed that, over the long term, mental health courts generate net institutional savings so long as they continue to be effective at reducing criminal recidivism. They also concluded, as in other studies, that diverting people with severe mental illness from incarceration into the mental health court poses no additional risk to public safety (Ridgely, Greenberg & DeMartini, 2007; Ferguson, Hornby & Zeller, 2008).

Given the relative dearth of information about the effectiveness of mental health courts nationally and the desire to introduce a more comprehensive multi-method research design, the Alaska Court System, funded by the Alaska Mental Health Trust Authority, contracted with Hornby Zeller Associates, Inc. in October 2007 to conduct a wide-ranging study of the PCRCP. The study was designed to answer the following key questions:

- What are the clinical and demographic characteristics of the PCRCP population being served? Is the PCRCP successfully reaching its intended target population?
- Why do some individuals elect to participate in the PCRCP and others not? Among those who do elect to participate, why do some of them opt out?
- How much time elapses between key decision points in the PCRCP admissions process (e.g., length of time between initial referral and final admission)?
- What are the characteristics of those who complete the PCRCP program versus those who do not complete it? Are there major differences between both groups?
- What impact does exposure to the PCRCP program have in changing the drug and/or alcohol use among participants with co-occurring substance-related disorders?
- What are the experiences of key actors and participants involved in the PCRCP? What are their thoughts and opinions about the program?
- What was the impact of the PCRCP on the quality of life of former participants?
- What are the clinical and criminal recidivism outcomes of PCRCP participants compared to an equivalent group of people not involved with the program?
- Is the PCRCP cost-effective?

Research Design and Methods

Involving both quantitative and qualitative techniques, the design for this study involves a multi-method approach that includes: in-depth, semi-structured interviews with participants of the Palmer Coordinated Resources Project (PCRP); an extensive array of interviews conducted with key stakeholders both directly and indirectly involved with the program; structured observations of PCRP operations; and finally, administrative data analysis using information obtained from the Alaska Department of Health and Social Services, Division of Health Care Services (DHSS), Alaska Psychiatric Institute (API), Alaska Department of Corrections (ADOC) and Alaska Court System (ACS).

Two different techniques are used to assess the effectiveness of the PCRP from the sources of administrative data mentioned above. The first technique involves a comparison of intermediary outcomes for four groups of people exiting the PCRP at various stages or levels of involvement (referral, initial opt-in, formal opt-in and graduates). The second technique involves a matched-pair design where both criminal and clinical recidivism outcomes are compared between a sample of 35 PCRP discharged participants (e.g., graduates, formal opt-outs) and an equivalent group of people with mental illness who were not referred to the PCRP. The comparison group was constructed using the abovementioned data sources and matched on a number of variables including date of exit, correctional institutional status, gender, mental health diagnosis, age and race. Criminal recidivism is defined as a new remand to the ADOC for an arrest on new criminal charges occurring in year after exiting the PCRP. Clinical recidivism is defined as any new psychiatric hospital admission occurring in the one year after exiting the ADOC for people who also had a psychiatric hospitalization in the year prior to being referred to the PCRP.

In addition, fifteen interviews were conducted with PCRP participants so as to gather various quality of life outcomes. Interviews with participants also included a number of questions about their experience with the program, recommendations for improvement and their insights into reasons behind successful and unsuccessful outcomes. Responses from 22 key stakeholder interviews provided the study with insight into how the PCRP works within the general context of the criminal justice and behavioral health systems. These interviews yielded recommendations for PCRP improvement and provided additional perspective in interpreting outcomes. The observational methodology employed to document the overall content and organization of the PCRP rounds out the last of the series of methods employed in the study. HZA observed a total of three PCRP status hearings in all.

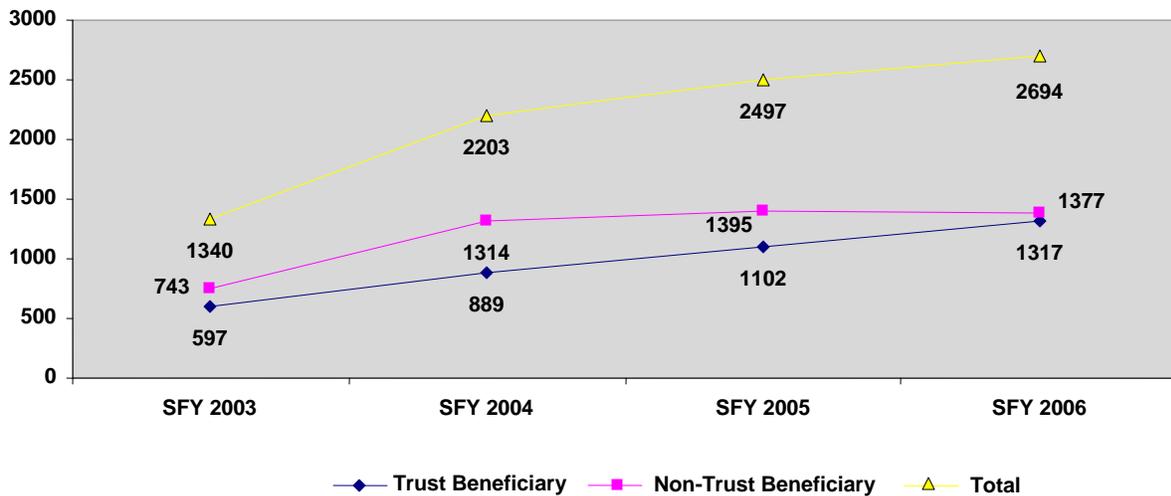
Epidemiological Profile of Trust Beneficiaries in the Matanuska-Susitna Borough

This section of the report is dedicated to providing an epidemiological profile of Trust Beneficiaries⁴ residing in the Matanuska-Susitna Borough who have had criminal justice system involvement between SFY2003 and SFY2006. The purpose of this profile is to both describe the prevalence and service needs⁵ of this Trust Beneficiary population and, more importantly, provide a contextual backdrop for those who have been and are currently being served by the Palmer Coordinated Resources Project (PCRP).

Located in south central Alaska and covering more than 23,000 square miles (approximately the size of West Virginia), the PCRP serves one of the largest and fastest-growing settlement areas in the state, and includes towns such as Palmer, Wasilla, Houston, Big Lake, Willow and Talkeetna. Population growth in the Matanuska-Susitna Borough has accounted for roughly 36 percent of all population growth in the state of Alaska (AK Department of Labor, 2007) and is currently the 31st fastest growing county/borough in the United States (Census Bureau, 2007). On the whole, the population of the Matanuska-Susitna Borough is less diverse than the rest of the state, with only 12 percent making up minority or ethnic populations. Commensurate with this population growth, crime here has also been on the rise (UCR, 2000-2006), as is the number of Trust Beneficiaries involved in the correctional system.

As shown in Figure 1, the rate of growth in the number of bookings in the Matanuska-Susitna Borough has increased from 1,340 in SFY 2003 to 2,694 in SFY 2006. In any given year, between 40 and 50 percent of all people booked in the Matanuska-Susitna Borough are Beneficiaries of the Trust. As shown in Figure 2, bookings in the Matanuska-Susitna Borough account for one out of every ten bookings statewide, more than double the rate experienced just a few years earlier.

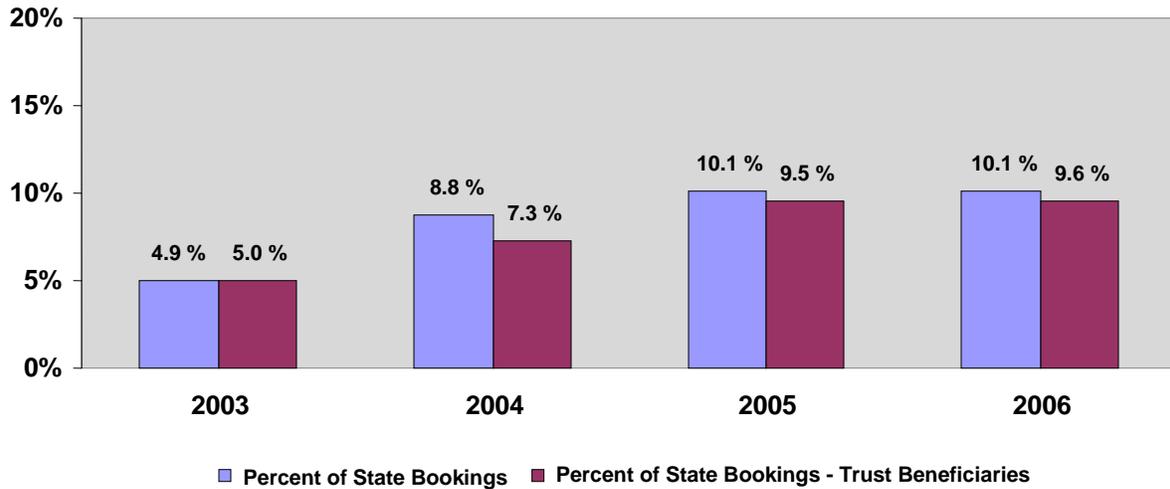
Figure 1: Rate of Growth in the Number of People Booked in the Matanuska-Susitna Borough



⁴ Trust Beneficiaries are people with: 1) mental illness; 2) developmental disabilities; 3) chronic alcoholism with psychosis; and 4) Alzheimer’s disease, related dementias and other cognitive impairments. See Appendix B for a more complete definition of Beneficiaries that fall under the purview of the AMHTA.

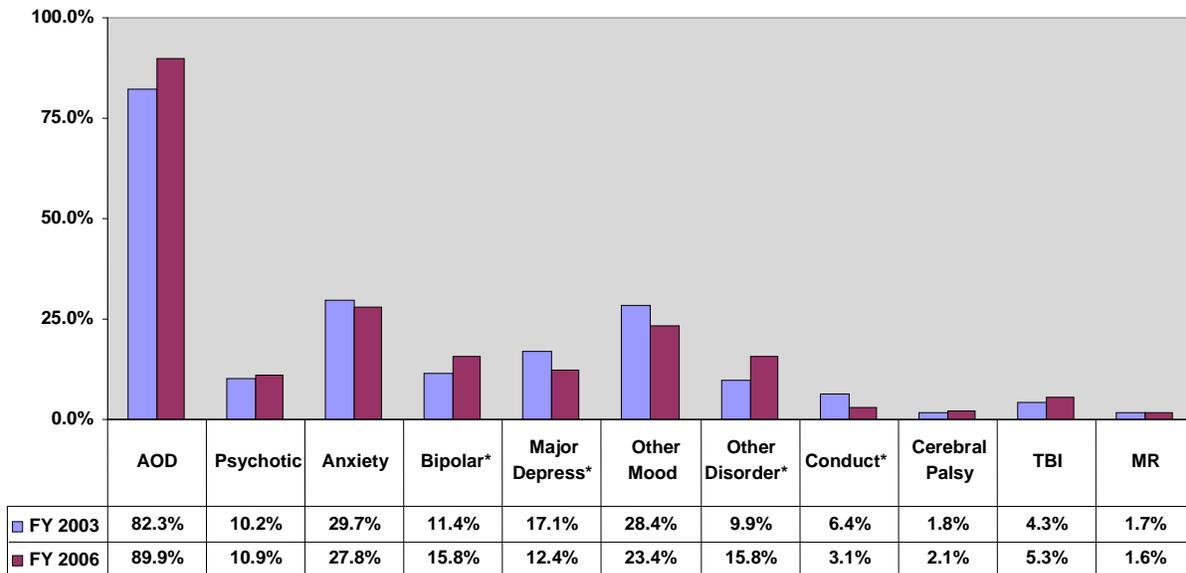
⁵ The analysis on services and service needs for the Trust Beneficiary population residing in the Matanuska-Susitna Borough is restricted to recipients of Medicaid services.

Figure 2: Matanuska-Susitna Borough Bookings Compared to the Rest of Alaska



Information presented in Figure 3 provides a clinical profile of the Matanuska-Susitna Borough Trust Beneficiary population and explores how these characteristics have changed over time. Findings indicate that nearly 90 percent of the Trust Beneficiaries in the Matanuska-Susitna Borough have an Axis I substance-related disorder in addition to an Axis I mental health disorder. More Trust Beneficiaries in the Matanuska-Susitna Borough were diagnosed with Bipolar disorder in 2006, compared to major depression or other mood disorders which were more prevalent in 2003. Other disorders such as sleep, eating and sexual disorders increased significantly between 2003 and 2006, whereas conduct disorders noticeably declined. Combined, nearly 10 percent of the Trust Beneficiaries in the Matanuska-Susitna Borough had developmental disabilities such as cerebral palsy, traumatic brain injury, or mental retardation.

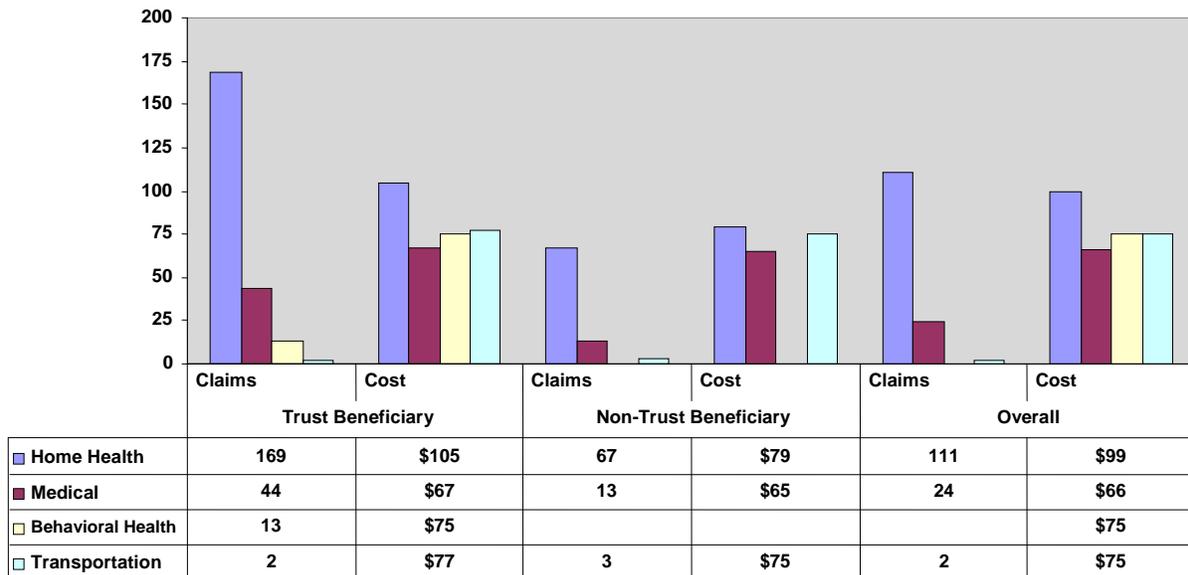
Figure 3: Clinical Comparisons of Trust Beneficiaries Residing in the Matanuska-Susitna Borough



* Denotes statistically significant result

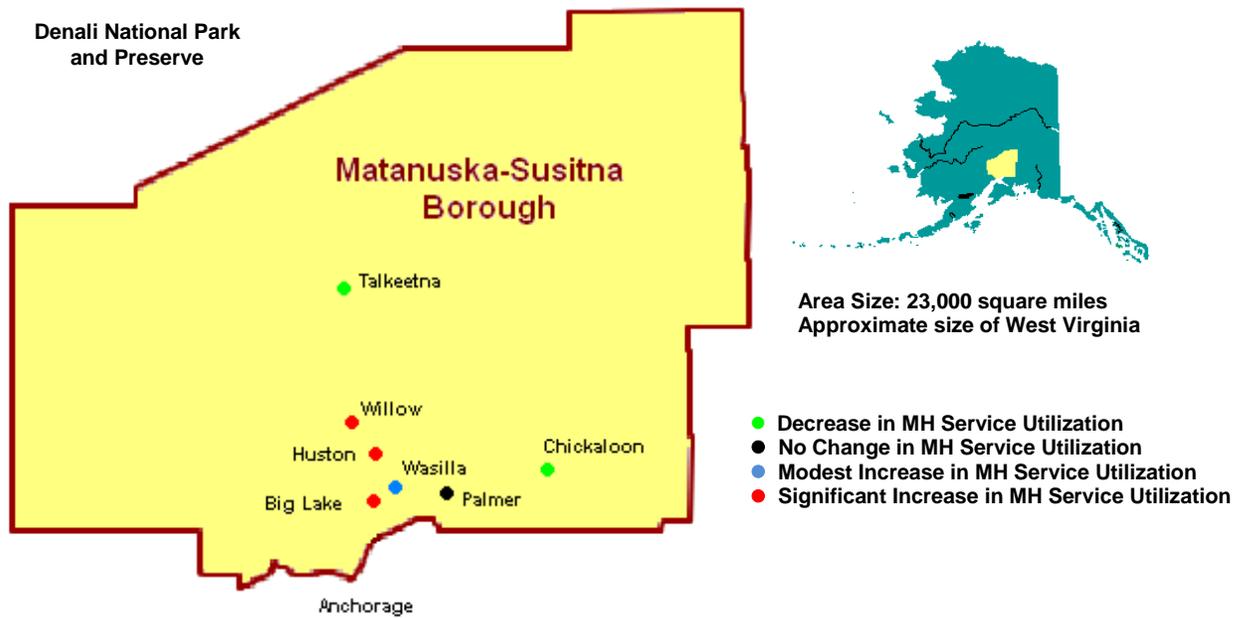
Figure 4 examines differences in the types and quantity of services used between Trust Beneficiaries and other Medicaid service recipients involved in the criminal justice system who did not have a mental health diagnosis. With the exception of transportation services, the Trust Beneficiaries in the Matanuska-Susitna Borough used almost three times as many medical and home health/care coordination services than non-Trust Beneficiaries at an average cost of more than \$14,500 per person. On the whole, the cost of providing services to the Trust Beneficiary population in 2006 amounted to \$34,986,448 compared to non-Trust Beneficiaries who cost \$4,018,032.

Figure 4: Services Used by Medicaid-eligible Matanuska-Susitna Borough Residents Involved in the Correctional System



Are there certain areas of the Matanuska-Susitna Borough where mental health service needs have either increased or decreased? The answer to this question is presented in Figure 5. Between 2003-2006, the mental health service needs of the Trust Beneficiary population has significantly increased among residents in Willow, Huston and Big Lake (representing more than a 100% increase) whereas there were significant declines in Talkeetna and Chickaloon. Overall, there was no change in mental health service needs among Trust Beneficiaries residing in Palmer, whereas the demand for mental health services in Wasilla increased by a modest 15 percent.

Figure 5: Geographic Areas Affected by Changes in Mental Health Service Utilization among Trust Beneficiaries in the Matanuska-Susitna Borough (SFY 2003-SFY2006)



Analyzing PCRP System Processes

While there are no two therapeutic courts that operate exactly alike, the Palmer Coordinated Resources Project (PCRCP) is comparable to other mental health courts in many respects in that it has: 1) a specialized court docket employing a therapeutic approach to criminal case processing for people who experience mental illness; 2) voluntary participation requirements and freedom to withdraw; 3) individually tailored community-based treatment plans; 4) follow-up care and hearings with each participant at which time his or her treatment plan and other conditions of participation are reviewed; 5) incentives and sanctions based on participant progress; and 6) some termination point at which a participant will either successfully complete the program and graduate or withdraw from the program and return to the regular court for regular criminal case processing.

A recent survey of such programs conducted by Erickson, Campbell & Lamberti (2006) reveal wide variations among mental health court operations suggesting that the differences among these courts far outnumber their similarities. As a result, there has been growing interest among practitioners, policymakers, researchers, and others in developing some consensus on what parameters mental health court programs should operate and strive to achieve.

Since 2002, the Bureau of Justice Assistance has provided support for the development of best-practice guidelines for mental health court programs and the result of those efforts has recently been disseminated in a publication entitled *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (Thompson, Osher, Tomasini-Joshi, 2008). Today, this serves as the only definitive guideline on the best practices, designs, and operations of mental health court programs nationally.

To further that effort, we will be using the *Essential Elements* contained in the Thompson report as a frame of reference for the current evaluation of the PCRCP. Information obtained from a review of official documents, interviews with key stakeholders and participants, administrative data, and a series of direct observations inform much of the analyses that follow.

Role of PCRCP Judges

It is important to emphasize that the role of the judge in the PCRCP looks very different from the role of a traditional judge in a regular court. In addition to being a detached arbitrator of facts and law, the PCRCP judge must also assume the role of team leader, overseeing a variety of legal and non-legal professionals (e.g., case coordinator, attorneys, service providers). The PCRCP judge must use his or her judicial leadership and convening skills to coordinate the work among these diverse players in order to promote the best possible outcomes for the PCRCP participant. In essence, the role of the PCRCP judge is central, and for the program to work, it requires on their part a strong sense of commitment, a significant investment in time and resources, and a compassionate interest in helping people who experience mental illness to escape the “revolving door” of the criminal justice system. For judges new to the field of mental health courts, this is not only unfamiliar territory, but a very challenging role to undertake.

The PCRCP is presided over by District Court Judge Honorable Gregory Heath who holds regular PCRCP status hearings on Wednesday afternoons each week. The PCRCP also has a back-up judge, District Court Judge Honorable William Estelle.

Role of PCRP Case Coordinator

One case coordinator from the Alaska Department of Corrections is responsible for assisting the PCRP in determining the defendant's clinical eligibility and in developing individualized treatment plans for defendant's who are interested in participating in the PCRP. The case coordinator is also responsible for arranging community behavioral health treatment options and monitoring a participant's adherence to his or her treatment plan. The case coordinator manages a targeted caseload of approximately forty people who may be in or out of custody at the time of referral. Over the past year, the number of participants monitored by the case coordinator was either at or exceeding the operational capacity of the program.

Role of PCRP Project Manager

The PCRP has a full-time project manager who is responsible for running the day to day operations of the program. The role of the project manager is to ensure the PCRP operates efficiently and in a manner consistent with its overall mission. The primary responsibilities of the project manager are to provide: 1) project administration; 2) assistance in the planning and implementation of improvements to the community behavioral health system; 3) oversight of project evaluation activities; 4) supervision; and 5) technical assistance, training, outreach and education.

Essentially, the role of the PCRP project manager is to "keep all the plates spinning," serving as both liaison and primary point person for all aspects of the program and its administration. Among many responsibilities, the project manager oversees initial eligibility screenings, processes new referrals, schedules all PCRP hearings, facilitates the processing of cases involving legal competency, and provides general administrative assistance to both PCRP judges. In addition, the project manager provides ongoing training and education for PCRP team members and broader community stakeholder groups, including responding to requests from other jurisdictions for technical assistance with mental health court start-ups or mental health courts experiencing implementation issues.

PCRP Eligibility Requirements and Target Population

One of the critical issues for mental health courts is the selection of participants among a vast population of potentially eligible defendants. Admitting people into a mental health court who do not meet the program's intended target population can have a significant impact on programmatic functioning and, ultimately, program outcomes. That is why the second *Essential Element* of effective mental health court programming concerns whether or not the program is reaching its desired target population. As stated in the *Essential Elements*, eligibility criteria should:

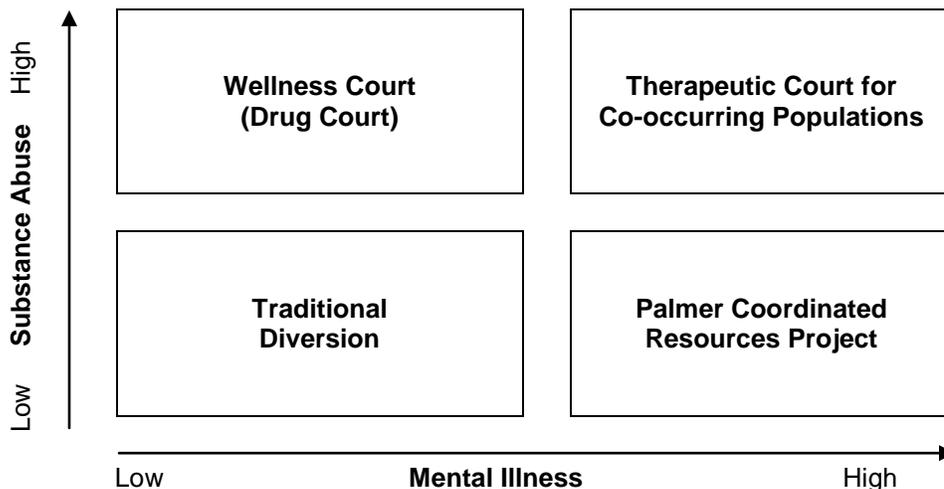
"...address public safety and consider a community's treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria [should] also take into account the relationship between mental illness and a defendant's offenses, while allowing the individual circumstances of each case to be considered." (Thompson, Osher & Tomasini-Joshi, 2008)

In order to participate in the PCRP, participants must meet both legal and clinical eligibility requirements, as well as residency restrictions. Defendants charged with misdemeanor offenses are legally eligible to participate in the program. However, a defendant charged with a felony crime that is reduced by the State to one or more misdemeanor charges prior to appearing before the PCRP is also legally eligible to

participate⁶. In addition, the PCRP will only hear cases involving individuals who reside in the Matanuska-Susitna Borough, who are eligible to receive or are receiving services in the borough, and who intend to reside in the borough for the duration of their program participation⁷. In order to meet PCRP clinical eligibility requirements, a defendant must be a Beneficiary of the Alaska Mental Health Trust Authority (AMHTA)⁸. Beneficiaries of the AMHTA are people with mental illness⁹, developmental disabilities, chronic alcoholism with psychosis, Alzheimer’s disease, related dementias or other cognitive impairments¹⁰.

As a general rule, people with major mental health and low-level or no substance abuse problems should be referred to the PCRP. People with more serious substance abuse disorders and presenting minor mental health problems should be referred to a Wellness Court (drug court), and a specialized court track should be developed for people presenting co-occurring serious mental health and substance abuse disorders. Figure 6 provides a conceptual model for effective therapeutic court programming that was adapted from a 2005 Bureau of Justice Assistance Publication entitled *A Guide to Mental Health Court Design and Implementation*.

Figure 6: Conceptual Model for Effective Therapeutic Court Programming



⁶A defendant who is charged with a misdemeanor and also charged with a felony, or a defendant who is charged with a misdemeanor while on felony probation is not eligible to participate in the PCRP. A defendant who is actively participating in the PCRP on a misdemeanor case and is charged with a new felony crime is not eligible to continue participating in the program.

⁷ According to the PCRP Policy and Procedures Manual, the PCRP does not have the resources to link defendants to services or provide court monitoring of services for people who reside outside the Mat-Su Valley Borough. However, a defendant charged with a state case in another jurisdiction who resides in the borough, or who wishes to move and reside in the borough and is otherwise eligible, can have their criminal case processed in the PCRP.

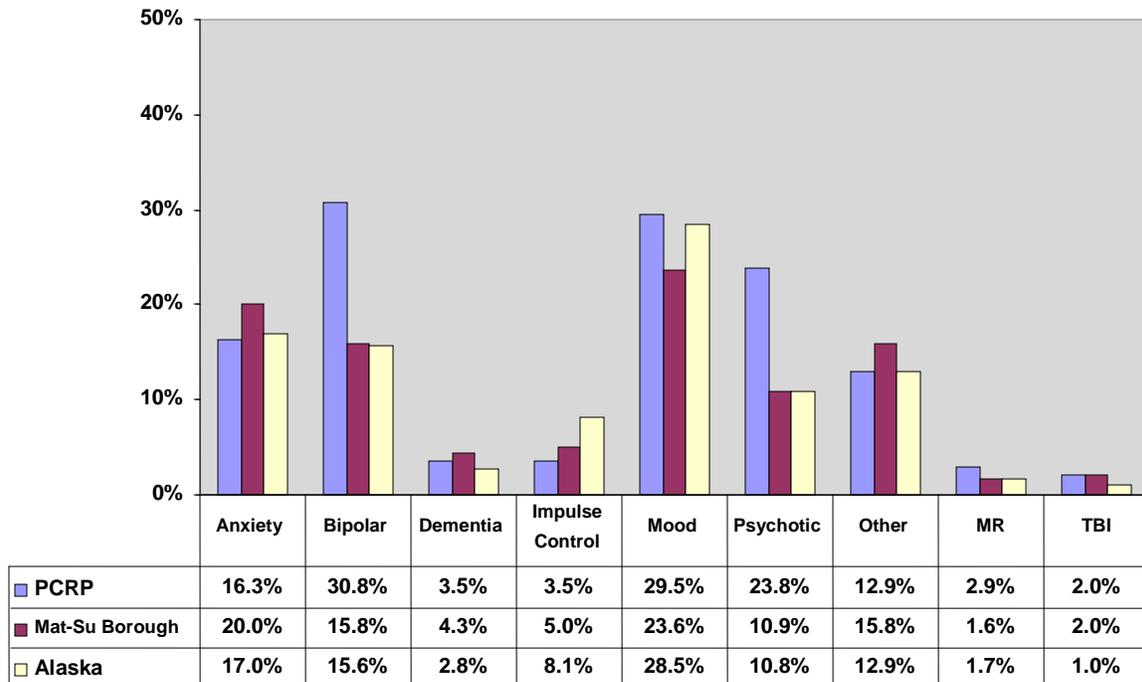
⁸ See Appendix A for a more complete definition of Beneficiaries that fall under the purview of the AMHTA.

⁹ As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). See Appendix B for the list of multi-axial classifications.

¹⁰ According to the PCRP Policy and Procedures Manual, defendants whose sole or primary diagnosis is an Axis II Personality Disorder will not likely be eligible to participate in the program, since intensive treatment for these disorders capable of court monitoring is not generally available in the community.

There are a number of different ways we can assess whether or not the PCRCP is reaching its intended target population. One way is to compare the clinical characteristics of Trust Beneficiaries enrolled in the PCRCP with other criminal justice-involved Trust Beneficiaries residing in the Matanuska-Susitna Borough and others in the State of Alaska. Referring to Figure 7, we find that the PCRCP does in fact enroll Trust Beneficiaries with more moderate to severe mental health diagnoses (e.g., bipolar and psychotic disorders) compared to the prevalence of Trust Beneficiaries with similar characteristics residing in the Matanuska-Susitna Borough and the rest of the state as a whole.

Figure 7: Comparison of PCRCP Clinical Characteristics with Other Criminal-Justice Involved Trust Beneficiaries in the Matanuska-Susitna Borough and Alaska



Another way we can assess whether or not the PCRCP is meeting its intended target population is to compare the severity of mental health diagnoses among those who were referred to the PCRCP with others who matriculated through the program at various other levels of programmatic involvement (e.g., initial opt-in, formal opt-in, graduates). This information is presented in Tables 1 and 2 for the 180 defendants who were referred to the PCRCP and had their cases closed between 2005 and 2007. As we can see from Table 1, only a handful of PCRCP Trust Beneficiaries with mild mental disorders matriculated through the formal opt-in stage or graduated. With a 90 percent success rate, we find that the PCRCP is enrolling defendants who largely meet its intended target population.

Table 1: Clinical Summaries of PCRPs Participants by Level of Program Involvement Prior to Exit

Mental Health Severity ¹¹	Referral Stage (N=104)		Initial Opt-In (N=14)		Formal Opt-in (N=20)		Program Graduates (N=42)		Overall (N=180)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Mild	14	13.5%			3	15.0%	3	7.1%	20	11.1%
Moderate	20	23.1%	6	42.9%	9	45.0%	18	42.9%	53	29.4%
Severe	24	19.2%	4	28.6%	8	45.0%	21	50.0%	57	31.7%
Unknown	46	44.2%	4	28.6%					50	27.8%
Substance Disorder	52	89.7%	7	70.0%	14	70.0%	26	61.9%	99	76.2%

Table 2: Clinical Characteristics of PCRPs Participants

Code	Primary Diagnosis	Frequency	Percent
296.80	Bipolar Disorder NOS	18	17.1%
294.9	Cognitive DO	12	11.4%
296.3x	Major Depressive Disorder Recurrent	10	9.5%
295.30	Schizophrenia, Paranoid Type	8	7.6%
295.70	Schizoaffective Disorder	6	5.7%
296.89	Bipolar II Disorder – Depressed	6	5.7%
298.9	Psychotic Disorder NOS	5	4.8%
296.90	Mood Disorder NOS	5	4.8%
296.43	Bipolar I Disorder, Most Recent Episode Hypomanic	5	4.8%
309.81	Posttraumatic Stress Disorder	4	3.8%
296.7	Bipolar I Disorder – Most Recent Episode Unspecified	3	2.9%
295.90	Schizophrenia, Undifferentiated Type	3	2.9%
296.2x	Major Depressive Disorder, Single Episode	3	2.9%
318	Moderate Mental Retardation	2	1.9%
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	2	1.9%
296.52	Bipolar I Disorder, Most Recent Episode Depressed	2	1.9%
300.00	Anxiety Disorder NOS	2	1.9%
345	Complex Partial Seizure	1	1.0%
296.33	Major Depressive Mood Disorder without Psychotic Features	1	1.0%
300.01	Panic Disorder	1	1.0%
300.14	Dissociative Identity Disorder	1	1.0%
311	Depressive Disorder NOS	1	1.0%
295.10	Schizophrenia, Disorganized Type	1	1.0%
309.4	Adjustment Disorder Without Disturbance of Emotion and Conduct	1	1.0%
301.13	Cyclothymic Disorder	1	1.0%
317	Mild Mental Retardation	1	1.0%
Total		105	100.0%

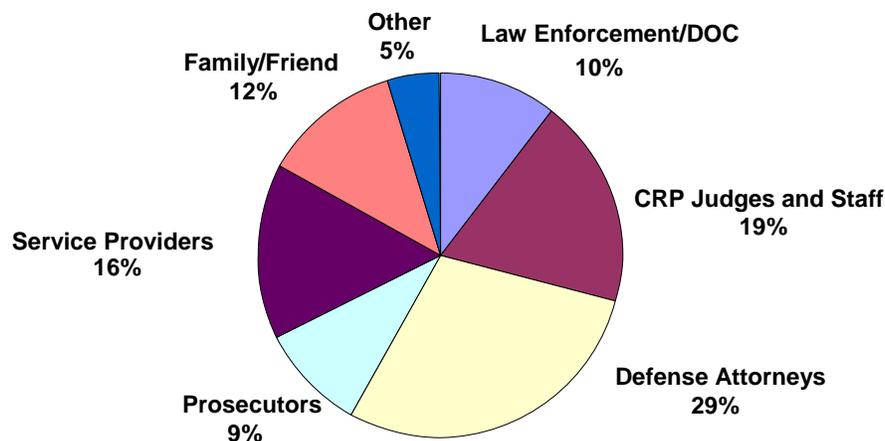
¹¹ Severity categorizations: mild disorders included mood disorders coded as mild, adjustment disorders, anxiety disorder NOS, mood disorder NOS, depression NOS and major depression with only one episode. Moderate disorders included mood disorders coded as “moderate,” recurrent mood disorders not coded with severity, PTSD, panic disorder, all bipolar disorders (unless specifically coded “severe”). Severe disorders include all psychotic disorders, all cognitive disorders and mood disorders coded as “severe.”

However, as suggested in Table 1, PCRP selection criteria are not perfect, particularly with respect to people who have both co-occurring mental health and substance-related disorders. Participants with co-occurring disorders are less likely to graduate from the PCRP compared to those with mental health disorders alone. This is not surprising, as people with co-occurring disorders are among the most difficult to diagnose, treat and generally tend to have worse outcomes (Peter & Hills, 1997). In general, they are at greater risk of relapse, re-hospitalization and homelessness, and more likely to be involved with the criminal justice system (Peters and Osher, 2004). In sum, while the PCRP is reaching its intended target population, it is still returning to regular court a high volume of participants with co-occurring substance-related disorders (83 percent).

PCR Referrals

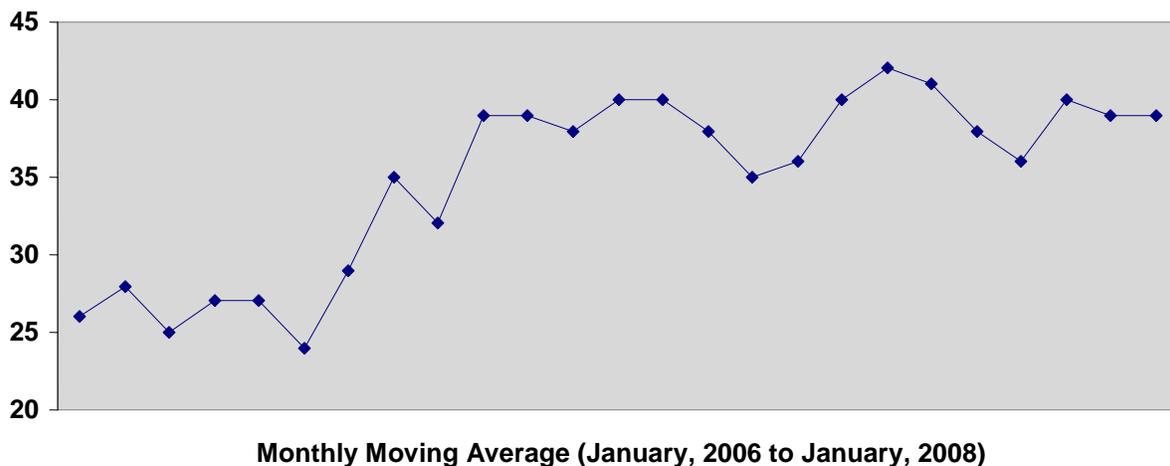
As alluded to in previous sections of the report, the process of becoming a participant in the PCRP begins at the point of referral. Anyone may refer a case to be heard in the PCRP. Once a referral has been made, the defendant will be scheduled to appear before the PCRP for an Initial Opt-In Hearing after arraignment, so that the defendant may consult with counsel, observe the court process and receive information about how the program works. Sources of referral are typically generated from defense attorneys (29 percent), PCRP judges and staff (19 percent) or service providers (16 percent). A breakdown of these and other referral sources are displayed in Figure 8 below.

Figure 8: Overall Distribution of PCR Referral Sources



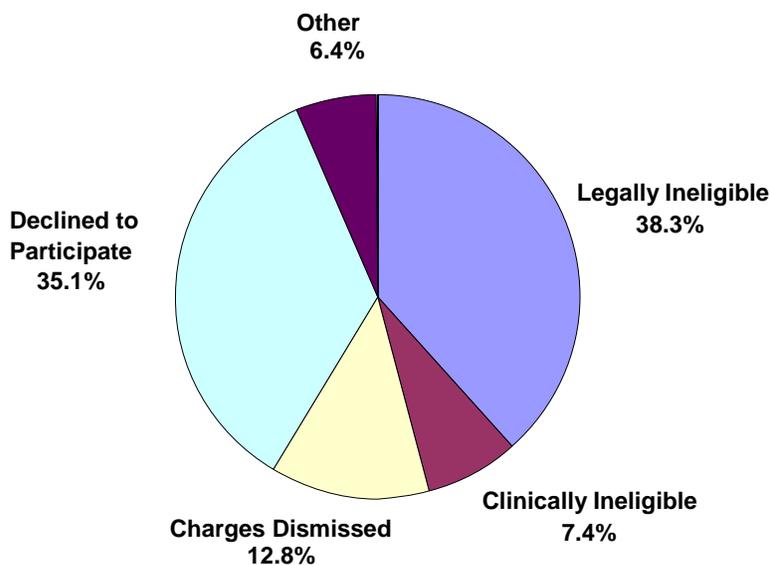
Since its inception, the PCRP has processed an average of eight new referrals each month, maintaining an average capacity of 35 participants. As shown in Figure 9 (next page), however, the PCRP has either been close to, at or above capacity during the majority of 2007, averaging 39 participants, compared to an average of 31 participants during 2006.

Figure 9: PCRP Enrollments Over Time



Although there are a number of people who are referred to the PCRP, not everyone will matriculate into the program for a variety of different reasons. Referring to Figure 10, more than one-third of all referrals to the PCRP did not meet the legal or clinical eligibility requirements, an equal number simply declined to participate, and a smaller number had their charges dismissed.

Figure 10: Primary Reasons Why Some People Do Not Matriculate into the PCRP

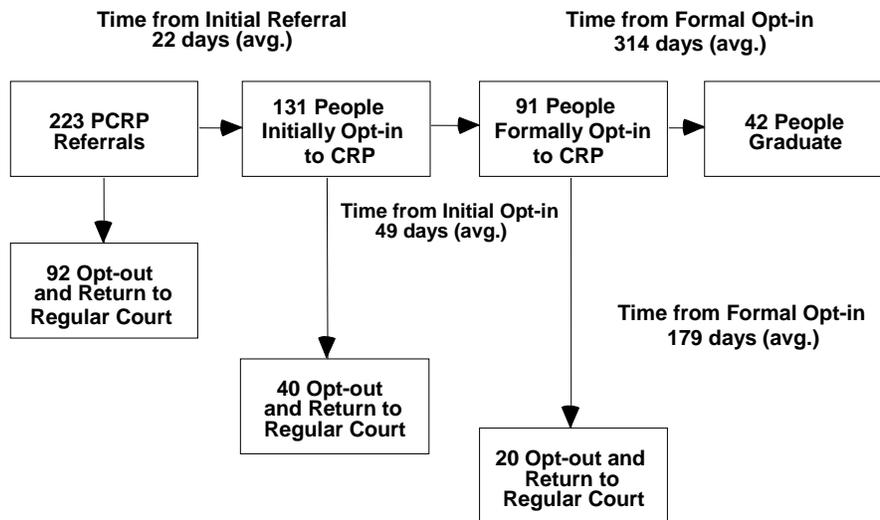


PCR System Flow

The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. As stated in the *Essential Elements*, participants must be “identified, referred, and accepted into mental health courts [early], and then linked to community-based service providers, as quickly as possible” (Thompson, Osher & Tomasini-Joshi, 2007). The reason for this principle is simple, as it is well known throughout the literature that the sooner one is placed into treatment, the better one’s short-term and long-term outcomes will be in the future.

Information about PCR system flow is graphically displayed as a flow chart in Figure 11. Of the 223 people referred to the PCR, a total of 92 people did not appear before the Initial Opt-In Hearing. Among the remaining 131 people who appeared at the Initial Opt-In Hearing, almost one-third (31 percent) did not matriculate into the program for a variety of reasons discussed earlier. The Motion for Initial Opt-In memorializes the defendant’s beginning date of participation in the PCR.

Figure 11: PCR Court System Flow



Once a defendant initially opts into the PCR, he or she is assigned to the PCR case coordinator so that actions can be taken to develop an individualized, community-based treatment plan that addresses all major life domains (e.g., housing, medications, treatment, benefits, social supports, legal involvement). This treatment plan is then presented at the Formal Opt-In Hearing, where the designated PCR judge considers the plan as well as the legal resolution that has been agreed upon by the defendant, his or her attorney, and the assigned state or municipal prosecutor.

If the PCR judge is in agreement, conditions of bail or release are set and the defendant officially becomes a participant in the PCR. At this point, a new court date is set for the participant to reappear before the PCR in order to review his or her adherence with the treatment plan. Periodic reviews of participant progress are set on a case-by-case basis, with next appearances generally recommended by the case coordinator and approved by the PCR judge. Referring back to Figure 11, of the 131 people who

initially opted into the PCRP, about 70 percent (n=91) will take the final step in becoming a participant by formally opting into the program.

The amount of time between the Initial Opt-In Hearing and the Formal Opt-In Hearing is somewhat lengthy, averaging 49 days. While there are no hard and fast rules governing how long this process should take, HZA would like the PCRP to consider establishing reasonable benchmarks (upon which all parties can agree) and to try to work within these parameters to shorten the length of time it takes for a participant to formally opt into the program.

PCR Pre-Court Sessions and Status Hearings

As previously noted, the PCRP status hearing is presided over by District Court Judge Gregory Heath, who holds regular PCRP status hearings every Wednesday afternoon. Like other therapeutic courts, the PCRP also holds a pre-court meeting; this is a time where members of the therapeutic court team convene to discuss the progress of each participant, as well as any new referrals to the program. The pre-court meeting is usually attended by the judge, prosecutor, defense attorney(s), project manager, case coordinator and, when available, a representative from treatment. Generally, the length of the PCRP pre-court meeting lasts about an hour, while the length of the PCRP status hearing is approximately two hours in duration.

In January 2008, HZA observed two scheduled sessions of the PCRP. Using a structured observational tool specifically designed for therapeutic courts¹², HZA staff recorded the amount of time PCRP team members devoted to one of sixty-four possible topic areas for discussion. These sixty-four items were then grouped into ten broad categories, which are graphically presented in Figure 12 below (items will not sum to 100 percent as they are not mutually exclusive).

As previously indicated, the observed length of the PCRP pre-court meeting was about an hour, whereas the PCRP status hearing was approximately two hours long. What happens during these sessions? As we can see from Figure 12, procedural matters (e.g., scheduling, new referrals) and discussions surrounding mental health treatment account for more than half the time spent during the PCRP pre-court meeting. Of the pre-court time dedicated to discussing new referrals, much of the time was spent discussing the applicant's overall "fit" for the program, especially in light of the PCRP wait list¹³. Similarly, procedural matters (e.g., scheduling, entering pleas) and discussions about treatment account for a significant amount of the PCRP status hearing. These topics are followed, to a lesser extent, by issues involving housing, relationships, and incentives and sanctions. A small fraction of the PCRP status hearing was allocated to drug use or testing and issues involving employment or education and benefits.

Like most therapeutic court status hearings, there is a great deal of activity that occurs during the course of a typical PCRP session with participants. As a general rule, graduations occur first, followed by in-custody cases and then out-of-custody cases.¹⁴ While there is no set order in hearing out-of-custody cases, preference is generally given to participants who are being accompanied by community behavioral health service representatives. Others may be afforded more or less of a priority depending on the

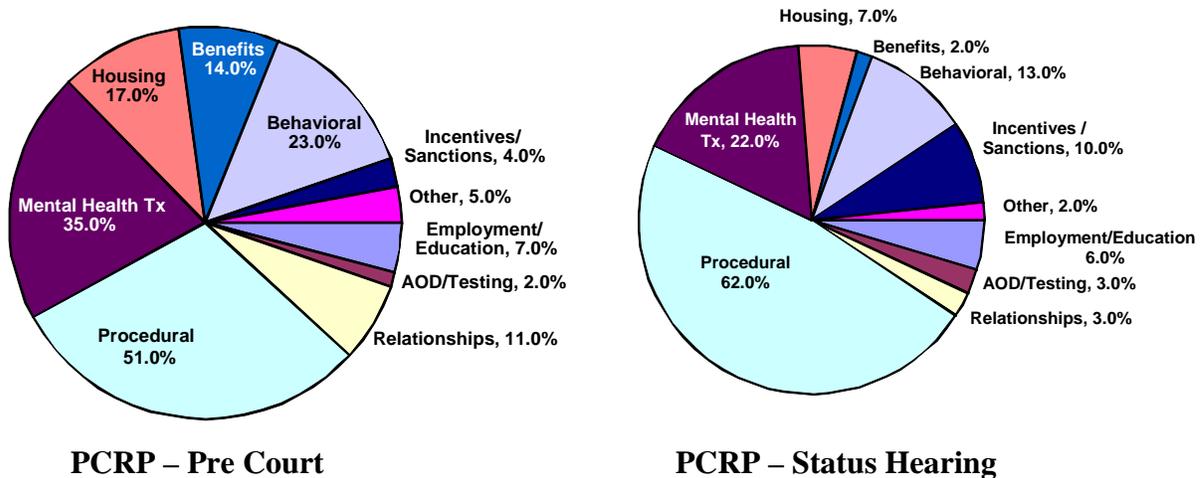
¹² This instrument was developed based upon observations of more than 200 various types of therapeutic courtroom environments located in Maine, Massachusetts, New York, Florida, Louisiana, Missouri, Oklahoma, Texas, California and Alaska.

¹³ Subjective valuations of prospective participants can be a relatively common occurrence in therapeutic courts which and can be very problematic. Subjectively projecting out the future and unknown outcome of person A over person B (among those who technically meet both clinical and legal eligibility requirements) can present a serious ethical dilemma and cause for concern about due process among others.

¹⁴ In-custody cases are generally heard first so as to more efficiently use the resources of law enforcement personnel.

individual circumstances of the case. Once a participant’s case is reviewed by the PCRCP judge, he or she is then allowed to leave.

Figure 12: Distribution of PCRCP Pre-Court and Status Hearing Discussion Topics



The average amount of the time each participant spent before the PCRCP judge is presented in Table 3 and Figure 13 (next page). Overall, 26 participant cases were reviewed during the PCRCP status hearing. More than 40 percent of the PCRCP status hearing was absorbed by the handling of in-custody cases (six minutes, five percent), entering pleas for those waiting to formally opt-in (22.5 minutes, 19 percent), and down time¹⁵ (22 minutes, 19 percent). The remaining time was spent on one participant who graduated from the program (14 minutes, 12 percent) and on active participants (55 minutes, 46 percent).

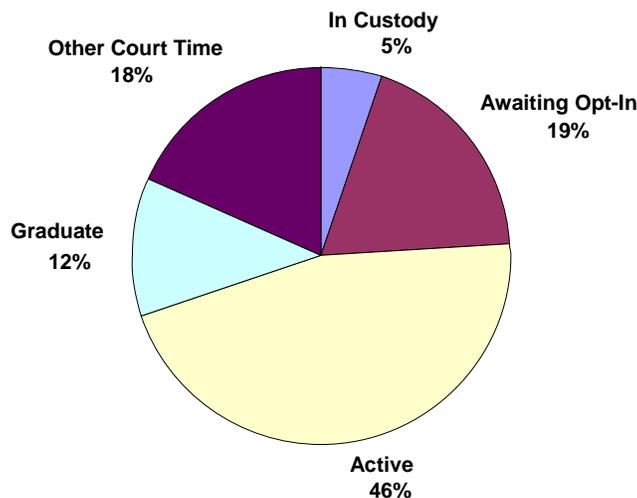
A common criticism among participants and key stakeholders interviewed concerned the order in which cases are heard during the PCRCP status hearing. Active participants and their support persons (e.g., family, service providers) are critical of having to wait one to two hours before they have a three to four minute dialogue with the PCRCP judge. The PCRCP may want to consider re-ordering the types of cases being heard (giving higher priority to active participants), or creating two separate PCRCP dockets that are shorter in duration. For example, one docket can be dedicated to in-custody cases, initial and formal opt-ins, while the other can be dedicated to graduates and active program participants. Both dockets can still be scheduled for the same day, but as an example, active participants and graduates would appear before the PCRCP at a different time.

¹⁵ Among the many things “down time” can refer to includes time spent scheduling, docketing, transitioning (i.e., bringing in-custody cases to and from the courtroom) and routine waiting (i.e., discussions between various parties before or after a case had been called).

Table 3: PCRP Status Hearing Time Allocation by Participant Status

Judge Time Spent with PCRP Participants	In Custody (n=4)	Awaiting Opt-In (n=7)	Active (n=14)	Graduates (n=1)	Overall (n=26)	Down Time
Session duration: 119 minutes						
Mean (seconds)	95.0	192.7	234.9	NA	223.6	NA
Median (seconds)	105	185	219.5	NA	206.5	NA
Range (seconds)	35-134	121-264	119-332	NA	35-841	NA
Sum (minutes)	6.32	22.48	54.82	14.02	96.89	22.11
Percent of Total Time	5.3%	18.9%	46.1%	11.8%	81.4%	18.6%

Figure 13: PCRP Status Hearing Time Allocation by Participant Status



Sanctions and Incentives

A graduated system of sanctions and incentives is one of the key ingredients in the *Essential Elements* of effective mental health court programming. Incentives promote adherence with program expectations, can increase program retention, and help motivate individuals to engage in more healthy and socially appropriate behaviors. Sometimes sanctions are necessary to respond to non-adherence to conditions of program participation. However, in the mental health court, the vast majority of circumstances dictate that the first response should be to review treatment plans, including medications, living situations, and other service needs. As a general rule, when violations increase in either frequency or severity, mental health courts should use individualized, graduated sanctions to maximize adherence to conditions of bail or release, as well as develop specific protocols to govern the use of jail as a sanction.

Additionally, mental health courts should develop a menu of incentives that is at least as broad as the range of available sanctions; they should be administered by a ratio of four incentives to each sanction at minimum (should a sanction need to be imposed).

Currently, the PCRP uses a variety of incentives, including individual praise and applause, certificates for program completion and decreased frequency of court appearances. Also, at the start of their participation in PCRP, everyone receives a calendar to keep track of appointments. PCRP sanctions take a variety of forms as well, but more often than not involve verbal cautions, scheduling court appearances sooner than would otherwise be expected, and imposing new bail or release restrictions (e.g., curfew amendment, no contact order). Occasionally a short jail sanction will be imposed for more serious violations.

As part of the evaluation, the research team presented key stakeholders with the following hypothetical scenario about a possible PCRP participant:

Scenario: Debra formally opted into the mental health court program two months ago. She is 20 years old, with bipolar disorder and a history of substance abuse. She lives with her mother and is trying to get her GED. Her drug of choice is prescription medication and she has three prior misdemeanor convictions for theft. To date, she has received verbal praise from the bench and has been in compliance with her treatment plan as of her last court session. Last week it was learned that she failed to attend two scheduled sessions with treatment, she quit her part-time job and has been arguing with her mother. She did meet with her case coordinator though and told him that “she feels too confined.” He thinks she may be abusing her medication. With the exception of cross-reactivity, all other drug and alcohol tests have been negative. Today she is at mental health court. What, if anything, should happen to Debra?

Key stakeholders had a wide variety of reactions to the scenario, with some recommending the use of sanctions and others not. While everyone was in agreement that the participant’s treatment plan should be reviewed, key actors were split between whether or not there should be a sanction imposed, as well as on what type of sanction should be imposed, if any. Of those recommending a sanction, one-third advocated for an increased level of supervision and monitoring (e.g., increased testing, attendance at treatment, more frequent court appearances), one-fifth recommend jail as a sanction, and one key stakeholder recommended the individual perform some kind of public service work.

While incentives and sanctions are used by the PCRP, the program has not developed a graduated system tailored to correspond to participant progress. Imposition of jail as a sanction for drug or alcohol use also varies between PCRP judges. Moreover, there is no dedicated funding stream for tangible rewards. The PCRP and its participants would benefit by developing an incentives and sanctions system that is not fixed (in that if one does X, one must necessarily receive Y), but rather one that is tailored to allow for a range of options; this would allow for the program to respond more appropriately to the individual, while at the same time preserving a sense of fairness among PCRP participants as a whole. How and in what way the PCRP applies sanctions should also be carefully explained to participants prior to their admission to the program.

PCRP Cross-Systems Integration

One of the *Essential Elements* guiding the best-practices of effective mental health court programming suggests that the planning and administration of a mental health court should include a broad-based group of stakeholders representing the criminal justice, behavioral health and service delivery systems. In this way, mental health courts work to facilitate wellness through a coordinated response designed to assist people with mental illness escape the revolving door of the criminal justice and mental health systems. The goal of any therapeutic court is move along a continuum from basic implementation (requiring judicial leadership) to integration (forging partnerships) to institutionalization (interwoven into the core fabric of a community).

Where does the PCRCP sit along this continuum? The short answer is that the PCRCP is not quite at the institutionalization stage yet, but has developed tremendously since its inception. The PCRCP has made significant strides in forging partnerships and building relationships with a vast array of key stakeholders in the Matanuska-Susitna Borough, all of whom have an important impact on the program as well as the people it serves.

Critical to the evolution and ongoing sustainability of the PCRCP is the cooperative effort that exists between the Judicial Branch and two departments of the Executive Branch (Department of Corrections and Department of Health and Social Services). Yet for the PCRCP to work as it is intended, it also requires local support. To this end, the PCRCP has established many additional partners, including those in law enforcement and emergency medical services.

The day-to-day operations of the PCRCP are managed through a cooperative effort provided by key stakeholders in the Alaska Court System, the Alaska Department of Corrections, the Alaska Department of Law, the Alaska Public Defender Agency, the Office of Public Advocacy and the Municipal Prosecutor's Office. In addition to these, there are a number of other partners working with the PCRCP, including:

- Alaska Family Services
- Alaska Mental Health Trust Authority
- Alaska State Troopers
- DayBreak, Inc.
- Mascot Transportation
- Mat-Su Health Services
- Nugen's Ranch
- Office of Public Advocacy
- Palmer Police Department
- Pathway to Sobriety
- Valley Residential Services
- Veterans Center
- Wasilla Police Department

Recidivism Outcomes

The strongest test of criminal justice diversion programs is the extent they actually reduce crime and save money. Although research on adult drug court programs have shown reductions in criminal activity among program graduates and overall costs savings, both in terms of prison time and criminal justice case processing (see generally Ferguson, 2006; Belenko, 1999, 2001; GAO, 2006; Rempel, 2003; and Carey, 2003), it has been more difficult for researchers to draw meaningful conclusions about such outcomes for mental health courts. Mental health courts are more recent and typically have had far fewer enrollments. As a result of these problems, there have been relatively few evaluations of mental health court programs nationally. Among the evaluations that have been conducted, few include analyses of post-program recidivism, incorporate an experimental design, or utilize multivariate models to assess program outcomes. Nevertheless, these studies have been suggestive of reduced criminal justice system involvement whether it is measured by days in jail, arrests or type of involvement (Moore & Hiday, 2006; Herinckx, Swart, Ama & Knutson, 2003; Trupin, Richards, Lucenko & Wood, n.d.).

The current study marks an innovative development in improving upon that which we know about mental health courts. The following analysis compares recidivism outcomes of 35 PCRCP participants with a matched comparison group of 35 similarly situated individuals who did not participate, nor were referred to, the PCRCP program. PCRCP participants were matched across a number of variables including date of exit, correctional institution status, gender, mental health diagnosis, age and race. This section of the report is dedicated to an examination of recidivism outcomes across multiple measures (e.g., severity, type, survival).

How do PCRCP participants fare with respect to criminal recidivism? Referring to Figure 14 and Table 4 (on the next page), the one-year, post-discharge recidivism rate for all PCRCP participants formally opting into the program is 17 percent, which compares very favorably against a matched comparison group of similarly-situated offenders who were not referred to the PCRCP (40 percent). Among those discharged from the PCRCP, program graduates were least likely to re-offend overall (five percent). Among those who did engage in new criminal conduct, PCRCP participants were less likely to commit new felonies, violent or drug related crimes. Hence, diversion of people with mental illness from incarceration into the PCRCP poses no greater risk to public safety than traditional adjudication.

Figure 14: One-Year Recidivism Outcomes for PCRCP and Comparison Group

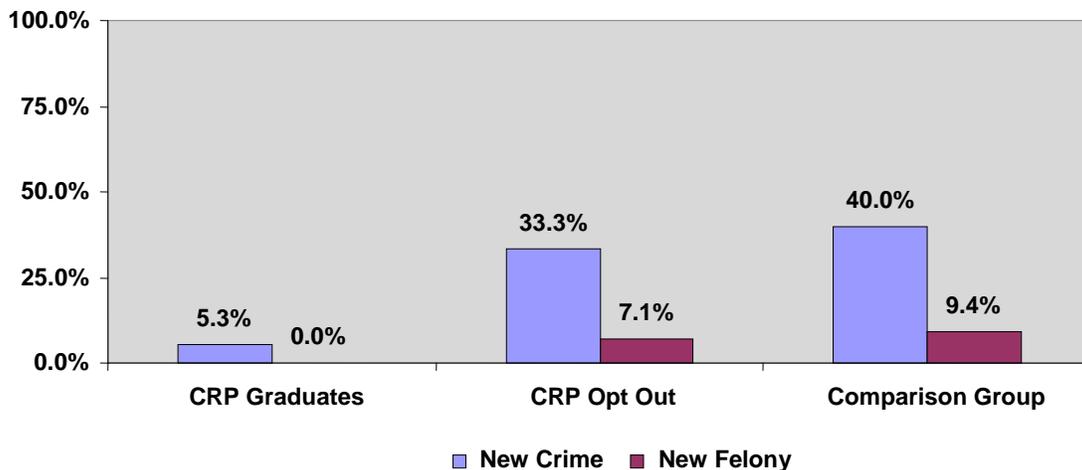


Table 4 – One-Year Recidivism Outcomes for PCRCP and Comparison Group

	PCRCP Graduates (N=20)		PCRCP Opt-Out (N=15)		PCRCP Combined (N=35)		Comparison Group (n=35)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Re-Arrested								
Yes	1	5.3%	5	33.3%	6	17.1%	14	40.0%
No	19	94.7%	10	66.7%	29	82.9%	21	60.0%
Felony Charge								
Yes	0	0%	1	7.1%	1	2.9%	3	9.4%
No	20	100%	14	92.9%	34	97.1%	32	90.6%
New Felonies								
ASSAULT 2			1	6.7%	1	2.9%		
ASSAULT 3							1	2.9%
BURGLARY 1							1	2.9%
SEX ABUSE OF MINOR 2							1	2.9%
New Misdemeanors								
ASSAULT 4							2	5.7%
CRIMINAL TRESSPASS			1	6.7%	1	2.9%		
DISORDERLY CONDUCT			1	6.7%	1	2.9%		
DRIVING WITH SUSP LICENSE	1	5.3%			1	2.9%	1	2.9%
DWI							2	5.7%
MISCONDUCT- SUBSTANCE 4							1	2.9%
RECKLESS DRIVING			1	6.7%	1	2.9%		
THEFT 3			1	6.7%	1	2.9%	2	5.7%
VIOL DV PROTECTIVE ORDER							1	2.9%
VIOL CONDITION OF RELEASE							2	5.7%

Information provided in Table 4 also examines the types of crimes these recidivists were charged with. While there were few differences between the two groups, on the whole, the comparison group was more likely to be charged with personal crimes compared to the PCRCP participants, who were more likely to be charged with property-related crimes.

Costs Associated with New Criminal Conduct

The following analysis is based on cost estimates derived from Miller, Cohen and Wierseman (2001) and French (1996), who calculated the cost associated with particular criminal events. Table 5 provides their estimates for the average cost per victimization; figures are adjusted for inflation¹⁶. These estimates are based on actual costs that are accrued by the public, including: costs incurred by crime victims (e.g.: medical care, mental health care expenditure, lost productivity); costs that accrue to the public (e.g.: victim’s services and compensation); and criminal justice costs, including the costs of incarceration. The estimate of costs incurred by crime victims and the costs accrued to the general public were calculated by multiplying the number of crimes (incidents) times the cost associated with each criminal event.

¹⁶ It should be noted that these are national estimates using data derived from the National Crime Victim Survey and the Federal Bureau of Investigation. Any bias that may result in the application of these estimates in Alaska cannot, unfortunately, be estimated.

Table 5: Costs Associated With a Criminal Act^a

<i>Offense</i>	<i>Cost of Incidence</i>	<i>Offense</i>	<i>Cost of Incidence</i>
Robbery	\$47,878	Forgery	\$448
Assault	\$2,578	Larceny/Theft	\$1,384
Burglary	\$4,093	Motor Vehicle Theft	\$8,577
Criminal Threatening	\$2,578	Criminal Mischief	\$462
Gross Sexual Assault	\$206,038	Receiving Stolen Property	\$507
Operating Under the Influence	\$3,480	Disorderly Conduct	\$432
Fraud	\$432	Aggravated Assault	\$115,155

^a Adapted from Harrell, Cavanagh and Roman (1998)
Original estimates from Miller, Cohen and Wierseman (1993) were adjusted for inflation.

Table 6 - Total Costs of Criminal Acts Among PCRP Participants and a Comparison Group

Type of Criminal Act	PCRP Combined (N=35)		Comparison Group (n=35)		Total Costs PCRP Combined	Total Costs Comparison Group
	Number	Percent	Number	Percent		
ASSAULT 2	1	2.9%	1	2.9%	\$115,155	\$115,155
ASSAULT 4	0	0%	2	5.8%	\$0	\$5,156
SEX ABUSE OF MINOR 2	0	0%	1	2.9%	\$0.00	\$206,038
BURGLARY 1- IN A DWELLING	0	0%	1	2.9%	\$0	\$4,093
CRIMINAL TRESPASS 2	1	2.9%	1	2.9%	\$462	\$462
DISORDERLY CONDUCT	1	2.9%	1	2.9%	\$432	\$432
DWI	0	0%	2	5.8%	\$0	\$6,960
THEFT 3	1	2.9%	2	5.8%	\$1,384	\$2,768
Total Costs for All Types of Criminal Acts					\$117,433	\$341,064

Referring to Table 6, results of the analysis indicate that the cost of new crimes committed by PCRP recidivists (\$117,443) is much lower than for the comparison group of traditionally adjudicated offenders with mental illness not involved in the PCRP (\$341,064).

Additionally, nearly one third of all PCRP participants had a history of a psychiatric admission to the Alaska Psychiatric Institute (API) prior to entering the program. Within one year after being discharged from the PCRP, not one individual has experienced a subsequent psychiatric hospitalization. Differences between the PCRP and the comparison group yielded a net gain of 26 days for the PCRP, or \$19,692 (\$757/day). This brings the total net gain for the PCRP to \$243,313.

PCRP Perspectives – Participant’s Point of View

As we have alluded to throughout this report, the definition and measurement of “success” in a therapeutic court can take a variety of forms. This is one of the reasons why HZA has employed a multi-method evaluation design to obtain more in-depth outcomes about the program and the participants it serves. In all, HZA staff talked with fifteen participants of the program. These interviews were designed to ascertain information about their experiences with the program and, based on those experiences, determine what they would recommend to make the system work better. The following are some of the things participants had to say about themselves and the services they received, as well as their opinions about the PCRP and various team members involved in the program.

Participants on their mental and physical well-being

“I can now see a tunnel through the fog.”

“Before, I didn’t really have a definition of normal.”

“It definitely has been a strain. Because of this, I lost my job, my home, everything. I’ve put on weight, I’m not working. They want me to live like a hermit.”

“It feels good to go into my 30s with so much confidence.”

“I was spiraling down before. Now I’m productive and it feels good.”

“I feel much better. Now I have more tools to deal with it.”

“I’ve improved a lot. I am on my 4th medication. I am not feeling like I am always hung over. I feel motivated and I’m more into my family now.”

“I was in a bad relationship, she was mental and we kept bumping heads. I feel much better now that we are not together. I like being single, clean and sober and my new neighbors don’t use either.”

“I’m doing well now with my classes. I am able to do a lot more things.”

“I feel centered now and a lot more productive than I used to be.”

“I’m learning a new trade now. I feel like I am starting all over again.”

Participants on Substance Use

“I was a binge drinker. Sometimes I would go as long as a month. Now, I don’t even really think about it. I keep busy. I haven’t had a drink in over 13 months.”

“If I hadn’t gotten into the court, I would have faced jail time and wouldn’t know how to stay sober.”

“They want me to stop drinking forever. All I had was two beers and I got three days in jail.”

“It would be nice for them to have a separate program for those people in recovery.”

“I never thought there was another sober person in the valley.”

“I was caught drinking and got eight days in jail. Now I go to more appointments, AA and I get tested a lot more too.”

“I do not know how I feel about this whole process. I can’t hang out with my friends anymore. They should put people up into two groups, heavy use and low use for people like me.”

“I don’t have that kind of problem but I’ve seen it [CRP] do really good for a lot of people who really want to clean up.”

“I don’t use drugs. If I did, I would be in a lot more trouble.”

“I am not going to be able to drink for another three years because I will be on probation. All I do is sit in my house, go to meetings, that’s it.”

“I owe them my life. I couldn’t have done it (stay sober), and they kept me in line until I got it for myself.”

Participants on Treatment Services

“They helped me to access services and made a treatment plan. I had been trying to but was unable to get help.”

“They bend over backwards to help you get the help you need.”

“It was hard to get the kind of treatment I needed but the CRP helped because they were able to coordinate everything.”

“This counselor is a lot better than my other one. I don’t get talked down like I am a child anymore. We can now work with each other.”

“They need more staff. Some of these counselors are really burnt out.”

“They’re great. There’s always someone to get a hold of. I’ve gotten all the support I need.”

“They are very helpful. Even though I graduated (from the treatment program) I still stayed on to work on some other issues.”

Participants on the PCR

“I would like to talk to the judge more.”

“The court gives you a lot of opportunities and they help you with a lot of things.”

“I like to go to court; it helps me get used to good habits.”

“The whole program was a reward.”

“I don’t like the length of the program. An entire year seems a little long.”

“[Before I decided to participate in CRP] It would have been nice to have someone to talk to who knew about the program.”

“It is a great program for people like me. It is family oriented. Now people who want to better their lives have that chance. I wished it was here when I was a teenager!”

“They helped me with my vehicle registration and housing options.”

“I never had this sort of court experience before. I looked forward to the next [CRP] date.”

“[CRP] helps to provide structure. It’s been helpful to see graduates and other people do good.”

“If they are going to ask people to do one million things, they have to make it reasonable. Transportation is a big deal out here.”

“The law is the law. While they bend the rules a little bit I think an 18 month program is a bit long for a first timer.”

“Instead of going to jail, I get to stay with my daughter.”

“This was the first time I ever got into trouble; it seems like a bit much.”

“I’m looking at 600 days and 5 years of probation. This is really worth it.”

Participants on the PCR Judge

“He has given me a lot of verbal praise. It makes me feel good.”

“He gives credit where credit is due, and it not biased against [people with] mental illness or substance abuse at all.”

“On a scale of 1 to 10, I’d give him a 3. He does his job. He understands the system but it’s the prosecutor you need on your side.”

“In the past, I was always petrified to go to court. But the judge has helped me to feel comfortable and that he isn’t there just to punish me.”

“He could see through my lies and gave me tough love.”

“He’s really nice and asks me about my kids.”

“If you are making an honest effort, the judge sees that and treats you with respect.”

“He makes the final call. I don’t always like it but I know he’s right.”

“I am different than everyone else. I was on the right track already. Coming here is just one more thing I have to do.”

“He’s not like other judges. He’s very friendly. He really gets people to follow through with their plans.”

Participants on the PCRCP Case Coordinator

“He really helped to get me an effective treatment plan.”

“I hated him at first, but it was because he was right and I couldn’t accept it. But he has listened to me when a lot of other people would have given me their opinions.”

“He is so helpful it’s intimidating. You don’t meet many people who are as energetic and inspiring as him.”

“He’s very understanding of people’s schedules and everything that is expected of them.”

“He takes the time to talk with you.”

“Awesome. He knows what people want and what people need. He’s done so much for me.”

“He goes to the end of the earth for people. He actually got a grant for me to pay the rent, buy food, anything, just call him.”

“He looks at you as an individual, not a case and another number.”

Participants on Defense Attorney(s)

“I didn’t spend a lot of time with them. [The Case Coordinator] really helped to organize everything.”

“She is great. She asks the right questions and seems really interested in everything. When I was in jail, I had gone through five or six attorneys.”

“They really didn’t take the time to talk with me. I would have appreciated that a little bit.”

“She gave me her card and was very supportive of me.”

“He even helped me with a math course I was taking – formulas and study suggestions.”

“I never really had a relationship with my defense attorney, it switched around a lot.”

“He’s really nice. He really pushed this on me.”

“He’s cool. You can talk with him. I even called him once. He understands how I feel about all this.”

“I’d give him a 10.”

Participants on the PCRCP Prosecutor

“He was very honest and fair, and accurate with his assessment of me.”

“He helped me to realize how much trouble could have occurred if I hadn’t gotten help.”

“He was very stern, but he was never unfair.”

“He’s on your side if you are doing what you are supposed to be doing. I’ve never seen a prosecutor like that.”

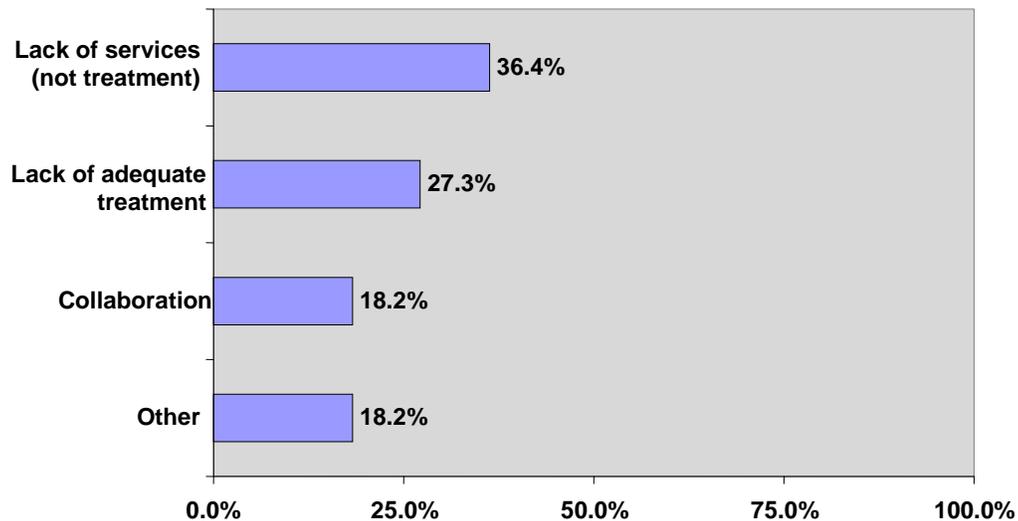
“He’s not too hard. He goes along with whatever. I don’t think he works very hard at all.”

“He’s nice. With him, it’s all about my mental plan.”

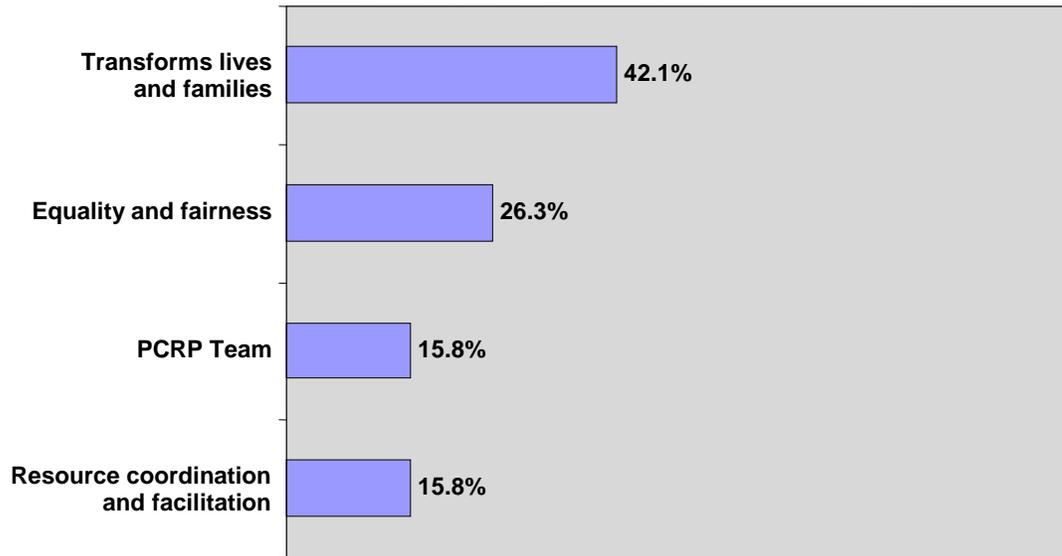
PCRP Perspectives – Key Actor’s Point of View

HZA staff also talked with twenty-two key stakeholders involved with the PCRP both directly and indirectly. Interviews were conducted with judges, lawyers, the PCRP case coordinator and project manager, as well as direct service providers, key collaborators and community members. Interviews were designed to collect information about perceived service needs and barriers and, based upon their experiences with the program, determine what recommendations they would make for overall systems improvement. Overall, there was widespread support for the PCRP among key stakeholders, with the majority recommending the creation of a similar program to manage those defendants whose primary problem is substance abuse as opposed to mental illness. However, there were a variety of concerns and opinions expressed about how the program functions, and how and in what ways it could be improved. Below are some of the questions we asked key stakeholders and their collective responses.

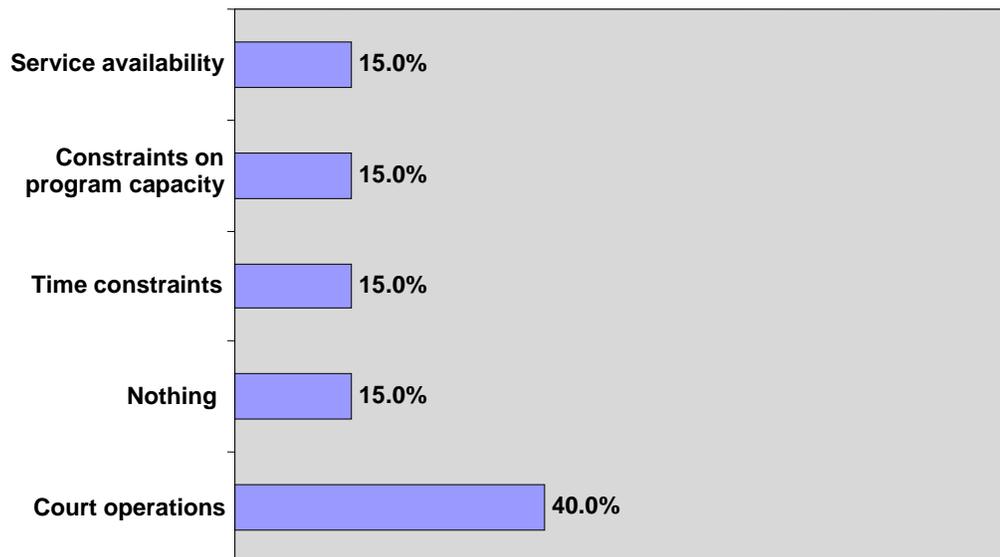
Question: Aside from financial resource limitations, what would you say are the major impediments to running the PCRP?



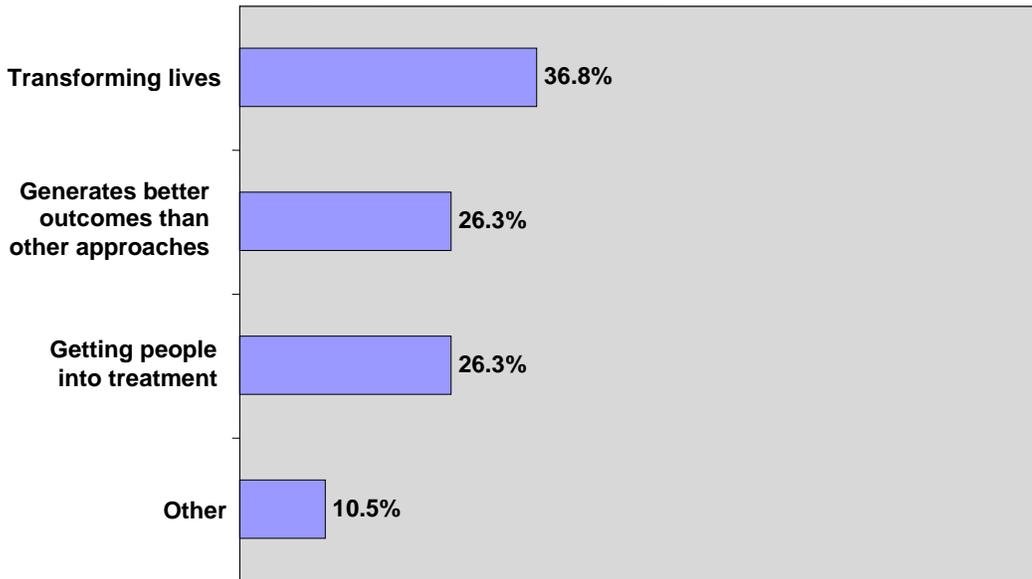
Question: What do you like most about the PCRP?



Question: What do you like least about the PCRP?



Question: What would you say has been the biggest accomplishment of the PCRP?



Some additional comments key actors made about the program and the local community behavioral health and social services system are provided below:

Key Actors on Service Provision

“Transportation is a really big deal. We serve a big area, and because of financial and service limitations, getting people to the treatment they need can be problematic.”

“There is a big gap in service availability, especially in regard to residential treatment services and when treatment is needed and when a person is accepted.”

“The service delivery system is not just at capacity, but completely over-run. There are a lot of waitlists and the caseloads are huge. But the quality of services a person receives increases by being involved in the court because [services] are more coordinated and information is communicated.”

“The level of care available is usually too low. It lacks intensity and responsiveness for people with severe mental illness.”

“There are not enough services to accommodate everyone who needs them. Some people just sit in jail and they are broken.”

“It’s hard when you go to court and there are as many providers as there are clients. You can wait a long time, and it takes up time that you might otherwise have with clients.”

“There is a huge gap in transportation and housing services. It’s also hard for people to receive medication management through an MD / Psychiatrist.”

Key Actors on Mental Health & Substance Use

“We enroll a lot of people with substance abuse and personality disorders. When someone does have a severe mental illness, the service delivery system is very clogged and it can be difficult to arrange services.”

“CRP provides a chance for people who may have been manipulated into doing something, like when a person with mental illness is taken advantage of.”

“It would be nice to have it more catered towards clients with a developmental disability. Or, I think the court needs to understand that the different populations (substance abuse, mental health, developmental disability) have different needs.”

“It’s nice to know that when a person with a mental illness gets into trouble, there is a supportive environment where they can get help, but they are also sanctioned if needed.”

“The court is very therapeutic and different than the “standard approach.” It is understanding of mental illness and substance abuse, and seeks a lot of clinical input before it makes decisions.”

“Drug testing is a stimulus for people to stay sober. It can be inconvenient, but it’s a way to show the court that you are sober.”

“It seems to be more of a drug court or a DUI court instead of one focused on mental illness. A lot of people who have been admitted don’t really have a major mental illness.”

Key Actors on the PCRCP

“We have a wait list. Once on it, people are accepted into the court based on referral order and program fit. We look at whether the person is willing and whether there are services available, as well as whether the person would benefit from the program.”

“Sometimes it seems as though the court puts too much on us (as case managers / providers). Sometimes, the actions of the client are out of [the case manager’s] control and I would appreciate the court having the client take more responsibility for their actions.”

“Some people have tested positive [for drugs or alcohol] three times before they are remanded. Some people might see that and see they can mess up X amount of times and not get in trouble for it. You can’t just keep saying ‘one more chance’ for some of the clients.”

“A big reward for people is not being in jail.”

“Court time is very consuming for clients and providers, it takes all afternoon. Maybe if it were split up into 2 days a week it would be better.”

“It would be helpful if there was more of an outline or structure for what is supposed to happen and what the expectations are for clients.”

“We are way off the policies and procedures, and need to go back and reevaluate what we want. No one wants to be a stickler, but it’s important to have structure.”

“It is very individualized as to when a person graduates. A lot depends on the person and the crime, and what the team thinks will work the best.”

“Some clients would respond better if there were more structure.”

“It’s great when a person receives verbal praise from the judge, it’s so important that this is coming from an authority figure.”

“The use of sanctions is individualized. It seems that one person may be sanctioned, while another person who committed the same act may not be sanctioned. It needs to be consistent.”

Key Actors on the PCRCP Team

“I have quite a bit of communication with the [CRP] team. Whenever we have a court date, I’m able to catch up with the team and case coordinator, as well as if there are any issues with my clients.”

“Everyone comes to court with a job to do, something you do outside of CRP. You just need to check your hat at the door and sometimes operate differently than you normally would.”

“I talk to the other team members on a daily basis. The hard work is done before court and in the pre-meeting, where everything is hammered out.”

“We [criminal justice and treatment personnel] have similar goals but different ways of getting at them.”

Key Actors on Community Awareness

“I think CRP is seen as both good and bad in the community. There are some feelings that, if another person (without mental illness) was to commit a similar crime, they would get into trouble for it and that the court is making exceptions for people just because they have a mental illness.”

“At first, there was a lot of skepticism that this was going to be the ‘easy way out.’ But now there is more understanding of how much is expected and the community benefits of such a program.”

“I don’t think that many people in the community are aware of CRP.”

“From a service provider perspective, the court is viewed very positively in the community.”

Summary of Key Findings

By and large, the impact of deinstitutionalization and the commensurate failure to simultaneously support mental health services in the community has led to a growing number of mentally ill persons housed in correctional facilities across the United States. As a result of this population growth, most jurisdictions such as the State of Alaska have tried to adopt new strategies to divert appropriate populations of mentally ill people from incarceration into community-based services. Established in 2005, the Palmer Coordinates Resources Project (PCRP) is one of many strategies the Alaska Court System and collaborating institutions have employed to address this important issue.

The report provides an important look into the operations of the PCRP and endeavors to make an important contribution to the modest, but growing body of literature on what we know and what we do not know about mental health courts nationally. Using a combination of administrative data, observations of program operations as well as interviews with PCRP participants and key stakeholders, major findings presented throughout the report reveal that the program is generating many positive outcomes for the State of Alaska. The PCRP has demonstrated marked reductions in reducing the criminal recidivism of the mentally ill and will be more cost effective with expanded capacity. The following are highlights presented throughout the report:

- The combined institutional savings generated by the PCRP (\$243,313) exceeds the estimated annual operational costs of the program.
- Diverting Trust Beneficiaries with severe mental illness from incarceration into the PCRP poses less of a risk to public safety than traditional adjudication.
- The average daily cost to operate the PCRP is estimated at \$16.98 per person, which is substantially less than the average daily cost of incarceration (\$121.60).
- Since its inception, a total of 223 people had been referred to the PCRP. Of these referrals, more than half elected to sign up to participate in the program (n=131).
- As of December 31st 2007, a total of 100 people had formally opted into the PCRP. Of these, 40 people successfully completed the program and graduated, while 20 elected to discontinue their participation in the program. Forty individuals were still active in the program.
- The PCRP's retention rate (80%) and program completion rate (67%) compare favorably with the mental health court program in Anchorage as well as other therapeutic court programs nationally.
- The PCRP reached its targeted operational capacity of 40 participants relatively soon after enrolling its first participant. In the past year (2007), the PCRP has been either at or above operational capacity, and has an ongoing waitlist of people desiring to participate in the program.
- Overall, PCRP participants were less likely to engage in new criminal conduct after exiting the program (17%) than an equivalent group of people experiencing mental illness also involved in the criminal justice system (40%). Among those who exited the PCRP, program graduates were least likely to re-offend overall (5%).

- Among those who did engage in new criminal conduct, PCRCP participants were less likely than an equivalent group to commit new felonies, violent or drug related crimes.
- Approximately one-third of all PCRCP participants had a history of a psychiatric admission to the Alaska Psychiatric Institute (API). Within one year after being discharged from the PCRCP, not one individual has experienced a subsequent psychiatric hospitalization.
- The vast majority of former PCRCP participants self-reported improvements along all quality-of-life domains as a result of their participation in the program.

Recommendations

As a result of the major findings presented throughout this report, HZA would like to encourage the Alaska Court System and key stakeholders within the State of Alaska to consider the following recommendations to improve systems performance, which will likely generate improved outcomes for the PCRCP as well as the people it serves.

Recommendation 1: Re-examine the methods by which the PCRCP identifies its intended target population and consider implementing a therapeutic court targeting individuals whose primary problem is substance abuse as opposed to mental health.

An analysis of participant diagnostic criteria and interviews with participants and stakeholders revealed that many PCRCP participants may be more appropriately served by a therapeutic court specializing in addictions (e.g., drug court) as opposed to a mental health court. Ideally, a mental health court should target individuals experiencing moderate to severe mental illness and mild or no problems relating to substance abuse. The Alaska Court System should consider implementing such a program, given the rising demand and impact of substance abuse in the Matanuska-Susitna Borough. The introduction of integrated actuarial assessments to the admissions process (rather than relying solely on clinical judgment) will also help the PCRCP identify its intended targeted population.

Recommendation 2: Develop a more formalized system of graduated sanctions and incentives, and increase funding to expand the range of incentives available for PCRCP participants.

As part of the evaluation, the research team presented many key stakeholders with a hypothetical scenario about a fictional PCRCP participant. Key stakeholders had a wide variety of responses to the scenario, with some recommending the use of sanctions and others not. While everyone was in agreement that the participant's treatment plan should be reviewed, stakeholders were split as to whether a sanction should be imposed or not, as well as what type of sanction should be imposed. Of those recommending a sanction, one-third advocated for an increased level of supervision and monitoring (e.g., increased testing, attendance at treatment, more frequent court appearances), one-fifth recommend jail as a sanction, and one key stakeholder recommend the individual perform some kind of public service work.

A graduated system of sanctions and incentives is an *Essential Element* of effective mental health court programming, and while used by the PCRCP, the program has not yet developed a formalized, graduated system. Moreover, there is currently no dedicated funding stream to support the provision of tangible rewards. The PCRCP and its participants would benefit by developing a system of incentives and sanctions that is not fixed (in that if one does X, one must necessarily receive Y) but rather, one that is tailored to allow for a range of options, so as to be able to more appropriately respond to the individual while at the same time preserving a sense of fairness among PCRCP participants as a whole. How and in what way the PCRCP applies sanctions should also be carefully explained to participants prior to their admission to the program.

Recommendation 3: Review PCRCP Policies and Procedures and develop a contingency management plan for turnover among PCRCP staff.

The relative success or failure of any therapeutic court program can often boil down to the level of investment, commitment, and dedication among key staff and service delivery system providers. When turnover occurs, it can have a significant impact on therapeutic courts as well as the participants they serve. The PCRCP would benefit from revising its Policies and Procedures to include a set of clearly

defined roles and responsibilities for project management staff; currently these are somewhat vague, particularly with respect to the role of the case coordinator and project manager. The PCRCP would also benefit from the implementation of a contingency management plan, to include specific trainings and resources for new team members.

Recommendation 4: Increase community recognition and support for ongoing programmatic sustainability.

Virtually all participants and key stakeholders interviewed expressed widespread, enthusiastic support for the PCRCP. At the same time, the overwhelming majority believed that the program is not well known in the community at large. The ultimate goal of any therapeutic court is to move along a continuum from basic implementation (requiring judicial leadership) to integration (forging partnerships) to institutionalization (being interwoven into the fabric of a community). Given the successful outcomes generated by the PCRCP, it would behoove the program to increase its public awareness profile. This can be accomplished by taking advantage of local media outlets, providing pamphlets for local agencies and organizations (both private and public), and development of a PCRCP advisory board as many key stakeholders indicated a desire to become more actively involved with the program.

Recommendation 5: Revise admissions-related procedures to reduce the time it takes to formally opt into the PCRCP.

The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. The reason for this principle is simple: it is well known throughout the literature that the sooner an individual, particularly one motivated by criminal justice involvement, is placed into treatment, the better his or her short and long-term outcomes will be in the future. The amount of time between the Initial Opt-In Hearing and the Formal Opt-In Hearing, where a formal intervention and treatment plan are adopted, averages 49 days. Although service plans are developed and service linkages are initiated during this interim period, the PCRCP should consider establishing earlier benchmarks (upon which all parties can agree) and try to work within these parameters to shorten the time it takes participants to be formally accepted into the program.

Recommendation 6: Provide resources to allow for a representative from the treatment community to be present at both pre-court meetings and status hearings.

Many treatment providers expressed the desire to be more actively involved in the PCRCP. However, the strain on available resources often limits the ability of providers to be present at either pre-court or PCRCP status hearings. It should be recognized that treatment professionals can provide important insights, as well as developing innovative strategies in the method by which the PCRCP responds to a wide variety of participant behaviors.

Recommendation 7: Revise existing methods by which PCRCP referrals and participant updates are reviewed by members of the PCRCP team.

Interviews with PCRCP team members and observations of PCRCP operations revealed inconsistencies in the content of the participant updates that are disseminated to team members at the pre-court meeting. The PCRCP should streamline the way in which participant updates are shared, so that information concerning the major life domains of each individual is presented more consistently. In addition, the PCRCP pre-court meeting often spends a great deal of time discussing new referrals to the program. These discussions typically involve whether or not the applicant is considered a “good fit” for the program, subjectively projecting out whether or not the individual will likely be successful. This is a common occurrence and ethical problem for many therapeutic court programs, as no one knows or can predict who will or will not

ultimately succeed. As long as the defendant meets the program's legal and clinical eligibility requirements, absent a veto from either the DA or PCRCP judge, that individual should be accepted into the PCRCP.

Recommendation 8: Provide additional support staff to streamline PCRCP operations.

Observations of PCRCP systems operations revealed the need to provide at least a part-time position to support the multitude of responsibilities of the one dedicated project manager. In light of the possibility of a future addictions court being created, there should be a reevaluation of the current project manager's role and responsibilities. It would behoove the Alaska Court System to consider elevating the PCRCP project manager position to project coordinator responsible for supervising both therapeutic courts. Two project assistant positions could be added (one for each court) which would help streamline court systems processes by eliminating potential duplication of effort.

Recommendation 9: Consider reorganizing the PCRCP status hearing.

A common criticism among participants and key stakeholders interviewed concerned the order in which cases are heard during the PCRCP status hearing. Generally, graduates appear first, followed by in-custody cases, formal and initial opt-ins; active participants are heard last. Active participants and their support persons (e.g., family, service providers) are critical of having to wait one to two hours before they have a two or three minute dialogue with the PCRCP judge. The PCRCP may want to consider re-ordering the types of cases being heard (giving more priority to active participants) or create two separate PCRCP dockets that are shorter in duration. For example, one docket can be dedicated to in-custody cases, initial and formal opt-ins, and the other can be dedicated to graduates and active program participants.

Recommendation 10: Consider implementing the recommendations put forth by former participants of the program.

It is rare for individuals who participate in therapeutic court programs to have their input on a large scale when it comes to program evaluation and developing strategies for systems improvement. In this study, active and former PCRCP participants were asked about what recommendations they would make to improve the program. While some participants said they would not change anything, others provided recommendations that generally centered on the following five areas:

- 1) Develop more supports and activities for participants;
- 2) Develop a method by which participants can better understand their legal situation (how their legal case will be resolved) as well as what their expectations are from the program;
- 3) Develop a separate program for people who are in substance-related recovery;
- 4) Hire more treatment staff as many counselors are burnt out; and
- 5) Provide more resources, particularly with respect to transportation.

References

- Alaska Court System. 2006. *“Policy and Procedures Manual for the Coordinated Resources Project (Anchorage Mental Health Court).”* Anchorage District Court.
- Atdjian, Sylvia and William A. Vega. 2005. *“Disparities in Mental Health Treatment in U.S. Racial and Ethnic Minority Groups: Implications for Psychiatrists.”* Psychiatric Services. 56:1600-1602.
- Bazelon Center for Mental Health Law. 2003. *“The Role of Mental Health Courts in System Reform.”* Judge David L. Bazelon Center for Mental Health Law. Washington D.C.
- Beck, Allen J. and Maruschak, Laura M. 2000. *“Special Report: Mental Health Treatment in State Prisons.”* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Boothroyd, Roger A., Cynthia Calkins Mercado, Norman G. Poythress, Annette Christy and John Petrila. 2005. *“Clinical Outcomes of Defendants in Mental Health Court.”* Psychiatric Services. 56:829-834.
- Carns, Theresa White, Michael G. Hotchkin and Elaine M. Andrews. 2002. *“Therapeutic Justice in Alaska’s Courts.”* Alaska Law Review. Duke University School of Law. 19(1):2-3.
- Carns, Theresa White, Susan McKelvie, Pat Scott and Kathy Grabowski. 2003. *“Coordinated Resources Project: Evaluation Report”* Prepared by the Alaska Judicial Council.
- Cohn, Larry, Stephanie Martin, Theresa White Carns and Susan McKelvie. 2007. *“Criminal Recidivism in Alaska.”* Prepared by the Alaska Judicial Council.
- Cosden, Merith, Jeffrey Ellens, Jeffrey Schnell, and Yasmeen Yamini-Diouf. 2004. *“Evaluation of the Santa Barbara County Mental Health Treatment Court with Intensive Case Management.”* Gevirtz Graduate School of Education, University of California, Santa Barbara. Available at: <http://consensusproject.org/downloads/exec.summary.santa.barbara.evaluation.pdf>
- Ditton, Paula M. 1999. *“Special Report: Mental Health and Treatment of Inmates and Probationers.”* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Erickson, Steven K., Amy Campbell and J. Steven Lamberti. 2006. *“Variations in Mental Health Courts: Challenges, Opportunities, and a Call for Caution.”* Community Mental Health Journal. 42(4):335-344.
- Ferguson, Andrew, Helaine Hornby and Dennis Zeller. 2007. *“Alaska Mental Health Trust Beneficiary Study: A Report on Mentally Ill Persons in the Alaska Department of Corrections.”* Technical Report Submitted to the Alaska Department of Corrections. Forthcoming.
- Goldkamp, John S. and Cheryl Irons-Guynn. 2000. *“Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.”* Washington, DC: Bureau of Justice Assistance.

- Herinckx, Heidi, Sandra Swart, Shane Ama and John Knutson. 2003. *“The Clark County Mentally Ill Re-arrest Prevention (MIRAP) Program: Final Evaluation Report.”* Regional Research Institute for Human Services, Portland State University.
Available at: http://www.rri.pdx.edu/pdfMIRAP_Final.pdf
- Herman, Madelynn. 2005. *“Mental Health Court Evaluations: An Annotated Review of the literature with Commentary.”* National Center for State Courts.
Available at: http://www.ncsconline.org/WC/Publications/KIS_MenHeaCtEvaluations.pdf
- Hermann, Richard C., H. Stephen Leff, R. Heather Palmer, Dawei Yang, Terri Teller, Scott Provost, Chet Jakubiak and Jeff Chan. 2000. *“Quality Measures for Mental Health Care: Results from a National Inventory.”* Medical Care Research and Review. 57(22):136-154.
- James, Doris J. and Lauren E. Glaze. 2006. *“Mental Health Problems of Prison and Jail Inmates”* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Lamb, Richard H., Linda E. Weinberger and Bruce H. Gross. 2004. *“Mentally Ill in the Criminal Justice System: Some Perspectives.”* Psychiatric Quarterly. 75:107-126.
- Lurigio, Arthur J. and James A. Swartz. 2006. *“Mental Illness in Correctional Populations: The Use of Standardized Screening Tools for Further Evaluation or Treatment.”* Federal Probation.
- Moore, Marlee E. and Virginia Aldigé Hiday. 2006. *“Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants.”* Law and Human Behavior. 30(6):659-674.
- Morrissey, Joseph P., Gary S. Cuddeback, Alison Evans Cuellar, and Henry J. Steadman. 2006. *“Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness.”* Psychiatric Services. 57(6):809-815.
- Morrissey, Joseph P., Kathleen M. Dalton, Henry J. Steadman, Gary S. Cuddeback, Diane Haynes and Alison Cuellar. 2006. *“Assessing Gaps Between Policy and Practice in Medicaid Disenrollment of Jail Detainees with Severe Mental Illness.”* Psychiatric Services. 57(6):803-808.
- O’Keefe, Kelley. 2006. *“The Brooklyn Mental Health Court Evaluation: Planning, Implementation, Courtroom Dynamics, and Participant Outcomes.”* Center for Court Innovation.
- Patel, Kavita K., Brittany Butler and Kenneth B. Wells. 2006. *“What Is Necessary to Transform the Quality of Mental Health Care.”* Health Affairs. 25(3):681-693.
- Peters, R. and Fred Osher. 2004. *“Co-occurring Disorders and Specialty Courts.”* National Gains Center and the TAPA Center for Jail Diversion.
- Petrila, John, Norman G. Poythress, Annette McGaha, and Roger A. Boothroyd. 2001. *“Preliminary Observations from an Evaluation of the Broward County Mental Health Court.”* Court Review. Winter Edition:14-22.
- Ridgely, Susan, John Engberg, Michael D. Greenberg, Susan Turner, Christie DeMartini and Jacob W. Dembosky. 2007. *“Justice, Treatment, and Cost: An Evaluation of the Allegheny County Mental Health Court.”* RAND Corporation.

- Steadman, Henry J., Susan Davidson and Collie Brown. 2001. "*Mental Health Courts: Their Promise and Unanswered Questions.*" *Psychiatric Services* 52(4):457-458.
- Steadman, Henry J. and Allison D. Redlich. 2006. "*An Evaluation of the Bureau of Justice Assistance Mental Health Court Initiative.*" Unpublished manuscript submitted to the U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Teller, Jennifer. L.S., Christian Ritter, Marnie Salupo Rodriguez, Mark R. Munetz and Karen M. Gil. Date Not Provided. "*Akron Mental Health Court: Comparison of Incarcerations and Hospitalizations for Successful and Unsuccessful Participants in the First Cohort.*" Kent State University, County of Summit Alcohol, Drug Addiction, and Mental Health Services Board, and Northeastern Universities College of Medicine. Ohio.
Available at: <http://consensusproject.org/mhcp/akron-mhc.pdf>
- Thompson, Michael, Fred Osher and Denise Tomasini-Joshi. 2007. "*Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court.*" Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project.
- Trupin, Eric, Henry J. Richards, Barbara Lucenko and Peter Wood. Date Not Provided. "*King County District Court Mental Health Court Phase I: Process Evaluation and Early Outcome Analyses.*" The Washington Institute for Mental Illness Research and Training, University of Washington.
Available at: <http://www.metrokc.gov/KCDC/execsum.htm>
- Weisman, Robert, Steven J. Lamberti and N. Price. 2004. "*Integrating Criminal Justice, Community Healthcare, and Support Services for Adults with Severe Mental Disorders.*" *Psychiatric Quarterly*. 75(1):71-85.

Appendix A – The Alaska Mental Health Trust Authority

The Alaska Mental Health Trust Authority

Prior to statehood, there were no mental health services available for individuals who experienced disabilities in the territory of Alaska. These individuals were removed from their homes by the federal government and sent to live in an institution in Portland, Oregon. As part of the transition from a territory to a state, Congress passed the Alaska Mental Health Enabling Act of 1956. This act transferred the responsibility of providing mental health services from the federal government to the Territory of Alaska and created the Alaska Mental Health Trust. To establish The Trust, the state selected one million prime acres of land to provide funds for the development of a comprehensive integrated mental health program.

The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect The Trust and to provide leadership in advocacy, planning, implementing and funding of a comprehensive integrated mental health program so as to improve the lives and circumstances of its beneficiaries. Trust beneficiaries are those experiencing: 1) mental illness; 2) developmental disabilities; 3) chronic alcoholism; 4) Alzheimer's disease and related dementias, and 5) traumatic brain injury.

The Alaska Mental Health Trust Authority coordinates with state agencies about programs that affect beneficiaries, proposes budgets for the state's comprehensive mental health program and reports to the legislature, governor, and the public about Trust activities.

The five categories of Trust Beneficiaries and the respective disorders that are covered are as follows:

1) People with Mental Illness include persons with the following mental disorders:

- Schizophrenia;
- Delusional (paranoid) disorder;
- Mood disorders;
- Anxiety disorders;
- Somatoform disorders;
- Organic mental disorders;
- Personality disorders;
- Dissociative disorders;
- Other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed above;
- Persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder.

2) People with Developmental Disabilities include persons with the following neurologic or mental disorders such as:

- Cerebral palsy;
- Epilepsy;
- Mental retardation;
- Autistic disorder;
- Severe organic brain impairment;
- Significant developmental delay during early childhood indicating risk of developing a disorder;

- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed above.

3) People with Chronic Alcoholism include persons with the following disorders:

- Alcohol withdrawal delirium (delirium tremens);
- Alcohol hallucinosis;
- Alcohol amnesiac disorder;
- Dementia associated with alcoholism;
- Alcohol-induced organic mental disorder;
- Alcoholic depressive disorder;
- Other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed above.

4) People with Alzheimer's Disease and Related Disorders includes persons with the following mental disorders:

- Primary degenerative dementia of the Alzheimer type;
- Multi-infarct dementia;
- Senile dementia;
- Pre-senile dementia;
- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

5) People with a Traumatic Head Injury Resulting in Permanent Brain Injury includes head injuries that result in cognitive impairment similar to that described in the Alzheimer's Disease or Related Dementia section above.

Appendix B – Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) – Multi-axial Classifications

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) - Multi-axial Classifications

The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:

Axis I: Clinical disorders, including major mental disorders as well as developmental and learning disorders.

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia.

Axis II: Underlying pervasive or personality conditions, as well as mental retardation.

Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder and mental retardation.

Axis III: Acute medical conditions and physical disorders.

Axis IV: Psychosocial and environmental factors contributing to the disorder.

Axis V: Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18 (on a scale from 100 to 0).