ABSTRACT

THE EFFICACY OF THE FRESNO COUNTY BEHAVIORAL HEALTH COURT

In response to the high recidivism rate associated with mentally ill offenders, many jurisdictions have developed specialized behavioral health courts. The following research examined the efficacy of the Fresno County Superior Court’s Behavioral Health Court (FCBHC) by comparing total number of arrests before and during participation in the FCBHC. Data from Fresno County Department of Probation files and Fresno County Superior Court records were used. During the baseline timeframe 6 out of 17 participants were dismissed from the behavioral health court. The results of this study showed a slight decrease in the number of total arrests among those that participated in the FCBHC. Future policy implications and suggestions for further research are discussed.

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THE EFFICACY OF THE FRESNO COUNTY BEHAVIORAL HEALTH COURT

by

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Soli Deo Gloria!
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CHAPTER 1: INTRODUCTION

This study will examine the arrest rates for a group of mentally ill offenders that either were currently participating in or had been participating in the Fresno County Behavioral Health Court program (FCBHC) during the period January 2010 through December 2010. The arrest rates prior to their acceptance into the court will be compared to arrest rates during their participation in the court up to December 2010. Violations of probation will also be considered.

Mental health professionals and those within the criminal justice system have become concerned about the rates of mental illness within our jails and prisons as well as the availability of treatment in these facilities and after release (Lamb, Weinberger, & Gross, 2004). One fourth of all jail inmates in 2002 had at least one previously diagnosed mental illness upon arrest (Constantine et al., 2010). Furthermore, individuals with a serious mental illness are eight times more likely to be imprisoned than admitted to a state mental facility (Ascher-Svanum et al., 2010). The high rate of recidivism associated with the mentally ill has increased the caseload in the courts and has not provided help to those suffering from severe mental illness.

A recent report by the Justice Center (2008) indicates that half of all inmates—over 1 million individuals—suffer from at least one mental health condition. They report that 50% of those with a serious mental illness reported three or more prior incarcerations. Other research

1 The terms behavioral health court and mental health court are synonymous and will be used interchangeably throughout this paper.
shows that 6%-20% of our jail and prison populations suffer from a serious mental illness (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Lamberti & Weisman, 2004; McNiel & Binder, 2007; Moore & Hiday, 2006). In 1999 both Riker’s Island jail and the Los Angeles County jail held more mentally ill inmates than the largest psychiatric facility in the United States (Justice Center, 2008). Similarly, Florida jails have become one of the largest state psychiatric facilities in the nation housing more than 10,000 persons with mental illness, many guilty of low-level offenses. This number represents five times the number of persons in Florida’s psychiatric hospitals (Perez, Leifman, & Estrada, 2003). In addition, they also found a person with a mental illness is more likely to be rearrested than a non-mentally ill person for the same crime and under similar circumstances.

Many people, when they think about a severely mentally ill offender, may be tempted to think of someone that fits the description of a “psychopath” or “sociopath” such as Adolf Hitler or Charles Manson. It is important to understand that the term “psychopath” refers to a person suffering from a personality disorder, not a mental illness. Juxtaposed to a mental illness, defining a personality disorder such as psychopathy can be quite difficult. The most common definition of a psychopath is a person that has not been properly socialized and grows up with no ability to feel compassion or empathy for others (Hagan, 1997). A personality disorder such as psychopathy is considered to be far less amenable to treatment than a mental illness.

Mental illnesses are treatable medical conditions. According to the Diagnostic and Statistical Manual of Mental Disorders (American
Psychiatric Association [DSM-IV-TR, 2000] an AXIS I mental illness is defined as,

a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual that is associated with present distress (e.g., a painful symptom) or disability (i.e., impaired in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (DSM-IV-TR, 2000).

For the purposes of this study, severe mental illness will include the following clinical disorders: Major Depression, Schizophrenia, Post-Traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), Panic Disorder, and Bipolar Disorder. The mental illnesses listed here are considered AXIS I diagnoses as differentiated from AXIS II diagnoses which consist largely of personality and developmental disorders (DSM-IV-TR, 2000).

The Era of the Asylum

Throughout history the mentally ill have been viewed as dangerous persons that needed to be taken out of society and placed in institutions or asylums that, in reality, offered little to no treatment, but simply kept them off the streets (Slate & Johnson, 2008). Dealing compassionately and humanely with the mentally ill is a relatively recent change in the overall approach to handling, not only the mentally ill, but the mentally ill offender (Wolff, 2002).

Until the 18th century, many of the treatments for mental illness were based on erroneous theories regarding the association between the
mind and body (Slate & Johnson, 2008). Throughout history, therapies such as removing a piece of the patient’s skull in order to release the evil spirit that was responsible for the person’s condition were commonplace. At one point in history, patients were thrown into a pit of snakes thinking that if this would make a sane person insane, it must work in reverse (Slate & Johnson, 2008). Sadly, given the rudimentary understanding of many pathological processes at the time there was little hope that someone with a severe mental illness would ever recover.

Beginning in the late 18th century the American public became aware of the cruel and inhumane conditions found in most psychiatric hospitals and a national movement was sparked to remedy this situation. One of the most important figures in the mental health reform movement was Dorthea Dix. During the 1800s she traveled to jails and prisons throughout America protesting the treatment of the mentally ill. She argued that the root cause of deviant behavior was not being addressed in the correctional system and that those suffering from mental illness needed treatment rather than incarceration (Bloom, 2010; Slate & Johnson, 2008).

In 1854 a piece of legislation in the U.S. Congress called the “12,225,000 Acres Act” was proposed. The act would have required the federal government to fund state psychiatric hospitals but it was vetoed by President Franklin Pierce (Bloom, 2010). President Pierce responded by saying,

I readily... acknowledge the duty incumbent on us all...to provide for those who, in the mysterious order of Providence, are subject to want and to disease of body or mind, but I cannot find any
authority in the Constitution that makes the federal government the great almoner of public charities throughout the United States. (p. 727)

Bloom (2010) notes that for most of our history, the federal government has taken the position advocated by President Pierce and has avoided establishing a federally funded mental health system. Despite the efforts of reformers such as Dorthea Dix, up until the early part of the 20th century persons suffering from severe mental illness languished in deplorable conditions found in most psychiatric hospitals.

During the 20th century there were several attempts to establish a federally funded mental health system. However, Ronald Reagan ended the federal funding of community mental health centers and instead funded block grants to support state services (Bloom, 2010). Unfortunately, there was no way to assure any of those funds would be used to support mental health services. Slate and Johnson (2008) remind us that the 20th century brought with it two world wars, and millions of young men returned home scarred- emotionally and physically. Most veterans returned to communities with limited mental health resources forcing them to deal with their problems by self-medicating with drugs and alcohol.

The national movement to address the poor treatment of the mentally ill continued to gain momentum in the 20th century with the publication of a 1943 *Time* magazine article titled “Bedlam 1946: Most U.S. Hospitals are a Shame and a Disgrace” and several feature length movies that brought the issue into the eye of the public (Slate & Johnson, 2008). Nevertheless, until the 1960s the mentally ill continued
to be housed in asylums or institutions with little concern for their mental or physical welfare (Peternelj-Taylor, 2008). However, in 1972 an important legal case, *Wyatt v. Stickney* (1971), established the right to treatment for those suffering from mental illness that had either been civilly committed or were confined in a correctional institution (Perez et al., 2003). The court found that simply providing room and board did not guarantee “the constitutional right to receive such individual treatment as will give each [individual with mental illness] a realistic opportunity to be cured or to improve his or her mental condition” (Perez et al., 2003, p. 63). This landmark case was finally decided by the court in 2003 and created minimum standards of care and rehabilitation for those with mental illness and mental retardation that have been emulated across the country (Carr, 2004).

Despite the efforts to address the needs of the mentally ill, state psychiatric facilities continued to be under funded. The overall population in state psychiatric hospitals has been reduced from 559,000 in 1955 to just over 100,000 in 1992; more recent data shows that number to be approximately 55,000 (Lamb et al., 2004; Torrey, Stieber, & Ezekiel, 1992). Bloom (2010) examined the Oregon state mental health system as a case study of state mental health systems and found that both state and private inpatient psychiatric facilities in Oregon are filled to capacity. In addition, Bloom (2010) also described several studies showing that the state mental hospitals are not serving the typical non-criminal Oregonian but are reserved mainly for those found to be incompetent to stand trial and have been committed by the State. They argue that the situation in Oregon is common in many other states and
has created a pathway from the state psychiatric facilities directly to the nation’s jails and prisons (Bloom, 2010).

From Deinstitutionalization to Criminalization

The term *deinstitutionalization* refers to the closing down of state mental hospitals that began in the 1960’s and continues to this day in many local jurisdictions and has forced millions of persons with serious mental illness to seek help in overcrowded and often underfunded, community based clinics (Perez et al., 2003; Peternelj-Taylor, 2008). In 1955 when the number of patients in psychiatric facilities was at its peak, there were 559,000 persons housed in state mental hospitals out of a total population of 165 million. As of the year 2000, with a total population that has doubled, there are approximately 55,000 patients in state mental health facilities (Lamb et al., 2004). Sadly, many of those patients that were once being treated in state mental facilities are now homeless (Perez et al., 2003) and will likely come into contact with the criminal justice system at some point. It is believed that one-third to one-half of all homeless persons suffer from severe mental illness (Slate & Johnson, 2008; Torrey et al., 1992). Research further suggests that 7% of all police contacts involve a homeless person suffering from mental illness (Lamberti & Weisman, 2004).

According to Lamberti (2007), deinstitutionalization has been one of the most well-intentioned, but poorly instituted policies ever carried out in the U.S. Former investigative reporter Peter Early (as cited in Slate & Johnson, 2008) reports that there were several convergent factors that led to the deinstitutionalization movement in America. These
included: attorneys fueled by the civil rights movement who were willing
to file class-action lawsuits against state hospitals for patient
mistreatment, the development of the drug Thorazine that helps control
the symptoms of some mental illnesses, the exposure of inhumane
conditions in state mental facilities by the media, the evolution of an
anti-psychiatry counter-culture (public distrust of anti-psychotic drugs),
and President Kennedy’s initiative to fund community mental health
centers. California has been on the front lines of deinstitutionalization,
and has also been on the forefront of discovering the untoward
consequences of this policy (Torrey et al., 1992). Our jails, prisons, and
courts are replete with the results of discharging millions of
unsupervised psychiatric patients and relying on limited local mental
health services to control the behavioral problems often associated with
these disorders (Accordino, Porter, & Morse, 2001; Bloom, 2010;
MacDonald, Hucker, & Hébert, 2010; Torrey, 1997).

This situation has led to what has been called the criminalization
of mental illness. According to Abramson (as cited in Banks, Pandiani, &
Boyd, 2009), criminalization of mental illness is the condition in which
criminal sanctions are applied in response to behavior that is the result
of mental disorder (Accordino et al., 2001; Litschge & Vaughn, 2009;
MacDonald et al., 2010).

Several studies have looked at the criminalization of mental illness.
In one study, Banks and colleagues (2009) examined all individuals who
received public mental health services in the state of Vermont. They
compared the relative rates of criminal charging and incarceration for
adults with severe mental illness to those in the general population.
They found that men and women 35 years and younger with severe mental illness were 2.6 times more likely to be charged with a crime than the general population and 3.8 times more likely to be incarcerated (Banks et al., 2009). Our correctional institutions are not equipped to nor were they ever intended to serve as mental health treatment facilities.

The lack of community based mental health treatment has forced jails and prisons into the role of default psychiatric facilities (Baillargeon et al., 2009; Hoge, Greifinger, Lundquist, & Mellow, 2009; Lamberti & Weisman, 2004; Slate & Johnson, 2008). Torrey (2010) offers the following quotes from jail and prison staffers:

“By default we’ve become the mental health agencies of the individual counties” (Pueblo County, CO. Sheriff, Kirk Taylor).

“Our jails and prisons collectively are the biggest mental-health facilities in the state...Jails have become asylums for thousands of inmates with mental illness whose problems and needs far exceeds what jails can provide” (Polk County, FL. Sheriff Grady Judd).

“The schizophrenic and chronically mental [patient] population just exploded and we found ourselves being the hospital” (Dr. Dana Tatum, supervisor of mental health care for the Gwinnett County, GA. Detention Center).
The result of placing those suffering with severe mental illness in jails and prisons was eloquently summarized in the words of a caring mother with a mentally ill child. She writes, 

incarcerating mentally ill people in jails and prisons is cruel, unjust, and ineffective. Prisons do not have adequate or appropriate facility resources or medical care to deal with the mentally ill. Poorly trained staff is unable to handle the difficulties of mental illness... They do not always comprehend the rules of jails and prisons. They are highly vulnerable and prone to bizarre behavior that prison staff must deal with and inmates must tolerate. (Peternelj, 2008, p. 186)

The lack of adequate medical care as well as mental health services within California prisons has resulted in a lawsuit (Brown v. Plata, 2011) being brought before the United States Supreme Court in 2009. The suit alleges that inmate’s 8th Amendment rights are being violated by inadequate mental health services due to over-crowding. If a significant number (over 40,000) of inmates are released, as is feared, the overburdened mental health care system in California will be even more stressed and it will be that much more difficult for the mentally ill to receive care. According to Vinci (2011), in a 5-4 ruling, the United States Supreme Court ordered the California Department of Corrections and Rehabilitation to reduce its inmate population in stages over the next two years. Justice Kennedy explained that the reduction is necessary to avoid unnecessary suffering and death (Vinci, 2011).
The Era of Diversion

Beginning in the 1990s in response to the high number of mentally ill offenders clogging the criminal justice system many local jurisdictions began to divert many of these offenders into treatment-based programs (Boothroyd, Calkins Mercado, & Poythress, 2005; Case, Steadman, Dupuis, & Morris, 2009; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Grudzinskas Jr., Clayfield, Roy-Bujnowski, Fisher, & Richardson, 2005; Lamberti, Weisman, & Faden, 2004). There are several diversion program models that bring emergency medical personnel together with law enforcement at the scene of an incident that is the result of mental illness in order to avoid unnecessary arrest and detention, but rather link the offender with treatment.

One of the most popular approaches among local jurisdictions has been the mental health court also known as a behavioral health court (Boothroyd, Poythress, McGaha, & Petrila, 2003; McNiel & Binder, 2007; Redlich, Steadman, Robbins, & Swanson, 2006). Mental health courts are a new addition to the problem-solving or “specialty” courts and are predated by other courts such as drug courts and juvenile justice courts (Redlich et al., 2006). Both drug courts and behavioral health courts are based on the philosophy of therapeutic jurisprudence (Bloom, 2010; Slate & Johnson, 2008) that was popularized by David Wexler.

According to Wexler and Winnick (1991), therapeutic jurisprudence is a perspective that regards the law as a social force that produces behaviors and consequences. Therefore seeking treatment for offenders in order to address the root cause of the offending behavior can be seen as a viable response by the law. Steadman, Davidson, and
Brown (2001) define therapeutic jurisprudence as, “the extent to which legal rule or practice promotes the psychological or physical well-being of a person subject to legal proceedings” (p. 457). According to Wexler and Winnick (as described in Slate & Johnson, 2008),

Therapeutic jurisprudence seeks to apply social science to examine law’s impact on the mental and physical health of the people it affects. ...whether we realize it or not, law functions as a therapeutic agent, bringing about therapeutic or non-therapeutic consequences. (p. 5)

Wexler and Winnick (1991) go on to say that whether we like it or not the law often acts as either a therapeutic agent or an anti-therapeutic agent.

The behavioral health court is generally seen as an outgrowth of the drug court movement that synthesized the principles of therapeutic treatment and judicial process (Watson, Hanrahan, Luchins, & Lurigio, 2001). The first drug court appeared in 1989 and was based on the recognition that drug possession is a legal issue as well as a public health concern. Slate and Johnson (2008) offer the following definition of a typical mental health court,

A specialized docket for certain defendants with mental illness that substitutes a problem solving model for traditional court processing. Participants are identified through specialized screening and assessments, and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan and other court conditions, non-
adherence may be sanctioned, and success or graduation according to specific criteria. (p. 142)

The genesis of many of these courts stems from Senate bill S. 1865 signed by President Bill Clinton in 2000 that provided for $10 million for the establishment and maintenance of up to 100 mental health courts. These courts are based on the theory that these offenders can best be handled by being diverted out of the traditional criminal justice system and into a therapeutic, non-adversarial case management approach (Boothroyd et al., 2005; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Cosden et al., 2005; McNiel & Binder, 2007). Several studies have shown that recidivism can be reduced if critical linkages can be forged between treatment providers and offenders in the community (Christy et al., 2005; Cosden et al., 2005; McNiel & Binder, 2007). The high rate of recidivism among this population when adjudicated in the traditional criminal justice system shows the ineffectiveness and futility of continuing to do what has been done in the past. Indeed, mental health courts are proving to be an effective and important solution to the problem of mentally ill offenders (Cosden et al., 2005; McNiel & Binder, 2007). The benefits of these courts include close supervision from court staff and clinicians, access to county mental health services as well as positive reinforcement. Some research based on the theory of social bonding, suggests that the relationship between the court staff and the client can serve as a significant motivating factor for reduced criminal offending (Goldman, Glied, & Alegria, 2008; Wales, Hiday, & Ray, 2010). According to Frailing (2010) there are now over 250 behavioral health courts across the country.
However, these courts are not without controversy. Wolff (2002) argues that behavioral health courts engage in preferred selection by choosing offenders who have committed low level offenses, such as pan handling or nuisance crimes or have limited criminal histories and reject more violent offenders thus ensuring the success of the court. She notes that the “preferred client” is also generally more open to treatment, and she goes on to cite research showing success for the motivated client. Tyuse and Linhorst (2005) argue that these courts can only serve a limited population and thus do little to alleviate the totality of the bigger societal problem. They also argue that “if services associated with mental health courts are adequately funded, more charges may be filed against people with mental illness to get them services, further criminalizing them” (p. 238). However, even in light of these concerns, mental health courts remain one of the most promising solutions to a problem that has seriously impacted the criminal justice system.

Mentally ill offenders present several challenges. One of the most significant obstacles in effectively helping these offenders is that often there is a co-occurring substance abuse diagnosis (Broner, Lattimore, Cowell, & Schlenger, 2004; White, Goldkamp, & Campbell, 2006). Of the 11 million people booked into jails each year, approximately 800,000 have a serious mental illness and 72% of these also have substance abuse issues (Mire, Forsyth, & Hanser, 2007). Concomitant substance abuse diagnoses are a source of much controversy within the behavioral health and criminal justice communities. Mire and colleagues argue that dual diagnosis inmates should initially be screened for receptiveness to treatment prior to being considered for any diversion program.
Overall, there is mixed evidence as to the effectiveness of these courts (Broner et al., 2004; McNiel & Binder, 2007; Sirotich, 2009). Most studies show a positive outcome, at least for some offenders, but more research is needed to understand the type of offender that can benefit from participation in a mental health court.

**Current Study Overview**

This study is an extension of a research project initiated by the Honorable Judge Hillary Chittick in conjunction with the County of Fresno shortly after the establishment of the Fresno County Behavioral Health Court (FCBHC) in 2008. Preliminary results of that study were presented at the 2010 American Society of Criminology conference held in San Francisco, CA.

The FCBHC is a post-conviction, three-phase, 36-month court. Defendants are sentenced to 3 years of probation under the direct supervision of a Superior Court judge. All members of the FCBHC team, consisting of the judge and representatives from the Department of Probation, office of the District Attorney, Public Defender, Department of Behavioral Health, and various community service providers, collaborate on participant selection. The FCBHC has an exclusive docket and provides intensive monitoring of the offender's adherence to the terms and conditions of their probation. Both misdemeanor and felony cases are accepted, but defendants facing violent felony charges are only accepted under certain circumstances. The defendants are graduated through each phase as they continue to follow the guidelines set forth by the court.
The FCBHC team meets every 2 weeks. During a pre-hearing conference each participant’s progress is discussed. Each case is reviewed and those participants who have violated the terms and conditions or have encountered problems since the previous court session are discussed and a team decision is made as to how the court will handle each participant at the hearing. The judge makes the final decision as to possible awards (for compliance) and sanctions (for noncompliance) for all participants. Participants who successfully obeyed all conditions of probation as well as any court orders are rewarded with applause along with a chance to win a gift card from a local business or restaurant. Participants who have violated the terms and conditions of their probation or are found to have committed a serious infraction can be sanctioned. Depending on seriousness of the misconduct, sanctions can include a warning, community service, termination from the program, or even incarceration. Those terminated from the program are generally placed back on normal probation. However, there is a possibility that probation will be completely revoked and the offender sent to state prison to serve out the remainder of his or her sentence. However, this is generally considered as a last option.

This study is designed to evaluate the effectiveness of the FCBHC by comparing the number of arrests for the total number of participants prior to acceptance in the court with the number of arrests while in the behavioral health court program. Based on prior research, it is hypothesized that those offenders that participate in the FCBHC will have fewer arrests after their acceptance in to the court than they did prior to their acceptance to the FCBHC.
The following chapter will include an examination of the relevant literature on the topic of mental health courts and other diversion programs. Chapter 3 will present the methodology utilized to evaluate the data derived from court and probation records. Chapter 4 will discuss the results of this research. Chapter 5 will examine the results, and chapter 6 will discuss the implications of the research, and suggest directions for future research.
CHAPTER 2: A LITERATURE REVIEW

This literature review will examine and summarize some of the most important studies that have been published on the topic of mental illness in the criminal justice system, including diversion programs, mental health courts, and the problem of substance abuse issues among mentally ill offenders.

A panel discussion was held in 2002 at the University of Rochester Medical Center with representatives from the criminal justice system and mental health systems to identify barriers to service between the two systems (Lamberti & Weisman, 2004). The panel identified several roadblocks that, if removed, may help reduce the involvement of people suffering from mental illness with the criminal justice system. The panel concluded that police officers should receive mental health training and that they should have access to a mental health professional for guidance at all times. They also recommended that the state laws that determine the level of discretion available to a police officer when dealing with a mentally ill offender should be investigated and possibly standardized across the country. Finally, the panel discussed several effective diversion strategies used by local police departments. They determined that the most popular model is the crisis intervention team (CIT) approach used in Memphis TN, Houston, TX, Portland, OR, Seattle, WA, and Albuquerque, NM. Other effective programs discussed included the Psychiatric Emergency Response Team (PERT) in San Diego and the Police Team with Mental Health Expertise in Birmingham, Alabama. The panel concluded that the differences between the criminal justice system and the mental health system arise from differing philosophies and the
social roles of each system. They expressed additional concerns that diversion programs could possibly lead to increased incarcerations of the mentally ill and that mentally ill offenders may be given preference to limited mental health services (Lamberti & Weisman, 2004).

**Diversion Programs**

Jail diversion has many forms, but typically it is a process whereby alternatives to criminal prosecution are offered to persons suffering from mental illness who have come into contact with the criminal justice system (Draine & Solomon, 1999; Petrila, 2005). Draine and Solomon (1999) note several conceptual problems in defining what exactly constitutes a jail diversion program. While crisis intervention and jail release planning may provide some of the same benefits as a jail diversion program, the purpose of these programs is much different. Despite this difficulty, there are generally two types of diversion programs; pre-booking or post-booking. A pre-booking model intervenes in an effort to prevent incarceration while a post-booking model attempts to link the offender with mental health services as a condition of release in lieu of prosecution (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003). Petrila (2005) argued that many mental health courts do not meet the definition of a true diversion program since the offender is often required to plead guilty as a condition of admission to the court. He went on to suggest that future research should focus on the specific treatment received and what impact these services have on outcomes.

A study by Hartford, Carey, and Mendonca (2006) found those suffering from mental illness are being arrested at a higher rate even for
minor offenses. The researchers hypothesize this is because (1) there are more people with mental illness on the streets, (2) the police are being given the responsibility of dealing with the immediate crisis, (3) and there is an overall lack of mental health resources in most communities. Tellis and Pruett (as cited in Hartford et al., 2008) cite the philosophy of *parens patriae* and the protection of the public as the basis for the involvement of the police with the mentally ill. *Parens patriae* is a legal concept that states that the role of the criminal justice system is to act as a surrogate parent by protecting those unable to care for themselves, such as the mentally ill or juveniles.

The idea of intervening with mentally ill offenders at the earliest stages of the criminal justice process is not a new idea and can be used for any number of social risk factors such as chronic unemployment, substance abuse issues, and various criminal offenses. The goals for each are similar: to deal with the underlying cause of the deviant behavior rather than to simply apply criminal sanctions. Judge Harold Birns, an appellate judge in New York City in the mid-seventies, recommended that a successful diversion program should include effective counsel, a centralized screening process, a motivated judiciary, formal guidelines, confidentiality, and a resumption of prosecution for failure to abide by guidelines (Birns, 1976).

In a study by Steadman, Cocozza, and Veysey (1999) 80 mentally ill arrestees were examined in a small mid-western town. The focus of the study was to determine the type of person diverted and the type of services received, two months after diversion. Two groups were created: (N=35) diverted and (N=45) nondverted. The nondverted group
continued through the normal criminal justice process while the diverted were enrolled in the mental health court program. Four different data collection instruments were utilized: a process baseline client interview, a follow-up client interview, a staff interview, and a criminal history form. Overall, the participants had a lengthy criminal history that began at a young age. Both groups were similar in demographics, criminal history, and mental health service utilization history. The results showed that at the 2-month interview all of those in the diverted group had been released back into the community, while only 64.4% of the non-diverted group had been released. They found that five individuals in the diverted group were hospitalized whereas none in the non-diverted group were hospitalized. This difference was attributed to closer monitoring of the diverted group. Finally, the most unexpected result was the rearrest rate for both groups was nearly identical: 28.6% of the diverted subjects and 24.1% of the nondiverted subjects (Steadman et al., 1999).

This study may have been more revealing if not for the extensive alcohol and drug abuse issues associated with a significant percentage (48%) of the sample. The presence of substance abuse issues can often hide the actual effects of diversion because whether or not a person reoffends may have more to do with an ongoing substance abuse problem rather than participating in a diversion program. In addition, the researchers were not able to locate several of the participants and therefore were not able to complete all final client interviews, which may have provided much more data leading to more conclusive results. In addition, having a longer follow-up period may also have helped provide more thorough results.
Sirotich (2009) conducted a review of the research literature to determine whether there is evidence to support the use of diversion programs to reduce recidivism and incarcerations among adults with serious mental illness. Twenty-one studies were examined for intervention type, size of treatment versus comparison groups, measurement methods, and findings. Sirotich (2009) reported mixed results regarding the effect of diversion on reducing recidivism and incarceration rates. Overall, the evidence suggested that diversion programs do not reduce recidivism among persons with mental illness. On the other hand, he found that diversion initiatives did reduce the time spent in custody for adults with serious mental illness. The results of the literature review may have been different if the studies chosen for review were more closely related in design. Furthermore, there did not appear to be any controlling for the effect of substance abuse issues among the diversion programs examined. However, this study indicated a need for a standard research design when court based diversion programs are examined in regards to recidivism.

Hartford and colleagues (2006) reviewed the existing literature on pre-arrest diversion programs within the criminal justice system. Using several popular search engines they uncovered 92 articles dealing with pre-arrest diversion model in North America, Great Britain, and Australia. Surveys were sent to 1,078 e-mail addresses in the U.S., Canada, Great Britain, Australia, and New Zealand. There were fifty-four completed surveys returned. The survey items concerned program structure and volume, policy details, networking, and training issues. Of the 54 respondents, 27% stated they had a formal diversion program in
place and 73% had an informal system of diversion. Nine respondents indicated a wide range of number of persons diverted: from a high of 1,700 to a low of 6. Hartford et al. (2006) also found that 55% of respondents provided the name of an agency used to divert offenders with serious mental illness. They also noted that 70.6% of officers surveyed received some kind of training in mental health issues. The researchers concluded that the pre-arrest diversion studies that were examined lacked several key components: control groups, longitudinal design in order to obtain long-term outcome data, and objective data on key variables so as to compare similar studies. There were several limitations of this study. First, the response rate to the survey was extremely low and thus the method utilized to approach survey respondents may need to be reconsidered. Second, the researchers failed to obtain any data that reflected the type of program examined or the effectiveness of these programs. Future research on these types of programs would benefit by focusing more on outcome data and the type of treatment offered to the defendant (Hartford et al., 2006).

**Effectiveness of Behavioral Health Courts**

Until recently, there have been relatively few studies done on the effectiveness of behavioral health courts, but the volume of empirical literature is increasing. Much of the research that has been done on behavioral health courts is based on the same methodology used to evaluate drug courts. However, research on behavioral health courts is beginning to evolve into a unique type of social science research. Measuring the effectiveness of behavioral health courts offers several
unique research challenges. Wolff and Pogorzelski (2005) suggest the difficulty is due to the complex nature of these courts, which they term as “fluid and non-standard entities” (p. 541). However Wolff and Pogorzelski (2005) argue that certain factors unique to the particular jurisdiction may be responsible for the effectiveness or ineffectiveness of these types of courts. For example, the actors, environment, or political climate may be unique to the court being examined.

In an often-cited study, Boothroyd et al. (2003) examined the process and service utilization of the first mental health court in the U.S. which was established in Broward County, Florida in 1997.\(^1\) The sample group (N=121) consisted of English-speaking defendants between 18-64 years of age that entered the court between December 1, 1999 and April 30, 2001. In order to be accepted into the Broward County mental health court a defendant must (1) be charged with a non-violent misdemeanor, city ordinance, or traffic offense, (2) have a mental illness, and (3) must make a voluntary choice to have their case adjudicated in mental health court. The comparison group (N=101) consisted of defendants that met the eligibility requirements, but resided in a Florida county that did not have a mental health court at that time (Boothroyd et al., 2003).

The researchers were interested in the treatment linkages that were most prevalent in a typical mental health court session. A treatment linkage is a reference to those services and programs that are offered to a defendant during a court session. They found that 35.3% of

\(^1\) Some credit Marin County, IN as having the first MHC in the U.S.
offenders were provided information about a service provider or encouraged to simply continue with the treatment plan and linkages previously established. Also 11.1% of offenders appearing before the court for the first time were too mentally unstable and needed treatment before returning to court (Boothroyd et al., 2005). This is important because it may show that the offender is not receiving adequate treatment or is not cooperating with his treatment plan.

Chi-square analysis was utilized to examine the relationship between expected treatment linkages and actual service utilization. No significant correlation was found between the type of treatment expected by the court and the likelihood that defendants would use behavioral health services in the 8 months following their final court hearing (Boothroyd et al., 2003).

The final outcome component of this study was the distribution of various aspects of the mental health court process across race and gender. The variables that were used to measure this were the number of utterances (i.e., instances of vocal communication between judge and defendant) made during a court session and the disposition of the cases. The sample consisted of 64 Caucasian defendants and 23 African American defendants. Boothroyd et al. (2003) found no evidence of preferential treatment due to racial differences.

Another study (Boothroyd et al., 2005) of the same court in Broward County, FL was conducted that compared the clinical outcomes of the Broward County Mental Health Court with a nonequivalent misdemeanor court in Hillsborough County. The Hillsborough court was used because it closely matched the Broward County court in
demographics and other important census variables. The defendants in each court were examined using the Brief Psychiatric Rating Scale (BPRS) to obtain a baseline of psychiatric symptoms ranging from “not present” to “extremely severe.” The BPRS measures psychoticism, depression, hostility, and other psychopathologies. The mean baseline scores for the group were $34.3 \pm 9.0$ (meaning a moderate level of psychopathology). All defendants were reclassified as having received treatment or as receiving no treatment. After an 8-month follow-up the treatment group BPRS scores increased an average of $0.8 \pm 9.9$ while the non-treatment group increased an average of $0.6 \pm 12.1$. These small changes were deemed as insignificant. While other research (Boothroyd et al., 2003) has shown that mental health court defendants are more likely to be linked with and receive mental health services, this study showed that receipt of treatment alone is not sufficient to effect positive changes in clinical status (Boothroyd et al., 2005).

In an often cited mental health court study McNiel and Binder (2007) looked at the role of mental health courts in reducing recidivism and violence among mentally ill offenders. This study examined 170 individuals diagnosed with an AXIS I mental disorder over the age of 18 that entered the San Francisco Behavioral Health Court between January 2003 and November 2004. They compared these offenders with potentially qualified candidates ($N=8,067$) for the mental health court who did not participate but did receive the treatment as usual (TAU) that was available to all offenders. Propensity weighting was used to correct for non-random assignment of each group. Those that graduated from the mental health court showed a longer time before any new charges
were filed as compared with the TAU group. In addition, the average effect of the mental health court on the probability of any new criminal charge was reduced by 54% as compared with the TAU group. The researchers concluded that participation in a mental health court does affect recidivism rates and that it may be possible for many courts to expand the clientele base beyond non-violent misdemeanors without compromising public safety. There were several limitations of this study. First, other mental health courts may not be similar to the San Francisco Mental Health Court and that may affect the generalizability of their findings. In addition, the extreme difference in sample size, even when controlled, may have had an effect. Also, it would have been useful to know whether the court accepted violent offenses and if so, what kind and under what circumstances.

There have been several multi-site studies (Erickson, Campbell, & Lamberti, 2006; Palermo, 2010; Schneider, 2010; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005) that have examined the variations, similarities, and outcomes of several mental health courts around the country. The studies are important because they examine a variety of courts and research questions.

Erickson et al. (2006) completed a secondary analysis of the 2004 GAINS (Government Access Information Network) Survey published by the National GAINS Center in order to compare similarities and differences in mental health court practices. The GAINS survey is a national survey used to evaluate mental health courts around the country that seeks to maintain information about mental health court practices nationwide in order to assist those preparing to establish a
mental health court. The actual number of respondents to the GAINS Survey was not reported; however, the researchers cite 100 courts operating in 38 states (far fewer than the 250 reported in Frailing, 2010).

It was found that 28% of participating courts require only a diagnosis of “mental illness”, while 38% require a formal AXIS I diagnosis for admission (Erickson et al., 2006). Further, only four percent of the courts examined accepted those charged with a violent felony. A breakdown of the sanctions utilized for non-compliance was reported as follows: jail (24%), “modified treatment” (22%), and termination from the program (14%). Erickson and colleagues (2006) raised several important concerns. First, they noted that defense attorneys are often in a conflicting position between zealously defending their client and collaborating with the mental health court team to ensure adherence to the treatment plan that may lead to problems with the treatment being implemented. Second, there was no mention as to how the competence of prospective mental health court clients was evaluated. One major limitation of this study was the failure to report the exact number of courts that responded to the survey.

Palermo (2010) examined two mental health courts operating in Nevada from 2007-2008: the Washoe County Mental Health Court (WCMHC) and the Clark County Mental Health Court (CCMHC). The research discovered several interesting similarities and differences in both process and outcome. Both courts accept misdemeanor and felony charges; however, CCMHC does not accept those guilty of sex offenses or those that have a history of violent crime. The terms *sex offenses* and *history of violent crime* were not clearly defined in the study. Both courts
require an AXIS I diagnosis but WCMHC requires proof of a direct causation between the criminal charges and the diagnosis. In the literature examined for this review, CCMHC was the only court with this policy. In addition, a written contract between the court and the offender is required in WCMHC, but not in CCMHC.

In WCMHC during 2007, a 78% decrease in jail days (12 months prior to entering the court) was found among the participants (N=106) with a cost-savings of over $400,000 based on the cost of incarcerating an inmate and other criminal justice expenses. Similarly, among the 60 graduates of the CCMHC there was significant reduction in arrests, violations of probation, and failures to appear. The most significant outcomes occurred in the CCMHC. There was a total arrest reduction of the graduates from the program of 95% while in the program and 93% two years after being released from the program. This study showed the substantial cost savings that can be achieved by keeping these offenders out of jail. In 2006, the CCMHC was honored with an Achievement Award from the National Association of Counties for its innovative and progressive program (Palermo, 2010).

Redlich et al. (2006) surveyed 90 mental health courts across the country looking exclusively at policies and procedures. They discovered that the capacity of a mental health court is a function of the size of the local jail from which clients are drawn. In all 90 courts the total number of active clients was 7,560. The docket size of each court ranged from a low of three to a high of 852 clients with a median of 36. Half of the courts accepted both misdemeanors and felonies; however, more courts excluded misdemeanors than felonies. They also found that in most
courts either mental health treatment providers or probation officers supervise clients. In addition, they found that 41% of the courts surveyed met once a week while only 15% met every two weeks. Using regression analysis, the number of active mental health court clients was positively predicted by three factors: (1) the court was in operation longer, (2) required less frequent court visits, and (3) had more forms of supervision. The concluded that the number of mental health courts is likely to increase across the country and most courts stated that they believed they would be in existence for at least for another 3 years (Redlich et al., 2006).

In conclusion, this literature review found that depending on the research methodology utilized, behavioral health court programs can be effective in (1) keeping those offenders that pose no threat to public safety out of jail, (2) linking mentally ill offenders with mental health services and (3) reducing future criminal behavior. However, a court’s effectiveness can be influenced by several factors including docket size, availability of quality treatment programs, and level and type of supervision utilized.

With a significant number of mentally ill offenders in the criminal justice system, the evaluation of behavioral health courts is important for those responsible for establishing these courts as well as the practitioners who operate them and those that will be developing polices for these courts. Hopefully, practitioners will be able to utilize this research to show the effectiveness of these courts and therefore increase the number of behavioral health courts, and ultimately help many more offenders suffering from mental illness.
From the research previously discussed, we know that there are many inmates in prisons and jails with untreated mental illness and further, we know that if they fail to receive treatment when they are released back into the community, it is very likely they will come into contact with the criminal justice system repeatedly. And therefore knowing the elements of an effective behavioral health court may help reduce the numbers of offenders with untreated mental illness. However the results are utilized, it is certainly a step in the right direction.

The focus of this research is to evaluate the effectiveness of the Fresno County Behavioral Health Court by examining arrests prior to acceptance into the court and comparing them to arrests after acceptance into the court. The hypothesis for this study is described below.

**Hypothesis**

The total number of arrests will be lower during the time the participants are in the FCBHC than before they were accepted into the court.
CHAPTER 3: METHODS

Data Collection

There were 17 participants enrolled in FCBHC during the 12 months that data was gathered. Records from both the Fresno Superior Court and Fresno County Department of Probation were reviewed for all 17 participants.

The following demographic data were extracted from the court and probation records:

a. Gender  
b. Age  
c. Ethnicity  
d. Psychiatric diagnoses  
e. Medications  
f. Hospitalizations

However, this study is limited to the analysis of the following demographic information:

a. Gender  
b. Age  
c. Psychiatric diagnosis

All researchers associated with data collection underwent a full background check by Fresno County followed by a complete security training session by the Fresno County Superior Court research attorney in order to access confidential court files. The training session covered all aspects of proper handling of confidential court documents to ensure all court records were handled according Fresno County Superior Court
Security requirements. In addition, all data were gathered was kept under lock and key in a secure office in the Department of Criminology at California State University, Fresno. No electronic versions of any sensitive records were created at any time during this study. Furthermore, at no time was any confidential data disclosed to unauthorized personnel. At the conclusion of the research project, all data will be destroyed according to Fresno County Superior Court requirements.

Data were gathered in two locations. The Fresno County Superior Court trial record data were obtained at the courthouse in Department 70 of the Fresno County Superior Court. The Fresno County Probation Department data were obtained in the Fresno County Probation Department on the 8th floor of the Fresno County courthouse and at a downtown annex. All data were collected utilizing a specially designed data collection form (see Appendix A). All data were gathered using pen and paper.

Arrest and violation of probation data was collected for the period defined by the length of time that each participant had been actively participating in the court and for an equal length of time prior to the participant’s acceptance into the FCBHC. For example, if a participant had been in the court for 6 months, all arrests and violation of probation data during this 6 month period and 6 months prior to FCBHC were recorded. No data was collected after December 2010. This procedure was chosen in order to get a balanced view of each participant’s progress.

In addition to examining court files and probation department records, this researcher attended most of the conferences and court
hearings that were held between January 2010 and December 2010. During these sessions, this researcher observed the proceedings and discussions that occurred.

**Outcome Variables**

The number of participant arrests was chosen to test the hypothesis. All arrests prior to and during the participant’s time in the court were compared. Prior arrests were examined for a period of time equal to the length of time the participant had been active in the court. For example, if a participant had been active in the court for 16 months then all arrests 16 months previous to admission to the court were examined. Arrest records were extracted from official court records and probation department files. The records did not clearly indicate whether the arrest eventually led to a formal criminal charge being filed or the outcome of the charge if indeed a formal charge was filed. Therefore only the charge and offense classification were noted. Arrests were operationalized as either a misdemeanor (A-m) or a felony (A-f).

As a participant in the FCBHC all offenders were serving a sentence of probation and thus any infraction from a minor violation (missed appointment) up to a serious violation (arrest for a criminal charge) would be deemed a violation of the terms and conditions of probation. These violations are a potentially an important variable as a measure of the courts effectiveness. However, VOPs will not be used to either accept or reject the hypothesis of this study due to incomplete records of all probation violations. Therefore, probation violations have been included only as a general indicator of court effectiveness.
Violations of probation while an active participant in the FCBHC were categorized as either, (1) a technical violation of probation (VOP-t) or, (2) a formal violation of probation (VOP-f), or a formal violation with arrest (VOP-fa). Technical violations (VOP-t) were defined as a failure to follow any rules or guidelines set forth by the court that did not result in a formal revocation of probation, an arrest, or formal criminal charges being filed by the District Attorney’s Office. The most common technical violations of probation included, but were not limited to, missed appointments, failure to communicate, failure to drug test, failed drug tests, disobeying court orders, and failure to abide by any other terms and conditions of probation. Formal violations of probation (VOP-f) included new criminal charges, continuous admitted drug use, and repeated failure to obey a direct court order that did not result in the revocation of probation arrest, or formal charges being filed by the District Attorney’s Office. The final category, formal violations with arrest (VOP-fa) was defined as any formal violation that resulted in an arrest. It is important to understand that determination of whether a violation was classified as technical or formal along with the decision to arrest, was made on a case by case basis by the Probation Officer or was a decision made by the judge in conjunction with the FCBHC team. Again, only formal violations with arrest (VOP-FA) will be used to either accept or reject the hypothesis of this study.

\[1\] Multiple technical violations of probation (failed drug tests, etc.) under certain circumstances may have resulted in a formal violation of probation.
CHAPTER 4: RESULTS

As shown in Table 1, there were a total of 17 participants that were either enrolled or had been accepted into the FCBHC during this study between January 2010-December 2010. Six of the participants were dismissed from the FCBHC for various reasons.

Table 1. FCBHC participant demographics (N= 17)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>88</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9</td>
<td>52</td>
</tr>
<tr>
<td>Black</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>AXIS I Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13</td>
<td>76</td>
</tr>
<tr>
<td>Major depression</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

As seen in Table 1, the group was predominantly white males with a diagnosis of schizophrenia. The entire group had a mean age of 39.2 years. Of the total cohort, 16 of the 17 (94%) participants had a history of substance abuse. Though not listed in the table, all of those with substance abuse diagnoses also had a history of alcohol abuse, and in addition two had ongoing marijuana abuse issues, and the remaining individuals had problems with cocaine, heroin, or methamphetamine or a
combination of multiple substances. Roughly three-quarters of the participants (76%) have been diagnosed with Schizophrenia. However, the records that were examined indicated that most of these individuals have been diagnosed with multiple mental disorders at various times. For purposes of this study, only the most recent AXIS I diagnosis was recorded.

Pre-FCBHC Admission Arrests

During the observation period, there were a total of 22 arrests for the entire group of participants. Among the 22 arrests there were 29 separate felony charges. Figure 1 shows the number of arrests and the corresponding charges prior to entering the court for the entire FCBHC group. Of the 17 participants in the court during this study, as a group they had a total of 22 arrests prior to being accepted into the FCBHC. This results in an average arrest rate of 1.29 arrests per participant. As shown in Figure 1, there were various types of crimes that these individuals were involved with prior to being accepted into the FCBHC, but the most common were vandalism and petty theft; the category in Figure 1 labeled burglary and theft includes petty thefts and burglary.

As previously noted, the baseline timeframe that was used to examine arrests prior to acceptance in the court was calculated to coincide with the length of time the participant had currently been in the FCBHC. Figure 1 is designed only to show the types of criminal activity these participants were involved with prior to being accepted into the court.
Post-FCBHC Admission Arrests

There were a total of 21 arrests among all 17 participants while they were active participants in the court from January 2010 through December 2010. During this study, six participants were terminated from the court. Among those terminated, there were a total of 14 arrests. Among those that remained active in the court, there were seven arrests. As shown in Table 2, 15 (80%) of the arrests were for drug use, a failed drug test, or failure to enroll in drug treatment. The three arrests for failed drug tests were the result of a series of failed drug tests and court warnings that led to the individual being remanded to the county jail. Of the total post-FCBHC admission arrests, two (10%) were for violent felonies; one for simple assault and one for armed robbery. The non-drug related offenses included a weapons charge and an outstanding warrant from another county. Not all of the arrests described above necessarily led to a criminal charge being filed by the District Attorney’s Office.
### Table 2. Post-FCBHC admission arrests (N=17)

<table>
<thead>
<tr>
<th># of arrests</th>
<th>% of total arrests</th>
<th>Reason for arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>52</td>
<td>Drug use</td>
</tr>
<tr>
<td>4</td>
<td>19</td>
<td>Failed drug test</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>Failure to enroll in drug treatment</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>Battery</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>Weapons</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>Armed robbery</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>Outstanding warrant</td>
</tr>
</tbody>
</table>

**Post-FCBHC Admission Violations of Probation**

As previously mentioned, all violations of probation that occurred during active participation in the FCBHC have been categorized as follows: 1) technical violation (VOP-t), 2) formal violation (VOP-f), and 3) formal violation with arrest (VOP-fa).

Table 3 shows that while actively participating in the court as a group there were 54 total VOPs. Of that total, there were 13 technical violations as a result of various issues such as missed appointments, failure to drug test, or dishonesty with a member of the FCBHC team. There were 20 formal violations for serious misconduct such as a failed drug test, disobeying a direct court order, or failing to enroll in drug treatment as ordered by the court. Formal violations and formal violations with arrest comprised over three-fourths (74%) of the total VOPs.
Table 3. Post-FCBHC Admission Violations of Probation (N=17)

<table>
<thead>
<tr>
<th>Participant</th>
<th>VOP-t</th>
<th>VOP-f</th>
<th>VOP-fa</th>
<th>Total</th>
<th>Time in Court (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>12*</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>13*</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>14*</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>15*</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>16*</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>17*</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>20</td>
<td>21</td>
<td>54</td>
<td>278</td>
</tr>
<tr>
<td>Mean</td>
<td>0.76</td>
<td>1.18</td>
<td>1.24</td>
<td>3.18</td>
<td>16.4</td>
</tr>
</tbody>
</table>

*Terminated from FCBHC
A number of these violations were the result of failed drug tests, admitted drug use, or a combination of various violations after being warned by the court. Again, whether or not a formal violation resulted in arrest was a decision made on a case by case basis. Most of the arrests occurred during a FCBHC hearing or by the FCBHC probation officer.

**Hypothesis**

It was hypothesized that after acceptance into the court the total number of arrests would be lower than before participating in the court. This research showed that the total number of arrests for the entire group (including those that were terminated during this research) went from 22 to 21 or a 5% reduction when comparing the number of arrests prior to entering the FCBHC with the time they were actively participating in the court. Therefore the hypothesis of this research is minimally supported; participants had fewer arrests while participating in the FCBHC than they did prior to their participation.

For the total group, there was an average post-court admission arrest rate of 1.24 arrests per participant. Of those that remained active in the court (N=11), there were a total of seven arrests or 34% of the total arrests. For the group that was terminated (N=6), there were 14 arrests or 66% of the total arrests. Therefore, the group that was terminated had 1.66 more arrests per participant during their participation in the court than those that remained. Interestingly, those that were terminated had been in the court an average of 17 months and the group that remained had been active for an average of 16 months.
It is important to note that while this study showed a minimal decrease in the number of arrests, the context of the arrests prior to participating in the FCBHC is quite different from those made after being a court participant. Prior to court participation, it is likely that the arrests were made on the street by a uniformed police officer, while the post-FCBHC arrests were ordered by either the judge during a FCBHC hearing or by the FCBHC probation officer. The limitations and context issues will be discussed in the following chapter.
CHAPTER 5: DISCUSSION

This study was designed to examine the efficacy of this court by comparing the number of arrests that occurred prior to participation in the court with the number of arrests while actively participating in the court. Results from this study provide only minimal support for the court’s effectiveness. However, the reduction of arrests was very minimal; there was only one fewer arrests within the entire group over the baseline timeframe. Furthermore, 6 of the 17 participants were dismissed (35% failure rate) from the court for repeated criminal violations. Five of these individuals were dismissed for various reasons, including continuous drug use or failure to obey court orders. These individuals have remained out of contact, were placed back on normal probation, or had their original sentences reinstated and were incarcerated. The sixth individual was placed on a conservatorship.

Individuals who remained in the court committed numerous VOPs ranging from minor issues such as missed appointments all the way to admitted drug violations. Prior to participating in the FCBHC, the level of supervision was likely much lower due to an increased case load for the non-FCBHC probation officer. However, for FCBHC participants, the probation officer was able to provide a much higher level of supervision. Thus, those issues that might have been overlooked while under normal probation often resulted in a violation while the individual was active in the court.
Court Mission

The FCBHC was established in 2008 as a response to the high recidivism rates that were being observed among those with severe mental illness in Fresno County. The goal of this new specialty court was to link offenders with mental health services and to improve the functioning of these offenders rather than continue to incarcerate the individual for offenses that were likely the result of mental illness. This research showed that indeed all participants in the FCBHC that were examined did receive county mental health services including outpatient and/or inpatient therapy, psychiatric services, medical care, and medications.

During this research it was found that there are several enrollment restrictions that may have reduced the number of eligible offenders. The court does not accept sex offenses, offenders represented by private attorneys, or certain violent offenses. There was no clear definition listed in the FCBHC Handbook as to the exact nature of these restrictions; each decision was handled on a case by case basis. However, after this research it was revealed that the decision to reject those represented by private attorneys was being reconsidered.

During pre-hearing discussions the topic of limited resources was often mentioned by the judge. The FCBHC is a very new court and is run on a limited budget. It was noted during one pre-hearing session that the judge inquired whether graduate students in clinical psychology from a local university could help with psychiatric evaluations. Thus, the quality of these assessments and other services may be impacted by financial constraints. Lack of funding also impacts the availability of
psychiatric services. For example, if a participant experiences behavior problems and needs to be moved from a home environment to an inpatient facility, and space is unavailable, the participant is more likely to commit a VOP.

It was concluded that the mission of the court is not being fully realized with so few participants. The ultimate test of the court’s efficacy is how well these participants do once they leave the jurisdiction of the court. Since no participants have yet graduated, the answer to this question will remain unanswered.

**FCBHC Team**

Each participant that entered the FCBHC was assigned his or her own Personal Service Coordinator (PSC) from the Fresno County Department of Behavioral Health. The PSC is responsible for monitoring the treatment of the defendant as well as arranging for housing, financial, and other personal matters in cooperation with the defendant. There was often a close relationship between the FCBHC client and the PSC. This relationship may have served as a controlling factor for VOPs.

In addition to the relationship between the participant and the PSC, the level of supervision these clients receive while in the court is an important aspect to consider when examining the effectiveness of this court. Most probation officers (PO) have a much larger caseload (typically several hundred). However, the PO assigned to the FCBHC handles only those participants assigned to the FCBHC and can therefore provide a much higher level of supervision and personal attention to these clients. Both the probation officer and PSC had
regular contact with these participants and were aware of many aspects of their personal life. This type of close supervision may have been a factor in the number of VOPs.

The representatives from the Department of Behavioral Health of Fresno County and Personal Service Coordinators are important members of the FCBHC team. Several staff members are regular attendees at the bi-monthly court sessions including mental health professionals and Personal Service Coordinators. The PSC plays an important role in the lives of these defendants as previously noted. Therefore, the level of training and experience in mental health issues must always be considered an important factor in this type of research. For example, a very experienced PSC may be able to gain control of a situation that would have resulted in a serious violation of probation if handled by a less experienced staff member.

As the mediator between the court and the contracted vendors for inpatient mental health services, the Department of Behavioral Health leverages a great deal of influence in the availability and type of treatment provided to the FCBHC clients. It was noted that the County contracts for inpatient mental health services with at least three separate agencies. Furthermore, with limited space in many mental health programs, the decisions they make can impact the FCBHC defendants in a variety of ways such as having no safe place to reside. Furthermore, the quality of services and the location of the facilities must also be considered especially if substance abuse issues are present. If the facility where these clients are required to attend is in an area of town where drugs are readily available, this may pose significant problems for
those being treated for substance abuse. The location of these county facilities was not noted during this research, thus this is strictly conjecture.

During this research it was noted several times that the existence of the FCBHC is unknown to many in the local criminal justice community. The reason for this is unclear. However, alerting more people in the criminal justice system to the existence of this court may help to increase enrollment, however, with the current enrollment policy, increasing the caseload may be difficult. The presence of the court may also affect how all mentally ill offenders are treated by the criminal justice system in general. For example, if a police officer comes into contact with a FCBHC client on the streets and he is aware that he is a FCBHC client, this may change a pending arrest decision. Likewise a non-FCBHC probationer may experience just the opposite and find himself back in jail. This may be especially true if the offender is being suspected of a drug violation.

Understandably, those members of the team that serve as officers of the court and representatives of the people can often find themselves in conflicting roles. On one hand, they are an integral part of the FCBHC team and are committed to helping these offenders obtain treatment for their mental health issues, but on the other hand, they have an obligation to report and even prosecute crimes. The representative from the Office of the District Attorney is in a unique position on the FCBHC team. He and the judge are the only two members of the FCBHC team with veto power on nomination decisions. Similarly, the Public Defenders traditional role is to make the “best deal” for her clients but as
a part of the behavioral health court team, however, she is agreeing to assume a different role in this instance. It is unclear what affect these often conflicting roles have on the operation of the court.

**FCBHC Participants**

The court participants that were examined during this study had extensive criminal records. The records indicated that for most of these individuals, there was a very long history of similar offenses being levied on a regular basis for 10, 15, and even 20 years. For those that were finding success in the court, this may have been the first time they were able to become mentally stable and avoid incarceration for an extended period of time. However, for others this was not the case. Of the six participants that were terminated, five of them were terminated for continuous positive drug tests and even after warning by the court, several of them refused to seek treatment which eventually led to a court dismissal. The sixth participant who was terminated was deemed too symptomatic and after two court sessions were missed the individual was placed a conservatorship.

The FCBHC clients generally report to court every 2 weeks. Under normal probation they may have only been required to see their Probation Officer once a month in a non-court setting. Further, most of the participants reside in a supervised board and care home and have regular contact with their assigned PCS. Research (Linhorst et al., 2009) has shown that the personal relationship that is fostered over time between the defendant and FCBHC team can itself be a motivating factor for reduced violations of probation.
This research showed that of those participants that were still active in the court upon close of this study, a majority of them had increased levels of psychosocial functioning according to the reports made during the bi-monthly court sessions. And many of the issues that had resulted in technical VOPs had been resolved after being in the court for several months. However, the significant role that substance abuse issues played in many of the problems the FCBHC participants encountered cannot be overstated.

Five of the six that were terminated from the court were terminated because of continuous drug use violations. The time in the court for all participants ranged from 5 months to 26 months. On average, those that were terminated had been in the court for over 16 months. One of them had been in the court for almost two years. Of those five, some of them have simply stopped communicating with their probation officer, some were placed back on normal probation, and a few were incarcerated. Furthermore, many of client problems discussed during the pre-hearing conferences were issues related to drug use in one way or another. Thus, the argument that this courts is in reality serving as a specialty drug court is certainly not without merit. In the future, policy changes may need to be considered as to how these types of issues will be handled while the client is under the purview of the court. During this research the issue of medical marijuana came up on several occasions; it involved only one participant. As the reality of legalizing marijuana in California gets closer, decisions may need to be made in advance how to best handle that situation. If marijuana indeed becomes legal in CA, a different approach may be warranted. In addition to
substance abuse, medication compliance was a key issue throughout this research.

During the observation of the pre-hearing conferences the importance of effective and stable medication compliance for these offenders was apparent; this is true especially for those diagnosed with schizophrenia. There were several instances in which a defendant stopped taking his medication and became severely symptomatic to the point of requiring hospitalization. Many mental health issues among the court participants are often directly related to chronic medical issues. For example, one such defendant in addition to schizophrenia also suffers from Type I diabetes. If his diabetes is not under control, his mental status can easily decline in spite of his other medications. This particular defendant has not had any violations of probation since his medical issues were brought under control.

Court Process

During the approximately 12 months that pre-hearing conferences were attended by this researcher, it was noted that the purpose or focus of the court seemed to change. During the initial months of attendance at these conferences, the response by the FCBHC team to minor infractions was generally to recommend a verbal warning or the writing of an essay. However, toward the latter end of the research period, there was an increase in the number of lengthy discussions involving seemingly trivial issues or minor infractions that resulted in substantial penalties being invoked. While this is possible with such a small number of clients and may be beneficial, if the size of the docket increases it may
be prudent to maintain the focus on those issues that are directly related to keeping the individual out of the criminal justice system. Moreover, since the purpose of the court is to alleviate instances of repeated serious criminal behavior, focusing on minor issues such as an instance of dishonesty may need to be reconsidered.

One of the criticisms of behavioral health courts is that judges who have minimal psychological training are often put in the position of making mental health decisions (Steadman et al., 2001). This argument could certainly be extended to the entire FCBHC team. It was unclear what kind of training the members had and how their different treatment philosophies may have impacted the participants. It was noted on several occasions that when a decision faced the court as to how to respond to an infraction, the decision appeared to be made for purposes of punishment and deterrence and not necessarily for the purposes of improved psychosocial functioning. On one hand, a severe response to an infraction can often act as a deterrent, but this kind of response may not be appropriate for all offenders. However, the judge always sought input from the entire team on any and all decisions. Again, that brings up the question, what is the primary goal of the court? If the purpose of the court is to provide access to mental health services in order to treat the underlying cause of the recidivistic offending behavior, then it may be prudent to forego a deterrent based response to minor infractions in favor of what will improve the mental health of the client. But with such small numbers of participants in the court, each case was handled on an individual basis.
Further, this researcher witnessed that the availability of jail as a sanction was a continuous problem during the time pre-hearing conferences were observed. As noted previously, when a client was in violation of probation, the sanctions could range from writing an essay explaining why the behavior was not appropriate to being sent to jail.\footnote{Sanctions also include revoking probation and reinstating a prison sentence, but this was never discussed as a serious option.} However, the Fresno County Jail is currently under federal orders to maintain the population at a specified level. Therefore, if the judge did sanction a client with a jail sentence, they were likely to be released almost immediately. The judge commented on one occasion, “They’ll be out before I even get home.” While on many occasions the judge would have preferred jail as a sanction, she was forced to impose less severe sanctions, such as increasing the frequency of court appearances or community service hours. This scenario leaves few punitive measures available to the judge for serious misconduct. Until the situation at the County Jail is changed, this problem is likely to continue. According to Griffin, Steadman, and Petrila (2002), many courts around the country are reluctant to use jail as a sanction unless public safety is an issue.
CHAPTER 6: CONCLUSIONS/IMPLIEDATIONS

This research revealed that the FCBHC is only having a minimal effect in reducing the number of arrests for the participants. While, it is true that many of those that were finally terminated, were given numerous chances to amend their conduct, it is important to remember that these individuals suffer from severe mental illness and are often unable even with proper treatment to consistently achieve a normal level of self-control.

Furthermore, this research showed that the FCBHC’s acceptance policies may be preventing the court from serving the mentally ill offender population of Fresno County. One of the most revealing findings of this study was that during the baseline timeframe the court experienced a 35% failure rate and had only a limited number of participants.

Currently, the court does not accept those offenders that have been convicted of drug sales, sexual offenses, certain violent offenses, or are being represented by a private attorney. With these enrollment polices in effect it is likely that very few mentally ill offenders will be accepted into the court. However, it was discovered that the policy to not admit those under private representation has recently been reconsidered. That decision may help to increase the size of the docket. There are some who argue that it goes against our system of jurisprudence to not accept people with severe mental illness into the FCBHC because of the nature of their crime or because they elected to retain private counsel. While the policy to not allow private representation is currently under review, the additional acceptance policy restrictions also need to be
reconsidered. These changes may open the door allowing many more people with severe mental illness that have been charged with criminal conduct to get the mental health services they need.

A majority of the participants in the FCBHC suffered from a severe mental illness, but also had substance abuse issues. While the court attempted to address these issues through county treatment resources, the participants with the most severe substance abuse issues were likely to be terminated from the court. It is clear from this research that addressing both issues through coordinated treatment is a key to future success of the behavioral health court model.

Future research is needed to discover whether or not those mentally ill offenders with long term mental illness and substance abuse histories are appropriate for placement in the FCBHC. It may be that intensive inpatient substance abuse treatment in addition to mental health care can help those individuals with severe dual-diagnoses. It was noted during several pre-hearing conferences, that a few of the participants had claimed that marijuana alleviated their mental illness symptoms, but the court was reluctant to allow the participants to even use medical marijuana which is currently legal under California state law, but not under federal law. Further research is needed to discover whether or not marijuana does in fact relieve the symptoms of certain mental illnesses and if so, how to best utilize that drug for the benefit of those suffering from severe mental illness. However, this judge appeared adamantly opposed to even considering the use of marijuana for any reason.
According to Redlich et al. (2006), the use of jail as a sanction in a mental health court goes against the therapeutic nature of a mental health court. Redlich et al. (2006) also found that there are more courts unwilling to use jail as a sanction. During this research the judge on several occasions remanded individuals to jail with a no release order in effect. Future research is needed to determine whether retaining the policy of using jail as a sanction should remain. Using jail as a sanction puts the court in a dilemma because each individual reacts differently to incarceration. More forceful use of community service may also prove beneficial.

The FCBHC is a relatively new court with very few participants unlike many of the larger courts around the country such as Broward County, FL. and therefore the results are not necessarily generalizable. However the findings are an important contribution to understanding the behavioral health court model within the criminal justice system.

In summary, in addition to the policy changes previously discussed, further research is needed to determine how many participants eventually graduated from the behavioral health court and how they are functioning in terms of obeying the law as well as psychologically. With answers to these questions, the real picture of the Fresno County Behavioral Health Court will begin to emerge.
REFERENCES
REFERENCES


APPENDIX
Client ______________________ Gender __________ DOB ____________

Education: ______ Race: ______ FCBHC acceptance date _____________

Diagnosi(e)s: ______________________________________________________

Current medications: _______________________________________________

**Criminal History**

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Drug tests: weekly/bi-weekly/monthly    # failed: ________________

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