

**Initial Performance Measures and Comparative Outcomes  
of the Douglas County Behavioral Health Court**

Jason Matejkowski, PhD  
jmate@ku.edu

Margaret Severson, JD  
mseverson@ku.edu

July 2019 (v. 2)

## Introduction

### **The Development of the Behavioral Health Court**

In 2015, Dr. Jason Matejkowski and Professor Margaret Severson (now Professor Emerita) entered into a series of agreements with Douglas County (initially, as consultants under a contract between TreanorHL and Douglas County) to provide consultation regarding possible alternatives to incarceration (diversion), and justice program evaluations and data generation and management services. Our contractual work extended through most of 2017, and the whole of that work can be found in our *Douglas County Final Report 2017*, presented to the Douglas County Administrator and the Douglas County Board of County Commissioners on October 25, 2017. Although the submission of that report marked the end of our official contract with the County, we continued providing support and consultation to the Douglas County Behavioral Health Court (originally known as the Mental Health Court), which was at that time in its very early stage of development and implementation. The report that follows provides the first Behavioral Health Court (BHC) program evaluation and addresses the performance measures identified as important (by the National Center for State Courts) early in the BHC development period. As such, the findings reported here are initial or preliminary findings. It is suggested that the results of this performance measurement serve as benchmarks with which to inform and assess the BHC's further development. Evaluation of the BHC should continue, as the court serves more individuals and time accrues to assess longer term outcomes than what are reported upon here.

The BHC was originally contemplated in 2015 and the intent to develop a BHC in Douglas County was embedded in the body of a Justice and Mental Health Collaboration Program (JMHCP) grant we wrote on behalf of Douglas County and the Douglas County Correctional Facility. In anticipation of the development of a BHC, we explored the operation of problem solving courts in other states, both through site visits and literature reviews. In fall 2015, the JMHCP funding was awarded and our work toward the development of a BHC in Douglas County began in earnest. Our 2017 *Douglas County Final Report* provided a brief background of that work:

During the BHC program planning stages that occurred between October 1, 2015 and July 31, 2016, we convened and facilitated several large group meetings that were attended by a cadre of stakeholders in the Douglas County community. We facilitated or were otherwise involved in more than 16 planning and policy development meetings, including a work session with the BOCC, and we provided guidance on the court's actual implementation and start up. We serve as consultants to the BHC team and as the leaders of the building of an evaluation protocol, including the building of an Access database in which information useful for the Court's evaluation will be recorded (p. 7).

Consistent with the original plans for the BHC, the eligibility criteria for involvement in the BHC remains as it was in 2017. To be eligible for the BHC, defendants must be (1) at least 18 years of age, (2) residents of Douglas County, (3) have a serious mental illness (SMI) or co-occurring SMI and substance use disorder, and provide (through collateral documentation and consultation) evidence that the behaviors which led to the defendants' arrest are primarily a result of mental illness rather than primarily related to criminal thinking, (4) are charged with certain non-violent misdemeanors and felonies, with the charges and the characterization of them as violent or non-violent being considered on a case-by-case basis, and (5) voluntary participants of the BHC.

Having an overarching goal of improving public safety by reducing recidivism in Douglas County, two primary objectives of the BHC were identified: (1) To reduce the number of people with serious mental illness and co-occurring disorders incarcerated in the Douglas County jail, by (2) connecting participants with necessary and appropriate community support services.

The amazingly skilled Amy Barnes, Senior Software Specialist with Douglas County Information Technology, designed and built a comprehensive Access Database, into which much of the data needed to assure a comprehensive evaluation of the BHC were uploaded. The data collected include certain personal and legal characteristics of each BHC participant (referral source, charge(s), descriptive/demographic information, information gleaned from screenings and assessments [e.g., criminal risk, mental health; substance use]); the types, locations, dosage and duration of the services BHC participants receive (length of stay in the BHC program and reason for discontinuation [e.g., withdrawal, graduation, termination], status hearings scheduled/attended; behavioral health services (substance related and mental health services) scheduled/received; sanctions and rewards); outcomes (e.g., reincarceration, hospitalization); and other miscellaneous data consistent with national best practices in program evaluations of BHCs and specialty courts. The cooperation of the BHC resource partners (i.e., the BHC Team) in gathering and providing these data was essential to this evaluation and to what we hope will be ongoing evaluations as well.

#### The National Evidence: Behavioral Health Courts

In 2015, we authored and presented a *Review of the Literature on Jail Diversion Programs and Summary Recommendations for the Establishment of a Mental Health Court and Crisis Center within Douglas County, Kansas* to the Douglas County Commissioners. The database and this evaluation of the Douglas County BHC is founded on the evidence that existed at that time and that has been produced since. We remarked then:

Because unmanaged psychiatric impairment can be the primary contributing factor in some criminal acts, standard criminal justice responses may be viewed as scientifically and therapeutically baseless. For these individuals, a model that incorporates both criminal justice supervision *and* structured therapeutic intervention may be more effective for addressing the dual objectives of public health and public safety. Mental health courts (MHCs) are specialized dockets for defendants with mental illnesses that seek the adjudication of criminal charges and municipal code violations by using a problem solving model... there is no consensus on what constitutes a mental health court; they are developed in the context of community need and they function differently based upon the range and availability of treatment and court resources in that community and service catchment area (p. 19).<sup>1</sup>

At the outset, we cautioned that most of the existing research lacked certain rigor, such as the random assignment of study participants to mental health court and a control group, and thus could not result in causal pronouncements. The experimental (rigorous designs) studies and the meta-analyses we reviewed suggested the use of a BHC held promise in terms of reducing re-arrest and days in jail. However, some research at the time also indicated “that reductions in costs associated with justice

---

<sup>1</sup>Christy, A., et al., *Evaluating the efficiency and community safety goals of the Broward County Mental Health Court*. Behavioral Sciences & the Law, 2005. **23**(2): p. 227-243.; Steadman, H., S. Davidson, and C. Brown, *Mental health courts: Their promise and unanswered questions*. Psychiatric Services, 2001. **52**(4): p. 457-458; Honegger, L.N., *Does the evidence support the case for mental health courts? A review of the literature*. Law and Human Behavior, 2015. **39**(5): p. 478-488.

system processing may not be offset by the increased behavioral services costs associated with participation in a mental health court” (p. 22).<sup>2</sup> In the end, we concluded and cautioned this (excerpted):

We can say with some confidence that the outcomes of MHCs appear to be equal across gender lines, that there is some measurable, though perhaps small, reductions in recidivism rates among those defendants involved in a MHC, at least in the 12 month period following court involvement.

[W]ithout a range of community resources to which defendants can be referred and treated, the MHC will have little impact. The judge must have the resources with which a treatment plan can be devised. The research points especially to the need for ACT services, i.e., intensive, multi-disciplinary mental health teams that carry small caseloads and provide ongoing, often daily services to consumers. There are currently no ACT services in operation in Douglas County.

While recidivism rates among defendants involved in a MHC appear to be lower than those among non-MHC participants, these reductions will not necessarily yield reductions in total jail populations. In many ways, recidivism rates among one group have nothing to do with arrest rates of another group of persons with similar characteristics. Thus, when thinking about designing a system that will address the challenges that come with managing persons with SMIs and co-occurring disorders and reducing jail populations, MHCs should be seen as one of several strategies that must be simultaneously in operation. It calls for a tripartite approach: Well-staffed courts, community resources, and smart arrest and diversion policies and procedures. (pp. 24-25).

### **Evaluation of The Douglas County Behavioral Health Court**

In the end, we encouraged the County Commissioners to pursue the development of the BHC as one diversion strategy among many, and one situated in this context: that the ultimate goal of services for justice-involved persons is to respond at the right time, in the right place, with the right intervention(s). That is as true for the use of the BHC as it is for any other diversion intervention now in operation or contemplated for development and implementation in Douglas County.

The evaluation reported in the following pages follows from this ultimate (ideological) goal and we encourage the reader to consider the whole of this evaluation rather than its parts, i.e.: Did the BHC serve the right person, at the right time, in the right place(s), and with the right intervention? When it did, what were the outcomes for the individual and the community? When it did not, what were the outcomes for the individual and the community?

---

<sup>2</sup> Steadman, H., Callahan, L., Robbins, P. C., Vesselinov, R., McGuire, T. G., & Morrissey, J. (2014). Criminal justice and behavioral health care costs of mental health court participants: A six-year study. *Psychiatric Services, 65*(9), 1100-1104. doi:10.1176/appi.ps.201300375

## Performance Measures

Behavioral Health Court performance measures assessed included the following Mental Health Court Performance Measures recommended by the National Center for State Courts.<sup>3</sup> These outcomes and their operational definitions are listed below.

1. **Time from Arrest to Referral:** The average length of time between a participant's arrest and referral to the BHC.
2. **Time from Referral to Admission:** The average length of time between the referral to BHC and when the participant was accepted into the program.
3. **Acceptance:** Percent of participants accepted to the BHC who decline participation in the BHC
4. **Attendance at Scheduled Judicial Status Hearings:** The percent of scheduled judicial status hearings attended by the participant.
  - i. Percentage of Scheduled Judicial Status Hearings Postponed.
5. **Average Number of Judge-ordered Sanctions per Participant:** The number of sanctions (not technical violations) administered by the Judge to each participant during their participation in BHC (also the dates the sanction was administered, the types of sanction, and the reasons the sanctions were administered). The performance measure is the average number of sanctions (as defined by the court) administered to participants by Type of Exit (e.g., graduates or dropouts).
6. **Average Number of Judge-ordered Incentives per Participant:** The number of incentives granted by the Judge to each participant during their participation in BHC (also the dates the incentives were granted, the types of incentive, and the reasons the incentive were granted). The performance measure is the average number of incentives (defined by the court) granted to participants by Type of Exit.
7. **Attendance at Scheduled Therapeutic Sessions:** The percent of scheduled therapeutic sessions (defined as services to address mental health and/or substance abuse problems) attended.
8. **In-Program Reoffending:** (whether an arrest occurred yes or no; whether a violation occurred yes or no). In-program reoffending is defined as an arrest that results in the offender being formally charged (excluding traffic citations other than DUI) and which occurs between admission and exit.
9. **Average Number of In-Program Jail Days:** The average number of days that participants spent in jail during program participation. Each time a participant is jailed the dates of admission and release and the charge(s) will be recorded and the number of days jailed will be subsequently calculated.
10. **Average Number of In-Program Hospitalization Days:** The average number of days that participants spent in a hospital or inpatient setting for psychiatric crisis or behavioral health stabilization during program participation. Each time a participant is hospitalized the dates of admission and release and the reason(s) will be recorded and the number of days hospitalized will be subsequently calculated.
11. **Living Arrangement:** the percent of participants who are homeless or not at exit, by living status at entry.
12. **Retention:** The percent of participants admitted to the BHC who exit the program by one of the following means: Successful completion, administrative closure, voluntary withdrawal while in compliance, discharge, transfer, and failure/termination.
13. **Total Time in Program:** The average length of time between a participant's admission into the BHC and permanent exit.

---

<sup>3</sup> Waters, N. L., Cheesman II, F. L., Gibson, S. A., & Dazevedo, I. (2010). *Mental health court performance measures: Implementation & user's guide*. Williamsburg, VA: National Center for State Courts.

14. **Need-Based Treatment and Supervision:** the percentage of participants who receive the highest (and alternatively lowest) level of services and supervision and whether those are the same participants who are designated as having highest (and lowest) needs.
15. **Participant-Level Satisfaction:** Perceived fairness of the program by the participant as expressed in a short 5-question survey administered by BHC treatment team member at program exit
16. **Participant Preparation for Transition:** Percent of correct responses by the participant identifying sources of assistance (e.g., for medication or mental health symptoms) to be used after exiting the program.
17. **Average Number of Days Hospitalized:** The average number of days of hospitalization that participants experienced during a tracking period (one and two years) after exit from BHC. Determined by the number of days hospitalized during the tracking period averaged by Type of Exit.
18. **Post-Program Recidivism:** Percentage of participants who reoffended within two years after exiting the BHC.

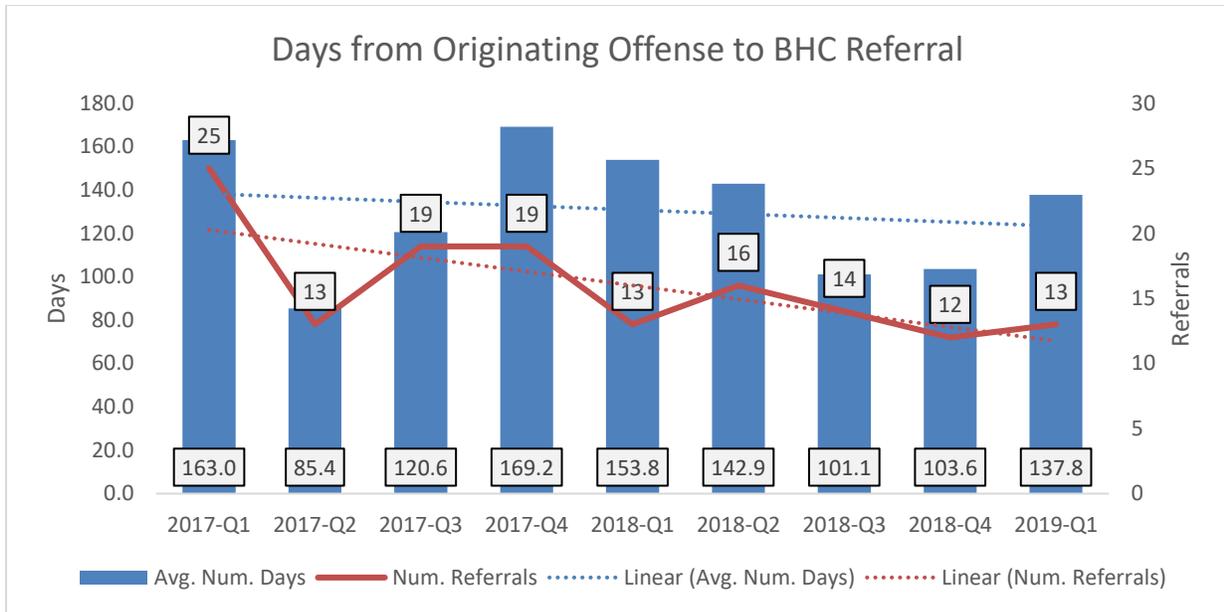
The following performance measures are based upon data reflecting activities that were recorded in the BHC database as occurring between January 1, 2017 and March 31, 2019, excluding the court's "test case." During this time period the BHC received 144 referrals. It accepted 43 of these individuals into the BHC and 41 of these 43 adults agreed to participate. Of the 41 participants, 17 exited the program either successfully (n = 6), unsuccessfully (n = 7), via voluntary withdrawal (n = 3), or transfer (n = 1). The remaining 24 participants are actively involved in the BHC at the end of the observation period referenced in this report.

#### **Time from Arrest to Referral**

All 144 referrals to the BHC during the observation period were included in calculating quarterly averages of the number of days from the date of the originating offense associated with the referral to the date the District Attorney's Office received the referral. Individuals could have been referred more than once to the program. In the event an individual has more than one offense origination date, the most recent origination date prior to referral is used. There is a slight trend to a decreasing number of referrals and a rather flat average trend in length of time between arrest and referral to the BHC (see: Days from Originating Offense to BHC Referral). Overall, the average (mean) length of time between arrest to referral (134.9 days) is influenced by outliers (extreme cases that took an unusually long time to be referred to the DA's office). The median length of time between arrest to referral is 78.5 days.<sup>4</sup>

---

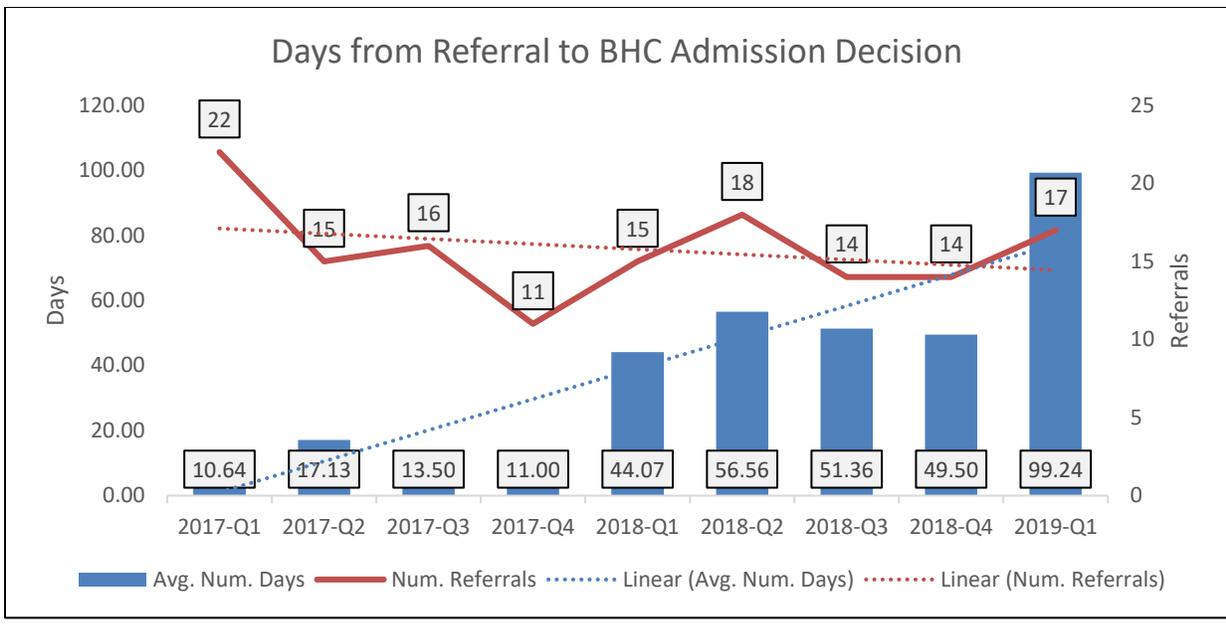
<sup>4</sup> The median is a measure of central tendency (like the mean or average) but is not influenced by outliers. The median indicates the midpoint of a set of values such that half of the values are above and half below the median. In this case half of the referrals took less than 78.5 days and half took longer than 78.5 days to reach the DA's Office.



### Time from Referral to Admission

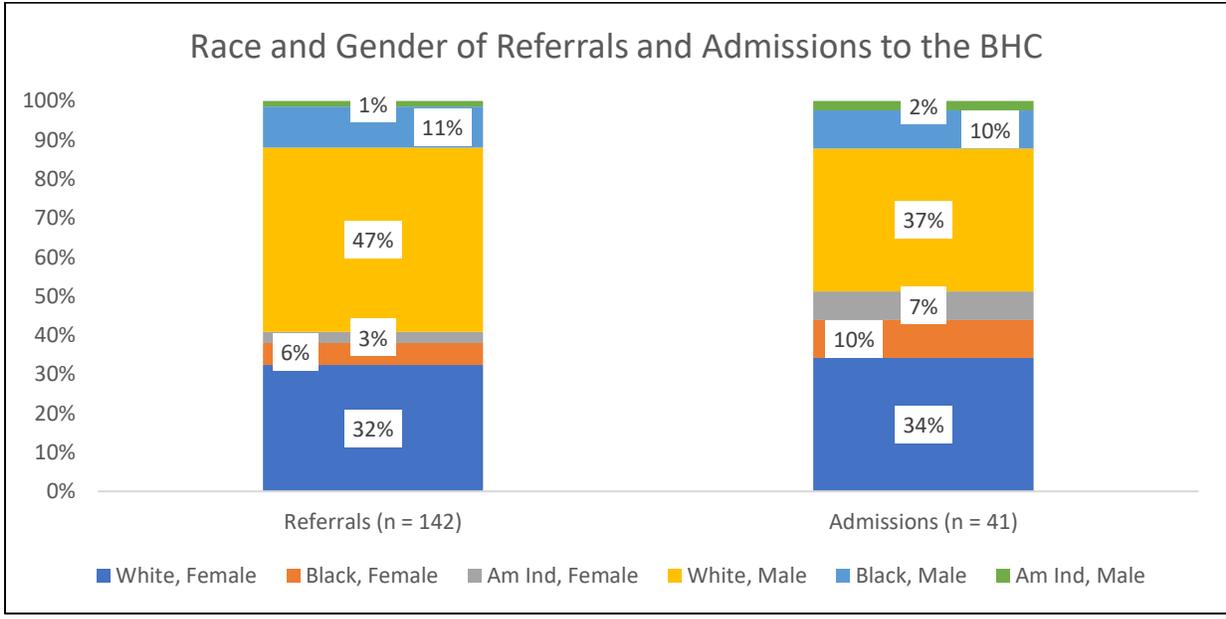
This process outcome reflects the average length of time between when an individual is referred to the BHC and when a decision whether to admit is provided by the BHC team (i.e., “wait time”). All referrals having decision dates other than “pending” were included in (n = 142) calculating quarterly averages of the number of days from the date of the referral to the District Attorneys’ Office and the date of the decision to admit by the BHC team. Individuals could have been referred more than once to the program. Overall, the average wait between referral and the BHC decision was 39.5 days (Median = 24.0 days). There was no significant difference ( $p > .05$ ) in the average number of days between referral and decision dates based upon acceptance (Mean = 39.3 days) or denial (Mean = 39.6 days) to the BHC.

The length of time between referral and decision is influenced by a number of factors including the timing of certain preadmission evaluations, the BHC team’s consideration of the application and supporting documents, the defense attorneys’ consultations with their clients, and the defendant’s decision process. Nonetheless, there appears to have been significant policy and/or procedural changes that occurred near the beginning of 2018 that resulted in substantial increases in wait times (see: Days from Referral to BHC Admission Decision).



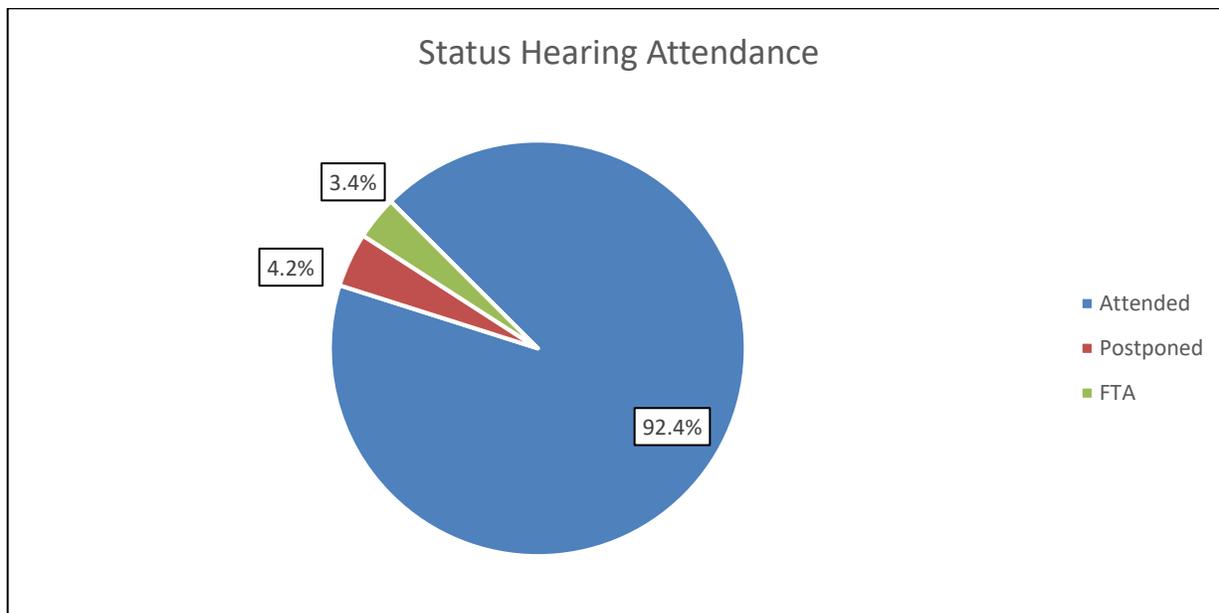
**Acceptance Rate**

Of the 43 referrals who were accepted into the BHC program, 41 agreed to be admitted (i.e., 95% acceptance rate). Race and gender of the 142 referrals and 41 admissions to the BHC are summarized in the following table (see: Race and Gender of Referrals and Admissions to the BHC).



### Attendance at Scheduled Judicial Status Hearings

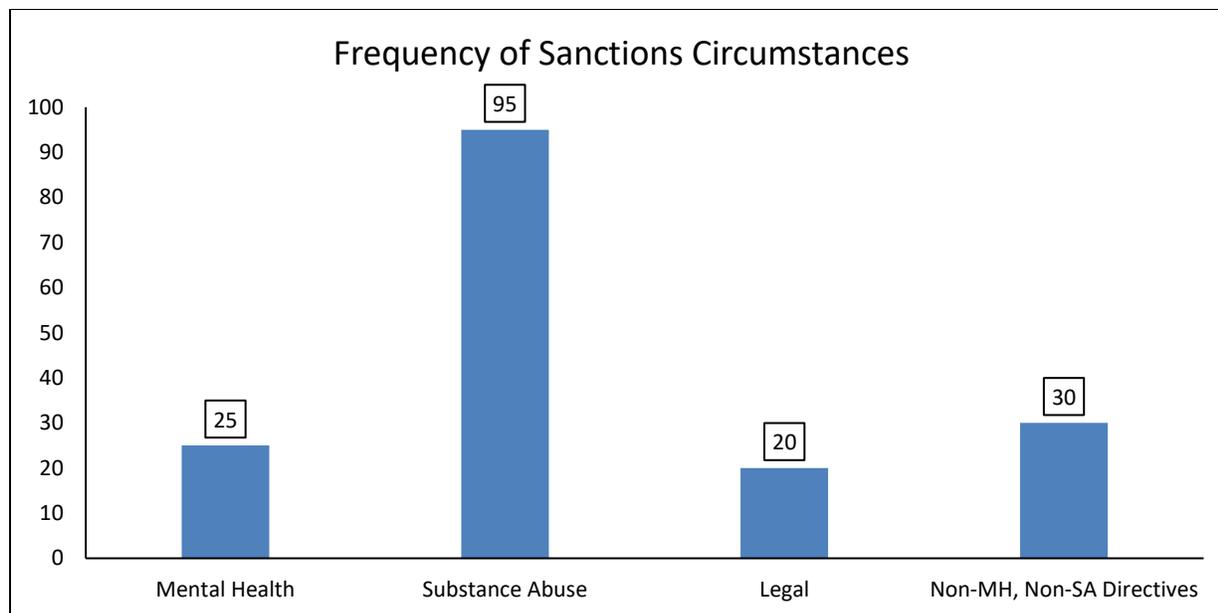
There were 711 status hearings scheduled during the observation period. Attendance is summarized in: Status Hearing Attendance.



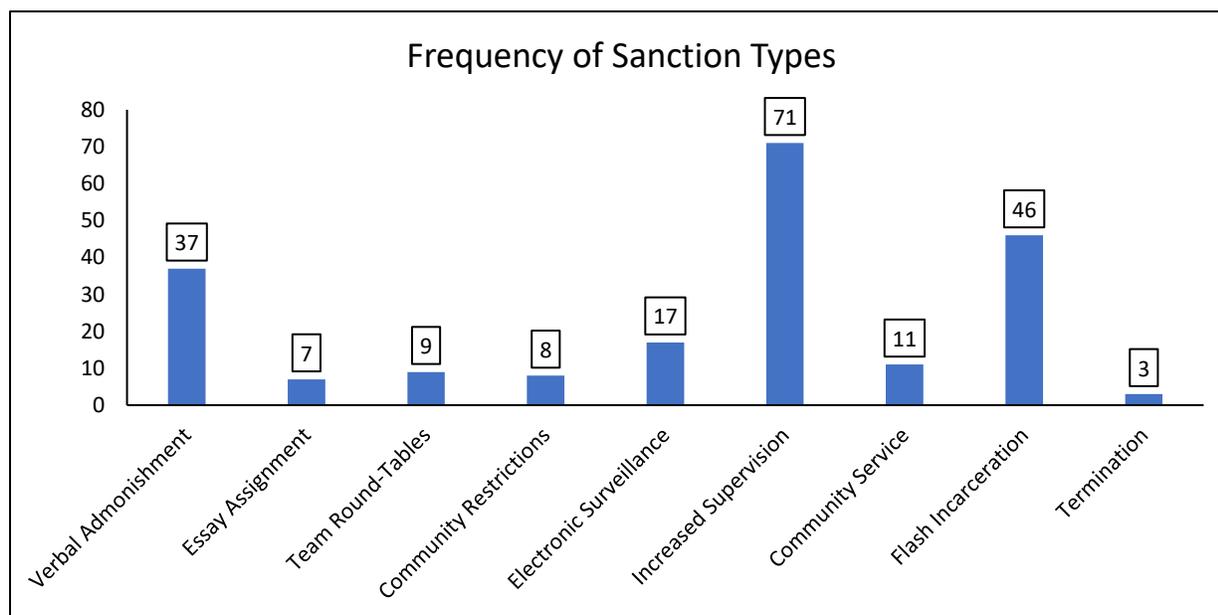
Of those who have exited the BHC, those who successfully completed had attended 95.6% of their status hearings. Successful completers had no recorded failures to appear (FTA). Those who were terminated from the program attended 89.7% of their status hearings and failed to appear for 4.7% of their status hearings.

### Average Number of Judge-ordered Sanctions per Participant

During the observation period, 29 of the 41 BHC participants received at least one sanction; totaling 124 sanctioning events. Circumstances related to sanctioning events are presented in: Frequency of Sanctions Circumstances. More than one circumstance could accompany a single sanctioning event. The most common circumstances were related to substance use (e.g., a positive urinalysis, missed substance abuse treatment appointments) followed by noncompliance with court directives, missed appointments at mental health treatment, and legal problems not associated with a new offense. The observation that the number of times substance use contributed to a sanctioning event is more than the number of times than all other contributing circumstances combined, indicates that co-occurring substance use problems among BHC were common as was the court's relative willingness to resort to sanctions to influence clients' substance using behaviors



Types and frequencies of sanctions administered by the court are presented in: Frequency of Sanction Types. A sanctioning event can include more than one type of sanction.

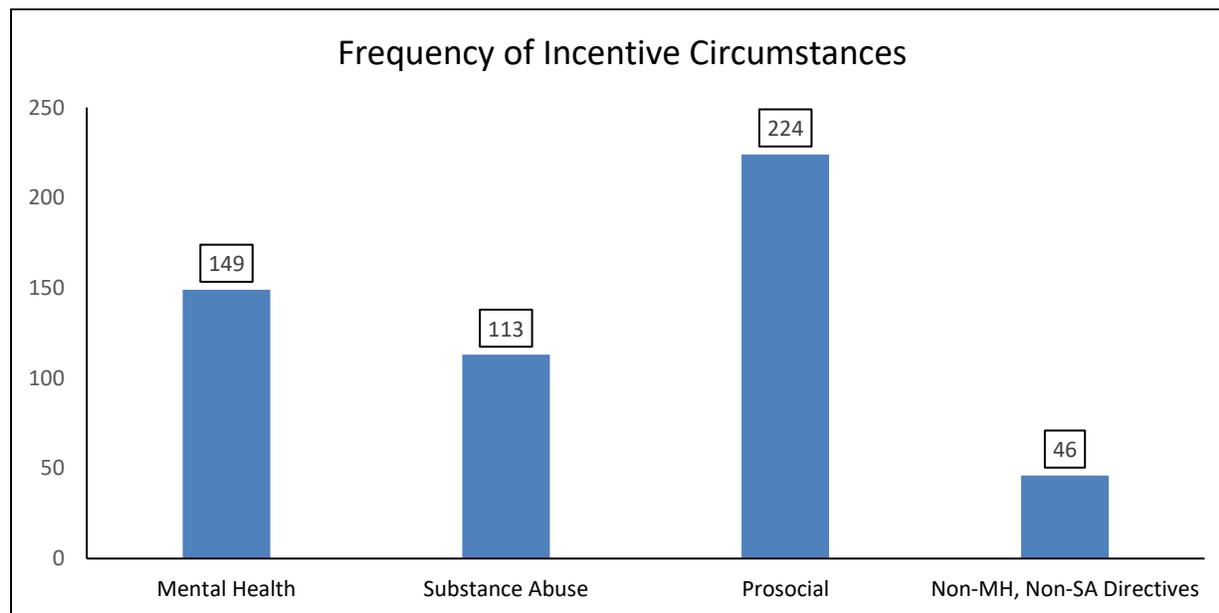


Across all participants ( $n = 41$ ), sanctioning events averaged 3.02. Those who had a sanctioning event and went on to successfully complete the BHC program ( $n = 2$ ) averaged 1.50 sanctions/participant. Those who had a sanction and were terminated from the program ( $n = 6$ ) averaged 8.33 sanctions/participant. Among all successful completers ( $n = 6$ ), sanctions averaged 0.50 sanctions/participant. Among all terminations ( $n = 7$ ), sanctions averaged 7.57 sanctions/participant.

Approximately 22% of sanctions involved a jail stay (i.e., flash incarceration). Minor sanctions listed toward the left side of the chart above, were less frequent. Following behavioral principles, “over-reliance on harsh sanctions in response to problematic behavior should be avoided. Learned helplessness and reduced motivation for treatment can result ... [and] if severe sanctions are too often applied either avoidance of the aversive stimulus (here the judge or the [problem-solving court]) or ceiling effects that diminish the sanction's ability to shape behavior can quickly result.”<sup>5</sup> As such, when risk to public safety allows, alternatives to flash incarceration (e.g., community service) should be employed more frequently.

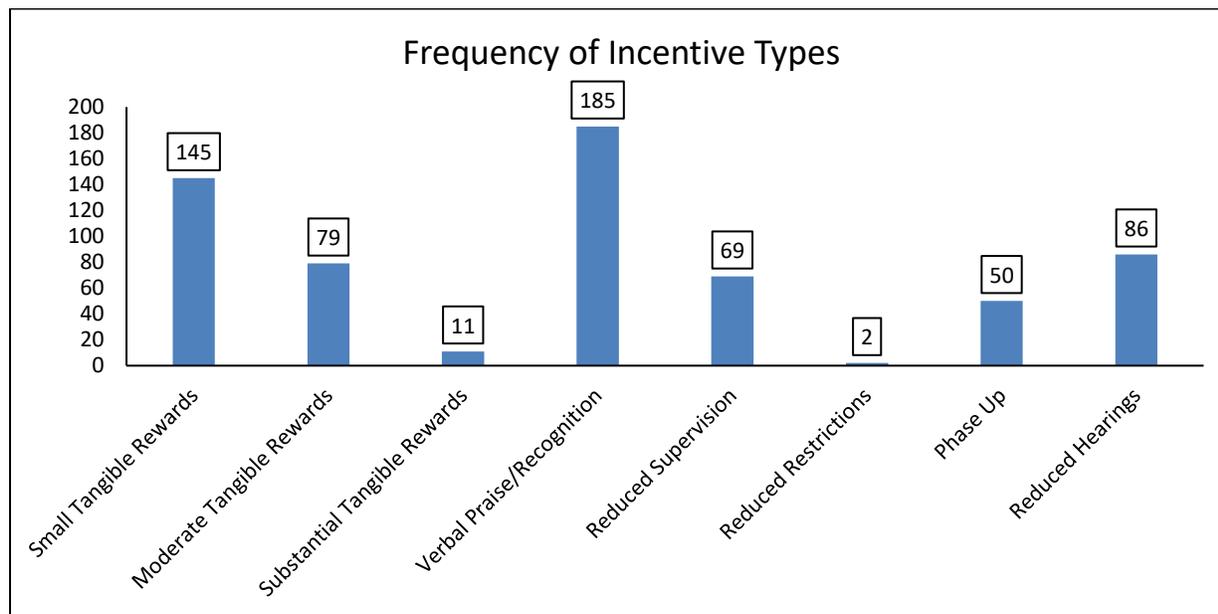
#### Average Number of Judge-ordered Incentives per Participant

There were 269 incentivizing events recorded with 37 participants during the observation period. Circumstances related to incentivizing events are presented in: Frequency of Incentive Circumstances. More than one circumstance could accompany a single incentivizing event. The most common circumstances were related to prosocial behaviors (e.g., accomplishing a goal) followed by incentives to reinforce behaviors associated with mental health treatment and substance abuse treatment, and court directives.



<sup>5</sup> Matejkowski, J. Festinger, D. Benishek, L. & Dugosh, K. (2011). Matching consequences to behavior: Implications of failing to distinguish between noncompliance and nonresponsivity. *International Journal of Law and Psychiatry*, 34, 269-274.

Types and frequencies of incentives administered by the court are presented in: Frequency of Incentive Types. An incentivizing event can include more than one type of incentive.

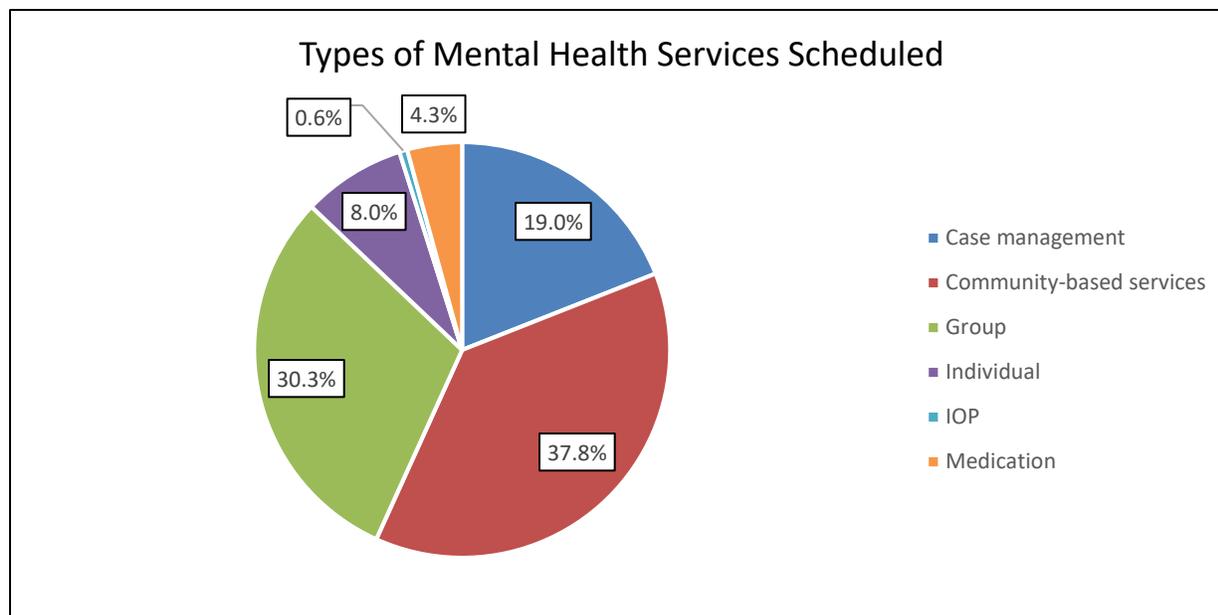


Across all participants ( $n = 41$ ), incentivizing events averaged 6.56 per participant. Those who had an incentivizing event and went on to successfully complete the BHC program ( $n = 6$ ) averaged 8.17 incentives/participant. Those who had an incentive and were terminated from the program ( $n = 5$ ) averaged 5.20 incentives/participant. Among all successful completers ( $n = 6$ ) incentives averaged 8.17 incentives/participant. Among all terminations ( $n = 7$ ) incentives averaged 3.71 incentives/participant. The lower number of incentives averaged by those terminated from the program may reflect a lower frequency of behaviors to incentivize.

### Attendance at Scheduled Therapeutic Sessions

#### *Mental health treatment services*

BHC participants were scheduled for 6,149 mental health services. These services are summarized in: Types of Mental Health Services Scheduled.



Attendance at each of these scheduled mental health services is summarized below.

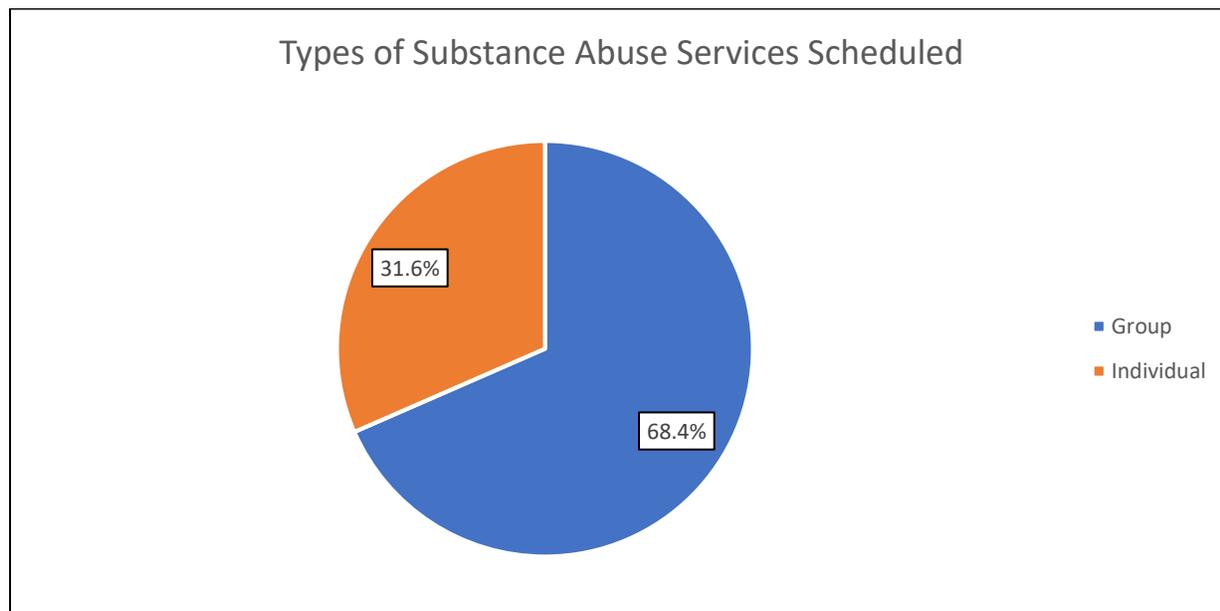
(data available/data points)	Attended	Failed to Appear/ Unexcused	Postponed/Excused
Case management (n = 1162/1169)	89.8%	5.5%	4.7%
Community-based services (n = 2314/2322)	95.0%	2.3%	2.7%
Group (n = 1857/1865)	74.5%	17.9%	7.5%
Individual (n = 492/493)	73.4%	9.8%	16.9%
IOP (n = 38/38)	65.8%	21.1%	13.2%
Medication (n = 261/262)	67.4%	11.9%	20.7%

In addition, 10 clients received a total of 302 days of psychiatric inpatient treatment (191 of these days were accrued to a single client).

#### *Substance abuse treatment services*

BHC participants were scheduled for 1,122 substance abuse treatment services. These services are summarized in: Types of Substance Abuse Services Scheduled. The number of participants' scheduled substance abuse treatment services was approximately one-fifth the number of mental health services. This lower level of substance use service provision likely reflects the court's eligibility criterion that the individual's arrest is primarily the result of mental illness (not substance abuse). However, given that problems with substance use were the main contributor to participants' sanctions (see: Frequency of

Sanctions Circumstances above), suggests that existing substance use problems could be responded to with more treatment rather than sanctions.



Attendance at each of these scheduled substance abuse services is summarized below.

(data available/data points)	Attended	Failed to Appear/ Unexcused	Postponed/Excused
Group (n = 768/768)	70.2%	27.6%	2.2%
Individual (n = 354/354)	67.8%	25.4%	6.8%

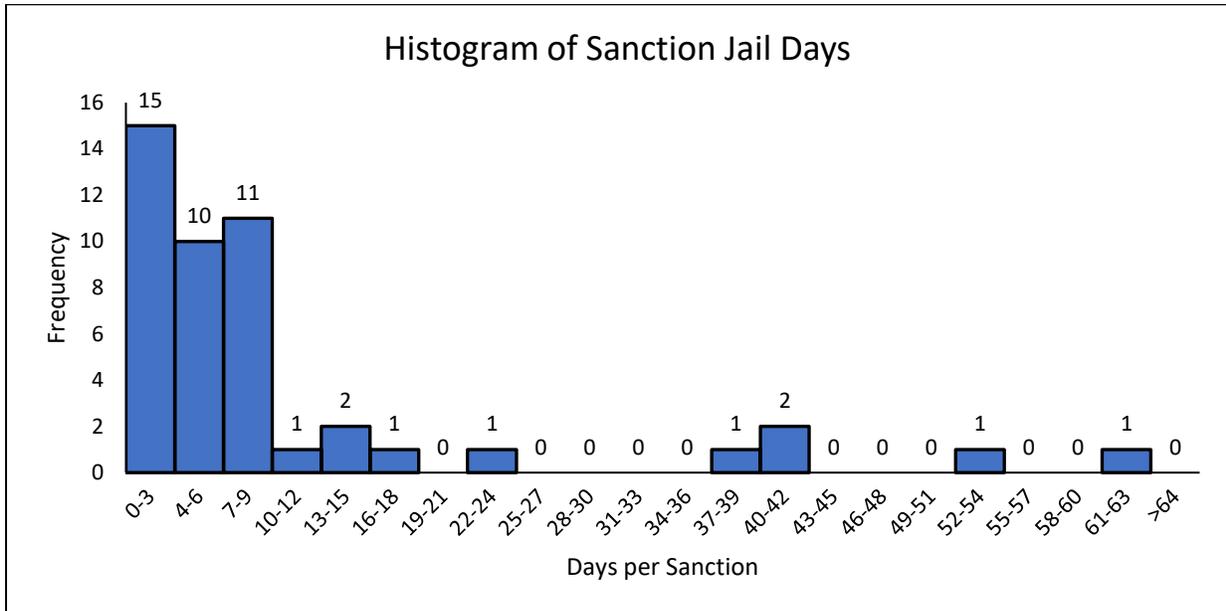
In addition to group and individual outpatient services, 10 clients received a total of 420 days of residential/inpatient substance abuse treatment (one-third [143] of these days were accrued to two clients).

#### **In-Program Reoffending and Average Number of In-Program Jail Days**

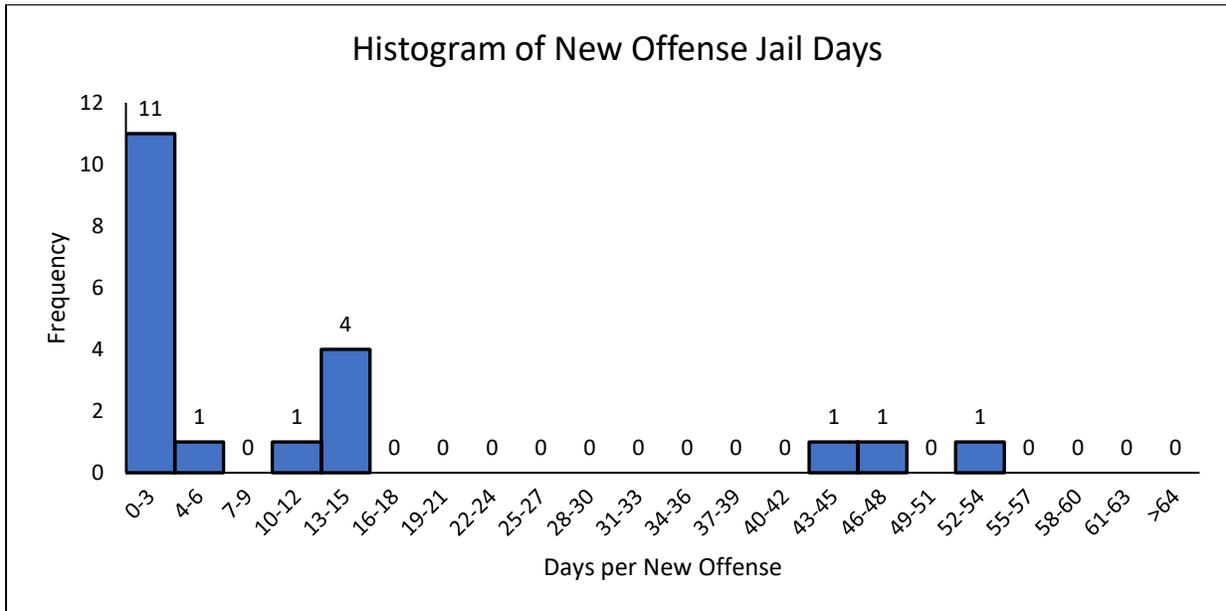
Of the 41 people who participated in the BHC between January 1, 2017 and March 31, 2019; 20 had a jail stay for a sanction or a new offense while a BHC participant (15 had a jail stay for a sanction, 13 had a jail stay for a new offense, and 8 had jail stays for both a sanction and a new offense). These 20 participants had a total of 66 jail stays and a total of 719 jail days.

Across all 41 BHC participants, jail stays for sanctions averaged 1.12/participant and jail days for sanctions averaged 11.7/participant. Across all participants, jail stays for a new offense averaged 0.49/participant and jail days for a new offense averaged 5.8/participant. Across all participants, jail stays for either a sanction or a new offense (n = 66) averaged 1.61/participant and jail days for a sanction or new offense (n = 719) averaged 17.54 days/participant.

Those 15 BHC participants who spent time in jail specifically for a sanction had a total of 46 jail stays for a total of 480 jail days (Mean = 10.4 days/stay, Median = 5.5 days/stay). Number of jail days for a single sanction ranged from 1 day to 62 days (see: Histogram of Sanction Jail Days).



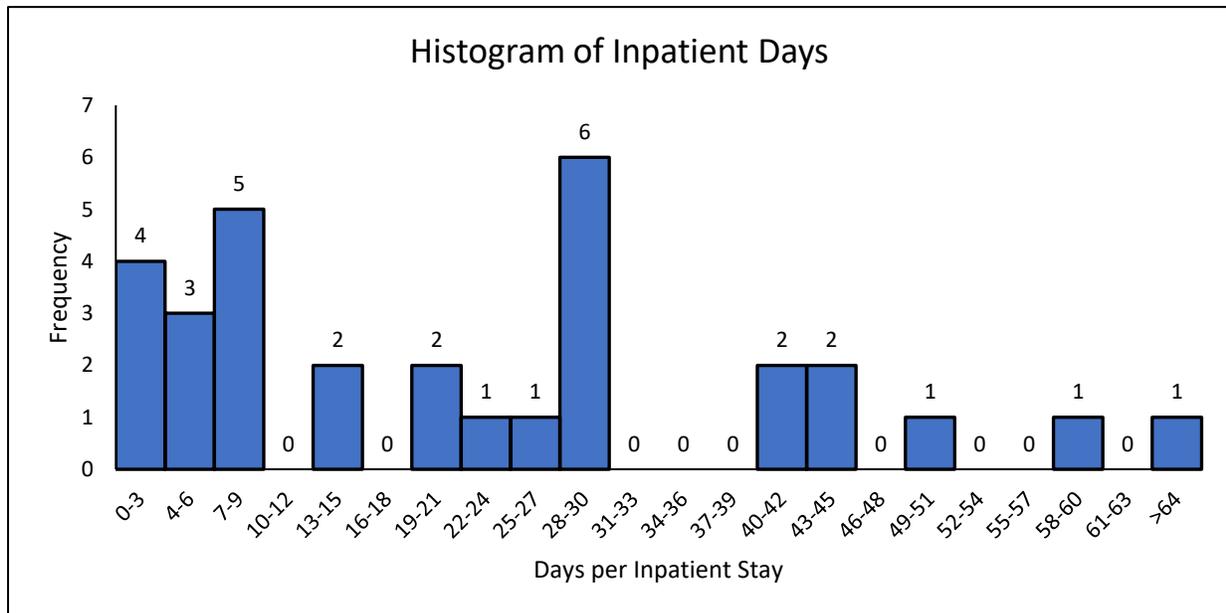
Those 13 BHC participants who spent time in jail specifically for a new offense had a total of 20 jail stays for a total of 239 jail days (Mean = 12.0 days/stay, Median = 3 days/stay). Number of jail days for a single sanction ranged from 1 day to 54 days (see: Histogram of New Offense Jail Days).



### Average Number of In-Program Hospitalization Days

Sixteen of 41 BHC participants had 31 inpatient stays for either a health (1 person, 1 stay), mental health (10 people, 16 stays), or substance use problem (10 people, 14 stays). Inpatient stays for a health problem totaled two days, for a mental health problem 302 days (Mean = 18.9 days/stay; Median = 8 days/stay), and for a substance use problem, 420 days (Mean = 30.0 days/stay; Median = 29 days/stay). Across all 31 inpatient stays, the average length of stay was 23.4 days/stay (Median = 21 days/stay, see Histogram of Inpatient Days).

Across all 41 participants, inpatient stays for a mental health problem averaged 0.39/participant and inpatient days for a mental health problem averaged 7.4/participant. Across all participants, inpatient stays for a substance abuse problem averaged 0.34/participant and inpatient days for a substance abuse problem averaged 10.3/participant. Across all participants, inpatient stays for either a health, mental health, or substance use problem (n = 31) averaged 0.76/participant and inpatient days for any of these problem (n = 724) averaged 17.7 days/participant.



### Living Arrangement

The 41 BHC participants entered the program with the following housing statuses. The housing status at exit of the 17 participants who exited the BHC is also shown in the next table.

Admit Status (n = 41)		Exit Status (n = 17)
Homeless at a shelter (n = 1; 2.4%)	→	
House/Apartment alone (n = 10; 24.4%)	→	House/Apartment alone (n = 1; 5.8%) House/Apartment with roommate (n = 1; 5.8%)
House/Apartment with family (n = 13; 31.7%)	→	House/Apartment with family (n = 4; 23.5%) Transitional housing (n = 1; 5.8%)
House/Apartment with roommate (n = 4; 9.8%)	→	House/Apartment with roommate (n = 1; 5.8%) Missing data (n = 1; 5.8%)
In custody (n = 9; 22.0%)	→	House/Apartment alone (n = 1; 5.8%) House/Apartment with family (n = 1; 5.8%) House/Apartment with roommate (n = 1; 5.8%) In custody (n = 2; 11.8%) Missing data (n = 1; 5.8%)
Literally homeless (n = 1; 2.4%)	→	Homeless at a shelter (n = 1; 5.8%)
Precariously housed (n = 1; 2.4%)	→	
Transitional housing (n = 2; 4.9%)	→	House/Apartment with family (n = 1; 5.8%)

### Retention

Seventeen participants exited the program during the observation period. Six of these participants successfully completed the program.

Exit Type/Retention	Through March 31, 2019
Successful Completion	6 (35.3%)
Failure/Termination	7 (41.2%)
Voluntary Withdrawal	3 (17.6%)
Transfer	1 (5.9%)

### Total Time in Program

The average length of time between these 17 participants' admissions into the BHC and permanent exit is displayed below.

Exit Type/Retention	Average Number of Days in Program
Successful Completion (n = 6)	361.5
Failure/Termination (n = 7)	266.86
Voluntary Withdrawal (n = 3)	78.0
Transfer (n = 1)	500.0

### Need-Based Treatment and Supervision

The BHC screens individuals for BHC participation with the Screening Version of the Level of Service Inventory-Revised (LSI-R: SV; see: <https://www.mhs.com/MHS-Publicsafety?prodname=lsi-rs>). Scores range from 0 – 8 with higher scores reflecting a higher likelihood for engaging in criminal behavior. Scores in the 0-2 range can be considered low-risk, 3-5 moderate risk, and 6-8 high risk for criminal behavior.<sup>6</sup> The 41 BHC participants scores on the LSI-R: SV were:

	N	Percentage
Low (0 - 2)	8	19.5%
Moderate (3 - 5)	28	68.3%
High (6 - 8)	5	12.2%

In addition, potential BHC participants are screened with the Violence Risk Appraisal Guide (VRAG)<sup>7</sup> to determine potential for future violent behavior. The 41 BHC participants' scores on the LSI-R: SV were:

	N	Percentage
Low (-24 - -8)	3	7.3%
Moderate (-7 - 13)	33	80.5%
High (14 - 32)	5	12.2%

### Participant-Level Satisfaction

Of the 17 participants who exited the program, five had data collected on program satisfaction; all were successful completers. Average scores on the 5-point, strongly disagree-strongly-agree scale are summarized below.

	Average
1. The way my case was handled was fair.	4.8
2. The judge listened to my side of the story before he or she made a decision.	4.8
3. The judge had the information necessary to make good decisions about my case.	5.0
4. I was treated the same as everyone else in the BHC.	5.0
5. I was treated respectfully during my time in BHC.	4.6

### Participant Preparation for Transition

Of the 17 participants who exited the program, five had data collected on transition preparation; all were successful completers. All five individuals reported that, after leaving the program, they knew who to contact if they needed help with (1) housing, (2) medication, (3) mental health symptoms, (4) substance abuse, and (5) medical problems.

<sup>6</sup> Lowenkamp, C. T., Lovins, B., & Latessa, E. J. (2009). Validating the Level of Service Inventory—Revised and the Level of Service Inventory: Screening version with a sample of probationers. *The Prison Journal*, 89(2), 192-204. doi:10.1177/0032885509334755

<sup>7</sup> Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (1998). *Violent offenders: Appraising and managing risk*. Washington, D.C.: American Psychological Association.

### **Average Number of Days Hospitalized**

During the observation period, three of the 17 individuals who exited the BHC program have experienced a psychiatric hospital stay since their exit. Within 1 year of exiting the program, these three BHC participants have totaled five hospital stays and 66 hospital days. Including stays that occurred greater than one year, but less than two years following program exit, these three participants totaled six psychiatric hospitalizations for 82 days.

Two of the six successful completers had a psychiatric hospital stay, while one of seven who were terminated from the program had a psychiatric hospitalization. The two successful completers had two hospitalizations for a total of 57 days, the one who was terminated from the program had 2 hospital stays totaling 25 days, during the two-year observation period.

### **Post-Program Recidivism**

During the observation period, eight of the 17 individuals who exited the BHC program have experienced a jail stay since their exit. Within 1 year of exiting the program, these eight BHC participants have totaled 17 jail stays and 537 jail days. Including stays that occurred greater than one year, but less than two years following program exit, these eight participants totaled 20 jail stays for 592 days.

One of the six successful completers had a jail stay, while five of seven who were terminated from the program had a jail stay and two of three who voluntarily withdrew from the program had a jail stay. The one successful completer had two jail stays for a total of three days, the five who were terminated from the program had 15 jail stays totaling 538 days, and the two who withdrew from the program had four stays for a total of 51 days during the observation period.

### **Participant Non-Participant Comparison**

*(Direct comparisons of findings from BHC participants across the two sections of this report should not be made, as they represent different samples.)*

As a preliminary test, we compared those BHC participants who were either graduates or active members (n = 18) to those who were eligible to participate in the BHC but either declined to participate, were considered at too high a risk for violent re-offense, had a disqualifying criminal history, were deemed not amenable to the program, or were already accessing all available services (n = 17). To be eligible for this comparison, as of March 19, 2019, six months had to have elapsed since the decision was made as to whether the individual was to enter the BHC.<sup>8</sup> Statistical testing consisted of T-tests; paired samples for comparing within groups, independent samples when comparing across groups, and one sample with a test value of zero for comparing against a group that had no events.

The sample sizes were small (depending upon the analysis, n = 35 or n = 17, 18) and reduced the power to detect statistically significant differences and associations. Thus, an indicator of effect size (Cohen's

---

<sup>8</sup> Six months was chosen as the follow-up period first because it is a common length of time used in the literature to assess recidivism and lengthier follow-up periods make it difficult to attribute findings to the intervention. That is, results can be confounded with other contributors to recidivism outside the purview of the intervention (e.g., a newly arisen substance abuse problem). Second, the nascent BHC had limited numbers of people to include in analyses that involved a lengthier follow-up period (sample size would have decreased to an unacceptable level had the follow-up period been longer than six months).

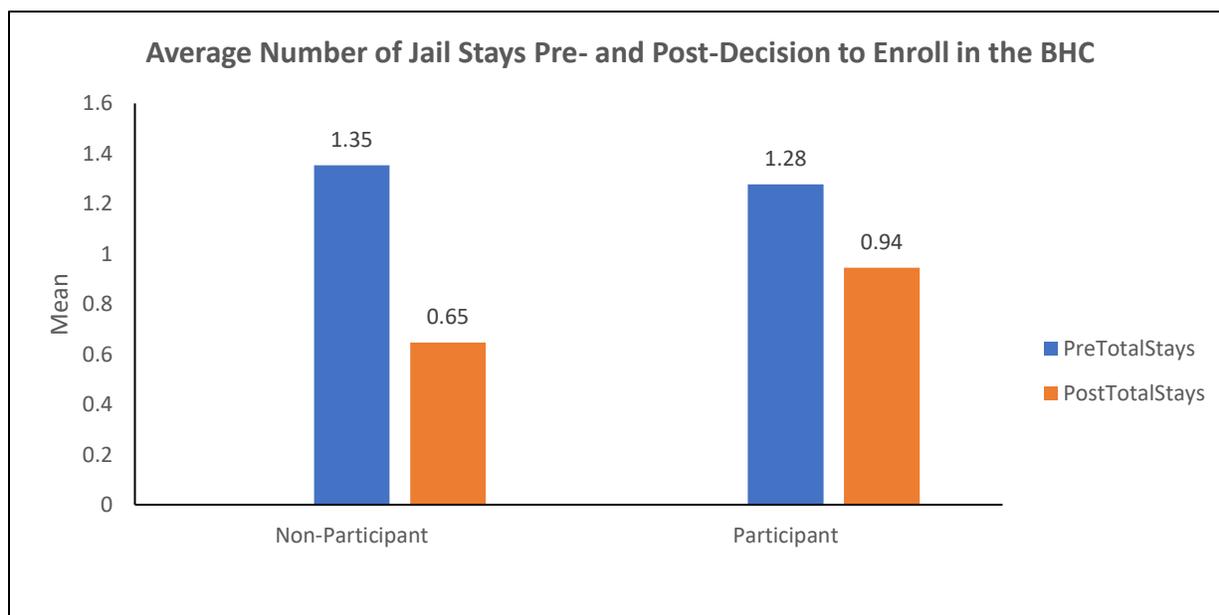
d)<sup>9</sup> is also provided. The effect size essentially indicates how much difference there is between the two groups or how strong the association is between two variables. While effect sizes of around 0.20 are often referred to as “small” in magnitude, those around 0.50 as “medium” and those around or above 0.80 are “large;” the reader should interpret effect sizes in their context.

### Jail Stays and Days

Data on jail stays and days, six months prior and six months following decision to enroll, were collected from the Douglas County Jail for each participant. During the follow-up period 18 participants totaled 17 jail stays and 154 jail days. Seventeen non-participants totaled 11 stays and 499 jail days during the follow-up period.

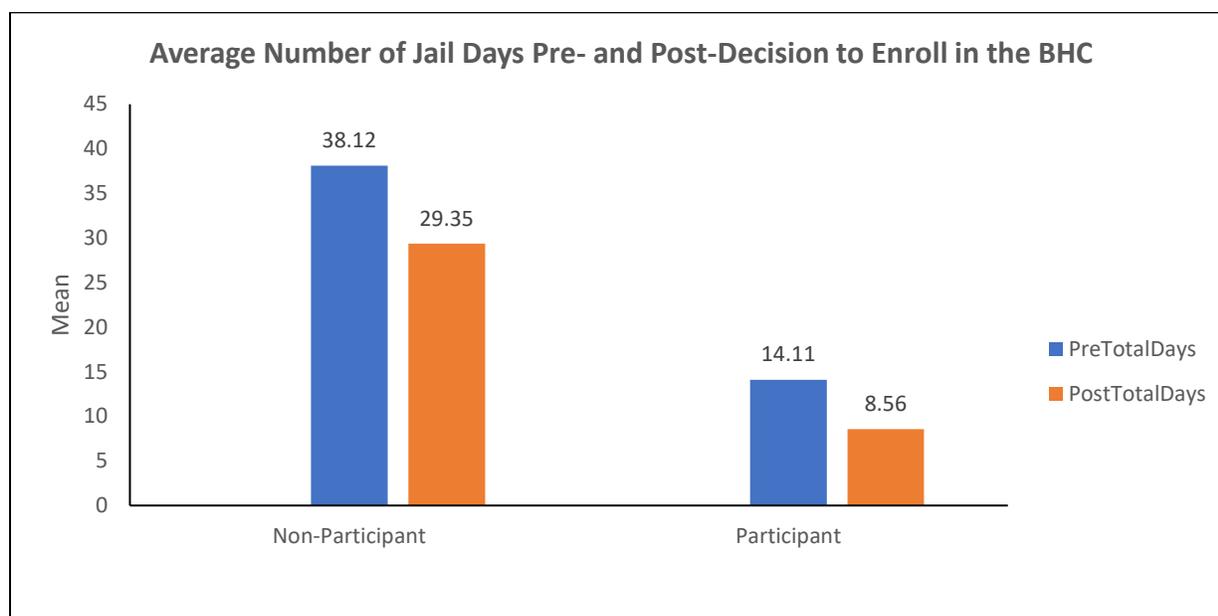
The two groups had similar average numbers of jail stays prior to decision to enroll (1.4 vs. 1.3;  $p = .854$ ;  $d = .06$ ). In the six months following decision to enroll, BHC participants had a slightly higher average number of jail stays than non-participants (0.7 vs. 0.9). While statistically non-significant, BHC participation had a small effect on the increased jail stays seen among participants ( $p = .423$ ;  $d = .27$ ). This difference in jail stays may be due to either the BHC’s utilization of “quick dip” jail sanctions or to non-participants having lower exposure to the community than BHC participants (i.e., non-participants spent more days incarcerated than BHC participants and were thus less likely to get arrested), or to a combination of these two factors.

Within groups, the reduction in pre-decision to post-decision jail stays among BHC participants (1.3 vs. 0.9) was non-significant and reflected a small effect ( $p = .231$ ;  $d = .29$ ). The pre-post difference among non-participants (1.4 vs. 0.7) was more substantial (both in terms of statistical significance and effect size) than what was seen among BHC participants ( $p = .018$ ;  $d = .64$ ). Again, this significant drop in jail stays could reflect reduced exposure to arrest in the community due to more days spent incarcerated.



<sup>9</sup> Zhang, Z., & Yuan, K.-H. (2018). *Practical statistical power analysis using Webpower and R* (Eds). Granger, IN: ISDSA Press. [<https://webpower.psychstat.org>]

Participants in the BHC spent substantially fewer days in the Douglas County Jail than nonparticipants (38 days vs. 14 days) in the six months prior to decision to enroll ( $p = .136$ ;  $d = .53$ ). This pattern held when considering the six months post decision to enroll (29 days vs 9 days;  $p = .186$ ;  $d = .47$ ). Within groups, the reduction in pre-decision to post-decision jail days among those who did not participate in the BHC (38 days vs. 30 days) was relatively small ( $p = .498$ ;  $d = .17$ ). The pre-post differences among BHC participants (14 days vs. 9 days) was relatively more substantial (both in terms of statistical significance and effect size) than what was seen among non-participants ( $p = .031$ ;  $d = 0.55$ ).



When controlling for age and gender, BHC participation was associated with an average 19-day reduction in jail days post-decision ( $p = .184$ ;  $d = -.47$ ). and (while additionally controlling for post-decision jail days) an average increase of .5 jail stays ( $p = .157$ ;  $d = .51$ ). Though both relationships are not statistically significant (again, likely due to small sample size), results indicate a medium effect of BHC participation on reducing jail days and on increasing jail stays.

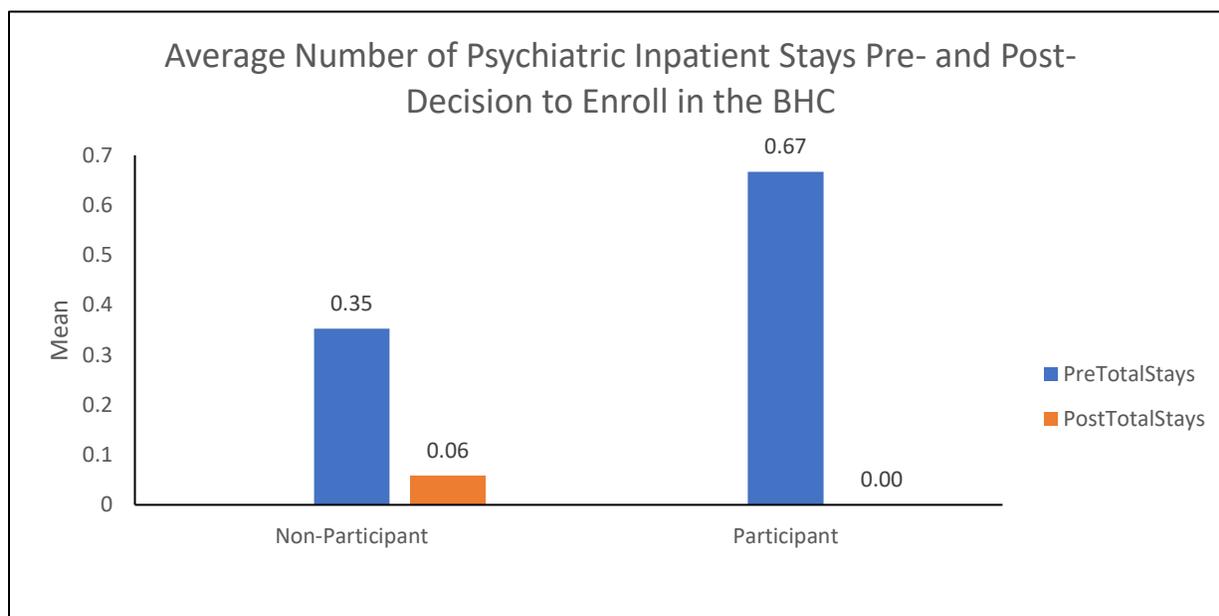
### **Inpatient Stays and Days**

We compared psychiatric inpatient stays and days with the same groups of individuals as above (BHC participants [ $n=18$ ] and non-participants [ $n=17$ ]). Again, to be eligible for this comparison, as of March 19, 2019, six months had to have elapsed since the decision was made as to whether the individual was to enter the BHC. Inpatient data were collected from the Bert Nash Community Mental Health Center database. Importantly, the Bert Nash database would have tracked all inpatient events for BHC participants (as all BHC participants are Bert Nash clients) but non-participant inpatient stays may have occurred outside Bert Nash's purview. As such, inpatient data for non-participants may underreport inpatient events of non-participants.

Inpatient events during the follow-up period were rare; a single inpatient stay was observed among non-participants (an 11-day stay) and no inpatient stays among participants. BHC participants had a slightly higher average number of psychiatric inpatient stays prior to decision to enroll (0.4 vs. 0.7;  $p = .241$ ;  $d = -.41$ ). In the six months following decision to enroll, BHC participants averaged no inpatient stays (0.1 vs.

0.0). While statistically non-significant, BHC participation had a small effect on decreasing inpatient stays among participants ( $p = .332$ ;  $d = .25$ ).

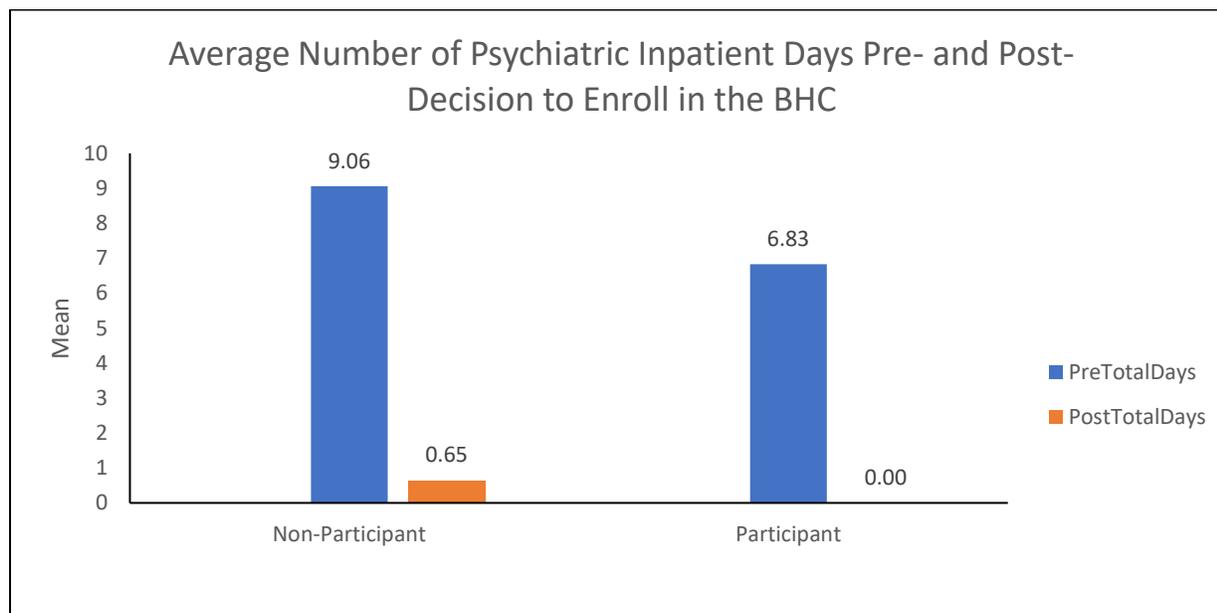
Within groups, the reduction in pre-decision to post-decision psychiatric inpatient stays among BHC participants (0.7 vs. 0.0) was significant and reflected a medium-large effect ( $p = .006$ ;  $d = 0.74$ ). The pre-post differences among non-participants (0.4 vs. 0.1) was non-significant and was smaller in effect than that seen among BHC participants ( $p = .096$ ;  $d = .43$ ).



Participants in the BHC spent, on average, slightly fewer days in a psychiatric inpatient setting than nonparticipants (9 days vs. 7 days) in the six months prior to decision to enroll ( $p = .680$ ;  $d = .14$ ). Both groups' average number of inpatient days dropped substantially during the six months post decision to enroll, to the point that there was little difference in average number of inpatient days between the two groups (1 day vs. 0 days;  $p = .332$ ;  $d = 0.24$ ).

Within groups, the reduction in pre-decision to post-decision inpatient days among those who did not participate in the BHC (9 days vs. 1 day) was not significant but indicated a small effect ( $p = .102$ ;  $d = .42$ ). In contrast, the pre-post reduction among BHC participants (7 days vs. 0 days) was significant and represented a larger effect ( $p = .021$ ;  $d = 0.60$ ).

Due to the rarity of its occurrence (one event across both groups), multivariate analysis of inpatient days and stays was not possible.



***The comparisons presented in the second portion of this report should be viewed as preliminary. Sample sizes were small and precluded inclusion of covariates important to modeling jail and hospital readmissions. Again, direct comparisons of findings from BHC participants across the two sections of this report should not be made, as they represent different samples.***

Controlling for the influence of race and gender, BHC participation was associated with *reduced jail days* following the BHC-entrance decision. Controlling for race and gender and time in the community (i.e., jail days), BHC participation was associated with *increased jail stays* following entrance decision. These findings reflect what was observed among the larger group of participants, whose data were presented in the first portion of this report – specifically, that flash incarceration was a frequent sanction employed by the BHC. As such, recommendations presented in items #3 and #4 below are reinforced. In addition, while the first half of the report indicates a substantial number of jail days being accrued among BHC participants, comparison findings presented in the second portion of this report suggest that the number of jail days remains, on average, lower than those accrued by similarly situated adults who do not enter the BHC. These findings, while preliminary, comport with the empirical literature indicating mental health courts as a promising method for reducing jail days.<sup>10</sup>

<sup>10</sup> Severson, M. and Matejkowski, J. (2015). Review of the literature on jail diversion programs and summary recommendations for the establishment of a mental health court and crisis center within Douglas County, Kansas. (Submitted to Douglas County Commission, Lawrence, KS).

Takeaways from the comparative analysis on psychiatric inpatient stays and days are limited due to the rarity of this event. During the observation period, no BHC participants experienced a psychiatric inpatient hospitalization (again, given the differing timeframes utilized in the two sections of this report, numbers of psychiatric hospitalizations differed considerably and should not be compared). Longer term follow-up should be conducted that includes a sample of the BHC's participants and a sample of comparison offenders to better identify the relationship between BHC participation and psychiatric inpatient service utilization.

### **Recommendations, Conclusion and Next Steps**

The performance measures presented in the first portion of this report can serve as initial benchmarks of the court's early functioning. As the nascent BHC program refines policies and procedures (and as resources are further developed in the community), the court should strive to improve on these measures. Suggestions that may help the BHC to do so are identified below.

1. Reduce the amount of time between originating offense and referral to the BHC. While the District Attorney's Office maintains a web site that provides information about the court, including referral processes (<https://www.douglascountyks.org/depts/district-attorney/behavioral-health-court-information>), a more active campaign to raise awareness of the BHC among law enforcement, defense attorneys, and judges could result in referrals being submitted more proximally to potential participants' originating offenses. Further, mechanisms to promote consistent communication between the BHC team and the county jail's AID program should be instituted to quickly identify potential BHC participants. AID program staff assess individuals admitted to the jail who screen positive for a potential serious mental illness and are therefore in an ideal position to make referrals to the BHC program. Similarly, the City of Lawrence's crisis intervention team (CIT) program was designed to respond to the needs of individuals whose psychiatric crises while in the community have resulted in a police response. Those community members who are unable to be immediately diverted by the CIT officer and whose crises lead to receipt of criminal charges should be quickly referred to the DA's office for consideration by the BHC Team. However, attempts to decrease referral times from officers should be balanced with the desire to prioritize immediate diversion over BHC referral whenever public safety allows.
2. Reduce the length of time between referral and admission decision. The BHC Team (including the District Attorney's Office and the health treatment providers who conduct the necessary assessments prior to which the BHC Team can make an admission decision) should explore what factors in early 2018 may have contributed to the steep increase in the length of time taken to determine whether an individual referred to the BHC is accepted into the BHC.

Taken together, the time between originating offense and admission decision averaged approximately five and one-half months. While this average is influenced by outliers (cases that take an unusually long time to process), half of those who received an admission decision received this decision nearly four months after the date of their originating offense. Whether delays are due to the amount of time between the event and the submission of police reports (which the DA's office use to aid in its determination of a referral's eligibility for the BHC), difficulty obtaining releases of information (necessary for the BHC Team to view referrals' mental health assessments), or other factors; these reasons should be identified and systematically addressed to provide those referred to the BHC the quickest possible decision with which to inform their legal planning.

3. Reduce frequency of sanctions for substance use. Sanctions for substance abuse outnumbered all other reasons for sanctions combined. One approach to reduce the occurrence of these sanctions is to make sure the court is serving the right people. To facilitate this, the court could include a formal substance abuse evaluation within the BHC eligibility screening process. Currently, the BHC's mental health treatment provider conducts a mental health evaluation that includes assessment of substance involvement; however, specialty substance abuse treatment providers may be able to obtain more valid information. With an accurate indicator of a referral's substance involvement, the BHC Team would be in a better position to determine the extent to which a serious mental illness rather than a substance abuse disorder contributed to a referral's instant offenses (this determination reflects one the BHC's eligibility criteria). With the County's planned drug court program, this substance evaluation could serve as a useful mechanism to refer appropriate individuals away from the BHC and into that program.

Acknowledging that substance use problems are common among this population, and even if a drug court is available to manage people whose substance use is their primary problem, the very nature of co-occurring disorders means that the BHC will always contend with participants' substance use. Therapeutic responses rather than punitive sanctions are indicated when responding to substance use among BHC participants, particularly when participants are in the early stages of the program. When considering a chemically dependent client (complete with compulsive use and cravings) in early stages of treatment, abstinence may be the goal, but relapse is the norm, and the court's response to substance use should be a graduated one. Research suggests that approximately 90 days is a critical retention threshold necessary for treatment engagement.<sup>11</sup> The BHC should institute policies in line with NIDA<sup>12</sup> recommendations to defer the implementation of sanctions beyond that period in order to allow the offender adequate time to achieve stable behavioral change after engaging in treatment. Given that substance abuse treatment service events were one-fifth that of mental health treatment service events, the BHC may not be utilizing these services to their full potential.

4. Reduce reliance on severe sanctions. Flash incarceration was the second most frequent sanction employed by the BHC. As mentioned in the findings above, overreliance on this severe sanction can reduce its effectiveness to shape behavior and may result in reduced motivation and increased avoidance among clients. Further, the effectiveness at reducing criminal recidivism of approaches that respond to supervision violations with "quick dips" in jail is not fully supported by the empirical evidence.<sup>13</sup> Intermediate sanctions (e.g., essay assignments, community service) could be used more frequently in response to problematic behaviors.

---

<sup>11</sup> Hepburn, J. R., & Harvey, A. N. (2007). The effect of the threat of legal sanction on program retention and completion: Is that why they stay in drug court? *Crime & Delinquency*, 53(2), 255-280.

doi:10.1177/0011128705283298; Simpson, D., & Joe, G. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of substance abuse treatment*, 27(2), 89-97.  
doi:10.1016/j.jsat.2004.03.001

<sup>12</sup> National Institute on Drug Abuse. (2007). *Principles of drug abuse treatment for criminal justice populations: A research-based guide*. Retrieved from Washington DC:

<sup>13</sup> Cullen, F. T., Pratt, T. C., & Turanovic, J. J. (2016). It's hopeless: Beyond zero-tolerance supervision. *Criminology & Public Policy*, 15, 1215. doi:10.1111/1745-9133.12260; Lattimore, P. K., MacKenzie, D. L., Zajac, G., Dawes, D., Arsenault, E., & Tueller, S. (2016). Outcome findings from the HOPE Demonstration Field Experiment. *Criminology & Public Policy*, 15(4), 1103-1141. doi:10.1111/1745-9133.12248

5. Increase the ratio of incentives to sanctions. Given the power of incentives to shape behaviors, it is recommended that the BHC think creatively to identify opportunities to reinforce positive behaviors among clients – particularly with those clients who are struggling in the program (the court’s “ticket” program is a good example of this). In addition, while the overall ratio of incentives to sanctions averaged approximately 2:1, research has suggested that higher ratios (up to 4:1) may be more effective at influencing behaviors among this population.<sup>14</sup>
6. Improve treatment and interventions targeting criminogenic needs to prevent new offenses. As part of the eligibility screening process, all referrals are screened with the Level of Service Inventory-Screening Version (LSI-SV). This tool measures the presence of eight risk factors that are strongly predictive of criminal behavior (i.e., criminogenic needs). Research has shown that amelioration of these criminogenic needs is an effective way to reduce subsequent criminal involvement.<sup>15</sup> Mental health treatment alone is not an effective method for reducing criminal behavior of individuals with mental illness who are involved in the criminal justice system.

It is recommended that those BHC participants who score high on the initial LSI-SV receive a full LSI assessment to identify the full extent of their criminogenic needs. Once identified, programming should be offered that directly targets the specific needs identified. Indeed, the court (through Bert Nash), has begun providing Decision Points programming – a program developed for correctional populations which targets the criminogenic need: antisocial cognitions/attitudes.<sup>16</sup> However, assignment of BHC clients to the Decision Points program is not based upon formal assessment of criminogenic need. Instituting formal assessment of criminogenic needs and assignment of BHC clients to services targeting these needs is an essential element of community-based behavioral health services for justice-involved individuals according to SAMHSA<sup>17</sup> and may help to reduce the number of new offenses and jail stays among clients during, and post-graduation from, the BHC program.

7. Reduce jail days associated with sanctions. The average jail stay for a sanction was 10.4 days and half of those who spent time in jail for a sanction spent more than five days incarcerated. The lengthier jail stays appear to be influenced by a desire on the part of the BHC Team to keep a person sober, safe, and stable while waiting for housing or an inpatient/residential treatment bed to become available. Extending jail stays not only undermines a primary aim of the BHC (to reduce jail days for this population), it also transforms the sanction into a protective service action that likely reduces the power of the sanction to shape behavior. While the county’s efforts to expand local treatment and supportive housing options may help to reduce these lengthy stays in the future, it is recommended that the BHC Team consider extending a client’s length of incarceration only once an imminent risk of harm to self or others has been established by a trained clinician. Those individuals

---

<sup>14</sup> Wodahl, et al., (2011). Utilizing behavioral interventions to improve supervision outcomes in community-based corrections. *Criminal Justice & Behavior*, 38, 386-405.

<sup>15</sup> Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, NJ: Matthew Bender.; The “central eight” criminogenic needs are: Antisocial personality/temperament, Antisocial cognition/attitudes, History of antisocial behavior, Antisocial companions, Family and/or marital stressors, Substance abuse, Lack of employment/education, Lack of pro-social leisure or recreation. The first four listed here are considered the most important to address. Note that mental illness and psychiatric symptoms are not listed as criminogenic needs.

<sup>16</sup> See: <http://www.decisionpointsprogram.com/>

<sup>17</sup> SAMHSA. (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. Rockville, MD: U.S. Department of Health and Human Services.

who do not meet this standard, once a sanction has been fulfilled, should be released from jail custody.

8. Reduce inpatient stays. There were 16 inpatient stays for mental health problems and 14 inpatient/residential stays for substance abuse problems during clients' participation in the BHC program. The recommendations provided in item #3 above may help to reduce the need for substance abuse residential stays among BHC clients (i.e., screening out and referring to the county's planned drug court those individuals with a primary substance use disorder). In terms of psychiatric hospitalizations, the BHC Team may want to consider a more preventative approach that, in addition to stepped-up case management and increased peer support, involves its use of intensive outpatient (IOP) mental health services. Specifically, intensive outpatient services were rarely used by the court. Given the close supervision of BHC clients, it seems plausible that psychiatric crises may be foreseen, and hospitalization prevented with swift ratcheting up of supports, including transition to IOP for those on the verge of psychiatric crisis.
9. Reduce time to termination. The seven individuals who were terminated from the program averaged nearly nine months (267 days) in the BHC prior to termination. The intensive services provided by the BHC coupled with the subsequent returns to incarceration by those terminated from the program can be viewed as economic losses to the community. Therefore, a process should be developed by the court to identify predictors of imminent failure among participants. Doing so, would provide the BHC Team more confidence in their decisions to continue or to terminate clients from the program and potentially reduce costs associated with the prolongation of intensive services.
10. Institute methods to promote data monitoring and quality. The data on performance measures, which form the core of this report, were made available through a dedicated BHC database. The data contained within this database can provide useful performance reports to the BHC Team but only if the data are reliably and accurately entered into the database. It is suggested that the BHC identify an individual to oversee this process (e.g., "a data oversight officer"). This person's responsibilities should include determining the BHC's (and perhaps the county's) information requirements and priorities and monitoring data quality. This oversight officer would be responsible for identifying lapses in data quality and ensuring that appropriate corrective action is implemented to reduce data error. This oversight may be conducted by IT personnel or by others who are end users of the data and have the authority to initiate corrective action.

Data quality can also be enhanced through appropriate training and familiarization with a comprehensive information system user manual that outlines data entry protocols and responsibilities.<sup>18</sup> The basic content contained in these manuals should include directions for data entry using accepted data definitions, security and communications protocols used between agencies, as well as clearly specified deadlines for updating the data. Regular data audits should be conducted to assess data quality and to understand (and address) the nature of the identified data quality problems. Based upon the results of these audits, data quality improvement plans can

---

<sup>18</sup> Camp, J., Krakow, M., McCarty, D., & Argeriou, M. (1992). Substance abuse treatment management information systems: Balancing federal, state, and service provider needs. *The Journal of Behavioral Health Services and Research*, 19(1), 5-20. doi:10.1007/bf02521303; Dunworth, T. (2000). Criminal justice and the IT revolution. *Federal Probation*, 65, 371-426.

include training and retraining as well as improvements and updates to user manuals and system software.

### **Conclusion**

We conclude as we started, with a reminder of the original goal and objectives of the BHC, that is: To improve public safety by reducing recidivism in Douglas County among those with serious mental illness and co-occurring disorders, by connecting them with necessary and appropriate community support services.

Our preliminary findings, that is, those outcomes determinable to-date, indicate that the BHC has met its objectives. In fact, as described in the first half of this report, all but one of the six BHC graduates has not had a jail stay since completion of the BHC program. This compares well to the five of seven terminated from the program who returned to jail within six months of their exit from the BHC. Further, the service data reported on our BHC participants suggest that the objective of connecting participants with necessary and appropriate community support services has also been met, at least to a certain extent. Still, a broader discussion of recidivism and service needs and opportunities is in order here as we look to the future of the BHC.

We are mindful that recidivism is a complex construct and when it is inserted as part of an overall goal, the holding out of recidivism reductions as the gold standard of success often blurs the reality of our limited understanding of how difficult it is to change human behavior. For example, only in recent years have justice researchers begun to parse the recidivism construct, by emphasizing intermediate objectives that form the building blocks to crime desistance, and by separating returns to incarceration resulting from violations of one's post-release supervision plan with that of returns for new charges. Even the distinctions in those latter definitions are less clear than one might think at first glance. For example, many community supervision agents will detain the probationer in order to interrupt the commission of criminal act and tell us that but, for that interruption, the return to incarceration would have been for a new criminal offense.

Further obscuring the measurement and meaning of recidivism are the time periods in which it is measured. In the research, recidivism is often viewed at 6, 12, 18, 24, 36 and 60-months intervals, post-release. These point-in-time checks are chosen in part on the basis of the general assumption that the longer a justice involved person is not incarcerated, the more likely it is that an incarceration event will happen. While true, the point at which the new incarceration event is no longer related to the influences that existed at the time of the initial incarceration event remains unknown and no doubt differs both by person and by the status of their dynamic (modifiable) criminogenic risks.

This desire to reduce recidivism, and to better manage system responses to criminal behavior by embracing alternatives to incarceration, is at the heart of justice changes in Douglas County. Our recommendations are designed to continue the local policy and practice trajectories in that direction. We believe recidivism reduction should be viewed in the context of the whole-health needs of individuals and the power of a jurisdiction to shape its services structure and funding priorities in ways that serve the interests of the public health. In this way, the measurement of recidivism is shifted beyond the individual behavior to include the system responses to individual risks and needs. Crime desistance and diversion programs make little sense if those needs are not addressed as part of a community's offerings.

Our recommendations are made with this in mind and they, too, take us back to the very beginning of the BHC, when we advised that the ultimate goal of services for justice-involved persons is to respond at the right time, in the right place, with the right intervention(s). What is needed now? As diversion programming continues to develop in the County, the importance of risk, need and responsivity assessments cannot be minimized. Tools such as the LSI-R give the BHC team and ultimately, the County, the power to identify where external action can have the most impact on the internal drivers of criminal thinking and behavior. If six months out of the justice system is to be extended to 12, 24, and 36 months, the person must have more than mental health and substance related services. Stable housing, gainful employment, and positive social supports combined with BHC structural changes such as increased substance abuse interventions and interruptions for those in need, increased opportunity for meaningful incentives, and reduced reliance on flash incarceration, all promise to yield better long-term outcomes.

What was not addressed as part of this evaluation were costs vis-à-vis benefits. We did not propose, nor did we pursue such an analysis, though we anticipate that some who read this report will be doing an informal calculation as they move from page to page. We think that it is ill-advised at this time. Benefits of interest have really yet to be defined and costs are at best, difficult to identify and quantify. Recall that in our 2015 *Review of the Literature* we wrote the following.

While the development of MHCs has been largely subsidized by the federal government, they are not inexpensive to operate, especially when one considers the average number of persons that can be followed by the court at any given time. Perhaps the best philosophical approach when considering the development of a MHC is to consider the benefits of it in support of maintaining and promoting the dignity and health of the consumer, leaving the goals of jail population reductions and cost reductions out of the equation.

We stand behind that assertion. As anticipated early on (see: Huskey and Associates, 2015),<sup>19</sup> a net reduction in the jail population was not anticipated nor projected as an outcome of the BHC, and it has not been realized in Douglas County. What has been realized are the personal successes of the BHC graduates. Most secured stable employment or income support, safe housing, a positive support network, and developed more thoughtful decision-making skills.

The evaluation reported in these pages sought to inform the answers to these questions: Did the BHC serve the right person, at the right time, in the right place(s), and with the right intervention? When it did, what were the outcomes for the individual and the community? When it did not, what were the outcomes for the individual and the community? At this stage in the process, we have tentative answers.

Yes, the right people were served. There may have been some “wrong” people served as well – e.g., those whose criminogenic risks did not warrant the intense supervision of the BHC or those whose substance abuse was primary or whose risks were so high as to warrant more restrictive system responses and interventions.

---

<sup>19</sup> Huskey and Associates. (2015). *Douglas County jail & mental health court study*. Lawrence, KS: Treanor Architects; <https://www.douglascountyks.org/groups/cjcc/media/report-serious-mentally-ill-persons-douglas-county-jail>

Was it the right time and right place? Yes. The team coalesced well. Judge Pokorny's leadership has brought the team together in both its attitudes and actions. There are lessons that have been learned and still to be learned, but the mechanisms, roles and relationships are in place to transform those lessons into action.

Was it the right intervention? Often; not always. Certainly there are indications that substance abuse treatment services need to be enhanced. Clearly, we have BHC participants who are at-risk because of insecure housing and food resources, poverty, inadequate education and employment, poor physical health and the lack of positive social supports. These are enhancements that need development for the population the BHC serves and in the community at large. The BHC and the other alternative justice responses being developed in the County should be viewed as essential informants for the community, and relied on to provide, as one service provider among many in the Douglas County community, a justice system that is similarly called on to serve the right person at the right time.

The outcomes for the individual and the community are inextricably connected. Crime desistance benefits both. It eliminates exposure to the not well understood but clearly deleterious effects of (even short term) incarceration; and it prevents personal and public trauma. As we learn more about those who did not successfully complete the BHC program, we find evidence of this trauma in the community.

### **Next Steps**

The specific recommendations provided, and the conclusions noted above set out the tasks and the tone for moving forward with the development of the BHC. Here, we suggest the path for doing so.

First and foremost, the findings reported here are preliminary in every sense: they reflect the record of BHC development and initial participant management. Moving forward, the opportunity to complete ongoing, formal outcome evaluations of the BHC should be seized. The comprehensive Access database that has been developed provides the platform for these evaluations. As part of their ongoing participation on the BHC Team, members must commit to making regular, accurate data entries and the County should embrace the ideal of securing independent evaluations of BHC outcomes. We do not think it is possible to provide a summative evaluation at this juncture and, given the nature of the BHC process and participant engagement, we suspect that will not be possible for several years.

We believe the continued development and momentum of the BHC can be maximized by convening a special session of the BHC Team to identify the characteristics and common challenges of participants who unsuccessfully terminated from the BHC program, with the goal of informing screening and eligibility criteria that may help to reduce the rate of unsuccessful termination. Recall that during the early period of the life of the BHC, those who were terminated from the program ( $n = 7$ ) outnumbered successful BHC graduates ( $n = 6$ ). However, looking at the most recent 3 months (through June 30, 2019), the period subsequent to the time frame reported in this evaluation, the BHC saw four additional participants successfully complete and three others who were terminated. In short, participation in and outcomes of the BHC are in flux, constantly changing as the personalities involved and the challenges posed are identified and managed. It is a good time to drill down into the factors associated with success and with that which falls short of it.

While the BHC's graduation rate is in line with what is reported in the empirical literature,<sup>20</sup> a concerted effort among BHC Team members (informed by the literature) to examine available clinical and criminal justice records to identify characteristics that differentiate successful from non-successful participants may be useful in informing screening referrals for entry into the BHC program. Additionally, qualitative interviews with members of both groups of individuals may serve to highlight specific and malleable challenges to completing the program. These qualitative interviews may also be useful to obtain valid program satisfaction outcomes. The satisfaction data reported in this evaluation were gleaned only from successful completers of the BHC and they are uniformly and likely misleadingly high.

Having been involved with the evolution of the BHC since its inception, we are thankful for the County's vision, and for its policy and fiscal leadership in bringing the BHC to a reality in Douglas County. We also acknowledge the power for change brought to the table by the community partners: The District Court, the District Attorney, the Public Defenders, Bert Nash, DCCCA, Court Services and many other segments of the local social service system. The continued participation of these community partners is critical to the long-term outcomes of the BHC and to the realization of justice innovations county-wide.

---

<sup>20</sup> ... "rates of those exiting MHC in other studies vary from 19% to 81% with an average graduation rate of 52%" Hiday, V., Ray, B., & Wales, H. W. (2014). Predictors of mental health court graduation. *Psychology, Public Policy, and Law*, 20(2), 191-199. doi:10.1037/law0000008 (p. 193)