Maryland Mental Health Court Performance Measures

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NATIONAL CENTER FOR STATE COURTS

January 2019

Acknowledgements

The Maryland Administrative Office of the Courts (AOC) and the National Center for State Courts (NCSC) would like to take this opportunity to gratefully acknowledge and thank all members of the Maryland Mental Health Court Performance Management Workgroup who have committed to this important project. The strong collaborative effort between the AOC, the Workgroup, and the NCSC team will advance Maryland's capacity to address performance and outcomes for individuals served by Maryland's Mental Health Courts. The NCSC would also like to thank the AOC team: Kathleen Maher, Gray Barton, and Robert Pointer, for their support, guidance, and dedication to this project.

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Table of Contents

Introduction

Since its popularization in the 1970s, performance measurement has become an important management tool in public and private nonprofit agencies in developed countries. Performance measurement is the process of regularly collecting and examining a program's outcome or output data throughout the year. It is accompanied by performance management, which is the use of performance measure data to inform managerial decisions in a way that provides continual improvements to program outcomes and outputs. These two factors—measurement occurring more frequently than an annual basis and the use of the resulting information to inform programmatic decisions—are key to effective use of performance measurement. Successful performance measurement must be a dynamic process that provides managers and employees with information that will assist them in continuously working towards the betterment of their organization and improved service to clients (Hatry, 2014; Ostrom & Hanson, 2010).

The cyclical nature of performance measures means that they are effective guards against drift, or the deterioration of services over the passage of time, by assessing fidelity to program objectives (Van Wormer, 2010). Performance measurement provides a high-level view of short- and long-term program outcomes. That is, it provides information about the aggregate effects of the program, not information about individual participants. A performance measure focused on the timeliness of case processing, for example, will report an average length of time that includes all cases from a given time period. In this way, performance measurement balances the effect of extreme situations. As a concrete example, an abnormally long time in the program (length of stay) is mitigated by the majority of cases resolved in a moderate amount of time as expressed through the measure's average. It is only when increasing numbers of cases have an unsatisfactory time to resolution - when the issue becomes a pattern rather than an anomaly - that the performance measurement results would indicate higher than desired results.

> ***Effectively designed and implemented performance measurement systems provide tools for managers to exercise and maintain control over their organizations, as well as act as a mechanism for governing bodies and funding agencies to hold organizations accountable for producing the intended program results.***
>
> *Waters, 2011*

The Performance Measurement Quality Cycle

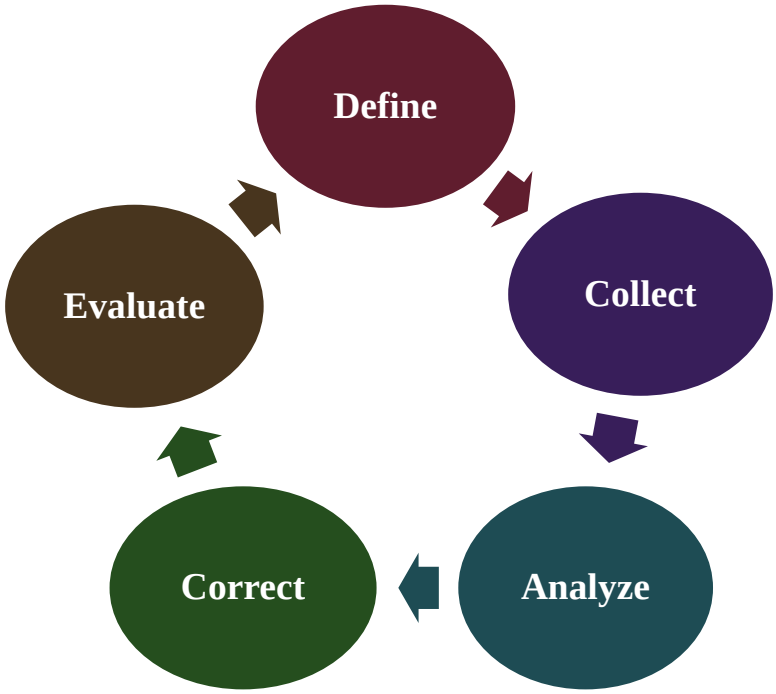
With the implementation of performance measures, a cyclical process begins (see **Figure 1**). First after reviewing performance reports, a potential performance issue is identified and defined. Continuing with the length of stay example above, a mental health court coordinator may notice that the report shows a noticeable increase in the average length of time participants spend in the program. The coordinator would ***define*** the concern as to whether an increasing length of stay in the program is justified.

Next, the coordinator would ***collect*** and ***analyze*** information about length of stay by compiling and examining the individual-level data that comprise the data in the performance measures. In this way, the aggregate performance measures help to define the issue, signify a need for a more in-depth examination of the underlying individual data, and thereby facilitating a better understanding of the issue and explore ways to address it.

After gaining a more detailed view of the problem through analysis, the coordinator and other mental health court stakeholders can take steps to ***correct*** a trend moving in an unanticipated direction by changing or implementing new policies or practices. The next step is to ***evaluate*** fluctuations by reexamining the performance measurement results after sufficient time has passed to see if the implemented measures effectively address the problem.

The cycle begins again if the previously identified issue has not been sufficiently resolved, or if the other performance measures indicate that another aspect of the program is not performing as expected.

Figure 1. Performance Measurement Quality Cycle (Ostrom & Hanson, 2010)



Performance Measurement in the Courts

Performance measurement has been adapted for use in the courts, most notably by Ostrom and Hanson's (2010) *High Performance Framework* for courts, and the complementary *CourTools* performance measures (www.courtools.org). The use of performance measurement in the courts allows for the early identification and communication of problems by court leadership, allowing them to address problems before they become entrenched and more difficult to resolve. Performance measures also allow local courts to manage their own performance. Furthermore, if courts seek an independent outcome evaluation by an external agency, performance measures provide evaluators with valuable data in which to explore the influence of various factors on outcomes.

One important principle of court performance measurement is that the terms of calculation and definition must be sufficiently general to apply broadly (e.g., limited jurisdiction, general jurisdiction, and applicable across local jurisdictions). Accordingly, the NCSC has adapted *CourTools* measurements to create performance measures for specialty courts and for specific case types or characteristics, including drug courts, mental health courts, and elder abuse cases. Each case type or characteristic embodies unique populations and targeted goals for success. Therefore, it is critical to consider implementation issues, specifically the applicability of measures in Maryland and its local communities. It is also critical to consider the target population (individuals with mental illness) and what is most relevant to measuring program success. The need to translate other performance measurement work to Maryland's Mental Health Courts is the impetus for the creation of the Workgroup.

Performance Measurement in Mental Health Courts

Implementing performance measurement in mental health courts (MHCs) is imperative because they are in competition with other facets of the criminal justice system for a limited amount of resources. Therefore, mental health courts must demonstrate that the limited resources provided to them are used efficiently and that this expenditure of resources produces the desired outcomes for participants. To this end, mental health court performance measures should ultimately permit stakeholders to demonstrate that 1) participants are identified and linked to services in a timely manner, 2) that participation improves their capability to function effectively in society, 3) to reduce criminal activity, and 4) that participants have access to resources in the community to maintain their mental health stability after program participation ends.

> ***"MHCs must demonstrate their accountability to funding sources, court leaders, the community, and stakeholders. Accountability translates to defining what is "success" as it relates to a stated mission. MHCs must assess whether the program meets those goals and demonstrate their sustainability."***
>
> *Waters, 2011*

Mental health courts can benefit from using performance measures in an exploratory capacity (Abernethy & Brownell, 1999; Spekle & Verbeeten, 2014). The measures can be used to gauge the efficacy of current polices and highlight any areas that may benefit from a change in policy. They also give courts the ability to examine the effects of newly implemented policies to determine if they are functioning as intended or if further revision is needed. The insights provided by performance measurement can assist in policy decision-making and resource allocation. Research indicates public sector organizations that use this exploratory approach to performance measurement see enhanced performance in productivity, work quality and accuracy, innovative approaches, and staff morale (Spekle & Verbeeten, 2014).

NCSC Recommended Performance Measures

Although the mental health field is evolving, there is a lack of methodologically rigorous evaluations of mental health courts (Sarteschi, Vaughn, & Kim, 2011; Wolff & Polgorzelski, 2005). Consequently, there is a corresponding lack of empirically-validated best practices for

mental health courts. Drug court performance measures, for example, draw heavily from the *Adult Drug Court Best Practice Standards* (National Association of Drug Court Professionals (NADCP), 2013; NADCP, 2015), two documents that provide empirically-based guidance on best practices for specific aspects of the drug court program. These standards are based on the *Ten Key Components of Drug Courts* (NADCP, 1997), which are comparable to the *Essential Elements of Mental Health Courts* (Bureau of Justice Assistance (BJA) 2007), in that they explicate important factors that should be addressed by the problem-solving court, but do not provide specific levels for those factors. Mental health court research has not yet progressed to a comparable level to that of the drug courts (as seen in the *Adult Drug Court Best Practice Standards*).

Consequently, mental health court performance measures reflect practitioner experience to a higher degree than do drug court performance measures. This can be a benefit, however, since performance measurement research indicates better outcomes when collaborators take an active and proprietary role in defining and setting goals for performance measures (Groen, Wilderom, & Wouters, 2015). The mental health court performance measures also rely on the guidance found in the *Essential Elements of Mental Health Courts* (BJA, 2007), the *High Performance Framework* (Ostrom & Hanson, 2010), the *Mental Health Court Performance Measures* (Waters, Cheesman, Gibson & Dazevedo, 2010), and applicable research from the *Adult Drug Court Best Practice Standards* (NADCP, 2013; NADCP, 2015).

As devised by Kaplan and Norton (1992), The *High Performance Framework* and the *Mental Health Court Performance Measures* both emphasize the need for a "balanced scorecard" approach to performance measurement. This balanced approach is important, since it promotes the inclusion of performance measures that may not be obvious indicators of a successful program, yet are nonetheless integral to case processing efficiency and program efficacy. The following recommended mental health court performance measures represent multiple domains to provide a balanced perspective for mental health court performance measurement (Waters, et al., 2010), and incorporate the above-described resources, practitioner experience, and theoretical perspectives to create a collection of performance measures designed to optimize mental health court operations.

> ***Performance measurement research indicates better outcomes when collaborators take an active and proprietary role in defining and setting goals for performance measures.***
>
> *Groen et al., 2015*

Maryland: Committed to Evidence-Based Practices and Performance Measurement

The NCSC team's experience has shown that sustained efforts to monitor performance require: 1) continued leadership support, 2) solid funding, and 3) regular assessment and monitoring. The Maryland AOC has embraced evidence-based practices and encouraged their adoption by Maryland mental health courts. As part of Maryland's embrace of evidence-based practices, the AOC has partnered with the University of Maryland's Institute for Governmental Service and Research (IGSR) to use their **S**tatewide **M**aryland **A**utomated **R**ecord **T**racking (SMART)

system,[1] a web-based tool that provides a consent-driven client tracking system for state agencies and private treatment providers. Used by treatment providers and mental health courts as a management information system, SMART enables a comprehensive approach for collecting data. SMART serves as an interagency data repository for performance reporting that allows for real-time collaboration between treatment facilities, mental health courts, and other state and local agencies, while meeting all federal and state confidentiality regulations. The SMART system will ultimately incorporate these selected performance measures and produce management reports summarizing information derived from the Mental Health Court Performance Measures Advisory Workgroup's endorsed performance measures.

This report documents a set of performance measures recommended by the Workgroup. The Workgroup members represented judges, program coordinators, the State's Attorney's Office, the Office of Public Defender, and the Behavioral Health Administration. The measures are listed below, by the relevant domain in **Table 1.** The subsequent section provides a discussion of the purpose, recommendations, and implementation issues for each measure.

Table 1: Maryland Mental Health Court Performance Measures by Objective

I	*To identify eligible participants early in the adjudication process and promptly connect them with identified services.*	1. Timeliness between key milestones
II	*Participants are expected to improve social functioning with a mental illness, establish a productive life in the community, and establish a network of support.*	2. Living Arrangement 3. Recovery and Functioning
III	*Aftercare is an essential element of mental health courts by preparing participants for successful transition into the community.*	4. Aftercare
IV	*To minimize use of jails, which are costly, do not improve outcomes, and are ill-equipped to handle individuals with mental illness.*	5. Time Spent in Jail
V	*To provide ongoing judicial interaction and oversight with participants so as to hold participants accountable and protect public safety.*	6. Failure to Appear in Court

[1] http://www.igsr.umd.edu/SMART/about.php

VI *To promote stability by ensuring that participants comply with medically prescribed treatment plans.*

7. Medication Compliance

VII *To effectively collaborate in a team-based environment with key service and treatment providers.*

8. Information Sharing

Table 2 below lists NCSC's proposed outcomes. The outcomes are functions of the extent to which the objectives listed in **Table 1** are accomplished. Outcomes are designed to measure progress toward the primary goal of mental health courts—to reduce the probability of recidivism and enhance social functioning.[2] Each measure and outcome may not be applicable to all participants. Therefore, the next section references to which track (voluntary and/or competency) each is applicable.

Table 2: Maryland Mental Health Court Outcome Measures

VIII *To reduce the revolving door in the criminal justice system for individuals with mental illness, ultimately improving public safety.*

9. Rearrests
   A. Percentage of graduated participants who were rearrested
   B. Average time between arrest for those who were rearrested

Measurement Considerations

In this section, important considerations relevant to the operationalization and utilization of the performance measures are discussed. These include:

- *Informational infrastructure to support measurement*
- *Use of entry and exit cohorts to organize the reporting of performance measures*
- *Measurement over time*

The performance measurement system described in this draft report requires an extensive informational infrastructure. This infrastructure must include a database, in this case, SMART,

[2] This project includes a complementary evaluation component and relies upon a Maryland Judiciary report from 2010. The report provides an outline of an evaluation of court-based mental health interventions and also provides suggested key outcome variables to consider for adoption. See https://www.igsr.umd.edu/applied_research/Pubs/Methodology%20for%20Evaluating%20Court-Based%20Mental%20Health%20Interventions.pdf

with the required data elements recorded for each individual participant. For example, the dates and duration of each jail stay must be recorded for each participant.

Important decisions must be made regarding the time frames for reporting the performance measures. In line with the National Drug Court Institute's *National Research Advisory Committee* 2006 recommendations and accepted research practice, [3] the NCSC recommends organizing participants into *cohorts* for reporting purposes. Entry (or longitudinal) cohorts and exit (retrospective) cohorts have long been a staple of bio-medical research, and more recently, of sociological and criminological research.

Entry cohorts consist of all participants admitted to the program during a specific period of time. Because all members of the cohort are admitted during the same timeframe, they will be equally subject to the same set of historical influences during the time they participate in mental health court. For example, policies may change as the cohort progresses through the mental health court (e.g., the frequency of court hearings may decrease as a result of a change in the number of judges assigned to the court). This allows the court to link changes in the performance of different entry cohorts to such policy changes or other changes within the justice system. For example, decreasing the frequency of court hearings may result in an increased termination rate compared to previous entry cohorts for which more frequent court appearances were expected. By tracking programmatic changes or trends in the criminal justice system, the court is better able to explain the performance differential due to these systematic differences between the cohorts. In effect, the use of entry cohorts controls for policy changes or historical artifacts that may lead to incorrect conclusions about performance.

Exit cohorts consist of all participants who exit (successfully or not) from the mental health court during a specified period of time. Exit cohorts do not provide the same level of protection against historical artifacts or policy changes as do entry cohorts. However, exit cohorts do avoid the delays in reporting information that are associated with entry cohorts (entry cohorts must be tracked until every member exits before having complete information). Because mental health courts do not operate in such a way that they would wait for all participants within an entry cohort to exit the program before the court can produce performance reports, the NCSC recommends the use of exit cohorts for most performance measures, except where noted.

[3] https://www.ndci.org/publications/monograph-series/navigating-performance-measures-and-process-evaluations/

Mental Health Court Objectives and Associated Performance Measures

EFFICIENCY

To identify eligible participants early in the adjudication process and promptly connect them with identified services.

1. TIMELINESS BETWEEN SELECT MILESTONES (VOLUNTARY & COMPETENCY TRACK)

Purpose: This set of measures tracks the time between procedural milestones for evaluating, admitting, and discharging participants of the voluntary and competency tracks. Measures of timeliness help to identify potential sources of delay or inefficiencies in the process prior to program entry, and trends in time to program exit (successfully or not). Individuals with mental illnesses are at risk for decompensation, particularly during incarceration or due to medication discontinuity, compelling courts to reduce elapsed time across this critical phase that links individuals with appropriate treatment and services.

Recommendations: The NCSC recommends tracking time between key milestones using standard definitions for each, as discussed by the Workgroup. While some of these processes are outside the court's control, there is value in tracking elapsed time with enough detail to identify the source(s) of delay. Such objective data can be leveraged in conversations with leadership of collaborating agencies to identify targeted resolutions that best serve the participants. The selection of key milestones should incorporate measures for individuals in both the voluntary and competency tracks.

Voluntary Track

Voluntary track milestone definitions:

Arrest: Date of arrest or initial appearance before a judicial officer.

Referral: Date that the MHC received the referral. All individuals who have been referred to the voluntary track, even if they have not signed a contract. This date marks their legal referral and should initiate the electronic record in SMART.

Assessment: Date when the MHC receives the assessment report(s). Each MHC will have difference resources and different information included in the assessment process; the recorded assessment date marks when all clinical and legal information has been shared with the court for eligibility determination.

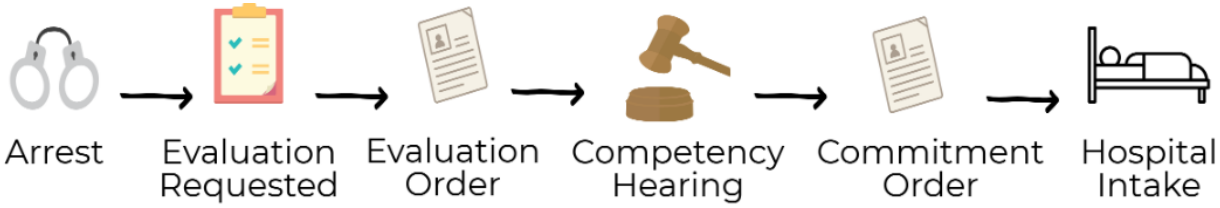
Entry: Date that a participant is admitted to the voluntary track. This date should be further discussed and agreed upon among the courts. This may be the date their contract

is signed, their first status hearing, or their first treatment contact according to their treatment plan.

Exit: Date the participant completes the program (successfully or not).

Competency Track

Not everyone will have a date entered for the entire timeline below. For example, if a participant is found CST, he or she may be released and not have a hospital intake date.



Competency track milestone definitions:

Arrest: Date of arrest or initial appearance before a judicial officer.

Evaluation Requested: Date the request for competency evaluation is received by the judge. This includes judges external to the MHC. If a judge on the regular docket receives a request for an individual's evaluation, this should be included in the individual's case file and input into SMART. This may be considered the referral to the competency track.

Evaluation Order: Date the evaluation order is signed. As above, a judge external to the MHC may sign the order for an evaluation. This individual is placed on the MHC docket, and their case file should include a record of the evaluation order. This date should be input into SMART.

Competency Hearing: Date the court holds a hearing on the results of the competency evaluation.

Commitment Order: Date a commitment order is signed for an individual's commitment to a hospital, following the competency hearing. This will not be applicable to some individuals but should be tracked for those who are committed.

Hospital Intake: Date the individual is admitted into the hospital.

Implementation: The NCSC recommends that the number of milestones tracked are limited and prioritized. The NCSC also recommends that statewide definitions are used to determine dates for each milestone. SMART has the capacity to capture most of the date fields described, and others will need to be developed and integrated following consensus on the definitions and selection of key milestones. The Workgroup discussed the importance in the distinction between when the treatment plan is approved versus engaged. If this is another milestone of importance, it may be added to the timeline.

SOCIAL FUNCTIONING

Participants are expected to improve social functioning with a mental illness, establish a productive life in the community, and establish a network of support.

Timeliness between milestones is then calculated by subtracting the previous date from the next. For example, time between Referral and Assessment in the voluntary track is simply the subtraction of the Referral date from the Assessment date, in days. This information can be used to track trends between cohorts and inform policy decisions or points of intervention to improve the process.

2. LIVING ARRANGEMENT (VOLUNTARY TRACK)

Purpose: This measure identifies the change in living arrangement between program entry and exit. One of the most fundamental, yet also most destabilizing factors for individuals with mental illness is housing. Housing addresses participants' responsivity needs, or those that interfere with sustaining effectiveness in treatment (Roman, 2009). Obtaining a stable living arrangement with an appropriate level of support is the goal.

Recommendations: Living arrangement captures the participant's progress towards securing stable housing that meets their individual needs. Housing status (i.e., homelessness) should be tracked using the federal definition: "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing," provided in the Public Health Service Act [330(h)(5)(A)]. Individuals living outside, in shelters, in temporary housing such as hotels or missions, or "couch surfing" should be classified as homeless.

Type of residence should also be tracked upon entry and exit. Type of residence indicates the level of support provided by the living arrangement. Supervised housing such as group homes or assisted living provide more oversight and support, yet offer less independence compared to living alone. The type of residence provides richer information on the change in living arrangements. For example, a participant may have entered and exited the program as "not homeless," signifying no change in their housing status, but may have moved from a group home to living alone, a notable improvement in their living arrangement that may also be linked to other social functioning improvements. Suggested residence type categories:

1) Living alone (own/rent)
2) Living with family or friends
3) Group home
    (i) General
    (ii) RRP-general
    (iii) RRP-intensive
4) Assisted living/long-term care
5) Temporary housing/homeless

Implementation: SMART has the capacity to capture all data elements necessary for this measure, and courts have reportedly been tracking living arrangement for participants, though this practice varies between courts. All courts should track living arrangement for all participants upon entry and exit, including homelessness and the type of residence. Ideally, living arrangement should be reported to the court by an objective data source, such as a treatment provider, community supervision monitor, or group home supervisor. If an objective reporter is not available, the court should use participant self-report during entry and exit interviews, and attempt to secure proof of address (e.g., mail addressed to the participant).

3. RECOVERY AND FUNCTIONING (VOLUNTARY TRACK)

Purpose: This measure identifies the change in self-reported recovery and social functioning between program entry and exit. Individuals with mental illnesses typically face a lifetime of managing negative mental, behavioral, and/or physical symptoms that may interfere with their ability to function in the community. The MHC model engages an individual treatment plan paired with consistent monitoring to promote participant rehabilitation. This measure intends to capture the participants' responsivity to treatment and their progress toward social reintegration.

Recommendations: Recovery and functioning captures the individual's perception that they are making progress towards stability, in terms of their role in the community, their ability to make decisions for themselves, and their ability to care for themselves. A standard measure should be chosen that focuses on the participant's perception of these key areas of recovery and functioning. This measure should be given at entry and exit from the program and may also be used at key milestones throughout the program to assess progress and change.

Implementation: This measure requires the use of a standard tool that is regularly scored upon entry and exit from the program. The Behavioral Health Administration (BHA) currently uses a measure as part of their Outcomes Measurement System that assesses the patient's perception of their social functioning and satisfaction with their recovery. This measure is used across all BHA hospitals and is given as part of their Adult Questionnaire. The NCSC recommends two implementation options for this performance measure: (1) if feasible, the courts should request that BHA report the participant's score on their standard measure if they are assessed by BHA; and (2) if the courts do not have access to data from BHA, they should adopt the same measure as it aligns with practices used by BHA, the primary healthcare stakeholder of the MHCs. In the future, it is recommended that the MHCs adopt a validated tool that has been tested in populations with mental illness, and report on the average change in scores between entry and exit.

AFTERCARE

Aftercare is an essential element of mental health courts by preparing participants for successful transition into the community.

4. AFTERCARE (VOLUNTARY & COMPETENCY TRACK)

Purpose: This set of measures tracks the timeliness and quality of aftercare plans, including reasons for their revision prior to court approval. The *Essential Elements of a Mental Health Court* advocates for a robust aftercare plan and suggests that this component is critical for sustaining successful outcomes when the participant reenters into the community (BJA, 2007). For the competency track, this includes maintenance of competency in order to assist in their legal defense; for the voluntary track, this means a sustainable plan to promote accountability once outside court supervision and reduced contacts with the criminal justice system.

Aftercare is meant to support the participant's successful transition back into the community following their release from the hospital or jail, or their exit from the voluntary track. Before release, the court must approve an aftercare plan developed by treatment and community agencies that provides a proposed set of parameters for their continued care in the community. Particularly for those individuals awaiting release from institutionalization, timeliness in the approval and engagement of their aftercare plan is essential to promoting stability in their mental health and community integration. The court is responsible for ensuring that the aftercare plan meets statutory requirements and aims to approve plans that meet certain quality standards. Factors that must be addressed in the aftercare plan are provided in Maryland Criminal Procedure §3-108:

1) mental health treatment, including providers of care;
2) vocational, rehabilitative, or support services;
3) housing;
4) case management services;
5) alcohol or substance abuse treatment; and
6) other clinical services.

Recommendations: The NCSC recommends that the court include a measure of timeliness of plan approval, measured as the time between first submission of the proposed aftercare plan to and the final court approval of the plan. The NCSC also recommends that the court include a measure of quality of aftercare plans, using a standard scale to indicate the robustness of each statutory factor included in the plan. This set of measures will inform the court of any delays in approval for aftercare plans, along with the primary factors that were unsatisfactory. This information may provide leverage for the court when addressing sources of delay for aftercare planning (e.g., lack of acceptable housing, delay from service providers).

Implementation: The courts do not currently track the data elements required for this measure. Data fields would need to be developed and integrated into SMART, with the capacity to track dates and score multiple factors of the aftercare plan. Minimal date fields to include are (1) the date of original plan submission and (2) the date of final court approval. More detailed fields

may be desired track the amount of time within court control, especially for aftercare plans that require at least one revision. Extra date fields may include date(s) of court-requested revisions of the plan and resubmission date(s) of the revised plan. This would allow for the calculation of delay on the part of the court versus service providers. Another approach is to capture the number of revisions requested for each plan, rather than the time between each revision.

Factors included in each plan are based on Maryland Criminal Procedure §3-108, and fields may be developed to allow for a dropdown or grading scale for each of the 6 factors. Scale points may include (1) Unacceptable, (2) Moderately Acceptable, and (3) Acceptable, with the option to indicate "Not Applicable" (N/A) for factors that do not apply to individual needs. If any revisions are necessary prior to court approval, the quality scales should be reapplied for each submission of the proposed plan. Each factor can be graded overall in terms of the percent of "Acceptable" upon first submission.

Taken together, this information allows for several calculations that may aid in expediting and improving the quality of aftercare plans submitted. Aggregating within cohorts, timeliness of plan approval can be paired with the most prevalent factors rated as "Unacceptable" to pinpoint sources of delay requiring the greatest attention. Cohorts may also be used to determine whether there are trends in the sources of delay or trends in the types of factors requiring revision.

PROCEDURAL FAIRNESS

Minimize use of jails, which are costly, do not improve outcomes, and are ill-equipped to handle individuals with mental illness.

5. TIME SPENT IN JAIL (VOLUNTARY & COMPETENCY TRACK)

Purpose: This measure tracks the number of days participants spend in jail between arrest or initial appearance before a judicial officer and exit from the program, as defined by the milestones identified in Measure 1. Jails, now the primary institutions for housing persons with mental illness, are ill equipped to provide for medical and psychiatric needs (Torrey, Kennard, Eslinger, Lamb & Pavle, 2010). Psychotropic medication is often not sustained while an individual is in jail because of insurance ineligibility and a lack of access to regularly prescribed medication (i.e., substitutions may be used to save costs). Individuals with mental illnesses are more likely to spend longer time in jails, more likely to be placed in solitary confinement, and more likely to commit suicide as compared to individuals in jails and prison without mental illness. Housing an individual with mental illness in jail is costlier than providing treatment in the community and does not improve criminal justice or mental health outcomes.

Recommendation: The NCSC recommends that MHCs track the number of days an individual spends in jail between arrest or initial appearance and exit from the MHC from either the voluntary or competency track. Reasons for time in jail should also be tracked. The reasons for jail time fall into two categories, each with two subcategories:

1) Punitive
    a. Sentence
    b. Sanction
2) Non-Punitive
    a. Nonexistent resource
    b. Insufficient resource
3) Other

The goals of this measure are twofold: (1) The punitive category should be used to track the court's use of jail as a sanction in the voluntary track and to record any time individuals spend in jail as a part of their sentence. Monitoring of increased or decreased frequency of jail sanctions can be linked by cohort to other measures to determine if use of jail sanctions is correlated with improvements or declines in other measures, and thereby inform court policy on use of jail sanctions. (2) Non-punitive reasons for jail time indicate resource insufficiencies that constrain the court to using jail as a method of ensuring public and participant safety due to a lack of services more appropriate for individuals with mental illness (e.g., awaiting entry decisions due to lack of treatment, restoration, or hospital services within the community, stabilization of mental health symptoms, or secure detoxification for individuals with substance use disorders). Non-punitive jail time falls into two subcategories: (a) Nonexistent resource is to be used when the resource does not exist, and (b) Insufficient resource, to be used when the resource exists, but an individual is unable to access the resource due to an inability to meet demand (e.g., no space

available, understaffing, failure to coordinate services, or delays in processing entry). The resulting measure of non-punitive days in jail can be used as evidence of the need for more resources in the community to avoid the use of jail in the absence of more appropriate options for individuals with mental illness.

All other time in jail should be recorded in the "Other" category with the reason noted in order to provide an inclusive picture of participants' time in jail during program participation. If a participant is detained for a new arrest during program participation, for instance, that should be recorded in the "Other" category, with that reason noted in a text field. The "Other" category is an important feature of this measure not only to allow the comprehensive tracking of jail time, but also to document additional reasons for jail time to inform later revisions of these exploratory performance measures.

This measure can yield additional information by examining how the days in jail are distributed over key milestones for the MHC, specifically from arrest to referral and from entry to exit. The benefits of tracking this time is to identify at what point there are inefficiencies in the system. Team members from Prince George's County and Baltimore City identified circumstances that led to increased and inappropriate usage of jail (e.g., medication stabilization or awaiting hospital beds, therapeutic services, housing availability, assessments, or evaluations). Such examples, while not directly within the court's control between arrest and referral, identify system-wide service gaps and provide leverage for discussing how to secure appropriate community resources to meet the needs of the MHC participants at early system intercepts. The MHCs should track the reason for each jail term, and, if more information is desired about time frame, look at the differences between jail time that occurs between arrest/first appearance and referral compared to jail time that happens during participation in the MHC.

Implementation: In order to properly track this measure, SMART must be updated to include a dropdown field supplying the reason participants are jailed, including an "Other" option with accompanying text field. Additionally, courts should determine if they want to include the distribution of jail days between arrest and referral compared to during program participation as a part of the performance measure, or if that is extra information that exists in a separate report but is not included in the performance measure itself. Courts should track individuals from their first contact with the justice system (e.g., arrest) and MHC (e.g., referral or evaluation order), as described in Measure 1, to ensure jail days for all individuals in both tracks are recorded for their case's duration.

PARTICIPANT ACCOUNTABILITY

To provide ongoing judicial interaction and oversight with participants so as to hold participants accountable and protect public safety.

6. FAILURE TO APPEAR IN COURT (VOLUNTARY TRACK)

Purpose: This measure tracks the rate of failure to appear (FTAs) occurrences at court hearings, an important aspect of accountability. Court hearings are integral to judicial supervision and court monitoring of participant progress, which improve public safety. This measure provides information about how well participants are complying with an integral aspect of the program. Improved outcomes are expected when participants stay engaged with the court.

Recommendation: The MHCs should record FTAs at all scheduled court appearances. Excused absences are not counted as FTAs nor included in the count of scheduled court appearances. This measure will be reported as the percent of scheduled court (progress/review) hearings for which participants do not appear. The number of unexcused absences divided by number of scheduled court appearances equals the FTA average. This should be computed overall across participants and can be calculated for each participant if desired. A further option is to track reasons for excused absences, to collect the most frequent obstacles for keeping scheduled court appearances and guide solutions.

Implementation: The SMART system already includes the necessary data elements for this measure and has the ability to create a report to provide the results for this measure. Tracking reasons for excused absences would need to be collected separately, or a new field may be built into the SMART database in future iterations, using standard, specific categories.

TREATMENT

To promote stability by ensuring that participants comply with medically prescribed treatment plans.

7. MEDICATION COMPLIANCE (VOLUNTARY TRACK)

Purpose: This measure tracks the rate of medication compliance among participants, tracked at each staff meeting. Medication stability is necessary for achieving improved outcomes for individuals with mental illness. Clearly, non-adherence is likely to remain a major public health problem despite treatment advances. However, increasing knowledge about factors affecting adherence and leveraging detection technologies can enhance its early assessment and adequate management, particularly for individuals with needs for psychotropic medication (Kane, Kishimoto, Correll, 2013).

Recommendations: The NCSC recommends that the courts continue to track medication compliance for all voluntary track participants at each staff meeting. Medication compliance should be defined as adherence to their clinical treatment plan, such as taking prescribed medications routinely. This information may be gathered using urinalysis results or other clinical tests as gathered by the treatment provider or community monitor. It may also be reported by a third party able to verify individual compliance (e.g., treatment provider, probation officer, group home coordinator, etc.).

Implementation: Currently a team member reports medication compliance during staffing/case review meetings. However, it is typically reported orally or captured within text-based commentary in existing databases. The NCSC recommends the creation of data collection/data sharing protocols, particularly as this measure will require input from collaborating agenc(ies). The SMART database requires modifications to specify medication compliance as a type of condition violation (currently the SMART database enables courts to track positive urine tests, but only use this field for participants with a substance use disorders for monitoring illegal drug or alcohol use). Providers should follow best practices and provide a report on medication compliance, a required program component, in preparation for participants' status hearings.

At each case review/staff meeting, all participants in discussion should be recorded as "compliant" or "non-compliant" on their medication plan. The average percent of those compliant represents the rate of compliance for that week. Over time, weeks can be aggregated to track change in compliance over time, and compliance can be tracked and compared across each cohort.

This performance measure requires the development of a reliable monitoring process to consistently collect information on a participants' medication usage. This may require additional staff resources to follow up with external agencies, or improved cooperation from local service providers for regular reporting, not only for noncompliance but also for continued compliance.

REOFFENDING

To effectively collaborate in a team-based environment with key service and treatment providers.

8. INFORMATION SHARING (VOLUNTARY & COMPETENCY TRACK)

Purpose: One of the primary components of an effective team is its ability to secure the buy-in of all team members into a shared vision. Collaboration is most effective when each agency and actor from the MHC team is aware of the others' interactions and viewpoints about the participants. Monitoring information sharing will allow MHCs to investigate a lack of resources, lack of commitment by individuals/agencies, and/or other barriers to effective collaboration. It also serves as a way to build in fairness and transparency on communicating expectations between representatives of collaborating agencies.

Recommendations: The Workgroup endorsed NCSC's recommendation that Maryland's MHCs track incidents in which the information required to make a team decision was not available during staffing/case review meetings When information is not available in a timely manner, it may delay the court's ability to make an informed decision and be informed of participants' progress. Any mode by which the information is transmitted should be included in this measure (e.g., fax, e-mails, notes, verbal reports, texts). The goal is to utilize a shared database for which each representative agency is provided access to enter or retrieve relevant information. While information sharing practices may not vary frequently, if the court identifies shifts in the availability of information previously available, the court will be better positioned to respond proactively to address shifting resources, priorities, and attend to inevitable staffing or leadership changes.

Implementation: MHCs will need to identify when information is missing for each staffing/case review meeting and identify the source of expected information. The NCSC has developed an Excel template for this measure that will guide integration of this information into SMART and related output report design (see http://www.ncsc.org/mhcpm MHCPM Data Analysis Templates to download the Excel file). Consideration should be made for confidentiality of shared information, ensuring a secure platform is used to exchange any data outside of the SMART system, in accordance with the Code of Federal Regulations 28 (part 2) and 42, and the Health Insurance Portability and Accountability Act (HIPAA). This template is not meant to replace or circumvent SMART tracking, but to provide and example for future SMART integration.

COLLABORATION

To reduce the revolving door in the criminal justice system for individuals with mental illness, ultimately improving public safety.

9. REARRESTS (VOLUNTARY TRACK)

A. PERCENTAGE REARRESTED
B. AVERAGE TIME BETWEEN ARREST

Purpose: While the primary outcome for participants is no additional involvement with the criminal justice system, researchers and practitioners argue that recidivism or rearrest rates do not fully capture successful outcomes within this population. However, as a public safety measure, recidivism must be included as a key component for a balanced set of performance measures.

Recommendations: This measure only applies to participants who exit in the voluntary track of the MHC. The NCSC recommends tracking the percent of participants who are rearrested following departure from the program (successfully or not). The NCSC also recommends a sub-component (9b) that measures the average time between arrests with the expectation that as participants progress in treatment, the time between each arrest will lengthen. Although mental illness is not a criminogenic risk factor (does not lead to increased rates of reoffending), recidivism is a critical outcome measure. General risk factors predicted recidivism, with no incremental utility added by risk factors unique to mental illness (Skeem et al., 2014).

The NCSC generally recommends using the definition for recidivism as an arrest that results in a conviction. Convictions provide an added layer of protection for local variations in arresting and charging practices. However, the NCSC recommends that MHCs track all rearrests, as participants may not be charged with a crime if they are found incompetent to stand trial, found not criminally responsible, or if they "time out" while in held in jail or in a hospital. Such factors impact conviction rates differently for this population and do not provide as accurate of a measure of criminal behavior.

Implementation: Monitoring post-program recidivism over time relies upon the consistent, accurate reporting of re-offenses among former participants. Collecting reliable data on arrests and convictions from different jurisdictions within the state and from other states is an important challenge, particularly for jurisdictions in Maryland that fall along state boundaries. If re-offenses are underreported due to an inability to gather arrest and conviction data, post-program recidivism will appear artificially low.

Changes in the reliability of reported arrest and conviction data can lead to an apparent increase or decrease in recidivism post-program when no such change has occurred. If court staff know that systems of data sharing or other programmatic changes will occur that could affect the accuracy of arrest or conviction information about their former participants, the timing of these changes should be documented to inform the interpretation of this measure over time.

Conclusions and Recommendations

Maryland, through execution of this project, has demonstrated its commitment to reaping the benefits of monitoring its performance and improving both criminal justice and mental health outcomes. Maryland should serve as a model to other states as it takes the first step in the process actively defining success. In May of 2018, the Mental Health Court Performance Measures Workgroup, comprised of key stakeholders, met to discuss state-specific policies and organizational structure as they informed the applicability, feasibility, and relevance of a balanced set of performance measures for Maryland's mental health courts. This report is a result of the Workgroup's recommendations.

The second step in the process of adopting a set of performance measures is implementation. Successful implementation requires support from leadership across numerous external stakeholder agencies. State and local treatment agencies, the Behavioral Health Administration, State's Attorney Office, the Office of the Public Defender, and detention facilities serve as important partners to the courts, among other community players. Effective partnerships require courts to develop data sharing protocols that outline expectations, access, permissions, privacy, and usage. Additionally, the courts' partnership with the University of Maryland's Institute for Governmental Service and Research (IGSR), those who maintain the SMART database, provides the necessary infrastructure for capturing, reporting, and responding to performance measurement data. Several implementation issues are noted throughout this draft that will require the addition and modification of specific SMART data fields. This report provides guidance on statewide definitions that will bridge jurisdictional gaps in both processes and data definitions.

The courts are encouraged to consider the impact that implementation and maintenance of these performance measures will have on staffing need. Indeed, dedicated staff resources will be required to ensure complete and accurate performance measurement data. Not only are staff needed for data entry, but also for ensuring data quality and completeness, reaching out to collaborating agencies for more information, running regular performance measurement reports, and distributing meaningful feedback based on performance measurement data.

Finally, long-term success of a performance management system, that is managing internal processes and developing policies informed by performance data, requires sustained efforts. Sustainability is most often successful when courts revisit, revise, and review the performance of the courts on a regular basis. The NCSC recommends that the OPS revisit the performance measures every two to three years. Such efforts require:

1) Continued leadership support,
2) Solid funding, and
3) Regular assessment and monitoring.

Statewide support, monitoring, and leadership by the OPSC will undoubtedly improve the impact mental health courts can have on individuals with mental illness, their loved ones, and the communities in which they live.

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