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Evaluating the Felony Mental Health Court of Harris County, Texas

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Evaluating the Felony Mental Health Court of Harris County, Texas

by

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Capstone

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Public Health

The University of Texas Medical Branch

July, 2013

Dedication

This work is multiply dedicated.

Firstly, to my partner Beck Noland, for her undying faith in me.

Secondly, to my intellectual co-heart, Sheena Marie Eagan Chamberlin, for her effortless pragmatism in all matters.

Thirdly, to my sister Larissa Bennett, for opening my eyes to these critical courts.

Acknowledgements

This degree would not have been possible without the love and support of my parents, Dave and Linda, and my siblings, Adam and Larissa. A distinct acknowledgement goes to Danny and Shanna for their immense love for me and their immense love for my loved ones. My thanks go to Dr. Jacques Baillargeon, Dr. Christine Arcari and Dr. Jason Glenn for their continued confidence in me and willingness to share their experience, expertise and guidance throughout this process. This project would not have been possible without endless assistance from the team at the Harris County Felony Mental Health Court. In particular, Laura Cohen and Dr. Clete Snell have been critical to the success of this project and I thank them for making the world a better place. I will be forever grateful to the Department of Preventive Medicine and Community Health for the compassionate eye with which they evaluated my application and accepted me into the program— non-traditional background and all. I similarly owe a great debt to the Institute for the Medical Humanities for their kindness in allowing me pursue simultaneous doctoral and masters studies. Two friends deserve particular praise. First is my orientation friend, Quynh Do, who suggested that I apply to the MPH program which had recently begun accepting non-clinicians. Secondly, my space friend, Becky Blue, without whom I would never have found my way out of the forest of statistics through which I was so often discovered, aimlessly wandering.

Evaluating the Felony Mental Health Court of Harris County, Texas

Publication No._____

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The University of Texas Medical Branch, 2013

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Mental health is one of the most critical yet complicated areas for public health researchers. The dynamic characteristics of contemporary clinical notions of mental illness and the accompanying landscape of ever-changing health policies can create unique challenges for research efforts. In spite of such difficulties, mental health research is ongoing at a national level. In 2004, the National Institute of Mental Health estimated that, for people over the age of eighteen, 57.7 million, or 26.2 percent of adults in the United States had a diagnosable mental disorder.[1] Within the United States incarceration settings bear a disproportionate burden of mental health illness. According to a 2005 report by the Bureau of Justice Statistics, over 50% of those in state prison, federal prison, and local jails have a diagnosable mental health condition.[2] In some jurisdictions, for individuals who have been convicted of a criminal offense- and who have a clinical history of mental illness, specialty mental health courts have been created to provide alternative sentencing in lieu of jail or prison time.

This project explores a number of key national public health goals as reflected in the objectives of "Healthy People 2020" including mental health and mental disorders, health-related quality of life and well-being, substance abuse, public health infrastructure,

access to health services, and social determinants of health. The complex intervention of mental health courts serves as a site through which the application of the relative success or failure of objectives can be revealed at the local level.

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UTMB	University of Texas Medical Branch
GSBS	Graduate School of Biomedical Science
MHC	Mental Health Court

Chapter 1 Introduction

PROJECT SUMMARY

Mental health is one of the most critical yet complicated areas for public health researchers. The dynamic characteristics of contemporary clinical notions of mental illness and the accompanying landscape of ever-changing health policies can create unique challenges for research efforts. In spite of such difficulties, mental health research is ongoing at a national level. In 2004, the National Institute of Mental Health estimated that, for people over the age of eighteen, 57.7 million, or 26.2 percent of adults in the United States had a diagnosable mental disorder.[3] Within the United States, incarceration settings bear a disproportionate burden of mental health illness. According to a 2005 report by the Bureau of Justice Statistics, over 50% of those in state prison, federal prison, and local jails have a diagnosable mental health condition.[4] In some jurisdictions, for individuals who have been convicted of a criminal offense, and who have a clinical history of mental illness, specialty mental health courts have been created to provide alternative sentencing in lieu of jail or prison time.

This study will evaluate deidentified data from the Harris County Felony Mental Health Court gathered throughout its first year of operation for administrative purposes. The study cohort comes from the court's client population. These clients are all over the age of 18 and have been convicted of a felony or misdemeanor crimes as adjudicated by courts in Harris County, Texas. The clients were referred to the court through one of various venues including legal counsel, Mental Health Mental Retardation Authority case managers, judges from another court or by the District Attorney's office. Each client successfully passed the court's screening process and received a deferred criminal sentence pending their successful completion of the court's individually tailored requirements. As clients of the court, those included in the study population are

classified as probationers until the conclusion of those same court requirements. Throughout the manuscript, these individuals will be referred to as participants, clients, study cohort, study population, or probationers.

This project explores a number of critical national public health goals as reflected in the objectives of "Healthy People 2020" including mental health and mental disorders, health-related quality of life and well-being, substance abuse, public health infrastructure, access to health services, and social determinants of health.[5] The complex intervention of mental health courts serves as a site through which the relative success or failure of public health policy objectives can be revealed at the local level.

SPECIFIC AIMS

SPECIFIC AIM 1

To describe the demographic and sociobehavioral characteristics of the study cohort.

SPECIFIC AIM 2

To describe the mental health, substance abuse, and comorbid medical characteristics of the study cohort.

BACKGROUND

Mental health courts (MHCs) were made possible on a large-scale when Congress enacted the *America's Law Enforcement and Mental Health Project Act* on January 24, 2000.[6] This legislation allocated 7 million dollars in federal funding for the development of state-based MHCs, some of which had already been created through state funding mechanisms alone.[7] Although this act marks a historic moment in this country's embrace of alternative strategies for those at the intersection of mental illness and crime, such legislative commitments have been late to arrive, and many people suffered due to policy

failures resulting in a lack of public mental health funding infrastructure. The historical background explores the unique challenges faced by people with mental illness who are incarcerated and the rise of these courts as a potential solution to those issues. Based on my review of relevant literature, I argue that very real problems contributed to the rise of MHCs, which are now providing an important alternative to the traditional criminal justice processes and, therefore, are serving a vital function for members of our human community.

The wide variation in organizational structure, funding pathways, protocols and procedures regarding client selection, and community level treatment resources make it quite challenging to compare courts without first acquiring a keen appreciation of the state of affairs on an individual court basis. This work will begin the conversation about the Felony Mental Health Court of Harris County by providing much-needed information about an initial cohort of participants. A thorough grasp of the clients' sociodemographic, mental health, and substance abuse characteristics will provide valuable insights to clinicians and public health planners. This information will provide an indispensable foundation for the development of targeted mental health court interventions.

There is considerable debate in the literature relating to the actual intervention being operationalized through the mechanism of treatment courts. Some scholars argue that the judge plays a key role in the success of such courts both through quality decision-making and quality interpersonal interactions with clients.[8] In criminal justice settings, the judge is an ever-present authority figure and symbol of state power. Although the power differential between the judge and the client is never absent, a judge's behavior has been found to increase client perceptions of procedural justice thereby encouraging a sense of individual commitment to the judge and the court process. This line of inquiry argues that interaction with the judge is a powerful intervention driver.

Other research finds that appropriate service provision is the most critical component of the intervention. Nancy Wolff's work[9] interrogates the notion that there is something unique about these courts and instead argues that they work because people with serious health problems are provided with much needed services. In a similar vein, Robin Pierce questions the ethical implications of fast tracking court participants towards community-based services.[10] Because many of these organizations have long waiting lists for first-time clients, Pierce is concerned about the phenomenon of queue jumping. Although she concedes that no one in society benefits from jailing non-dangerous persons with mental illness, there must be adequate attention to the critique that criminals may have an easier time accessing mental health services than non-criminals. In contrast to the work examining the role of the judge as the primary animator in the intervention, scholars Wolff and Pierce locate access to treatment as the principal factor driving these courts' successes.

One point not up for debate is the fact that public health interventions are most successful when there is a comprehensive understanding of the target population. Optimal development of MHC linked interventions requires a thorough understanding of the target population. Acquiring and assessing reliable data is critical and it is the responsibility of the public health practitioner to evaluate the target population both during the intervention design phase, and also in the early stages of implementation to determine for whom, and how well the program is working.

To some extent, an intervention like a specialty court cannot be adequately pilot-tested. Because the courts require such an extensive administrative commitment from stakeholders such as judges, offices of District Attorneys, correctional staff at the state and county level, and numerous service providers, it is simply too formidable a task to operationalize on a small-scale. As a way to address this issue, many courts, including the court at the heart of this project, receive funding in the form of a short, 1-3 year

demonstration-type grant. Evaluation mechanisms are often front and center in these grants so as to prioritize the courts' continued existence by demonstrating its efficacy.

These ongoing evaluations make up for the lack of pilot testing by weaving in adaptability apparatuses, so course corrections are possible. Work such as this functions as a single thread in the evaluation tapestry. By aptly assessing the court's initial cohort in terms of their sociodemographic and medical characteristics, this project can assist the court in satisfying their evaluation obligations which will in turn support positive change among the key stakeholders in terms of refining court processes to better meet the needs of the intervention's target population.

PEOPLE WITH MENTAL ILLNESS IN JAILS AND PRISONS

Mental health courts are a response to a particular problem. These courts exist because prison and jail environments adversely affect people with mental illness as compared to those without mental illness. Many aspects of such environments tend to exacerbate mental illness thereby causing unique suffering within this group. Those working within the framework of public health have made notable contributions to this area of research. In the 2010 *Lancet* article, "The Health of Prisoners," Seena Fazel and Jacques Baillargeon found that one in seven U.S. prisoners had a treatable mental illness and, thus, prisoner populations bear a substantial burden of psychiatric disorders relative to the general population.[11] One in seven represents approximately 775,000 inmates in the United States. The most common forms of illness among imprisoned people include psychosis, major depression, personality disorders, and post-traumatic stress disorder. [12] Because of the stigmatization of mental illness, it is reasonable to assume that this figure represents a conservative estimate due to potential lack of reporting. Being mentally ill in prison is a struggle on a number of levels, not the least of which is lack of access to appropriate treatment. This work puts forward the position is that evidence-based assessment and treatment for mental illness is owed to all who are incarcerated which is

why it is critical to demonstrate an understanding of the sociodemographic and clinical characteristics of those at the intersection of mental health and crime.

Fazel and Baillargeon report findings from a 2008 survey of 80 jails in North Carolina. This survey revealed that none of the sampled facilities used evidence-based screening tools for mental illness and that only 15% of the jails employed mental health staff members.[13] The survey investigators do not focus on the potential relationship between inadequate or inappropriate mental health screening and inadequate or inappropriate of mental health care. However, if there are no jail staff members equipped to perform the tasks of screening and assessment, what might this indicate about that same staff's ability to provide the necessary therapies for individuals whose assessment for mental disorders is positive?

Because of the temporary character of such facilities, it may be challenging to justify the financial expense incurred by maintaining jail-based mental health practitioners. A lack of funds for counselors, psychologists, or psychiatrists may explain the finding that 42% of surveyed jails chose to seek community-based mental health screening or care for incarcerated people.[14] Although surveyed prison staff received six hours of education in mental illness, those interviewed expressed concern that such limited training did not prepare them to provide the kind of services they were routinely expected to administer to their mentally ill incarcerated wards.[15]

In addition to the evidence that mental health care screening and treatment are lacking in jails and prison, there are further concerns that certain elements of the prison environment itself may make people sick. A qualitative study from 2003 revealed that some prisoners become addicted to drugs while incarcerated due, in part, to provide a mental break from the monotony of incarceration.[16] Both prisoners and prison staff noted that isolation strategies have a severely negative effect on the mental status of those who are segregated.[17] Fazel and Baillargeon also find that common prison practices such as solitary confinement exacerbate mental illness among those with preexisting conditions.[18]

Attorney, Jamie Fellner and physician, Jeffrey L. Metzner provide further evidence regarding the detrimental effect of solitary confinement in a 2010 article entitled: "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics."[19] As a method of practicing in-prison punishment, solitary confinement varies from facility to facility but generally involves a period of continuous surveillance, removal of all normal stimuli, total isolation, and a reduction of out-of-cell time to three-five hours per week.[20] Solitary confinement exacerbates symptoms and provokes recurrence of previously controlled disorders in part because of the conditions of confinement including the removal of individual and group therapy and any recreational activities that serve a therapeutic purpose.[21] The authors cite the necessity of crisis care among the mentally ill while in solitary confinement as an indicator that these individuals simply do not get better until they are released from confinement and receive appropriate medical care.[22]

Once having been released from confinement and then finally released from prison, what fate awaits those former prisoners with mental illness? An answer to this question is provided in a 2009 article by Baillargeon, et al.[23] In this, the first ever study examining the association of multiple episodes of incarceration and psychiatric disorders, the authors found that Texas inmates with major psychiatric disorders had vastly increased risks for multiple incarcerations over the six year period. The largest risk was among those with bipolar disorder who were 3.3 times more likely to have had four or more incarcerations when compared to those without major psychiatric disorders.[24] The authors interpret these results as an indication of the need for new approaches to discharge planning and an increase in alternatives to incarceration including post-booking programs like MHCs.[25] Baillargeon and coauthors also argue for the creation of new correctional facilities that might provide appropriate clinical environments for offenders whose crimes make them ineligible for jail diversion programs.[26] Because jail and prison are such ineffective spaces for the treatment of and recovery from mental illness, high

rates of recidivism seem to be a logical consequence of incarceration. Repeated incarceration then serves as a contributing factor for continued mental illness.

This view is supported by physicians Josiah D. Rich and Scott A. Allen as seen in a letter to the editor in the *New England Journal of Medicine*.[27] The authors argue that physicians have a responsibility to advocate for the reform of systems, which they see as operating in ways that compromise patient health. They find that incarceration is dangerous for mental health and argue that in prisons, "rehabilitation has been largely abandoned in favor of punishment, which conflicts with a therapeutic approach and often results in neglect of the psychological and medical needs of patients with mental illness or addiction."[28] These clinicians believe that their fellow physicians have an obligation to demand changes in sentencing laws that support enhanced community-based treatments for mental illness.[29]

Personal narratives of prisoners with mental illness provide stories that match the concerns presented by the various scholars above. In their 2008 book, *The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System*, authors Slate and Johnson intersperse their academic analysis with personal stories of mentally ill prisoners.[30] One story belongs to Richard A. Street, who committed suicide on Thanksgiving Day 2004 while in his facility's administrative segregation unit. Street had schizoaffective disorder and referred to himself as Jesus Christ, Future King of the Vampires. While incarcerated, his behaviors included dancing naked around an outdoor basketball court and self-mutilation. Within the six-week period leading up to his death, Street swallowed pieces of metal, smeared feces into his hair, repeatedly tore gouges in his skin and was found hanging by the neck in his cell on two occasions. After one of the hangings, his correctional care provider noted in Street's chart that Street was neither depressed nor at any risk of harm due to his mental illness.[31] Street had complained that solitary confinement was making him mutilate himself, further supporting to the

argument put forth in Metzner and Fellner's work. Street was the first of 12 suicides that would follow in the next 26 months at this facility.[32]

The arguments presented above highlight the ways in which correctional environments adversely affect people with mental illness. Such recognition illuminates the need to address the reality of this situation through an alternate-to-incarceration approach.

MENTAL HEALTH COURTS

The first of approximately 120 mental health courts opened in 1997 in Broward County, Florida. It represents just one example of what are called "special jurisdiction courts."[33] Treatment-oriented courts following this model have been created for specific types of defendants whose situations "do not fall within the province of judicial decision making."[34] MHCs operate on a philosophy of "therapeutic jurisprudence," which, according to legal scholar David Wexler, is an interdisciplinary approach to legal practice that understands the law as a potentially therapeutic agent that ought to focus on therapeutic applications of the law.[35] As such, these courts have a radically different orientation than traditional courts as represented in **Table 1** below:[36]

Traditional Court	Treatment/Problem Solving Court
Resolve disputes	Avoid disputes
Legal outcome	Therapeutic outcome
Adversarial process	Collaborative process
Case-oriented	People-oriented
Rights-based	Interest/Need-based
Judge as arbiter	Judge as coach
Backward looking	Forward looking
Few participants and stakeholders	Many participants and stakeholders
Individualistic	Interdependent

Table 1: Traditional versus Treatment Court Orientations

Wexler's concept of "therapeutic jurisprudence" holds that laws and legal proceedings can have therapeutic or antitherapeutic affections on people interacting with the legal system.[37] The idea of the legal system as a therapaeutic agent is particularly intriguing from a public health perspective in terms of the ways in which positive legal interactions may be understood as contributing to improved quality of life for those involved. In addition, these courts have a duty to prioritize public safety, which is weighed against the courts' concurrent duty to honor individual liberty. The wealth of evidence associating jail time with increased exposures to negative health risks puts these courts in a problematic public health position because of the courts' role as arbiters as to whether individuals will have their punishments served in jail or community-based programs.

Despite the clear implications for public health, mental health courts have not been properly considered part of the larger public mental health infrastructure. According to the National Institute of Mental Health's (NIMH) "Strategic Plan," the third strategic objective is to "[d]evelop new and better interventions for mental disorders that incorporate the diverse needs and circumstances of people with mental illness."[38] This objective focuses on mental health interventions in various care settings to reveal how community delivery strategies affect outcome markers.[39] Mental health courts ought to be considered an intervention according to this NIMH objective because both the implicit goals of the court and the goals of the strategic plan prioritize helping people with mental illness to live full and productive lives.

Broadly speaking, the two goals of mental health courts are:[40]

1. To interrupt the cycle of worsening mental illness and crime
2. To provide effective treatment options instead of criminal sanctions

Like other treatment oriented courts, MHCs function to divert individuals away from jails and prisons and towards mental health treatment based on the notion that if untreated mental illness was a contributing factor to the criminal action, acquiring

treatment might offer the best course of action, as opposed to assigning punishment.[41] In a 2007 *JAMA* article, Bridget M. Kuehn argued that some communities have MHCs for the explicit purpose of keeping people with mental illness out of jails.[42] This sentiment further evidences that the prison and jail systems within the U.S. are considered inappropriate places for people with mental illness, even if they have a history of having committed criminal offenses.

SIGNIFICANCE

The significance of this work is to increase awareness about the systemic dearth of community mental health treatment in the U.S. and to expand the dialogue concerning alternative sentencing for people with mental illness by placing Mental Health Court programs within the framework of a public mental health infrastructure. Reframing jail diversion programs as public-health interventions opens them up for analysis as to whether or not they uphold the tenants of social justice, which the practices of public health are obligated to meet. Beyond contributing to a specific line of inquiry within the field, my study will address larger national goals as established by the nation's foremost research foundation, the National Institute of Mental Health (NIMH).[43]

The Institute's Strategic Plan, as referenced earlier, also prioritizes suicide prevention, which is a key area of intervention served by mental health courts due to the increased risk for suicide facing incarcerated individuals with mental illnesses. By diverting people with mental illnesses out of jails and prisons and into community-based treatment, courts, such as the one that exists in Harris County, may help facilitate the successful implementation of the NIMH's goal to prevent suicide among individuals most at risk.

In terms of the competencies valued by public health, this study will demonstrate fluency with a variety of ways of representing knowledge. Biostatistics, epidemiology, and, health policy and management, will play critical roles in this project. A deidentified

dataset will provide the material for biostatistical analysis. The prevalence of various mental illnesses within the court participants will be captured to demonstrate the epidemiologic profile of the target population. Finally, an analysis of health policy and management will ground the historical background highlighting the rise of mental health courts in the United States. Against these broad areas of public health inquiry, this project focuses largely on the Felony Mental Health Court of Harris County.

There is no literature on the Felony Mental Health Court program in Harris County. The specific aim of this study is to conduct descriptive data analysis from the first year of the Felony Mental Health Court of Harris County by examining a number of critical variables as seen below in **Table 2.**

Category	**Data Source**	**Definition**
Demographics		
Age	Justice Information Management System (JIMS)	Age in years at the time of referral
Sex	JIMS	Female, Male, Transgender
Ethnicity	JIMS	White, Black, Hispanic, Asian
Offense	JIMS	Drug related [Tex. Health & Safety Code §481.102-483.041], Property related [Tex. Penal Code 31.03(a), (d), (e) (3)] Public nuisance [Tex. Penal Code § 37.12(a), (d), (e)], etc. as determined by the Texas Department of Criminal Justice.
Health Conditions		
Mental health diagnosis	JIMS	Bipolar disorder (296.00-296.89), Major depressive disorder (296.20-296.36), Schizophreniform disorders (295.10-295.90) Intellectual disability disorder (317-319), Polysubstance abuse disorder (304.80), Alcohol dependence (303.90), Opioid dependence (304.00), etc. according to the Diagnostic Statistical Manual IV.[44]
Assessments		
Evaluation date	JIMS	Date at which client was evaluated
Evaluations	JIMS	Risk versus needs assessment, Global Assessment of Functioning (GAF), etc.

Table 2. Description and Definition of Study Variables.

Chapter 2 Data and Methods

DATA

The Justice Information Management System (JIMS) is a database that was collected by the Texas Department of Criminal Justice for administrative purposes. These routinely collected, and deidentified data are the source of the information used for this research project. All data management and analysis was conducted on personal computers at UTMB by myself and was reviewed by Dr. Baillargeon. All data used in this study have been previously stripped of all personal identifiers and were maintained on a double password protected personal computer in a locked office at the University of Texas Medical Branch (UTMB). All data in this manuscript will be presented in aggregate form. All data analysis, management, and abstraction were conducted in compliance with HIPPA regulations. Since this project involves secondary analysis of an already deidentified dataset, it did not require full Institutional Review Board review. Even so, the Institutional Review Board of UTMB at Galveston reviewed and approved this study.

METHODS

A retrospective cohort study design was used for this project. The study cohort (n = 64) consisted of probationers who were eligible to participate in the Felony Mental Health Court of Harris County, Texas. Statistical methods used were relevant for assessing descriptive data and included prevalence estimates, means, medians, and standard deviations.

Analysis for specific aim 1: Demographic and sociobehavioral characteristics of the study cohort were assessed using standard epidemiologic measures including frequencies and proportions. For continuous variables, means and medians were examined.

Analysis for specific aim 2: Medical characteristics of the study cohort were assessed using standard epidemiologic measures not limited to frequencies and proportions.

Misclassification bias and data omission are the study's strongest limitations due to the historical cohort study design. Because these data were not collected for the purposes of primary research, misclassification may be present in the dataset. The major strength of this study is that it will be the first analysis of the court's initial year in operation. This novel study will provide critical information about important population characteristics and will help inform future interventions.

Chapter 3 Results

This study made use of a subset of routinely collected deidentified administrative records from the JIMS. The study cohort an *n*= 63 consisted of all individuals who were accepted into, and then chosen to participate, in the Felony Mental Health Court. Only 16% of the study cohort had missing data on any of the study variables. The occasional missing data points were not considered enough to compromise the integrity of the results as reported herein.

SPECIFIC AIM ONE: STUDY SAMPLE DESCRIPTIVE STATISTICS

SEX, AGE, ETHNICITY

As presented in **Table 3**, the study cohort was $n = 63$, with 36 female and 27 male clients. Age, ethnicity, and current offense are the variable categories being assessed. The average age of participants was 35 years ± 11 years, with an age range of 17 to 61 years. Although the potential relationship between ethnicity and age was not a primary focus of this work, a relationship between these characteristics was captured through statistical testing. Using an Analysis of Variance (ANOVA), we found a significant difference in mean age within the ethnicity category ($p = .03$). A Student's t-test revealed a significant difference in mean age between Non-Hispanics and all other groups ($p = 0.003$) with Non-Hispanic court clients averaging 38.5 ± 11.5 years of age and all other ethnicities averaging 30.0 years old ± 9.2 years of age (not reported in **Table 3**).

We assessed the distribution of ethnicity and offense classifications overall and according to gender. Due to the small number of observations in both offense and ethnicity cells, Fisher's exact tests were used. The table shows that the distribution of these characteristics (ethnicity, offense classification) did not vary significantly by gender.

Table 3. Cohort Demographic Factors.

	Overall	Females	Males	*p*-value
Age yrs.	63 (100)	36 (57)	27 (43)	
Median	33	36	31	0.35
Range	17-61	20-56	17-61	
Ethnicity *n* (%)				
Non-Hispanic	38 (60)	24 (63)	14 (27)	0.93
Hispanic	13 (21)	8 (62)	5 (38)	
Caucasian	2 (3)	1 (50)	1 (50)	
Other	9 (14)	3 (33)	6 (67)	
Unknown	1 (2)	0	1 (100)	
Current Offense *n* (%)				
Property	31 (49)	17 (55)	14 (45)	0.98
Drug	23 (37)	12 (52)	11 (48)	
Nuisance	7 (11)	5 (71)	2 (29)	
Violent	1 (2)	1 (100)	0	
Other	1 (2)	1 (100)	0	

Age *p*- value determined through Student's t-test. Ethnicity and Current Offense *p*-values determined through Fisher's exact tests.

CRIMINAL HISTORY

The decidedly distinctive quality of specialty courts makes them difficult to compare due to a lack of streamlined judicial structures across the 50 states. Like its sister courts in the state of Texas and across the country, there are varied paths by which an individual case can make its way into the court. The Felony Mental Health Court in Harris County maintains a client base largely supported by referrals from attorneys. During this, the court's inaugural year of operation, 42 of the 63 participants (66%) were referred to the court by private counsel. Of the various court divisions in Harris County, an overwhelming majority of court participants' cases (57 of 63; 90%) were initially under the jurisdiction of the felony courts with only 5 cases originating from the Justice of the Peace courts, the misdemeanor courts, and finally as a result of an adult probation interstate compact.

Collectively, the 63 court participants' current offenses represent 28 criminal classifications. The collective offenses can be broken down into 5 major categories, which are presented in the above **Table 3**. This table represents the current offense for each client and the one for which the clients received deferred sentences in exchange for their participation in the court.

Within the database, criminal history is further categorized by the number of prior criminal justice contacts, the number and type of prior criminal charges filed, and finally, the date of an individual's first criminal filing date which is the initial point at which the person was first charged with a criminal offense. Extrapolating from this information reveals a total of 739 cumulative years of criminal history among the 63 court clients with a range of <1 year to 29 years and an average of 11.6 ± 8.31 years of criminal history.

The total number of criminal charges was 699 with a range of 0 charges for offenders whose first criminal charge was deferred due to their participation in the court

to 50 charges for a single client. The mean number of criminal charges for a representative client was 11 ± 10.27 charges. These prior criminal charges are broken down into two larger categories of prior felony and prior misdemeanor. The cumulative number of prior felonies is among the 63 clients is 251 with an average of 4 ± 5 felonies per client with a range of 0 to 18 felonies. The most common number of prior felony offenses is 0 with 20% of clients having their first and only offense deferred due to their participation in the court. Misdemeanor charges far outpace felony charges and the aggregate number of prior charges is 396 with an average of 6 ± 7 misdemeanors per client (with a range of 0 to 33 offenses). However, the most common number of misdemeanor charges per client is also 0, with 12.7% of clients similarly having their first and only misdemeanor deferred.

In terms of prior criminal justice contacts, the cumulative number for all clients was 557 contacts with an average of 8.84 ± 8.13 prior contacts per client (and a range of 1 to 39 prior contacts). Therefore, the number of criminal justice charges, versus with the number of criminal justice contacts demonstrates that individuals were often charged with multiple criminal offenses during a single criminal justice contact.

MENTAL HEALTH HISTORY

The psychiatric history of the 63 clients was, in some cases, largely unknown to the court before the time at which an individual became a participant. The court team conducts a health history as part of their evaluation process in order to establish a sketch of the client's current and past medical conditions. In many instances, the court team has submitted formal requests for release of a client's medical records but such requests often go unaddressed, and the records have failed to materialize even as much as 6 months later. Although it may be reasonable to assume that some of the clients had an existing medical diagnosis for a given psychiatric condition, this information was not included in the dataset.

SPECIFIC AIM TWO: MENTAL HEALTH CHARACTERISTICS OF THE STUDY POPULATION

In regards to this aim, the study population will be stratified into three groups for comparison purposes: those with exclusively mental health diagnoses, those with exclusively substance abuse diagnoses, and those with comorbid mental health and substance abuse diagnoses. Some may disagree with this stratification on the grounds that substance abuse and mental health diagnoses all fall under a single categorization that is mental illness. For the purposes of this study, these groups will be treated as though they are discrete. It is understood that this separation may be an arbitrary, if not wholly artificial, one. On the aggregate, there are 96 individual diagnoses assigned to 54 of the 63 (86%) clients. The remaining 14% of clients (n = 9) have no listed medical diagnoses. All clients must have at least one diagnosable mental health condition to be eligible for the court, therefore, the lack of diagnoses in the dataset does not represent a lack of illness but rather, a failure to maintain seamless administrative records. The analysis to follow will focus on those 54 clients who have diagnoses included in the dataset, which are summarized in **Table 4**.

EXCLUSIVE MENTAL HEALTH DIAGNOSES

The dataset includes 39 individual diagnoses for various mental health conditions. Of the 54 clients who have medical diagnostic information in the dataset, 18 of the clients (33%) have exclusively mental health diagnoses (n = 18 clients). Although 1 (6%) of those with exclusively mental health diagnoses maintains two diagnoses (Schizophrenia and Intellectual Disability Disorder), the remaining 17 individuals (94%) all maintain a single medical diagnosis with no noted secondary, tertiary, or quaternary conditions.

Table 4. Client Medical Diagnoses.

	Mental Illness *n* (%)	Mental Illness with Substance Abuse *n* (%)
Schizophreniform Disorders	5 (9)	9 (16)
Bipolar Disorder	8 (15)	17 (31)
Major Depressive Disorder	5 (9)	9 (16)

The average age of this subset of court clients is 34 years old (interquartile range = 18 years) with a median age of 39 ± 12.5 years. There are 10 males (56%) and 8 females (44%) in this group. Of all the males in the subset of those whose mental health diagnoses data are accounted for in the dataset, 43% (*n* = 10) had an exclusive mental health condition. Of all the females in the same subset, 26% *(n* = 8) had an exclusive mental health condition. Among those with exclusively mental health diagnoses, there are 66% are Non-Hispanics (*n* = 12), 22% Hispanics (*n* = 4), and 11% are Other ethnicities (*n* = 2). 29% of those in this subset of clients were exclusively diagnosed with a mental health condition (*n* = 18).

Exclusive Substance Abuse Diagnoses

In contrast to the many participants with solely mental health diagnoses, there was only a single individual who was exclusively diagnosed with a substance abuse disorder. This participant was diagnosed as alcohol dependent and maintained no other comorbid diagnoses. This participant was diagnosed as alcohol dependent and maintained no other comorbid diagnoses.

He was a Non-Hispanic male who enrolled in the court when he was 49 years old. The subset of those with exclusively substance abuse diagnosis is only 2% of the total study population (n =1).

COMORBID MENTAL HEALTH AND SUBSTANCE ABUSE DIAGNOSES

Of the 54 clients for whom we have documented medical diagnoses, a large number of this group (n = 35, 65%) have been dually diagnosed as having at least one mental health condition and being dependent at least one substance to the point of abuse. Within this group of 35 clients, they have been diagnosed with 77 different conditions. There are 12 males (34% of those with dual diagnosis) and 23 females (66% of those with dual diagnosis) in this subset. This subset of comorbidly diagnosed clients makes up over half (56%) of the total study population.

The average age of a client in this group is 35.7 years (interquartile range = 15.2 years), and the median age is 35 ± 11.2 years. The youngest in this group is 20 years old, and the eldest is 60 years old. In terms of ethnic categorization, the group is 23% Hispanics (n = 8), 60% Non-Hispanic (n = 21), 6% Caucasian (n = 2), 9% Other (n = 3), and 1% Unknown (n = 1). This subgroup of comorbidly diagnosed clients includes 100% of the Caucasian study population. Again in terms of the overall study, this subgroup contains 55% (n = 21) of all the Non-Hispanic study participants (n = 38).

For the purpose of analysis, all schizophreniform disorders were combined into a single category before being compared to bipolar and major depressive disorder diagnoses substrata using Pearson's chi-square analysis (p = 0.36) and Fisher's exact test (p = 0.37). Comorbid diagnoses were compared to psychiatric exclusive diagnoses using Pearson's chi-square analysis (p = 0.15). Ethnic groups were compared using Fisher's exact test (p = 0.25) and Pearson's chi-square analysis (p = 0.45). Age was also compared using Pearson's chi-square analysis (p = 0.34).

Chapter 4 Implications

The major findings from the study reveal large percentages of Non-Hispanic persons when compared to all other ethnicities in this court cohort. As dataset categories, ethnicities are not defined in terms of which individuals occupy the various groups. For a person who identifies as Black or African American, it is uncertain into which ethnicity category such a person might find themselves. The cohort also contains large percentages of property drug offenses when compared to all other offenses and there are exceedingly few court clients who have been charged with a violent offense. Bipolar and schizophrenia represent the majority of mental health diagnoses, but there is extensive overlap with substance abuse diagnoses among those in the bipolar and schizophreniform substrata.

These findings have serious implications in terms of potential interventions. Clients dually diagnosed with mental health and substance abuse diagnoses may require unique programs and services not routinely offered for those with an exclusive mental health or substance abuse diagnosis. The clients who have a schizophreniform disorder represent 25% of the subset of clients whose diagnoses are in the dataset (n = 14). The court is successfully diverting mentally ill individuals away from the prison system. Clients with such diagnoses receive access to services tailored to their needs as determined by the clinical team who then facilitates a relationship between the court participant and either a community-based or in-patient program. Because Harris County does not maintain a locked ward facility for individuals with substance abuse challenges, court clients whose conditions require continuous care are remanded to "New Choices." This program operates out of the Harris County Jail and lasts 90-days. Clients who are placed in "New Choices" are considered too risky to be released in terms of their mental

health and substance abuse evaluations. This is clearly problematic and could be rectified if Harris County were to support the development of a locked-ward facility.

In terms of the association between age and ethnicity, it is unknown why younger individuals of all other recorded ethnic groups are being referred to the court earlier in their lives, or, conversely, why Non-Hispanic persons are almost a decade older than their Hispanic, Caucasian, and Other participant counterparts. No significant findings in terms of years of criminal history illustrate that Non-Hispanic persons are not entering into the criminal justice system at a unique rate or unique time compared to other groups, however, these individuals' lives may be disparately affected by their later arrival into the court as compared with those who are screened into the court when they are a decade younger.

There are a number of serious limitations in the study. The first is the small sample size of the study population. The issue of small sample sizes challenges public health research such as this, in terms of evaluating complex interventions that are often designed and implemented on a small scale. Misclassification bias and data omission are perhaps, the most detrimental limitations affecting the current study because this dataset was collected for purposes other than this research study. This is particularly troubling regarding the loss of recorded mental health diagnosis data. Screening for mental health challenges within the felony and misdemeanant population is a critical component of the court's organizational structure and overall raison d'être. Loss of this type of data is an omission that needs to be rectified in an effort to more accurately represent the sociodemographic characteristics of the court clients.

The discerned association between age and Non-Hispanic ethnicity may be the result of misclassification bias in terms of clients being incorrectly categorized by ethnicity. Because the categories of ethnicity have been constructed out of a particular historical legacy for a specific administrative function, it is unrealistic to accept the accuracy of such categorizations without critique. At the broadest level, it is unlikely that

individuals within the court identify as ethnically "other," yet if a client self-identifies as Asian, for example, their only options for declaration of an ethnic background is to choose the category of "Non-Hispanic" or "other." Similarly, I would argue that there is something counterintuitive about a category labeled Non-Hispanic as it is unlikely an individual would chose to identify as not being in a group rather than belonging to a specific group. If such an approach is reasonable, ought we instead ask people to fill out driver's license forms by marking off all the years old they are not? It is unknown how the information in this database was collected which may have led to incorrect ethnic categorizations and thus a potentially spurious finding. Nonetheless, this finding might help guide the court team in terms of building new relationships with community-based treatment providers. Rather than explain a precise phenomenon, this association should inform future studies by illuminating possible linkages worthy of investigation.

There are variables that are not captured within the database such as the circumstances surrounding the instances in which various clients committed new offenses. Without understanding why a person committed the new offense, any statistical efforts to understand the usefulness of this and similar courts lack a certain sophistication. I know this because I observed many of the court proceedings and can attest to the hollowness of the information captured in the database and thus in my quantitative analysis. Although it lies outside the scope of this particular work, it is critical that future research on this court must include both quantitative and qualitative data. Satisfying the requirements of funding authorities will always be beneficial and researchers can help accomplish this mission by assisting such specialty courts in their efforts to demonstrate their economic usefulness. Yet, if these courts have value for reasons that fall beyond that which is financially measurable, it is the researcher's task to illuminate those areas of merit as well.

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Vita

Alina Bennett was born on February 1st in Spokane, Washington. She is the first child of David Bennett and Linda Garcia. Alina attended Washington State University for three years before transferring to Pitzer College where she completed her Bachelor of Arts in Gender and Feminist Studies in 2000 earning both academic and thesis honors.

In 2008, she completed a Master of Arts degree in Women's Studies at The Ohio State University where she also earned a Graduate Interdisciplinary Specialization in Disability Studies. While a student, she won the Joellen Thomas Writing Award for Outstanding Paper on Women and Disability, as well as a number of conference travel grants for paper presentations at national meetings including the National Women's Studies Association, and the Midwestern Modern Language Association. Her publications while at OSU included a single-authored book review and a press review, both published in *Disability Studies Quarterly*, and a collaborative book review published in the *National Women's Studies Journal*.

After graduating, Alina held a lectureship appointment in Women's Studies at her alma mater where she continued to teach introductory women's studies courses, as well as the department's course in women's health. While working as a Lecturer in Women's Studies, Alina won a grant from the Faculty and Teaching Assistant Development program and successfully developed and implemented a professional development strategy for the department's Teaching Assistants.

In 2009, Alina began doctoral studies with the Institute for the Medical Humanities at the University of Texas Medical Branch (UTMB). She was then accepted to the Master of Public Health degree program in January of 2011 with the Public Health graduate program.

While at UTMB, Alina has continued to present at national meetings including the American Society for Bioethics and the Popular Culture Association/American Culture Association while maintaining a regional scholarly presence at conferences including UTMB's Annual Pediatric Update, the McGovern Center for Humanities and Ethics, and the National Student Research Forum. During her dual degree studies, Alina has published a book review, a dissertation review, a book chapter and a co-authored article in the *Journal of Pastoral Psychology*. Her commitment to teaching has continued here at UTMB and Alina has served as a Teaching Assistant in the Humanities, Ethics, and Professionalism section of the Practice of Medicine course, and a co-facilitator for the Ethics of Scientific Research course. Alina has twice taught the undergraduate Medical Ethics course, which is part of the Joint Admissions Medical Program, held yearly here at UTMB.

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This capstone was typed by Alina Bennett.

Appendix Footnotes

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