

JACKSON COUNTY MENTAL HEALTH COURT



Annual Progress Report, January - December 2008

Prepared for:
Jackson County Community Mental
Health Fund

Mental Health Court Commission

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Picture: One of Bartle Hall's art deco pylons, an unmistakable fixture in the Kansas City skyline.

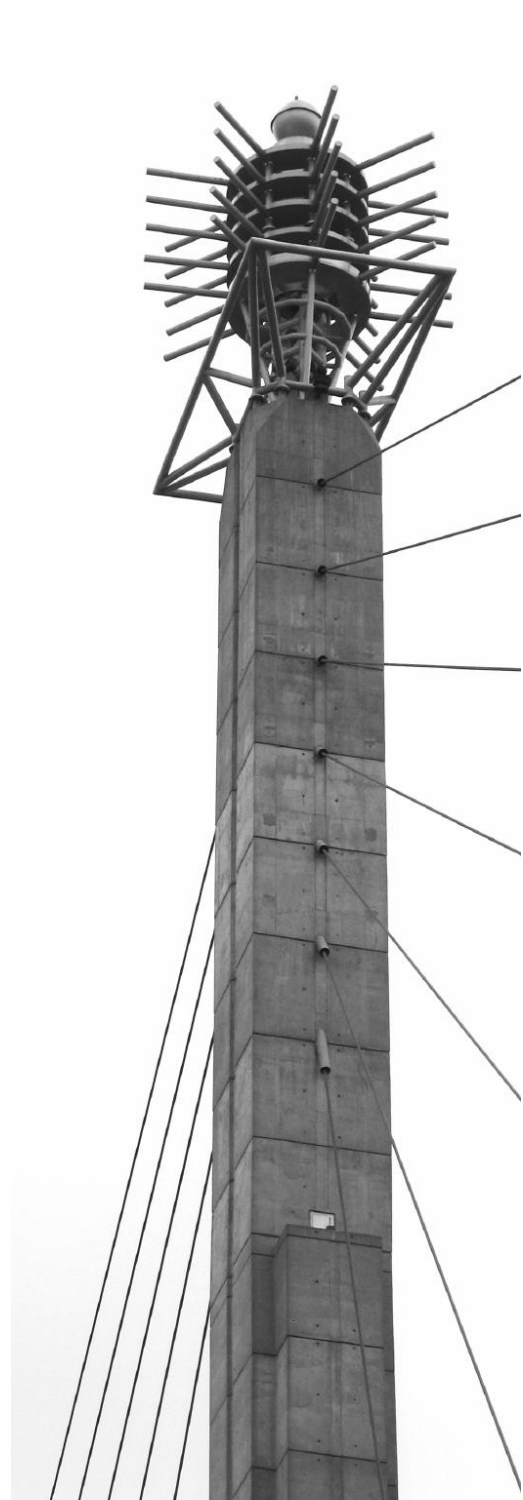


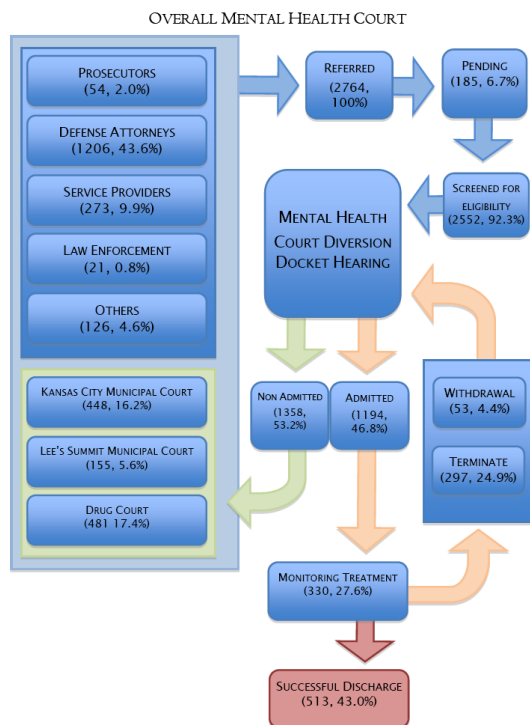
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EXECUTIVE SUMMARY

This report presents findings of the evaluation of the Mental Health Court (MHC) Program in Jackson County, Missouri. The evaluation includes data collected through December 2008. It includes three courts: Kansas City Municipal Court, Lee's Summit Municipal Court and Drug Court. The evaluation is funded by the Jackson County Community Mental Health Fund, a local tax levy for indigent mental health services.



During 2008, two noteworthy events transpired that will have significant impact on the Mental Health Courts: 1) the award of the Bureau of Justice Assistance (BJA) grant to enable expansion of the current Mental Health Courts, and, 2) implementation of the *Managing Our Success* process, a dialog on the current state of the Mental Health Court model.

Overall outcomes indicate that the MHC program continues to successfully divert persons with mental illness, who have been arrested for city ordinance violations (or low class felonies for Drug Court), from incarceration to mental health treatment. Nearly half (46.8%) of those referred are admitted to the program. Once in the program, clients reports satisfaction with their treatment in court and with their mental health care. Of those admitted, 43% have successfully completed the program, 4.4% have withdrawn, 24.9% have been terminated and 27.6% remain in the program. The post-program conviction rate for all discharged clients, regardless of previous convictions was only 8.7%.

The number of referrals made to the MHC program has dramatically increased since inception in 2002. MHC has seen a 114% increase in referrals (308 vs. 658) just since 2006. Respondents to stakeholder interviews expressed concern that the MHC did not have the resources to add new consumers. Nearly three fourths (73%) of the respondents indicated that the current MHC system is over operating capacity and cannot maintain current client levels. In response to such concerns, and through collaborative efforts among MHC partners, various changes were implemented in relation to the processes of the MHC system. These process changes included: docket schedules, staffing schedules, pre-screening processes, communication, and requirements of individual MHC staff's duties. The initial response of MHC stakeholders to these changes has been positive.

INTRODUCTION

This annual report presents findings of the evaluation of the Mental Health Court (MHC) Program in Jackson County, Missouri. The evaluation includes data collected January through December, 2008. Three courts are included in the evaluation: Kansas City Municipal Court, Jackson County Drug Court, and Lee's Summit Municipal Court. The evaluation is funded by the Jackson County Community Mental Health Fund, a local tax levy for indigent mental health services.

The annual MHC evaluation report contains four main sections;

1. *Process evaluation* includes information on the expansion of the MHC program throughout Jackson County and how new processes are impacting the individual courts and the clients.
2. *Stakeholder interviews* were conducted to provide in-depth information on program success and challenges.
3. *MHC flowcharts* were created to provide a visual representation of how clients are moved through the MHC program. Charts for the overall program, as well as the individual courts are examined in this report. MHC flowcharts represent client data through December 31, 2008.
4. *Quantitative MHC results* utilize client data through the end of 2008. Data is collected and entered by MHC staff. Data regarding referrals, admissions, and discharges were analyzed to examine MHC clients and outcomes. Data is presented both cumulatively and yearly.

METHODS

Process Evaluation

Several qualitative methods were employed to assess the structure of the MHC Program as a whole:

1. Evaluators continued to observe sessions of the MHC in Lee's Summit, Kansas City and Drug Court to gather information on court proceedings.
2. Evaluators continued to attend full Commission and committee meetings to gather information on program activities.
3. Evaluators attended MHC Expansion meetings to assess the processes being implemented to expand the program.
4. Evaluators conducted a complete external and internal review of the databases, processes, and reporting mechanisms being utilized to provide feedback and information to MHC.

Stakeholder Interviews

Interviews to examine capacity concerns were conducted with key stakeholder, including personnel in the Mental Health Court system and case monitoring personnel.

MHC Flowcharts

Based on the principles of the MHC program, flowcharts were created. These charts will assist in the expansion of the program by providing a visual outline of the systems created by the overall programming. Data included in the charts are cumulative for the program.

Quantitative Analysis

The quantitative analysis section of this report was restructured to present results in four sections: 1) Referrals; 2) Admissions; 3) Discharges; and 4) Recidivism.

Diagnoses: To maintain consistent and accurate data, RDI streamlined transfer of data from the Swope Health Services Dataset to a RDI maintained database. However, due to database limitations, client diagnoses were collapsed further into broader categories: Schizophrenia (inclusive of Paranoid Schizophrenia), Mood Disorders (Bipolar and MDD), Depression, Character or Personality Disorders, Medical Psychosis, Other Psychosis, Mental Retardation, Anxiety, Substance Abuse, Co-Occurring Disorders, and Other (Autism, Drug Related Disorder,

Alcohol Related Disorder, and Dementia). Primary, secondary and Axis II diagnoses were used to categorize clients.

Recidivism: RDI was provided information from the *Alert* system to analyze recidivism among MHC 2008 discharged clients. Only convictions were examined. Only clients that possessed a prior conviction within a year of MHC admission were able to recidivate. Due to MHC being a diversion program, RDI recognizes that all clients have appeared in court, but may have not been convicted of a crime. Because of this, the post-program conviction rate for all clients, regardless of previous convictions, are also included.

PROCESS EVALUATION

Consumer Observations

Since early March 2008, data has been gathered on the consumer experience with the Mental Health Court process from a consumer perspective. A consumer/observer has attended court sessions weekly in Kansas City Municipal, monthly in Lee's Summit Municipal, and less frequently in Drug Court. A consistent theme during this period was the observed display of "compassion" and "patience" by the judges when making decisions in MHC, indicating a judicial understanding of the complex issues faced by people with mental illness.

As 2008 concluded, few changes in the consumer's impression emerged over the course of the observations. The consumer/observer communicated that compassion and a consistent attempt to respond to the wide range of issues that confront the court has been observed throughout this process. The following examples reported by the consumer/observer reflect impressions that are generally consistent with past reporting:

- "There was a case where a consumer was given a continuance only because he had not paid the fine he was supposed to pay. Therefore the judge told the consumer the fine must be paid or he will not be able to participate in the MHC program. The consumer told the judge he will pay the fine before the next court date."
- "There were two graduations this day. One turned out to be just ceremonial. The judge issued the certificate. The court monitors issued the consumer his movie passes. Then this was the end of the process for the consumer. The other graduate seemed to have been on friendlier terms with the judge. The judge seemed genuinely interested in this

consumer. So the consumer was delighted to receive his certificate announcing he had graduated from the program.”

- “It seems the more I attend the court sessions the more I have a different opinion of the court. This means what I thought was out of the ordinary situations no longer appear ordinary. It has become a standard. I have to remind myself each week that there will be out of the ordinary situations (that really are not that out of the normal). So I try to keep focused on situations that are new or out of the ordinary.”
- “I have also noticed there is a different mood each week when I go to the courtroom. If there are a lot of continuances that are normal, then things just roll along. When there are situations where there are complications with a case then things change. The court session runs longer. It does not move as smoothly as if there were not any problems. And I can tell it makes a difference on the attitudes of all the parties involved.”
- “There was the case of the consumer who has been in and out of the program for the past two years. Every time I have seen him in court he pleads his innocence. He asks for another chance. Each time the judge has given him another chance. This time he was told it will all come to an end if he does not follow the Mental Health Court Program again. It was the first time the judge issued that statement. We will see how it turns out. Only time can tell.”
- “There was a case regarding a guardianship issue. The consumer did not understand what it meant to have a guardian. So he questioned his right to have a guardian. The prosecutor tried to tell the consumer what this meant. But, the consumer still did not understand. The case was given a continuance. It was given because the consumer needed more time to find out what having a guardian meant. Then he would be given the choice to have a guardian or not.”
- Today the courtroom was in a jolly mood. Maybe it was because of the holidays. There did not seem to be much complaining about the amount of time consumers had to wait. Plus, there was no excess noise in the courtroom as the cases were called before the judge. It helped that there were four graduations. This was a good way to end the year.

The consumer/observer has met with the evaluation team in regards to adjusting the format for continued observations. It is the consumer’s and evaluator’s opinion that adjusting the data that is gathered would provide relevant data. An alternative plan for consumer observation has been developed and will be presented to the Management Team and the MHC Commission.

Process Audit

RDI conducted a complete external and internal review of the databases, processes, and reporting mechanisms being utilized to provide feedback and information to MHC. An emphasis was placed on data exchange and maintenance that is less cumbersome and hones the focus on needed reporting elements, refining consumer input, and ensuring the qualitative analysis of the MHC process so that it is synced to the needs of the Commission.

Significant changes in the operation of the Mental Health Court System, as well as changes in factors impacting the evaluation process of the Mental Health Court, occurred throughout the 2008 calendar year. The Mental Health Court Commission has been engaged in discussion about necessary adjustments to the delivery of services. Several changes have already been instituted and the process of evaluating needed adaptations continues. These discussions take on heightened urgency as the MHC Commission engages in the expansion of jurisdictions.

The loss of court monitors due to budget cuts, increase in demand for MHC services, and policies/procedures that were developed prior to the current level of growth has contributed to several stakeholders altering the way services are provided. The caseloads at Swope Health Services in the past year have grown beyond their capacity to maintain service levels. During parts of 2008 new consumers could not be processed. Additionally, Legal Aide was experiencing a similar problem with caseloads. Changes were implemented that included adjusting the way consumers were reviewed and what services would be delivered. The following list was distributed by Swope Health Services and reflects adjustments made to this process.

“Mental Health Court Process Changes:

1. Staffing is on Monday @ 1:00 pm (unless there is a holiday, then other arrangements are made according to staff schedules)
 - The Legal Aide Attorney and the Prosecutor determine whether the legal provides the SHS staff with legal eligibility clients;
 - i. If a client is eligible, they are provided with a screening date;
 - ii. The screening date, time and monitor is added to the client update list and when time allows, an assessment order is provided by the court clerk and signed by the Judge prior to court proceedings.
 - iii. If a client is ineligible, the Legal Aide Attorney and the Prosecutor determine another course of action;
 - iv. Problem cases are also identified and other plans of action are staffed and are subject to team approval.
2. Court proceedings
 - Staff arrive at court @ 1:00 pm
 - The Judge is provided with the court report with the clients and ether compliments them on their compliance or discusses what follow up treatment is required as a result of their noncompliance;
 - At 1:15pm clients enter the court room and are checked in by Melanie (if they do not have a case manager) and Tina (if they do have a case manger);

- This information is then given to the court clerk who personalizes the call list for the Judge;
- There are several attempts to make sure everyone who arrives to the court room on time is included on the Judge's initial call list;
- One the Judge enters the court room, he begins to call the clients in an order that accommodates the attorneys and case managers, as well as other clients who may have a medical condition;
- New clients who are interested in participating in the program are provided with their signed assessment order, advised to present at their appointment and are provided with their next court date;
- Court monitors write the appointments down for their clients and hand them all of their contact information;
- For clients who have missed at least two appointments, they are referred to the Prosecutor to discuss their willingness to participate in the program and their commitment to the program;
- At the end of the proceedings, if a client has missed an excessive amount of appointments and has not had contact with any court personnel or SHS staff, a warrant is issued;
- Depending on where the client is in the process, a client may be kept in custody for Rapid Response, released and provided with their next court date, and can also be provided with a sanction pending the Judge's approval."

The process audit and the continued evaluation of MHC processes identified several key findings and resulted in several adaptations over the course of 2008.

- RDI is currently able to access conviction records from the Kansas City Police Department ALERT system. This allows for receiving data from a wider range of jurisdictions than was previously possible. Conviction records may now be accessed from the following law enforcement jurisdictions: Kansas City, Blue Spring, Grandview, Raytown, Sugar Creek, North Kansas City, Lee Summit, Raymore, Platte, Riverside, Liberty, Avondale, Gladstone, and Independence. Lee' Summit conviction records are attained separately. This process improvement allows for a more precise examination of recidivism rates as well as a more detailed look at types of offenses committed by Mental Health Court clients.
- An improved exchange of data with Swope Parkway Mental Health allows for an increase in the amount of accessible data and a decrease in the amount of time needed to analyze and report information. Previously a time lag of 3 or more months was required to process the database. RDI is now able to report on data from the previous month.
- Consumer observations that have been conducted over the past year are not revealing new information. The size of dockets and the reality that much information regarding

the consumer's experience on their court date happens prior to the actual docket has made it difficult for the observer to capture much information beyond general impressions. An evaluator has met with the consumer observer and developed a new process that will be presented to the Commission.

- It is problematic to gather consistent and timely information from file audits. Case files are not uniform in nature due to changes in staffing patterns, data recording tools being altered, switching from paper to electronic information gathering, etc. Not all information that is currently gathered is present in all files. In addition, information on education status, job status, GAF scores, and living arrangements can be many years old. Much of this data is gathered at intake and not updated at discharge.
- Processes for dealing with change and problems within the Mental Health Court system are not formal. This creates great flexibility in responding to challenges, but the lack of a standardized process has led to changes being implemented prior to full understanding of the changes by the Management Group and the Commission as a whole. The differing cultures and processes from docket to docket create a need for flexibility, but some stakeholders have expressed concern over how decisions are made and implemented.
- Regardless of challenges and issues with implementing system change, stakeholders are generally pleased with the adjustments that have been made and are confident that improvements are being made.
- In the upcoming year it will be valuable for the evaluator to establish a baseline for measuring the impact of system changes. Stakeholders are in the process of capturing and documenting the formalized model that accurately reflects current operating practices.

STAKEHOLDER INTERVIEWS

Stakeholder Capacity Interviews

Interviews with key personnel in the Mental Health Court system were conducted to examine capacity concerns. During this reporting period the Mental Health Court system has changed personnel and processes. The process changes are the result of individual elements being stressed and implementing new procedures to relieve that stress. The adjustments were being enacted concurrently with these interviews, however these questions relate to capacity status prior to adaptations in the system.

Eleven key personnel in the MHC system were interviewed to provide better understanding of the need for adapting the MHC system. The questions addressed the following areas:

1. Has the Mental Health Court System hit capacity for current resources?
2. Have individual elements hit capacity and therefore are restricting the rest of the system?
3. If capacity has been met by all or some of the system elements, is it due to increase in demand, shrinking resources, or both?

A complete list of the interview questions are attached to this report (see Appendix A).

A summary of the responses follows:

Has the system hit capacity for current resources?

Question: Do you believe the current MHC system:

Response	Number of Positive Responses	Percentage
Has enough resources to take on more clients	0	0%
Is at full capacity.	3	27%
Is over operating capacity and cannot maintain current client levels	8	73%

Question: Do you believe resources are being used as effectively as possible to operate the MHC system?

Response	Number of Responses	Percentage
Yes	6	55%
No	4	36%
Don't know	1	9%

Question: What additional resources would be most effective to maintain and build the MHC?

Suggestions included:

- An increase in staffing with Swope and Legal Aide,
- Resources to accept the sickest and severely-mentally ill clients,
- Resources to provide appropriate housing for consumers,
- Appointing someone to check the best practices around the country,
- Interfacing with national court group here in Kansas City this summer,
- Training on MHC for other attorneys,
- Developing a formal way to address crisis,
- An increase in focus on CIT, and
- A database that all could access and tool kits for families.

Notes: None of the respondents believed that the Mental Health Court had the resources to add new consumers. Nearly three fourths (73%) of the respondents believe that the current MHC system is over operating capacity and that it cannot maintain current client levels. The majority of the respondents believe this is due to; heavy caseloads, long waiting list for treatment, and an increase in the number of program participants.

More than half of the respondents believe the resources within the MHC system are being used as effectively as possible to operate the current system. However, many believe that adjustments need to be made in regards to the current model, shifting the programs focus towards cases with better prognosis, and adjusting various roles of staff within the court system. The following suggestions were made in regards to those adjustments:

- The court monitor needs authority to hold the mental health centers accountable.
- The current system is based on individual jobs and they can only control certain aspects within their realm of the current system.
- Brokerage versus case monitoring – the court will not provide monitoring, but will provide monthly reports from case managers with court system.

The following respondent observations were illustrative of the responses to the issues of system capacity and resources:

- Caseloads have grown from 60 in 2004 to over 90 in 2009.
- Long waiting lists for admits to mental health centers and extended timelines for treatment have become a critical issue.
- Limited availability of treatment facilities has created delays for consumers.
- The system has experienced an increase in the number of participants in MHC and in the severity level of mental illness.
- The system is heading in the right direction and could become more focused on cases with a better prognosis; other options should be utilized for more demanding cases.
- The current program has grown to have a loose structure, and has become kind of “willy-nilly” in nature.

Have individual elements hit capacity and therefore are restricting the rest of the system?

Question: Has your program/agency established a maximum number of clients that can be maintained over a given period of time?

Response	Number of Responses	Percentage
Yes	4	36%
No	7	64%

Question: Has there been a conversation with MHC partners regarding disparities in the capacity of programs and how to adjust or compensate for those disparities?

Response	Number of Responses	Percentage
Yes	8	73%
No	3	27%

Question: In the last year, have you experienced any changes in the way your program/agency works with partners in the MHC system?

Response	Number of Responses	Percentage
Yes	9	82%
No	2	18%

Notes: The majority of agencies/programs within the MHC system have not established a maximum number of clients they can serve over a given period of time. Concern was expressed over who defines capacity and how capacity is defined. Several respondents pointed out that the original maximum capacity for caseloads was set at 50. Multiple respondents expressed that current capacity stress is due to an increase demand and a decrease in the number of resources available to the MHC system.

A majority of the stakeholders reported significant changes in the interaction between partners in the last year. Examples of reasons reported for this change include:

- Personnel shortages,
- Elimination of the Rapid Response screening process,
- Legal Aid becoming more engaged with MCI and gaining a better understanding of issues,
- Program success,
- An empathetic, team approach with more focus on communication as causing changes within the system,
- A high number of caseloads,

- Increased involvement with ACT, leading to an increase in engagement and referrals from court monitors,
- Involvement in Rapid Response meetings and MHC management meetings,
- Change in the schedule to allow more opportunities for pre-court staffing,
- Frustration related to wanting to help make a difference in the consumer's lives,
- Court monitors being more accessible for clients and improving contact with clients,
- Wanting to build a program that the staff and consumers can firmly believe in.

If capacity has been met by all or some of the system elements, is it due to increase in demand, shrinking resources, or both?

Question: Describe any changes in the last year, in funding, staffing, or other resources, and the impact of those changes.

- Multiple respondents believe that since the MHC was not funded by Jackson County in 2008, that the limited amount of funding had significant impacts on the entire MHC system.
- Multiple respondents also believe that staffing issues, MCI mental health funding, and the Truman partnership all had a significant impact on the MHC system.
- DOC at the state level is referring more MH clients in the justice system to the Kansas City area, and more training and resources are needed to handle the overload.
- Gaining funding in the last year for Legal Aid to provide an attorney was helpful to the MHC system.
- There has been difficulty hiring officers since the new grant has yet to be enacted.

Question: Has the last year been typical in regards to demands on your program, or has the impact of MHC changed in some way?

- An overwhelming majority of the respondents felt that demands on their program have not been typical in relation to previous years.
- Multiple respondents cited a surge in the number of MHC program participants.
- Multiple respondents reported that the system is changing its "one size fits all approach."
- An increase in the severity of illness of MHC consumers was noted.

Mental Health Court Process Changes and the Impact on MHC Consumers

As reported, in 2008, through collaborative efforts among Mental Health Court partners, various changes were implemented in relation to the processes of the Mental Health Court system. These process changes include, but are not limited to, the following; docket schedules, staffing schedules, pre-screening processes, communication, and the requirements of individual MHC staff's duties. The initial response of MHC stakeholders has been positive.

RDI conducted interviews with a total of six court personnel and case monitoring personnel to assess what impact they believed the implemented changes in service delivery has had on MHC consumers. All stakeholders interviewed were in agreement that the recent changes in the MHC system have had a positive impact on participants. It is noted that these are preliminary impressions and it is agreed that it will take further time and evaluation to fully understand the impact of new processes.

Summary of reported positive impacts on MHC participants follows:

- The majority of respondents agreed that recent changes in the screening process have resulted in a noticeable decrease in the amount of waiting time participants experience during the MHC program admission process.
- Respondents reported that shortened court sessions seem to have resulted in a reduction in the participant's stress, anxiety, and frustration levels during the court session.
- Swope reported a 96% client satisfaction rate.
- Swope client satisfaction surveys also revealed an increase in participants that display positive attitudes towards the program in general.

Key MHC partners reported advantages they believed were a direct result of process changes implemented in the MHC system in 2008.

- According to the majority of respondent's observations, MHC participants are completing the MHC program requirements in a shorter amount of time.
- MHC staff does not have to spend as much time working with individuals who are not going to be participating in the MHC program.
- Respondents reported a noticeable increase in the manageability of the MHC program due to lighter caseloads, screening process changes, and an increase in collaboration.
- Profound improvements were noticed in relation to the use of communication channels between mental health professionals and participants within the MHC system. The respondents noted these improvements in communication resulted in an increase in the quality of service provided to participants of the MHC system.
- MHC process changes have produced an increase in the availability of more accessible resources, such as housing, food, clothing, and mental health services for MHC participants.
- Changes related to lighter caseloads for case managers and court monitors within the MHC system decreased the amount of time spent working with individuals who are not in the MHC program.

Some of the key partners within the MHC system reported having to overcome challenges associated with the implementation of the new process in 2008. These challenges included:

- Doing more work than what was originally anticipated,
- Handling issues surrounding staffing and preparation for MHC hearings,
- Paperwork flow issues related to prosecutors determining MHC eligibility at an earlier stage,
- Determining the proper disposition for individuals who are not in the MHC program,
- Maintaining collaboration efforts within the MHC system, and
- Making schedule adjustments.

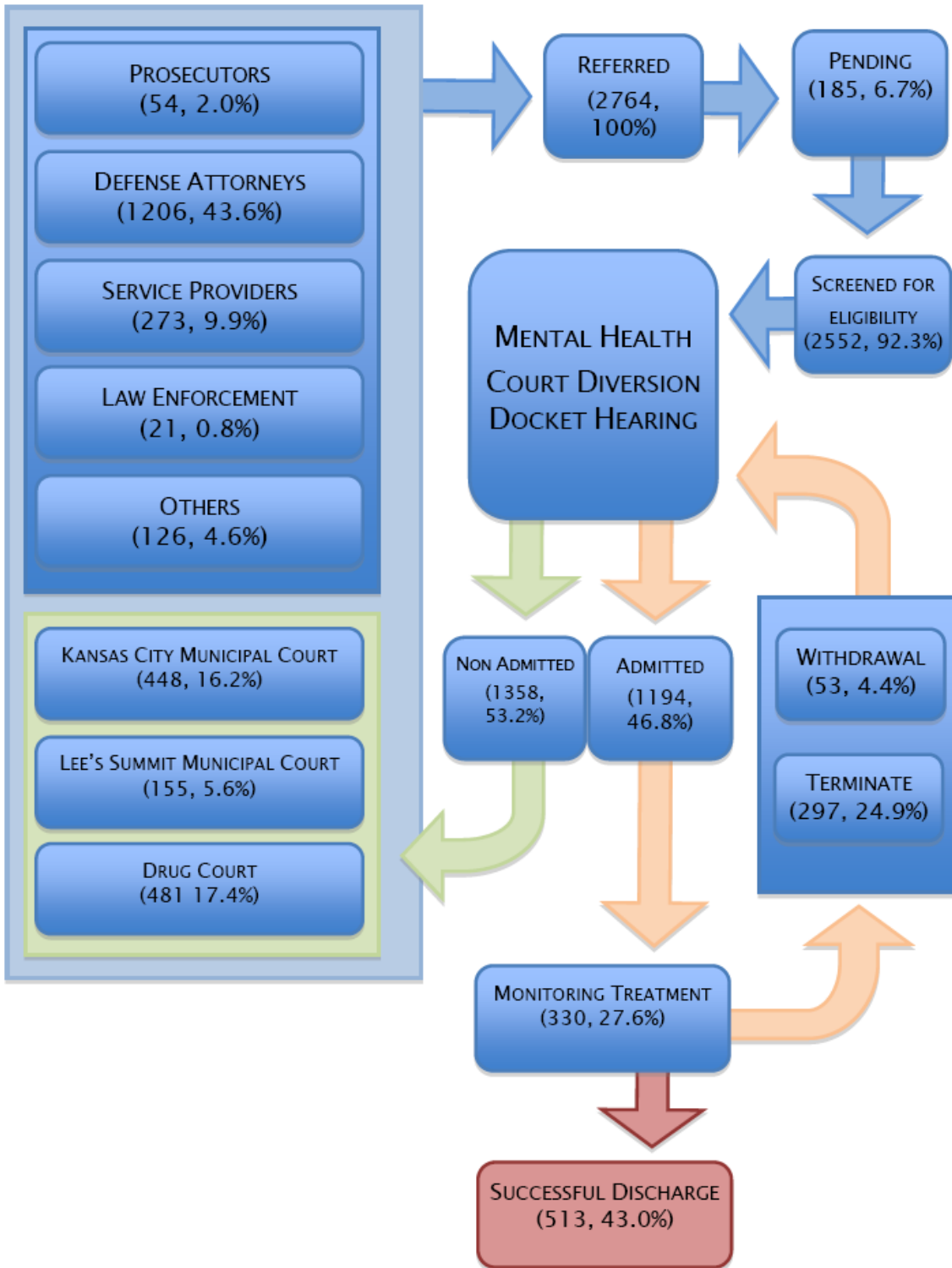
Respondents reported how the changes in the MHC system occurred. This includes:

- Collaboration between partners regarding program issues,
- Discussion in MHC meetings regarding how to make the program better,
- Overload and blockage in both the court case manager's and court monitor's meetings created a need for the change,
- Synergy between partners as they examined the needs of their individual organizations,
- A demonstrated desire to do what was in the best interest of the participants, and
- A need for capacity levels to be re-examined as the system became overstressed.

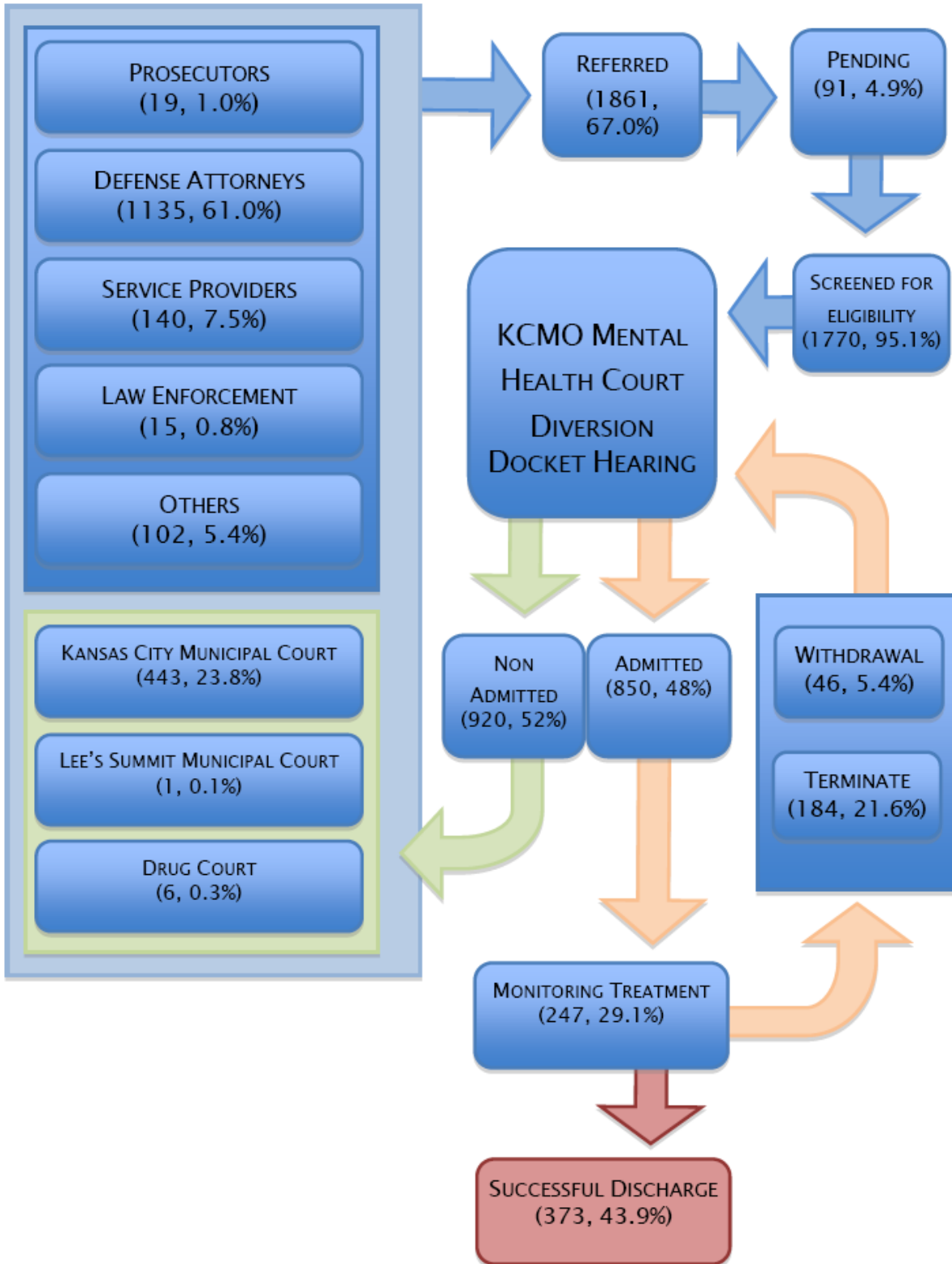
MHC FLOWCHARTS

Based on the principles of the MHC program, flowcharts were created. These charts will assist in the expansion of the program by providing a visual outline of the systems created by the overall programming. Data included in the charts are cumulative for the program. Presented in the following pages is an overall MHC flow chart, followed by flow charts for each MHC jurisdiction.

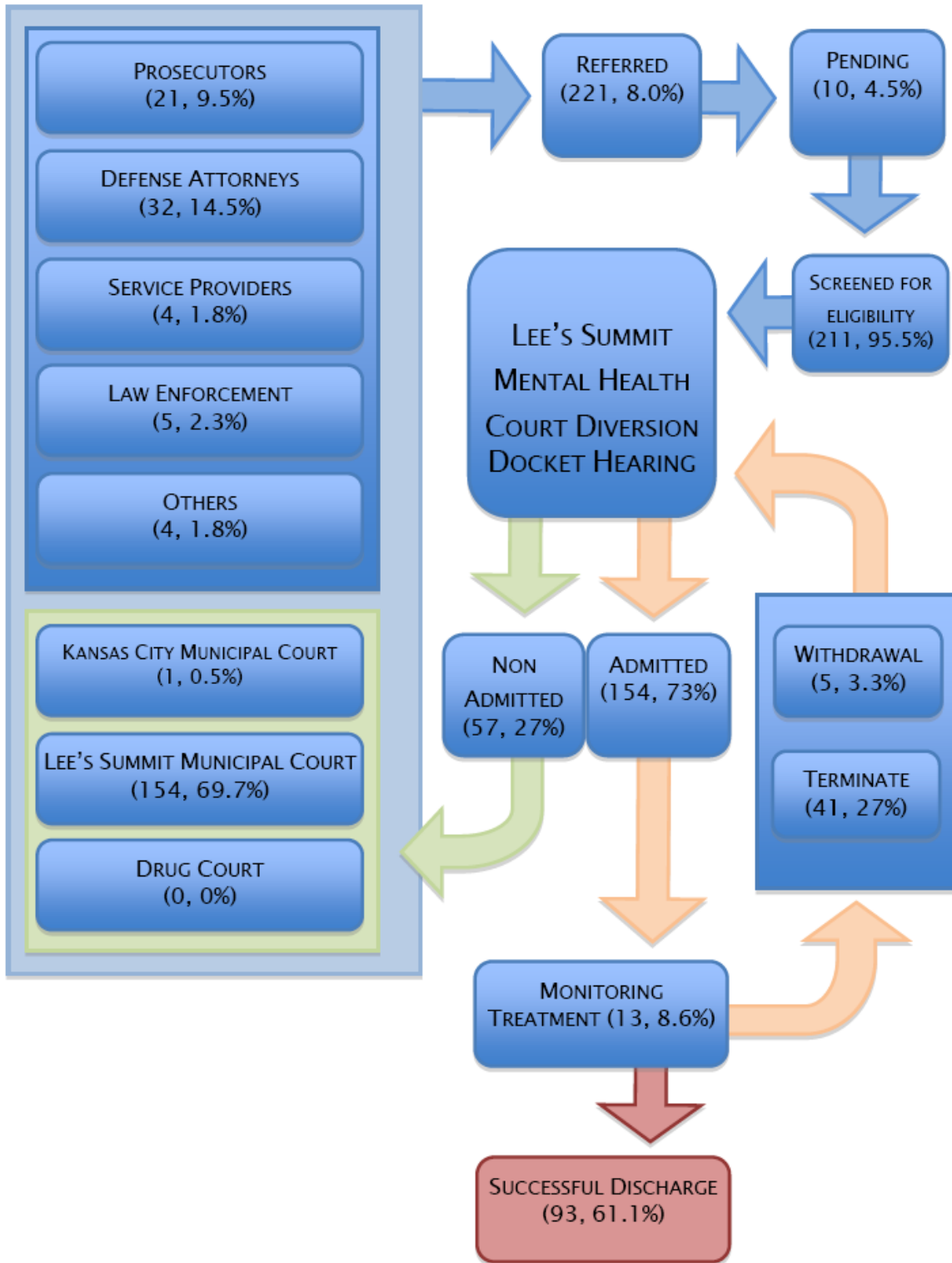
OVERALL MENTAL HEALTH COURT



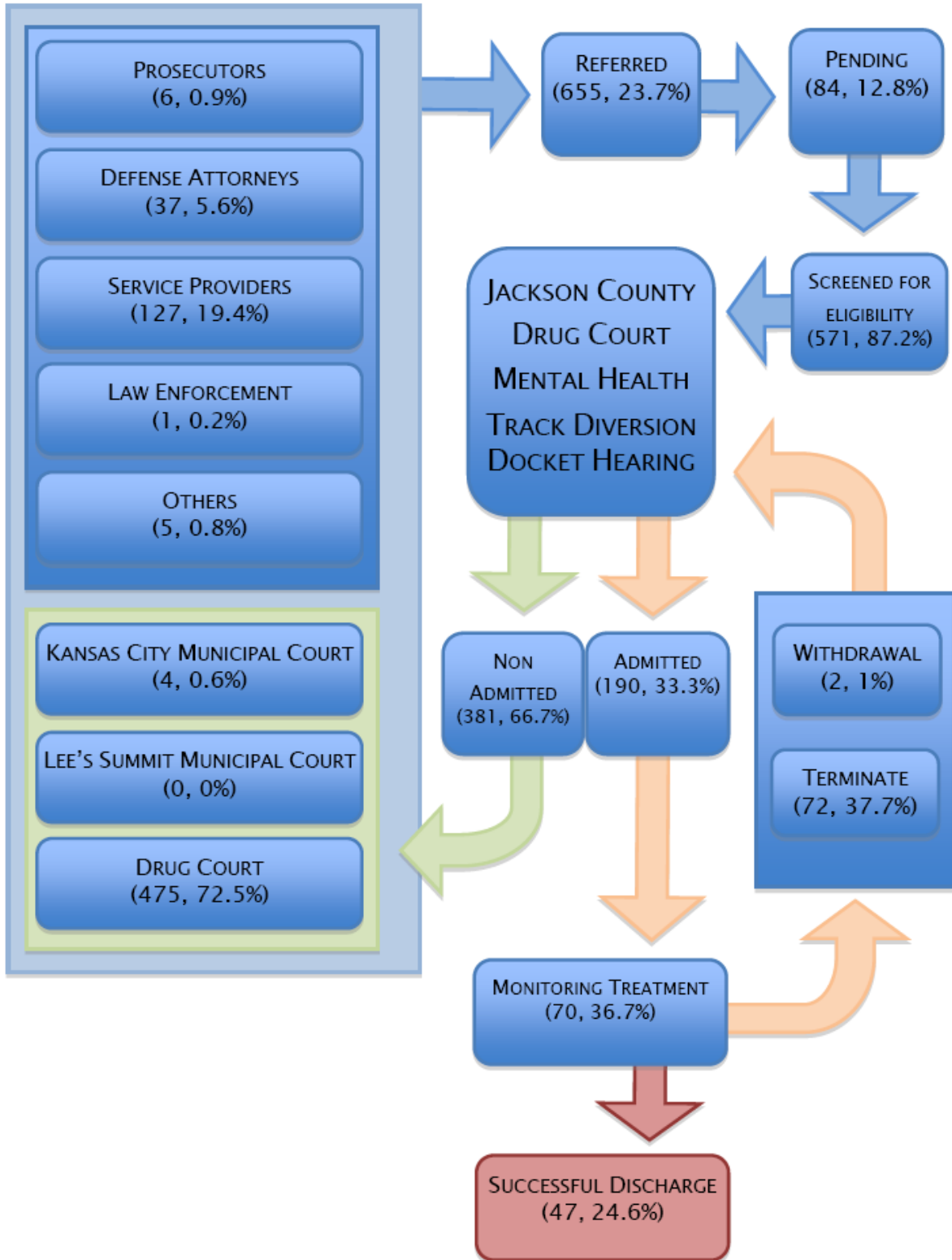
KANSAS CITY MUNICIPAL MENTAL HEALTH COURT



LEE'S SUMMIT MUNICIPAL MENTAL HEALTH COURT



JACKSON COUNTY DRUG COURT MENTAL HEALTH TRACK



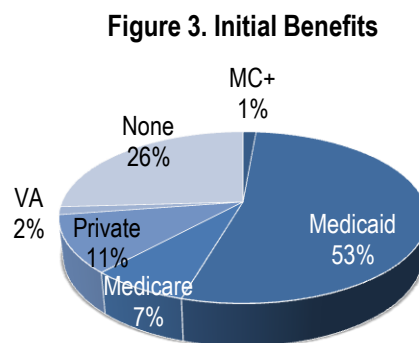
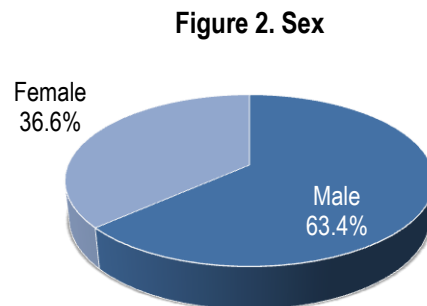
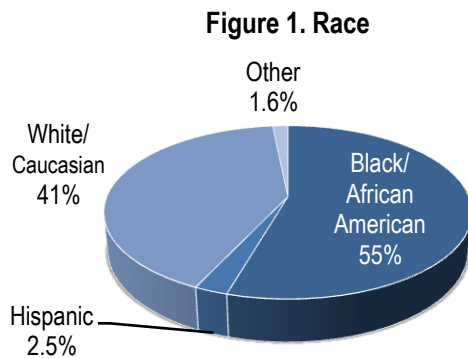
MHC REFERRALS

There has been a total of 2,766 referral made to the Jackson County Mental Health program since 2002. This section will examine demographics of the referred, referral dates, referral sources, clients with multiple referrals, and referral dispositions.

Demographics

As presented in Figure 1, over half of the referrals (54.5%; 1,508) were *Black/ African American*; while the remaining referrals were *White/ Caucasian* (41.4%; 1,146), *Hispanic* (2.5%; 69), or reported *Other* (1.6%; 43). In addition, males (63.4%; 1,754) were predominantly referred (Figure 2). The average age of the clients referred to the program is 34 and the median age was 33 years old. The youngest referral was 12 and the oldest was 87 years old.

At time of referral, benefits were reported for 1,052 clients. *Medicaid* (42.9%; 452) was the most common benefit indicated. Reported benefits are presented in Figure 3. An additional 1,697 referrals reported benefits as *unknown* and are not included in the results.



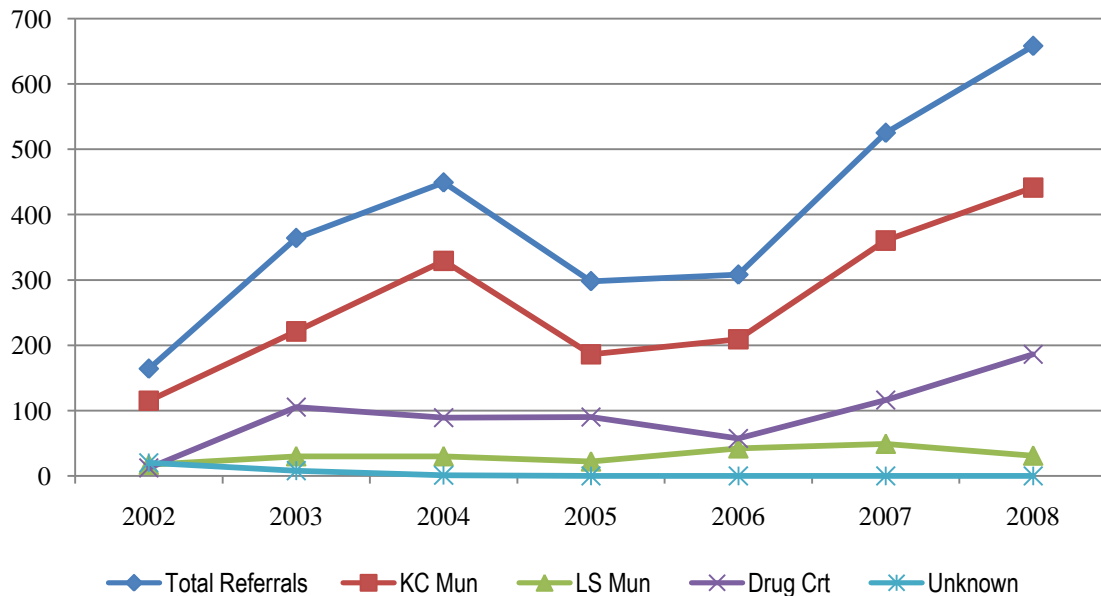
Referral Trends

Increased Numbers: The total number of referrals made to the Mental Health Court program has dramatically increased since inception in 2002. Since as recently as 2006, Mental Health Court has witnessed a 114% increase in referrals (308 vs. 658). Referrals, by jurisdiction are presented in Table 1 and Figure 4.

Table 1. Referrals by Jurisdiction

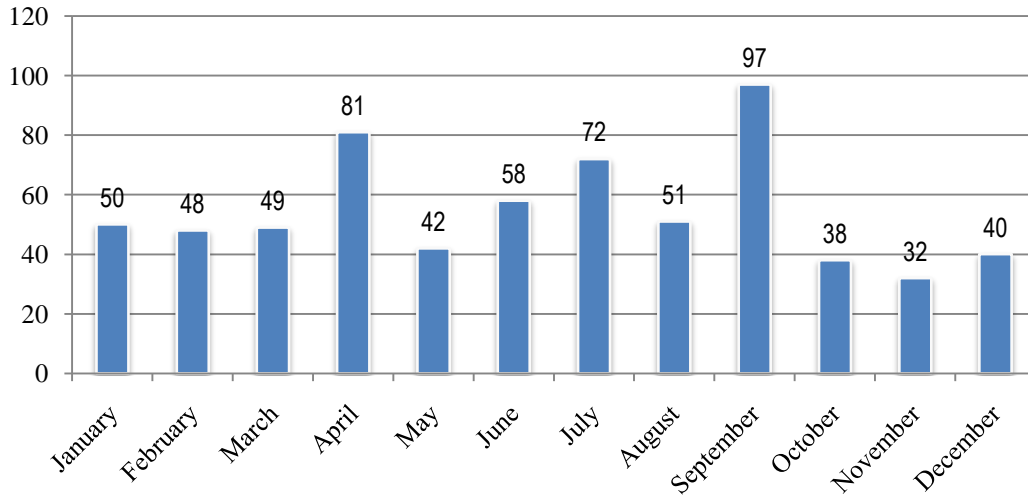
	2002	2003	2004	2005	2006	2007	2008
Drug Court	12	105	89	90	57	116	186
KC Mun	115	221	329	186	209	360	441
LS Mun	17	30	30	22	42	49	31
Other/Unknown	20	8	1	0	0	0	0
Total	164	364	449	298	308	525	658

Figure 4. Total Referrals by Year by Jurisdiction



During 2008, large fluctuations were seen in the number of referrals month to month. September and April reported the largest number of referrals (97 & 81); while, November reported the fewest (32). Referrals by month are presented in Figure 5.

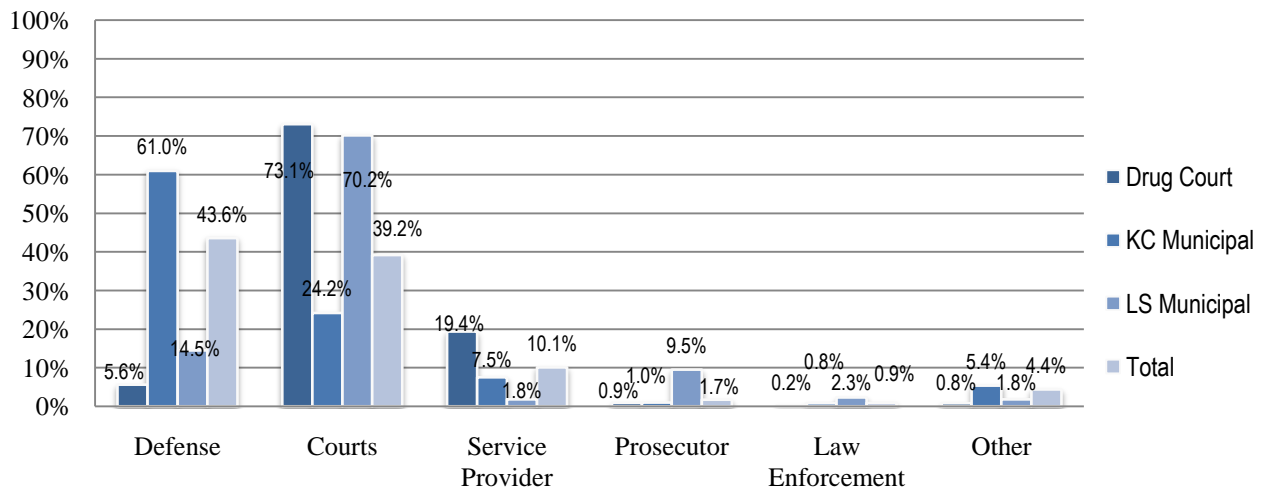
Figure 5. 2008 Referrals by Month



Referral Source:

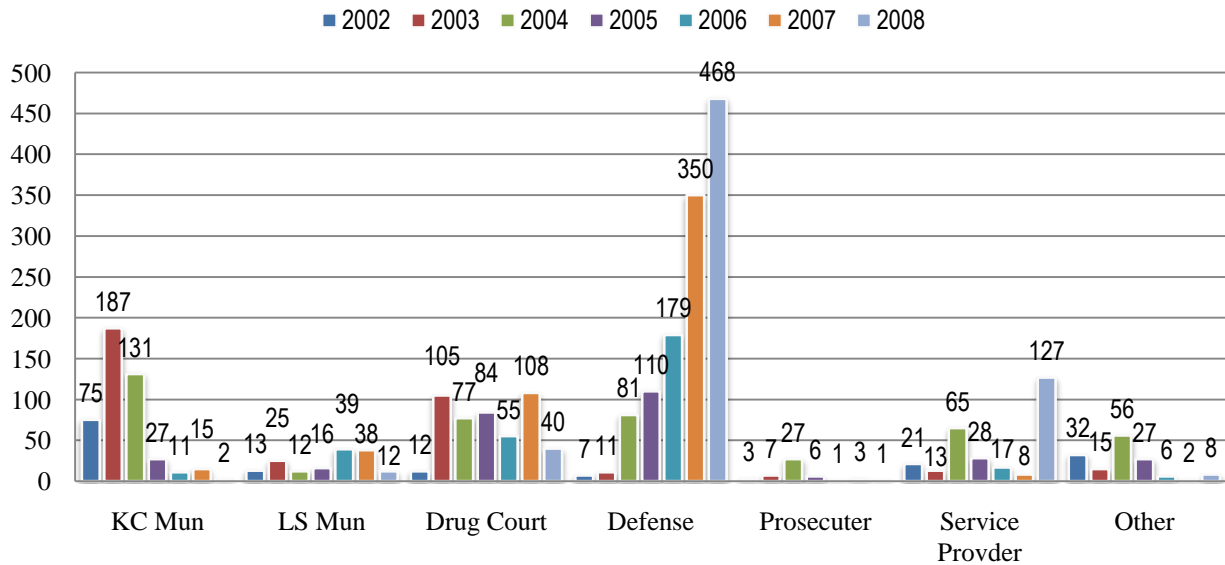
The vast majority of their MHC referrals for Drug Court and LS Municipal Court were from *courts* (73.1% & 70.2%), while KC Municipal Court received 61.0% of their referrals from *defense* attorneys, with less than one quarter (24.2%) coming from the *courts* (See Figure 6). Referral sources vary greatly between the courts, indicating different systems and partnerships that have been established within the referral process.

Figure 6. Referral Source by Jurisdiction



As presented in Figure 7, the number of referrals from *defense* has increased by 162% since 2006 (179 vs. 468). Referrals from *service providers* also increased in 2008.

Figure 7. Number of Referrals From Sources



As expected, most jurisdictions sent referrals to their own jurisdiction. The total number of referrals from *defense* (94.1%) and *other* sources (79.5%) were sent to KC Municipal court system at a disproportionate rate compared to the other referral sources (see Table 2).

Table 2. Referral Source to Jurisdiction

	Drug Court	KC Mun	LS Mun	Other	Total
Drug Court	475 (98.8%)	6 (1.2%)	0 (0%)	0 (0%)	481
KC Mun	4 (0.9%)	443 (98.9%)	1 (0.2%)	0 (0%)	448
LS Mun	0 (0%)	1 (0.6%)	154 (99.4%)	0 (0%)	155
Defense	37 (3.1%)	1135 (94.1%)	32 (2.7%)	2 (0.2%)	1206
Service Provider	127 (46.5%)	140 (51.3%)	4 (1.5%)	2 (0.7%)	273
Prosecutor	6 (11.1%)	19 (35.2%)	21 (38.9%)	8 (14.8%)	54
Other	6 (4.1%)	116 (79.5%)	9 (6.2%)	15 (10.3%)	146

**Multiple Referrals:
Individuals**

Of the total 2,167 individuals referred to MHC, 427 (19.7%) were referred to MHC multiple times. Three individual were referred six times, 13 individuals were referred five times, 32 were referred four times, 123 referred three times and 427 individuals were referred two times.

Number of Referral

The increase in referrals appears to be the result of both an increase in new first-time referrals and an increase in the numbers of multiple/repeat referrals (see Table 3).

Table 3. Number of the Referral by Year

	1 st Referral	2 nd Referral	3 rd Referral	4 th Referral	5 th Referral	6 th Referral	Total
2002	164 (100.0%)	- -	- -	- -	- -	- -	164
2003	340 (93.4%)	21 (5.8%)	2 (0.5%)	1 (0.3%)	- -	- -	364
2004	351 (78.2%)	79 (17.6%)	16 (3.6%)	2 (0.4%)	1 (0.2%)	- -	449
2005	234 (78.5%)	50 (16.8%)	13 (4.4%)	1 (0.3%)	- -	- -	298
2006	239 (77.9%)	46 (15.0%)	15 (4.9%)	6 (2.0%)	- -	1 (0.3%)	307
2007	406 (77.3%)	80 (15.2%)	28 (5.3%)	8 (1.5%)	3 (0.6%)	- *	525
2008	433 (65.8%)	151 (23.0%)	49 (7.4%)	14 (2.1%)	9 (1.4%)	2 (0.3%)	658
Total	2167 (78.4%)	427 (15.4%)	123 (4.5%)	32 (1.2%)	13 (0.5%)	3 (0.1%)	2765

Disposition of Referrals

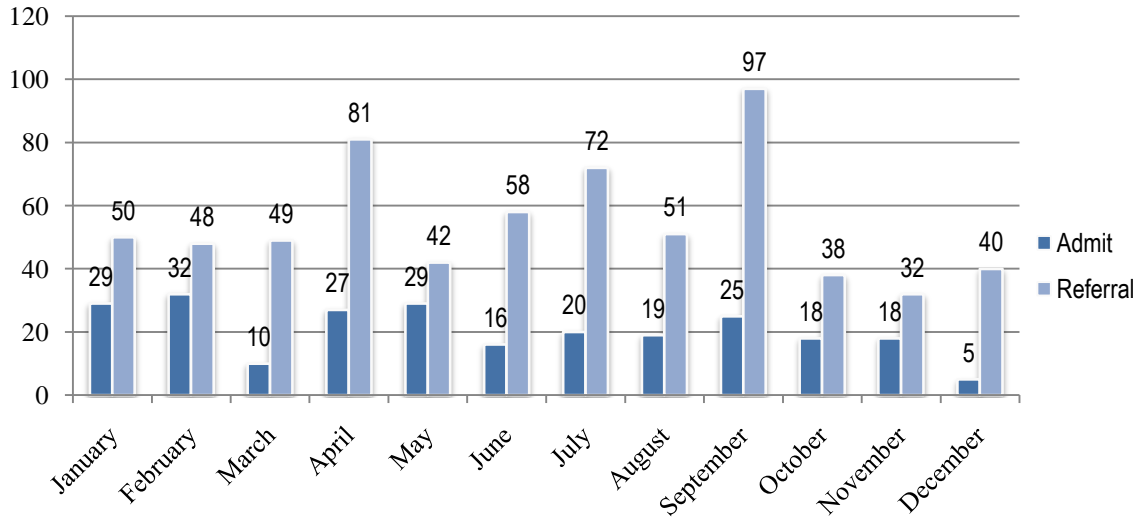
Those referred to MHC fall into three categories, *Admitted*, *Not Admitted*, or *Pending*. Percent of referrals admitted has fluctuated over the length of the program from a high in 2006 of 57.2% to a low in 2008 of 29.8%. However, there were 185 pending cases as of December 31, 2008 that may lead to admittance. Referral dispositions are outlined in Table 4.

Table 4. Disposition of Referrals at the End of the Calendar Year

	2002	2003	2004	2005	2006	2007	2008
Not Admitted	71 (43.3%)	170 (44.3%)	279 (62.1%)	168 (56.4%)	132 (42.9%)	290 (55.2%)	277 (42.1%)
Admitted	93 (44.5%)	194 (46.4%)	170 (37.9%)	130 (43.6%)	176 (57.2%)	235 (44.8%)	196 (29.8%)
Pending	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	185 (28.1%)
Total Referrals	164	364	449	298	308	525	658

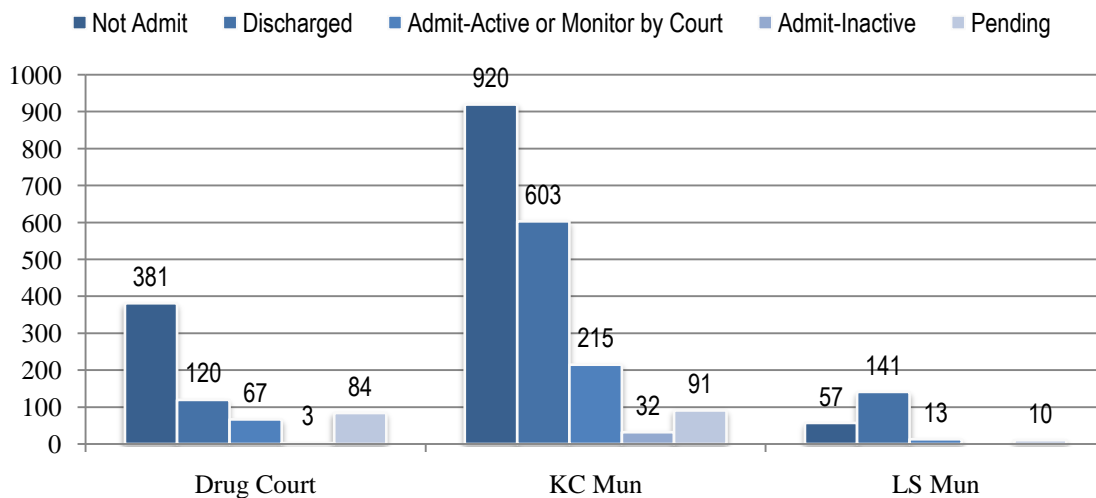
The number of referrals and admitted clients in 2008 is examined in Figure 8.

Figure 8. Referrals and Admits for 2008



At the end of 2008, KC Municipal reported the highest number of currently active, admitted clients (215), followed by Drug Court. Status results are examined in Figure 9.

Figure 9. Status by Jurisdiction



MHC ADMISSIONS

In order for a client to be admitted to the program, the client must first qualify for the program. Qualification into the program entails:

- A screening which determines whether the client has a serious persistent mental illness
- The client must agree to do an assessment
- The client must agree to MHC mandated conditions
- The client must agree to see his/her social worker
- The client must agree to a drug analysis
- The client must agree to see a psychiatrist who may prescribe medications based upon his/her condition, which the client must also agree to take as prescribed.

This section will examine demographics of clients admitted, trends of admission, referral sources of clients admitted, diagnoses of clients admitted, and current treatment for clients admitted.

Demographics

Race:

As presented in Figure 10, over half of the admitted clients were *Black/ African American* (52.9%; 632); while the remaining referrals were *White/ Caucasian* (43.9%; 524), *Hispanic* (1.4%; 17), or reported *Other* (1.8%; 21).

Figure 10. Race of Those Admitted

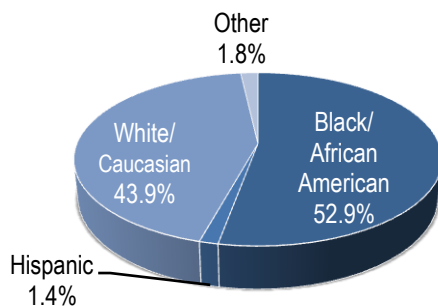
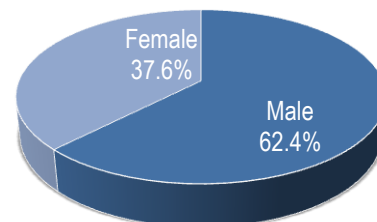


Figure 11. Sex



Sex:

In addition, the percentage of males (62.4%; 745) admitted was reflective of the distribution between male and female referrals (Figure 11).

Age:

The average age of the clients admitted to the program was 36 and the median age was 35 years old. The youngest referral was 13 and the oldest was 76 years old.

Admissions by Court

Of clients with an identified court, 70.9% were admitted to the Kansas City Municipal Court, 16.2% were in Drug Court, and 12.9% were in Lee's Summit Municipal Court.

Admissions through Time

There have been 1,194 admissions into the Mental Health Court program since April 2002, with an overall average of 169 admissions per year. The number of individuals who were admitted into the MHC program fluctuated substantially from month to month and year to year. In 2003 and 2008, the average number of admissions per month was 15; while, in 2004, 2005, and 2006, the average dropped slightly to 13 per month. In 2007, the MHC program had its highest rate with 17 new admissions per month. Presented in Table 5 is the rate of admission throughout program years.

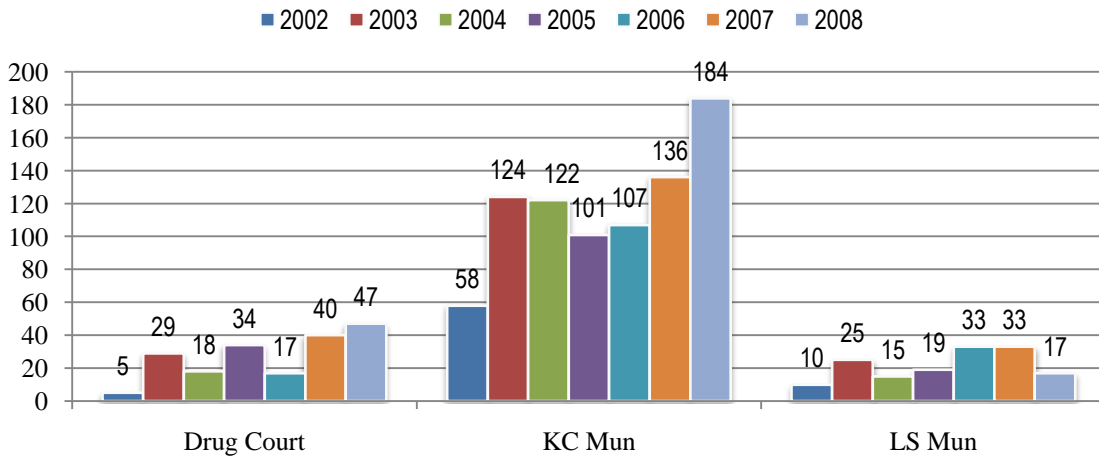
Table 5. Admission by Referral Year

Year	Admitted	Non-Admitted	Total
2002	93 (56.7%)	71 (43.3%)	164
2003	194 (53.3%)	170 (46.7%)	364
2004	170 (37.9%)	279 (62.1%)	449
2005	130 (43.6%)	168 (56.4%)	298
2006	176 (57.1%)	132 (43.8%)	308
2007	235 (44.8%)	290 (55.2%)	525
2008*	196 (29.8%)	277 (42.1%)	473
Total	1,194 (45.7%)	1,387 (54.3%)	2,581

*An additional 185 referrals (28.1%) are currently pending.

Through December 31, 2008, there have been 1,194 Mental Health Court admissions. Number of admits by year and jurisdiction is presented in Figure 12.

Figure 12. Admisssion by Jurisdiction and Year



Detailed in Table 6, are the number of admissions per month for the 2008 program year. These numbers are based on *admission date*, unlike the previous table that used the *referral date* to present the data.

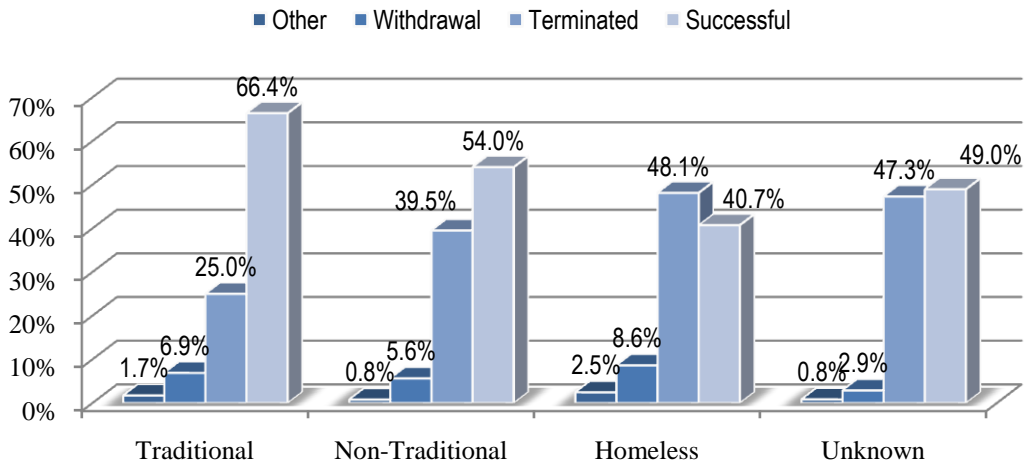
Table 6. Number of Admissions by Admission Date

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.
Referrals Admitted	29	32	10	27	29	16	20	19	25	18	18	5

Housing at Admission

Clients having *traditional housing* (66.4%) and *non-traditional housing* (54.0%) at admission reported higher rates of success as compared to *homeless* (40.7%) or *unknown* housing (49.0%). Figure 13 show disposition of the client with the housing condition at admission.

Figure 13. Disposition by % of Housing at Admission



Diagnostic Characteristics

High rates of admittance were seen for all diagnoses. However, *other* (dementia, alcohol/drug related disorder, or autism) reported 100% admittance, followed by *personality or character disorder* (90.0%) (Table 7).

Diagnosis of a disorder was determined by examining primary, secondary, and Axis II diagnosis. Many clients had more than one diagnosis, so totals do not equal 100%. All courts reported the highest incidence of diagnosis as a *mood disorder* (Bipolar or MDD), both in the previous year and since the beginning of the program. Other diagnosis with high rates in the past year included *substance abuse* and *co-occurring disorders*. The highest rate of *co-occurring disorders* in the past year was from Drug Court (44.8%), followed by KC Municipal (20.0%) and Lee’s Summit Municipal (16.7%). Diagnoses are outlined in Table 8.

Table 7. Diagnosis by Admission

	Admitted	Not Admitted	Pending
Schizophrenia	295 (85.3%)	49 (14.2%)	2 (0.6%)
Mood Disorder (Bipolar or MDD)	511 (88.6%)	57 (39.9%)	9 (1.6%)
Depression	39 (84.8%)	7 (15.2%)	0 (0%)
Other Psychosis	44 (83.0%)	8 (15.1%)	1 (1.9%)
Medical Psychosis	20 (87.0%)	3 (13.0%)	0 (0%)
Personality or Character Disorder	108 (90.0%)	11 (9.2%)	1 (0.8%)
Mental Retardation	31 (88.6%)	3 (8.6%)	1 (2.9%)
Substance Abuse	474 (87.6%)	55 (10.2%)	12 (2.2%)
Anxiety	70 (89.7%)	8 (10.3%)	0 (0%)
Other	11 (100%)	0 (0%)	0 (0%)
Co-Occurring	468 (89.5%)	44 (8.4%)	11 (2.1%)

Table 8. Diagnoses of Admitted Clients by Court

	KC Municipal		Drug Court		LS Municipal		All Courts	
	2008	Overall	2008	Overall	2008	Overall	2008	Overall
Schizophrenia	22 (15.7%)	259 (30.5%)	1 (3.4%)	19 (10.0%)	0 (0%)	17 (11.0%)	23 (12.7%)	295 (24.7%)
Mood Disorder (Bipolar or MDD)	43 (30.7%)	330 (38.8%)	15 (51.7%)	101 (53.2%)	4 (33.3%)	80 (51.9%)	62 (34.3%)	511 (42.8%)
Depression	4 (2.9%)	21 (2.5%)	0 (0%)	13 (6.8%)	0 (0%)	5 (3.2%)	4 (2.2%)	39 (3.3%)
Other Psychosis	1 (0.7%)	31 (3.6%)	1 (3.4%)	8 (4.2%)	0 (0%)	5 (3.2%)	2 (1.1%)	44 (3.7%)
Medical Psychosis	0 (0%)	16 (1.9%)	0 (0%)	0 (0%)	0 (0%)	4 (2.6%)	0 (0%)	20 (1.7%)
Personality or Character Disorder	6 (4.3%)	70 (8.2%)	1 (3.4%)	18 (9.5%)	0 (0%)	20 (13.0%)	7 (3.9%)	108 (9.0%)
Mental Retardation	1 (0.7%)	26 (3.1%)	0 (0%)	3 (1.6%)	0 (0%)	2 (1.3%)	1 (0.6%)	31 (2.6%)
Substance Abuse	28 (20.0%)	306 (36.0%)	13 (44.8%)	124 (65.3%)	2 (16.7%)	44 (28.6%)	43 (23.8%)	474 (39.7%)
Anxiety	8 (5.7%)	41 (4.8%)	2 (6.9%)	20 (10.5%)	0 (0%)	9 (5.8%)	10 (5.5%)	70 (5.9%)
Other (Dementia, Alcohol/Drug Related Disorder, Autism)	0 (0%)	7 (0.8%)	0 (0%)	4 (2.1%)	0 (0%)	0 (0%)	0 (0%)	11 (0.9%)
Co-occurring Substance Abuse and Mental Health	28 (20.0%)	302 (35.5%)	13 (44.8%)	123 (64.7%)	2 (16.7%)	43 (27.9%)	43 (23.8%)	468 (39.2%)

DISCHARGE

Discharge by Year:

At the end of 2008, there had been 863 MHC discharges. The number of discharges per year is presented in Table 9.

Table 9. Discharges by Year

Year	Discharges
2002	11
2003	111
2004	184
2005	172
2006	106
2007	145
2008	130
Missing	4
Total	863

Discharge by Month:

Discharges from 2008 are presented, by month, in Table 10.

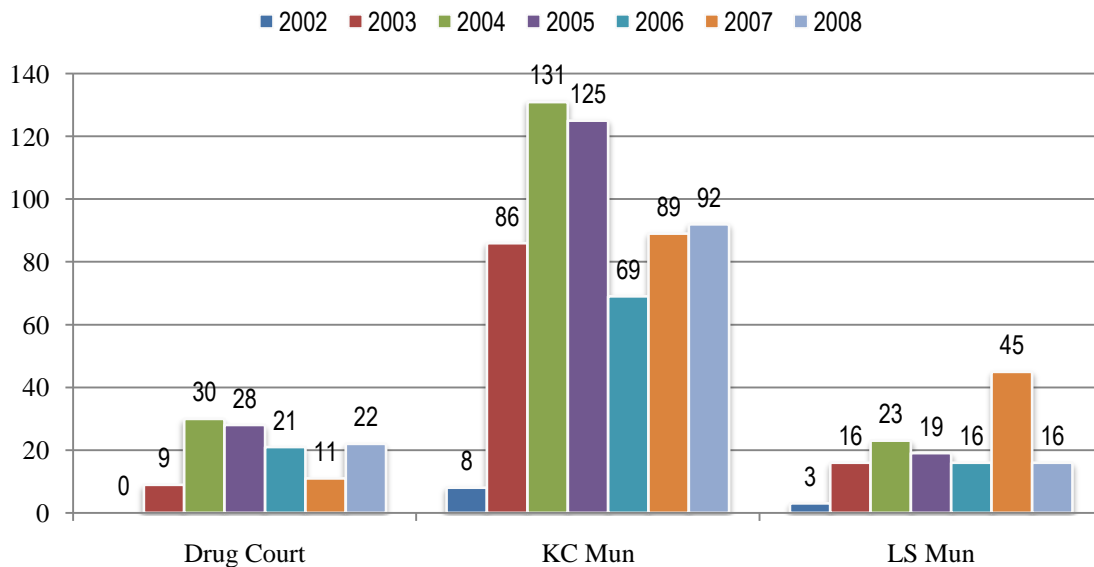
Table 10. 2008 Discharges by Month

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul	Aug.	Sept.	Oct.	Nov.	Dec.
Discharged	14	14	6	11	13	5	6	12	14	9	11	15

Discharge by Jurisdiction:

Illustrated in Figure 14 are the numbers of discharges for each jurisdiction by program year. Large fluctuations were found between the different years of the program. For both KC Municipal and Drug Court, 2004 resulted in the most discharges, while LS Municipal reported a large increase in discharges in 2007.

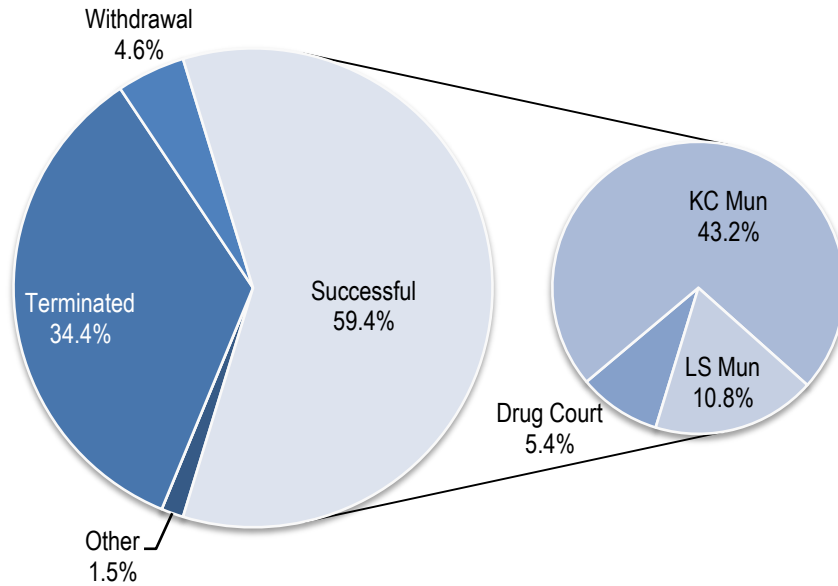
Figure 14. Discharge by Jurisdiction



Discharge Disposition

Four dispositions were possible for discharged clients, *Successful, Terminated, Withdrawal, or Other (Dismissed, Deceased)*. The majority of discharged clients were *successful* (59.4%). Discharge dispositions are presented in Figure 15.

Figure 15. Discharge Dispositions; Successful by Court



Presented in Figure 16 are discharge dispositions for the three jurisdictions. Figures 17, 18, and 19 examine the dispositions for each jurisdiction by program year.

Figure 16. Discharge Disposition by Court

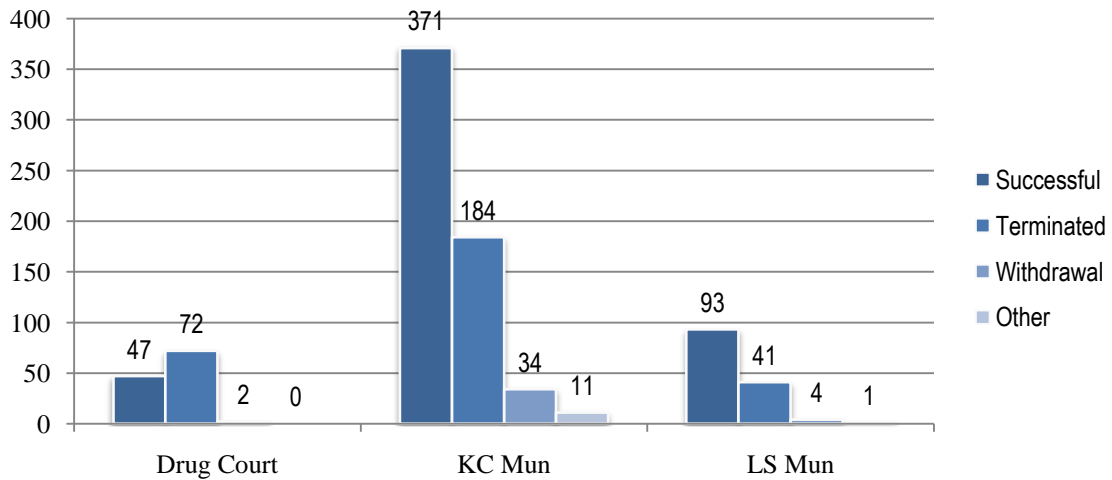


Figure 17. Drug Court Discharge Dispositions

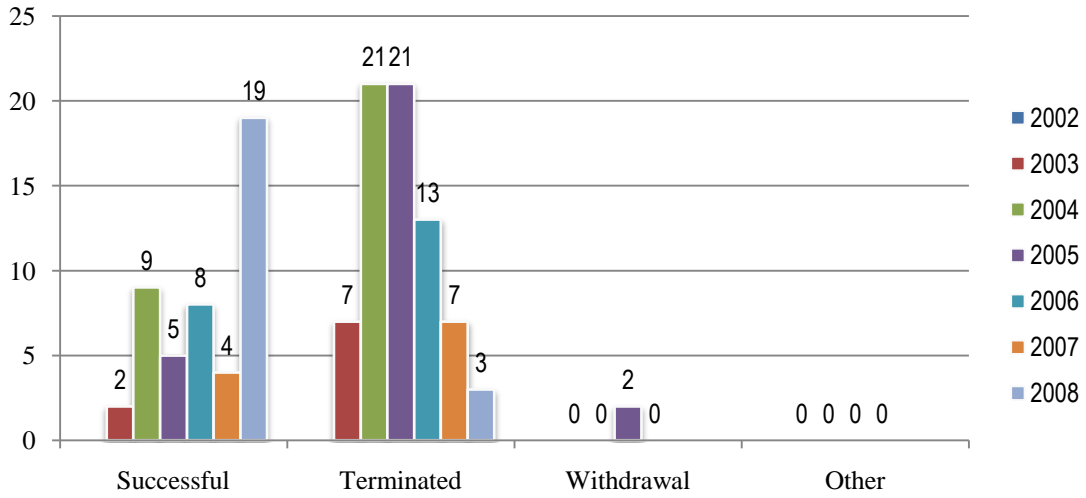


Figure 18. KC Municipal Discharge Dispositions

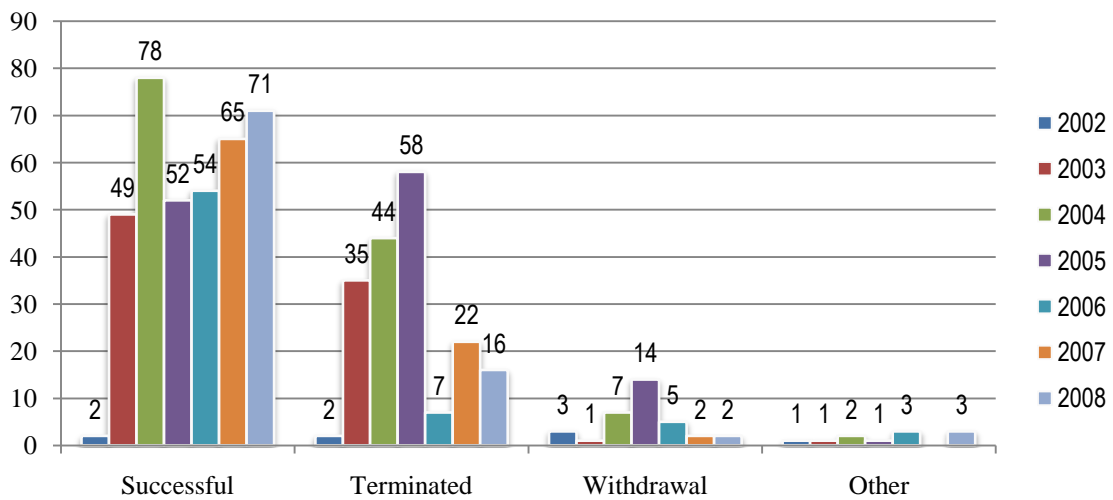
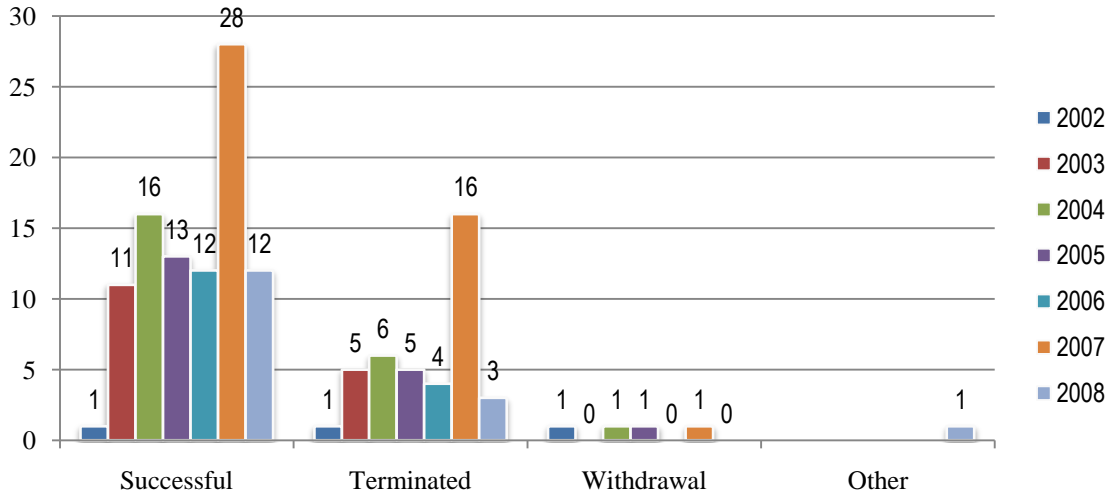


Figure 19. LS Municipal Discharge Dispositions



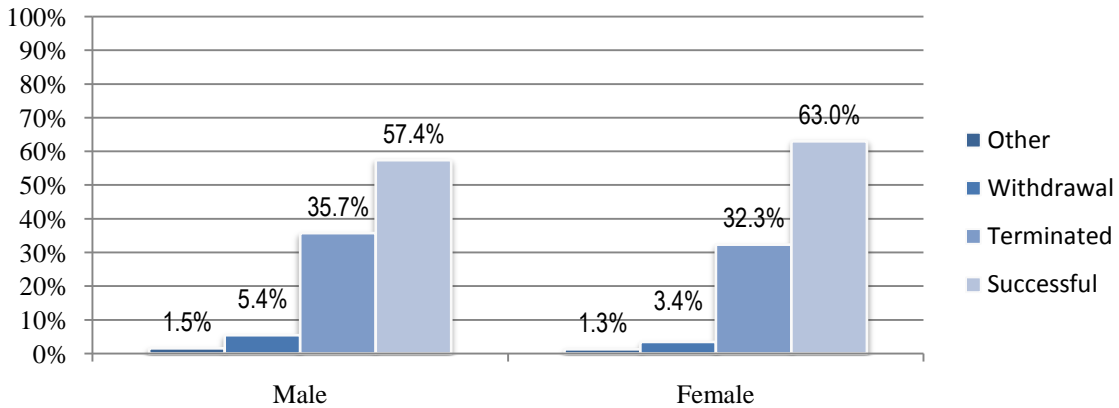
Discharge Disposition by Demographics:

Discharge dispositions by client demographics are presented in Figures 20, 21, and 22.

Sex

Female MHC clients reported a higher rate of success compared to *male* clients (63.0% vs. 57.4%).

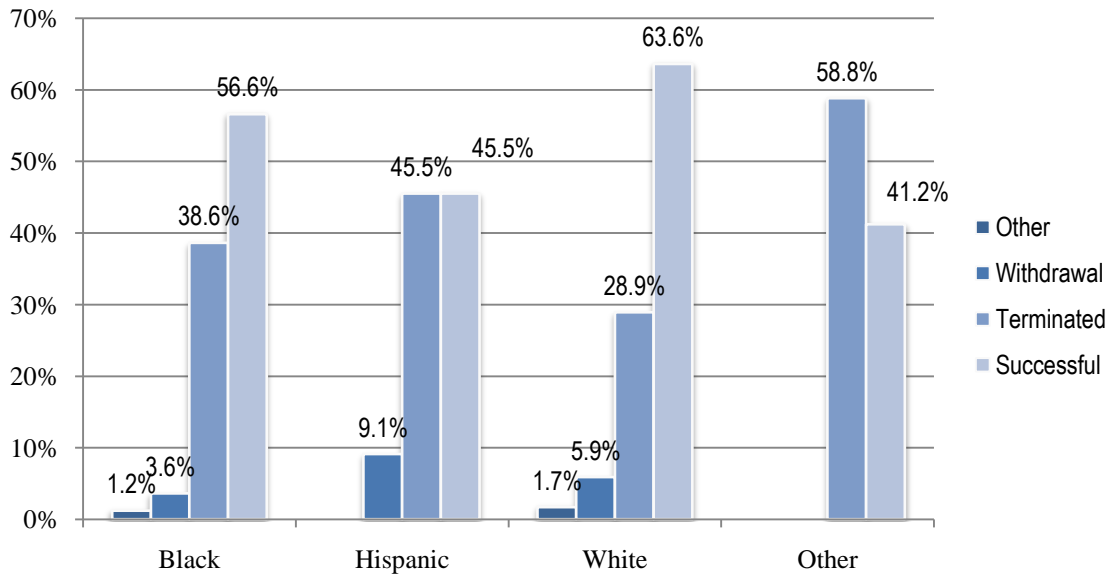
Figure 20. Disposition by Sex



Race

White MHC clients reported the highest rate of success (63.6%).

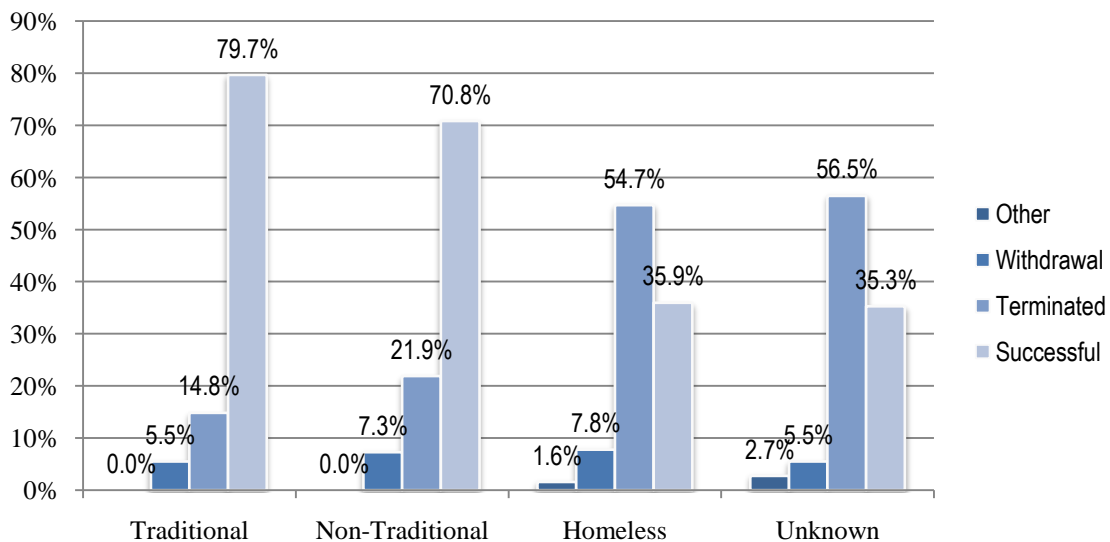
Figure 21. Disposition by Race



Housing

Clients reporting *traditional housing* at discharge also reported high rates of success (79.7%), compared to *non-traditional housing* (70.8%) and *homeless* (35.9%).

Figure 22. Disposition by Percentage of Housing at Discharge



Discharge Disposition by Diagnoses:

Presented in Figure 23, clients diagnosed with *mood disorder* have the highest number of *successful completion* (231), followed by *substance abuse* (189). While the numbers of successful discharges are presented below, the percentage of *successful completions* by diagnoses is outlined in Figure 24. Four of the diagnoses (*schizophrenia, medical psychosis, character diagnosis, and anxiety*) reported success rates over 60%.

Figure 23. Discharge Disposition by Diagnosis

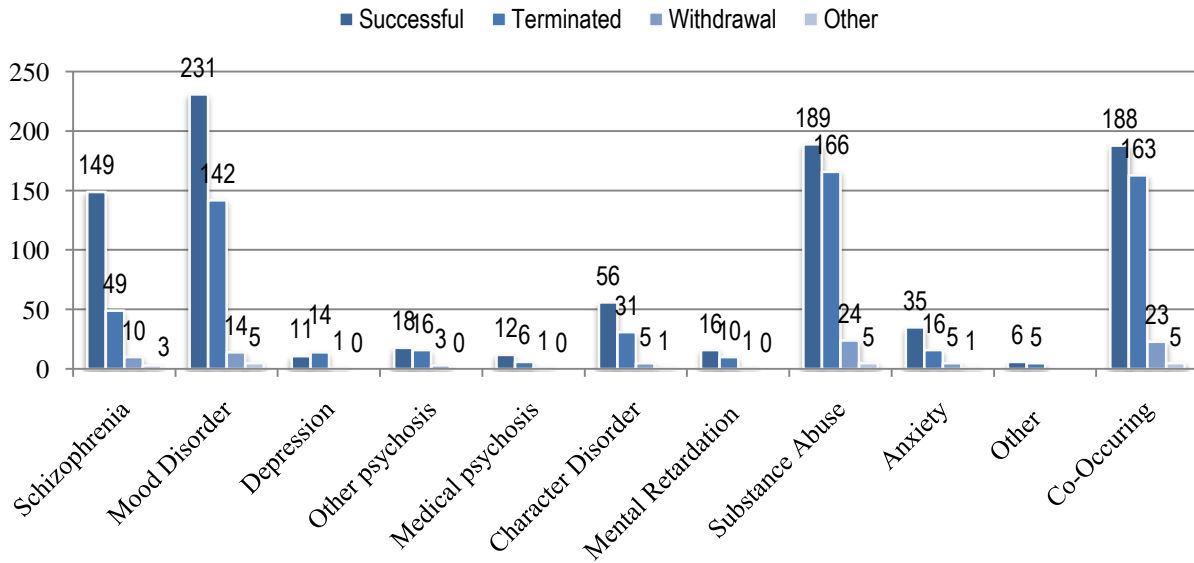
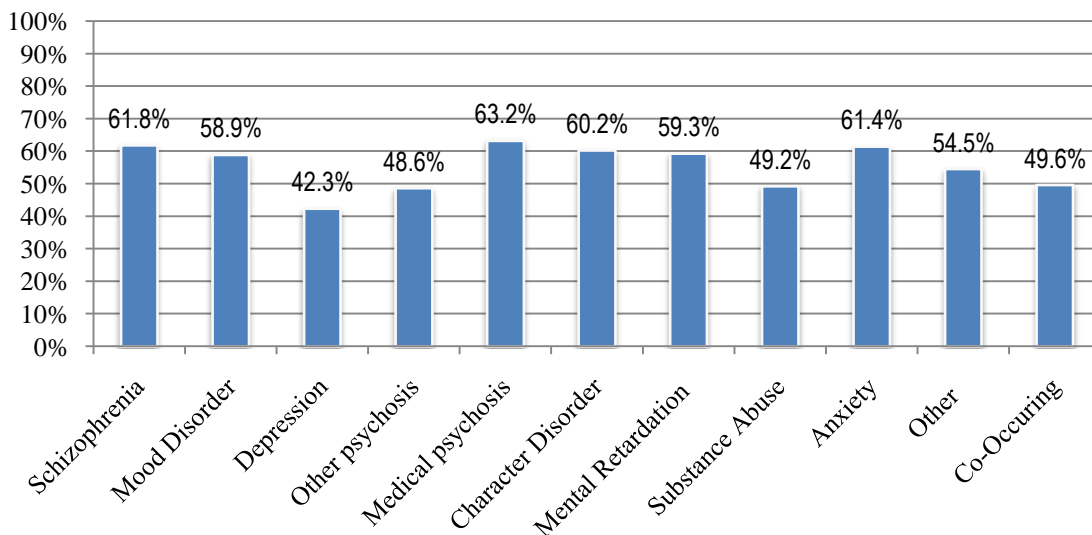
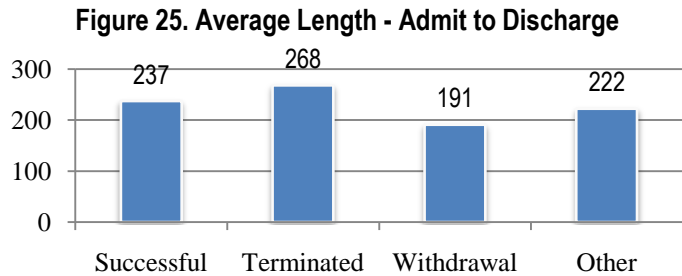


Figure 24. % Successful by Diagnosis



LENGTH OF TIME IN MHC

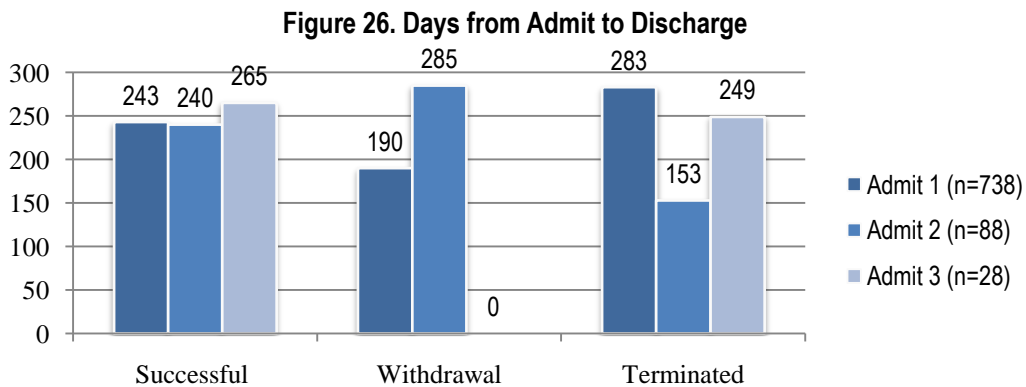
On average, clients spend 255 days from admission to discharge. Presented in Figure 25 are the average numbers of days from admission to discharge by discharge disposition. The average number of days spent in the program for successful clients was 237 days.



Days from Admit to Discharge

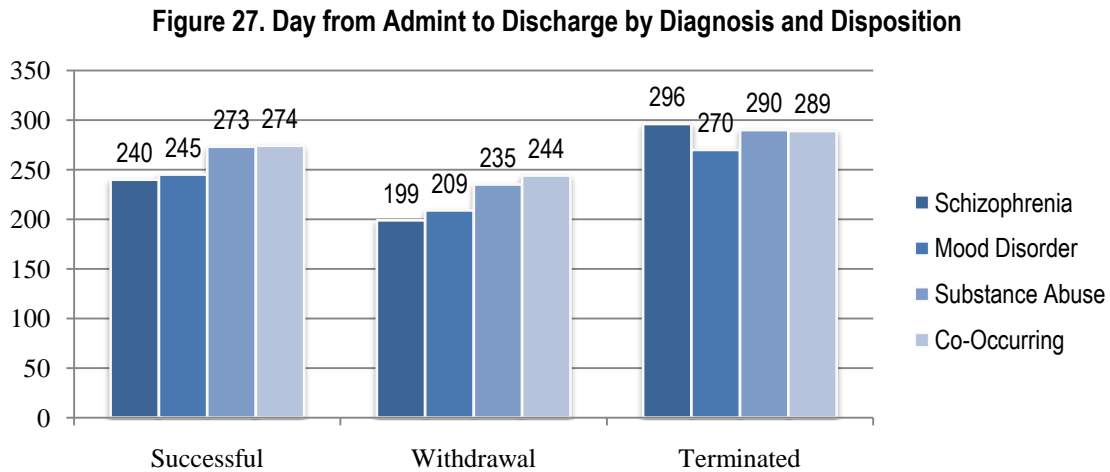
By Disposition by Number of Admits:

Days in Mental Health Court were similar for first and second admissions for successful clients (243 & 240 days); however, third admits reported a longer involvement with an average of 265 days. Clients who withdrew from the program reported a shorter length of involvement for the first admission compared to their second admission (190 days vs. 285 days). Days of involvement for terminated clients varied widely for the three admissions. This variation may be due to decreased leniency from first to second admission. Days from admit to discharge by disposition and number of admission is shown in Figure 26.



By Disposition and Diagnosis:

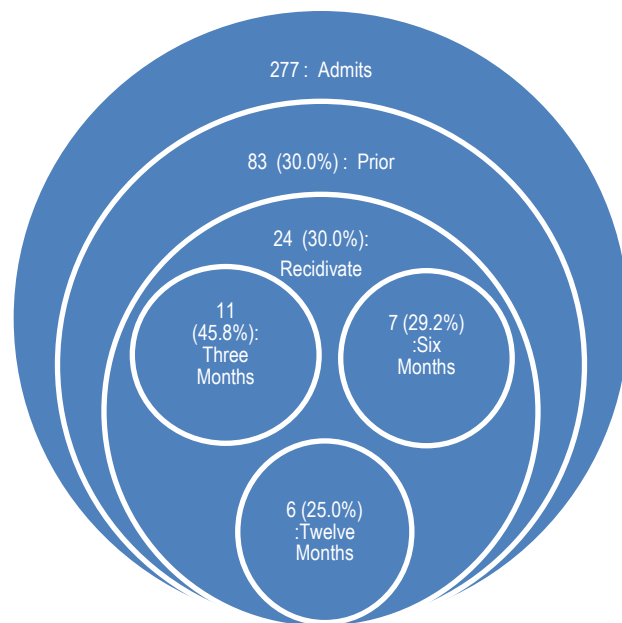
Average days from admission to discharge by success and diagnoses were also examined. In Figures 27, the results are examine for the four most common diagnoses, schizophrenia, mood disorder, substance abuse, and co-occurring.



RECIDIVISM

Recidivism is defined as a person with prior convictions, who after participating in the MHC program received another conviction. Of the 277 client discharge from the program in 2008, 83 (30%) of the clients had prior a conviction. Within that group 24 (30%) of the 83 discharged recidivated within one year, 11 (45.8% of the 24) of those within three month, 7 (29.2% of the 24) within six month and 6 (25.0% of the 24) within twelve month (Figure 29). When compared to the total number of clients discharged, the clients that had post-program convictions made up only **8.7%**.

Figure 28. Recidivism



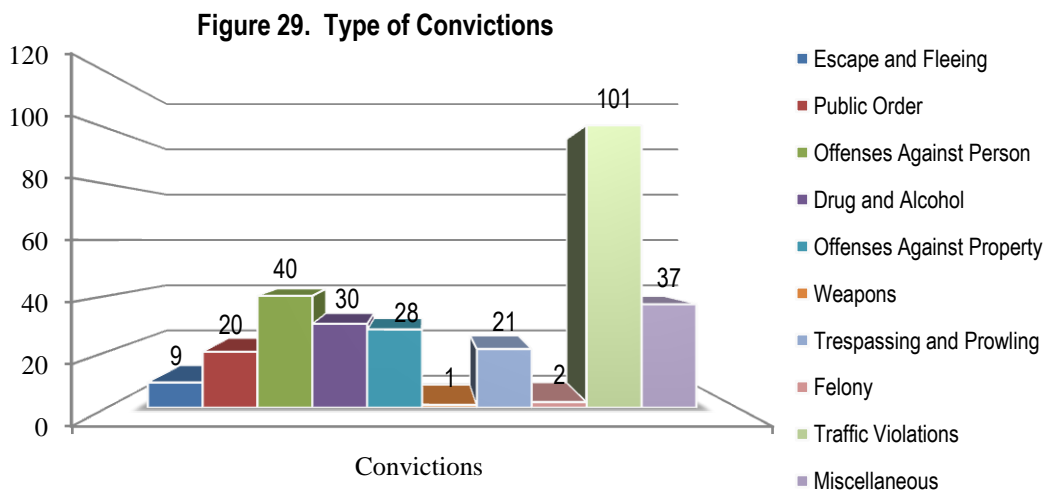
The number of convictions prior to, during, three month after, six month after and twelve months after the program are presented

in Table 11. The results reveal high numbers of prior convictions when entering the program. After entering the program the number of conviction dramatically drop during the program and three months after discharge. There is an increase in the number of conviction at six months then it reduces again at twelve months after being discharged from the program. Results indicated that the total number of convictions at one year after program discharge was far less then the total number of conviction one year prior to the program. There is a reduction of 69% in convictions from prior to the program to being discharged from the program.

Table 11. Number of Conviction by Time Period

Number of Convictions for the Time Period	Number of Clients: Prior to Admission	Number of Clients: During the Months of Admission	Number of Clients: Three Months after Discharge	Number of Clients: Six Months after Discharge	Number of Clients: Twelve Months after Discharge
1	37	18	11	13	10
2	36	22	2	8	
3	42	12	3	3	
4	40	4		4	
5	10	5			
6	6				
7	7				
Total	178	61	16	28	10

Presented in Figure 29 are the types of convictions reported. These results include all convictions from one year prior to program admission to one year after discharge. *Traffic* was the most common conviction (101). Further explanation regarding the breakdown of the conviction types is provided in Appendix B.



CONCLUSIONS

Overall outcomes indicate that the MHC program continues to successfully divert persons with mental illness, who have been arrested for city ordinance violations (or low class felonies for Drug Court), from incarceration to mental health treatment.

The total number of referrals made to the Mental Health Court program has dramatically increased since inception in 2002. Since as recently as 2006, Mental Health Court has witnessed a 114% increase in referrals (308 vs. 658).

Nearly half (46.8%) of those referred are admitted to the program. Over half of the clients admitted to the MHC program were *Black/ African American* (52.9%; 632); while the remaining referrals were *White/ Caucasian* (43.9%; 524), *Hispanic* (1.4%; 17), or reported *Other* (1.8%; 21). The percentage of males (62.4%; 745) admitted was reflective of the distribution between male and female referrals (63.4% male). The average age at admission was 36 years old.

Once in the program, clients reports satisfaction with their treatment in court and with their mental health care. Of those admitted, 43% have successfully completed the program, 4.4% have withdrawn, 24.9% have been terminated and 27.6% remain in the program. The post-program conviction rate for all discharged clients, regardless of previous convictions was only 8.7%.

Respondents to stakeholder interviews expressed concern that the MHC did not have the resources to add new consumers. Nearly three fourths (73%) of the respondents indicated that the current MHC system is over operating capacity and cannot maintain current client levels. In response to such concerns, and through collaborative efforts among MHC partners, various changes were implemented in relation to the processes of the MHC system. These process changes included: docket schedules, staffing schedules, pre-screening processes, communication, and requirements of individual MHC staff's duties. The initial response of MHC stakeholders to these changes has been positive.

APPENDIX A. Mental Health Court Capacity Interview Questions

Has the system hit capacity for current resources?

Do you believe the current MHC system:

- Has enough resources to take on more clients
- Is at full capacity.
- Is over operating capacity and cannot maintain current client levels

What information leads you this response?

Do you believe resources are being used as effectively as possible to operate the MHC system?

- Yes
- No

If no, how do you think resources could be utilized more effectively?

What additional resources would be most effective to maintain and build the MHC?

Have individual elements hit capacity and therefore are restricting the rest of the system?

Has your program/agency established a maximum number of clients that can be maintained over a given period of time?

- Yes
- No

If yes, what is the number and how was this number established?

Has there been a conversation with MHC partners regarding disparities in the capacity of programs and how to adjust or compensate for those disparities?

- Yes
- No

If yes, please describe:

In the last year, have you experienced any changes in the way your program/agency works with partners in the MHC system?

- Yes
- No

What do you think caused the change?

In the last year, have you changed the way you work with the other partners in the MHC system?

- Yes
- No

What do you think caused the change?

If capacity has been met by all or some of the system elements, is it due to increase in demand, shrinking resources, or both?

Describe any changes in the last year, in funding, staffing, or other resources, and the impact of those changes.

Has the last year been typical in regards to demands on your program, or has the impact of MHC changed in some way?

APPENDIX B. Conviction Definitions

- **Escape and fleeing** includes any conviction involving, but not limited to, hindering a police officer, escaping, fleeing a crime scene and resisting an officer.
- **Public order** includes any conviction involving, but not limited to, disturbing the peace, disturbing public order, noise violations, and prostitution.
- **Offenses against person** include any conviction involving, but not limited to, assault and battery, child abuse, and endangering a minor.
- **Drug and Alcohol** include any conviction involving, but not limited to the possession of paraphernalia or illegal substance, drunk in public, minor in possession, and driving under the influence.
- **Offenses against property** include any conviction involving but not limited to larceny, vandalism, littering, burglary or destruction of property.
- **Weapons** include any conviction specifically stating a weapon in use, such as possession of a weapon, concealed weapon or unlawfully use of a weapon.
- **Trespassing and prowling** includes any conviction involving but not limited to trespassing, prowling, loitering and vagrancy.
- **Felony** includes any conviction involving higher count felonies such as murder, rape, or indecencies with a minor and assaulting an officer.
- **Traffic Violations** includes any conviction involving traffic or automobiles related violations, not including driving under the influences.
- **Miscellaneous** includes any conviction involving but not limited to housing issues and technical violations such as warrants, parole and probation violations.