



# **Outcomes from the Last Frontier:**

**An Evaluation of the Anchorage Mental Health Court**  
*Anchorage Coordinated Resources Project*

*Funded by*  
**The Alaska Mental Health Trust Authority**

*Produced for*  
**The Alaska Court System**

*Produced by*  
**Hornby Zeller Associates, Inc.**

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# Table of Contents

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|  |    |
|--|----|
| Executive Summary .....                              | i  |
| Background and Context .....                         | 1  |
| Research Design and Methods.....                     | 5  |
| Analyzing ACRP System Processes .....                | 7  |
| Role of Judges.....                                  | 7  |
| Role of Case Coordinators.....                       | 8  |
| Role of Project Management Staff.....                | 8  |
| Catchment Area .....                                 | 8  |
| Eligibility Requirements and Target Population.....  | 9  |
| Referrals .....                                      | 12 |
| System Flow .....                                    | 14 |
| Status Hearings .....                                | 16 |
| Sanctions and Incentives .....                       | 18 |
| Cross-Systems Integration.....                       | 18 |
| Criminal Recidivism Outcomes .....                   | 21 |
| ACRP Demographic Characteristics .....               | 21 |
| ACRP Clinical Characteristics.....                   | 23 |
| Comparing Recidivism Outcomes .....                  | 24 |
| Costs Associated with New Criminal Conduct.....      | 27 |
| Survival Analysis .....                              | 29 |
| Clinical Recidivism Outcomes .....                   | 33 |
| ACRP Perspectives – Participant’s Point of View..... | 37 |
| Judges .....   | 39 |
| Case Coordinators .....                              | 40 |
| Defense Attorneys.....                               | 41 |
| Prosecutors.....                                     | 41 |
| ACRP Program Improvements .....                      | 42 |
| Quality of Life Outcomes .....                       | 43 |
| Mental and Physical Health.....                      | 43 |
| Safety and Support .....                             | 44 |
| Alcohol and Drug Use.....                            | 45 |
| Criminal and Clinical Outcomes.....                  | 46 |
| Summary of Key Findings.....                         | 49 |
| Recommendations .....                                | 51 |
| References .....                                     | 55 |
| Appendices .....                                     | 59 |



## Executive Summary

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It is well documented that people with mental illness and cognitive impairments are over-represented in the criminal justice system compared to their prevalence in society. Over the last thirty years, there have been widespread efforts aimed at diverting this population from incarceration into community-based mental health services, with some diversionary efforts showing promise and others not. Among the most recent innovations are mental health courts, spearheaded by such programs as the Anchorage Coordinated Resources Project (ACRP), in operation since 1998 and one of the first mental health courts established in the United States.

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

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

Nationally, studies on mental health courts have consistently shown that they can successfully divert defendants from jail into treatment. They help to provide more treatment and faster linkages into treatment than traditional avenues afforded those experiencing mental illness in the criminal justice system. However, we also know that mental health courts have little control over the type and quality of services available in the respective communities they serve. While mental health courts act as a fulcrum for leveraging available resources, their outcomes are largely dependent on the type, quantity and quality of services available in the community that they are able to divert defendants to.

Notwithstanding, the growth and expansion of mental health court programs has spawned a great deal of interest among policy makers and community stakeholders. With limited resources, policy-makers are interested in whether mental health court programs “work” and researchers have been pressed to identify the relative merits of these programs. Today, the broader and sustained impact of these programs on the criminal justice system and on the individuals participating in these programs is just starting to be explored. Do mental health courts help reduce crime? What is the impact of mental health courts on the quality of life of those who participate? Are mental health courts cost-effective? To answer these questions, the Alaska Mental Health Trust Authority (AMHTA) in conjunction with the Alaska Court System commissioned a study to provide an in-depth analysis of the ACRP – the Anchorage Mental Health Court – on a wide variety of individual and system-level outcomes.

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

Results of the study provide the State of Alaska with a unique opportunity to explore the impact of a major collaborative effort aimed at diverting people experiencing mental illness (Beneficiaries of the AMHTA<sup>1,2</sup>) who are caught in the revolving door of the mental health and criminal justice systems. The study also provides an important look into the operations of the ACRP and endeavors to make an important contribution to the modest, but growing body of literature on what we know and what we do not know about mental health court programs nationally.

Major findings presented throughout the report reveal that the program is generating many positive outcomes for the State of Alaska and Beneficiaries of the AMHTA. The ACRP has demonstrated marked reductions in criminal recidivism of its mentally ill participants, showed modest improvements along clinical outcome measures and can be more cost-effective with expanded capacity.

The following provides a summary of highlights presented throughout the report:

- The combined institutional savings generated by the ACRP (\$705,390) is estimated to be almost two and one-half times the annual operational costs of the program (\$293,000).
- Diverting Trust Beneficiaries with severe mental illness from incarceration into the ACRP poses less of a risk to public safety than traditional adjudication.
- Over the past five years (SFY 2002-2007), the number of referrals to the ACRP has been on the rise ranging from a low of 224 referrals in 2002 to a high of 307 referrals in 2007.
- The average daily cost to operate the ACRP is estimated at \$19.82 per person which is substantially less than the average daily cost of incarceration (\$121.60).
- ACRP participants were less likely to engage in new criminal conduct after exiting the program than an equivalent group of people experiencing mental illness also involved in the criminal justice system. ACRP graduates were least likely to re-offend overall.
- Among those who did engage in new criminal conduct, ACRP participants were less likely than an equivalent group to commit new felonies, violent or drug related crimes.
- Fewer incarcerations, psychiatric hospital visits and reductions in the length of stay between both institutional settings generated a net savings for the ACRP both over time as well as against a comparison group (\$97,685).
- Prior involvement in alcohol or drug treatment and individuals with personality disorders increase the likelihood that future criminal recidivism will occur.
- The vast majority of former ACRP participants self-reported improvements along all quality of life domains as a result of their participation in the program.

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

<sup>2</sup>As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). See Appendix B for the list of multi-axial classifications.

- There is a significantly higher rate of program completion for participants in the ACRP Jail Alternative Services (JAS) Program track compared to participants in the Alaska Alcohol Safety Action Program track (ASAP). There were no differences, however, between participants in either track in the overall rate of post-discharge criminal recidivism.
- There is an indication of a net ACRP effect; that is, some level of intervention through the ACRP tended to decrease recidivism compared to those who received no intervention at all.

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

**Recommendation 1: Increase access to community treatment services and resources for those with co-occurring mental health and substance-related disorders.**

The ACRP is returning to regular court a high volume of participants with co-occurring mental health and substance-related disorders whose needs typically exceed the available services offered in the Anchorage community. Analysis of administrative data and interviews with key stakeholders revealed a general lack of community-based mental health and, in particular, substance abuse treatment services for the growing number of Trust Beneficiaries seeking services through participation in the ACRP. For example, of the 401 people with co-occurring mental health and substance-related disorders who were referred to the ACRP, fewer than one out of five could be successfully enrolled in and graduated from the program. This clearly suggests that there is a high volume of people with co-occurring disorders cycling through the District Court who are not being reached.

Indeed, this will be a particularly daunting task given that funding for needed mental health and substance abuse services is in a perpetual state of flux. For the past several years the State of Alaska has experienced not only funding cuts, but also workforce shortage issues. Even when funding is available, the workforce may not be available to provide needed services. In recent months Anchorage has experienced the closure of a detoxification facility, the loss of several co-occurring treatment beds and is facing the inevitable relocation of the region's primary residential substance abuse treatment facility. Additionally, the largest community mental health center in Anchorage has temporarily shut its front door, even to priority populations (e.g., criminal justice involved Trust Beneficiaries) due to resource limitations and funding shortfalls. Given that approximately three-quarters of all ACRP participants receive services from that single service provider, the ACRP's capacity to serve future participants may be significantly diminished if treatment alternatives are not identified. If the ACRP is to continue to provide favorable criminal justice and behavioral health outcomes, the behavioral health system must be capable of providing participants with immediate access to a range of services. Alternatively, the program will need to secure funding for dedicated treatment slots, which has not been necessary to date.

**Recommendation 2: Dependent upon assured access to appropriate community behavioral health services, implement a therapeutic court for Trust Beneficiaries charged with felony crimes.**

ACRP project management staff maintains a confidential list of past ACRP referrals and former participants. Each day, this list is compared against the daily in and out of custody arraignment calendars in order to flag defendants who may be eligible for participation in the ACRP. Overall, only one percent of all defendants arraigned are flagged by ACRP staff, and two out of five of those flagged were deemed ineligible because the defendant either had a pending felony or was on felony probation. The high volume of arraignments and the disproportionate prevalence of mental illness among those defendants arraigned, combined with the overwhelming support among key actors interviewed in this study supports the view

that a mental health court should be introduced to hear felony cases for Trust Beneficiaries in the Anchorage Superior Court.

**Recommendation 3: Expand the number of ACRP case coordinators and the overall operational capacity of the ACRP.**

Among former ACRP participants interviewed, the single most common criticism of ACRP case coordinators was their general lack of availability due to the size of their respective caseloads. Interviews conducted with key stakeholders and observations of ACRP operations supported this criticism as well. The current caseload of forty participants per coordinator is an ambitious number to provide the level of monitoring and support needed for the intended target population of the ACRP. Given that both case coordinators have caseloads that are either at or exceeding capacity, it would behoove the ACRP to consider hiring an additional case coordinator who could reduce current caseloads while at the same time generating more positive outcomes for an even greater number of people in need of ACRP services.

**Recommendation 4: Revise admissions-related procedures to reduce the time it takes to formally opt into the ACRP.**

The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. The reason for this principle is simple – it is well known throughout the literature that the sooner an individual, particularly one motivated by criminal justice involvement, is placed into treatment, the better his or her short and long-term outcomes will be in the future. The amount of time between the Initial Opt-In Hearing and Formal Opt-In Hearing where a formal intervention and treatment are adopted averages 74 days. Although service plans are developed and service linkages are initiated during this interim period, the ACRP should consider establishing earlier benchmarks (with which all parties can agree) and try to work within these parameters and shorten the time it takes participants to be formally accepted into the program.

**Recommendation 5: Revise existing methods by which ACRP referrals and participant updates are reviewed by members of the ACRP team.**

Interviews with ACRP team members and observations of ACRP operations revealed inefficiencies in the method by which participant updates were disseminated to team members as well as discontent among some team members about admissions related procedures. The entire ACRP team should consider convening to discuss ACRP policies and procedures surrounding programmatic admissions, hold more frequent pre-court meetings (including representatives from the treatment community) to discuss sanctions, and streamline the manner in which participant updates are shared so that information is consistently presented about each case as it relates to all major life domains of the individual (i.e., employing a consistent approach that embraces the emotional, physical, social, cognitive and material aspects of well-being).

**Recommendation 6: Develop a more formalized system of graduated sanctions and incentives and increase funding to expand the range of incentives available for ACRP participants.**

A graduated system of sanctions and incentives is one of the key ingredients in the *Essential Elements* of effective mental health court programming. Incentives promote adherence with program expectations, can increase program retention and helps motivate individuals to engage in more healthy and socially appropriate behaviors. On the other hand, sanctions are sometimes necessary in cases of non-adherence, but the vast majority of circumstances dictate that a first response should be to review treatment plans, including medications, living situations, and other service needs. As a general rule of thumb, when violations increase in either frequency or severity, mental health courts should use graduated sanctions

that are individualized to maximize adherence to the participant's conditions of release and develop specific protocols to govern the use of jail as a sanction.

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

**Recommendation 7: Provide more resources for the collection and entry of data for all therapeutic courts in Alaska.**

For many years, the ACRP has been using a database modeled after a shareware system developed in the mid-to-late 1990s which was designed to collect basic information for adult drug court participants. The ACRP database contained few variables for tracking purposes. Many data elements necessary to meet the evaluative needs of a mental health court were missing. The database was also designed to be docket-driven as opposed to person-driven requiring significant duplication of effort in data entry. As a result, ACRP project management staff keeps separate spreadsheets from which they generate tallies for basic reporting requirements, representing yet another duplication of effort.

Unfortunately, this is a common problem among therapeutic court programs nationally as well as with Alaska's other therapeutic courts. The Alaska Court System should consider investing in a new management information system for all therapeutic court programs as there are many elements common across programs. Such a system would streamline therapeutic court operations, reduce duplicative efforts and allow for more systematized data collection and reporting mechanisms that would benefit all therapeutic court programs the Alaska Court System supports.

**Recommendation 8: Consider implementing the recommendations put forth by former participants of the program.**

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

- 1) Increase activities for participants and make sure they keep as active as possible;
- 2) Create a peer/mentor group of past participants to provide support and information about resources or contacts;
- 3) Either add more case coordinators or decrease their caseloads as it is difficult to contact them outside of assigned appointments;
- 4) Increase monitoring and consequences for participants not in adherence with the program;
- 5) Enforce random drug testing for those with co-occurring disorders; and,
- 6) Pay more attention to the underlying circumstances surrounding the offense and remind participants of these at regular status hearings.



## Background and Context

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Major findings from a recent study indicate that approximately 42 percent of all inmates in custody of the Alaska Department of Corrections are people with mental disabilities, or beneficiaries of the Alaska Mental Health Trust Authority (AMHTA)<sup>3</sup>. Among those identified, findings suggest that Trust Beneficiaries spend significantly more time in custody than other inmates, are more likely to recidivate, recidivate sooner, and many are not reconnected with community-based mental health service providers upon release (Ferguson, Hornby & Zeller, 2007).

In response to the escalating number and overrepresentation of people in the criminal justice system who experience mental illness, the concept of establishing specialized mental health courts emerged in the late 1990s as a means to divert non-violent mentally ill defendants from incarceration into a regimen of court-supervised, community-based treatment and social services. Today, there are 184 mental health courts in operation across the United States (Raines & Laws, 2008) pioneered by such programs as the Anchorage Coordinated Resources Project which was one of the first operational mental health court programs in the United States.

The recent growth and expansion of mental health courts largely grew out of the success and popularity of their drug court counterparts, which expanded considerably throughout the United States during the 1990s. With the national boom of drug court programs, it was only a matter of time before these courts would have to grapple with the special needs presented by individuals who also experience mental illness. Drug court judges found these participants much harder to place into treatment (Denckla & Berman, 2001), many programs intentionally screened out this population entirely from the admissions process, and many drug court participants with co-occurring disorders were expelled from these programs because of use of psychotropic medications (Peters & Osher, 2004).

For these and other reasons, the drug court concept soon was applied to a variety of sub-populations including offenders with multiple and diverse needs. Today, there are more than 2,600 therapeutic treatment courts in operation across the country including juvenile drug courts, family drug courts, domestic violence courts and mental health courts, to name but a few. Consistent with national trends, the State of Alaska has implemented a variety of therapeutic court programs numbering 14 at present, of which two (located in Anchorage and Palmer) are dedicated to exclusively serving adult populations who are Beneficiaries of the AMHTA.

An important rationale for the emergence of mental health courts is the demonstrated success of other specialized court programs in reducing recidivism against the backdrop of historical problems experienced by law enforcement and corrections officials managing individuals who experience mental illness. Other factors necessitating the need for a fresh approach include deinstitutionalization<sup>4</sup>, jail overcrowding and the emerging philosophy of the courts emphasizing therapeutic jurisprudential goals<sup>5</sup> over conventional practices involving draconian criminal justice case processing.

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

<sup>4</sup> Deinstitutionalization refers to the replacement of psychiatric hospitals with smaller, less isolated community-based alternatives for the care of people who experience severe mental illness (Bachrach, 1996).

<sup>5</sup> The term therapeutic justice has been defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects." Today, more and more laws and legal processes are beginning to be employed specifically for what are perceived as therapeutic purposes (Carns, Hotchkin & Andrews, 2002).

The impetus for the development of the Anchorage Coordinated Resources Project (ACRP) began in 1998 when the Alaska Department of Corrections (ADOC) received funding from the AMHTA to develop a pilot program (Jail Alternative Services, or “JAS”). The JAS program provides community-based mental health services placement for misdemeanor inmates housed in the ADOC. About the same time, the Criminal Justice Assessment Commission, spearheaded by the Honorable Stephanie Rhoades, was working to develop what is known today as the Anchorage Coordinated Resources Project (ACRP), a court-based program designed to identify Trust Beneficiaries charged with misdemeanor crimes who could be diverted into community-based mental health treatment. In conjunction with funding for JAS, the AMHTA provided additional funds to support this new court project and in July 1998, the ACRP was born. The mission of the ACRP is to:

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

Nationally, studies on mental health courts have consistently shown that they can successfully divert defendants from jail into treatment, provide more treatment, better treatment and faster linkages into treatment than traditional avenues afforded those experiencing mental illness in the criminal justice system. However, definitive outcomes of mental health courts programs are just emerging and remain relatively few and far between.

Generally, most studies are encouraging, showing positive results in some areas and mixed results in others. For example, several studies show that mental health courts have demonstrated reductions in criminal justice system involvement (Moore & Hiday, 2006; Herinckx, Swart, Ama & Knutson, 2003; Trupin, Richards, Lucenko & Wood, n.d.), whereas other studies show mixed results when examining clinical outcomes and quality-of-life measures (Boothroyd, Mercado, Poythress, Christy & Petrila, 2005; Cosden, Merith, Jeffrey Ellens, Jeffrey Schnell & Yasmeen Yamini-Diouf, 2004). In terms of cost-effectiveness, one major study conducted by RAND suggests that over the long term the mental health court should generate net institutional savings, to the extent that participation in mental health court is associated with reduced recidivism. They also concluded as in other studies that diverting people with severe mental illness from incarceration into the mental health court poses no additional risk to public safety (Ridgely, Greenberg & DeMartini, 2007).

The ACRP has also been the subject of descriptive studies (Goldkamp & Irons-Guynn, 2000) as well as studies relating to outcomes (Carns, McKelvie, Scott & Grabowski, 2003). This latter study, involving a pre-post study design, showed mental health court participants improving across all major criminal and clinical domains (i.e., fewer arrests, incarcerations and psychiatric hospitalizations before and after participation in the ACRP.).

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

- What are the clinical and demographic characteristics of the ACRP population being served? Is the ACRP successfully meeting its target population?
- Why do some individuals elect to participate in the ACRP and others not? Among those who do elect to participate why do some of them opt-out?

- How much time elapses between key decision points in the ACRP admissions process (e.g., length of time between initial referral and final admission)?
- What are the characteristics of those that complete versus those who do not complete the ACRP? Are there major differences between both groups?
- What impact does exposure to the ACRP program have in changing the drug and/or alcohol use among participants with co-occurring disorders?
- What are the experiences of key actors and former participants involved in the ACRP? What are their thoughts and opinions about the program?
- What was the impact of the ACRP on the quality of life of former participants?
- What are the clinical and criminal recidivism outcomes of ACRP participants compared to an equivalent group of people not involved with the program?
- Is the ACRP cost-effective? What are the costs and savings of the ACRP when compared to traditional, criminal justice case processing?



## Research Design and Methods

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

Two different quasi-experimental techniques are used to assess the effectiveness of the ACRP from the sources of administrative data mentioned above. The first technique involves a pre-post design where differences in clinical and criminal recidivism outcomes are compared for four groups of people exiting the ACRP at various stages or levels of involvement (referral, initial opt-in, formal opt-in and graduates). Criminal recidivism is defined as a new remand to the ADOC for an arrest on new criminal charges occurring in year after exiting the ACRP. Clinical recidivism is defined as any new psychiatric hospital admission occurring in the one-year after exiting the ADOC for people who also had a psychiatric hospitalization in the year prior to being referred to the ACRP. The second technique involves a matched-pair design where both criminal and clinical recidivism outcomes are compared between a sample of 218 ACRP discharged participants (e.g., graduates, formal opt-outs) with an equivalent group of people with mental illness who were not referred to the ACRP. The comparison group was constructed using the abovementioned data sources and matched on a number of variables including date of exit, correctional institution status, gender, mental health diagnosis, age and race.

In addition, a retrospective, pre-post design was employed in a number of interviews that were conducted with former CRP participants so as to gather various quality-of-life outcomes. Interviews with former participants also included a number of questions about their experience with the program, recommendations for improvement and their insights into reasons behind successful and unsuccessful outcomes. It should be noted that locating former ACRP participants proved to be a daunting task. Of the 125 people the research team tried to locate, many had either moved or changed phone numbers, others declined to participate and some who agreed to an interview failed to show. In all, a total of 29 people were interviewed, of which three were excluded because they had no recollection of ever being involved in the ACRP, or the court itself. Reliance on ACRP participant memories to report before and after outcomes also yielded unreliable results in a few selected cases.

Responses from 40 key stakeholder interviews provided the study with insight into how the ACRP works within the general context of the criminal justice and behavioral health systems. These interviews yielded recommendations for ACRP improvement and provided additional perspective in interpreting outcomes. The observational methodology employed to document the overall content and organization of the ACRP rounds out the series of methods employed in the study. In all, HZA observed a total of seven ACRP status hearings with each of the two ACRP judges presiding (Judge Rhoades, N=4; Judge Lohff, N=3).

In addition, the ACRP database used by project staff to collect information on its participants was a modified version of a shareware database which was developed in the mid 1990s to collect basic information for adult drug court participants. There were few variables allocated for tracking purposes and many important elements that were missing (e.g., clinical diagnosis). These missing elements were resurrected from either hard copy records maintained by ACRP case coordinators or from official records maintained by ACRP court staff.



## Analyzing ACRP System Processes

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

Although following the Goldkamp and Irons-Guynn (2000) survey of the first four mental health courts (including the ACRP), a recent survey of such programs conducted by Erickson, Campbell & Lambert (2006) reveal wide variations among mental health court operations suggesting that the differences among these courts far outnumber their similarities. As a result, there has been growing interest among practitioners, policymakers, researchers, and others in developing some consensus on what parameters mental health court programs should operate and strive to achieve.

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

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

### ***Role of ACRP Judges***

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

The ACRP is presided over by two District Court judges (Honorable Stephanie Rhoades and Honorable John Lohff) who hold regular ACRP status hearings three afternoons each week (Tuesday through Thursday). Judge Rhoades presides over the Tuesday and Thursday calendar and Judge Lohff presides over the calendar set on Wednesdays. The ACRP also has a “back-up” judge who presides over the ACRP if neither judge is available.

### ***Role of ACRP Case Coordinators***

Two case coordinators<sup>6</sup> are responsible for assisting the ACRP in determining a defendant's clinical eligibility and in developing individualized treatment plans for defendant's who are interested in participating in the program. They are also responsible for arranging community behavioral health treatment options and monitoring participant adherence with his or her treatment plan. Combined, the two case coordinators oversee a maximum caseload of eighty participants.

The case coordinator from the Jail Alternative Services (JAS) program manages a targeted caseload of approximately forty people. The targeted population for the JAS caseload includes people incarcerated at the time of their referral to the ACRP who are either diagnosed with a major psychiatric disorder with psychotic features (35 slots) or people with developmental disabilities, organic mental disorders or traumatic brain injuries (five slots). The second case coordinator is from the Alaska Alcohol Safety Action Program (ASAP). The ASAP coordinator also has a caseload of up to 40 people who may be either in or out of custody at the time of referral. Contrary to the JAS coordinator, the targeted caseload for those in the ASAP track is broader including anyone who is a Beneficiary of the AMHTA.

Over the past year, the number of ACRP participants assigned to both case coordinators was either at or exceeding the operational capacity of the program. Interviews with participants, key stakeholders as well as observations of ACRP operations revealed the need for an additional case coordinator so as to both reduce caseloads and expand the overall operational capacity of the program.

### ***Role of ACRP Project Management Staff***

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

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

### ***ACRP Catchment Area***

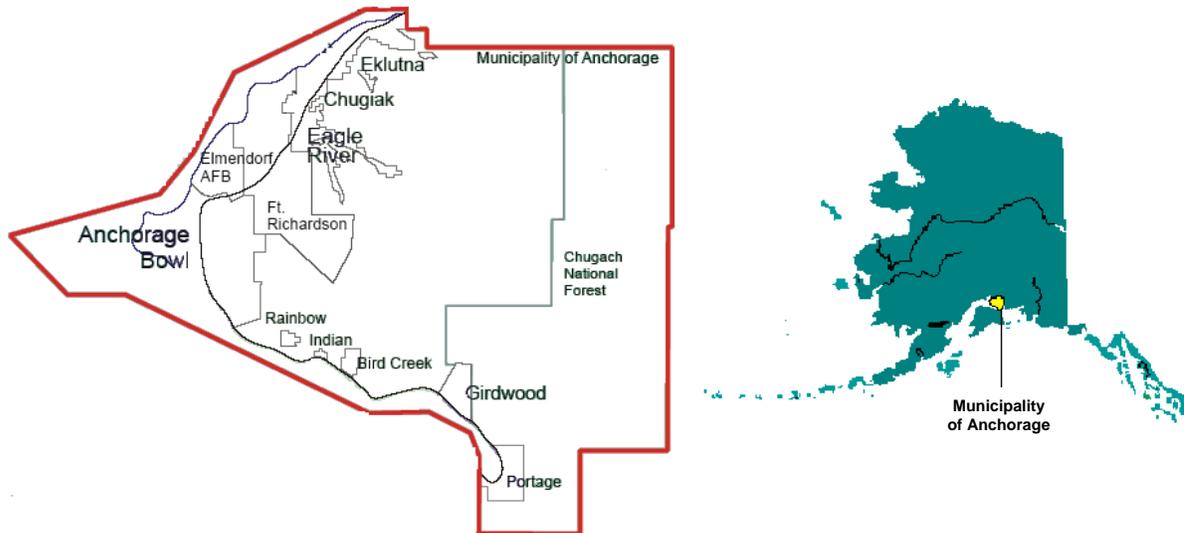
Located in South central Alaska, the ACRP catchment area spans the Municipality of Anchorage (1,961 square miles, or roughly the size of Delaware) stretching from Portage Glacier in the south to Eklutna in the north (see Figure 1). The Municipality of Anchorage has approximately 280,000 residents which makes it Alaska's largest city, representing more than two-fifths the state's total population. Anchorage is also the most ethnically diverse city in Alaska, with 28 percent of residents making up one or more

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<sup>6</sup> As of July 1, 2008 a third case coordinator position will be added to manage a caseload of 35 Trust Beneficiaries, with each case coordinator managing a reduced caseload of 35 clients, bringing the total ACRP caseload to 105.

minority or ethnic groups. When compared with U.S. cities of similar size, Anchorage has a comparable rate of violent crime and a lower rate of property crime. Anchorage, and Alaska in general, have very high rates of sexual assault in comparison with the rest of the country and Alaska Natives are victimized at a much higher rate than their prevalence in society.

**Figure 1: ACRP Catchment Area**



### ***ACRP Eligibility Requirements and Target Population***

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

*“...address public safety and consider a community’s treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria [should] also take into account the relationship between mental illness and a defendant’s offenses, while allowing the individual circumstances of each case to be considered.” (Thompson, Osher & Tomasini-Joshi, 2007)*

In order to participate in the ACRP, participants must meet both legal and clinical eligibility requirements as well as reside in the Municipality of Anchorage (MOA). Defendants charged with misdemeanor offenses are legally eligible to participate in the program. However, a defendant charged with a felony crime that is reduced by the State to one or more misdemeanor charges prior to appearing before the ACRP is also legally eligible to participate<sup>7</sup>. In addition, the ACRP will only hear cases involving individuals who reside in Anchorage, who are eligible to receive or are receiving services in Anchorage

<sup>7</sup>A defendant charged with a misdemeanor and who is also charged with a felony or who is charged with a misdemeanor and is on felony probation is not eligible to participate in the ACRP. A defendant who is actively participating in the ACRP on a misdemeanor case and is charged with a new felony crime is not eligible to continue participating in the program.

and who intend to reside in Anchorage for the duration of their program participation<sup>8</sup>. In order to meet ACRP clinical eligibility requirements, a defendant must be a Beneficiary of the Alaska Mental Health Trust Authority (AMHTA)<sup>9</sup>. Beneficiaries of the AMHTA are people with mental illness<sup>10</sup>, developmental disabilities, chronic alcoholism with psychosis, and Alzheimer’s disease, related dementias or other cognitive impairments<sup>11</sup>.

One of the ways we can assess whether or not the ACRP is meeting its intended target population is to compare the clinical characteristics among those who were referred to the ACRP with others who matriculated through the program at various other levels of programmatic involvement (e.g., initial opt-in, formal opt-in, graduates). This information is presented in Tables 1 and 2 for the 722 defendants who were referred to the ACRP between SFY 2003 and SFY 2006. As we can see in Table 1, among those who were not deemed to be a Beneficiary of the AMHTA, the majority of defendants discontinued their involvement with the program at the formal opt-in stage or earlier.

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

|                           | Referral Stage<br>(N=153) |         | Initial Opt-In<br>(N=257) |         | Formal Opt-in<br>(N=183) |         | Program Graduates<br>(N=129) |         | Overall<br>(N=722) |         |
|---------------------------|---------------------------|---------|---------------------------|---------|--------------------------|---------|------------------------------|---------|--------------------|---------|
|                           | Number                    | Percent | Number                    | Percent | Number                   | Percent | Number                       | Percent | Number             | Percent |
| <b>Diagnosis</b>          |                           |         |                           |         |                          |         |                              |         |                    |         |
| <b>Mental Health Only</b> | 31                        | 20.3%   | 65                        | 25.2%   | 30                       | 16.4%   | 51                           | 39.5%   | 177                | 24.5%   |
| <b>Substance Only</b>     | 8                         | 5.2%    | 13                        | 5.1%    | 7                        | 3.8%    | 2                            | 1.6%    | 30                 | 4.2%    |
| <b>Both</b>               | 71                        | 46.4%   | 131                       | 51.0%   | 123                      | 67.2%   | 76                           | 58.9%   | 401                | 55.5%   |
| <b>Neither</b>            | 43                        | 28.1%   | 48                        | 18.7%   | 23                       | 12.6%   | -                            | -       | 114                | 15.8%   |

Another indication that the program is enrolling its intended target population is to examine those with only substance-related disorders. These are defendants who may be more appropriately served by the Anchorage Wellness Court which offers a specialized track for misdemeanor defendants whose primary problem is substance abuse as opposed to mental illness. As we can see from Table 1, a small percentage of those presenting only Axis I substance-related disorders matriculate through initial ACRP screening or the initial opt-in stage of the program. While a small number matriculated through the formal opt-in stage of the program, most of these were returned to the regular court for traditional criminal case processing and only two graduated from the program. With a 90 percent success rate, we find that the ACRP is enrolling defendants who largely meet its intended target population. That is, the ACRP is successfully screening out individuals who are not Beneficiaries of the AMHTA.

<sup>8</sup> According to the ACRP Policy and Procedures Manual, the ACRP does not have the resources to link defendants to services or provide court monitoring of services for people who reside outside the Anchorage area. However, a defendant who is charged with a state case in another jurisdiction but who resides in Anchorage or who wishes to move and reside in Anchorage and is otherwise eligible can have his/her criminal case processed in the ACRP.

<sup>9</sup> See Appendix A for a more complete definition of Beneficiaries that fall under the purview of the AMHTA.

<sup>10</sup> As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). See Appendix B for the list of multi-axial classifications.

<sup>11</sup> According to the ACRP Policy and Procedures Manual, defendants whose sole or primary diagnosis is an Axis II Personality Disorder will not likely be eligible to participate in the program since intensive treatment for these disorders capable of court monitoring is not generally available in the community.

However, as suggested in Table 1 and explored in greater depth in Table 2, ACRP selection criteria is not perfect, particularly with respect to people who have both co-occurring mental health and substance related disorders. Participants with co-occurring disorders are significantly less likely to graduate from the ACRP compared to those with mental health disorders alone. This is not surprising, as people with co-occurring disorders are among the most difficult to diagnose, treat and generally tend to have worse outcomes (Peter & Hills, 1997). In general, they are at greater risk of relapse, re-hospitalization and homelessness, and tend to be more involved with the criminal justice system (Peters and Osher, 2004).

**Table 2: Clinical Characteristics of People Involved with the ACRP at Various Levels of Programmatic Involvement**

|                            | Referral Stage (N=153) |         | Initial Opt-In (N=257) |         | Formal Opt-in (N=183) |         | Program Graduates (N=129) |         | Overall (N=722) |         |
|----------------------------|------------------------|---------|------------------------|---------|-----------------------|---------|---------------------------|---------|-----------------|---------|
|                            | Number                 | Percent | Number                 | Percent | Number                | Percent | Number                    | Percent | Number          | Percent |
| <b>Axis I<sup>12</sup></b> |                        |         |                        |         |                       |         |                           |         |                 |         |
| Adjustment                 | 17                     | 11.1%   | 20                     | 7.8%    | 21                    | 11.5%   | 8                         | 6.2%    | 66              | 9.1%    |
| Alcohol                    | 60                     | 39.2%   | 104                    | 40.5%   | 105                   | 57.4%   | 60                        | 46.5%   | 329             | 45.6%   |
| Anxiety                    | 28                     | 18.3%   | 33                     | 12.8%   | 57                    | 31.1%   | 28                        | 21.7%   | 146             | 20.2%   |
| Bipolar                    | 42                     | 27.5%   | 74                     | 28.8%   | 85                    | 46.4%   | 43                        | 33.3%   | 244             | 33.8%   |
| Dementia                   | 17                     | 11.1%   | 31                     | 12.1%   | 14                    | 7.7%    | 15                        | 11.6%   | 77              | 10.7%   |
| Drug                       | 54                     | 35.3%   | 98                     | 38.1%   | 105                   | 57.4%   | 54                        | 41.9%   | 311             | 43.1%   |
| Impulse Control            | 15                     | 9.8%    | 39                     | 15.2%   | 30                    | 16.4%   | 16                        | 12.4%   | 100             | 13.9%   |
| Mood                       | 43                     | 28.1%   | 75                     | 29.2%   | 74                    | 40.4%   | 36                        | 27.9%   | 228             | 31.6%   |
| Psychotic                  | 28                     | 18.3%   | 56                     | 21.8%   | 57                    | 31.1%   | 38                        | 29.5%   | 179             | 24.8%   |
| Schizophrenic              | 29                     | 19.0%   | 65                     | 25.3%   | 73                    | 39.9%   | 61                        | 47.3%   | 228             | 31.6%   |
| Sexual                     | 3                      | 2.0%    | 8                      | 3.1%    | 10                    | 5.5%    | 7                         | 5.4%    | 28              | 3.9%    |
| Somatiform                 | 4                      | 2.6%    | 8                      | 3.1%    | 5                     | 2.7%    | 1                         | 0.8%    | 18              | 2.5%    |
| Other                      | 23                     | 15.0%   | 29                     | 11.3%   | 38                    | 20.8%   | 19                        | 14.7%   | 109             | 15.1%   |
| <b>Axis II</b>             |                        |         |                        |         |                       |         |                           |         |                 |         |
| Personality                | 48                     | 31.4%   | 104                    | 40.5%   | 84                    | 45.9%   | 41                        | 31.8%   | 277             | 38.4%   |
| MHMR                       | 7                      | 4.6%    | 19                     | 7.4%    | 16                    | 8.7%    | 10                        | 7.8%    | 52              | 7.2%    |
| None                       | 98                     | 64.0%   | 134                    | 52.1%   | 83                    | 45.4%   | 78                        | 60.4%   | 393             | 54.4%   |
| <b>Multiple Axis I</b>     |                        |         |                        |         |                       |         |                           |         |                 |         |
| Yes                        | 88                     | 57.5%   | 172                    | 69.6%   | 142                   | 77.6%   | 68                        | 52.7%   | 470             | 65.1%   |
| No                         | 65                     | 42.5%   | 85                     | 30.4%   | 41                    | 22.4%   | 61                        | 47.3%   | 252             | 34.9%   |
| <b>API History</b>         |                        |         |                        |         |                       |         |                           |         |                 |         |
| Yes                        | 53                     | 34.4%   | 98                     | 38.1%   | 83                    | 45.4%   | 51                        | 39.5%   | 285             | 39.5%   |
| No                         | 101                    | 65.6%   | 159                    | 61.9%   | 100                   | 54.6%   | 78                        | 60.5%   | 438             | 60.5%   |

Information presented in Table 2 (above) provides a more detailed examination of the clinical characteristics of people who matriculated through the ACRP at various levels of programmatic involvement. Indeed, there are some differences between the various groups that rise to the level of statistical significance. These differences are summarized in Table 3, on the following page.

<sup>12</sup> Axis I diagnoses presented in Table 1 are not mutually exclusive; instead, they are based upon the rate of occurrence rather than most severe diagnosis presenting among multiple possible diagnoses.

**Table 3: Significant Differences Between People Involved with the ACRP at Various Levels of Programmatic Involvement**

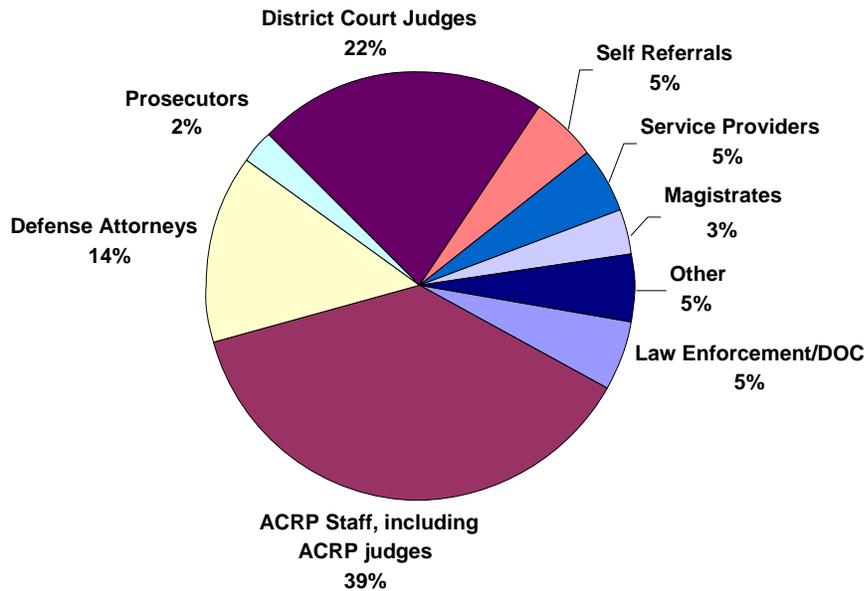
| <b>What are the significant characteristics of people who initially opted into the ACRP compared to those who did not?</b>   |   |
|--|---|
| <b>More Likely to Initially Opt-In</b>   | <b>Less Likely to Initially Opt-In</b>  |
| <ul style="list-style-type: none"> <li>• Personality Disorders</li> </ul>  | <ul style="list-style-type: none"> <li>• Older Participants</li> </ul>  |
| <b>What are the significant characteristics of people who formally opted into the ACRP compared to those who did not matriculate through the Initial Opt-In Stage?</b>   |   |
| <b>More Likely to Formally Opt-In</b>  | <b>Less Likely to Formally Opt-In</b>   |
| <ul style="list-style-type: none"> <li>• Schizophrenia</li> <li>• Psychotic Disorders</li> <li>• Bipolar Disorders</li> <li>• Anxiety Disorders</li> <li>• Mood Disorders</li> <li>• Substance-Related Disorders</li> <li>• Prior Psychiatric Hospitalization</li> <li>• Receiving Mental Health Services</li> </ul> | <ul style="list-style-type: none"> <li>• None</li> </ul>  |
| <b>What are the significant characteristics of people who graduated compared to those who did not?</b>   |   |
| <b>More Likely to Graduate</b>   | <b>Less Likely to Graduate</b>  |
| <ul style="list-style-type: none"> <li>• Engaged in Treatment Prior to Entry</li> <li>• Participants in the JAS track</li> </ul>   | <ul style="list-style-type: none"> <li>• Personality Disorders</li> <li>• Bipolar Disorders</li> <li>• Substance-Related Disorders</li> <li>• Prior AOD Treatment</li> <li>• Multiple Axis I Disorders</li> </ul> |

In sum, while the ACRP is meeting its intended target population, it is returning to regular court a high volume of participants with co-occurring disorders. While admirable, the program is taking on some very difficult cases whose service needs likely extend beyond that which the ACRP is able to provide, given the resources that currently exist in the community. Nonetheless, these findings do raise a major question about therapeutic court programming. That is, how do we define success? As will be shown in a later section of the report on criminal recidivism (see page 29), we reveal that people who received some level of ACRP intervention had a lower rate of recidivism than people who received no intervention at all.

***ACRP Referrals***

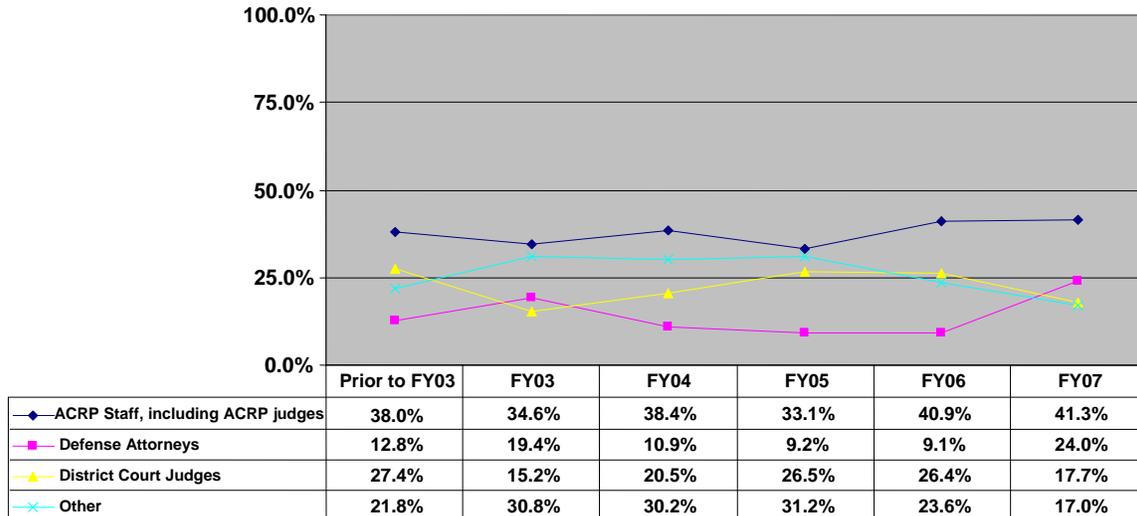
As alluded to in previous sections of the report, the process of becoming a participant in the ACRP begins at the point of referral. Anyone may refer a case to be heard in the ACRP by contacting ACRP project management staff. Once a referral has been made, the ACRP project manager will schedule the case for an Initial Opt-In Hearing, after arraignment, so that the defendant may consult with counsel, observe the court process and receive information about how the program works. Sources of referral are typically generated from ACRP judges and project management staff (37.7%), non-ACRP judges (22.1%) or defense attorneys (14.4%). A breakdown of these and other referral sources are displayed in Figure 2.

**Figure 2: Overall Distribution of ACRP Referral Sources**



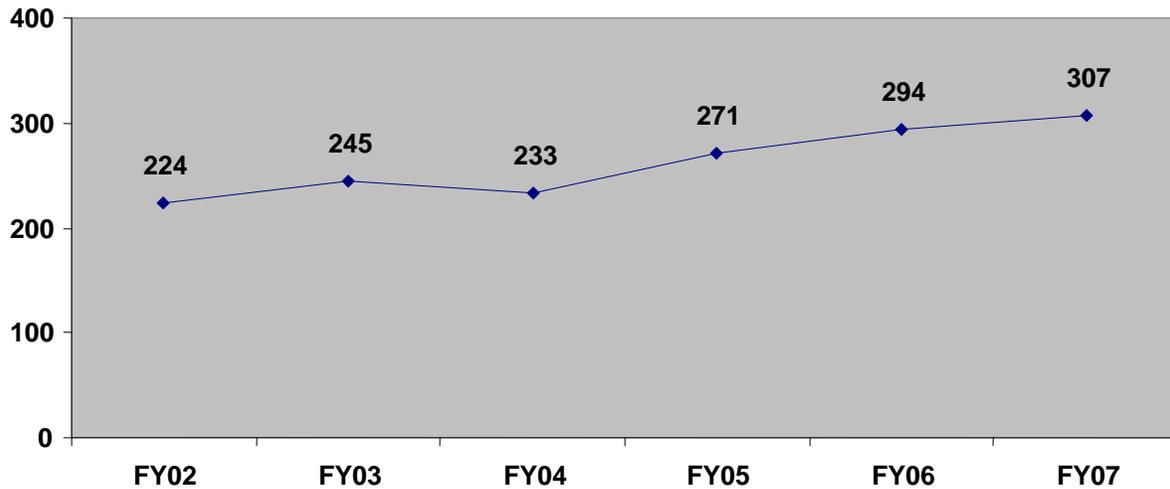
Indeed, there has been some modest fluctuation in the sources of these referrals over time. As displayed in Figure 3 below, we find that in any given year, the ACRP receives more than two-thirds of its referrals from either staff, judges or defense attorneys, and these three sources combined generated more than four out of five referrals to the ACRP in SFY 2007.

**Figure 3: Distribution of ACRP Referral Sources Over Time**



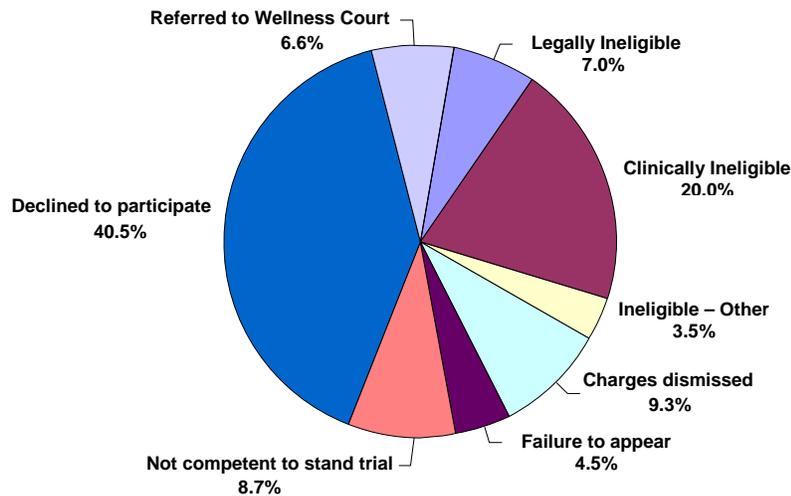
And, the number of referrals to the ACRP has risen each year despite a slight dip in SFY 2004. Referring to Figure 4 (next page), the number of referrals to the ACRP ranged from a low of 224 referrals in SFY 2002 to a high of 307 referrals in SFY 2007, representing an overall increase of more than 37 percent.

**Figure 4: Number of ACRP Referrals Over Time**



Although there are a number of people who are referred to the ACRP, not everyone will matriculate into the program for a variety of different reasons. Referring to Figure 5 (below), approximately one-third of all referrals to the ACRP did not meet legal or clinical eligibility requirements, two out of five declined to participate, and a smaller number either had their charges dismissed, were found incompetent to stand trial or were referred to the Anchorage Wellness Court (addictions court).

**Figure 5: Primary Reasons Why Some People Do Not Matriculate into the ACRP**



### ***ACRP System Flow***

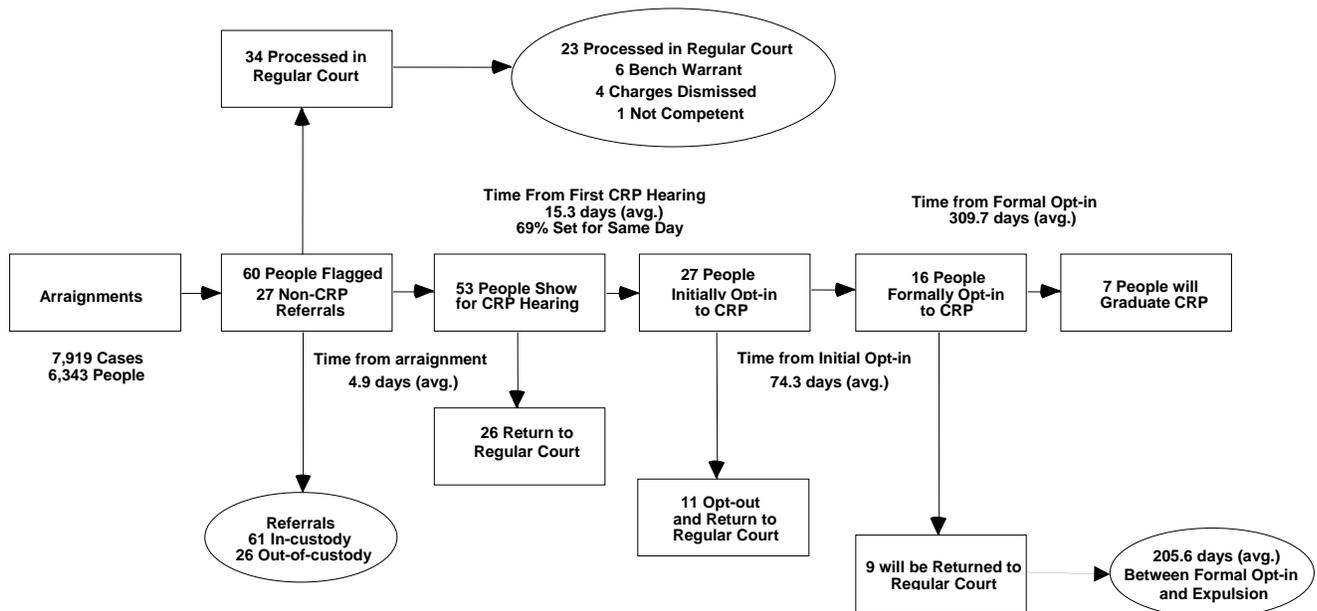
The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. As stated in the *Essential Elements*, participants must be “*identified, referred, and accepted into mental health courts [early], and*

then linked to community-based service providers, as quickly as possible” (Thompson, Osher & Tomasini-Joshi, 2007). The reason for this principle is simple, as it is well known throughout the literature that the sooner one is placed into treatment, the better his or her short and long-term outcomes will be in the future.

In order to examine ACRP system flow, HZA with the assistance of ACRP project management staff, collected information about all arraignments scheduled before the Anchorage District Court over the course of a 90-day period and tracked ACRP cases from arraignment through the remainder of key decision points involved in becoming enrolled in the program. This information is graphically displayed as a flow chart in Figure 6 below.

Recalling from above, ACRP project management staff maintains a list of former ACRP referrals and participants. The list is regularly updated and kept confidential for staff use only. Each day ACRP project management staff compares the list against the daily in and out of custody arraignment calendars and flags potentially eligible participants so that an Initial Opt-In Hearing can be scheduled following arraignment. Referring to Figure 6, ACRP project management staff flagged a total of 60 cases during this 90-day time period and another 27 cases were referred to the ACRP from outside sources. An equal number were either in custody at the time of referral (n=61); the remaining 26 were out of custody.

**Figure 6: Ninety Day Snapshot of ACRP-Court System Flow (April-June, 2007)**



Of the 87 people referred to the ACRP, a total of 34 people did not appear at the Initial Opt-In Hearing. Among the 34 people who did not appear, 23 were handled in the regular court system for traditional case processing, six were issued a bench warrant, four had their charges dismissed and one person was found not competent to stand trial. Among the remaining 53 people who appeared at the Initial Opt-In Hearing, almost half (49%) did not matriculate into the program for a variety of reasons discussed in the previous section. Of the 87 people referred to the ACRP, a total of 27 (31 percent) agreed to pursue the development of a community behavioral health treatment plan and a Motion for Initial Opt-In was filed

with the ACRP. The Motion for Initial Opt-In memorializes the defendant's beginning date of participation in the ACRP. The amount of time between arraignment and the Initial Opt-In Hearing is relatively short, averaging about five days in duration.

Once a defendant initially opts into the ACRP, he or she is assigned to one of the two ACRP case coordinators (JAS or ASAP) so that actions can be taken to develop an individualized community-based treatment plan that addresses all major life domains (e.g., housing, medications, treatment, benefits, social supports, legal involvement). This treatment plan is then presented at the Formal Opt-In Hearing where the designated ACRP judge and attorneys will consider the plan as well as the legal resolution that has been agreed upon by the defendant, his or her attorney, and the assigned state or municipal prosecutor. If all parties are in agreement, conditions of bail or release are set and the defendant officially becomes a participant in the ACRP. At this point, a new court date is set for the participant to reappear before the ACRP in order to review his or her adherence with the treatment plan. Periodic reviews of participant progress are set on a case by case basis with next appearances generally recommended by the assigned case coordinator and approved by the ACRP judge. Referring back to Figure 6, of the 27 people who initially opted into the ACRP about 60 percent (n=17) will take the final step in becoming a participant by formally opting into the program.

The amount of time between the Initial Opt-In Hearing and the Formal Opt-In Hearing is lengthy, averaging 74 days. While there are no hard and fast rules governing how long this process should take, we find that the ACRP is performing rather well on the front-end of the admissions process (up to the initial opt-in stage) but that more could be done to work on the back end (time between the Initial Opt-In Hearing and the Formal Opt-In Hearing). HZA would like the ACRP to consider establishing reasonable benchmarks (from which all parties can agree) and try to work within these parameters to shorten the length of time it takes for a participant to formally opt into the program.

### ***ACRP Status Hearings***

As previously noted, the ACRP status hearing is presided over by two District Court judges (Honorable Stephanie Rhoades and Honorable John Lohff) who hold regular ACRP status hearings three afternoons each week (Tuesday through Thursday). Judge Rhoades presides over the Tuesday and Thursday calendar and Judge Lohff presides over the calendar set on Wednesdays.

Many therapeutic courts often hold a pre-court meeting; a time where members of the therapeutic court team convene to discuss the progress of each participant and new referrals to the program. The ACRP rarely holds a pre-court meeting; rather, information about participants and new referrals are disseminated electronically to team members prior to the ACRP status hearing<sup>13</sup>. These team members primarily include the two judges, two case coordinators, Municipal and State prosecutors, defense attorneys and ACRP project management staff. In general, it was observed that the hours immediately preceding the ACRP status hearing were hectic, particularly for case coordinators and project management staff who scramble to assemble and disseminate participant updates to various team members for review during the ACRP status hearing.

On average, the typical ACRP status hearing lasts about one and a half hours. As a general rule, in-custody cases are typically heard first, followed by out-of-custody cases<sup>14</sup>. While there is no set order in hearing out-of-custody cases, preference is generally given to participants who are being accompanied by community behavioral health service representatives, whereas others may be given more or less of a priority as either an incentive (allowing them to leave early) or sanction (require them to stay for the

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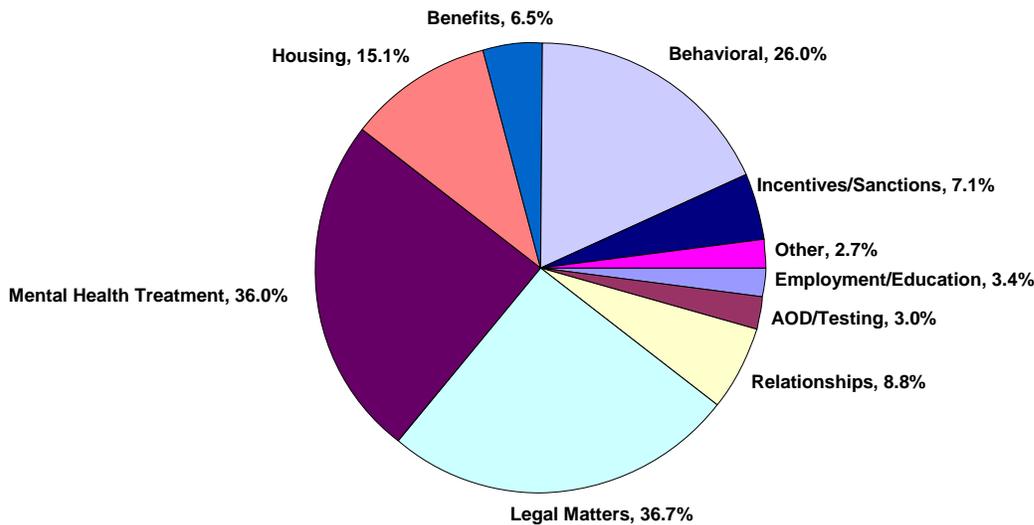
<sup>13</sup> In cases requiring more team coordination and where privacy concerns are heightened, a pre-court meeting will typically occur upon request.

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

duration). In addition, priority may be given to participants who can only appear before the court telephonically. Once a participant's case is reviewed by the ACRP judge, he or she is then allowed to leave<sup>15</sup>.

Like most therapeutic courtroom sessions, between procedural matters and discussions with participants there is a great deal of activity that occurs during the course of a typical ACRP status hearing<sup>16</sup>. These were documented by HZA using an observational tool consisting of sixty-four topic areas common to most therapeutic courtroom sessions<sup>17</sup>. The tool was designed to measure the amount of time spent on various topics by recording, in 30 second intervals, the amount of time dedicated to each area. These sixty-four items were then collapsed into ten broad categories that are presented in Figure 7 (next page). Overall, legal matters (e.g., scheduling, entering pleas), discussions surrounding mental health treatment and participant behaviors dominate the typical ACRP status hearing. These are followed, to a lesser extent by issues surrounding housing, relationships, incentives and sanctions and benefits. A small fraction of the time was allocated to drug use or testing and areas surrounding employment and/or education.

**Figure 7: Overall Distribution of ACRP Status Hearing Discussion Topics**



It will be recalled that status hearings were observed by both presiding ACRP judges. Although difficult to quantify, anecdotally, one appeared more reserved whereas the other seemed more charismatic; one tended to be more punitive, the other a little more assertive. So, in order to see if there were any fundamental differences between the two ACRP judges, HZA analyzed the data obtained from the observational tool by presiding ACRP judge. This information is presented in Figure 8 (next page).

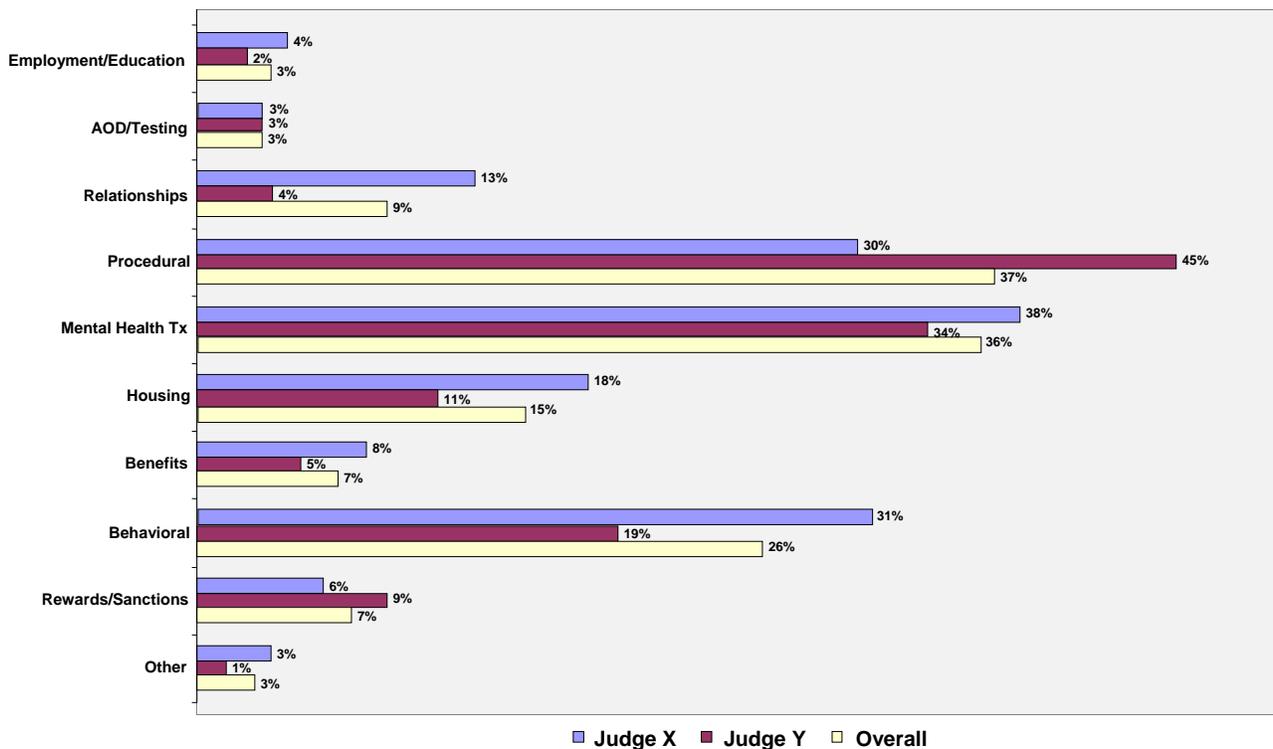
<sup>15</sup> Potential clients interested in participating in the ACRP typically observe the entire court session.

<sup>16</sup> More activity was observed particularly with respect to hearings set on Tuesdays and Wednesdays where disruptions are more likely to occur given the mix of State and Municipal cases. The Thursday calendar is dedicated to Municipal cases only.

<sup>17</sup> This instrument was developed based upon observations of more than 200 various types of therapeutic courtroom environments located in Maine, Massachusetts, New York, Florida, Louisiana, Missouri, Oklahoma, Texas, California, Alaska and York (U.K.).

As we can see, there are some differences between the two therapeutic courtroom environments. More time was dedicated to procedural matters in one setting (45% versus 30%) whereas the other tended to have more time allocated to discussing participant relationships (13% versus 4%), behaviors (31% versus 16%) and housing matters (18% versus 11%). However, in both courtroom environments, topics surrounding mental health treatment, benefits, employment, education, and incentives or sanctions were equally observed.

**Figure 8: Distribution of ACRP Status Hearing Discussion Topics by Judge**



ACRP sanctions also take a variety of forms, but more often than not involve verbal cautions, scheduling court appearances sooner than would otherwise be expected, imposing new bail or release restrictions (e.g., curfew amendment, no contact order). Occasionally a short jail sanction will be imposed for more serious violations.

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

***ACRP Cross-Systems Integration***

Another *Essential Element* guiding the best-practices of effective mental health court programming suggests that the planning and administration of a mental health court should include a broad-based group

of stakeholders representing the criminal justice, behavioral health and service delivery systems. In this way, mental health courts try to promote treatment goals through a coordinated response in an effort to assist people who experience mental illness escape the revolving door of the criminal justice and mental health systems. The goal of any mental health court is move along a continuum from basic implementation (requiring judicial leadership) to integration (forging partnerships) to institutionalization (interwoven into the fabric of a community).

Where does the ACRP sit along this continuum? The short answer is: the ACRP is not quite there yet but it has come a long way since its inception. It has made significant strides in forging partnerships and building relationships with a vast array of key stakeholders in the Anchorage community who have an important impact on the program as well as the people it serves.

Critical to the evolution and ongoing sustainability of the ACRP depends upon the cooperative effort that exists between the Judicial Branch and two departments of the Executive Branch (Department of Corrections and Department of Health and Social Services). Yet for the ACRP to work requires local support and the ACRP has established many additional partners spanning law enforcement to emergency medical services.

The day-to-day operations of the ACRP are managed in a cooperative effort provided by key stakeholders in the Alaska Court System, the Alaska Alcohol Safety Action Program, the Alaska Department of Corrections, the Alaska Department of Law, the Alaska Public Defender Agency, the Office of Public Advocacy, the Law Offices of Gorton, Logue and Graper, and the Anchorage Municipal Prosecutor's Office. Additionally, there are a variety of other community partners within the substance abuse, medical, behavioral health, housing and benefits systems, law enforcement, and consumer groups that work alongside the ACRP to provide a holistic system of care for Beneficiaries of the Trust. The ACRP recognizes the reliance on, and support of, community partners is essential to the success of the program, as the linkages to existing community services is vital to the client's success during and after participation in the ACRP. The following section is intended to provide a brief description of how some of these collaborations are at work.

A major collaborator of the ACRP is the **Alaska Mental Health Trust Authority (a.k.a., the Trust)**. Members of the ACRP team work alongside local and statewide representatives on the Disability Justice Workgroup, which is one of four primary committees dedicated to developing effective strategies in the spending of Trust dollars. ACRP team members are also involved in a joint subcommittee with the Housing Trust workgroup to develop housing and treatment services for the most difficult to serve consumers in the statewide community. Some of the many contributions from the Trust to the ACRP over the years included supporting the ACRP project manager, project assistant, and case coordinator positions; providing funds to ACRP participants who are in emergent need of monies for housing, shelter, food, transportation or emergency medicine; and funding contracts with two Anchorage psychologists who perform neuropsychological evaluations for statewide therapeutic court participants. And, as referenced in the title of this report, the Trust also provided the funding to support this evaluation, as well as a forthcoming evaluation of the mental health court in Palmer.

A police officer is often the first responder to a person with mental illness and the officer must use discretion in choosing how to most appropriately respond to the individual (i.e., diversion to either the criminal justice system or community-based services, or a combination of the two). Key partners of the ACRP are members of the Anchorage Police Department's **Crisis Intervention Team (CIT)**. These are specially trained officers who respond to emergency calls involving persons that experience mental health problems. The officers are educated about mental illnesses, medications, suicide and crisis intervention and are particularly skilled with the use of a variety of de-escalation techniques. These officers are aware of participants in the ACRP, make referrals to the program and provide valuable support to the team in

coordinating effective strategies and developing problem-solving solutions for both participants as well as members of the broader Anchorage community who experience mental illness.

The ACRP team also works intimately with key stakeholders from **Alaska Psychiatric Institute (API)**, the state psychiatric hospital. Institutional staff and ACRP team members work together on discharge planning for participants who enter API to ensure a smooth transition to the community is made. ACRP staff and the Alaska Court System also work actively with API to improve methods for processing competency evaluations for ACRP and all Anchorage District Court and pre-indicted felony cases.

Several behavioral health agencies in the community have worked with the ACRP to prioritize the criminal justice population by providing expedited assessment and linkage to treatment services for ACRP participants. **Anchorage Community Mental Health Services (ACMHS)** is the largest provider of behavioral health services in the Municipality of Anchorage and a major collaborator of the ACRP. Community providers such as ACMHS offer a wide range of trauma-sensitive, substance abuse and life skills services for participants, including such models as: Trauma Recovery and Empowerment (TREM), Dialectical Behavioral Therapy (DBT), Mindfulness, Mentally Ill Chemically Addicted and Aware (MICAA), Wellness Recovery Action Plan (WRAP) and Moral Reconciliation Therapy (MRT). The ACRP has a Memorandum of Agreement with ACMHS that gives priority to specialized services for individuals in the criminal justice system who experience mental illness. This collaborative relationship has paved the way for expedited access to medication, benefit assistance, case management supports, and housing assistance, as well as providing best practice treatment to ACRP participants.

As a community partner, the ACRP is able to give back in a variety of ways as well. The ACRP team philosophy is that it is important to continually educate the community. Whenever possible, ACRP team representatives proactively take steps to educate services providers, legislators, funding agencies, court system staff and community members by making presentations and welcoming people to tour the mental health court in action. The ACRP also responds to frequent technical assistance requests from new and existing mental health courts all across the country.

## Criminal Recidivism Outcomes

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The strongest test of criminal justice diversion programs is the extent to which they actually reduce crime and save money. Although research on adult drug court programs have shown reductions in criminal activity among program graduates, and overall costs savings both in terms of prison time and criminal justice case processing (see generally Ferguson, 2006; Belenko, 1999, 2001; GAO, 2006; Rempel, 2003; and Carey, 2003), it has been more difficult for researchers to draw meaningful conclusions about such outcomes for mental health courts. Mental health courts are more recent, typically have had far fewer enrollments, and are strategically more difficult to research given the high degree of confidentiality – and in many cases inaccessibility – of the mental health treatment records that are essential in developing viable comparison groups from which to assess program outcomes.

As a result of these problems, there have been relatively few evaluations of mental health court programs nationally. Among the evaluations that have been conducted, few include analyses of post-program recidivism, incorporate an experimental design, or use multivariate models to assess program outcomes. Nevertheless, these studies have been suggestive of reduced criminal justice system involvement, whether measured by days in jail, arrests, or type of involvement (Moore & Hiday, 2006; Herinckx, Swart, Ama & Knutson, 2003; Trupin, Richards, Lucenko & Wood, n.d.).

Hence, the current study marks an innovative development in improving upon what it is that we know about mental health courts. The following analysis compares recidivism outcomes of 218 ACRP participants with a matched comparison group of 218 similarly situated individuals who did not participate, nor were referred to, the ACRP. ACRP participants were matched across a number of variables including date of exit, correctional institutional status, gender, diagnosis, age and race.

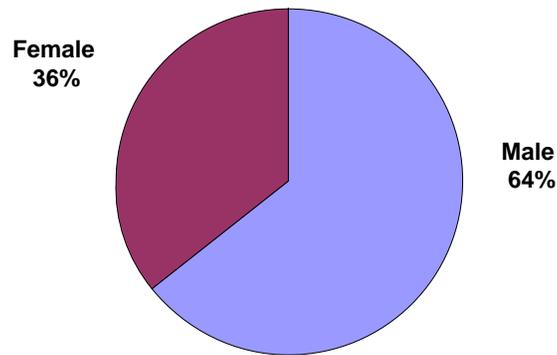
ACRP demographic characteristics are provided in Table 4 below as well in Figures 9, 10 and 11 (next page). ACRP clinical characteristics are provided in Table 5 and Figure 12 (pages 21 and 22). To summarize, the majority of ACRP participants and their respective comparisons are male, white, over the age of 40, who largely experience very severe mental disorders such as schizophrenia, bipolar disorder, or other major depressive disorders.

### *ACRP Demographic Characteristics*

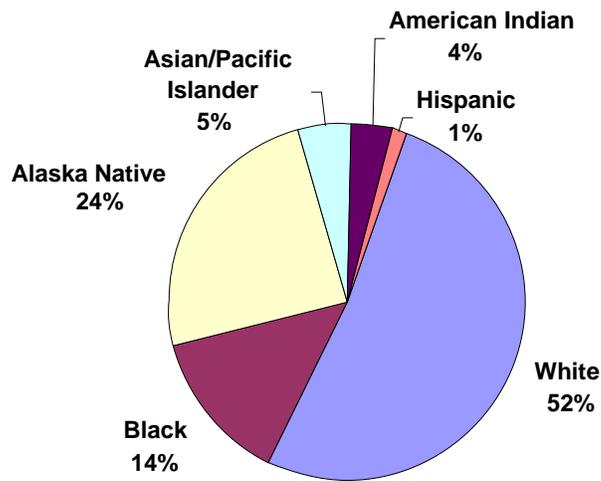
**Table 4: ACRP Demographic Characteristics**

|                        | Number | Percent |
|------------------------|--------|---------|
| <b>Gender</b>          |        |         |
| Male                   | 140    | 64.2%   |
| Female                 | 78     | 35.8%   |
| <b>Race</b>            |        |         |
| White                  | 112    | 51.6%   |
| Alaska Native          | 53     | 24.4%   |
| Black                  | 30     | 13.8%   |
| Asian/Pacific Islander | 11     | 5.0%    |
| American Indian        | 8      | 3.7%    |
| Hispanic               | 3      | 1.4%    |
| <b>Age</b>             |        |         |
| Under 21               | 29     | 13.4%   |
| 21-30                  | 58     | 26.7%   |
| 31-40                  | 67     | 30.9%   |
| 41-50                  | 50     | 23.0%   |
| Over 50                | 13     | 6.0%    |

**Figure 9: ACRP Participant Characteristics - Gender**

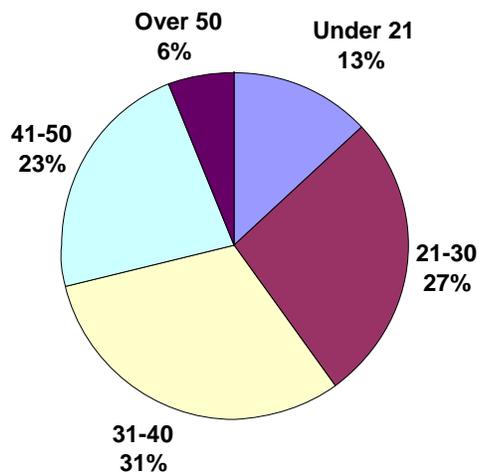


**Figure 10: ACRP Participant Characteristics - Race**



34

**Figure 11: ACRP Participant Characteristics - Age Group**



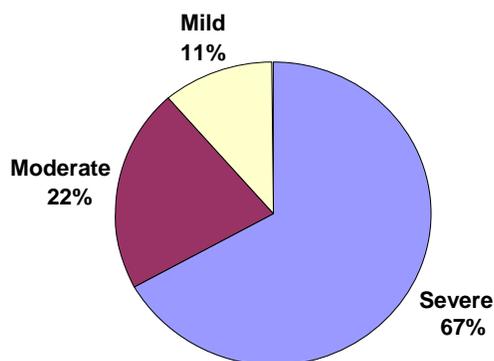
*ACRP Clinical Characteristics*

**Table 5 – ACRP Clinical Characteristics**

| <b>Code</b> | <b>Primary Diagnosis</b>  | <b>Frequency</b> | <b>Percent</b> |
|-------------|---|------------------|----------------|
| 295.10      | Schizophrenia, Disorganized Type                                      | 34               | 15.6%          |
| 298.9       | Psychotic Disorder NOS  | 24               | 11.0%          |
| 296.80      | Bipolar Disorder NOS  | 23               | 10.6%          |
| 295.30      | Schizophrenia, Paranoid Type  | 21               | 9.6%           |
| 295.70      | Schizoaffective Disorder – Bipolar Type                               | 18               | 8.3%           |
| 295.90      | Schizophrenia Undifferentiated Type                                   | 14               | 6.4%           |
| 296.3x      | Major Depressive Disorder Recurrent                                   | 13               | 6.0%           |
| 311         | Depressive Disorder NOS   | 11               | 5.0%           |
| 296.5x      | Bipolar I Disorder, Most Recent Episode Depressed                     | 7                | 3.2%           |
| 295.70      | Schizoaffective Disorder – Depressive Type                            | 5                | 2.3%           |
| 296.6x      | Bipolar I Disorder, Most Recent Episode Mixed                         | 5                | 2.3%           |
| 296.90      | Mood Disorder NOS   | 4                | 1.8%           |
| 296.4x      | Bipolar I Disorder, Most Recent Episode Manic                         | 4                | 1.8%           |
| 294.10      | Dementia Due to Head Trauma Without Behavioral Disturbance            | 4                | 1.8%           |
| 296.2x      | Major Depressive Disorder, Single Episode                             | 4                | 1.8%           |
| 295.70      | Schizoaffective Disorder  | 3                | 1.4%           |
| 296.7       | Bipolar I Disorder, Most Recent Episode Unspecified                   | 3                | 1.4%           |
| 309.81      | Posttraumatic Stress Disorder   | 3                | 1.4%           |
| 312.30      | Impulse-Control Disorder NOS  | 2                | 0.9%           |
| 300.00      | Anxiety Disorder NOS  | 2                | 0.9%           |
| 294.11      | Dementia Due to Head Trauma With Behavioral Disturbance               | 2                | 0.9%           |
| 296.40      | Bipolar I Disorder, Most Recent Episode Hypomanic                     | 1                | 0.5%           |
| 300.4       | Dysthymic Disorder – Late Onset                                       | 1                | 0.5%           |
| 312.34      | Intermittent Explosive Disorder                                       | 1                | 0.5%           |
| 295.20      | Schizophrenia, Catatonic Type   | 1                | 0.5%           |
| 309.24      | Adjustment Disorder With Anxiety                                      | 1                | 0.5%           |
| 297.1       | Delusional Disorder   | 1                | 0.5%           |
| 301.13      | Cyclothymic Disorder  | 1                | 0.5%           |
| 293.81      | Psychotic Disorder, With Delusions                                    | 1                | 0.5%           |
| 294.11      | Dementia of Alzheimer's Type, Early Onset With Behavioral Disturbance | 1                | 0.5%           |
| 300.21      | Panic Disorder With Agoraphobia                                       | 1                | 0.5%           |
| 309.28      | Adjustment Disorder With Mixed Anxiety and Depressed Mood             | 1                | 0.5%           |
| 302.2       | Pedophilia <sup>18</sup>  | 1                | 0.5%           |
|             | <b>Total</b>  | <b>218</b>       | <b>100.0%</b>  |

<sup>18</sup> This individual also had a diagnosis of Depressive Disorder NOS.

**Figure 12: Severity of ACRP Participants Mental Illness<sup>19</sup>**



***Comparing Recidivism Outcomes***

How do ACRP participants fare with respect to criminal recidivism? Referring to Table 6 below, the one year post-discharge recidivism rate for all ACRP participants formally opting into the program is 39 percent, which compares very favorably against a matched comparison group of similarly-situated offenders who were not referred to the ACRP (47 percent). Among those discharged from the ACRP, program graduates were least likely to re-offend overall (30 percent). Among those who did engage in new criminal conduct, ACRP participants were less likely to commit new felonies, violent or drug related crimes. Hence, diversion of people with mental illness from incarceration into the ACRP poses less of a risk to public safety than traditional adjudication.

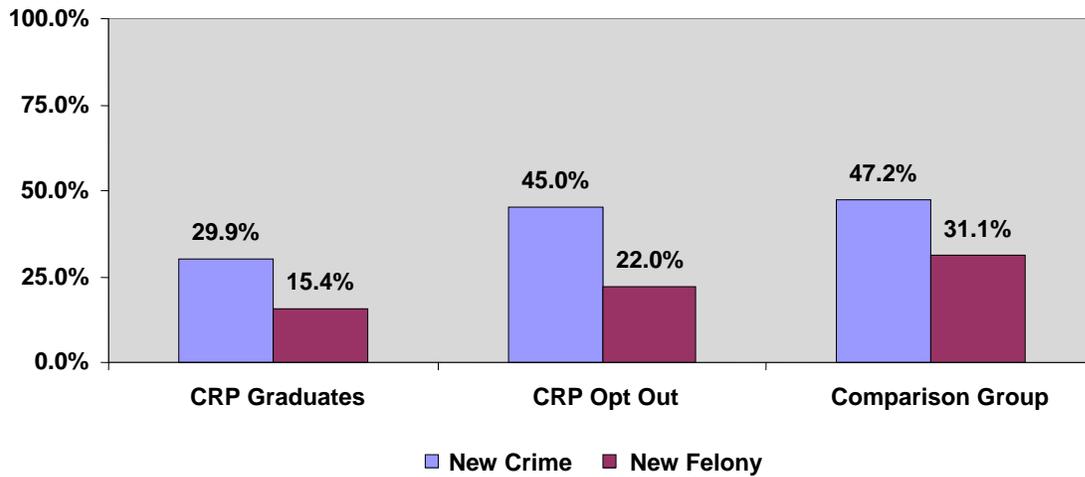
**Table 6: Criminal Recidivism Outcomes - One-Year Post-Discharge**

|                            | ACRP Graduates (N=87) |         | ACRP Opt-Out (N=131) |         | ACRP Combined (N=218) |         | Comparison Group (n=218) |         |
|----------------------------|-----------------------|---------|----------------------|---------|-----------------------|---------|--------------------------|---------|
|                            | Number                | Percent | Number               | Percent | Number                | Percent | Number                   | Percent |
| <b>Remanded to Custody</b> |                       |         |                      |         |                       |         |                          |         |
| <b>Yes</b>                 | 26                    | 29.9%   | 59                   | 45.0%   | 85                    | 39.0%   | 103                      | 47.2%   |
| <b>No</b>                  | 61                    | 70.1%   | 72                   | 55.0%   | 133                   | 61.0%   | 115                      | 52.8%   |
| <b>Felony Charge</b>       |                       |         |                      |         |                       |         |                          |         |
| <b>Yes</b>                 | 4                     | 15.4%   | 13                   | 22.0%   | 17                    | 20.0%   | 32                       | 31.1%   |
| <b>No</b>                  | 22                    | 84.6%   | 46                   | 78.0%   | 68                    | 80.0%   | 71                       | 68.9%   |
| <b>Offense Type</b>        |                       |         |                      |         |                       |         |                          |         |
| <b>Public Order</b>        | 5                     | 19.2%   | 9                    | 15.3%   | 14                    | 16.5%   | 11                       | 10.7%   |
| <b>Personal</b>            | 10                    | 38.5%   | 12                   | 20.3%   | 22                    | 25.9%   | 31                       | 30.1%   |
| <b>Property</b>            | 6                     | 23.1%   | 22                   | 37.3%   | 28                    | 32.9%   | 17                       | 16.5%   |
| <b>Drug/Alcohol</b>        | 3                     | 11.5%   | 6                    | 10.2%   | 9                     | 10.6%   | 13                       | 12.6%   |
| <b>MV</b>                  | 2                     | 7.7%    | 2                    | 3.4%    | 4                     | 4.7%    | 5                        | 4.9%    |
| <b>Probation/Parole</b>    |                       |         | 4                    | 6.8%    | 4                     | 4.7%    | 17                       | 16.5%   |
| <b>Other</b>               |                       |         | 4                    | 6.8%    | 4                     | 4.7%    | 9                        | 8.7%    |

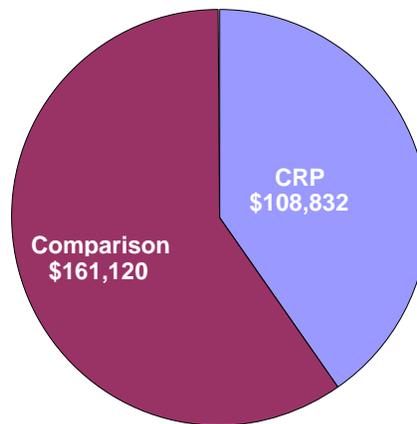
<sup>19</sup> Severity categorizations: mild disorders included mood disorders coded as mild, adjustment disorders, anxiety disorder NOS, mood disorder NOS, depression NOS and major depression with only one episode. Moderate disorders included mood disorders coded as “moderate,” recurrent mood disorders not coded with severity, PTSD, panic disorder, all bipolar disorders (unless specifically coded “severe”). Severe disorders include all psychotic disorders, all cognitive disorders and mood disorders coded as “severe.”

In all, among those that recidivated, the length of time that was spent in custody among the ACRP participants equaled a total of 895 days, versus 1,325 days for the comparison group. Since the average daily cost to house an inmate in the Alaska Department of Corrections is estimated at \$121.60<sup>20</sup>, this represents a total cost of \$108,832 for the mental health court participants who returned to the ADOC. The comparison group, in contrast, cost approximately \$161,120 in correctional-related expenditures (see Figure 14). This yields a net correctional institutional savings of \$52,288.

**Figure 13: Criminal Recidivism Outcomes – One Year Post-Discharge**



**Figure 14: Criminal Recidivism Outcomes - Cost of New Custodial Placements**



Information provided in Table 7 (next page) also examines the types of crimes these recidivists were charged with. While there were few differences between the two groups, on the whole, the comparison group was more likely to be charged with personal crimes whereas ACRP participants were more likely to be charged with property-related crimes. Property-related crimes were largely committed by the group of ACRP participants opting out of the program whereas ACRP graduates were more likely to commit new crimes against a person. The specific offense charges for all three groups are provided in Table 7 (next page).

<sup>20</sup> Cost estimate derived from personal communication with ADOC officials.

**Table 7: Criminal Recidivism Outcomes - Most Serious Offense Charge**

| FELONIES                          | ACRP Graduates (N=26) |              | ACRP Opt-Out (N=59) |              | ACRP Combined (N=85) |              | Comparison Group (n=103) |              |
|-----------------------------------|-----------------------|--------------|---------------------|--------------|----------------------|--------------|--------------------------|--------------|
|                                   | Number                | Percent      | Number              | Percent      | Number               | Percent      | Number                   | Percent      |
| ASSAULT 2                         | 1                     | 3.8%         | 3                   | 5.1%         | 4                    | 4.7%         | 2                        | 1.9%         |
| ASSAULT 3                         | 2                     | 7.7%         | 1                   | 1.7%         | 3                    | 3.5%         | 6                        | 5.8%         |
| ATTEMPTED ARSON 2                 |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| ATTEMPTED SEX ASSAULT I           |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| BURGLARY 1- IN A DWELLING         |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| BURGLARY 2                        |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| CRIMINAL MISCHIEF 2               |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| DANGEROUS DRUGS-OTHER             |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| FELONY DWI - 2+ PRIORS            |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| ROBBERY 2                         |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| SEX ABUSE OF MINOR 2              |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| TERRORISTIC THREATENING           |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| THEFT 2                           | 1                     | 3.8%         | 2                   | 3.4%         | 3                    | 3.5%         |                          |              |
| MISCONDUCT- SUBSTANCE 2           |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| MISCONDUCT WEAPONS 3              |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| VEHICLE THEFT 1                   |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| <b>FELONY TOTAL</b>               | <b>4</b>              | <b>15.3%</b> | <b>9</b>            | <b>15.3%</b> | <b>13</b>            | <b>15.3%</b> | <b>22</b>                | <b>25.3%</b> |
| MISDEMEANORS                      | Number                | Percent      | Number              | Percent      | Number               | Percent      | Number                   | Percent      |
| ASSAULT 4                         | 5                     | 19.2%        | 5                   | 8.5%         | 10                   | 11.8%        | 13                       | 12.6%        |
| CONTEMPT OF COURT                 | 1                     | 3.8%         | 2                   | 3.4%         | 3                    | 3.5%         | 1                        | 1.0%         |
| CRIMINAL MISCHIEF 4               |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| CRIMINAL TRESPASS 1               |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| CRIMINAL TRESPASS 2               |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| CRIMINAL TRESPASS                 | 1                     | 3.8%         | 4                   | 6.8%         | 5                    | 5.9%         | 1                        | 1.0%         |
| DISORDERLY CONDUCT                | 2                     | 7.7%         | 1                   | 1.7%         | 3                    | 3.5%         | 7                        | 6.8%         |
| DRIVING WITH LIC SUSP/REVOKED     | 1                     | 3.8%         | 1                   | 1.7%         | 2                    | 2.4%         | 3                        | 2.9%         |
| DV ASSAULT                        | 2                     | 7.7%         |                     |              | 2                    | 2.4%         | 3                        | 2.9%         |
| DWI                               | 3                     | 11.5%        | 5                   | 8.5%         | 8                    | 9.4%         | 9                        | 8.7%         |
| FAILURE SATISFY JUDGEMENT         |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| FAILURE TO APPEAR                 |                       |              | 4                   | 6.8%         | 4                    | 4.7%         | 5                        | 4.9%         |
| FURNISH ALCOHOL TO MINOR          |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| HARASSMENT                        |                       |              | 1                   | 1.7%         | 1                    | 1.2%         |                          |              |
| ILLEGAL USE OF PHONE              | 1                     | 3.8%         |                     |              | 1                    | 1.2%         |                          |              |
| INSURANCE OR SECURITY REQUIRED    |                       |              | 1                   | 1.7%         | 1                    | 1.2%         | 1                        | 1.0%         |
| LEAVING SCENE OF ACCIDENT         | 1                     | 3.8%         |                     |              | 1                    | 1.2%         |                          |              |
| MAKING A FALSE REPORT             |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| DESTRUCTION OF PROPERTY           |                       |              | 2                   | 3.4%         | 2                    | 2.4%         | 2                        | 1.9%         |
| MISCONDUCT- SUBSTANCE 6           |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| MISCONDUCT WEAPONS 4              |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| PROBATION VIOLATION               |                       |              | 4                   | 6.8%         | 4                    | 4.7%         | 13                       | 12.6%        |
| PROSTITUTION                      | 1                     | 3.8%         | 1                   | 1.7%         | 2                    | 2.4%         | 1                        | 1.0%         |
| RECKLESS DRIVING                  |                       |              |                     |              |                      |              | 1                        | 1.0%         |
| RESIST ARREST OR ASSIST ESCAPE    |                       |              | 3                   | 5.1%         | 3                    | 3.5%         |                          |              |
| THEFT 3                           |                       |              | 1                   | 1.7%         | 1                    | 1.2%         | 2                        | 1.9%         |
| THEFT 4- VALUE <\$50              |                       |              |                     |              |                      |              | 2                        | 1.9%         |
| THEFT BY SHOPLIFTING              | 2                     | 7.7%         | 7                   | 11.9%        | 9                    | 4.7%         | 3                        | 2.9%         |
| THEFT OF SERVICES                 | 2                     | 7.7%         | 1                   | 1.7%         | 3                    | 3.5%         |                          |              |
| VEHICLE TAMPERING                 |                       |              | 2                   | 3.4%         | 2                    | 2.4%         |                          |              |
| VIOLATE DV RESTRAINING ORDER      |                       |              | 2                   | 3.4%         | 2                    | 2.4%         | 2                        | 1.9%         |
| VIOLATION OF CONDITION OF RELEASE |                       |              | 1                   | 1.7%         | 1                    | 1.2%         | 4                        | 3.9%         |
| <b>MISDEMEANOR TOTAL</b>          | <b>22</b>             | <b>84.6%</b> | <b>50</b>           | <b>84.6%</b> | <b>72</b>            | <b>84.6%</b> | <b>65</b>                | <b>74.7%</b> |

### *Costs Associated with New Criminal Conduct*

The analysis that follows is based on cost estimates derived from Miller, Cohen and Wierseman (2001) and French (1996), who calculated the cost associated with particular criminal events. Table 8 provides their estimates for the average cost per victimization; figures are adjusted for inflation through 2006<sup>21</sup>. These estimates are based on actual costs that are accrued by the public, including: costs incurred by crime victims (e.g.: medical care, mental health care expenditure, lost productivity); costs that accrue to the public (e.g.: victim’s services and compensation); and criminal justice costs including the costs of incarceration. Estimating the costs incurred by crime victims and the costs accrued to the general public are calculated by multiplying the number of crimes (incidents) by the cost associated with each criminal event.

**Table 8: Costs Associated With a Criminal Act<sup>a</sup>**

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

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

Referring to Table 9 on the following page, results of the analysis indicate that the cost of new crimes committed by ACRP recidivists (\$921,440) is much lower than for the comparison group of traditionally adjudicated offenders with mental illness not involved in the ACRP (\$1,529,145).

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<sup>21</sup> It should be noted that these are national estimates using data derived from the National Crime Victim Survey and the Federal Bureau of Investigation. Any bias that may result in the application of these estimates in Alaska cannot, unfortunately, be estimated.

**Table 9: Criminal Recidivism Outcomes - Cost of New Criminal Activity**

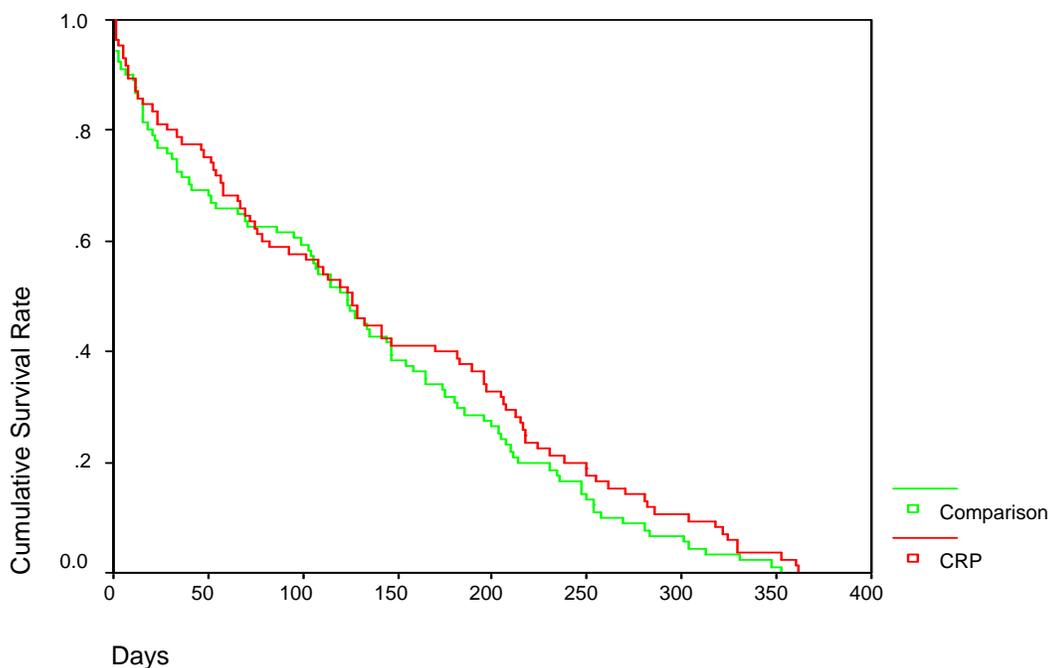
| Type of Criminal Act   | ACRP Combined (N=85) |         | Comparison Group (n=103) |         | Total Costs ACRP Combined | Total Costs Comparison Group |
|--|----------------------|---------|--------------------------|---------|---------------------------|------------------------------|
|  | Number               | Percent | Number                   | Percent |                           |                              |
| ASSAULT 2  | 4                    | 4.7%    | 2                        | 1.9%    | \$460,620.00              | \$230,310.00                 |
| ASSAULT 3  | 3                    | 3.5%    | 6                        | 5.8%    | \$345,465.00              | \$690,930.00                 |
| <b>Total Costs for Criminal Act: Aggravated Assault</b>            |                      |         |                          |         | <b>\$806,085.00</b>       | <b>\$921,240.00</b>          |
| ASSAULT 4  | 10                   | 11.8%   | 13                       | 12.6%   | \$25,780.00               | \$33,514.00                  |
| DV ASSAULT   | 2                    | 2.4%    | 3                        | 2.9%    | \$5,156.00                | \$7,734.00                   |
| <b>Total Costs for Criminal Act: Assault</b>                       |                      |         |                          |         | <b>\$30,936.00</b>        | <b>\$41,248.00</b>           |
| SEX ABUSE OF MINOR 2   | 0                    | 0.0%    | 2                        | 1.9%    | \$0.00                    | \$412,076.00                 |
| <b>Total Costs for Criminal Act: Gross Sexual Assault</b>          |                      |         |                          |         | <b>\$0.00</b>             | <b>\$412,076.00</b>          |
| BURGLARY 1- IN A DWELLING  | 1                    | 1.2%    | 0                        | 0.0%    | \$4,093.00                | \$0.00                       |
| BURGLARY 2   | 0                    | 0.0%    | 2                        | 1.9%    | \$0.00                    | \$8,186.00                   |
| <b>Total Costs for Criminal Act: Burglary</b>                      |                      |         |                          |         | <b>\$4,093.00</b>         | <b>\$8,186.00</b>            |
| CRIMINAL MISCHIEF 2  | 1                    | 1.2%    | 0                        | 0.0%    | \$462.00                  | \$0.00                       |
| CRIMINAL MISCHIEF 4  | 0                    | 0.0%    | 1                        | 1.0%    | \$0.00                    | \$462.00                     |
| CRIMINAL TRESPASS 1  | 1                    | 1.2%    | 0                        | 0.0%    | \$462.00                  | \$0.00                       |
| CRIMINAL TRESPASS 2  | 0                    | 0.0%    | 1                        | 1.0%    | \$0.00                    | \$462.00                     |
| CRIMINAL TRESPASS  | 5                    | 5.9%    | 1                        | 1.0%    | \$2,310.00                | \$462.00                     |
| DESTRUCTION OF PROPERTY  | 2                    | 2.4%    | 2                        | 1.9%    | \$924.00                  | \$924.00                     |
| <b>Total Costs for Criminal Act: Criminal Mischief/Trespass</b>    |                      |         |                          |         | <b>\$4,158.00</b>         | <b>\$2,310.00</b>            |
| DISORDERLY CONDUCT   | 3                    | 3.5%    | 7                        | 6.8%    | \$1,296.00                | \$3,024.00                   |
| <b>Total Costs for Criminal Act: Disorderly Conduct</b>            |                      |         |                          |         | <b>\$1,296.00</b>         | <b>\$3,024.00</b>            |
| DWI  | 8                    | 9.4%    | 7                        | 6.8%    | \$27,840.00               | \$24,360.00                  |
| FELONY DWI – 2+ PRIORS WITHIN 5 YEARS                              | 0                    | 0.0%    | 1                        | 1.0%    | \$0.00                    | \$3,480.00                   |
| <b>Total Costs for Criminal Act: Operating Under the Influence</b> |                      |         |                          |         | <b>\$27,840.00</b>        | <b>\$27,840.00</b>           |
| HARASSMENT   | 1                    | 1.2%    | 0                        | 0.0%    | \$2,578.00                | \$0.00                       |
| ILLEGAL USE OF PHONE   | 1                    | 1.2%    | 0                        | 0.0%    | \$2,578.00                | \$0.00                       |
| TERRORISTIC THREATENING  | 1                    | 1.2%    | 0                        | 0.0%    | \$2,578.00                | \$0.00                       |
| <b>Total Costs for Criminal Act: Criminal Threatening</b>          |                      |         |                          |         | <b>\$7,734.00</b>         | <b>\$0.00</b>                |
| ROBBERY 2  | 0                    | 0.0%    | 2                        | 1.9%    | \$0.00                    | \$95,756.00                  |
| <b>Total Costs for Criminal Act: Robbery</b>                       |                      |         |                          |         | <b>\$0.00</b>             | <b>\$95,756.00</b>           |
| THEFT 2  | 3                    | 3.5%    | 0                        | 0.0%    | \$4,152.00                | \$0.00                       |
| THEFT 3  | 1                    | 1.2%    | 2                        | 1.9%    | \$1,384.00                | \$2,768.00                   |
| THEFT 4- VALUE <\$50   | 0                    | 0.0%    | 2                        | 1.9%    | \$0.00                    | \$2,768.00                   |
| THEFT BY SHOPLIFTING   | 9                    | 4.7%    | 3                        | 2.9%    | \$12,456.00               | \$4,152.00                   |
| THEFT OF SERVICES  | 3                    | 3.5%    | 0                        | 0.0%    | \$4,152.00                | \$0.00                       |
| <b>Total Costs for Criminal Act: Larceny/Theft</b>                 |                      |         |                          |         | <b>\$22,144.00</b>        | <b>\$9,688.00</b>            |
| VEHICLE TAMPERING  | 2                    | 2.4%    | 0                        | 0.0%    | \$17,154.00               | \$0.00                       |
| VEHICLE THEFT 1  | 0                    | 0.0%    | 1                        | 1.0%    | \$0.00                    | \$8,577.00                   |
| <b>Total Costs for Criminal Act: Motor Vehicle Theft</b>           |                      |         |                          |         | <b>\$17,154.00</b>        | <b>\$8,577.00</b>            |
| <b>Total Costs for All Types of Criminal Acts</b>                  |                      |         |                          |         | <b>\$921,440.00</b>       | <b>\$1,529,145.00</b>        |

## Survival Analysis

Another approach to assess criminal recidivism is to examine the length of time to recidivate, so as to measure the overall amount of time that offenders refrained from criminal behavior. Here we introduce survival analysis to compare the timing of recidivism between ACRP and the comparison group of similarly-situated offenders not referred to the ACRP.

Results of the survival analysis indicate that ACRP participants “survive” slightly longer in the community before being arrested than the comparison group. The graph in Figure 15 illustrates the percentage of offenders not yet recidivating on the vertical axis. The number of days is displayed on the horizontal axis. For example, from the point of discharge from the ACRP (time zero) no one had recidivated. After 180 days, 42 percent of ACRP participants had not yet recidivated (58% had) compared with 30 percent in the comparison group (70% had been re-arrested). The average length of time to recidivate for ACRP participants is 127 days, versus 140 days for the comparison group.

**Figure 15: Survival Analysis for ACRP Participants and the Comparison Group**



Some of the predictors of criminal recidivism identified in the literature for the mentally ill tend to center on age, arrest history, prior incarcerations and substance abuse, with some variation depending upon the availability of data and specific focus of the study (See generally: Ventura, Cassel, Jacoby & Huang, 1998; Draine, Solomon & Meyerson, 1994; Sosowsky, 1980). For example, Ventura and her colleagues (1998) found that recidivism was associated with age, employment, previous arrests, and receipt of community-based case management. They also discovered that receipt of jail-based case management was indirectly associated with criminal recidivism, in that it increased the overall likelihood of receiving community-based case management upon release.

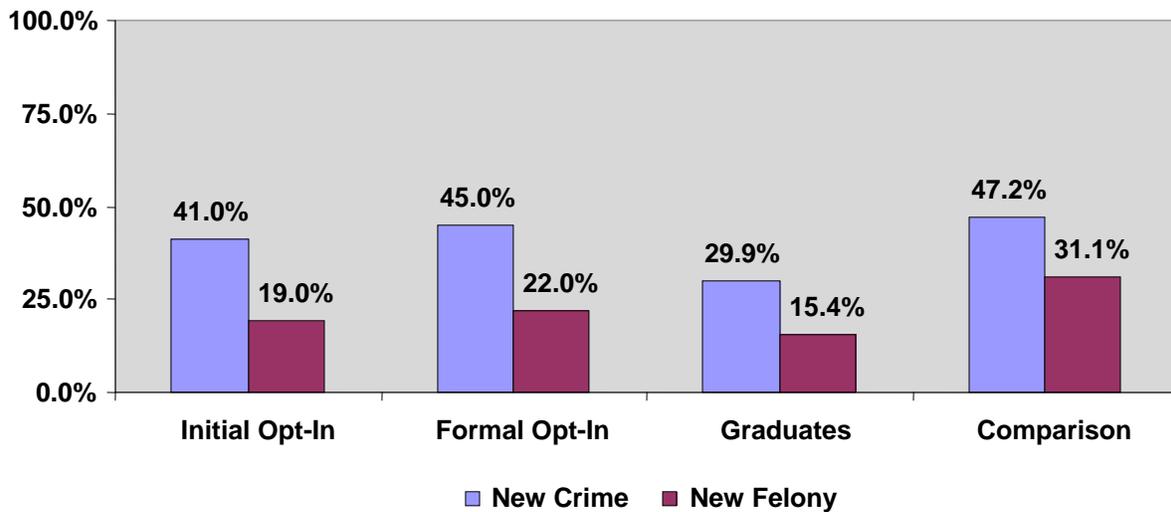
One of the unique contributions of this study will be to explore the relationship between specific diagnostic criteria and criminal recidivism outcomes, while at the same time controlling for a host of other characteristics such as gender, age, custody length, and institutional status upon release. Results of the analysis are provided at the bottom of Table 10, a table that was expanded from an earlier presentation to show how some relationships between intermediate outcomes and final outcomes may be related. Referring to Table 10, ACRP participants diagnosed with personality disorders and substance-related disorders are significantly more likely to commit new crimes, as are participants who receive prior AOD treatment before entering the program. Conversely, ACRP graduates or participants who had a prior psychiatric hospitalization were less likely to recidivate.

**Table 10: Significant Differences Between People Involved with the ACRP at Various Levels of Programmatic Involvement**

|   |   |
|---|---|
| <b>What are the significant characteristics of people who initially opted into the ACRP compared to those who did not?</b>  |   |
| <p><b>More Likely to Initially Opt-In</b></p> <ul style="list-style-type: none"> <li>• Personality Disorders</li> </ul>   | <p><b>Less Likely to Initially Opt-In</b></p> <ul style="list-style-type: none"> <li>• Older Participants</li> </ul>  |
| <b>What are the significant characteristics of people who formally opted into the ACRP compared to those who did not matriculate through the Initial Op-In Stage?</b>   |   |
| <p><b>More Likely to Formally Opt-In</b></p> <ul style="list-style-type: none"> <li>• Schizophrenia or other Psychotic Disorders</li> <li>• Bipolar Disorders</li> <li>• Anxiety Disorders</li> <li>• Mood Disorders</li> <li>• Substance Related Disorders</li> <li>• Prior Psychiatric Hospitalization</li> <li>• Receiving Mental Health Services</li> </ul> | <p><b>Less Likely to Formally Opt-In</b></p> <ul style="list-style-type: none"> <li>• None</li> </ul>   |
| <b>What are the significant characteristics of people who graduated compared to those who did not?</b>  |   |
| <p><b>More Likely to Graduate</b></p> <ul style="list-style-type: none"> <li>• Engaged in Treatment Prior to Entry</li> <li>• Participants in the JAS track</li> </ul>  | <p><b>Less Likely to Graduate</b></p> <ul style="list-style-type: none"> <li>• Personality Disorders</li> <li>• Bipolar Disorders</li> <li>• Substance Related Disorders</li> <li>• Prior AOD Treatment</li> <li>• Multiple Axis I Disorders</li> </ul> |
| <b>What are the significant characteristics of ACRP participants who committed new crimes compared to those who did not?</b>  |   |
| <p><b>More Likely to Recidivate</b></p> <ul style="list-style-type: none"> <li>• Prior AOD Treatment</li> <li>• Personality Disorders</li> <li>• Substance Related Disorders</li> </ul>   | <p><b>Less Likely to Recidivate</b></p> <ul style="list-style-type: none"> <li>• Prior Psychiatric Hospitalization</li> <li>• ACRP Graduates</li> </ul>   |

One of the major questions surrounding therapeutic court programming concerns how “success” is defined and measured. Among those who did not matriculate into the ACRP, how do they fare in terms of recidivism? Although not involving an equivalent design, we can begin to explore whether or not there is a net ACRP effect; that is, was there a difference in recidivism when comparing people who received some level of intervention (people who did not matriculate past the Initial Opt-In Stage) versus those who received no intervention at all? Recidivism outcomes for ACRP participants at various levels of programmatic involvement are presented in Figure 16. Overall findings indicate that all three groups of ACRP participants had lower rates of recidivism than a comparison group of similarly situated defendants who were traditionally adjudicated.

**Figure 16: Criminal Recidivism Outcomes by Level of Program Involvement**





## Clinical Recidivism Outcomes

One of the goals of the ACRP is to reduce the amount of time participants spend institutionalized, whether time spent incarcerated or in a psychiatric institution. Among the studies of mental health courts, most show reductions in jail days, but are more mixed in terms of demonstrating any improvements along clinical outcome measures (Boothroyd, Mercado, Poythress, Christy & Petril, 2005; Cosden, Merith, Jeffrey Ellens, Jeffrey Schnell & Yasmeen Yamini-Diouf, 2004.). Thus far, we have examined the criminal justice outcomes of ACRP participants and now we turn to an examination of their clinical outcomes.

Later in this report, we provide results from a series of ACRP participant interviews who self-reported improvements along many clinical outcome and quality-of-life measures. Now we examine whether or not the broader ACRP showed any improvements to clinical outcomes (e.g., psychiatric hospital stays) derived from administrative data obtained from the Alaska Psychiatric Institute.

The analysis that follows is both pre-post and comparative in design whereby we examine the clinical recidivism among qualifying individuals only (i.e., people who had a psychiatric hospital admission during the one year immediately preceding entry into the ACRP), as well as against the matched group of comparison subjects who were not involved in the ACRP.

Referring to Table 11, we find virtually no difference between the various groups on the occurrence of a psychiatric hospital stay over time or in relation to the comparison group. Overall, slightly more than one-quarter of ACRP participants and comparison group subjects had a psychiatric hospital stay in the year prior to and year after exiting the ACRP.

**Table 11: Clinical Recidivism Outcomes – One Year Post-Discharge**

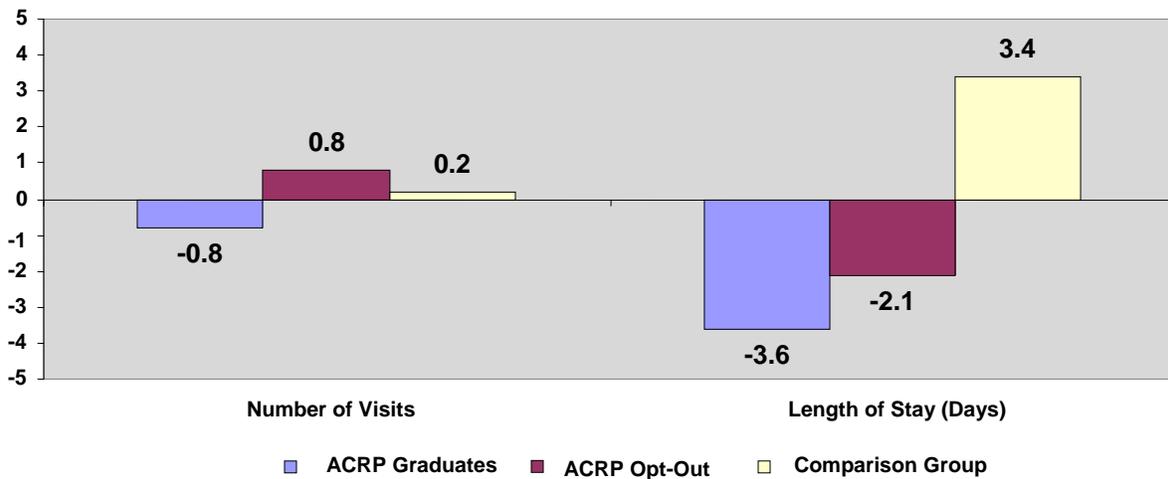
|                            | ACRP Graduates (N=87) |         | ACRP Opt-Out (N=131) |         | ACRP Combined (N=218) |         | Comparison Group (n=218) |         |
|----------------------------|-----------------------|---------|----------------------|---------|-----------------------|---------|--------------------------|---------|
|                            | Number                | Percent | Number               | Percent | Number                | Percent | Number                   | Percent |
| <b>API- One Year Prior</b> |                       |         |                      |         |                       |         |                          |         |
| <b>Yes</b>                 | 21                    | 24.1%   | 39                   | 29.8%   | 60                    | 27.5%   | 64                       | 29.4%   |
| <b>No</b>                  | 66                    | 75.9%   | 92                   | 70.2%   | 158                   | 72.5%   | 154                      | 70.6%   |
| <b>API- One Year Post</b>  |                       |         |                      |         |                       |         |                          |         |
| <b>Yes</b>                 | 22                    | 25.3%   | 35                   | 26.7%   | 57                    | 26.1%   | 57                       | 26.1%   |
| <b>No</b>                  | 65                    | 74.7%   | 96                   | 73.3%   | 161                   | 73.9%   | 161                      | 73.9%   |

However, when we examine the clinical outcome data beyond mere occurrence, we find that there are more meaningful differences between the groups on measures related to frequency and duration of these psychiatric hospital stays. Referring to Table 12 and Figure 17, we find that the ACRP group as a whole had a higher average number of visits than the comparison group (eleven versus eight) during both intervals, which was largely driven by the group opting out of the program (average of 14) versus ACRP graduates (average of six). The total number of psychiatric visits was also lower for the comparison group, although there were reductions for all three groups over time. The clinical outcome measure that ACRP participants most improved upon pertained to the average length of stay during each visit. Length of stay declined by 2.5 days for the group as a whole, versus the comparison group, where length of stay actually increased by 3.4 days.

**Table 12: Clinical Recidivism Outcomes – One Year Post-Discharge**

|  | ACRP Graduates (N=87) | ACRP Opt-Out (N=131) | ACRP Combined (N=218) | Comparison Group (N=218) |
|--|-----------------------|----------------------|-----------------------|--------------------------|
| <b>Number of API Visits (avg.)</b>           |                       |                      |                       |                          |
| Pre  | 6.5                   | 13.4                 | 11.0                  | 8.1                      |
| Post   | 5.7                   | 14.2                 | 10.9                  | 8.3                      |
| Difference                                   | -0.8                  | +0.8                 | -.01                  | +0.02                    |
| <b>Total Number of API Visits</b>            |                       |                      |                       |                          |
| Pre  | 136                   | 524                  | 660                   | 523                      |
| Post   | 125                   | 497                  | 622                   | 471                      |
| Difference                                   | -11                   | -27                  | -38                   | -52                      |
| <b>Average Length of Stay (days)</b>         |                       |                      |                       |                          |
| Pre  | 21.2                  | 17.3                 | 18.3                  | 18.8                     |
| Post   | 17.6                  | 15.2                 | 15.9                  | 22.2                     |
| Difference                                   | -3.6                  | -2.1                 | -2.4                  | +3.4                     |
| <b>Average Cost Per Stay (\$757 per day)</b> |                       |                      |                       |                          |
| Pre  | \$104,315             | \$175,488            | \$152,384             | \$115,276                |
| Post   | \$ 75,942             | \$163,391            | \$131,196             | \$139,485                |
| Difference                                   | -\$ 28,373            | -\$ 12,097           | -\$ 21,188            | +\$ 24,209               |

**Figure 17: Clinical Outcomes – Pre Post Differences in Psychiatric Hospital Admissions and Length of Stay**



Given that the average cost for spending one day at the Alaska Psychiatric Institute (\$757), these reductions in length of stay when calculated by the average number of visits translates into a net institutional savings for the ACRP of \$21,188 over time, and a difference of \$45,397 against the comparison group.

## ***Maintaining Benefits***

Many ACRP participants exiting the Alaska Department of Corrections (ADOC) are Medicaid-eligible and rely upon federal entitlements for income support, medications and mental health care in the community. Depending on the length of stay, these benefits can be interrupted or terminated, as Medicaid funds cannot be used to pay health care providers for health care costs of incarcerated individuals. On the other hand, if appropriately diverted to community based alternatives, Medicaid could be accessed to offset certain treatment costs such as psychiatric assessments, medications, and rehabilitation services that are otherwise being paid for by the Department of Corrections.

Maintaining beneficiary eligibility status is important according to two recent studies by Morrissey and his colleagues (2007). When examining the extent to which Medicaid enrollment increased access to and use of services among people with severe mental illness released from jail, studies revealed that having Medicaid benefits at release was associated with a 16 percent reduction in the number of subsequent incarcerations, increased service utilization, and more timely access to services (Morrissey, Steadman, Dalton, Cuellar, Stiles & Cuddeback, 2007; Morrissey, Cuddeback, Cuellar & Steadman, 2007). According to a recent study only 72 percent of Medicaid-eligible people with mental illness exiting the Alaska Department of Corrections retained their benefits within one year after release.

Referring to Table 13, we find that virtually all ACRP participants (98 percent) will have reengaged in Medicaid eligible services by the time they formally opt into the program. This compares very favorably against the state-wide average (72 percent) for individuals with mental illness exiting the Alaska Department of Corrections. The majority of people in the earlier stages of the ACRP admissions process are re-connected as well (85 percent).

**Table 13: Clinical Outcomes – Maintaining Medicaid Eligibility**

|  | ACRP Referrals<br>(N=53) |         | ACRP Initial Opt-Out<br>(N=102) |         | ACRP Formal Opt-Out<br>(N=96) |         | ACRP Graduates<br>(n=55) |         |
|--|--------------------------|---------|---------------------------------|---------|-------------------------------|---------|--------------------------|---------|
|  | Number                   | Percent | Number                          | Percent | Number                        | Percent | Number                   | Percent |
| <b>Medicaid Eligibility Maintained</b> |                          |         |                                 |         |                               |         |                          |         |
| <b>Yes</b>                             | 45                       | 84.9%   | 91                              | 89.2%   | 93                            | 96.9%   | 55                       | 100%    |
| <b>No</b>                              | 8                        | 15.1%   | 11                              | 10.8%   | 3                             | 3.1%    | 0                        | 0%      |



## ACRP Perspectives – Participant’s Point of View

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As alluded to throughout this report, “success” in a therapeutic court can be defined and measured in a variety of ways. While the ideal situation is one where a client receives appropriate treatment, graduates from the program and does not re-offend, the reality of therapeutic courts is that many participants do not follow such a straight path; many clients need more than one attempt at success, while others will never graduate but may still be able to achieve some form of success in terms of their mental illness or offending status.

For example, consider a person who, without proper medication, has violent outbursts as a symptom of a severe mental illness. Now imagine if this person enrolled in the ACRP and was able to receive appropriate treatment, especially in regard to medication management, but was unable to successfully complete the program. Soon after release from the program, this person is charged with a minor, non-violent offense, such as shoplifting, but is also found to have maintained the medication management schedule originally assisted by the court. Among the volumes of therapeutic court evaluations compiled to date, this person would technically be considered a “failure” because of the re-offense.

Yet it can be argued that the court was able to successfully help a previously violent offender receive needed treatment, and while a new crime was committed, it was not of the serious nature that originally brought the person into the ACRP. This is one of the reasons why HZA has employed a multi-method evaluation design to produce more in-depth outcomes about the program and the participants it serves. HZA staff talked with former ACRP participants and others to help gain a thorough understanding of program participation. Consider the following examples of former ACRP participants and ask this question: is this person a “success”?

Susan (fictitious name) is a 24 year-old Alaska Native diagnosed with a substance-induced psychotic disorder. While she entered the ACRP on charges relating to assault, her underlying problems in the past have almost exclusively related to her prostitution, which in turn supported her addiction to methamphetamine. Susan has a history of sexual abuse, unstable housing and multiple periods of incarceration and psychiatric admissions. After entering the ACRP, Susan continued to engage in a variety of addictive behaviors, did not engage in treatment or adhere to her treatment plan and was unsuccessfully discharged from two assisted living facilities due to substance use. As a result, Susan was sanctioned by the ACRP judge and she ultimately discontinued her participation in the program.

However, Susan was soon charged with another crime and readmitted to the ACRP. The barriers that Susan would need to overcome seemed insurmountable; she was continually denied benefits because of her severe substance use disorder, was unable to secure stable housing and continued to experience auditory hallucinations. Despite these challenges, the ACRP team supported Susan in her efforts at recovery. Her ACRP coordinator assisted Susan with her fourth SSI application and testified at her hearing, finally allowing Susan to receive benefits. The coordinator also worked with Susan to gain stable housing, access a new doctor to address medication concerns, and enroll in a culturally and gender-specific treatment program. It was at this treatment program that Susan was able to work through her past trauma, which she acknowledged was never previously addressed. Today, Susan continues to make progress in all aspects of her life and is supported by her friends, family and the ACRP team.

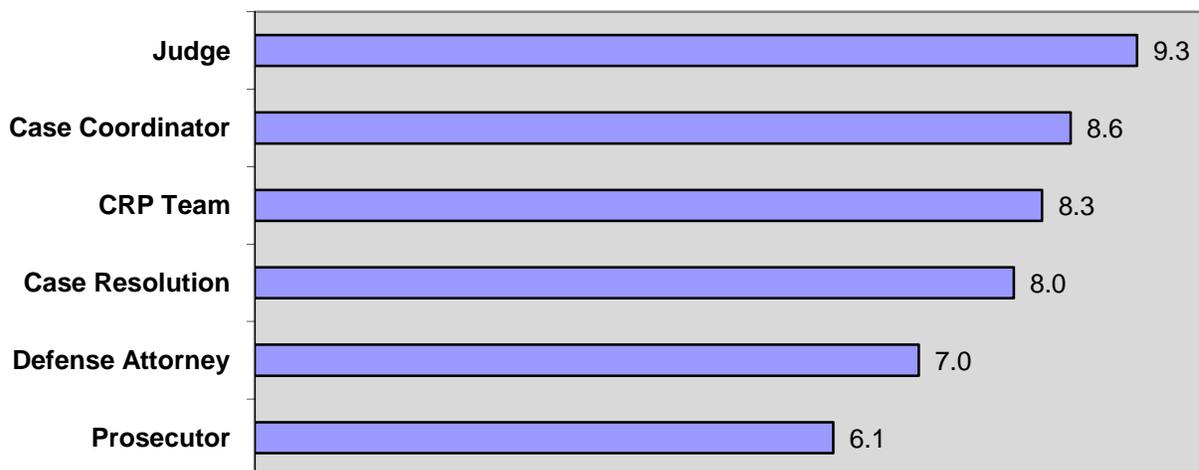
Sam (fictitious name) is a 54 year-old man with bipolar disorder. He was a former government employee with no previous criminal activity, but he got picked up one day driving the wrong way down a major highway. He entered the ACRP and was adherent with his treatment plan. Moreover, he enjoyed participating in court and did everything requested of him. Despite his participation in court and treatment, Sam’s mental illness continued to worsen, to the point where hospitalization was necessary.

Because Sam is a veteran, he was able to transfer to a state hospital in Arizona where he could receive the “last resort” of treatment options – Electroconvulsive therapy (ECT). When he returned to Anchorage, he graduated from the ACRP, established independent housing and generally seemed to be doing well. Soon after his graduation, though, Sam began to have difficulties with small, everyday tasks; one day, he left his house without turning the oven off. Sam’s brother eventually had to become his legal guardian but was unable to care for him on a full-time basis. As such, Sam sold his house and moved into an assisted living facility, where he currently remains.

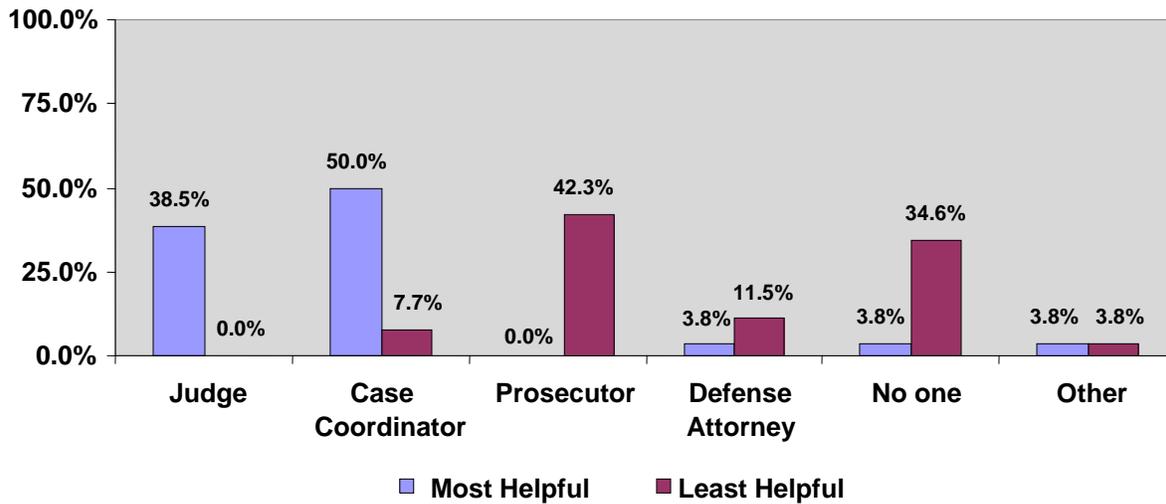
Both of these case studies highlight the complexity of defining “program success.” While both of these participants successfully participated in the court, they had very different eventual outcomes. Moreover, they highlight the complexity of mental illness and challenge the concept of recovery, whether it is from a mental illness or a substance use disorder, or both.

HZA staff talked with a number of other former participants of the ACRP as well. These in-depth interviews were designed to obtain information about their experiences with the program and, based on those experiences, determine their recommendations for system improvement. One of the questions we asked concerned satisfaction with various members of the ACRP team, as well as with the resolution of their criminal case. Referring to Figures 17 and 18, former participants were generally satisfied, with each of the various ACRP team members ranking the judges and case coordinators highest in overall satisfaction. Participants ranked defense attorneys somewhat lower in terms of overall satisfaction, while state and municipal prosecutors were ranked lowest overall.

**Figure 17: Question - On a scale of 0 to 10 with ten being the most satisfied, how satisfied were you with the following?**



**Figure 18: Among all ACRP team members, who was the most helpful to you?  
Who was the least helpful?**



**ACRP Participant Perspectives - ACRP Judges**

With the exception of a couple of participants, the overwhelming majority of participants were very pleased with their experiences with the two ACRP judges. Below are some of the comments that were made about them:

*“Real understanding, caring.”*

*“Worked with me and was available when needed.”*

*“Too strict; wanted to see me do time. They are not friendly.”*

*“Great – Judge Rhoades was proud of me; gave me a hug.”*

*“Very organized; encouraging to my sobriety and treatment.”*

*“Understands clients and knows how to get their attention. Talks one-on-one with people. Knows their problems – reads reports; does a great job to ensure clients comply with treatment.”*

*“A few years ago, I had to go to API over Thanksgiving. My family didn’t see or call me, but I received a surprise visit from Judge Rhoades. I will never forget her.”*

*“Compassionate, caring, understanding.”*

*“Treated me like a human being.”*

*“Fun to joke around with – although needed to be serious too.”*

*“Personable, can contact her directly. She is cool; I am usually scared of judges.”*

*“On my side.”*

*“Excellent, concerned about the people; has a heart. Supportive.”*

*“Really cares about people she is trying to help. Relates well and listens.”*

*“Judge always believes in giving people a second chance – has lots of faith in people [and] sees the best in them.”*

*“Influenced me to keep going with the program.”*

*“Understood my nervousness. She was generally concerned.”*

*“Sense of humor that alleviated my stress. She talked at my level. I was like a scared rabbit and the judge would explain things and calm me down.”*

### ***ACRP Participants on Case Coordinators***

Similarly, participants were generally pleased with their experiences with the ACRP case coordinators; however their results were a bit more mixed. Here are some of the comments made about them:

*“She was always there when I needed to talk to her.”*

*“Very good – they look out for you. Family-oriented.”*

*“Great help – supportive and concerned; there for me.”*

*“Gruff and abrupt.”*

*“Got me going in the right direction.”*

*“Super friendly, nice person.”*

*“Case Coordinator was stern when things went wrong – was disappointed and angry, but would calm me down and provide me with options and suggestions.”*

*“Not enough contact.”*

*“Helped me with difficulties; focused on counseling, treatment and meds. Really helped out: always traveled to treatment team meetings and always accommodated me by meeting me in other locations.”*

*“Good – sympathetic, but held ground; connected me with resources and programs. Case Coordinator used ‘honor system’ with me.”*

*“Not enough contact with me.”*

*“Not enough contact; just wanted me to sign papers – no choice, had to get payee.”*

*“Talked to me, ensured that I followed my plan.”*

*“Kept me notified of court dates and explained things to me. Returned my phone calls. Felt treated like a person instead of a number. Pulled some strings for me to get into treatment otherwise I would have had to wait.”*

*“All the little 15 minute appointments with 10 minute waits was irritating.”*

*“Need more people to help the case coordinator – always seemed overloaded.”*

*“I wanted the old case coordinator back.”*

### ***ACRP Participants on Defense Attorneys***

For the most part, when participants were asked to explain in more detail about their experiences with prosecutors and defense counsel, they had little to say or could not entirely remember their experiences with them. Those that did share their experiences were generally mixed in their responses. Here are some of the comments that were made about them:

*“They worked directly with the judge and case coordinator.”*

*“Advice was very helpful – answered questions and gave honest opinions.”*

*“Did her job; was businesslike and wasn’t disrespectful.”*

*“Informed me about what he was doing and worked well with the lawyer judge.”*

*“Didn’t do very much – just represented me. He did paperwork.”*

*“Hard to get in touch with him. No-showed on my court date.”*

*“Didn’t return my phone calls, never explained anything to me and was a little tough.”*

*“Keep doing what he is doing – giving good advice. He did “high fives” and gave me compliments at court sessions. Was easy to talk to – inspired confidence, trusting.”*

### ***ACRP Participants on Prosecutors***

*“On the defensive until they got to know me.”*

*“Looked professional.”*

*“Helpfulness of the prosecutor was raised after my involvement.”*

*“Not good at all.”*

### ***ACRP Participants on ACRP Program Improvements***

Participants were also asked what aspects of the ACRP program they would change to improve it. While some participants said they would not change anything, others provided recommendations that generally centered on the following six areas:

- 1) Increase activities for participants and make sure they are as active as possible.
- 2) Create a peer/mentor group of past participants to provide support and information about resources.
- 3) Either add more case coordinators or decrease their caseloads as it is difficult to contact them outside of assigned appointments.
- 4) Increase monitoring and consequences for participants not in adherence with the program.
- 5) Enforce random urinalyses (UAs) for those with co-occurring disorders.
- 6) Pay more attention to the underlying circumstances surrounding the offense and keep us more informed about what is going on legally.

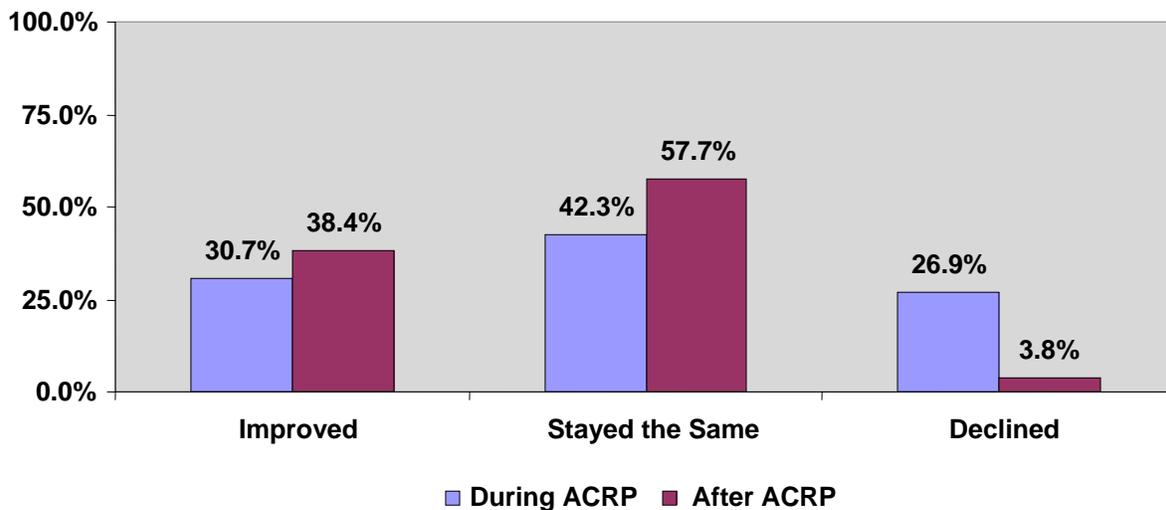
## Quality of Life Outcomes

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### *Participants on Mental and Physical Health*

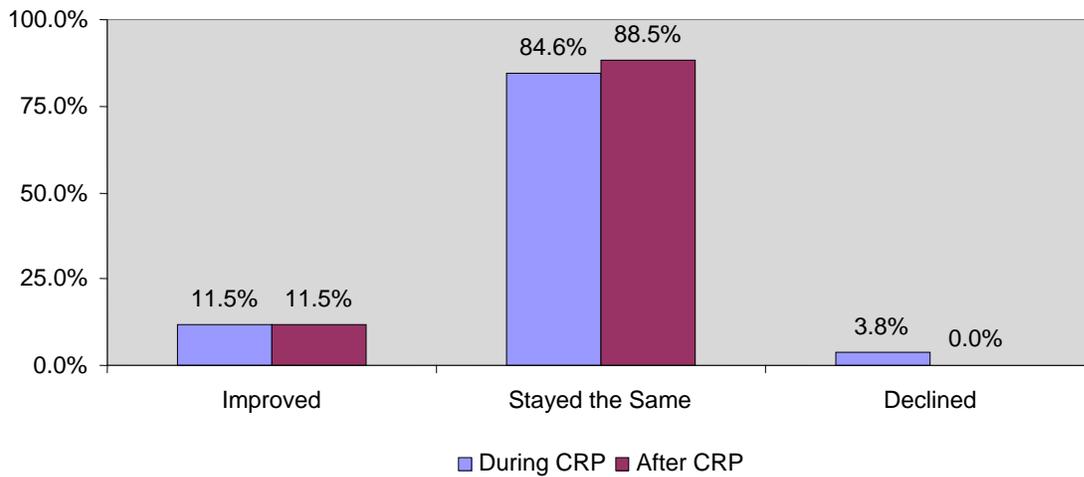
We asked former participants to describe as best they could, their emotional and physical well-being in the year prior to entering the ACRP, during involvement with the program, and the year after exiting the ACRP. When participants were asked to describe how often mental or emotional problems kept them from doing normal daily activities over the course of these different intervals, more participants indicated improvements in this area than declines, while about half indicated no real change in their emotional well-being.

**Figure 19: What best characterizes how often mental or emotional problems kept you from doing normal daily activities in the year prior to, during and after your involvement in the ACRP?**



Similarly, participants were asked to describe how often their physical health problems kept them from doing normal daily activities before, during and after ACRP participation. The vast majority of participants indicated no real change in their physical health, although the number of improvements slightly outweighed the number of declines on this measure.

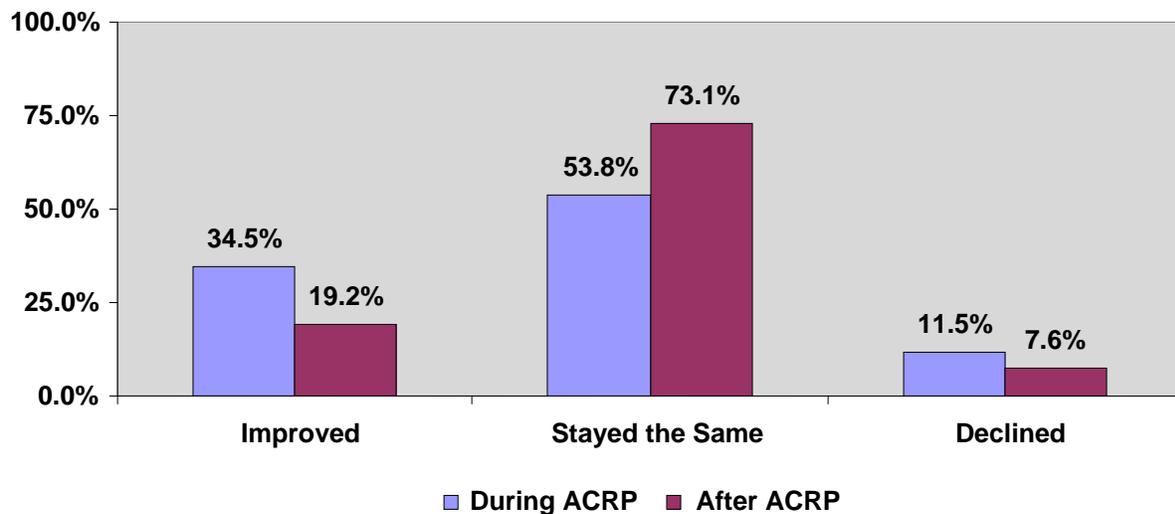
**Figure 20: What best characterizes how often physical health problems kept you from doing normal daily activities in the year prior to, during and after your involvement in the ACRP?**



***Participants on Safety and Support***

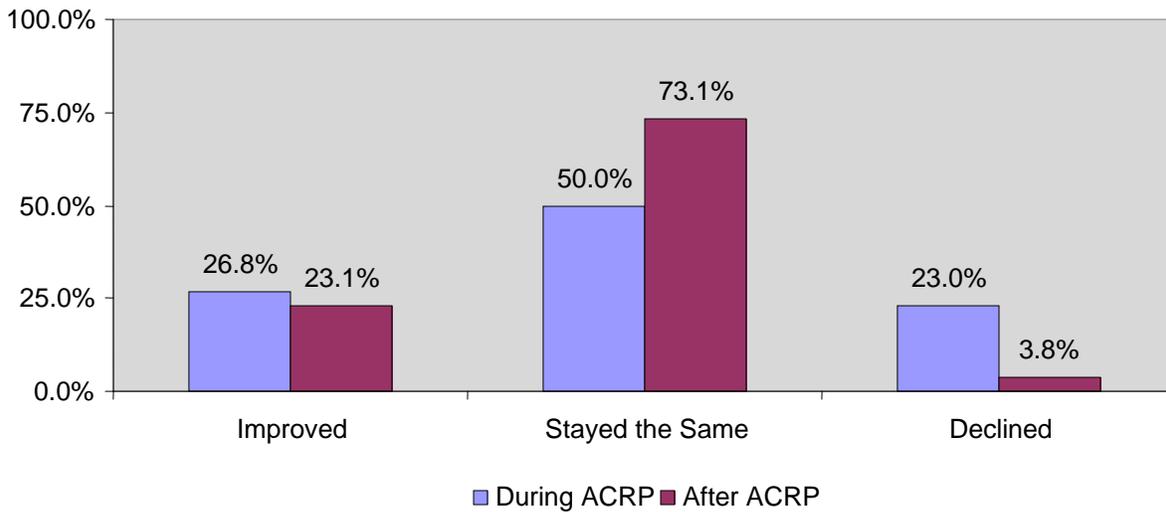
Participants were also asked to describe their general feelings about how safe they felt whether it was in their home, school, community or village for the period of time occurring before participation in the ACRP, during and after ACRP involvement. The majority of participants indicated no real change in their feelings of safety although there were more improvements along this measure than there were declines.

**Figure 21: What best describes your feelings about safety, whether it be in your home, school, community or village prior to, during and after your involvement in the ACRP?**



When participants were asked to describe the general level of support they received from family, friends, co-workers and peers, the majority of participants indicated no real change in their feelings about the level of support they were receiving. The biggest improvement occurred after exiting the ACRP where there were many more improvements than there were declines.

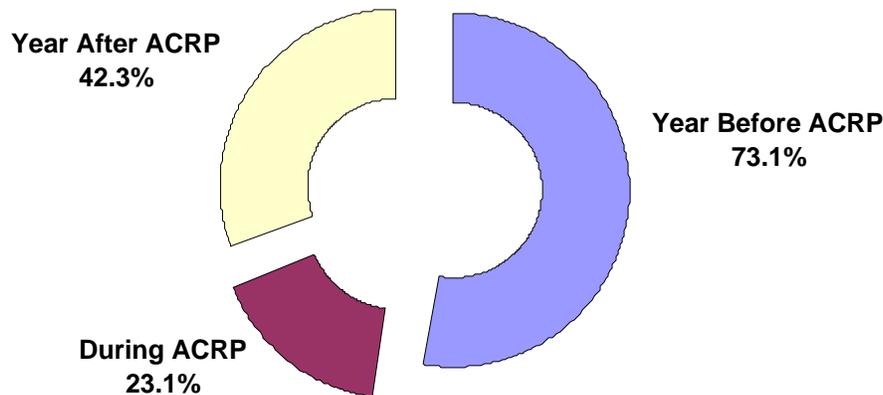
**Figure 22: What best describes how people in your life have supported you prior to, during and after your involvement in the ACRP?**



***ACRP Participants on Alcohol and Drug Use***

Referring to figure 23, ACRP participants also reported reductions in their alcohol and drug use. Alcohol and drug use among ACRP participants declined overall but mostly during their participation in the program.

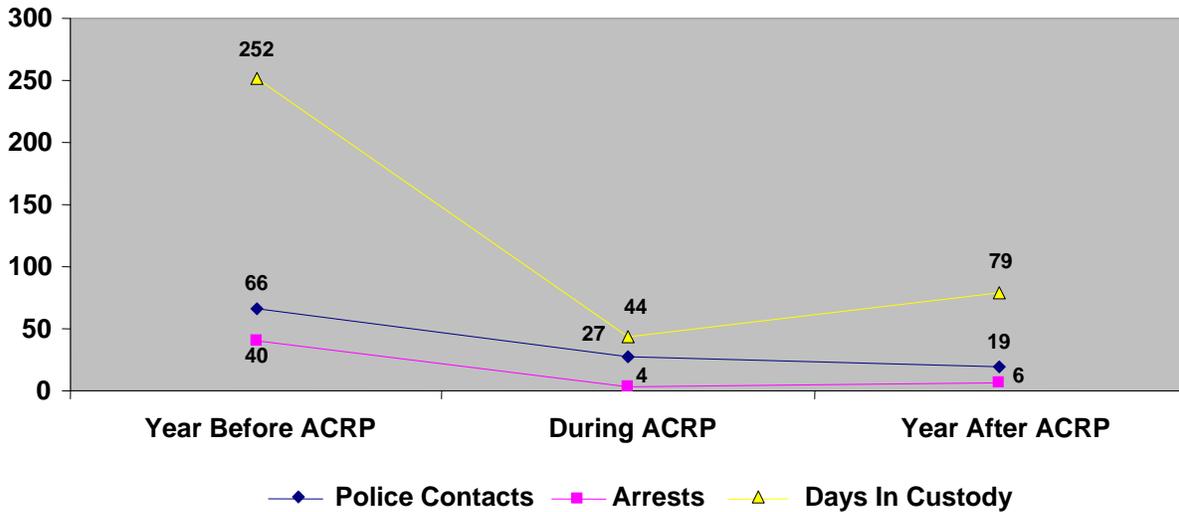
**Figure 23: (If applicable) Please describe the extent of your drug and alcohol use in the year prior to, during and after your involvement in the ACRP.**



### Participants on Criminal and Clinical Outcomes

We also asked ACRP participants about the extent of their criminal justice involvement prior to entering the ACRP, during their participation and after leaving the ACRP. Referring to Figure 24, we find that participants reported substantially fewer police contacts, subsequent arrests and days in jail after entering the ACRP. This pattern held true upon leaving the ACRP, with the exception of the number of days in jail which increased from 44 days during program participation to 79 days upon exit.

**Figure 24: Please describe the extent of your (criminal) legal involvement in the year prior to, during and after your involvement with the ACRP.**



ACRP participants also fared better on measures of homelessness and psychiatric hospital admissions. Referring to Figure 25, six participants reported being homeless in the year prior to entering the ACRP, for a total of 630 days. After entering the ACRP, only one participant reported being homeless for about one month. After leaving the ACRP, three participants reported being homeless for a total of 300 days. Participants also indicated reductions in psychiatric hospital admissions, which decreased slightly after entering the ACRP. Seven people reported a total of 182 days of hospitalization prior to ACRP participation. Three people reported 150 days of hospitalization during program participation, while five people reported 70 days of psychiatric hospital admission after exiting the ACRP.

**Figure 25: How many days did you spend in a psychiatric hospital or were homeless in the year prior to, during and after your involvement with the ACRP?**

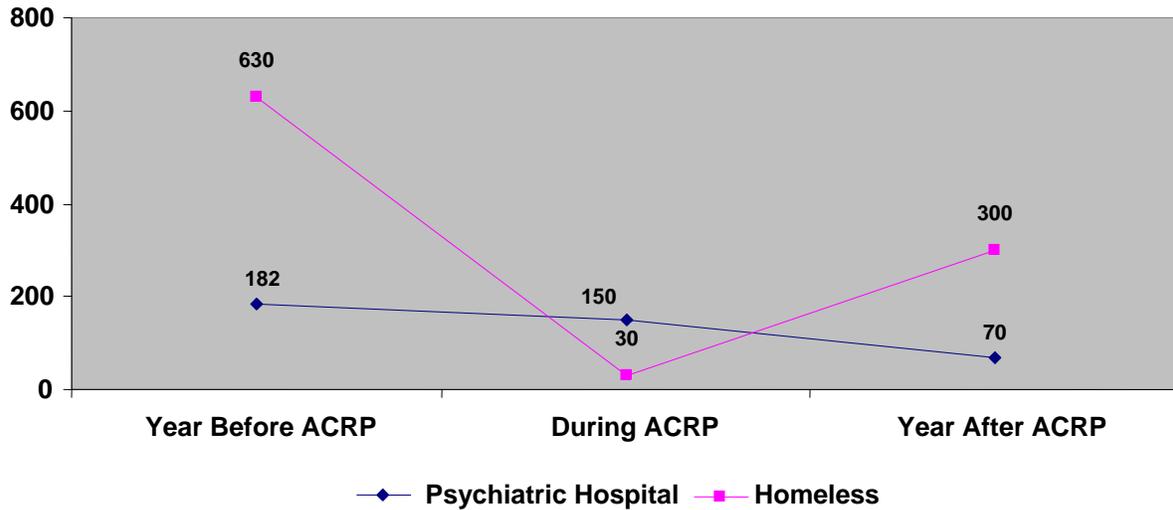
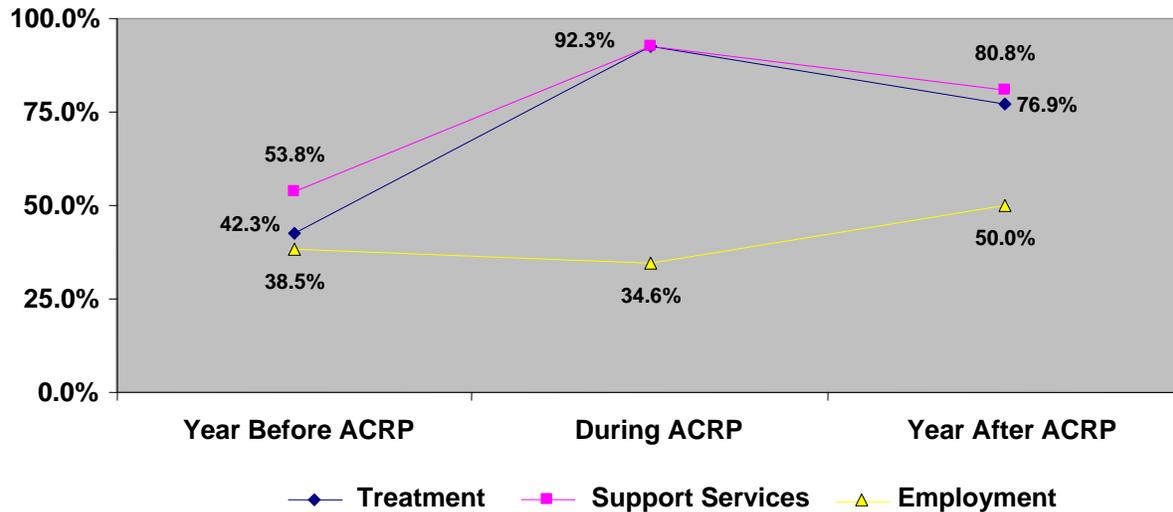


Figure 26 shows ACRP participant use of treatment and support services as well as employment outcomes for the three time intervals. Overall, participants engaged in treatment and social supports improved dramatically after entering the ACRP and many continued to be engaged in services upon leaving the ACRP. To a lesser extent, participants also reported improvements in employment as well.

**Figure 26: Were you either employed, in treatment or receiving support services in the year prior to, during and after your involvement with the ACRP?**





## Summary of Key Findings

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By and large, the impact of deinstitutionalization and the commensurate failure to simultaneously support mental health services in the community has led to a growing number of mentally ill persons housed in correctional facilities across the United States. As a result of this population growth, most jurisdictions such as the State of Alaska have tried to adopt new strategies to divert appropriate populations of mentally ill people from incarceration into community-based services. Established in July 1998, the Anchorage Coordinated Resources Project (ACRP) is one of many strategies the Alaska Court System and collaborating institutions have employed to address this important issue.

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

- The combined institutional savings generated by the ACRP (\$705,390) is estimated to be almost two and one-half times the annual operational costs of the program (\$293,000).
- Diverting Trust Beneficiaries with severe mental illness from incarceration into the ACRP poses less of a risk to public safety than traditional adjudication.
- Over the past five years (SFY 2002-2007), the number of referrals to the ACRP has been on the rise, ranging from a low of 224 referrals in 2002 to a high of 307 referrals in 2007.
- More than half of all people referred to the ACRP do not enter the program because they did not meet the program's eligibility requirements or because they elected not to participate. A smaller number did not enroll into the ACRP because charges were dismissed or they were found incompetent to stand trial.
- The average daily cost to operate the ACRP is estimated at \$19.82 per person, which is substantially less than the average daily cost of incarceration (\$121.60).
- ACRP participants were less likely to engage in new criminal conduct after exiting the program than an equivalent group of people experiencing mental illness who were also involved in the criminal justice system. ACRP graduates were least likely to re-offend overall.
- Among those who did engage in new criminal conduct, ACRP participants were less likely than an equivalent group to commit new felonies, violent or drug related crimes.
- Fewer incarcerations and psychiatric hospital visits, and reductions in the length of stay between both institutional settings generated a net savings for the ACRP both over time as well as against a comparison group (\$97,685)
- Prior involvement in alcohol or drug treatment and individuals with personality disorders increase the likelihood that future criminal recidivism will occur.

- The vast majority of former ACRP participants self-reported improvements along all quality-of-life domains as a result of their participation in the program.
- There is a significantly higher rate of program completion for participants in the ACRP Jail Alternative Services (JAS) Program track compared to participants in the Alaska Alcohol Safety Action Program track (ASAP). There were no differences, however, between participants in either track in the overall rate of post-discharge criminal recidivism.
- There is an indication of a net ACRP effect; that is, some level of intervention through the ACRP tended to decrease recidivism compared to those who received no intervention at all.

## Recommendations

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As a result of the major findings presented throughout this report, HZA encourages the Alaska Court System and key stakeholders within the State of Alaska to consider the following recommendations, so as to improve systems performance which will likely generate improved outcomes for the ACRP.

### **Recommendation 1: Increase access to community treatment services and resources for those with co-occurring mental health and substance-related disorders.**

The ACRP is returning to regular court a high volume of participants with co-occurring mental health and substance-related disorders whose needs typically exceed the available services offered in the Anchorage community. Analysis of administrative data and interviews with key stakeholders revealed a general lack of community-based mental health and, in particular, substance abuse treatment services for the growing number of Trust Beneficiaries seeking services through participation in the ACRP. For example, of the 401 people with co-occurring mental health and substance-related disorders who were referred to the ACRP, fewer than one out of five could be successfully enrolled in and graduated from the program. This clearly suggests that there is a high volume of people with co-occurring disorders cycling through the District Court who are not being reached.

Indeed, this will be a particularly daunting task given that funding for needed mental health and substance abuse services is in a perpetual state of flux. For the past several years the State of Alaska has experienced not only funding cuts, but also workforce shortage issues. Even when funding is available, the workforce may not be available to provide needed services. In recent months Anchorage has experienced the closure of a detoxification facility, the loss of several co-occurring treatment beds and is facing the inevitable relocation of the region's primary residential substance abuse treatment facility. Additionally, the largest community mental health center in Anchorage has temporarily shut its front door, even to priority populations (e.g., criminal justice involved Trust Beneficiaries) due to resource limitations and funding shortfalls. Given that approximately three-quarters of all ACRP participants receive services from that single service provider, the ACRP's capacity to serve future participants may be significantly diminished if treatment alternatives are not identified. If the ACRP is to continue to provide favorable criminal justice and behavioral health outcomes, the behavioral health system must be capable of providing participants with immediate access to a range of services. Alternatively, the program will need to secure funding for dedicated treatment slots, which has not been necessary to date.

### **Recommendation 2: Dependent upon assured access to appropriate community behavioral health services, implement a therapeutic court for Trust Beneficiaries charged with felony crimes.**

ACRP project management staff maintains a confidential list of past ACRP referrals and former participants. Each day, this list is compared against the daily in and out of custody arraignment calendars in order to flag defendants who may be eligible for participation in the ACRP. Overall, only one percent of all defendants arraigned are flagged by ACRP staff, and two out of five of those flagged were deemed ineligible because the defendant either had a pending felony or was on felony probation. The high volume of arraignments and the disproportionate prevalence of mental illness among those defendants arraigned, combined with the overwhelming support among key actors interviewed in this study supports the view that a mental health court should be introduced to hear felony cases for Trust Beneficiaries in the Anchorage Superior Court.

**Recommendation 3: Expand the number of ACRP case coordinators and the overall operational capacity of the ACRP.**

Among former ACRP participants interviewed, the single most common criticism of ACRP case coordinators was their general lack of availability due to the size of their respective caseloads. Interviews conducted with key stakeholders and observations of ACRP operations supported this criticism as well. The current caseload of forty participants per coordinator is an ambitious number to provide the level of monitoring and support needed for the intended target population of the ACRP. Given that both case coordinators have caseloads that are either at or exceeding capacity, it would behoove the ACRP to consider hiring an additional case coordinator who could reduce current caseloads while at the same time generating more positive outcomes for an even greater number of people in need of ACRP services.

**Recommendation 4: Revise admissions-related procedures to reduce the time it takes to formally opt into the ACRP.**

The third *Essential Element* of effective mental health court programming concerns the early identification of participants and timely access to community-based services. The reason for this principle is simple – it is well known throughout the literature that the sooner an individual, particularly one motivated by criminal justice involvement, is placed into treatment, the better his or her short and long-term outcomes will be in the future. The amount of time between the Initial Opt-In Hearing and Formal Opt-In Hearing where a formal intervention and treatment are adopted averages 74 days. Although service plans are developed and service linkages are initiated during this interim period, the ACRP should consider establishing earlier benchmarks (with which all parties can agree) and try to work within these parameters and shorten the time it takes participants to be formally accepted into the program.

**Recommendation 5: Revise existing methods by which ACRP referrals and participant updates are reviewed by members of the ACRP team.**

Interviews with ACRP team members and observations of ACRP operations revealed inefficiencies in the method by which participant updates were disseminated to team members as well as discontent among some team members about admissions related procedures. The entire ACRP team should consider convening to discuss ACRP policies and procedures surrounding programmatic admissions, hold more frequent pre-court meetings (including representatives from the treatment community) to discuss sanctions, and streamline the manner in which participant updates are shared so that information is consistently presented about each case as it relates to all major life domains of the individual (i.e., employing a consistent approach that embraces the emotional, physical, social, cognitive and material aspects of well-being).

**Recommendation 6: Develop a more formalized system of graduated sanctions and incentives and increase funding to expand the range of incentives available for ACRP participants.**

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

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

**Recommendation 7: Provide more resources for the collection and entry of data for all therapeutic courts in Alaska.**

For many years, the ACRP has been using a database modeled after a shareware system developed in the mid-to-late 1990s which was designed to collect basic information for adult drug court participants. The ACRP database contained few variables for tracking purposes. Many data elements necessary to meet the evaluative needs of a mental health court were missing. The database was also designed to be docket-driven as opposed to person-driven requiring significant duplication of effort in data entry. As a result, ACRP project management staff keeps separate spreadsheets from which they generate tallies for basic reporting requirements, representing yet another duplication of effort.

Unfortunately, this is a common problem among therapeutic court programs nationally as well as with Alaska's other therapeutic courts. The Alaska Court System should consider investing in a new management information system for all therapeutic court programs as there are many elements common across programs. Such a system would streamline therapeutic court operations, reduce duplicative efforts and allow for more systematized data collection and reporting mechanisms that would benefit all therapeutic court programs the Alaska Court System supports.

**Recommendation 8: Consider implementing the recommendations put forth by former participants of the program.**

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

- 1) Increase activities for participants and make sure they keep as active as possible;
- 2) Create a peer/mentor group of past participants to provide support and information about resources or contacts;
- 3) Either add more case coordinators or decrease their caseloads as it is difficult to contact them outside of assigned appointments;
- 4) Increase monitoring and consequences for participants not in adherence with the program;
- 5) Enforce random drug testing for those with co-occurring disorders; and,

Pay more attention to the underlying circumstances surrounding the offense and remind participants of these at regular status hearings.



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## **Appendix A – The Alaska Mental Health Trust Authority**



## The Alaska Mental Health Trust Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Axis III:** Acute medical conditions and physical disorders.

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

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