



Lessons from the Broward County Mental Health Court Evaluation

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Abstract

The creation of specialty mental health courts has emerged as a strategy to address the impact of persons with mental illness in the criminal justice system by consolidating the management of certain types of cases into a single court. This article describes an evaluation of the nation's first such court, the Broward County Mental Health Court. The purpose is to alert those who may conduct future evaluations of these types of courts to some of the contextual, logistic, and management features of our evaluation and the challenges we have encountered doing field research in this unique legal setting. © 2002 Elsevier Science Ltd. All rights reserved.

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1. Introduction

One of the most important policy questions to emerge in the United States in the 1990s was how to address the widespread prevalence of mental illness and substance abuse among people entering the criminal justice system. The most conservative estimates suggest that at least 6% of individuals in that system at any one time have an acute mental illness, while the overall prevalence of mental illness and substance abuse diagnoses may be over 60% (Ditton, 1999).

The impact has been enormous. Individuals with mental illness typically are incarcerated 2–3 times longer than similarly situated defendants without a mental illness (Axelson & Wahl, 1992). Jails must pay for medication, suicide prevention, and other costs associated with the care of seriously ill individuals in settings whose primary purposes are detention and security, not treatment. The court system is affected as well, particularly in urban areas: a judge with a docket of thousands of cases may become frustrated with the time it takes to process the case of a person with a serious mental illness, and with problems in obtaining services for an individual who without treatment may be re-arrested.

One response has been the creation of special jurisdiction courts designed to consolidate the management of certain types of cases in a single court. Such courts are assumed to increase judicial efficiency and to be better able to obtain

treatment for defendants. The most prominent example is the drug court. In 1992, there were two such courts, while as of June 2000, there were slightly over 500 in operation, with almost another 300 planned (American University, 2000). Drug courts provide treatment to individuals charged with drug-related offenses who typically do not have a prior record and whom the court believes may benefit from treatment; a failure to adhere to treatment may result in criminal punishment. Based in part on findings from a number of evaluations, such courts are generally considered a success in reducing future criminal involvement of the participants while increasing access to treatment (Brennan, 1998).

Drug courts do not address the needs of individuals with mental illness. In response, in June 1997 the nation's first mental health court (MHC) was created in Broward County, Florida (Ft. Lauderdale). Like the drug court in some respects, the MHC was created to meet the needs of a special criminal justice population—defendants with mental disorders charged with relatively minor offenses and who may have a history of frequent contact with the legal system. Since establishment of the Broward MHC, it appears that at least one-dozen other jurisdictions have created MHCs, and the US Congress recently passed a bill that would provide for up to an additional 125 MHCs nationwide (United States Congress, 2000).

There appears to be widespread, if occasionally cautious, optimism that the MHC may engage this difficult to serve, and often underserved, population in more sustained mental health services while simultaneously reducing criminal justice involvement (Goldkamp & Irons-Guynn, 2000). However, there are no empirical reports of either the process

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or outcomes of the MHC. Given the impact of evaluations on drug court policy, it would appear that future evaluations of MHCs would be very helpful to both stakeholders and policy makers who presumably will want to know whether, to what degree, and how efficiently MHCs meet their diverse goals.

With a grant from the John D. and Catherine T. MacArthur Foundation and additional funding from the Florida Legislature, we are conducting an evaluation of the Broward MHC. In this article our purpose is to alert those who may conduct future evaluations of MHCs or similar specialty courts to some of the contextual, logistic, and management features of our evaluation and challenges that we have encountered doing field research in this unique legal setting. While guides exist for the evaluation of drug courts (Peters, 1995), nothing comparable exists for the evaluation of mental health courts. We first provide a brief description of the origins, operation and goals of the Broward MHC. We then provide a brief description of the main components of our study design. Finally, we will relate important *contextual*, *logistical*, and *management* issues in the evaluation.

2. Origin and operation of the Broward County Mental Health Court

The Broward MHC grew from the work of a Mental Health Taskforce that was formed in 1994 to address problems related to the ‘care, handling and community placement of mentally ill defendants’ in the county (Broward County Mental Health Court Third Year Progress Report, 2000, p. 4). Chaired by a circuit judge, the Taskforce included representatives from the state attorney’s office, the public defender’s office, Broward County Jail, and various service providers from the community. The Taskforce, considering a variety of issues related both to clients’ service needs (e.g. the need to insure access to quality mental health services) and to system efficiency concerns (e.g. reduction in the number of days in jail and number of jail admissions) ultimately established the MHC in June 1997.

The Broward MHC at this time accepts only defendants charged with minor offenses –a non-violent misdemeanor, criminal traffic offense (excluding ‘driving under the influence’), or an ordinance violation from Broward County or any municipality in Broward County. Police, jail staff, families of consumers, or any other interested party may identify individuals as candidates for the MHC. Magistrates or first appearance court refer many clients after screening by clinical psychology graduate students from a local university (Rabasca, 2000). Other defendants are referred from regular misdemeanor courts.

The presiding MHC judge must accept defendants into the MHC. Individuals may not qualify for a variety of reasons, such as insufficient evidence of a mental disorder,

insufficient motivation, or previously existing charges of a more serious nature not meeting MHC parameters. Participation is voluntary; some defendants choose not to be a part of the MHC and are transferred to a regular misdemeanor court for disposition of their cases.

The MHC judge may dispose of the defendant’s case at the initial MHC hearing or keep the charges open (in order to maintain jurisdiction). The court monitors progress and compliance with services via ‘status’ hearings.¹ For cases disposed of at the initial MHC hearing and for those kept open the judge may encourage the client to pursue services already in progress or refer the client to appropriate service providers. A few clients receive probation, although conditional release orders are more common. If rearrested in Broward County for a charge accepted by the MHC, the client’s case is referred back to MHC.

The client at any time may be referred to new services, have services amended, or be encouraged to pursue services more vigorously. In addition to mental health and substance abuse services, the court may attempt to facilitate services related to physical health, developmental disability, housing, employment, or the application for benefits (e.g. Medicaid, SSI) that may be helpful to the client or his/her family. Administrative and treatment personnel from state and local agencies typically attend court hearings to assist in this process.

Cases not resolved at the initial MHC hearing are resolved when the court determines that the individual has become satisfactorily involved in appropriate services. Such cases are rarely resolved ‘on the facts’ and the official legal outcome is often ‘adjudication withheld’. Individuals who do not demonstrate adequate effort or progress in treatment may be dismissed from MHC involvement for return to regular misdemeanor court.

3. Overview of the Broward MHC evaluation

Evaluations of the MHCs differ in one important way from those of drug courts. Given their established history, drug courts have published standards regarding who should be eligible, the array of treatment services that are needed, procedures for monitoring of client compliance, and how treatment should be integrated with the justice system (US Department of Justice, 1997). These guidelines help to frame the evaluation questions and provide a basis for interpretation of the findings. This is not the case with mental health courts (Steadman, Davidson, & Brown,

¹ Other mental health courts differ in some ways (e.g. whether the treatment referral takes place pre- or post-adjudication) from the Broward MHC, although most have common features such as requiring voluntary participation by defendants, including only defendants whose mental illness is thought to have contributed to their legal involvement, and rapid release from jail confinement and referral to services. In the interest of public safety, MHC is usually limited to misdemeanor defendants with a non-violent history. For a comparison of four MHCs, see Goldkamp and Irons-Guynn (2000).

2001). Established guidelines regarding which clients are appropriate, what services are needed, and how the court interfaces with the mental health system do not exist and thus differ from court to court. Therefore, it is important to include in any evaluation, a process component that will enable understanding the processes and context under which the court is operating.

Our study design involved a mix of qualitative and quantitative methods to describe and evaluate the operation of the court and to assess its impact on clients. The four main components were: key informant interviews, description of the court process, a longitudinal outcomes study of MHC clients, and secondary data analysis of criminal justice and mental health services administrative data sets containing information on MHC clients. Because our research plan has been described in greater detail elsewhere (Petrla, Poythress, McGaha, & Boothroyd, 2001) and our primary purpose here is to alert future investigators to potential issues with implementation, we briefly describe here our original strategies for data collection with minimal emphasis on substantive issues.² In subsequent sections, we indicate how these original strategies have been affected by contextual and logistic factors.

3.1. Key informant interviews

Our plan called for key informant interviews with about two-dozen individuals from a variety of institutions, agencies, and other stakeholder groups having an interest in the MHC. The interviews explored respondents' perceptions of the social and political circumstances that gave rise to the court, expectations about the court's impact and whether those expectations had been met, and ways that they (or their agencies) had been affected by the creation of the court.

3.2. Description of court process

We sought to describe the court process, primarily because the MHC operates so differently from an ordinary criminal court. To do this, we decided initially to code in-court communications using trained observers. A complex form was devised for coding each verbalization in a given case, including who spoke to whom and the substantive nature of the communication, i.e. whether it dealt with mental health issues, housing issues, or criminal justice issues. As noted later, this strategy was modified significantly after the evaluation began.

3.3. Longitudinal outcomes study design

Because random assignment of MHC-eligible clients to either the MHC or regular misdemeanor court was not feasible, a non-equivalent control group design was used in the longitudinal study component of the evaluation (Cook &

Campbell, 1979). Hillsborough County (Tampa) was chosen as the control site. Although no comparison site provided an identical match with Broward County, Hillsborough County was reasonably similar in terms of population demographics, criminal justice statistics, and mental health services system. Our recruitment goal was 100 defendants at each site (later increased to 120 at the Broward site), with 80% retention over follow-up interviews scheduled for 1, 4, 8, 12, and 16 months.

The research protocol included a wide variety of interview and self-report and previously validated measures related to constructs and behaviors of interest, including demographic and social history information, current symptomatology, mental health service utilization history, perceptions of MHC experience (e.g. perceived coercion, procedural justice), quality of life, recent violent/aggressive behavior, sources of support, and so forth. Table 1 provides a summary of the primary domains of data collection in the research protocol.

3.4. Administrative data

Additional data about clients in the longitudinal study were sought from agencies with which they might have contact over the course of the study. During recruitment, clients signed comprehensive release forms authorizing us to obtain records from myriad treatment providers. Additional information was obtained, either by reviewing files or by retrieval from electronic (management information system) databases maintained by the MHC, clerk of the court, county jail systems, and other criminal justice or community agencies.

4. Contextual factors affecting the Broward MHC evaluation

Several contextual factors have affected the implementation of our study and may influence the interpretation of findings from this or future MHC evaluations. These include difficulties in obtaining random assignment in the court system, the political context and community environment in which the court was created, the dynamic nature of the system in which the MHC functions, the comparative complexity of MHC processes, the underlying legal philosophy of the court, and cost.

4.1. Random assignment may not be available

We understood from the beginning that the court system would not randomly assign some individuals to the MHC while not assigning others. The public defenders' office made clear that it considered such a strategy ethically problematic, because it would deny some individuals what the office saw as a clearly more acceptable alternative than that provided in traditional misdemeanor court. This affected our decisions regarding the creation of a 'control' group.

² Interested readers may contact us for more detailed information and for a copy of the main research protocol.

Table 1
Longitudinal study protocol contents

Question domain	Specific instruments	Intake	Follow-ups
Demographics	Age, gender, race/ethnicity, education, marital status, number of children	X	X
Understanding of court process		X	X
Perceived coercion of choice into MHC (Broward only)		X	X
Procedural justice	Interactions with attorney, judge; outcome satisfaction	X	X
Community violence	MacArthur Community Violence Instrument (Monahan, 1999) of mild to severe violence toward others	X	X
Psychopathology	Machievellian Egocentricity subscale of the Psychopathic Personality Inventory (Lilienfeld, 1999)	X	X
Psychiatric symptomatology	Brief Psychiatric Rating Scale (Overall & Gorham, 1962)	X	X
Benefits	Medicare, Medicaid, SSI, VA, private insurance, county funded services benefits	X	X
Living situation	Where client is living	X	X
Quality of life	Quality of life with living situation, family relationships, finances, work and school, and health using Lehman's (1988) 'Quality of Life Interview for Chronically Mentally Ill'		X
Family	How much contact Support from other resources		X
Work/school	Employment status How many hours spent at work and how much earned		X
Health	SF-12 (Keller, Kosinski, & Ware, 1996) to assess physical illness, general health and physical activity		X
Clinical status	Significance of emotional or psychiatric problems, age of onset (Agency for Health Care Policy and Research et al., 1995)		X
Functioning	Adapted from the Schizophrenia PORT Inpatient study (Agency for Health Care Policy and Research et al., 1995) and the Cross Disability Integrated Healthcare Study (CDIHOS: The Evaluation Center at HSRI, 1996)		X
Substance abuse and use	Addiction Severity Index (Luborsky, McLellan, O'Brien, & Woody, 1980)		X
Services	Perception of how helped Self-reported service use Satisfaction with services (Larson, Attkisson, Hargreaves, & Nguyen, 1979)		X
Empowerment	Empowerment as a result of mental health services received (Mental Health Statistics Improvement Program task Force on a Consumer-Oriented Report Card, 1996).		X
Suicide attempts	Prior and current number of attempts		X
Compliance	Perceived importance of treatment Compliance with medications prescribed Compliance with scheduled mental health care appointments Reasons for non-compliance		X

4.2. The political context and community environment of the MHC

For a period of 2–3 years before the MHC was established, the Taskforce, convened by a judge, discussed and considered

potential approaches and solutions to problems arising from the prevalence of mental illness in the criminal justice system. This process undoubtedly forged relationships among higher-level agency representatives that likely became further stabilized during the 2.5 years of MHC operation prior to the evaluation.

Our evaluation has likely been favorably affected by these prior events in several ways. First, we could identify potential participants for our key informant interviews and obtain their cooperation and participation. Main players in this long-established network were easily identified and nominated during our preliminary conversations with the judge who chaired the Taskforce and other key individuals. Several of these individuals have also been instrumental over the course of the longitudinal study (as described later) in overcoming logistical problems related to accessing clients and agency data sets. The capacity to identify and communicate directly with senior staff in various agencies, and to request communications between them on our behalf, has enabled us to resolve logistical problems more rapidly than might otherwise have been possible.

Circumstances may be less benign for evaluators in jurisdictions creating a mental health court without the degree of prior planning and negotiation that occurred in Broward County. More groundwork may need to be laid and more resources required to conduct an evaluation in settings where such stable relationships and established agreements are not in place. This reinforces the notion that the ‘mental health court’ is much more than merely a particular chamber in the courthouse; whether and how any particular MHC ‘works’, and the ways and degree to which evaluators may assess that functioning, will depend substantially on the larger political and community environment in which the MHC operates.

4.3. *The dynamic system*

The MHC exists in a dynamic human services system in which developments affecting the court frequently occur. For example, during our evaluation, the Broward MHC received a grant that provided funds to operate a 24 bed, minimum-security unit, enabling the court to refer transient and homeless clients there for temporary placement and services. Similarly, aware of the MHC judge’s concern about the limited services available for women defendants, staff from a local university created a special treatment program.³ Such changes can impact an evaluation study, from revising release of information forms to obtain treatment-related outcome data from these new agencies, to revising the procedures used to track and locate clients.

4.4. *The greater complexity of MHC*

In regular misdemeanor courts, participants usually include the judge, state attorney, public defender, and defendant. In contrast, participants in a MHC hearing, in addition to the legal officials just noted, usually include liaison staff from the state mental health agency and the county’s largest mental health care provider, the Ft. Lauderdale City attorney, and at least one graduate student involved in client

screening. Clients’ caseworkers, family members, or friends are often present in court. Because of this wider array of participants in the MHC, coding forms had to be modified as noted below.

4.5. *The legal philosophy underlying the MHC court*

We have described elsewhere (Poythress, Pettila, McGaha, & Boothroyd, 2002) the legal philosophy of ‘therapeutic jurisprudence’ that underlies the Broward MHC. Therapeutic jurisprudence asserts that traditional court processes and roles may undercut achieving the most desirable results in relation to mental health outcomes, and that variations in role and procedure may be required to achieve therapeutic aims.

The Broward MHC has embraced this philosophy, so the process of the MHC is less formal and structured than in the typical courtroom. There is relatively little ‘lawyering’ in the traditional sense; witnesses are not ‘called’ or sworn and the attorneys do not question participants about a defendant’s criminal case. Rather, clients, caseworkers, and family members are encouraged to speak directly to the judge. Discussion often focuses on how the client is feeling, his or her prior treatment history, the family’s experience, and the caseworker’s recommendations.

Multiple conversations about a single case, or separate conversations about multiple cases can occur simultaneously. For example, while MHC participants attempt to arrange services for one client, the court may proceed with the next case, although such transitions are not always clear and discussion may abruptly return to a prior case as placement plans solidify.

This increased complexity in the court affected our study significantly in two ways. First, we simplified the forms for coding in-court communications. We were often unable to determine *to whom* a particular communication was intended, and when several individuals spoke simultaneously we had difficulty, using our (initially) complex array of categories, coding both the frequency of comments being made and the appropriate category for each. We ultimately decided to purchase transcripts that could be more easily coded,⁴ a change that affected the study budget.

Second, even for research assistants not involved in coding but who were present in court for purposes of recruiting participants, it was sometimes difficult to determine something as apparently simple as whether or not a client had been accepted into the MHC or where the client was going after being released from court. This, along with the often-incomplete docket information and the lack of a consistent designation of clients as present for new versus status hearings, had implications for staffing levels and task allocation among research staff.

³ This program was only in existence for one year, losing its funding after one year of operations.

⁴ Transcripts, however, were not necessarily more complete or accurate. Anecdotally, on one occasion an attorney asked the court recorder to please read back what had just been said. The court recorder responded with evident frustration, “I can’t...they were all talking at once!”

4.6. Cost

The amount of money available will affect the design and scope of any evaluation. We had approximately \$280,000 to conduct this evaluation, plus in-kind contributions from several faculties. Most of this money has been spent on salaries to maintain two teams of interviewers, one in Broward County and one in Hillsborough County (the control site). We chose to devote most of our resources to conducting the longitudinal part of this evaluation—an evaluation team with less money might choose to focus on archival information; a team with more money might choose to extend the longitudinal part of the evaluation beyond the 16 months over which we interview each person.

Costs for this particular study were increased in part because our primary data collection site (Ft. Lauderdale) is quite distant (approximately 540 miles round trip) from the university where the research team is based. Costs included travel cost for administrative staff from Tampa to Ft. Lauderdale, staff time, mileage for research assistants, and payment of \$20 to participants per completed protocol. Multiple individuals traveled from Tampa to Ft. Lauderdale to interview and hire staff and the Broward staff traveled to Tampa for a two-day training. The project coordinator traveled to Broward as often as weekly to conduct staff meetings and collect materials. The project director, principal investigator, and co-investigators traveled to Ft. Lauderdale as needed for completion of qualitative interviews, meetings with agency staff to coordinate activities of the evaluation, in-court process coding, and for additional staff training as needed.

At various points, staff time was extended beyond what other research designs might require. Enrollment into the study was not as simple as getting a list of clients with new cases for the day, finding them and interviewing them. Individuals could not be recruited into the study until they were accepted as MHC clients, decisions that were made during the daily MHC. Status hearings were sometimes held before or in between the new case hearings for individuals eligible for enrollment, resulting in MHC sessions that sometimes ran several hours. Then potential study participants had to be approached immediately after their initial hearing because they were often released directly into the community from court. This meant that recruitment of individuals into the study required attendance at the entire MHC hearing schedule for the day, and on some occasions none of the eligible defendants agreed to participate in the study. This added to the cost of staff time.

Research assistants also spent considerable time locating individuals for their follow-up interviews. There were a possible 900 follow-up interviews to be conducted (600 follow-up interviews at the Broward site and 300 at the Hillsborough site), which presented 900 occasions in

which individuals needed to be located.⁵ Broward (1197 miles) and Hillsborough (1048 miles) Counties encompass large geographic areas, resulting in costs related to staff travel time and mileage. Individuals from the Broward site seemed to be particularly mobile, including into adjacent Palm Beach and Dade counties. Staff time and mileage were spent locating clients with known addresses, but also on regular visits (such as weekly) to the numerous places frequented by homeless individuals and/or people with transient housing—e.g. homeless shelters, places providing food to the needy, transient hotels, bars, and even street corners. Certain locations along Broward County's 23 miles of beaches where transient individuals were known to receive food at specified times, to shower, or to in general frequent were visited regularly. These visits involved staff time and mileage costs.

The interview itself took approximately an hour, with considerable variation. Interviews conducted in jail sometimes involved substantial waiting time due to the logistics of entry into the jail and/or of bringing the individuals to the interview room, particularly at the Broward site. Several individuals were interviewed in Florida prisons, which involved a substantial amount of coordination time and waiting time at the prisons.

5. Logistical problems

We made several changes to our initial procedures in response to unanticipated logistical problems. We discuss first the problems in gaining access to clients.

5.1. Physical access to MHC clients

To explore client perceptions of coercion and procedural justice in the MHC process, it was desirable to have the protocols administered as close in time to the hearing as possible. We had pilot-tested procedures to recruit defendants immediately after completion of the initial hearing at which they were accepted as MHC clients. The informed consent process and initial interview were administered to participants in a jury room in the back of the courtroom. Although this procedure seemed to work well at the pilot phase, difficulties were encountered during implementation.

First, clients were frequently released directly from open court without returning to jail for processing. Often, clients were reluctant to enroll in the study because either (a) they were eager to leave the courthouse immediately after their hearing, or (b) mental health staff or family members who were going to assist them returning to the community were not able to wait while the interview was completed. This

⁵ A decision was made to *not* conduct the 12 and 16-month follow-up interviews at the Hillsborough (control) site because the cost, in terms of staff time, travel and participant reimbursement, was not felt to be worth the additional information that could be obtained from these interviews. Therefore, follow-up interviews were conducted with participants at the Hillsborough site at 1, 4, and 8 months post study enrollment.

affected enrollment, and therefore we revised our procedure to permit the completion of initial interviews within 7 days of the hearing, emphasizing completion as soon as possible after the hearing. Research assistants arranged to meet such clients at a place in the community that was convenient for them, often at the client's home or assisted living facility, at treatment centers, or in restaurants.

Similar problems arose regarding the recruitment of clients released from MHC who returned to the jail for exit processing. Attempts to interview such defendants in the jury room after their hearings often conflicted with deputies' schedules for transporting defendants to-and-from the jail. Ultimately, arrangements were made to approach and interview these defendants at the jail while, or soon after, their discharge paperwork was prepared. Security clearances were obtained for the research assistants to enter the city and county jails and procedures were developed to locate defendants upon their return to the jail and to find interview space. Because multiple jail personnel processed these clients on different shifts, some were still released or transferred before an interview at the main jail visitation area could be commenced. This necessitated locating the client later in the community, leading to a greater emphasis, during the first contact with MHC clients, on obtaining as much follow-up information as possible in case they could not be located in the jail prior to their release.

5.2. Problems in random selection

Research assistants were initially to recruit MHC clients randomly from those eligible for the study. To minimize selection bias by the RA, which might compromise the generalizability of the study's findings, research assistants were to use the daily docket to determine the names of all new MHC clients, order these names using a random number table, and approach clients in that order. This approach had several problems.

First, the MHC docket was not reliable for this purpose. The docket may be incomplete until right before court starts, is sometimes amended once court has started, and may not distinguish between new clients and those clients already involved with the court who are returning for status hearings (so not eligible for recruitment into the study). As a result, it was difficult to correctly identify new cases and to apply the random number procedure. Second, clients were released from court in a manner that made our initial plan unfeasible. Clients were often brought in as a group, with some individuals leaving the courtroom or returning to jail once their individual hearings were concluded. Thus, clients randomized to lower positions on the list might not be available to approach if those randomly designated to be approached first and second did not agree to be interviewed, did not agree to be in mental health court, or were not qualified by the judge for the court. Thus, a number of recruitment opportunities were missed.

We eventually learned that there were typically no more than three or four new cases each day and that consultation with MHC administrative staff at the beginning of (and during) court could identify new cases. After this, the research

assistants attempted to make brief contact with *every* new MHC client who came to court and briefly explained the nature and purpose of the research to all eligible clients, distributed business cards with information as to how to contact the research assistant, and obtained information about how the research assistant might contact them over the next few days for participation in the study. This procedure, combined with the expanded time window (discussed earlier) for the completion of baseline protocols, resulted in a steadier rate of enrollment and fewer missed MHC clients.

These logistical problems were not encountered recruiting control group participants. In Hillsborough County, the magistrate's court hearing was conducted within the jail via remote video connection to the courthouse. Thus, even when defendants were scheduled for release after their hearings, research assistants were already at the jail and could approach clients for recruitment and protocol administration during the several hours of discharge preparation.

5.3. Identification of appropriate control clients

One of our most challenging problems was identifying appropriate cases at the control site. Unlike Broward County, where a multitude of 'case finders' (e.g. jail staff, magistrates) may identify and refer defendants to the MHC, the typical misdemeanor court has no such process. While some jurisdictions without a mental health court may have other mechanisms to divert individuals with mental illness (e.g. civil commitment, or other diversion programs lacking the active referral and monitoring functions of a MHC) recruiting only those defendants designated for civil commitment or diversion might not produce a control sample comparable to the MHC sample. Our major concern was that only more severely ill individuals might be targeted for such dispositions in Hillsborough, whereas it appeared that the Broward MHC served a very heterogeneous (in terms of severity of illness) group of defendants. Therefore, we developed a complex strategy to identify clients in Hillsborough County who were persons with mental illness faced with the types of charges typically seen in the MHC.

First, research assistants daily screened the magistrate's docket to determine which of the 100+ individuals scheduled for first appearance were eligible for the study based on charges. The exclusion of individuals with felony, DUI, domestic violence, or battery charges typically narrowed the list to at most a few dozen individuals. Second, research assistants obtained from a nurse at the jail a list of clients referred for psychiatric care in the jail in the past day. Third, the docket was used to identify clients housed on the jail's mental health unit(s). Finally, research assistants attended magistrate court to observe for comments or behaviors suggesting possible mental disorder. These processes resulted in a shorter list of clients who were on the nurse's list, on a mental health unit, or potential candidates based on direct observation.

Not all of the defendants assigned to the jail's designated

‘mental health units’ had been identified by the jail staff as persons with mental illness. Due to high daily census, the jail often had to use every available bed, which meant occasionally placing a person with no mental illness on mental health units. Therefore, when approaching defendants housed on the mental health unit, research assistants did a brief screening interview to ascertain whether the defendant had (a) a history of treatment for mental health problems, (b) recently gone to a mental health center in the community or currently had a case manager, (c) recent or current thoughts (or attempts) at hurting themselves, or (d) taken psychotropic medications.⁶

5.4. Matching samples

We also sought to assure that the MHC and control samples not differ significantly on demographic (age, race/ethnicity, gender) or mental status (symptom severity) variables. We wanted to avoid confounds between the samples that might complicate interpretations of results and inferences about group differences that might otherwise be attributable to differences in type of court at the two sites.

To match the samples on demographic variables, we lagged the recruitment of control subjects two months behind that of MHC clients. We then calculated the proportions of various demographic features in the MHC sample and began recruitment of the control sample, monitoring these same variables. This process was repeated periodically to determine whether, and what types of, adjustments in recruiting the control sample were required to attain matched samples. For example, when the percentage of female participants was found to be substantially higher in the control sample, only male research participants were recruited in Hillsborough until the gender percentages in the two samples were again approximately equal.

As noted earlier, we reasoned that jurisdictions without a MHC would more likely limit jail treatment services or utilize mental health diversion mechanisms to individuals with acute symptoms; thus, the major challenge for the matching process was to identify the lower acuity cases at the control site. We periodically compared the mean scores of the two samples on our measure of psychopathology (Brief Psychiatric Scale—Anchored Version [BPRS—A], Overall & Gorham, 1962). When this comparison suggested more severe psychopathology in the control sample, research assistants would discontinue recruiting clients who were on the nurse’s list or who were on the mental health unit and focus instead on those identified as possible research participants through observation in the magistrate’s court.

⁶ This screening interview was also used to determine eligibility for the study with clients identified through observations at the magistrate’s court as possibly mentally ill.

5.5. Inclusion of emergency commitment/civil commitment clients

Jail staff or the MHC judge send some clients to crisis stabilization units (CSUs) at designated receiving facilities for evaluation for emergency commitment that by Florida statute is not to exceed 72 hours, with the possibility of continued involuntary care with a petition for continued commitment. Such individuals usually were floridly symptomatic in the court (or in the jail) and judged unable to consent to voluntary participation in the MHC. These individuals came back to the MHC upon their release from the receiving facility, either because receiving facility staff determined that clients did not meet emergency commitment criteria or after clients had been at the receiving facility for some time they were ready for release. After stabilization, these individuals can be qualified as MHC clients and, the court can dispose of their cases or hold them open for status hearings. Such defendants ‘counted’ in our study as MHC clients linked to services, albeit prior to actually being qualified by the court.

We therefore attempted to recruit a comparable number of defendants evaluated for involuntary emergency psychiatric admission or otherwise directly transferred to the main screening CSU in Hillsborough county because not including such clients would have favored the direction of the research hypothesis that the MHC more successfully links people to mental health services than does the typical misdemeanor court. This was accomplished by obtaining from the jail social worker names of individuals who were being transferred to the CSU from the jail who had been recently booked into the jail and whose charges met the requirements of the study. These individuals were then either interviewed in the jail prior to being transferred to the CSU or were interviewed at the CSU. However, there were substantial logistical difficulties encountered, leading to very few study participants being recruited into the study in this way. Possible study participants were often too symptomatic at the jail prior to transfer to the CSU to understand the consent and complete the interview. Once at the CSU individuals frequently were either still not able to consent to or complete interviews within the seven-day time period we allowed or were not interested in participating. Unlike the MHC, clients at the control site who were sent to the CSU typically had their charges dropped and were released to another treatment setting or into the community upon their release from the CSU, further complicating efforts to find individuals within a week of their arrest for the initial interview. Data for the estimated 20% of MHC (Broward) participants who have an emergency examination as a result of the arrest from which they were referred to the MHC will be taken out of certain analyses comparing data from the Broward to the Hillsborough site to account for the discrepancy in emergency examinations between the control and the study site.

5.6. Problems with client reimbursements

Each study participant received \$20 for each completed

interview. Although payment of research participants can be routinely accomplished in many research settings, various problems were encountered in the MHC evaluation. First, jail regulations prohibited paying clients who were in custody; thus, at recruitment, we could only give a ‘promise to pay’ and clients were given information on how to contact us upon release from jail to arrange payment. This turned out to be positive, as many clients contacted study staff upon their release from jail in order to receive monies owed, giving us valuable follow-up information. Second, access to a petty cash account was essential. Although using a checking account for research participant payments is more convenient for researchers, payment in cash was preferred because many study participants did not have active bank accounts, creating difficulty cashing a check or money order. However, when it became necessary to conduct a few interviews by phone with clients who moved out of state, money orders were used.

5.7. Minimizing attrition during follow-up

Minimizing attrition was a significant concern because of its potential impact on internal validity, external validity and statistical power via reduced sample size (Ribisl et al., 1996). The prior experience of some of our research team members with follow-up in a large evaluation of Medicaid managed care clients provided a starting point for developing strategies which, ultimately, closely mirrored Ribisl et al.’s suggestions for effective retention and tracking.

First, comprehensive locator information was collected at the initial interview. Participants were asked to provide: (a) their anticipated living address, (b) any plans to change locations in the near future, and (c) contact information for three people who might help locate them for follow-up interviews. Those with a history of homelessness were also asked to identify places frequented (e.g. bars; public areas, such as woods or parks). At recruitment research assistants recorded the participant’s physical description and any notable identifying marks or features, facilitating identification for follow-up interviews, sometimes conducted by an RA other than the recruiting RA.⁷ Previous longitudinal studies that included homeless individuals have demonstrated the usefulness of photographs for identification purposes (Wright, Allen, & Devine, 1995). Copies of pictures taken at booking were made available to us by the Broward County Clerk’s Office as needed.

Second, informal and formal relationships were fostered with public and private agencies. Numerous contacts at jails in the study counties and surrounding counties helped to locate study participants who had been rearrested and facilitated access for follow-up interviews in jail. Web sites

allowed us to check daily jail bookings, minimizing the need to ask already overworked staff to hand check lists of names. Court-related staff, jail mental health program staff, other mental health and substance abuse providers at various agencies, public and private agencies catering to the homeless population, and even police who walk areas frequented by clients in the study proved to be invaluable in locating study participants.

Third, a project identity was created. Although the formal name of the study was printed on the consent form, a more informal name, ‘MacArthur Foundation Project’, was used for phone or written messages for clients as an easy way to identify the study without divulging the content of the study as necessary to maintain client confidentiality. Research assistants were given a photo-ID badge that included the informal name of the study and the USF logo. At each contact (e.g. enrollment, a follow-up meeting) study participants were given business cards with the USF logo, informal project name and a toll-free number to FMHI that could be used to reach research staff. Also, a letterhead with these elements was used in any written correspondence with participants.

Fourth, the importance of continuity and tracking was continually emphasized. Follow-up interviewers were instructed to contact research participants within a week of enrollment and to make informal contacts frequently to sustain their commitment over the four-month intervals between interviews. Initial efforts to maintain contact emphasized inexpensive and simple methods such as telephoning clients or client-identified collateral contacts, and dropping off or mailing reminder letters (sent first class mail, with forwarding address correction requested). More time-intensive methods were also used, including driving by clients’ homes, ‘hanging out’ in parks, beaches and other areas frequented by homeless populations, and posting notes at various homeless shelters and places where people receive food. Occasionally, county morgues were contacted to check for mortality.⁸

Project supervisors also stressed the need to check various court, jail, and prison computerized information systems to determine whether study participants had additional involvement with the criminal justice system. When clients temporarily lost to follow-up were relocated (e.g. by being re-arrested), they were visited regardless of whether or not it was time for a scheduled follow-up, reminded of their involvement in the study and their next interview target date, and given a business card.

Weekly staff meetings at each site were used to discuss locator information for study participants and the efforts of research assistants to locate clients. Research assistants kept written logs documenting their efforts to contact participants, which enabled project supervisors to monitor research assistants’ efforts and discuss alternative strategies.

⁷ In retrospect it would have been preferable that the RA who enrolled a participant also be the RA who conducted the follow-up interviews with that person because of the rapport established at the initial interview and the greater ease with which that RA would have been able to identifying the participant.

⁸ Five clients enrolled in the study have been identified as deceased in the first two years of the study, either through information obtained from collaterals or from morgue records.

These logs also were important instructional guides for new staff coming into the project.

Fifth, the research was designed to make it convenient and rewarding for research participants. We obtained a toll-free telephone line for the project so that study participants, many of whom were indigent, would not have to pay to contact us (e.g. to indicate that they were out of jail, to report change of residence, to arrange follow-up appointment). Research assistants met participants as soon as possible upon release from jail to pay them for the initial interview, and interviews in the community were conducted at locations convenient to study participants.

Finally, follow-up efforts were continually customized to the features of study participants. A higher-than-expected number of participants were highly transient, if not homeless. This led to an increasing emphasis on learning about community resources for persons who are homeless, building relationships with the appropriate agencies, and requiring visits to certain areas or centers (such as parks or the community shelters) as part of the research assistants' follow-up routine. Keeping abreast of changes in the array of services available to individuals who are homeless proved to be essential, particularly in the control site that underwent substantial changes over the course of the study in the delivery of services to individuals who are homeless. The high percentage of MHC clients with substance abuse problems led to a working relationship with one of the residential alcohol and drug treatment centers in Broward County. The realization that a small, yet meaningful, percentage of study participants was HIV + led to the development of relationships with agencies that serve these individuals.

6. Maintenance and entry of data

Although data eventually needed to reside in a statistical analysis package, regular entry of data into a relational database provided a dynamic tool for managing the evaluation. We noted earlier the need to periodically examine our data for purposes of sample matching. Similarly, examining data en masse provided a perspective we might have missed had we merely been proofing hard copies of completed protocols. For example, in one instance we queried research assistants about one item of frequently 'missing data' and discovered confusion regarding when the item should be administered. The protocol was revised to make the branching instructions clearer and research assistants were re-trained as to the circumstances under which this follow-up question should be asked.

6.1. Lessons learned

As noted earlier, our evaluation of the Broward County MHC is not designed to determine if the court works, because such a conclusion will depend on the perspective of the observer or participant. It does seem clear that those

involved in the design of the court are pleased with its operation to date (Petrla et al., 2001). In addition, the court seems to have accomplished its goal of assuring that those appearing before the court as defendants are treated respectfully. We have found that such individuals report that they are treated fairly and given voice, compared to those in our comparison site. They also report very low levels of 'perceived coercion' (Poythress et al., 2002). Some have theorized that individuals who perceive that they are treated fairly in a legal process, and perceive that they have choice over legal dispositions, will respond more favorably to treatment. We will be analyzing service utilization and health status data over the coming months, but the court does appear to have created an environment in which individuals perceive themselves as treated fairly.

In terms of the evaluation itself, three points are worth making. First, in our view, it is important to acknowledge that evaluations like this are not designed to determine whether a specialty court works. Individuals may have different perspective on what it means for a court like this to 'work'-from the sheriff's perspective, diverting people with mental illness quickly from jail may be the most successful outcome imaginable, while to a family member a MHC does not work unless people obtain access to treatment that reduces or eliminates criminal justice recidivism. Therefore, it is important to understand the goals of the various participants and that those goals may vary. In addition, it is critical to have the endorsement of a wide variety of people in the criminal justice and treatment systems before attempting such a study.

Second, in our view, an interdisciplinary team is very useful in an evaluation such as this. We have on our team research psychologists with experience in conducting multi-system evaluations in the context of managed behavioral health care, as well as research psychologists who have worked closely with the criminal justice system on a wide variety of forensic issues such as competency and coercion. In addition, the team includes an attorney with long experience in mental disability law. This has enabled the team to perhaps better understand the complexities of an intervention mounted in the criminal justice system but in which those subject to the intervention spend much of their time in treatment and social welfare systems. The prior experience of some team members in tracking transient populations was also critical in attempting to address the issue of retaining the significant number of individuals enrolled in the study who were homeless.

Third, if we were starting over with the evaluation, we would attempt to learn more about how people entering the court were processed not only during court but after. We spent a significant amount of time making adjustments in our initial recruiting and follow-up strategies, and such difficulties might have been ameliorated had we shadowed a small group of individuals through the criminal justice and mental health systems prior to initiating the study on a broad scale.

These evaluations are complex and are often conducted under less than ideal circumstances. However, given the importance of the policy issues that have arisen at the intersection of the criminal justice and mental health/substance abuse systems, such evaluations are critical in attempting to inform policy makers of what happens when innovations such as mental health courts are implemented.

7. Conclusions

The emergence of specialty courts to address the needs of persons with mental illness and substance abuse diagnoses is an important development in the United States criminal justice system. Evaluations of drug courts played an important role in creating a consensus that such courts could meet their stated goals. We have described in this paper a number of issues encountered in evaluating the nation's first mental health court in the hope that it will inform future evaluations done at the crossroads of the legal and mental health service systems.

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