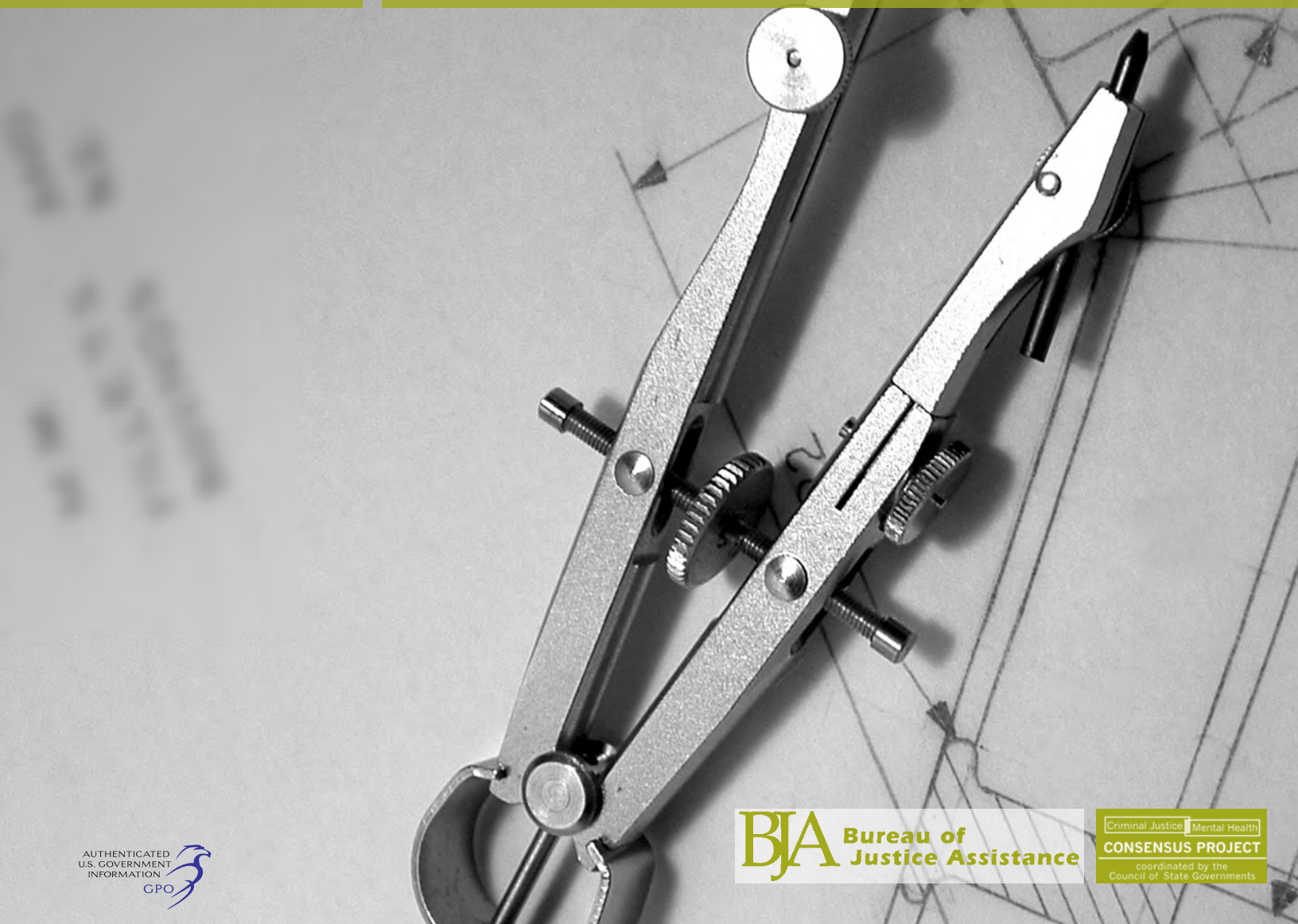
BJA MENTAL HEALTH COURTS PROGRAM

A Guide to Mental Health Court Design and Implementation



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A Guide to Mental Health Court Design and Implementation

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The Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system. BJA provides leadership, services, and funding to America's communities by emphasizing local control; building relationships in the field; developing collaborations and partnerships; promoting capacity building through planning; streamlining the administration of grants; increasing training and technical assistance; creating accountability of projects; encouraging innovation; and ultimately communicating the value of justice efforts to decisionmakers at every level. **www.ojp.usdoj.gov/BJA/**

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The development of this guide was overseen by staff of the Criminal Justice Program of CSG's Eastern Office, which also coordinates the Criminal Justice/Mental Health Consensus Project.

About the Criminal Justice/Mental Health Consensus Project

Coordinated by the Council of State Governments (CSG), the Criminal Justice/Mental Health Consensus Project is an unprecedented national effort to improve the response to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. The landmark Consensus Project Report, which was authored by CSG and representatives of leading criminal justice and mental health organizations, was released in June 2002. Since then, the Consensus Project has continued to promote practical, flexible approaches to this issue through presentations, technical assistance, and information dissemination. This includes providing technical assistance to the Bureau of Justice Assistance Mental Health Courts Program.

A Guide to Mental Health Court Design and Implementation

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Executive Summary

THE LAST FIVE YEARS HAVE WITNESSED A BOOM in the development of mental health courts. From only a handful of such courts in the late 1990s, there are now more than 100 nationwide. With this recent surge, mental health courts are quickly becoming the most popular strategy across the country to address the overrepresentation of people with mental illnesses in the criminal justice system.

Even in their infancy, much has already been written about mental health courts, including evaluations of individual courts, analyses of practices across courts, and commentaries on the merits of the mental health court concept. This guide attempts to build on that substantial body of work by providing a roadmap, based largely on the experience of existing mental health courts, for those interested in establishing a mental health court in their jurisdiction.

The guide is organized according to the three basic steps, described below, that should be followed by any community considering the establishment a mental health court:

1. Understanding the mental health court concept.
2. Determining whether a mental health court is appropriate
3. Considering elements of mental health court design and implementation

STEP ONE: UNDERSTANDING THE MENTAL HEALTH COURT CONCEPT

Mental health courts are part of the growing problem-solving court movement, which includes drug courts, community courts, domestic violence courts, reentry courts, and others. These specialized court dockets replace the traditional adversarial process with a focus on addressing the underlying problems that lead to criminal justice involvement. While mental health courts share much in common with other problem-solving courts, important differences have already emerged. For example, despite the significant overlap of their target populations (75 percent of offenders with mental illnesses have a co-occurring substance abuse disorder) mental health courts and

drug courts differ in terms of charges accepted, monitoring practices, responses to violations, and modes of service delivery.

Their recent popularity notwithstanding, mental health courts are not the only strategy that court systems use to better respond to defendants with mental illnesses. In fact, mental health courts are closely related to specialized pretrial release programs, court-based diversion programs, and dedicated probation caseloads for people with mental illnesses. What differentiates mental health courts from these other approaches are their use of a specialized docket and their regular, judicially supervised, team-based approach to monitoring participants' treatment and adherence to court conditions. This difference is not trivial—there are important philosophical and practical distinctions between mental health courts and the other court-based strategies mentioned above. Nevertheless, much in this guide is relevant to court-based efforts that do not fit the description of a mental health court.

Among programs that share the "mental health court" label, diversity is the rule. The more than 100 mental health courts nationwide differ widely in terms of their eligibility criteria, case processing, treatment options, how they dispose of cases upon program completion, and in many other ways. Understanding the mental health court concept means recognizing that not only are multiple options available for improving the court's response to defendants with mental illnesses, but also that there are numerous ways to design and implement a mental health court.

Program planners should also be aware of the limited evidence base for mental health courts. While these programs show great promise, their long-term viability depends on empirically documented results. More research is needed to better understand mental health court processes, to identify the specific categories of defendants who benefit the most from a mental health court, and to isolate the components of the mental health court model most responsible for its effectiveness.

STEP TWO: DETERMINING IF A MENTAL HEALTH COURT IS APPROPRIATE

If understanding the mental health court concept means a step forward, the question of whether to establish a mental health court requires a step back. Because mental health courts are just one response to the involvement of people with mental illnesses in the criminal justice system, key stakeholders in a jurisdiction should analyze the dynamics of that problem, and the needs and attributes of their community, before determining the appropriateness of a specialized docket.

Regardless of where the proposal for a mental health court comes from—a charismatic judge, a mental health advocate, a state legislator, or elsewhere—the full array of policymakers and practitioners affected by the involvement of people with mental illnesses in the criminal justice system should discuss its viability. This discussion should include representatives of criminal justice agencies, mental health and substance abuse treatment providers, mental health and victims' advocates, and housing and benefits officials, among others. Ideally, this dialogue would be chaired by a member of the judiciary, who carries the neutrality of the court and possesses the ability to moderate discussions among parties with differing viewpoints and priorities.

Rather than simply weighing the pros and cons of a mental health court, the stakeholder group should consider the full range of problems that occur when people with mental illnesses enter the criminal justice system. This assessment should include step-by-step mapping of the way in which individuals with mental illnesses are processed, how decisions are made, and how they might be improved. The discussion should be informed by empirical data, which can pinpoint the imperatives of the local population and establish baseline measures needed to evaluate the effectiveness of whatever response is developed. Stakeholders should also take the time to discuss their different priorities, goals, duties, funding mechanisms, and core concerns. Establishing common ground in these areas is essential for building the collaboration that must underlie any response to the problems at the intersection of the mental health and criminal justice systems.

Through this process, stakeholders in a jurisdiction should answer the following questions, among others that arise, before deciding to establish a mental health court.

- Where on the criminal justice continuum will the community focus?
- If the focus is on a court-based intervention, is a specialized docket the right strategy?
- Is a mental health court the only court-based strategy that will be employed?

Whatever the answers to these questions, a mental health court will not be a panacea, and should be considered one aspect of a systemic strategy to improve the response to people with mental illnesses across the criminal justice and mental health systems, from before arrest to after reentry.

STEP THREE: CONSIDERING ELEMENTS OF MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION

To aid communities that do decide to establish a mental health court, this guide highlights ten elements of mental health court design and implementation. With limited research knowledge, and the youth of the mental health court field, it is impossible to suggest that there is universal agreement on, or an evidence base to confirm, the importance of these elements. Rather, the guide identifies them as aspects of a mental health court that should be considered carefully throughout the planning and operation of the program. The guide does not offer prescriptions about how jurisdictions should structure these elements, but rather describes the virtues and drawbacks of different approaches to each one.

To help readers understand the information contained in the guide, the table on the following pages identifies the ten elements and some of the questions that the guide can help program planners to answer. Ultimately, the path for a particular jurisdiction will be dictated by the characteristics of the local population, the priorities of the stakeholders involved, and the available community resources.

Section Number	Mental Health Court Element	Key Questions
1	**Goals**	What are the specific goals for the mental health court: increased public safety, increased treatment engagement, improved quality of life, and/or more effective use of resources?
		How will progress towards these goals be measured?
2	**Target Population**	Will the court accept defendants charged with misdemeanors, felonies, or both?
		Must a relationship between defendants' mental illnesses and their charges be demonstrated? If so, how will that relationship be established?
		Will those accused of violent crimes or with a history of violence be eligible for the program?
		Will the court establish eligibility criteria related to defendants' criminal histories?
		What kind of diagnostic criteria will the court establish?
		How will the court coordinate with other programs (such as the drug court)?
3	**Confidentiality**	How will prospective participants be asked to consent to the release of information, and to whom will it be released?
		How will clinical information be handled in open court?
		How will federal regulations related to the sharing of mental health and substance abuse treatment information affect program design?
4	**Terms of Participation**	What kind of plea arrangement will the court establish for program participants? Will a guilty plea be required?
		How will cases be disposed when participants successfully complete the program? What about when participants are unsuccessful?
		How often will participants report to the court for status hearings?
		How long will the court program last? Will it vary for each individual? If so, what will be the basis?
5	**Informed and Voluntary Choice**	How will the court ensure prompt assessment of legal competency?
		How will the court ensure that defendants are fully informed about the program before opting into the court?
		How will the court encourage participant input into treatment plans and other conditions?

Section Number	Mental Health Court Element	Key Questions
6	**Participant Identification**	From which agencies or individuals will the court accept referrals?
		How will high rates of inappropriate referrals be avoided?
		Who will screen referrals for legal and clinical eligibility?
		How will information required for treatment planning be gathered?
		How will the final determination of eligibility be made? Who will have ultimate authority to accept participants?
		What speed of processing targets will the court set?
7	**Integration of Treatment and Community Supports**	How will the court determine what kinds of mental health treatment are available in the community? How will the court respond to gaps in treatment?
		How will the court address the treatment needs of participants with co-occurring psychiatric and substance abuse disorders?
		How will the court ensure that treatment for court participants does not reduce treatment availability for non-court participants?
		How will the court make use of peer support services?
		How will the court account for the specific treatment needs of women and minorities?
		How will the court transition participants from court supervision to unsupervised treatment?
8	**The Court Team**	Who will compose the court team?
		How will team members be selected?
		What kind of training, both initial and ongoing, will be provided to team members?
		How long will staff be assigned to the mental health court program?
9	**Monitoring Adherence to Court Conditions**	Who will monitor or supervise participants in the community? Will these staff have a mental health background (e.g., case managers), a criminal justice background (e.g., probation officers), or will a team approach be used?
		Who will manage information about participants' adherence to court conditions?
		Who will attend case staffing meetings during which participants' progress is discussed?
		What kind of rewards and incentives will be provided to encourage compliance?

Section Number	Mental Health Court Element	Key Questions
continued		
9	**Monitoring Adherence to Court Conditions**	How will the court determine when to adjust treatment plans and when to apply sanctions in response to non-adherence?
		What kinds of sanctions will be applied? When, if at all, will jail be used as a sanction?
		How will the court resolve differences of opinion about how to best respond to violations of court conditions?
10	**Sustainability**	From what sources will the court obtain long-term funding or resources to operate?
		When will the court develop written policies and procedures?
		Which outcome data will be collected and who will collect them?
		How will the court respond to program failures, such as well-publicized new crimes committed by program participants?
		How will the court educate other agencies and community members about the goals and processes of the court?

With the aid of this guide, readers will better understand how mental health courts across the country have negotiated the questions above, and will be better prepared to develop answers in their own jurisdictions. As with the decision of whether to establish a mental health court, answers to these questions should be based on the input of stakeholders throughout the criminal justice, mental health, substance abuse, and related systems. Without a strong collaborative base, no mental health court, or any program to address the involvement of people with mental illnesses in the criminal justice system, can be successful. But by working together, practitioners and policymakers from across these systems have the opportunity to improve the lives of individuals with mental illnesses, the functioning of the criminal justice and mental health systems, and the health and safety of communities across the country.

Introduction

PEOPLE WITH MENTAL ILLNESSES ARE FAMILIAR FACES in courtrooms across the country. Some act strangely, muttering to themselves or to invisible companions; others are distant, eyes cast to the floor, hardly aware of the proceedings taking place before them. Many are disheveled and possibly homeless, with few apparent ties to the community. And some appear no different from other defendants, their symptoms undetectable during the cursory court process. Most have been booked on low-level crimes, often no more than public manifestations of their untreated mental illnesses.

If the court becomes aware of a defendant's mental illness, it may evaluate his or her legal competency. Beyond the question of competency, most people with mental illnesses cycle through the nation's court systems with little attention paid to their conditions. Many will serve short sentences in jail, where the stress of crowding, isolation, and the threat of violence may cause further decompensation. Release to the community rarely involves the comprehensive planning needed to ensure connection with community treatment providers. All too often, defendants with mental illnesses are back before the court shortly after their release.

Few courts are capable of interceding in this vicious cycle. In cases where community treatment might be preferable to incarceration, the court lacks sufficient information, time, or resources to develop appropriate treatment plans. Further, judges

diverse people, diverse terminology

Many different terms are used to describe people involved with the mental health system and the criminal justice system. In this guide, we have chosen to use the following:

- **Individual with a mental illness —** someone with a mental illness.
- **Consumer—**someone receiving mental health treatment.
- **Defendant—**someone appearing in court after being charged with a criminal offense.
- **Participant—**someone who is participating in a mental health court program.

and prosecutors, rightfully concerned about public safety, are wary of transferring responsibility for these defendants to the mental health system, which appears to have had difficulty engaging these people in the first place.

But in select communities across the country, court officials, mental health advocates, treatment providers, representatives of other criminal justice agencies, and consumers have sought to develop court processes and procedures that are more responsive to the needs of defendants with mental illnesses, while continuing to protect public safety and ensure the integrity of the court process. Some communities have developed court-based diversion programs that do not entail a separate docket; other jurisdictions have infused traditional court processes with relevant information about the mental health needs of defendants without developing a separate program. And some jurisdictions—more than 100 nationwide—have developed specialized dockets, or mental health courts, which are the focus of this guide.

ABOUT THIS GUIDE

This guide helps readers determine whether a mental health court is right for their communities, and explains how to design and implement a mental health court that both responds to local needs and reflects the knowledge gained from existing mental health courts. It is intended for the diverse array of policymakers and practitioners who are interested in mental health courts, including judges, mental health advocates, prosecutors, consumers of mental health services, defense attorneys, mental health and substance abuse treatment providers, pretrial services administrators, and many others.

The guide is organized according to the three basic steps that should be followed by any community considering the establishment a mental health court. Step I—"Understanding the Mental Health Court Concept"—provides a working definition of a mental health court and helps readers understand the origins of mental health courts and the status of their development across the country. Step II—"Determining if a Mental Health Court is Appropriate"—guides readers in deciding whether or not to establish a mental health court in their community. The third and most important step—"Considering Elements of Mental Health Court Design and Implementation"— identifies ten key aspects of mental health courts that can help guide planners and administrators when establishing a specialized mental health docket. Throughout steps II and III are examples from various jurisdictions around the country.

These examples are included to offer concrete illustrations of how courts have operationalized these elements and put various ideas into practice, and are not intended as recommendations or models of "best practices."

The Council of State Governments (CSG), which provides technical assistance to the Mental Health Courts Program of the Bureau of Justice Assistance (BJA), published this guide along with three other documents, which are referenced often throughout:

- *What Is a Mental Health Court?*
- *Navigating the Mental Health Maze: A Guide for Court Practitioners*
- *A Guide to Collecting Mental Health Court Outcome Data*

The first is a basic primer on mental health courts, while the second and third documents provide in-depth elaboration on topics of particular concern to mental health court practitioners. Readers from the courts or other criminal justice agencies are particularly encouraged to consult *Navigating the Mental Health Maze,* and to work with local mental health providers and advocates to understand the complicated dynamics of mental illnesses and their treatment. Mental health courts represent an intersection of the criminal justice and mental health systems; as this guide often points out, representatives of these systems must understand the nature of each others' goals, methods, and concerns in order to be effective partners.*

METHODOLOGY

In addition to using reviews of recent research and analysis of mental health courts, CSG also relied heavily on information from BJA Mental Health Court Program grantees and other mental health courts in the development of this guide. Telephone interviews with representatives of each of the 37 BJA grantee courts elicited comprehensive information about the courts' organization and operation, including the number of clients served, composition of the courtroom team, length of the program, and plans for sustainability. In addition, CSG responded to requests from grantee and non-grantee courts for targeted technical assistance. During the course of these responses, CSG staff and consultants obtained first-hand views of the many varieties of mental health courts and the complex issues with which they must contend. CSG staff and consultants also had the opportunity to visit several mental health courts that were not BJA grantees.

*Mental health professionals should consider consulting a similar publication from the TAPA Center for Jail Diversion: *Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know,* which is available at: http://www.gainsctr.com/pdfs/tapa/Massaro.pdf

In January 2002, on behalf of BJA, CSG convened a national meeting of representatives of all 37 BJA grantees, which included approximately 130 mental health court practitioners. During the two-day meeting, in a series of interactive workshops, grantees discussed the barriers they faced and strategies for overcoming them. Workshop topics included identifying and screening clients, monitoring adherence to court conditions, integrating community treatment, and sustaining court operations. These sessions helped CSG to understand the variety of ways these issues are managed and to identify innovative practices developed by individual courts.

Given that research on mental health court operation and outcomes remains limited, the experience of existing courts is perhaps the best source of guidance for jurisdictions interested in launching such programs. Those experiences have substantially informed what follows.



Understanding the Mental Health Court Concept

MENTAL HEALTH COURTS ARE ONE RESPONSE to a broad systemic problem that has evolved over the past several decades: the overrepresentation of people with mental illnesses in the criminal justice system. The magnitude of this problem is startling. According to a 1999 U.S. Department of Justice study, the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population.[1] Almost half of inmates with mental illnesses are incarcerated for non-violent crimes.[2] The Los Angeles County Jail and New York City's Riker's Island Jail each house more people with mental illnesses than any public or private mental health institution in the country.[3] Though statistics on the prevalence of mental illness are most easily obtained from correctional institutions, the impact on law enforcement and the courts has also been well documented.[4] Simply put, for too many people with mental illnesses, the criminal justice system has become a never-ending revolving door.

A WORKING DEFINITION

If observers of mental health courts agree on anything, it is that there is not yet a universally agreed upon definition of a mental health court. In fact, the only existing nationwide survey of mental health courts offers no descriptive model, relying instead on jurisdictions to identify themselves as having mental health courts.[5] The more

than 100 courts identified by this survey differ widely in the types of cases and defendants they accept, the manner in which those cases are processed, the treatment to which participants are connected, and the manner in which those cases are resolved when a participant completes the term of supervised treatment. The medley of existing approaches reflects the grassroots nature of mental health courts' development. But while their variability is undeniable, most mental health courts have similar basic characteristics.

In general, the term "mental health court" describes:

> A specialized court docket for certain defendants with mental illnesses 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 is defined according to specific criteria.[6]

This description summarizes the components that are common to the majority of mental health court programs across the country. As mentioned previously, within this general description mental health courts vary widely in terms of target population, plea arrangement, intensity of supervision, program duration, and types of treatment available. Furthermore, research is not yet able to explain how changes in the arrangement of these components affect outcomes. But when a jurisdiction says it is launching a mental health court, the program almost always fits the above description.

There are many court-based efforts to improve the response to defendants with mental illnesses that share components of this definition. For example, some pretrial services agencies have implemented specialized screening and assessments for defendants with mental illnesses; specialized mental health probation programs regularly apply sanctions and incentives geared toward people with mental illnesses. What differentiates mental health courts from these other approaches are their 1) designation of a specialized court docket for some portion of criminal cases involving defendants with mental illnesses, and their 2) team-based monitoring of participants that includes regular judicial supervision. Nevertheless, there is much in this guide relevant to court-based strategies that does not fit the description of a mental health court.

> "People with mental illnesses are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate."
>
> Criminal Justice / Mental Health Consensus Project Report

A BRIEF HISTORY OF MENTAL HEALTH COURTS

Mental health courts have emerged alongside numerous other collaborative strategies to improve the response to people with mental illnesses in the criminal justice system. Over the past two decades, state and local criminal justice and mental health agencies have enhanced training for law enforcement officers, developed programs to divert certain offenders with mental illnesses from jail, established specialized probation and parole caseloads, and improved transition planning from correctional facilities.

These parallel efforts have coalesced into a national, bi-partisan consensus on the need to improve the criminal justice and mental health systems' response to this population. In 2002, the Council of State Governments released the *Criminal Justice / Mental Health Consensus Project Report,* which reflected the input of more than 100 leading practitioners and policymakers from across the criminal justice and mental health systems. The report contained recommendations on improving the response to people with mental illnesses throughout the criminal justice continuum, from before their involvement with law enforcement to after their release from prison or jail. The comprehensive recommendations were a testament to the broad agreement among criminal justice, mental health, substance abuse, and other policymakers and practitioners about what should, and could, be done to address this complex issue.

Federal leadership has been instrumental in supporting these state and local activities. Congress has provided grant funding for jail diversion programs through the Substance Abuse and Mental Health Services Administration (SAMHSA). Additionally, America's Law Enforcement and Mental Health Project of 2000 (P.L. 106-515), sponsored by Sen. Mike DeWine (R-OH) and Representative Ted Strickland (D-OH), established the Mental Health Courts Program, administered by the Bureau of Justice Assistance (BJA) of the Office of Justice Programs, U.S. Department of Justice. Building on these programs, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003, just recently signed into law by the President, authorizes $50 million in funding for collaborative efforts between criminal justice and mental health agencies.

The impact of the considerable local, state, and federal efforts described above is difficult to gauge empirically, but the last ten years have clearly witnessed a surge of activity intended to reverse the overrepresentation of people with mental illnesses in the criminal justice system. Mental health courts are one of the best-known components of this emerging movement. In the late 1990s, only a few mental health courts were accepting cases.*[8] Since then, mental health court development has boomed, with more than 100 additional courts either established or in the planning phase.

Just as mental health courts are one link in a chain of strategies across the criminal justice system to better respond to people with mental illnesses, they also share common ground with other efforts to drastically reconfigure the court processing of certain defendants.

*The mental health courts in Broward County (Florida), King County (Washington), Anchorage (Alaska), and San Bernardino (California) are recognized as the "first judge-supervised, court-based innovations designed to address the problems of mentally ill defendants and offenders in the criminal caseload in the United States."— "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload" by John Goldkamp and Cheryl Irons-Guynn.

PROBLEM-SOLVING COURTS

As has been explained at length elsewhere, in the late 1980s and 1990s, many court systems began to look beyond the simple determination of guilt and innocence and toward the underlying causes of crime. This expanded outlook led to the development of problem-solving courts, of which mental health courts are one example.

Most scholars agree that the modern problem-solving court movement originated with a drug treatment court established in Miami in 1989. Since then, drug courts have proliferated rapidly, and other problem-solving models have emerged, including

the Bureau of Justice Assistance (BJA) Mental Health Courts Program

As of 2004, BJA's Mental Health Courts Program provided support to 37 mental health courts in 24 states. The goal of the program is to decrease the frequency of contact between people with mental illnesses and the criminal justice system. BJA-funded projects, as with all mental health courts, vary considerably, but all involve continuing judicial supervision of participants who have mental illnesses, mental retardation, or co-occurring mental illnesses and substance abuse disorders, and who are charged with misdemeanors or nonviolent offenses.[7] A list of BJA Mental Health Court Program grantees appears in Appendix A.

The Mental Health Courts Program is coordinated closely with the SAMHSA Targeted Capacity Expansion Jail Diversion Program, and the technical assistance providers for the two programs—the Council of State Governments and the TAPA Center for Jail Diversion—work together to ensure that their activities are complementary.

community courts, domestic violence courts, and reentry courts.[9] As one study put it, these courts were "developed in response to frustration by both the court system and the public to the large numbers of cases that seemed to be disposed repeatedly but not resolved."[10] Problem-solving courts, as their name suggests, seek to unite the legal system with other social service agencies to solve the problems that bring people before the court. In 2000, the Conference of Chief Justices and Conference of State Court Administrators adopted a resolution titling these initiatives "problem-solving courts," encouraging their careful study, and, perhaps most importantly, promoting the integration of their core concepts into the general administration of justice. A subsequent resolution in 2004 reaffirmed their commitment to the 2000 action items and to increased curriculum development, expanded educational opportunities, the identification of best practices, and expansion of resources available to problem-solving courts. (A copy of the most recent resolution appears in Appendix B.)

Within the field of problem-solving courts, some use an even more specific rubric to describe the underlying concepts of interventions like mental health courts: therapeutic jurisprudence. In fact, this concept has its roots in the analysis of developments in mental health law. One of the leading architects of this concept, David Wexler, describes it as "the study of the role of the law as a therapeutic agent."[11] In practice, the application of therapeutic jurisprudence means incorporating both legal and therapeutic goals in response to violations of the law. Treatment is not prioritized over the requirements of the legal system, but rather integrated into its very processes. Thus, mental health courts are a prime example of therapeutic jurisprudence in action.

Of the various problem-solving court models, drug courts are the closest relative of mental health courts.* Drug courts respond to substance-abusing offenders with comprehensive supervision, drug testing, and treatment services to address the addictions that led to their criminal justice involvement.[12] The overlap between drug court and mental health court target populations is substantial: three out of four people with mental illnesses who become involved in the criminal justice system have a co-occurring substance abuse disorder.[13]

In fact, some of the earliest mental health courts were created when drug court practitioners recognized that people with serious mental illnesses did not fare well in drug court programs.[14] The implications of the substantial number of defendants with co-occurring disorders for drug courts and mental health courts will be discussed at greater length later in this guide (see Step III, Element 7, Integration of Treatment and Community Supports).

*Those interested in more detailed information about drug courts should consult the National Drug Court Institute (www.ndci.org), the National Association of Drug Court Professionals (www.nadcp.org), and the Bureau of Justice Assistance (www.ojp.usdoj.gov/BJA/).

Not surprisingly, mental health courts have numerous features in common with drug courts. Both have special court "teams" that largely eschew the adversarial process; both include "outsiders" in the court process, i.e. mental health or addiction professionals; and both use sanctions and incentives to encourage adherence. Despite these similarities, the two types of courts have important differences. While serious mental illness and drug addiction can both lead to criminal justice system involvement, they are different types of disorder with distinct treatment methods and relationships to the criminal justice system. As one researcher has pointed out, "mental illness, in contrast to [the possession or purchase of illegal substances], is not itself a crime, nor is there an equivalent to the urine screen as a monitoring device."[15]

Though comparative research on mental health courts and drug courts is only beginning, initial observations indicate a number of differences between drug court and mental health court operations (see table). These early observations are evidence that jurisdictions interested in developing a mental health court based on an existing drug court will need to significantly adapt the drug court model to effectively serve people with mental illnesses.

RESEARCH AND ANALYSIS TO DATE

Scholars and practitioners have written extensively about the mental health court concept and the operation of specific programs. In addition to reviewing the information in this guide, those interested in mental health courts should also refer to these analyses:

- Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. U.S. Department of Justice, April 2000. John Goldkamp and Cheryl Irons-Guynn.
- The Use of Criminal Charges and Sanctions in Mental Health Courts. Patricia A. Griffin, Henry J. Steadman, and John Petrila. *Psychiatric Services* 53, October 2002.
- Law and Psychiatry: Mental Health Courts: Their Promise and Unanswered Questions. Henry J. Steadman, Susan Davidson, and Collie Brown. *Psychiatric Services,* April 2001.
- Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform. *Judge David L. Bazelon Center for Mental Health Law,* January 2003.

key differences between drug courts and mental health courts

Program Component	Drug Courts…	Mental Health Courts…
Charges accepted	Focus on offenders charged with drug- or alcohol-motivated crimes.	Include a wider array of charges because mental illness itself is not a crime.
Monitoring	Rely on urinalysis or other types of drug testing to monitor adherence.	Do not have an equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions.
Response to violations	Apply behavior management grid that includes incentives and sanctions for compliance / noncompliance. Graduated sanctions culminate in brief jail sentences.	Adjust treatment plans and apply sanctions in response to non-adherence; rely more heavily on incentives; use jail less frequently.
Role of advocates	Feature only minimal involvement from substance abuse advocacy community, which is generally not as large or well organized as the mental health advocacy community.	Have been promoted heavily by some mental health advocates, who are often involved in the operation of specific programs; other mental health advocates have raised concerns about mental health courts, either in general, or in terms of how they are designed.
Service delivery	Often establish independent treatment programs for their participants.	Usually contract with community agencies; require more resources to coordinate services for participants.
Expectations of participants	Require sobriety, education, employment, self-sufficiency, payment of court fees, and stabilization of co-occurring disorders; some charge participation fees.	Recognize that even in recovery, participants are often unable to work or take classes and require ongoing case management and multiple supports; few charge a fee for participation.

- Broward Mental Health Court: Process, Outcomes, and Service Utilization. Roger A. Boothroyd, Norman G. Poythress, Annette McGaha, and John Petrila. *International Journal of Law and Psychiatry* 26, January–February 2003.
- The Effectiveness of the Broward Mental Health Court: An Evaluation. John Petrila. November 2002. A policy brief derived from the *International Journal of Law and Psychiatry, Evaluation and Program Planning, Court Review,* and *Psychiatric Services* articles.
- Evaluation of the Santa Barbara County Mental Health Treatment Court With Intensive Case Management. Merith Cosden et al. Funded by the California Mentally Ill Offender Crime Reduction Program. 2004.
- The Second Generation of Mental Health Courts. Allison D. Redlich & Henry J. Steadman, et. al. In Press, *Psychology, Public Policy, and the Law.* 2004
- From Referral to Disposition: Case Processing in Seven Mental Health Courts. Henry J. Steadman and Allison D. Redlich, et. al. In press, *Behavioral Sciences and the Law.* 2004.

It is far too early in the development of mental health courts to identify a validated model, a set of "best practices," or the most effective arrangement of components. Nevertheless, this guide is intended to help communities consider some of the important issues related to mental health court design and implementation. As will be discussed later, expectations about the impact of a mental health court should be realistic. No mental health court, no matter how carefully planned, will be the sole answer to all the issues that arise at the nexus of the criminal justice and mental health systems. In fact, a separate mental health court may not even be appropriate in some jurisdictions. Furthermore, in communities that do implement a mental health court, many cases will not be eligible for the specialized docket and will require some other response to their mental health needs.

With those caveats in mind, the next part of this guide is designed to help readers decide whether a mental health court is a viable solution to the specific problems observed in their jurisdictions.



Determining if a Mental Health Court Is Appropriate

THE IMPETUS FOR STARTING A MENTAL HEALTH COURT can come from a variety of sources. Communities may consider mental health courts in response to jail crowding, following a high-profile tragedy involving an offender with mental illness and law enforcement, or based on a recommendation from an outside observer. It might first be proposed by an advocacy organization or mental health administrator, or it might be the brainchild of a judge, defense attorney, or drug court coordinator. No matter who first proposes the idea, a diverse group of stakeholders must determine whether a mental health court makes sense in a particular jurisdiction. Policymakers and practitioners affected by the overrepresentation of people with mental illnesses in the criminal justice system should be engaged in a conversation about this problem and the ways in which a mental health court may or may not resolve it.

INVOLVING KEY STAKEHOLDERS

The forum for discussing a mental health court should include input from the many officials and agencies whose participation and support will be essential to the success of the court. The venue for such discussions will vary widely. Some communities have formed criminal justice coordinating councils or commissions, which often involve representatives of mental health, substance abuse, housing, and other social service agencies.

EXAMPLE: Anchorage Court Coordinated Research Project (Alaska)

The Anchorage CRP (the official title for the specialized mental health docket in that jurisdiction) emerged as a recommendation from the 1997 Alaska Criminal Justice Assessment Commission. The Commission was established by the National Institute of Corrections' Criminal Justice System Project. Through that commission, representatives from the Alaska Department of Corrections, the Alaska Department of Health and Social Services, and the Alaska Court System, along with members of other agencies, participated in a statewide cross-systems effort to develop more cost-effective and cooperative systems of criminal justice sanctions.[16]

In other jurisdictions, *ad hoc* or formal groups have been formed to respond to the diverse problems related to mental illness in the criminal justice system. Elsewhere, task forces have been established specifically to examine the possibility of launching a mental health court. If an appropriate vehicle is not already available, those interested in developing a mental health court should consider how to create one.

EXAMPLE: Summit County Criminal Justice Forum (Ohio)

In 2000, in response to a recommendation from the National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System, stakeholders in Summit County, Ohio, formed a Criminal Justice Forum. The forum comprises representatives from criminal justice, mental health, and substance abuse treatment agencies and includes working groups to investigate specific issues including training, reentry, cross-systems communication, and the viability of a mental health court. The mental health court working group spawned the Akron Municipal Mental Health Court. The forum now meets quarterly to decide on major priorities, hear reports from working groups, and ensure communication among participating agencies.

Though the initial push for a mental health court may come from a variety of sources, the ensuing discussions are likely to be most effective if convened and overseen by a judge. Judges carry with them the neutrality of the court in the criminal process and they are well-positioned to moderate discussions between parties (prosecutors, defense attorneys, mental health providers, advocacy organizations, etc.) with different priorities and attitudes toward a mental health court and its appropriate organization. Just as importantly, if a respected judge convenes a meeting to explore the potential for a mental health court, other stakeholders, regardless of their opinions about such a strategy, are more likely to attend.

EXAMPLE: King County District Court Mental Health Court (Washington)

In response to the murder of a Fire Department Captain by a person with a mental illness, the King County chief executive formed a task force to examine the involvement of people with mental illnesses in the criminal justice system. The "Mentally Ill Offenders Task Force" was chaired by the former chief justice of the Washington State Supreme Court and made numerous recommendations, one of which called for the establishment of a pilot mental health court.

> "When I was a public defender trying to address this problem, I called a meeting of all the key stakeholders, and no one came. When I became a judge I called the same meeting. Everyone was five minutes early."
>
> **Judge Steven Leifman,** Associate Administrative Judge, Miami-Dade County, Florida, 11th Judicial Circuit

Ideally, the presiding or chief judge chairs such an effort. If not, the judge who takes the lead should seek to gain the support of the chief or presiding judge and, if possible, the full bench. For some chief judges, mental health courts (or any specialized docket) may not be viable, and putting significant effort into examining the potential for a mental health court could be a waste of energy. Even when a chief judge is receptive to specialized dockets, a mental health court has implications for staffing, case scheduling, and resource allocation. Garnering the support of the chief judge for initial discussions helps ensure that these issues are considered early and are ultimately incorporated into the proposal to implement a mental health court.

The key stakeholders who should be involved in any discussions about launching a mental health court include:

- Judges
- Prosecutors
- Defense counsel
- Probation
- Court administrators
- Jail administrators
- Jail medical and mental health staff
- Pretrial services
- Community mental health treatment providers
- Community substance abuse treatment providers
- Consumers

- Law enforcement officials
- Crime victims and advocates
- Family members and advocates for people with mental illnesses
- Housing providers/shelters
- Emergency room (psychological and medical) administrators
- Public guardians/conservators
- Adult protective services

SYSTEMS MAPPING

The group tasked with discussing the advantages and disadvantages of a mental health court should not begin by simply weighing the viability of a specialized docket. Rather, it should identify and assess the problems that occur when people with mental illnesses enter the criminal justice system and discuss the merits of a variety of strategies for resolving these problems. Depending on the nature of the problems identified, a mental health court may not be the best, and certainly not the only, way to address them.

To guide the initial discussions, the committee should examine, step-by-step, how people with mental illnesses are processed through the criminal justice system, a method referred to by some as "systems mapping."[17] What happens when police respond to a call involving a person with mental illness? What options are available to the officer besides jail? When these arrestees enter the court, what approach is taken by the judiciary, the defense counsel, and the prosecutor? At the defendant's first appearance in court, what resources are available to the judicial officer if the defendant's mental health is in question? The committee should examine each step in the system, from arrest to re-entry into society. At each step, the committee should ask the following questions:

- What decision is being made, and how does it affect people with mental illness?
- Who makes the decision?
- What information is available to the decision maker?
- What options are available to the decision maker?
- Are the available information and options sufficient to make the best possible decision?

The Criminal Justice / Mental Health Consensus Project Report can help guide this process. The report identifies 23 decision points on the criminal justice continuum and provides a policy statement about how the response to people with mental illnesses could be improved at each point, along with recommendations for implementing the policy statement. (See flowchart on following page.) Recognizing that each jurisdiction is organized differently, the report does not propose specific programmatic models, but rather suggests overarching strategies for making informed decisions regarding people with mental illnesses in the criminal justice system. Some jurisdictions have used the report's policy statements as a tool for evaluating their current systems and for devising strategies for moving forward.

EXAMPLE: **Jefferson County Criminal Justice Strategic Planning Committee (Colorado)**
The Jefferson County Criminal Justice Strategic Planning Committee, formed in 1995, established a Criminal Justice / Mental Health Subcommittee in 2003. The subcommittee used the policy statements of the Consensus Project Report to analyze the movement of people with mental illnesses through the Jefferson County criminal justice system. The subcommittee identified local strengths and weaknesses related to each policy statement, and assigned priorities for the coming year.

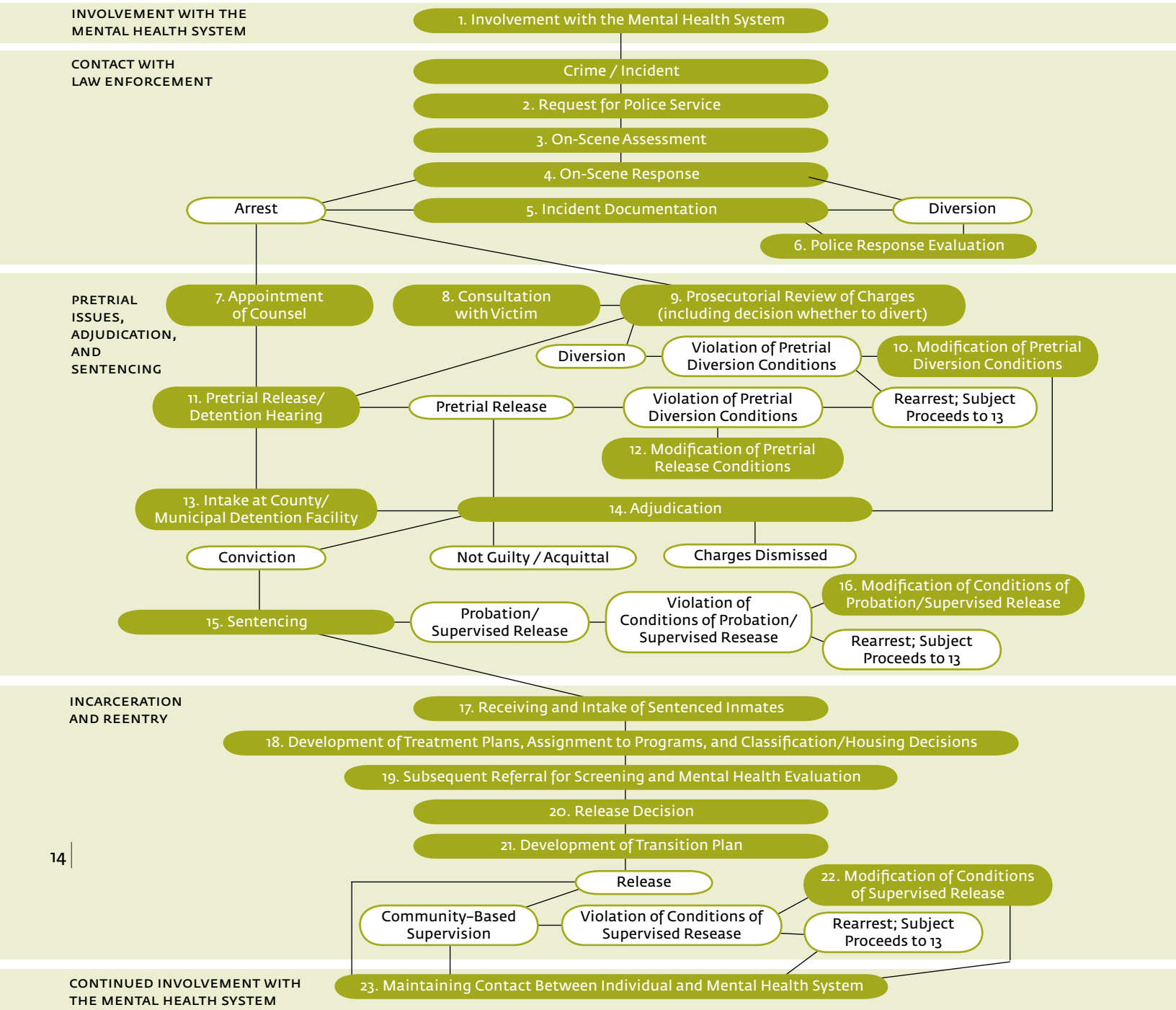
Another useful framework for this discussion is the "sequential intercept model," developed by consultants from the GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.[18] (See diagram on page 15.) This model proposes five points on the criminal justice continuum at which people with severe mental illnesses and co-occurring disorders can be "intercepted":

1. Law Enforcement/Emergency Services
2. Initial Detention/Initial Court Hearings
3. Jails, Courts, Forensic Evaluations, and Hospitalization
4. Re-entry
5. Community Corrections and Community Support

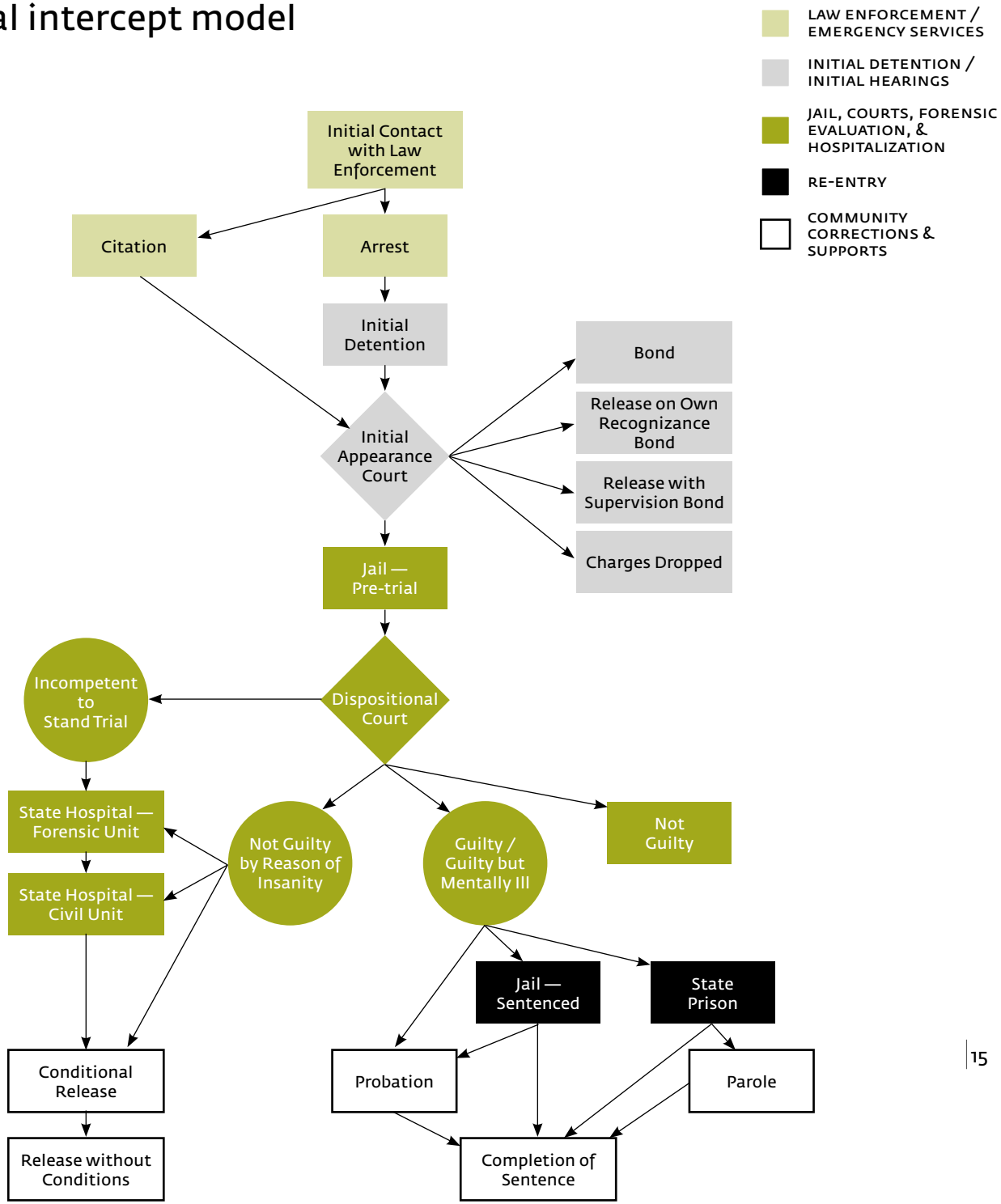
The model suggests that at each intercept point, procedures should be developed to ensure:

- Prompt access to treatment
- Opportunities for diversion
- Timely movement through the criminal justice system
- Linkage to community treatment providers

a person with mental illness in the criminal justice system: a flowchart of select events



sequential intercept model



Obviously, the first three intercept points are most relevant to the mental health court discussion. But the broader point is that discussions concerning the viability of a mental health court should also consider the movement of people with mental illnesses throughout the entire criminal justice system. The many strategies jurisdictions employ at the different "decision" or "intercept" points have been documented elsewhere and are beyond the scope of this guide.*

*For more information on strategies for responding to people with mental illnesses in the criminal justice system (aside from mental health courts), interested readers should consult the Consensus Project Report, the Consensus Project Web site (www.consensusproject.org), or contact the GAINS Center for Evidence-Based Practices (www.gainsctr.com) and the TAPA Center for Jail Diversion (www.tapacenter.org), a branch of the GAINS Center.

COLLECTING AND USING DATA

In addition to a map of system flow, the discussion about whether to launch a mental health court should be informed by as much hard data as possible. These data must go beyond experience, anecdotes, or "best guess" estimates. While estimates can be helpful in understanding how the criminal justice and mental health systems function generally, they are often distorted by the estimator's own perceptions and should not be relied upon when planning systemic change. Instead, deliberations about how to better respond to people with mental illnesses in the criminal justice system should be based on accurate statistics compiled from a variety of sources.

Generating local data is critical for two reasons. First, planning efforts, no matter the scope, must be driven by the imperatives of the local population. For example, policymakers may be interested in reducing the number of misdemeanants with mental illnesses housed in the jail. Before developing an intervention to accomplish this goal, the dimensions of the problem must be fully analyzed: how many misdemeanants are in the jail on any given day? What is their average length of stay? What proportion of these inmates have mental illnesses and how does their average length of stay differ? Such an analysis may reveal that, contrary to general perceptions, the vast majority of inmates with mental illnesses are booked on felony charges. If the planning committee bypassed the data collection and analysis phase, the resulting intervention would likely fall short of the desired impact.

Second, collecting relevant data at the outset of program planning is the only way to evaluate the impact of the changes resulting from the intervention. Without accepted baseline data, decision makers cannot assess whether a program or policy change accomplished its intended goals.

Collecting data on people with mental illnesses in the criminal justice system can be extremely difficult. Data on this population is maintained by multiple agencies in both systems. Even within particular agencies, information technology may be

outdated or ill-equipped to provide specific information related to people with mental illnesses who become involved in the criminal justice system. Because of these obstacles, sufficient data may not be available to answer the full range of questions that a planning committee would want to consider. For example, the jail may track the number of inmates receiving psychotropic medication, but may not have aggregate data on inmate diagnoses. Ultimately, data-driven answers to a more limited set of questions are preferable to anecdotal responses to a broader range of questions.

useful data for planning purposes

The following statistics will be useful for jurisdictions considering the development of a mental health court. Because the availability of data varies widely across jurisdictions, jurisdictions should focus on data that is already available, or relatively easy to obtain.

- Percentage of law enforcement calls for service that involve an individual with mental illness
- Dispositions of law enforcement calls for service involving people with mental illnesses (e.g., how many are arrested, taken to the emergency room, diverted to other community resources?)
- Percentage of current jail inmates with mental illnesses
- Percentage of jail inmates with mental illnesses in past years
- Percentage of jail inmates receiving mental health treatment or psychotropic medications in jail
- Percentage of jail inmates with mental illnesses who have been involved in treatment
- Specific diagnoses of jail inmates receiving mental health treatment or psychotropic medications in jail
- Average length of stay for inmates with mental illnesses compared to that of the general population
- Types of charges of jail inmates with mental illnesses compared to those of the general population (e.g., what percentage are felony or misdemeanor, violent or non-violent)
- Percentage of all current jail inmates who have five or more prior bookings
- Percentage of jail inmates with mental illnesses who have five or more prior bookings
- Costs resulting from the 25 to 50 heaviest users of jail, detoxification, psychiatric hospital, emergency room, and community-based mental health services
- Average length of time required for competency evaluations

OVERCOMING DIFFERENCES

Representatives of the criminal justice and behavioral health systems often speak different languages, but the gaps between these systems are more than linguistic. They may also have different (and sometimes opposing) goals, methods, and underlying assumptions. In fact, even within each system, different actors have diverse and sometimes competing priorities. Within the criminal justice system, prosecutors are charged with public safety, defense counsel protect the rights and interests of their clients, judges are responsible for maintaining the fairness of the court process, and probation officers must ensure compliance with release conditions. These players have different interests to protect when contemplating the role of a mental health court and its impact on their responsibilities.

Any substantial, cross-system dialogue must provide an opportunity to uncover and discuss these differing perspectives. Representatives from both systems should be offered the opportunity to explain their duties, clients, funding mechanisms, agency goals, and core concerns with regard to people with mental illnesses who become involved in the criminal justice system. During this process, assumptions, stereotypes, and personal beliefs about the target population can be discussed and, in some instances, corrected. Though these discussions may seem off-topic or unproductive, they can lead to common ground on which to begin deliberations about starting a

how much does a mental health court cost?

The question of cost will be an important factor for many jurisdictions considering a mental health court. As with all aspects of mental health courts, the answer to this question varies, depending on the design of the court and the available community resources. Some courts have been started with no new resources, literally run during lunch hours or after other court business has been concluded. Others have required the development of one or multiple new staff positions, and have apportioned resources to purchase treatment services for court participants. The question of cost is further complicated by the lack of concrete information about cost savings or shifting. While the potential for mental health courts to improve treatment engagement and reduce criminal justice involvement suggests that they will result in a net savings, current data is equivocal, and savings may not be realized to the agency that absorbs the cost of operating the court. Determining how much a mental health court would cost requires the consideration of different program designs, identification of available staff resources, evaluation of community treatment capacity, investigation of potential new funding sources, and a host of other issues.

> "The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illnesses is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system."
>
> Criminal Justice/Mental Health Consensus Project Report

mental health court. Without a collaborative and cooperative foundation in which participants feel free to express their views, the success of a mental health court—or any initiative in this area—is in jeopardy before it starts.

Of course, wide-ranging discussions about people with mental illnesses who become involved in the criminal justice system can be difficult and exhausting. A comprehensive analysis of the system's components can expose a plethora of issues, not all of which can be addressed at once. Collecting data can be time consuming and frustrating. At some point, priorities must be set, direction must be established, and action must be taken. Among others, a community should try to answer the following questions before moving ahead:

1. Where on the criminal justice continuum will the community focus?

As discussed above, there are numerous points (or intercepts) on the criminal justice continuum at which the response to people with mental illnesses can be improved. Addressing each of these points should be a long-term goal for any community, but targeting the entire criminal justice process simultaneously can overwhelm even the most organized collaborative effort. A limited number of priorities should be identified for initial action. If the priorities include improving the way in which people with mental illnesses are processed through the courts, launching a mental health court may be appropriate. But after substantial discussion, a jurisdiction may choose instead to focus on issues related to law enforcement, jail booking, jail reentry, or other decision points, and postpone considering the viability of a mental health court.

2. If the focus is on a court-based intervention, is a specialized docket the right strategy?

Many communities have decided to improve their court system's response to people with mental illnesses without starting a mental health court. Their reasons for eschewing mental health courts varied. Some communities felt that judicial resources were insufficient to devote time to a specialized court. Others were doubtful that a mental health court would result in better outcomes. Still others had concerns about establishing a specialized docket based on people's mental conditions rather than the types of crimes they committed. Nevertheless, these communities sought to infuse many of the core principles of mental health courts—early identification of defendants with mental illnesses, treatment in lieu of incarceration, and monitoring or community treatment—into their traditional court processes.

For example, a recent monograph—*Non-specialty First Appearance Court Models for Diverting Persons with Mental Illness*—profiled twelve jurisdictions that have incorporated screening for mental illness into their pretrial release decision-making process, providing information about a defendant's mental illness, pretrial release recommendations, and needed treatment services to judicial officers at the first appearance in court.[19] Other jurisdictions have established programs to divert people with mental illnesses at subsequent points in the criminal justice process without establishing a separate docket to streamline that process and supervise people while they are in the community.

These examples are not intended to suggest that other strategies are more or less effective than a mental health court. In fact, research in this area is at such an early stage that arguing convincingly for or against a specialized mental health court based on outcomes is nearly impossible. These examples are offered simply as a reminder that a variety of options, including, but not limited to, a mental health court, are available to improve the response of the courts to people with mental illnesses.*

3. Is a mental health court the only court-based strategy that will be employed?

Establishing a mental health court is a serious endeavor requiring collaboration among numerous entities. Nevertheless, a mental health court will serve only a fraction of the people with mental illnesses who become involved in the court system. Prior to launching a mental health court, communities should discuss other court-based strategies that might be employed, either immediately or later on, to address other aspects of this systemic problem.

*Jurisdictions interested in strategies other than mental health courts should contact the Consensus Project (www.consensusproject.org/212-482-2320) or the GAINS Center for Evidence Based Practices and the TAPA Center for Jail Diversion (www.gainsctr.com/800-311-GAIN).

For jurisdictions that undertake the difficult process of cross-system dialogue and determine that a mental health court fits their needs and goals, the remainder of this guide provides direction for the numerous and difficult issues they will need to resolve.



Considering Elements of Mental Health Court Design and Implementation

LIKE DECIDING TO ESTABLISH A MENTAL HEALTH COURT in the first place, designing a mental health court requires considering complex issues and soliciting input from a diverse group of stakeholders. While each mental health court must be adapted to local concerns and imperatives, there is much to be learned from the experiences of other jurisdictions. Based on the structure and operation of existing courts and the substantial literature that has accompanied their development, this guide identifies ten elements of mental health court design and implementation and offers guidance on addressing each of them.

elements explained

This list of elements is inspired by "Defining Drug Courts: 10 Key Components," published by the National Association of Drug Court Professionals, but should not be considered a direct counterpart to that document. The initial list of elements was developed by CSG and presented at the BJA Mental Health Court Program conference in January 2004. The list was then revised based on commentary from conference attendees. During 2005-2006, CSG plans to coordinate a process to determine which of these elements should be considered essential to a mental health court program, and to establish benchmarks by which the presence of these elements can be measured.

The intent is not to suggest that a mental health court should be designed or operated in a particular way, but rather that these issues should be considered before the mental health court is established and should be revisited throughout its operation.

When designing a mental health court, communities should rely on a planning and implementation model similar to the one recommended for deliberating whether to launch one. Discussions should include all the people and agencies that will be involved in or affected by the operation of the court, including:

- Judges
- Prosecutors
- Defense counsel
- Probation officers
- Jail administrators
- Jail medical and mental health staff
- Pretrial services
- Mental health providers
- Substance abuse treatment providers
- Consumers
- Law enforcement officials
- Crime victims and advocates
- Family members and advocates for people with mental illnesses
- Housing providers/shelters
- Emergency room (psychological and medical) administrators
- Public guardians/conservators
- Adult protective services

To facilitate cross-system dialogue, many communities have formed a mental health court task force, either as a subcommittee of a larger group or as a stand-alone body. Relying on a task force helps ensure a program design that reflects the input of all stakeholders. Furthermore, such a group can help monitor the progress of the court program and inform strategic decision-making as it moves forward. Whatever the mechanism, the planning and oversight for the court should mirror the interdisciplinary, cross-system nature of its operation.

Of course, even after careful and comprehensive planning, the court's operation will uncover additional complexities. A successful mental health court requires more

than just a thoughtful design; it demands effective leadership, dedicated court staff, and a willingness to continually reexamine the functioning of the court. For this reason, the elements described below can be used not only to steer the planning process, but also to guide periodic reviews of the design of the court.

Elements of Mental Health Court Design and Implementation

1. Goals
2. Target Population
3. Confidentiality
4. Terms of Participation
5. Informed and Voluntary Choice
6. Participant Identification
7. Integration of Treatment and Community Supports
8. The Court Team
9. Monitoring Adherence to Court Conditions
10. Sustainability

determining the need for changes in law or policy

Many mental health courts have been successfully implemented with no explicit law, rule, or policy changes. Some mental health court planning groups discover, however, that a change in law or court policy is required to launch a mental health court in their jurisdiction. Such changes may be necessary in order to identify a lead agency responsible for the court's operation, transfer jurisdiction to the specialized docket, define eligibility for the court, gain legislative or policymaker interest in the pilot program, or gain formal approval from the court administrator or chief judge. Planning groups should familiarize themselves with relevant state statutes and court administrative procedures and, once a basic program has been designed, identify any changes that should be proposed.

EXAMPLE: **Oklahoma 22 O.S. § 472**[20]

The "Anna McBride Act" of 2002 permitted any district or municipal court to establish a mental health court pilot program subject to the availability of funds. The Department of Mental Health and Substance Abuse Services was named the primary agency to assist in program development; eligible charges and criminal history were outlined and the district attorney's office was given discretion over defendant participation.

New Hampshire: Senate Bill 435, 2002[21]

New Hampshire Senate Bill 435 ordered the establishment of a mental health court in the Keene District Court to serve misdemeanor offenders, and provided for a legislative oversight committee to study the program and make recommendations on its continuation, funding, and expansion to other counties.

I. GOALS

The broad goal of all problem-solving courts, including mental health courts, is to address the issues underlying people's repeat contacts with the criminal justice system so they will not return, or not return as frequently. Such an overarching goal provides important context, but it is not sufficient to guide the operation and measure the impact of a mental health court program. The stakeholders involved in planning a mental health court should agree on a limited number of specific goals that are both realistic and measurable.*

In general, goals for mental health courts can be grouped into the following categories: 1) Increased public safety; 2) increased treatment engagement; 3) improved quality of life; and 4) more effective use of resources. Within each category, jurisdictions should determine the precise goals for their courts, clearly specifying how progress toward those goals will be assessed. In doing so, court planners should consider the following issues:

*For more on measuring the impact of a mental health court, readers should review *A Guide to Collecting Mental Health Court Outcome Data*, a companion piece to this guide.

Increased public safety

Mental health courts have the potential to positively impact public safety by reducing criminal justice involvement among program participants, which means fewer crime victims in the community. Mental health court planners should remember that many participants will have extensive criminal histories and complicating social factors (e.g., homelessness, poverty, lack of family connections), along with chronic and potentially disabling mental health conditions. A mental health court cannot solve these numerous problems by itself, and eradicating all future criminal justice involvement for program participants is not a realistic goal. Rather, mental health courts should, for example, pursue incremental reductions in the number of law enforcement contacts, jail days, probation violations, or new charges for program participants.

While mental health court planners will naturally focus on the period of court supervision, they should also set goals for when supervision ends. If the mental health court cannot reduce criminal justice involvement for participants once the oversight of the court is stopped, important questions will (and should) be raised about the ultimate value of the intervention.

Increased treatment engagement

Many mental health court participants have long histories of inconsistent treatment engagement. They may have experienced repeated crises and have, at some point,

been hospitalized involuntarily. For too many consumers, especially those who become involved in the criminal justice system, treatment has not been a positive experience. Likewise, mental health providers may view them as their most difficult-to-serve clients, and see them as unmotivated or beyond help. For this reason, most mental health courts identify improved consumer engagement as a primary goal.

At times, treatment engagement is equated solely with medication adherence, but mental health courts should consider a wider range of treatment issues when setting goals. For example, goals related to the venue for receiving treatment (e.g., emergency facilities vs. outpatient clinics), the types of treatment provided (e.g., integrated treatment for co-occurring substance abuse disorders), and the level of consumer satisfaction all offer a more powerful assessment of the court's impact on treatment engagement. Further, the extent to which engagement is maintained beyond the period of supervision provides a measure of the court's ability to effect long-term change.

Improved quality of life

At its heart, a mental health court is designed to improve the lives of its participants. Engaging in treatment and avoiding criminal justice contact are usually correlated with such improvements, but mental health courts should also consider establishing other goals related to quality of life. Along with self-perceived quality of life, measures of stable housing, family and peer relationships, employment and education status, drug and alcohol use, and victimization are also important indicators of the extent to which mental health court participation has brought about tangible changes in its participants' daily lives. Quality of life is also affected by the extent to which participants are able to manage the symptoms of their mental illnesses and any physical ailments. Given the racial and ethnic diversity of mental health court participants, mental health courts should employ culturally sensitive and bias-free instruments when measuring progress.

More effective use of resources

Many mental health courts cite cost savings as one of the central objectives of the court, and a key justification for long-term funding. While the goal of making better use of limited criminal justice and mental health resources is laudable, mental health courts should be careful about establishing cost-related goals. Cost data are very difficult to gather correctly, and some studies suggest that mental health courts and related programs result in an initial net cost increase and that savings may not be

realized for several years.[22] In addition, even if "per-person" savings are realized and can be tracked successfully, these savings may not actually accrue to any particular agency. For example, although a mental health court may reduce the consumption of jail bed days for its participants, the overall cost of operating the jail will remain the same. Accordingly, caution is warranted when making promises about decreased expenditures resulting from the mental health court.

This should not dissuade mental health courts from setting goals related to resource use. In addition to their chronic entanglement with the criminal justice system, many mental health court participants cycle repeatedly through other social service systems (psychiatric hospitals, detoxification facilities, emergency rooms) and may fit the profile of "high utilizers" described in the sidebar below. Reducing the consumption of these limited resources among program participants is both realistic and measurable. For example, courts such as Anchorage, Alaska, have demonstrated reduced consumption of jail and hospital bed days among program participants.[23] Mental health courts should consider the specific resources they hope to impact and devise systems by which the use of these resources by court participants can be monitored.

Producing substantial reductions in jail overcrowding is another goal that mental health court planners should be wary of adopting. Compared to the number of inmates admitted to a local jail, the number of participants accepted by mental health courts is relatively small; thus, the decreased utilization of jail resources by court participants is not likely to have a measurable impact on the overall jail census. However, jail inmates with mental illnesses require significant staff resources to manage, protect from harm, and treat, and the cost of providing psychotropic medications can

tracking service usage of "high utilizers"

Several jurisdictions have collected data on the group of people with mental illnesses who cycle repeatedly through the criminal justice and other social service systems. During 2000, King County, Washington spent more than $1.1 million on mental health treatment, drug and alcohol acute services, and criminal justice resources for just 20 people. In Summit County, Ohio, during 2001, services for a similar group of 20 people cost taxpayers $1.3 million. These calculations included neither the time invested by law enforcement or the court, nor the costs of transportation to different facilities. Perhaps most disturbing, despite these considerable expenditures, the level of functioning and quality of life did not improve for the majority of these people.[24]

be staggering. For these reasons, preventing the return to jail of only a few mental health court participants could be very significant to the jail administrator.

EXAMPLE: King County Mental Health Court

The King County Mental Health Task Force outlined the following goals for its mental health court:[25]

1. Reduce the number of future criminal justice contacts among offenders with mental illnesses;
2. Reduce the inappropriate institutionalization of people with mental illnesses;
3. Improve the mental health and well-being of defendants who come in contact with the Mental Health Court;
4. Improve linkages between the criminal justice system and the mental health system;
5. Expedite case processing;
6. Protect public safety;
7. Establish linkages with other County agencies and programs that target people with mental illnesses in order to maximize the delivery of services.

Jurisdictions seeking to establish a mental health court should give great care to the wording of their goals for the court.* Clearly identified goals become the benchmarks against which the court's effectiveness can be measured. Not only must the goals be both realistic and measurable, but the processes for obtaining or tracking the necessary data should also be developed and implemented along with the court's operation. (For more on data collection in mental health courts, readers should consult the *Guide to Collecting Mental Health Court Outcome Data,* a companion to this guide.)

***The process of** mental health court goal setting can be easily adapted to other interventions for people with serious mental illnesses in the courts, not just those involving a specialized docket.

2. TARGET POPULATION

Most existing mental health courts have established basic eligibility criteria across four main categories: current charges, violence, diagnosis, and prior criminal record. The target population for mental health courts must be carefully defined; the court's inherent specialization requires a focus on a subset of defendants with mental illnesses who come through the court system. Communities should be judicious in determining the segment of the population likely to be best served by this limited resource.

Setting eligibility criteria raises important political, ethical, and operational issues. For example, stakeholders may disagree vehemently about the types of charges to authorize for admission. Likewise, only defendants with certain diagnoses will be

eligible. The choice of eligible diagnoses will, in turn, determine the types of treatment resources the court will need to secure. The process of selection also involves exclusion, leading to ethical questions about who may not have access to treatment. Mental health court planners must wrestle with the consequences, implications, and trade-offs of these important decisions.

Current charges

There are two major components of criminal charges that most mental health courts consider in their criteria for eligibility: the severity of the charge and the relationship to a person's mental illness. The second of these components is difficult to determine. There is no recognized measure to assess the degree to which an alleged offense was "caused by" a person's illness, and courts vary widely in how they apply this standard, if at all. Those that do require some link between a defendant's illness and charge should rely on the input of a mental health professional to determine whether the type of behavior with which the defendant is charged could be related to his or her diagnosis.

Many of the earliest mental health courts denied admission to people charged with felonies, often in response to public safety concerns from judges or prosecutors. Since mental health courts are a form of diversion from traditional criminal justice processing, prosecutors, judges, and victim advocates, among others, may be concerned that allowing people to participate in treatment in lieu of incarceration may jeopardize public safety, or send the wrong message about offender accountability.

EXAMPLE: Jackson County Mental Health Court (Missouri)

Because of public safety concerns and the high volume of low-level offenders with mental illnesses, the planning commission for the Jackson County Mental Health Court decided to target people charged with misdemeanors, particularly ordinance violations such as trespassing and public urination. Many court participants have a history of multiple misdemeanor offenses, though first-time offenders are eligible. The only participants charged with felonies are referred from the local drug court. The mental health court currently operates in two municipal court systems within the county, and is considering expansion into several more.

On the other hand, recent research suggests that mental health courts are increasingly accepting defendants charged with felonies. A 2002 study of eight mental health courts found that seven focused on defendants charged with misdemeanors, and only two accepted felony defendants.[26] When these courts were surveyed again two years later, all but two accepted defendants with felony charges.[27] In addition, in a recent study of seven mental health courts (all of which received grants from the

Bureau of Justice Assistance), all seven accepted felony-level defendants, and three dealt exclusively with defendants charged with felonies.[28]

> **EXAMPLE: Monroe County Mental Health Court (New York)**
> The majority of the participants accepted into the Monroe County Mental Health Court are charged with felonies. A defendant charged with a misdemeanor may be accepted if his or her original felony charge was subsequently reduced to a misdemeanor or if he or she has a history of felony charges. The decision to focus on defendants charged with felonies ensured the buy-in of the public defender and allowed for the development of a longer program duration, which court planners felt would improve the likelihood of effective treatment.

The reasons underlying the shift toward accepting those charged with felonies are not certain, and this guide does not recommend that new courts follow this trend blindly. But mental health court planners should recognize that, in developing their target population, the line between misdemeanors and felonies can be blurry. While many people who commit felonies do so after committing a series of misdemeanors, many misdemeanants may also have prior felony convictions. Furthermore, the considerable discretion in charging decisions means that similar offenses can end up in different charge categories depending on the circumstances of the case. From the treatment perspective, a person with schizophrenia who commits a misdemeanor and a person with schizophrenia who commits a felony have the same disorder and will likely have similar treatment needs.

Upon close analysis, the decision about whether to accept defendants charged with misdemeanors, felonies, or both has little to do with a particular individual's likelihood of success in mental health court. Rather, charge-related eligibility criteria amount to political and strategic decisions that should be assessed periodically for their effect on the court's ability to achieve its goals. Along this line, there are several issues related to the question of charges that warrant further consideration.

First, as discussed in Step II: Determining if a Mental Health Court is Appropriate, mental health courts should be only one of a variety of strategies employed to address the overrepresentation of people with mental illnesses in the criminal justice system. Interventions occurring earlier on the criminal justice continuum—such as police-based diversion programs or diversion mechanisms that do not include ongoing judicial supervision—could serve offenders who commit less serious crimes, thus making the mental health court more appropriate for felony offenders.

Second, potential reductions in the number of jail days consumed by court participants depend in large part on the seriousness of charges deemed eligible. A court accepting only defendants charged with misdemeanors, given their shorter sentences,

has less potential to demonstrate jail bed savings, particularly in states with presumptive sentences for felony crimes.

Third, people charged with misdemeanors may be less inclined to opt for mental health court participation, which is likely to extend for a significant time, in lieu of a jail sentence that is likely to be very short. For this reason, defense attorneys may advise clients charged with misdemeanors that the mental health court is not in their best interests.

Courts that do target defendants charged with misdemeanors should consider establishing treatment plans and other conditions that are the least restrictive as possible while still ensuring public safety. Highly restrictive conditions increase the likelihood that violations will be detected, which can intensify the involvement of participants in the criminal justice system as compared to the normal court process. This scenario would run counter to a core goal of mental health courts, which is to lessen criminal justice involvement for their participants. Research from the drug court context supports this concept: several studies suggest that lower-level offenders fare worse in programs that require more frequent status hearings and intensive supervision.[29]

Less restrictive conditions, when complemented by firm partnerships with treatment providers, also encourage participants to turn to the mental health system for support in times of crisis, thus lessening the likelihood of future criminal justice involvement. Lastly, having less restrictive conditions lessens the frequency of court hearings and other supervision requirements that may be sources of considerable stress for participants.

Along with decisions about the severity of the charge, mental health court planners must also consider whether they will accept people who have already been sentenced in another courtroom or court program. For example, some mental health

matching charges to court jurisdiction

The decision of which charges to accept will affect the court system in which the mental health court can be established. In most communities, a limited jurisdiction court based in a single county or municipality deals with misdemeanors (and sometimes ordinance violations) only, and a general jurisdiction court that may involve multiple counties takes all felony cases. Several mental health courts have decided to accept defendants charged with both felonies and misdemeanors and, as a result, have established two separate dockets in two separate court systems to account for jurisdictional limitations.

courts accept offenders who have violated the terms of their probation and are referred by a judge or probation officer who believes the probationer may benefit from the involvement of the judge and regular status hearings.

EXAMPLE: Mental Health Probation Violation Court (Maricopa County, Arizona)

The Mental Health Probation Violation Court in Maricopa County, Arizona, targets people on the specialized mental health probation caseload. A probationer can be brought before the court after a violation, or if their probation officer determines them to be at risk of violation. If the probationer admits to a violation, he or she can be terminated and returned to the Department of Corrections, but in most cases the probationer is sanctioned and then remains on probation. Thereafter the court works with the probationer, probation officer, and treatment providers to determine the obstacles to successful adherence to court conditions. Participants return for status hearings at which sanctions and incentives are applied until the difficulties that brought them before the court are resolved, after which they resume their probation. In this way, the program serves as an alternative response to probation violations that usually avoids re-incarceration, thus saving costly prison beds and helping maintain continuity of treatment and community tenure for probationers with mental illnesses.

Violence

Most mental health courts exclude people charged with violent offenses or who are charged with driving while intoxicated. Of the 37 BJA grantee courts, more than 75 percent automatically deny admission to those charged with violent offenses, while the other 25 percent consider defendants with violent charges on a case-by-case basis.[32] The reasons for these exclusions are obvious: diverting people who have committed violent offenses from jail to the community is a public safety risk few court officials are willing to accept.

mental illnesses and violence

Many popular beliefs about violence and mental illness are not based in fact. Recently, several large-scale research projects found only a weak statistical association between mental disorders and violence. Serious violence by people with major mental disorders is concentrated in a small fraction of the total population, particularly among those who use alcohol and other drugs and those without access to effective services.[30] The vast majority of people with mental illnesses are not violent; in fact, they are more likely to be victims than perpetrators.[31] Because the majority (75 percent) of defendants with mental illnesses have co-occurring substance abuse disorders, this research makes clear the necessity of making effective substance abuse treatment a priority for mental health court participants.

Some charges involving violence may, however, be more complicated than they first appear. For example, some cases of assault on police officers by people with mental illnesses may result from officers' lack of awareness about mental illnesses or insufficient training to properly deescalate a situation. In these instances, a trespassing violation can quickly deteriorate into a shoving match, and a charge involving violence.[33] Similarly, domestic violence cases involving defendants with mental illnesses can result from minimal behaviors like pushing, shoving, and agitation against parents, siblings, caretakers, or co-residents in housing facilities. These cases differ significantly from the documented cycle and endemic risk factors of ongoing spousal domestic violence. Mental health courts should consider potential participants based on the facts and circumstances underlying the charges to account for these situations.

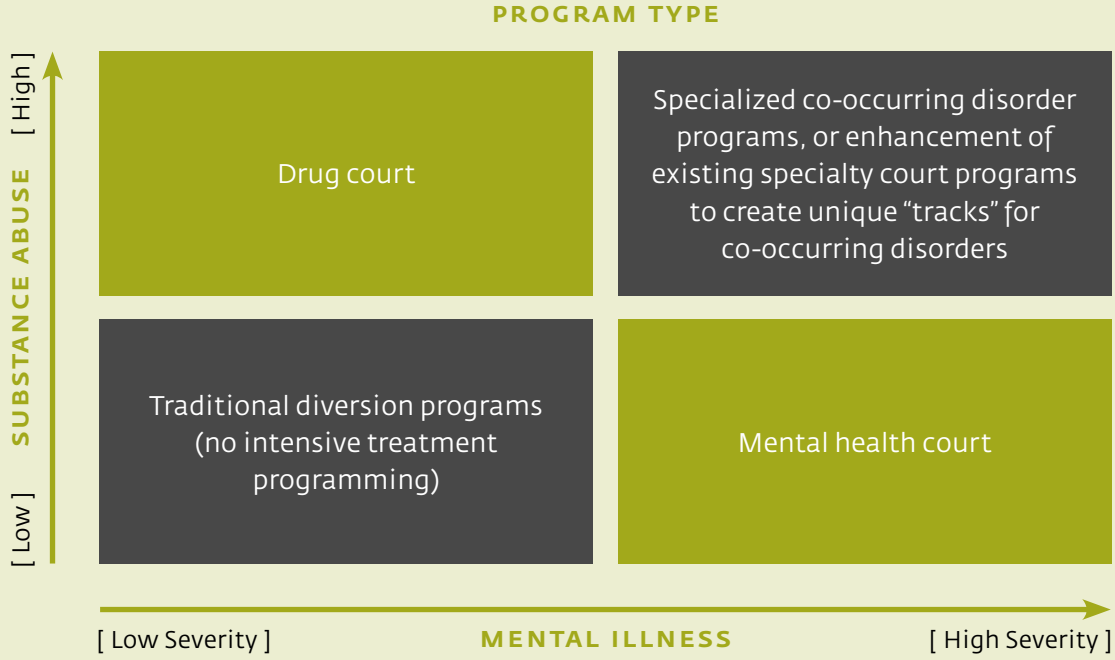
Diagnosis

Diagnosis-related eligibility criteria should be established in consultation with mental health treatment providers, giving careful consideration to the community's capacity for treatment and the most effective use of existing resources. As with criteria related to charges and violence, diagnosis-related eligibility criteria vary widely across mental health courts. Of the 37 BJA grantee courts, more than half have very specific criteria, such as requiring an Axis I diagnosis, "serious and persistent mental illness" as defined by state law, or an Axis I and co-occurring substance abuse disorder. The other courts have much broader criteria and include defendants with brain injuries, developmental disabilities, and less serious mental illnesses.

Decisions related to eligible diagnoses will have perhaps the greatest impact on the success of court participants. As discussed later in this guide, the key intervention provided by mental health courts is not identifying and processing defendants, but connecting them to treatment. Accordingly, whichever diagnoses the court decides to include, it must consider whether the corresponding treatment is available in the community, and how that treatment will be accessed. When discussing the complex issues related to the different types of mental illness and how they are treated, court officials should look to local mental health providers and administrators for guidance, and may also want to refer to *Navigating the Mental Health Maze: A Guide for Court Practitioners,* a companion to this guide.

coordination with drug courts

The prevalence of co-occurring psychiatric and substance abuse disorders suggests that mental health courts would be wise to consider mechanisms for coordinating with the local drug court. More than 1,100 drug courts operate across the country, and are present in most of the communities considering or operating a mental health court. Because of the significant overlap in the target populations for these related programs, mental health court planners should work with the administrators of their local drug court to ensure that all participants are connected to the most appropriate interventions. While there are no hard and fast rules for this coordination, a recent monograph on co-occurring disorders and specialty courts suggests that, in cases where criminal charges are not the deciding factor in court referral, people with more serious mental health problems (and less serious substance abuse problems) should be referred to mental health courts, and people with more serious substance abuse problems (and less serious mental health problems) should be referred to drug courts. Special programming should be developed for people with severe mental health and substance abuse disorders.[34]



Criminal history

Finally, a jurisdiction may want to limit eligibility based on criminal history. For example, many courts exclude defendants with prior convictions for violent crimes, even if the defendant's current offense is nonviolent. Screening out people previously convicted of sex offenses is also a common practice among existing mental health courts. While issues of community safety will always be primary considerations, other criminal record issues—such as failure to appear in court—may be directly related to a person's mental illness, and should not necessarily be cause for exclusion. Accordingly, many courts refuse to exclude defendants automatically based on criminal record information, choosing to determine eligibility on a case-by-case basis. Mental health court planners will also have to decide whether to accept cases involving graduates who have re-offended and whether to take post-sentence cases involving probation violations.

Criminal history can also be a reason for inclusion. Some courts specifically target defendants with extensive criminal records—the proverbial "revolving-door" defendants for whom traditional court processing appears to have been consistently ineffective.

> EXAMPLE: **Eighth Judicial District Mental Health Court (Clark County, Nevada)**
> In order to realize the greatest savings of criminal justice resources, the Eighth Judicial District Mental Health Court in Nevada targets defendants with at least five jail bookings in the previous five years. This strategy, along with the decision to include defendants charged with gross misdemeanors and felonies, allows the court to maximize the number of jail and prison beds for court participants.

With little comparative research on the impact of mental health courts on different types of defendants, courts will need to set criminal history-related eligibility criteria based on their established goals and the collective perception of how the court can have the greatest impact.

Setting eligibility criteria to establish a target population requires weighing the political climate of the jurisdiction, the available resources, and the specific objectives of the mental health court. This process leads to different results across communities. As one judge said, "Our philosophy is if someone has a mental illness, there's no such thing as 'inappropriate for mental health court.' Even if they're tough to deal with, locking them up is good for nobody."[35] But another jurisdiction has resolved to focus on certain kinds of defendants with mental illnesses. As the judge there put it, "We have to triage to determine who will do well in the program, who we can actually

juvenile mental health courts

Mental illness in the juvenile justice system is as prevalent, if not more so, than in the adult criminal justice system. Nearly two-thirds of boys and nearly three-quarters of girls in juvenile detention facilities have at least one psychiatric disorder, far exceeding the 15 percent among the general population.[36] Recently, this issue has received attention from Congressional lawmakers in the form of a report prepared for Rep. Henry Waxman (D-California) and Senator Susan Collins (R-Maine) titled, "Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States," which chronicles the trend of youth with serious mental disorders being detained without criminal charges, or being eligible for release but remaining in detention because of insufficient surface slots.[37]

Only a handful of jurisdictions (including Santa Clara, San Diego, and Los Angeles, California, and Cincinnati, Ohio) have adapted the mental health court concept to the juvenile justice system, so even less is known about their operation and effectiveness than is known about adult mental health courts. Juvenile mental health courts do appear to confront many of the same operational issues as those for adults, but because of their participants' status as minors, juvenile mental health courts must also address a separate range of issues, including:

- **Involving parents and guardians.** Juvenile mental health courts must focus even more than adult courts on developing services that address the psychosocial needs of the family, as well as those of the youth.[38]
- **Linking with the foster care system.** Upon arrest, children in foster care are more likely to be sent to juvenile detention centers than back home.[39] This can exacerbate mental health issues and result in a child's losing his place in the foster care or group home. Juvenile mental health courts may include child welfare representatives to protect the stability of the youth's living arrangement.
- **Reporting child abuse.** Many youth in the juvenile justice system have been neglected or physically or sexually abused. Mandatory reporting laws require that all social service professionals, including those in the mental health court, report a suspicion of child abuse to their state's child protective services agency.
- **Working with schools.** When a youth's mental illness interferes with her learning and ability to progress in the regular school curriculum, she may be eligible for special education services. These services can support court-ordered treatment by providing a structured environment that responds to the unique needs of each youth.[40]
- **Recognizing developmental issues.** Most youth with mental illnesses experience the same developmental issues as healthy adolescents. Juvenile mental health courts must design interventions in a manner that responds to these unique developmental needs.

help."[41] The ideals of inclusiveness and triage can often be at odds, and communities must resolve these and other conflicts as they solidify their courts' target populations.

3. CONFIDENTIALITY

Mental health court processes require that considerable information about participants be collected and shared at all points of the court process, from the initial screening to the eligibility determination and throughout the entire period of judicial supervision. The need to share information raises important and difficult concerns related to confidentiality, requiring mental health court planners to consult all relevant state and federal regulations. Within these statutory limits, participants' medical, mental health, and substance abuse treatment information must be safeguarded, and participants must be allowed to specify with whom information can be shared, all the while maximizing collaboration between agencies that are sharing information.

Any discussion of confidentiality issues immediately raises the specter of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects patients from the unauthorized release of their medical information. This law has created some confusion about what information can be exchanged within and across criminal justice and mental health settings, and has significant implications for mental health courts. Fully resolving this confusion is, unfortunately, beyond the scope of this guide. However, the safest way to comply with HIPAA requirements is to assure that mental health court participants provide their written consent to release information on a form that specifically identifies what information will be released and the parties to whom it will be released.

EXAMPLE: **Buffalo Mental Health Court (New York)**

Participants who enter the Buffalo Mental Health Court sign a series of releases of information for collecting medical and mental health information. The information included in those releases is then entered into a database that mental health court personnel can review. The database indicates which staff members are authorized to speak to which treatment providers, what kind of information can be shared, and the dates when releases expire. This process protects the participant's confidentiality by preventing inappropriate accidental communications between unauthorized court personnel and treatment providers. (A copy of this release form is in Appendix D.)

Courts can also address confidentiality issues by instituting rules for excluding clinical information from the public record of the court, or by simply allowing such information to be discussed only in sidebar or chamber conversations.

Information-sharing protocols should also take into account the potential impact of clinical information on the regular processing of defendants' criminal cases if they are not accepted into, or do not successfully complete, the mental health court program. Defense attorneys have an important role here; their position as client advocates should include concern for privileged information about their clients' mental health conditions.[42]

With such a large percentage of mental health court participants suffering from co-occurring substance abuse disorders, federal regulations related to substance abuse treatment information also deserve careful attention.* The relevant federal regulations for substance abuse treatment information are 290dd-2 of Title 42 of the United States Code, which applies to all drug treatment programs, and 42 C.F.R. § 2.20, which explains how federal and state laws interact when their confidentiality provisions differ. As with HIPAA, a defendant's written consent to the release of information can overcome most information-sharing restrictions in these federal regulations.

*For more information on the confidentiality of substance abuse treatment information, readers should consult "Federal Confidentiality Laws and How They Affect Drug Court Practitioners," available at http://www.ndci.org/admin/docs/confid.pdf. Much of the guidance in that document is directly applicable to mental health courts.

4. TERMS OF PARTICIPATION

Mental health court planners must consider a number of issues when establishing the terms of program participation, including the plea participants are required to enter, the duration of the program, the conditions of supervision, and the impact of program completion. These general terms should be adapted to the specific conditions of each defendant, who should have the opportunity to consider the terms with the advice of defense counsel before agreeing to enter the court program.

prevalence of required guilty pleas in mental health courts

An examination of eight selected mental health courts undertaken in 2002 found that five of eight required a guilty plea for program entry.[43] In a subsequent examination of some twenty mental health courts, The Bazelon Center for Mental Health Law found that approximately half required a guilty or no contest plea for program entry.[44] Approximately 40 percent of the 37 BJA grantee courts require a guilty plea for *all* participants, though the percentage requiring a guilty plea for *some* participants (e.g., those charged with felonies) is somewhat higher.[45]

Plea

Determining the type of plea a program participant will be required to enter is one of the most contentious operational decisions. While there are nuances related to different plea options in different states, the core issue is whether the court will require the participant to enter a guilty plea. Powerful arguments support both sides of this issue, and practices in the field follow suit.

From the prosecutor's standpoint, a guilty plea is desirable in case the person fails in the mental health court and is returned to the regular court process. Without a guilty plea, the prosecution will have to remain vigilant about the defendant's constitutional right to a speedy trial and will have to reopen the case if it is returned to regular court. The definition of speedy trial varies across states, but when the time limit is reached and a case has not been disposed of, the case is generally dismissed. This is a distinct possibility when a mental health court participant leaves the program, either of his or her own volition or because of non-adherence to court conditions. Accordingly, mental health courts that choose not to require a guilty plea should consider the development of a form through which participants waive their right to a speedy trial. If the case does return to regular court, the prosecution's task will be complicated. The offense might have occurred months—or even years—in the past; witnesses may no longer be available and evidence may be lost.

From the defense's point of view, requiring a guilty plea leaves a client virtually unprotected if he or she fails in the mental health court. The client will have given up all the rights afforded to an innocent person, and the sole issue on which the defense would have input would be sentencing. In a similar vein, advocates have argued that requiring a guilty plea unfairly stigmatizes defendants with mental illnesses, leaving them with a black mark on their records that will hamper their ability to get a job, find housing, and receive treatment.[46] These concerns are important, as many people with serious mental illnesses have histories of minor offenses. A guilty plea entered in mental health court may also affect how the criminal justice system treats subsequent crimes. For example, a recently passed Florida law requires a mandatory minimum six-month jail sentence for persons convicted for the fifth time of a misdemeanor offense. Other jurisdictions have legislated habitual offender statutes that make it a felony offense to commit a misdemeanor crime more than twice.

Mental health courts have devised a variety of strategies to weigh the interests of the prosecution, defense counsel, and the defendant in establishing the plea arrangements for their programs. Some courts accept a conditional guilty plea: charges are dismissed if the defendant is successful in the mental health court. Others hold

charges in abeyance or defer prosecution during the period of judicially supervised treatment. Still others vary the plea arrangement depending on the severity of the charge (e.g., misdemeanor vs. felony). And in some mental health courts, the prosecutor extends two plea offers: a more favorable one, which applies if the prospective participant graduates from the mental health court (such as a dismissal or a no jail time offer), and a second offer, which applies if the prospective participant decides to return to the regular court or is returned for non-adherence. The second offer is the offer that a defendant would typically receive in the regular court. Whichever plea arrangement a mental health court decides to adopt, prospective participants must fully understand the implications of the plea, especially if they are not able to complete the terms of participation outlined by the court.

Mental health court planners should also consider establishing a protocol for accepting people who have already been sentenced in another court (e.g., probation violators), and for resolving outstanding charges or conditions prior to program participation. Some defendants may come to the mental health court with another case pending or with an existing probation order. In these situations, the conditions that the original court placed on the defendant may contradict the mental health court conditions. Likewise, the staff member responsible for monitoring the potential participant, such as a probation officer, will have no mandate to coordinate their supervision with the mental health court.

Duration

Mental health court planners must also decide how long participants will—or might—remain under the auspices of the court. This issue is more difficult to resolve in the context of a mental health court than in a traditional court setting. Mental health courts are designed to help participants avoid future criminal justice involvement, which depends on many factors specific to an individual's situation. Simply matching certain offenses with set program durations is not likely to serve this broader goal. For this reason, many mental health courts establish minimum and maximum periods of participation, but vary the specific length of judicially supervised treatment for each participant. Most programs last between one and two years, but some are as short as six months or as long as three years (or more).

EXAMPLE: Orleans District Mental Health Court (Louisiana)

All participants in the Orleans District Mental Health Court, whether charged with a misdemeanor or a felony, are in the program for a minimum of one year. The maximum period of judicially supervised treatment is equivalent to the maximum length of probation (two years for misdemeanors, five years for felonies). Within this range, the program duration is individualized. The

court team determines specific goals that a participant must meet to move through the three phases of supervision intensity and to graduate from the program. Because of the diversity of participants' functioning and abilities, no two participants have the exact same expectations placed upon them. In some cases, participants will graduate much earlier than their maximum period of probation.

With the existing variability in the length of court programs, clear guidelines for establishing program duration are difficult to identify. Some suggest limiting the length of time the participant is under the court's jurisdiction to the maximum penalty the defendant could receive if found guilty of the instant charge or charges in the traditional court process. This simple concept has merit—mental health courts should not serve as mechanisms to extend a person's involvement with the criminal justice system—but the calculus is actually quite complicated.

The modern criminal justice system relies on a system of plea-bargaining that makes it highly unusual for any individual to receive the maximum sentence for the crime with which he or she is charged, particularly for low-level, non-violent offenses. Accordingly, the maximum penalty someone *could have* received is almost never commensurate with the penalty they *would have* received in practice, were they not to enter a mental health court. But some low-level offenders will have the most complicated treatment needs, and would require a considerable period of court-supervised treatment to achieve stability in the community, which would be totally disproportionate to the severity of the charges against them.

On the other hand, mental health courts do provide significant benefits to participants that may justify a term of supervision longer than the jail term that they would have received in traditional court. Mental health courts provide resources to assist participants in obtaining treatment in a fragmented, difficult-to-access service system. Some participants may see the requirements of treatment, status hearings, and other conditions as a greater restriction on their freedom than a brief jail term, but from the point of view of the criminal justice system, a respite from jail is a reasonable trade-off for a significant period of community treatment.

These difficult and conflicting concerns reaffirm the importance of informed choice, the next element discussed. Whatever duration a mental health court team sets, prospective participants should have the opportunity to consider the mental health court option carefully, with the advice of defense counsel and treatment providers, before deciding to enter the program. Ensuring the voluntariness of this decision is the best way to match program duration to the needs and interests of the participants.

> "In any diversion program, including a mental health court, the intervention is not the process by which the person is being diverted—it is the treatment that they receive. The success or failure of the program depends on linking participants to effective treatment in the community."[47]
>
> Henry J. Steadman, President, Policy Research Associates

Supervision

Court planners should also develop standards for the frequency of court appearances and other scheduled meetings participants will be expected to attend, such as reporting to probation, pretrial services or other court agencies. Unlike the plea arrangement, which is established firmly when a participant enters the court, the terms of supervision and status hearings are usually adjusted according to the participants' progress in treatment and adherence to court conditions. In fact, many courts have divided the program into phases with differing levels of supervision and reporting requirements. The mechanics of supervision, status hearings, and monitoring adherence to court conditions are discussed in more depth in Element 9 (Monitoring Adherence to Court Conditions).

Treatment

The terms of an individual's treatment are the most important yet also the most difficult to determine. Unlike plea arrangements or the duration of program participation, treatment plans must be highly individualized, and therefore, general standards are not particularly useful. In addition, treatment plans often change, sometimes multiple times, based on a participant's response to treatment. Treatment conditions should be determined with input from mental health professionals, and the procedures for integrating treatment providers into the court process are discussed in more depth later in this guide (see Element 7, Integration of Treatment and Community Supports). In addition, court practitioners interested in learning more about mental illnesses and their treatments should consult *Navigating the Mental Health Maze: A Guide for Court Practitioners,* a companion to this guide.

Impact of program completion on charges

Finally, court planners will have to decide the impact of program completion—both favorable and unfavorable—on participants' cases. This component of the program is linked closely to the plea arrangement, in that the impact of program completion is usually (and should be) determined prior to entry. Mental health courts usually vary the impact of successful program completion based on the severity of the charges; many courts dismiss misdemeanor charges, while those that accept felony charges may reduce them or place participants on probation after program completion.

The impact of unsuccessful program completion depends largely on the plea arrangement. Courts that require a guilty plea usually agree upon a sentence up front that would be applied if the participant does not complete the program. Mental health courts that do not require a guilty plea typically send the participant back to the original court of jurisdiction. In structuring these arrangements, court planners should strive to ensure that participants who voluntarily leave the program do not have negative repercussions in their case that stem from leaving the program, and are not related to the original criminal charge.

5. INFORMED AND VOLUNTARY CHOICE

Like any diversion program or sentencing alternative, all mental health courts are voluntary, and defendants must not face negative repercussions if they decline to participate. But voluntariness in the mental health court context is more complicated than simply presenting the option of participation to defendants. Mental health courts must establish procedures to ensure that defendants are legally competent and that they fully understand what participation in the court involves prior to accepting admission. Attention should also be paid to the experience of court participants after they have decided to enter the program.

legal competency defined

The definition of competency for legal proceedings varies among states, but in general, a defendant is considered legally competent when he or she can understand the legal situation and the proceedings and can also assist his or her attorney in the defense.[48] If a person is not competent to stand trial, he or she is not competent to decide to enter a mental health court program.

The question of legal competency must be addressed prior to considering any defendant for participation in the mental health court (see sidebar on previous page). If a defendant is not competent to aid in his or her defense, he or she is certainly not competent to volunteer for participation in a mental health court program. Some mental health courts rely on existing mechanisms to determine competency. However, these processes are often time-consuming, which is particularly problematic in misdemeanor cases, for which the time to determine competency often exceeds the maximum likely jail time for the offense. In response to this obstacle, some mental health courts have developed expedited processes for determining competency.

EXAMPLE: Anchorage Court Coordinated Resources Project (Alaska)
The Anchorage CCRP (the title for the mental health court there) identified the need for expedited competency evaluations as a way to speed resolution of misdemeanor cases and reduce unnecessary periods of incarceration while awaiting evaluation for competence. With assistance from the Alaska Mental Health Trust Authority, CCRP achieved an agreement with the relevant state agencies to expand capacity for competency evaluations by dedicating a full-time, doctorate-level clinician to performing forensic examinations. This clinician is able to complete competency evaluations in misdemeanor cases within one week—often within one day of the order—significantly decreasing the time for resolution of criminal cases and avoidable periods of incarceration.

Other courts have established unique relationships with the competency determination and restoration process, targeting defendants who have been referred for competency evaluations and providing an alternative to traditional criminal processing for those whose competency is restored.

EXAMPLE: Broward County Felony Mental Health Court (Florida)
When competency issues are raised in a felony case in Broward County, the case is transferred to the mental health court for monitoring while the defendant's competency is restored. If the defendant's competency is restored, the case remains with the mental health court, which, in exchange for a guilty plea, can downwardly adjust the sentence and place the defendant on felony mental health probation instead of sending him or her to prison.

Once competency is established, defense counsel play a critical role in making sure defendants understand the implications of all of their available options, including entering the mental health court. Defense counsel should discuss with their clients the requirements of program participation and the consequences for failing to abide by court conditions, and should help them weigh the mental health court option against traditional criminal case processing. In courts where a guilty plea is required for participation, the implications of that plea should also be explained.

Recent research indicates that ensuring that court participants are fully aware of their ability to opt in or out of mental health court is difficult: a study of the original Broward County Mental Health Court, which targets defendants charged with misdemeanors, found that about one-third of study participants were unaware of their ability to choose between mental health court and regular misdemeanor court.[49] For this reason, many courts have wisely listed all the court terms in a written, formal contract that is concrete, easy-to-read, and free of legalese and other jargon. Defendants have the opportunity to review the contract with their defense attorneys before signing and accepting entry into the court.

EXAMPLE: Oklahoma County Mental Health Court (Oklahoma)

The Oklahoma County Mental Health Court provides participants with a comprehensive handbook. The handbook includes information on terms of participation, transition from the court back to the community, contact information for relevant court agencies, confidentiality protections, and a performance contract. The contract is individualized for each participant; it includes agreements to make appointments, acknowledgement of the possibility of sanctions for non-adherence, and rules for courtroom behavior. After careful review with the team, the participant, the judge, the defense attorney, and the DA all sign the contract. (A copy of this contract is included in Appendix E.)

The question of voluntariness does not end with entry into the court program. Mental health court planners should also consider how the development of treatment plans, the structure of status hearings, and other program components contribute to participants' perceptions of the court, particularly the extent to which they experience the process as coercive. The relationship between coercion (either actual or perceived) and the effectiveness of mental health treatment is empirically unclear, but there is reason to think that a participant who perceives the mental health court process as fair, respectful, and open to his or her input will be more likely to adhere to the treatment plan and other court conditions and to respond positively to requests from the courtroom team.[50]

The experience of participants should be considered in all aspects of the court process: Are participants offered options as to where they will receive treatment? Do they have the opportunity to request changes in their treatment plans or explain their reasons for non-adherence? Are court team members familiar with the details of participants' personal interests? Do court team members use stigmatizing language? Many mental health court practitioners take considerable steps to address these issues, and it is not surprising that some participants describe the mental health court team as a positive support structure or even part of their family. Attention to the subjective

experience of court participants is another aspect of ensuring voluntariness, and may help improve the success of court participants.

6. PARTICIPANT IDENTIFICATION

The prompt identification of potential participants and quick determination of their eligibility for the court is essential. Efficient and effective participant identification requires the development of processes for:

- Receiving referrals
- Screening referrals for eligibility
- Gathering further information about those who screen positive
- Making final eligibility determinations

Each court accomplishes these tasks differently, based on the organization of its criminal justice system and its staffing complement. The guide describes these four processes as separate events in order to highlight the various components of

screening defined

In this section, the term screening refers to the process by which a mental health court determines whether a defendant is eligible for the program according to the legal and clinical criteria established. A positive screen does not mean that the defendant will ultimately be admitted into the program, just that they fit within the target population, and that more information should be gathered to determine their appropriateness for the mental health court.

The term screening has a distinct meaning in correctional institutions. In general, screening in jails and prisons is divided into two segments.[51]

- **Receiving Mental Health Screening.** Mental health information and observations, particularly risk of suicide, gathered about every new inmate or detainee when they arrive at an institution, usually based on a standard screening form.
- **Intake Mental Health Screening.** A more comprehensive screening performed within 14 days of arrival at an institution, which usually includes a review of the receiving screening, behavior observations, and an inquiry into mental health treatment history.

Inmates who screen positive at either juncture are usually referred for a more comprehensive mental health assessment.

participant identification. However, some mental health courts accomplish multiple tasks simultaneously (e.g., screening and gathering further information).

Referrals

Information that an arrestee may have a mental illness can come from a number of different sources, including police, jail staff, probation officers, judicial officers, drug court programs, pretrial services staff, prosecutors, defense attorneys, mental health or substance abuse treatment providers, family, friends, or defendants themselves. Almost all mental health courts accept referrals from a combination of these sources, helping to ensure the identification of appropriate participants. But casting a wide net carries with it complications: ultimately many people are found to be ineligible, either because of their legal charges, their diagnoses, or their decision not to participate. These negative screenings mean that significant court staff time is devoted to people who will not participate in the program.*

For this reason, court planners should consider identifying primary and secondary referring agents (e.g., the public defender's office, the jail) from which they receive most of their referrals.[52] A recent study of seven mental health courts revealed that four of the courts received more than 40 percent of their referrals from one office or program (e.g., the public defender's office).[53] Pretrial services programs, which interview people shortly after arrest to gather information to be used by the court at a bail-setting hearing, are particularly well-positioned to identify and refer people to the mental health court.

EXAMPLE: Hamilton County Pretrial Services Program (Ohio)
In Hamilton County, the pretrial services program added questions to its standard interview to identify mental health issues. When issues are discovered, pretrial staff immediately schedule an assessment by an in-house psychiatrist. As a result, at the defendant's first appearance, the pretrial report contains information related to defendants' mental health status and, where appropriate, a recommendation from the court psychiatrist as to appropriate conditions of release. The report may also suggest a referral to the mental health court for eligible defendants.

Courts should also consider educating potential referral sources about the mental health court's eligibility criteria to reduce time spent processing improper referrals.

EXAMPLE: Allegheny County Mental Health Court (Pennsylvania)
Allegheny County Mental Health Court staff distribute referral forms to any member of the community upon request. To improve the quality and reliability of referrals, the court conducts training for staff from systems likely to supply referrals, including law enforcement officers, judges, public defenders, prosecutors, service providers, and consumer advocates. Initially, court staff

*"**Negative" screenings** for mental health courts represent an opportunity that mental health court staff should not neglect. People who have mental health problems but are not legally eligible for the mental health court can and should be referred to community mental health services.

used trainings to provide an overview of mental illness and mental health court policy and procedure. After identifying a high rate of inappropriate referrals, court staff decided to focus training on eligibility requirements. Since this change in emphasis, the rate of accepted referrals has increased. (A copy of the referral form used in Allegheny County is in Appendix C.)

Screening for eligibility

Once referrals are received, mental health courts need to screen them for legal and clinical eligibility for the program. Across mental health courts, screening mechanisms differ substantially as does the person responsible for this task. Most commonly, courts identify a single staff member, usually one with a mental health background, to manage this function. This helps ensure consistency in applying screening instruments and in analyzing eligibility criteria. In some courts, this screener makes recommendations to the court regarding eligibility of the defendants and may even propose a treatment plan. In other courts, screened participants undergo a more comprehensive assessment before a treatment plan is developed.

EXAMPLE: San Bernardino Mental Health Court (California)

In San Bernardino County, prospective mental health court participants are screened by the district attorney, public defender, and mental health staff, each of whom have veto power over admission. Before a clinical assessment is preformed, the district attorney and the public defender assigned to the mental health court review the defendants' legal histories and current charges. The district attorney essentially sets the upper limit or "legal ceiling" for potential participants: defendants with histories of violence or crimes of a sexual nature are disqualified. The public defender sets the lower limit or "legal floor" for acceptable charges, usually vetoing admission for defendants with limited criminal histories and low level misdemeanor charges. If both the district attorney and public defender agree to recommend a defendant for participation, a licensed clinician assesses the defendant for mental health history and current mental status. Individuals with serious and persistent mental disorders who meet the legal criteria are recommended for admission to the court.

Because of the high frequency of co-occurring disorders among the target population, mental health court screening protocols should include information on both mental health and substance abuse needs.

Gathering information

After the initial screening, more comprehensive information about potential participants is required, both to confirm the initial positive screen and to develop a treatment plan which will be presented to the participant and the court team. As with

the screening, the information gathering process is usually centralized in the hands of one or two staff members, who work with staff representing the different components of the criminal justice and mental health systems to gather the necessary background information.

Information about potential participants must be drawn from a variety of sources. Most offenders with mental illnesses have had multiple contacts with the mental health and criminal justice systems, and these agencies can provide information relevant to eligibility and treatment needs. Accessing pre-existing information controls costs by keeping new evaluations to a minimum and also ensures continuity of care. Furthermore, mental health and criminal justice agencies may be able to contribute relevant facts that the defendant is unable or unwilling to provide, such as past offenses, employment history, family contacts, medical insurance and benefits information. As discussed previously, information sharing must comply with all privacy laws and regulations; obtaining a defendant's written consent to release information is the surest way to adhere to these regulations.

EXAMPLE: Muscogee County Mental Health Court (Georgia)

The Muscogee County Mental Health Court operates two separate dockets: state court for misdemeanors and superior court for felonies. Referrals for both dockets are sent to the mental health court program director or the case manager, both employees of New Horizons, a community-based mental health treatment agency. The New Horizon employees visit prospective participants individually in the jail clinic (if they are still being detained) or at the New Horizons office (if they have been bonded out) to discuss mental health court programs and to have interested people sign a HIPAA-compliant release of information form. Prospective participants consult with

mental health assessments

Many mental health courts have a full mental health assessment for each defendant completed prior to making a final determination of eligibility. An assessment (which may also be called an evaluation) requires a mental health professional to examine health records, observe behavior, and administer mental status exams. Proper assessment also requires careful attention and adequate time to rule out medical conditions or substance use that could account for abnormal mood, behavior, or thinking. Often, multiple assessments are needed to sort out diagnoses, duration, and disability. For this reason, some mental health practitioners argue that an assessment is not a discrete event but rather a continuous process of evaluating a consumer's illness and progress. In some courts, the assessment is completed by a clinician employed by the court, and in others the task is assigned to an outside mental health provider. The timing for assessments also varies: some courts require a completed assessment before eligibility is determined, while some wait until after the participant has volunteered for and been granted entry into the program.

defense counsel either prior to meeting the New Horizon employees or soon thereafter. Some prospective participants are met several times before the information release form is signed to ensure that consent is fully informed. Once the release form is signed, the New Horizon employees compile any past treatment history with the agency, speak with family members, and then prepare a treatment plan. The plan is presented to the court team at the case staffing before the next mental health court session, at which point final eligibility is determined by the prosecutor and the judge.

Final eligibility decision

Once defendants are screened, legal and clinical eligibility is reviewed, and information is gathered about the participant, a final decision must be made to accept or reject a defendant for participation in the mental health court. Court planners should ensure that all team members have input into this decision. While it is not uncommon for the prosecutor and or the judge to have veto power over all potential participants, efforts to maximize the collaborative nature of the final eligibility decision will serve the team well in the long run.

As noted in the sidebar on assessments (previous page), some courts make a final decision about eligibility and accept a defendant into the court before a full mental health assessment has been completed and before a treatment plan is developed. In these cases, a subsequent hearing may be held to determine the precise treatment and other conditions to which the participant will adhere.

EXAMPLE: Anchorage Court Coordinated Research Project (Alaska)

Participation in the Anchorage CCRP is determined during an initial opt-in hearing and a second, formal opt-in hearing. At the initial opt-in hearing, which occurs about a week after the individual is screened, defendants sign a waiver of their speedy trial rights and an information release form, after which they are released to the supervision of a mental health case coordinator. The case coordinator develops the treatment plan in conjunction with the defendant, and subsequently shares the plan with the defense attorney. If the defendant and his or her attorney approve the plan, it is shared with the prosecutor and the judge. Upon agreeing to the plan, the defendant returns for a formal opt-in hearing, which occurs, on average, one month after the initial opt-in hearing. Along with ensuring speedy release to the community for potential participants, this process helps to ensure the confidentiality of mental health information, as the defendant, with advice of counsel, has the opportunity to review the plan before it is shared with the prosecution or judge.

As mental health court teams develop systems for identifying and accepting participants, benchmarks for the speed with which defendants will be processed

through these systems should be established. Time limits are especially important for misdemeanor cases, in which defendants could spend more time in jail waiting for a treatment plan to be developed than they might otherwise serve if their cases were processed through the regular court. In such situations, one of the core goals of most mental health courts—reducing jail time for program participants—could be compromised. On the other hand, identifying appropriate treatment resources is difficult, especially for defendants with more significant needs and more serious charges. The need to balance the goals of timeliness, appropriate treatment, and public safety leads to wide variety in processing time across court programs: some mental health courts screen, gather information, and determine eligibility in less than one week, while others take months.

EXAMPLE: Tempe Municipal Mental Health Court (Arizona)

Because the Tempe Municipal Mental Health Court targets only people who have an existing case manager with the local mental health system, the court is able to identify most participants and confirm their participation within less than a week of their arrest. Most participants are identified by the prosecutor at pretrial conference, at which they are offered the opportunity to participate in the court program. Interested defendants sign a preliminary contract and release of information form, after which the mental health court liaison works with their case manager to identify the problems that led to their criminal justice involvement and to develop a revised treatment plan. Defendants then appear at the next weekly mental health court hearing, at which point they can decide (with the advice of defense counsel) either to participate or to return to regular court. Even after they have agreed to participate, defendants can opt out of the program at any time with no negative repercussions for their case. Defendants who remain in the court program generally report for status hearings on a monthly basis.

EXAMPLE: Bronx Mental Health Court (New York)

The Bronx Mental Health Court targets defendants with mental illnesses who are charged with felony offenses or persistent misdemeanors. A majority of the defendants who are accepted also have co-occurring substance use, trauma histories, and personality disorders. One-third of the participants accepted for diversion are residing in the community following their initial hearing, and are facing jail and prison incarceration; two-thirds of participants, who are typically facing a minimum of two years in prison, are evaluated for diversion while detained in jail. Due to their serious charges, significant service needs, supervision requirements, and lack of community ties, this group stays in jail an average of three months awaiting placement. The Bronx Mental Health Court addresses service gaps by supplementing community resources with intensive direct clinical case management, psychiatric consultation liaison services to the community providers, and with court monitoring.

Either way, ambitious but realistic targets will help the court reduce the time spent in jail for people with mental illnesses who can be supervised safely and effectively in the community.

7. INTEGRATION OF TREATMENT AND COMMUNITY SUPPORTS

A mental health court's success is predicated on its participants receiving comprehensive treatment in the community. Unfortunately, this is not as simple as assessing a participant, making a diagnosis, and setting up an appointment for services. People with serious mental illnesses, particularly those who become involved in the criminal justice system, have extensive and complicated needs. Typically, they have co-occurring substance abuse disorders and complicating medical conditions. They are more likely than the general population to be homeless and may lack resources to pay for treatment and other basic needs.

A mental health court that has effectively defined its goals, established a target population, assured voluntariness and confidentiality, developed terms of participation, and identified eligible participants—in other words, a court that has addressed all of the elements discussed thus far—has achieved only the precursors to program success; it has yet to actually apply the intervention designed to produce positive outcomes. This section provides guidance on integrating treatment and related supports into the court process, including identifying the treatment needs of court participants, developing treatment plans, contending with the high prevalence of co-occurring disorders, and planning for the transition of participants out of the mental health court program.

To address these issues, court practitioners will need to understand basic information about mental illnesses and their treatment, subjects which are beyond the scope of this guide. For this reason, CSG has published *Navigating the Mental Health Maze: A Guide for Court Practitioners* as a companion to this document. *Navigating the Mental Health Maze* provides detailed information about the mental health service system, the types of mental illnesses that court participants have, how those illnesses are diagnosed, and the kinds of treatment and supports that participants require. Representatives of criminal justice agencies participating in mental health court programs are strongly encouraged to consult that guide.

Identifying treatment needs

Developing strategies to meet the treatment needs of mental health court participants requires in-depth discussions to answer questions such as the following:

- What are the expected treatment needs of the participants?
- Who is able to provide each type of treatment?
- How much will these services cost?
- How will treatment providers be compensated?

Obviously, these questions can only be answered with criminal justice and mental health representatives at the table together. Courts cannot simply expect treatment to be made available to their participants without the buy-in of community-based treatment providers. As many court officials have learned, this often requires reaching out to an array of agencies. For example, more than 75 community-based agencies have provided services to participants in the Brooklyn Mental Health Court.[54] In other jurisdictions, such as in the example below, service slots may be somewhat easier to identify.

EXAMPLE: Bonneville County Mental Health Court (Idaho)

The Bonneville County Mental Health Court relies on an existing Assertive Community Treatment (ACT) team to serve all court participants. Because of the low client-to-staff ratio of ACT programs, the mental health court accepts no more than 20 clients at any given time. The court chose to rely on an ACT Team to ensure public safety and to overcome the inherent difficulty of accessing treatment in a rural setting.

Recognizing the current gaps in the service system, some courts have secured resources and contracted with providers for a pre-determined number of beds or treatment slots. While this strategy may improve access to treatment for mental health court participants, it raises important philosophical and practical issues. One of the most trenchant criticisms of mental health courts is that they prioritize treatment for court-involved consumers above treatment for those who have not committed a crime.* Isolating treatment slots for mental health court participants contributes to the perception, and in some cases the reality, that becoming involved in the criminal justice system makes it easier to obtain services. In response to this criticism, mental health court planners should establish clear arrangements with mental health treatment providers that ensure treatment access for mental health court participants without jeopardizing treatment availability for the general public.

*"**Criminalization of** People with Mental Illnesses: The Role of Mental Health Courts in System Reform," by The Bazelon Center for Mental Health Law, offers a thorough discussion of this concern. Available at: www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/.

As discussed later in this section, mental health court participants are likely to require care long after judicially supervised treatment has ended and, as a result, are best served by linkages with community-based providers who are prepared to treat consumers regardless of their court status. When defendants receive services from one agency while under court supervision and from a separate agency after the program ends, continuity of care is hampered. One exception to this view is court-based case management. Court-based case managers perform essential planning and monitoring functions of court-ordered treatment and support and this function can be readily transferred to a community-based case manager upon program completion without disrupting the flow of treatment.

The mental health court planning committee should identify all available services, particularly those previously unknown to the court, and ensure that these programs are willing and able to accept court referrals. Estimated capacity needs for the various types of treatment should be informed by local data on the projected size of the target population and the types of diagnoses anticipated among court participants. As mentioned above, a complete discussion of the likely treatment needs of mental health court participants is included in *Navigating the Mental Health Maze: A Guide for Court Practitioners*. These needs include:

- Psychiatric hospitalization
- Inpatient mental health treatment (crisis stabilization)
- Outpatient mental health treatment

paying for services and supports: the role of benefits programs

Practitioners working at the intersection of the criminal justice and mental health systems, including those in mental health courts, are increasingly paying attention to the importance of federal benefit programs such as Medicaid and Social Security Insurance as funding sources for treatment and other supports. In general, federal funds cannot be accessed for people who are incarcerated, but steps can be taken to accelerate the reinstatement of benefits after incarceration, including the establishment of policies to suspend, rather than terminate, Medicaid benefits, and the development of prerelease application procedures with local, state, and federal benefit agencies. Mental health courts should take steps to ensure that eligible participants are connected as quickly as possible to federal benefit programs, and consult guides such as the Bazelon Center for Mental Health Law's "Arrested? What Happens to Your Benefits If You Go to Jail or Prison," and case studies recently developed by the Council of State Governments about efforts in four states to address these issues.[55]

- Substance abuse treatment
- Medication and symptoms management
- Housing (including supported housing)
- Benefits (e.g., Medicaid, SSI, SSDI, veterans)
- Transportation
- Supported employment

Some mental health providers may be reluctant or even unwilling to accept clients referred by the criminal justice system, especially those charged with felonies. Court officials should respect these concerns and provide information and consultation to mental health providers to help alleviate them. For example, courts can provide data to mental health providers demonstrating that many of their existing clients have been involved in the criminal justice system at some point in their lives. Emphasizing that the clinical requirements are comparable regardless of criminal justice involvement may make mental health treatment providers more amenable to serving court participants. Treatment providers can also be reminded that the addition of court

peer supports

One of the emerging practices in mental health treatment is the use of consumers to provide support to their peers to aid recovery. Some mental health courts are adapting this strategy to their programs. Consumers, whether or not they have been involved with the criminal justice system, are ideally suited to support mental health court participants because of their unique insight into the dynamics of recovery. Peer supports can be important components in helping mental health court participants remain in treatment and develop adaptive, crime-free lifestyles.

EXAMPLE: St. Louis County Mental Health Court (Missouri)

The St. Louis County Mental Health Court makes available a peer support specialist for all participants. This specialist provides one-on-one consultation, facilitates group meetings, introduces participants to consumer education, and provides other supports as needed. For some participants, the peer support specialist serves as an intermediary with his or her mental health treatment providers to ensure a collaborative treatment environment. The peer support specialist also provides trainings on the use of public transportation, household management, budgeting, and social networking, among other issues. The peer support specialist is not a full-time employee but receives a stipend to cover costs associated with this work.

leverage to a treatment regimen often creates better overall outcomes for both the treatment and criminal justice systems.

Developing treatment plans

Treatment plans provide the framework for services delivered to consumers; particularly when treatment is delivered by multiple providers and supervised by yet another agency, treatment plans are essential to ensure treatment integrity. The various court and mental health professionals involved with the participant should be involved in formulating the treatment plan, along with the participant himself, family and significant others, and other community supports (e.g., Alcoholics Anonymous sponsor, mentor). While language conventions and philosophical approaches will vary across providers, the end product should provide a framework for how the consumer will manage his or her issues and identify specific steps toward recovery. Treatment plans must be responsive to each consumer's individual needs, and should also provide specific benchmarks for progress. Treatment planning involves five basic steps:[56]

1. Identifying the Problem: clinicians must identify the most significant problems interfering with the consumer's functioning. Having a smaller, more manageable number of problems keeps the treatment plan focused.
2. Defining the Problem: the way in which the problems are manifested in terms of the consumer's behavior should be clearly articulated.
3. Setting Goals: broad, long-term goals should describe how the targeted problems will be resolved.
4. Specifying Objectives: specific and measurable steps for attaining each treatment goal should be listed, along with expected dates of completion. When appropriate, this section may also be used to discuss signs of relapse and to provide the consumer with specific strategies for resisting common triggers.
5. Identifying Interventions: specific interventions will vary according to the consumer's needs and the clinician's expertise, but will generally include a combination of cognitive, psychodynamic, behavioral, pharmacological, and family-oriented therapies; medical care; assistance with housing, employment, or education; peer-based supports; and concrete supports such as transportation and child-care. The people responsible for providing the various interventions should be clearly identified.

gender-specific and trauma-informed services

Women with mental illnesses involved in the criminal justice system have particular needs to which mental health courts should attend. For example, most women who are arrested have one or more children in their custody; maintaining custody and ensuring that their children are appropriately cared for may be primary concerns for female defendants. In addition, histories of trauma are considered the norm for women in the criminal justice system: 94 percent of incarcerated women report violence or sexual assault by intimates over the course of their lifetime. Mental health courts that do not consider these issues may inappropriately exclude some women (because of inaccurate diagnoses), apply sanctions ineffectively, or otherwise hamper the ability of female participants to adhere to court conditions. A recent monograph, *Special Needs of Women with Co-Occurring Disorders Diverted from the Criminal Justice System*, recommends that mental health courts and other diversion programs take the following steps to develop "gender-specific" and "trauma-informed" programs:[57]

- **Examine policies and procedures—**to ensure that gender and trauma issues are considered, particularly in staff training.
- **Adapt screening and assessment—**to account for histories of trauma and abuse and to determine whether female defendants have children in their custody.
- **Develop treatment plans—**that respond to the specific needs of women and their children, including trauma-specific services, parenting classes, sexual assault and domestic violence groups, and children's health care.
- **Link women to long-term services—**to ensure that women's involvement in treatment continues past their term of judicial supervision.

ensuring cultural competency

Mental health court planners must also take steps to ensure the cultural competence of their programs, particularly in light of the racial disparities in the criminal justice system. Consensus panels convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) have defined **cultural competency** as: "An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations." Examples of culturally competent program adaptations are the use of peer counselors and the availability of interpreters. Consumers can provide particularly valuable input on how courts can address these issues.

Treatment plans are not intended to be static documents, but rather living instruments that are reviewed and updated periodically. As court staff and treatment providers learn more about the participants and their strengths and resources, plans may be made more specific. Not only should the plan be used to track consumer progress or lack thereof, but also to hold court and treatment partners accountable for their commitments to provide services.

Co-occurring substance abuse disorders

Among mental health court participants, co-occurring psychiatric and substance abuse disorders are the rule, not the exception, a fact that must be considered in all aspects of the court's operation. Recent research on managing co-occurring disorders in the context of a specialty court (particularly drug courts) offers the following recommendations to enhance the quality of care:*

- Screen and assess potential participants for both mental health and substance abuse problems.
- Educate participants about both mental health and substance abuse disorders.
- Ensure access to both medication monitoring and drug testing.
- Work closely with both community mental health and substance abuse treatment providers.
- Include conditions, goals, and objectives related to mental health treatment and substance abuse treatment in treatment plans for all participants with co-occurring disorders.[58]

Of all the actions that mental health courts can take to ensure the success of participants with co-occurring disorders, perhaps the most important is identifying and promoting integrated treatment. Integrated treatment involves the simultaneous and coordinated treatment of both mental health and substance abuse disorders, as opposed to the sequential or parallel treatment strategies, which are common in most communities. Research has consistently demonstrated that integrated treatment leads to superior outcomes among people with co-occurring disorders.[59] In general, integrated treatment combines interventions targeting both the psychiatric and the substance abuse disorders within the same context, ideally delivered by cross-trained staff (see sidebar on next page).

*__Co-Occurring__ *Disorders and Specialty Courts* was published by the National GAINS Center for People with Co-occurring Disorders in the Criminal Justice System and the TAPA Center for Jail Diversion, and is available at: http://www.gainsctr.com/pdfs/CoOccurringSpecialty04.pdf.

EXAMPLE: The Substance Abuse and Mental Illness (SAMI) Court Program (Butler County, Ohio)

The SAMI Court Program in Butler County is based on the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model.[60] As its name suggests, the program serves persons with serious mental health *and* substance abuse disorders. Only defendants charged with felonies are eligible. All participants receive integrated treatment from a specially trained, dedicated team that includes an alcohol and drug abuse specialist, a psychiatrist, a case manager, and a probation officer. Integrated treatment is not generally available in Butler County, so the court has also conducted trainings on integrated treatment for mental health and substance abuse treatment providers across the county.

modes of treatment for co-occurring disorders

Sequential Treatment—the consumer with co-occurring disorders is not eligible for treatment for one disorder until the other problem is resolved or suitably stabilized.

Parallel Treatment—the consumer has both disorders treated simultaneously, but by different providers who have no formal relationship or shared treatment planning.

Integrated Treatment—the consumer has both disorders treated simultaneously by providers who develop a single treatment plan addressing both conditions.

High-quality Integrated Treatment Programs:

- Utilize a multidisciplinary team.
- Deliver treatment in sequential stages that correspond to the client's readiness (engagement, motivation, action, relapse prevention).
- Provide access to residential treatment, supported employment, family psychoeducation, illness management and recovery, and assertive community treatment.
- Deliver treatment over a long period, modifying intensity based on the client's degree of recovery.
- Provide information and offer practical assistance to the client during outreach.
- Use motivational interviewing techniques to express empathy and empower the client.
- Focus on relapse prevention strategies in counseling.
- Address both disorders in group treatment.
- Involve family members.
- Require clients to participate in self-help groups (e.g., AA or NA).
- Use psychotropic medications to address psychiatric symptoms.
- Target the full range of physical, social, and behavioral effects of substance abuse in counseling.
- Make secondary interventions available for those who do not respond to treatment initially.

SOURCE: SAMHSA. *Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Fidelity Scale*. Washington, DC, SAMHSA, 2003. Available at http://media.shs.net/ken/pdf/toolkits/cooccurring/IDDTFidelityScaleAJ1_04.pdf

Creating broad access to integrated treatment presents a significant challenge; integrated treatment is not widely available in most communities, and in some, not at all. The reasons for the dearth of integrated treatment slots are complex, relating to funding requirements, standard practices, and systemic inertia. While mental health courts cannot solve these problems on their own, they can become vocal advocates for expanding access to integrated treatment, both for court participants and for the community at large.

Transition Planning

As mental health courts mature and participants begin to successfully complete their term of treatment, the following scenario has become increasingly common. After a year of judicially supervised treatment during which several setbacks were overcome, a participant gets "back on her feet" and graduates from the court. Her life appears to be headed in a positive direction and the mental health court strategy appears vindicated. Six months later, she is back in the mental health court, having committed a crime similar to the one that precipitated her initial involvement. Even if this only happens to a few participants, the psychological impact on the court team's morale (not to mention that of the participants) can be significant, as the return of the participant to the court suggests that all the hard work of the consumer and those supporting her was for naught. Though frustrating, these situations offer valuable lessons.

The return to court of some proportion of "successful" graduates is inevitable. Serious mental illness is a lifelong ailment, and even with the good intentions and collaborative efforts of numerous people, psychiatric disorders often lead to behavior that brings people into repeated contact with the criminal justice system. Accepting this fact is an important step toward establishing realistic expectations at the outset of a mental health court project and toward deciding whether to re-accept graduates on new offenses.

Much can be learned from the mental health system's experience in this area. "Discharge planning begins on admission" is the mantra of inpatient psychiatric services, and should be adopted by mental health courts. In the early phases of participation, the court is appropriately focused on engaging the individual and ensuring that he or she understands the court's expectations. Mental health court practitioners must also recognize from the outset that the mental health court intervention is time-limited, while the individual's mental health problems may be chronic and ongoing. Mental health and court staff must attend to the inevitable end of judicial supervision

from the date of admission and be prepared to address the client's concern, anxiety, or outright decompensation as graduation approaches.

One of the best ways to help people navigate this transition is to acknowledge, collectively, its potential difficulty. Reciprocal engagement between the consumer and treatment providers should be the focus; that is, the court participant must be engaged with her treatment providers, and the treatment providers must be prepared to continue working with the individual after the court mandate has been lifted.

For many participants, the structure provided by the mental health court is itself a clinical intervention; the clear expectations communicated by the court can be therapeutic. In some cases, the structure of the mental health court should be replaced by another structured intervention (e.g., day treatment, intensive case management, Assertive Community Treatment, etc.). For others, the increased intensity of court-brokered services during the transitional period may suffice. In addition, court and mental health providers should ensure that all participants have adequate housing and resources to pay for needed services, including access to Medicaid, cash and food stamps benefits, and SSI. Above all else, strong, collaborative relationships between court staff and the entire spectrum of community-based service providers is the best way to ensure that success in the mental health court breeds success in the community, over both the short and long term.

EXAMPLE: Washoe County Mental Health Court (Nevada)

The Washoe County Mental Health Court has taken steps to ensure a smooth transition for program participants ending their period of judicially supervised treatment. The court team is developing a system through which court participants maintain the same case manager, doctor, comprehensive service plan, and amount of contact after leaving the court program. This allows the treatment provider to mirror the structure and supervision provided by the court. The team is also identifying potential graduates three months in advance and working with the participants and mental health treatment providers to develop aftercare plans, to identify issues for concern during the transition period, and to promote continuity of care and engagement.

Collaborative advocacy

Even courts with strong mental health partnerships struggle to rectify the chronic limitations of the community treatment system. The inadequacies and fragmentation of the mental health system have been well documented in several recent major reports, most notably the report of the President's New Freedom Commission on Mental Health.[61] In the radical shift from a system of large, centrally-managed

> "Having a chief judge and sheriff testify against cuts to the mental health budget has a much bigger impact than any mental health official could ever have."
>
> Assemblywoman Sheila Leslie (D-NV)

institutions to a community-based system of care, numerous agencies, including agencies within the criminal justice system, assumed some responsibility for the treatment and support of people with serious mental illnesses. This fragmentation presents enormous challenges for the effective delivery of services. But in the context of mental health courts it may also present opportunities.

Developing a mental health court brings with it a new investment of the court in the availability of treatment. If certain treatment options are unavailable, court and other criminal justice officials should collaborate with policymakers and providers from the mental health and other systems to address these gaps, both for mental health court participants and for all consumers of mental health services. Many people's involvement in the criminal justice system is precipitated by their inability to access adequate mental health treatment in the community. Making community treatment more accessible and affordable can help prevent this involvement in the first place. Partnerships developed for the initial purpose of developing mental health courts or related programs are also powerful political coalitions that can be used in the service of improving the quality and availability of mental health care.

EXAMPLE: Florida Partners in Crisis

Florida Partners in Crisis (PIC) is an advocacy and educational organization committed to promoting access to quality services and treatment for people with mental illnesses and substance abuse disorders. Partners comprise traditional and non-traditional advocates, including judges, law enforcement and corrections officers, prosecutors and public defenders, service providers, hospital administrators, people with mental illnesses and substance abuse disorders, and family members. PIC primarily targets legislators to advocate increased funding and resources to the community mental health and substance abuse treatment systems and to advocate on specific policy issues related to this population. Overseen by a state director, state coordinator, and steering committee, PIC produces a brochure, editorials, billboard campaigns, legislative packets, meeting materials, and public service announcements, as well as holding press conferences. PIC leaders have met with the Governor and other key legislative leaders such as the Speaker of the House and the Senate President.

8. THE MENTAL HEALTH COURT TEAM

No matter how sophisticated the planning, the ability of the mental health court to engender change among participants depends on the composition of the courtroom team—those who work in the court on a daily basis. As one mental health court judge remarked to a new participant, the courtroom team is the "group of people whose job it is to make sure you are successful in this program."[62] Analyzing the dynamics of a mental health court team is complicated by the variability in how such teams are structured. All court teams include a judicial officer and a treatment provider or case manager (either a court employee or staff from a program providing direct services to court participants). In addition, many also include a single prosecutor and defense attorney, although those positions change in some courts on a case-by-case basis. Some court teams also include a court supervision agent, such as a probation or pretrial services officer. Lastly, many courts employ a court coordinator or project manager, who serves as a liaison between the various court and mental health professionals. Regardless of the team arrangement in a particular jurisdiction, selecting appropriate team members and providing sufficient training opportunities are challenges that all courts face.

Selecting team members

Mental health courts require team members to rethink and expand their professional roles. Shifting away from the adversarial model, the mental health court team works together to achieve the best outcome for the defendant. Setting aside these traditional conventions can be difficult: prosecutors are trained to uphold public safety, not work in the best interest of the defendant; defense attorneys want to limit the penetration of their client in the criminal justice system, not extend the period of their supervision; and judges are impartial arbiters of fact, not probation officers or social workers.

Mental health court planners should select team members who are willing to adapt to this non-traditional setting. Judges, prosecutors, defense counsel, and probation or pretrial services officers who have demonstrated an interest in mental health issues or a willingness to entertain alternative strategies in responding to defendants with mental health issues make ideal candidates. On the other hand, a prosecutor or probation officer who is determined to respond to all probation violations with punitive sanctions and incarceration will quickly clash with mental health practitioners who favor adjusting treatment plans in response to non-adherence to court orders.

Likewise, mental health providers with experience or expressed interest in the criminal justice system will make good additions to the project, while treatment professionals who are unprepared to appreciate the public safety concerns of the court will not. Mental health providers who refuse to accept even the occasional use of punitive sanctions will make effective teamwork nearly impossible.

No matter their professional affiliation, team members often struggle with the unfamiliar court process and may find that their peers are not supportive or view them in a different light. One defense attorney noted the contradictory roles: "You want to be part of the team, but you've always got to guard against 'going along,' and make sure it's the best thing for your client."[63] Said one judge, "My brethren on the bench said, 'If you want to do that, fine, but you're going to have to fit it into your regular calendar.'"[64] A probation officer who successfully applied for the new position in a mental health court talked about how his peers were both curious and jealous. As he put it, "I have a smaller caseload, but it's a harder one to work."[65]

Many mental health court practitioners prefer team membership to remain fixed over time. Some courts assign team members for a year or two, while others have indefinite terms of membership, terminated at staff's own request. Such longevity contributes to trusting professional relationships, smooth teamwork, familiarity with the unique processes of the mental health court, a sense of consistency for the participants, and an improved ability to assess the progress of individual participants during their time in the court program. Clearly, to achieve optimum functioning, a team needs time to gel.

However, some courts have also offered persuasive arguments against indefinite or lengthy assignments to mental health court teams. Mental health consumers are

the role of victim advocates and victims' services providers in mental health courts

Mental health court planners should work closely with court-based victim advocates and community based victims' services providers to address the needs and interests of crime victims. These include providing victims with input on the entry of defendants into the program, providing updates to victims about the status of defendants' cases, and connecting crime victims to counseling and other services. Crime victims issues are particularly important in light of the increasing willingness of mental health courts to accept defendants charged with more serious crimes. Courts should also consider the needs of the many family members who are both caretakers and victims of crime.

some of the court's most difficult-to-serve clients, and some staff may become burned out after multiple years of working in a mental health court. Even if some team members would prefer to remain in the mental health court indefinitely, such an arrangement prevents other interested staff members from participating in the program. Perhaps most importantly, rotating staff on the mental health court team can prevent the isolation of the mental health court and enhance awareness throughout the legal system about mental illness generally and the mental health court in particular. Staff who have served in the mental health court at one time will be well-positioned to help the traditional court process better respond to the many defendants with mental illnesses who will not participate in the mental health court.

Courts should strive to balance the virtues of a fixed mental health court team with the importance of involving multiple staff members in the mental health court, and above all recognize that some turnover among court team members is inevitable.

rural mental health courts

Several rural jurisdictions, including communities in West Virginia and South Carolina, have recognized that the mental health court concept must be adapted to account for their smaller case volume and less comprehensive service systems. Examples of these adaptations include the following:

Smaller Case Volume

The West Virginia Supreme Court of Appeals established a multi-jurisdictional mental health court for Hancock, Brooke, Ohio, and Marshall Counties. Spreading the court across four counties ensures sufficient volume to justify the development of a specialized program. The cases for the mental health court are distributed across the dockets of four magistrates and two judges. Case staffing is held in a central location, but hearings are held in all four counties, to which the court team travels on a regular basis.

In Marlboro County, South Carolina, the social worker assigned to the mental health court also provides an array of services for people in criminal or civil court who are not eligible for the mental health court. This includes counseling for jail detainees and providing input on commitment hearings.

Service gaps

Court planners in West Virginia have worked to augment the existing services by seeking support from local foundations and federal agencies, and by adapting criminal justice services to respond to people with mental illnesses. For example, the probation department has added mental health and co-occurring disorder treatment capacity to its day reporting center, and has submitted a grant to develop housing dedicated to probationers (including mental health court participants) with mental illnesses.

In Marlboro County, South Carolina, there is no soup kitchen, no homeless shelter, no alcohol and drug treatment program, and limited self-help groups for people with substance abuse problems. In response to this shortage, the social worker assigned to the mental health court there has begun to receive training on substance abuse treatment in order to provide those services to court participants.

Staff changes should be preceded by a period of training, exposure to the policies and procedures of the court, and on-the-job mentoring by the outgoing team member when possible. These efforts ensure ongoing fidelity to court goals as well as operational consistency. A project manager or court coordinator can be of particular use here, serving as the team member that institutionalizes orientation and training materials, ensures that all team members understand their roles, and maintains high levels of intra-team communication.

(Cross) Training

Even with the selection of high-quality team members, training is required to bridge the gaps between the often disparate perspectives of mental health and criminal justice, and to help team members grow accustomed to their new roles. A mental health court judge must learn to be a counselor, cheerleader, moderator, and team leader, along with serving in the traditional role of final arbiter. Mental health professionals will need to familiarize themselves with legal terminology and develop expertise in the workings of the criminal justice system. Courts should identify education and training resources, both inside and outside of the court, to help judges, other court officials, and treatment providers learn and adapt to their new positions. If possible, training should be extended beyond the mental health court practitioners to allow staff from throughout the criminal justice, mental health, and substance abuse treatment systems to improve their knowledge and ability to collaborate.

EXAMPLE: Hennepin County Mental Health Court (Minnesota)

The Hennepin County Mental Health Court has conducted trainings for mental health and criminal justice personnel. The court has held five training sessions for mental health case managers on the operation of and interaction with the criminal justice system. The court has also held focus groups with probation officers to inform training materials on mental health issues for criminal justice personnel. Coordinating these sessions with the training department of the relevant target agencies has allowed the mental health court to reach the broadest possible audience.

EXAMPLE: Summit County Cross-Training (Ohio)

The Summit County Criminal Justice Forum, which comprises representatives from criminal justice, mental health, and substance abuse treatment agencies, has instituted biannual cross-training sessions for practitioners from all three systems. The two-day training sessions involve staff from specialized programs such as the Akron Municipal Mental Health Court as well as non-specialty practitioners. The first day of training features break-out sessions on the criminal justice system, mental health system, and substance abuse treatment system, which are typically attended by staff from other systems (i.e., criminal justice practitioners learn about the mental health or substance abuse systems, and vice versa). The second day provides opportunities

for dialogue about core assumptions, current problems, and potential improvements to cross-systems collaboration. Faculty are drawn from local participating agencies.

EXAMPLE: National Judicial College Training Courses

The National Judicial College offers courses of relevance to mental health court judges or any judges interested in mental health issues. The Managing Cases Involving Persons with Mental Disabilities course covers mental health issues that affect and are affected by the justice system and provides judicial strategies to respond to defendants with mental disorders. The Co-Occurring Mental and Substance Abuse Disorders course provides information on the physiological and pharmacological aspects of substance abuse and major mental disorders, appropriate judicial strategies and tools for treatment and monitoring, and the implementation of systems or ideas to address co-occurring disorders.[66]

9. MONITORING ADHERENCE TO COURT CONDITIONS

In the effort to distinguish mental health courts from other diversion strategies, the phrase "judicially supervised treatment" is often applied. In reality, the judge is the final link of a supervision chain that relies first on mental health and criminal justice staff who meet regularly with participants to monitor their adherence to court conditions. As with all other aspects of mental health court design and operation, different courts rely on different processes to accomplish this task. In some cases, the same staff who perform the initial screening and develop the treatment plan are responsible for monitoring the participants' behavior in the community. In other courts, supervision is the purview of a particular team member.

Whoever the mental health court designates to monitor participants in the community, the overall objective is to ensure that court orders are being followed, to reward adherence, to adjust treatment plans as necessary, and to sanction non-adherence. This section provides guidance on different supervision strategies, and on the use of regular status hearings to review each participant's progress and to determine whether incentives or sanctions will be imposed.

Supervision strategies

Courts have three basic options for monitoring participants during their involvement with the program, each with its own advantages and disadvantages. The use of these strategies may vary depending on the type of offense a participant is charged with, or other case-specific criteria.

Supervision by mental health providers

Some courts rely on mental health treatment providers, usually case managers, to report on the participant's adherence to court conditions. This case manager may be an employee of the court or may be employed by a partnering community agency. In smaller courts, one case manager may supervise all participants, while a larger court may split the caseload between two or more case managers. Regardless of the employing agency, the essential component of this strategy is that the supervising agent has a mental health background and is actively involved in facilitating the participants' linkage to community treatment.

One obvious benefit of this strategy is efficiency: a single point of contact is responsible for coordinating and monitoring all aspects of the court participant's progress, making it easier for other team members (e.g., the judge, prosecutor, defense counsel) to obtain updates and streamlining the process of collecting information to prepare for team meetings and status hearings. Furthermore, the case manager is well-positioned to identify potential causes for non-adherence and to propose changes to the treatment plan or court conditions to address those underlying issues.

On the other hand, this arrangement creates the potential for role conflicts, as the case managers find themselves as both facilitators of the participant's support structure and as potentially punitive extensions of the legal system. This dual role may impede the development of a trusting relationship with the participant. In addition, some judges and prosecutors are uncomfortable assigning the responsibility for supervision to someone with a non-criminal justice background. Thus, with this approach, coordination with other team members is critical to best manage this role.

EXAMPLE: Orange County Community Resource Court Program (North Carolina)

Most of the participants in the Orange County Community Resource Court Program are accepted pre-plea and supervised by a community-based mental health case manager: either the case manager dedicated to the mental health court program or a case manager from one of two local Assertive Community Treatment (ACT) teams. Case managers report on the progress of each participant, including adherence to treatment plans and other court conditions, during monthly case staffing meetings. The court team decides jointly how to respond to any violations, with the judge as the arbiter of any disagreements. The court partners have worked to ease the role confusion of relying on mental health-based supervision by having the judge stress to participants the team nature of all court decisions, thus lessening the connection between the case manager and any sanctions that are applied.

Supervision by criminal justice staff

Some courts assign the monitoring role to criminal justice staff, usually a probation officer, or sometimes the mental health court coordinator or a pretrial services officer. As with the mental health-based supervision strategy described above, the criminal justice agent may be permanently assigned to the court, supervising all of its participants, or may be based in another agency (e.g., probation) and involved only in certain cases. In this arrangement, the probation officer meets with the defendants on a regular basis, consults family, coworkers, and employers, and receives detailed reports from treatment providers about attendance and progress toward established goals. Rather than being the person responsible for communicating with the court, the treatment provider becomes one of multiple sources of information on the success with which the defendant is adjusting in the community.

Courts assigning responsibility for supervision to a criminal justice staff member may do so because of concerns about public safety, particularly when the court serves defendants charged with felonies. On the other hand, a criminal justice agent may not be as well versed in identifying treatment-based solutions in response to nonadherence to court orders. Courts employing this strategy should ensure that mental health staff have input into the responses to supervision violations.

EXAMPLE: Orange County Dual Diagnosis Court (California)

A probation officer is assigned full time to the Orange County Dual Diagnosis Court to supervise all program participants. Court participants are monitored more closely than other probationers, although the frequency and form of monitoring varies with their level of progression through the program. At the outset, participants report twice weekly to the probation office for review of progress and for drug and alcohol testing. As participants successfully progress through the program, their supervision is adjusted so that they can report by phone, at the probation office, or via home visits, and drug and alcohol testing becomes less frequent. Violations of court conditions result in an immediate sanction, which may include time in custody (usually one to three days), community service, essay writing, journaling, or increased probation monitoring. The Dual Diagnosis Court team makes all sanction recommendations.

Joint supervision by criminal justice and mental health staff

Finally, some courts employ a combination of the two strategies above, with a mental health provider and criminal justice officer working together to monitor adherence. This strategy helps maintain clarity between treatment and supervision roles, but increases the need for close collaboration between the two supervising staff members. In addition, with two staff members serving a single function, per-participant costs increase.

EXAMPLE: Court Coordinated Services (Yamhill County, Oregon)

The Yamhill County Mental Health Court varies supervision arrangements depending on whether a participant is accepted pre-plea or post-plea. For pre-plea participants, the treatment court coordinator, who has a mental health background and is an employee of the court, acts as the liaison between the judge and the treatment provider, assessing a client's engagement with the treatment plan and reporting to the judge. Most participants who are accepted post-plea are placed under probation, and supervised jointly by a probation officer and the treatment court coordinator.

Comparative research has not demonstrated the superiority of one strategy over the others in terms of ensuring adherence to court orders and encouraging treatment engagement among participants. Accordingly, court planners must devise a supervision strategy by weighing public safety, efficiency, coordination, and resource concerns.

Case staffing

Most mental health courts hold a separate meeting of the court team prior to when mental health court actually convenes. In this meeting, often referred to as "case staffing" or a "pre-meeting," the court team discusses all the cases on the calendar for that day, including potential new participants and existing participants appearing for status hearings. For new participants, the court coordinator or mental health provider presents the team with basic information about each individual in terms of his or her characteristics across each of the eligibility criteria. Team members discuss the case and make a determination on the defendant's appropriateness for the program. For existing participants appearing for status hearings, the team member or members responsible for monitoring the participant report each participant's progress and offer suggestions for how the judge should respond (e.g., praise, changes to the participant's treatment plan, or sanctions).

Case staffing can be a time-consuming and difficult process. Differences of opinion about managing participants, both practical and philosophical, will surface. Effective teams engage in a productive give-and-take that results in compromises. Where collaboration and teamwork are less developed, case staffing discussions may be contentious and difficult to resolve. At the very least, the basic ground rules for these discussions should be set at the outset of court operations. Important questions include:

- Who is authorized to attend these meetings based on confidentiality concerns?

- Who is responsible for managing information about court participants?
- Who presents status reports during case staffing?
- Who has final authority to grant admission to the court program?
- How will the court resolve differences of opinion about how to respond to violations of court conditions?

Status hearings

Judicial involvement in the supervision of mental health court participants occurs during the status hearings that all courts employ. Participants are required to appear before the judge on a regular basis (e.g., weekly, bi-weekly, monthly, depending on individual circumstances) to discuss their progress. In some courts, the judge is the primary spokesperson for the court during these hearings, commenting on information provided by other team members during the case staffing discussions. Other courts rely on a team approach, wherein case managers or probation officers offer brief reports on the participant's progress, followed by a discussion of key issues among the case manager or probation officer, defendant, and the judge.

Because most mental health courts maintain a non-adversarial atmosphere, and because status hearings do not have a natural counterpart in the traditional court process, some courts make the presence of defense counsel at status hearings optional. This practice may help control costs and ease scheduling conflicts, but it raises significant concerns. Despite their distinctness from traditional court processing, regular status hearings still represent a function of the criminal justice system, and as such present the opportunity for court participants to put themselves in further jeopardy. For example, participants may appear at status hearings after having been recently booked on new crimes, or may volunteer information to the court that puts them in violation of their court conditions and thus eligible for jail time. The role of defense counsel is to advise their clients throughout their involvement in the criminal justice system, not just prior to entry into the mental health court program, and the preceding scenarios illustrate the difficulties that can arise when defense counsel are absent from status hearings.

The principal purpose of status hearings is to formally dispense rewards and sanctions, which are discussed below. But court personnel should also pay attention to how status hearings are conducted. Is the courtroom structured in a way that participants feel intimidated? Are participants offered an opportunity to discuss their successes or explain the reasons why difficulties may have arisen? Do court team

> "A mental health court may be the first time some participants have heard a kind word from anyone in their life, let alone a criminal justice official."
>
> **Judge Winston P. Bethel,** Chief Magistrate, Dekalb County, Georgia

members show interest in participants as individuals? These intangibles may significantly affect how participants experience the mental health court, and, by extension, their adherence to court conditions and the ultimate success of the program.

Rewarding adherence

Mental health courts are based on the premise that treatment engagement will lead to improved health and public safety outcomes for program participants. It is appropriate, then, for mental health court planners to focus first and foremost on developing ways to offer positive reinforcement to participants who adhere to their treatment plan and other court conditions. Mental health courts employ an array of strategies for rewarding participants who are engaged in treatment and making good-faith efforts to adhere to all conditions of supervision. Given the complexity of the tasks facing program participants, small, incremental achievements should be recognized and rewarded along with long-term treatment goals. Rewards that mental health courts employ include:

- Priority position in the order of cases called
- Praise from the judge
- Applause in court
- Increased time between status hearings
- Certificates for completion of treatment
- Food items or gift certificates from local businesses
- Birthday and special occasion cards
- Reduced fees for probation supervision or drug testing
- Special seating while participants are in court

- Extended privileges (i.e., where people are allowed to live, whom they may visit)
- Graduation ceremonies

EXAMPLE: Youngstown Municipal Mental Health Court (Ohio)
The Youngstown Municipal Mental Health Court offers several rewards to participants who are adhering closely to the court's conditions: verbal praise from the judge; less frequent status hearings (e.g., every other week instead of every week); gift certificates from local businesses; and modifications to treatment plans (e.g., less stringent requirements to attend groups or other treatment components). The judge decides which rewards to offer, with input from the entire team, prior to each court session.

Mental health court planners should also consider, as many courts have, dividing the program into a set of phases that mark the progress of participants. These phases may be tied to changes in court conditions (e.g., frequency of status hearings, intensity of supervision, extension of privileges), but they can also serve to formally recognize the accomplishments of program participants throughout their time in the court.

EXAMPLE: Brooklyn Mental Health Court (New York)
The Brooklyn Mental Health Court program is divided into four phases, described in treatment plans as "Adjustment," "Engagement in treatment," "Progress in treatment," and "Continued progress in treatment and successful completion of the mandate." To move from phase to phase, participants must comply with all terms of their participation. When a phase is completed, the defendant receives a certificate from the judge, which has proved a powerful motivator for many participants. Completing a phase may result in less intensive supervision or less frequent status hearings. A defendant can graduate from the court after completing all the phases and remaining in treatment for 12 to 24 months. Upon graduation, charges may be dismissed or reduced to a misdemeanor (with a sentence of either probation or a conditional discharge) depending on the nature of the charges and the defendant's criminal history."[68]

Adjusting treatment plans

At some point during their tenure in the court program, most mental health court participants will miss a treatment appointment, test positive for drug use, or otherwise have difficulty adhering to all of the court's conditions. Responses to such violations should balance the court's need for accountability with the recognition that relapse is an expected component of recovery. Some violations (such as committing a new crime) are serious and require an immediate and significant punitive response. But for most violations, especially those related to treatment adherence,

the appropriateness of the treatment plan should be assessed prior to the application of any sanction. In response to a violation, the mental health court team should ask questions such as:

- Has the participant been taking his or her medication?
- If not, why not? Are side effects an issue? Should the type of medication, the dosage, or the manner of administration be reexamined?
- Has the participant been attending treatment sessions?
- If not, why not? Does the participant have sufficient transportation and childcare?
- Where does the participant live? Is the living situation conducive to treatment engagement?

The responses to these questions will be different in every case, as will the appropriate response. Court teams will need to analyze the seriousness of the violation and the underlying causes before determining the response. In many cases, the appropriate response will be an adjustment or intensification of treatment. If the court team decides to *intensify* treatment in response to a condition violation, this change should not be described as a sanction. The team should remember that increasing long-term treatment engagement entails, in part, encouraging participants to view treatment services as beneficial, supportive aspects of their life, not as punishment. How the court explains its decisions regarding participants' treatment conditions may

mental health court graduation

Because of their highly individualized nature, their small caseloads, and their relative youth, mental health court programs do not often have multiple participants completing the program simultaneously. Nevertheless, most courts formally recognize program completion, either by taking time out of the normal court process, or by reconvening a group of participants who have recently "graduated" for a special ceremony. There is general agreement among mental health court practitioners that program completion should be lauded. But some have cautioned that courts should not equate program completion with treatment completion, as most participants will have chronic conditions that require ongoing support. For this reason, some courts avoid the term "graduate" altogether, feeling that it suggests a false finality to the broader goals of ongoing treatment engagement and avoidance of future criminal justice involvement.

have significant consequences for their attitude toward treatment in general, particularly after the period of court supervision is over.

Applying sanctions

Of course, some violations of the court's orders are not easily justified or explained by the participant's illness and are clearly volitional. In these situations, a punitive sanction may be appropriate. Many mental health courts have turned to the example of drug courts for guidance in this area. Over the years, drug courts have come to rely on a series of "graduated sanctions" to respond to violations (such as positive drug tests); each subsequent violation results in a more serious sanction, usually culminating in a short jail sentence. Research on drug court sanctions emphasizes the need for immediate and consistent application of sanctions that are of sufficient intensity and are targeted to the specific violation and individual.[69]

The applicability of drug court sanctions within the mental health court context has not yet been empirically determined. However, anecdotal reports from mental health court practitioners suggest that the drug court model may not translate well for many mental health court participants. Given their unique diagnoses, differing functional abilities, and individualized treatment plans, a formulaic application of a sanctioning grid may not address the root causes of a violation. Many mental health court judges underscore that mental health consumers do not respond as well, or at all, to punitive actions from the court. Because no research base exists to guide the application of mental health court sanctions, court teams should tailor sanctions to the specific violation and participant, and should maintain internal data on the effectiveness of these sanctions in encouraging adherence. General rules for the application of sanctions will be helpful, but they cannot replace the evaluation of each violation on a case-by-base basis. Sanctions could include:

- Judicial reprimands
- Journal assignments
- Increased frequency of status hearings
- Increased supervision intensity (e.g., meetings with a probation officer or case manager, drug testing)
- Restriction of privileges (e.g., curfew, travel)
- Community service

- Jail
- Expulsion from the program

EXAMPLE: Oklahoma County Mental Health Court (Oklahoma)

The Oklahoma County Mental Health Court employs a variety of sanctions to respond to non-adherence to court conditions. These include written assignments, increased supervision, more frequent court appearances, more frequent drug testing, curfews, demotion to a lower level of court status, community service, and jail time. Sanctions are targeted to the specific behavior and graduated in severity upon recurrence of the unacceptable behavior. Sanctions are applied with the goal of assisting participants in making progress toward treatment goals, and eventually succeeding in the program. Participants may be expelled from the program for repeated non-adherence to their court requirements or after available graduated sanctions have been exhausted without correction of the identified problematic behavior. The team must inform the participant that he is at risk for expulsion with enough notice to allow the participant to correct the problematic behavior. A new offense is immediate grounds for expulsion.

More than the specific responses to individual violations, some mental health court practitioners feel that the key to successfully engaging court participants is continued interaction with the courtroom team. As one court coordinator noted, "Lectures aren't useful if there's just one contact. But if you're there through ups and downs, people will respond. They'll show up even when they screw up, because they

jail as a sanction

One sanction worthy of substantial discussion on its own is jail. The diverse practices among courts indicate the variety of opinions on this issue. Some courts rarely, if ever, use jail in response to non-adherence, citing the belief that while jail may satisfy the desire to punish, it does little to actually improve a participant's long-term ability to comply with treatment. (Practitioners in these courts note that incarceration, through the disruption of a participant's mediation, treatment regime, housing, and other stability factors can cause a person to decompensate.) Some practitioners also doubt the deterrence potential of incarceration, suggesting that some court participants may welcome time in jail because of the stability it can afford. Other courts use jail more liberally: when they feel that community safety is at risk, to "shake-up" a participant, to stabilize someone in crisis, or as a form of detoxification.

Recent research suggests that as courts begin to accept more defendants charged with felony offenses, they are relying increasingly on jail, usually for public safety reasons.[70] Absent evidence from research, mental health courts must develop a policy relying only on anecdotal observation, politics, and philosophical approaches. This policy should identify the conditions under which jail may be ordered and establish mechanisms to evaluate its effectiveness over time.

feel it's part of the relationship or process. Sometimes people will come to court even when it's not their week because it's a positive place to go."[71]

Whatever the sanctions employed, a complete list should be compiled for the benefit of the court team and the participants. In some courts, defense counsel have requested such a list to ensure that the consequences of a violation are clear to their clients before they enter the program.

10. SUSTAINABILITY

Mental health courts, like all pilot strategies, have to contend all too quickly with the challenge of sustainability. Postponing the consideration of this issue until the court becomes well established is a common and understandable approach. With the considerable work required to design and implement the court, finding the time to plan for subsequent years of operation may seem to be a low priority. Courts must resist this temptation and begin planning for long-term sustainability early in their operation. This includes developing written policies and procedures, collecting outcome data, securing funding, responding to failures, effectively reaching out to the community at large, and eventually coordinating the activities of multiple courts in a particular state.

Developing written policies and procedures

Mental health court policies and procedures should quickly be institutionalized in writing, particularly if the court's creation relied heavily on the interest or impetus of one team member, such as a judge. Courts early in the implementation phase may prefer to postpone developing written materials until after the program design is well established; but revising outdated program documents is far easier than creating them after key staff have left the court. Written materials related to all the issues described in this guide should be developed, including:

- Project history and partners
- Project goals and objectives
- Eligibility criteria
- Information sharing protocols
- Referral and screening procedures
- Treatment resources

- Case staffing and status hearing procedures
- Sanctions and incentives
- Advocacy efforts

Partner agencies should also strongly consider developing a memorandum of understanding (MOU). These documents can solidify agreements between agencies that will outlast the participation of specific people who made verbal agreements to collaborate. Along with standardizing court practices, written policies and procedures and agreements between agencies are useful when submitting reports to funders or when applying for continued financial support.

Outcome data

A court's most important ally in the pursuit of long-term funding is empirical data. As one noted researcher has pointed out, mental health courts are funded for the first time on promises; they are funded after that based on results.[72] Data on the individual- and system-level impacts of the court should be collected and maintained from the first day of operation. As discussed in element 1 (goals), the specific data targeted for collection should be guided by the stated goals of the court. For example, if the court was launched, in part, to reduce the number of jail bed days consumed by people with mental illnesses, the court must be able to demonstrate whether program participants spent fewer days in jail compared to a period prior to court participation, or compared to a similarly-situated group of people who did not participate in the mental health court.

Most mental health courts have little, if any, time and resources budgeted for data collection and evaluation, which severely limits their ability to measure their success, and possibly, to sustain their programs. To provide guidance for courts in this situation, CSG has published a companion to this guide, *A Guide to Collecting Mental Health Court Outcome Data*. This guide offers practical advice about the types of data courts should collect, methods for compiling data, common data collection challenges, and strategies for overcoming them. For that reason, those issues will not be addressed here, except to recommend (as that guide does) that courts enact data collection strategies as early as possible, seek resources and allies in the community, and set realistic data collection goals that match their staffing capacity and budget.

Funding

Mental health courts have turned to a number of different sources for funding: federal grant programs, local foundations, county agencies, and state legislatures among them. Just as with the other aspects of mental health court design, no one size fits all, but the experience of existing courts provides some useful lessons. First, long-term funding must be contemplated early in the court's planning. Potential funding sources should be identified and cultivated from the start. Second, the value of personal experience with the court cannot be overestimated. Observing a mental health court session (particularly a graduation ceremony) during which a formerly homeless individual with serious mental illness receives glowing praise from a judge is a powerful experience. While such anecdotal evidence should not and cannot stand in for empirical documentation, interested state legislators, county commissioners, foundation officials, and other potential funders should be offered the opportunity to see the mental health court in action.

Lastly, mental health court team members should be both clear and realistic in their claims about the mental health court's potential accomplishments. Is the court designed to reduce the consumption of jail bed days? Is the court being pitched as a money-saving strategy? Is its core goal to connect people to treatment and improve their quality of life? Each court will have different answers to these questions, but when pursuing funding, the answers must be consistent and must be supported by reliable data.

Responding to failures

Hopefully, collecting and analyzing outcome data will provide empirical verification of the positive impact of the mental health court. However, courts must also prepare for the possibility that a participant will commit a serious and violent crime while under court supervision. Such an incident can easily attract unfavorable press and jeopardize the sustainability of the court, even if it is the one exception to an otherwise stalwart record. Many high-profile crimes catalyze significant (and sometimes appropriate) county-wide or statewide changes in criminal justice policy or practice; mental health courts are not immune from this phenomenon.

The various agencies involved with the court should establish a plan, in advance, to respond to incidents that attract negative publicity, in order to ensure that pressure to react quickly does not result in finger-pointing. This plan should include an agreement on how to respond to inquiries from the legislature, other state or local governing bodies, the media, and attorneys. Because a high profile crime committed by a program participant will raise significant public safety concerns, the court team

would be wise to have a judge or prosecutor be the lead spokesperson for the court in these situations. While an emergency plan is helpful, the ultimate ability to weather the storm of negative publicity will depend on the depth of collaboration among the various agencies, which reaffirms the importance of cross-system dialogue, cross-training, and other strategies discussed throughout this guide.

Community outreach

In addition to preparing for the worst-case scenario, collaborating agencies should also publicize the activities and successes of the mental health court. The overrepresentation of people with mental illnesses in the criminal justice system is a community problem, and the community—including related agencies and community members in general—should be aware of the innovative solution being undertaken to address this problem. When making information available, representatives of the court should make clear the underlying reasons why the mental health court was started, and its potential impact on the community, while taking care not to reinforce common stereotypes about people with mental illnesses (e.g., that they are inherently violent or unable to live successfully in the community). Members of criminal justice and mental health agencies who may not be directly involved in the operation of the court should be made aware of its existence as a new component of the criminal justice and mental health systems, and should be educated about its key features and about how its philosophy differs from normal court processing.

EXAMPLE: West Virginia's Mental Health Court
(Hancock, Brooke, Ohio, and Marshall Counties, West Virginia)

The multi-jurisdictional mental health court in West Virginia has energetically publicized its program across the four participating counties. Court staff members have held information sessions for attorneys, other court personnel, law enforcement officers, civic groups and churches, and the community at large. These sessions have explained the national, state, and local dynamics of the involvement of people with mental illnesses in the criminal justice system, the goals and design of the mental health court program, and procedures for referring potential participants.

Local newspapers are increasingly showing interest in innovative responses to the overrepresentation of people with mental illnesses in the criminal justice system, and many courts have obtained favorable news coverage and even editorial support. Funding sources also like to promote the promise of their initiatives, and mental health courts should consider developing brief, clear, easy-to-read reports for funders, whether they are required or not. Finally, mental health court teams should select an

individual to represent the court at public hearings or other meetings at which the court will be discussed.

Ongoing input of stakeholders

Mental health court administrators must be careful not to let the day-to-day administration of the court program prevent opportunities for the ongoing input of the stakeholders who participated in the decision to establish a court. Regular meetings should be convened with lead officials from relevant criminal justice, mental health, substance abuse, advocacy, and other agencies to review the progress of the program. Such meetings do more than just keep various stakeholders abreast of program activity; they also help to ensure that the mental health court adheres to the original goals outlined by the agencies that signed on to its development, and improves the likelihood that representatives of those agencies will take steps to ensure the long-term sustainability of the program.

Coordination across courts

As more mental health courts are launched, it becomes increasingly likely that two or more will exist in a particular state. Some of these courts have recognized that coordination across jurisdictions can help gain the interest and support of the legislature or relevant statewide agencies, along with providing an opportunity to share strategies and discuss common challenges. Such coordination may entail developing common goals, program designs, or data collection strategies.

EXAMPLE: Nevada Mental Health Courts

The mental health courts in Clark County (Las Vegas) and Washoe County (Reno) are developing a plan to collect common outcome data. This will ensure that the report to the Legislature about the courts' progress will be based on consistent measures and will offer a clear understanding of the impact of the two programs. The court planners will also work to ensure that subsequent courts in the state use the same outcome measures.

EXAMPLE: New York State Unified Court System

Five mental health courts, each designed according to the unique needs of their communities, currently operate in New York State: Bronx, Brooklyn, Buffalo, Monroe County, and Niagara Falls. The New York State Unified Court System, through its partnership with the Center for Court Innovation, sponsored a meeting with representatives of each court to share and collect knowledge and to begin developing guiding principles for the establishment and operation of courts within the state, without insisting on a single "model" for all localities.

Conclusion

THE PROLIFERATION OF MENTAL HEALTH COURTS has been driven by collaboration between criminal justice and mental health staff at the local level, responding to the numerous challenges presented by people with mental illnesses who enter the court system.[73] Fueled by individual success stories, the popularity of problem-solving courts in general, and the desire to respond to an intractable social problem, jurisdictions will likely continue to establish mental health courts in the coming years. Their efforts should be applauded. In the face of overwhelming numbers of defendants with mental illnesses, many of whom appear repeatedly before the court, the development of new, creative solutions is admirable. Further, the limited available research and the experience of jurisdictions across the country both suggest that mental health courts show great promise.

But the expansion of mental health courts must be matched by rigorous efforts to assess their impact. More research is needed to better understand mental health court processes (i.e., how participants are identified and supervised), to identify the specific categories of defendants who benefit most from mental health court intervention, and to isolate the components of the "mental health court model" most responsible for its effectiveness. Such evaluations will be used not only to refine the design of current and future mental health courts, but also to advocate for their long-term sustainability. If the mental health court concept is to be supported over time, its effectiveness must be documented empirically. Individual courts can contribute to the development of this knowledge by collecting data about their own operation and outcomes.

Until that research emerges, the best guide for communities interested in implementing a mental health court is the experience of other jurisdictions, and the goal of this guide is to compile those experiences in a format useful to interested parties across the criminal justice, mental health, and related systems. With the enormous diversity in mental health courts across the country and insufficient evidence/base for them, prescriptions for structuring a mental health court are inappropriate, and this guide has attempted to avoid hard and fast rules. Nevertheless, readers will, hopefully,

develop a sense of how other courts have negotiated the complex issues related to the design and implementation of a mental health court, and which options may be best suited to their jurisdictions.

Regardless of their ultimate effectiveness, mental health courts—by definition intensive, specialized programs—lack the capability to respond fully to the vast numbers of people with mental illnesses who enter the criminal justice system. Accordingly, mental health court planners, court systems generally, and all criminal justice and mental health policymakers should consider how mental health courts may fit into a larger strategy for reversing the overrepresentation of people with mental illnesses in the criminal justice system. Toward that end, mental health courts should be closely coordinated with related programs, such as police-based and post-booking jail diversion programs, drug courts, and specialized probation caseloads for people with mental illnesses. Court administrators should also investigate the extent to which strategies at the core of mental health courts can be integrated into the general court system. Finally, criminal justice and mental health policymakers must ensure that the criminal justice system generally—and mental health courts in particular—do not become the preferred route to access mental health services.

Overcoming these broad challenges, and the practical difficulties of establishing effective mental health courts, will require the collective energy of numerous dedicated professionals, advocates, and consumers. Together, their efforts play an important role in a growing, nationwide effort to improve the lives of people with mental illnesses, the functioning of the criminal justice and mental health systems, and the health and safety of communities across the country.

Appendix A 2002-2003 BJA Mental Health Court Program grantees

Program name	State	Phone number
Allegheny County Mental Health Court	PA	(412) 350-7337
Athens County Mental Health Court Project	OH	(740) 594-8302
Bonneville County Mental Health Court	ID	(208) 356-6880
Boone County Mental Health Court	MO	(573) 886-4000
Bronx County Mental Health Court	NY	(718) 590-6954
Brooklyn Mental Health Court	NY	(718) 643-5603
Broward County Mental Health Court	FL	
Cheshire County Mental Health Court Project	NH	(603) 352-8215
Chittenden County Mental Health Court	VT	(802) 865-6179
Clackamas County Mental Health Court	OR	(503) 722-686
Court Coordinated Services (Yamhill County)	OR	(503) 434-7523
Court Transition Project (Pasadena)	CA	(626) 403-4370
Eighth Judicial District Mental Health Court (Las Vegas)	NV	(702) 455-6188
Franklin County Mental Health / SAMI Court	OH	(614) 222-3724
Hennepin County Mental Health Court	MN	(612) 348-3876
Jackson County Mental Health Court	MO	(816) 221-5000
King County Mental Health Court	WA	
Lane County Mental Health Court	OR	
Mahoning County Mental Health Court	OH	
Marlboro County Mental Health Court	SC	(843) 454-0841

Program name	State	Phone number
Santa Ana Mental Health Court	CA	(714) 834-2956
Mental Health Enhanced Supervision Project (Louisville)	KY	(502) 574-6336
Mental Health Treatment Court of Santa Clara	CA	(408) 491-4772
Missoula Mental Health Court	MT	(406) 258-4728
Multi-Jurisdictional Mental Health Court (Washoe County)	NV	(775) 325-6769
Muscogee County Mental Health Court	GA	(706) 596-5510
Buffalo Mental Health Court	NY	(716) 851-4157
Oklahoma County Mental Health Court Program	OK	(405) 522-8117
Orange County Community Resource Court Program	NC	(919) 913-4237
Orleans District Mental Health Court	LA	(504) 827-3470
Richland County Mental Health Court	SC	(803) 576-1964
St. Louis County Mental Health Court	MO	(314) 615-4772
Statewide Mental Health Court Program	DE	(302) 577-2711
Tarrant County Mental Health Court	TX	(817) 884-3218
Tempe Municipal Mental Health Court	AZ	(602) 506-3916
West Virginia's Mental Health Court (Brooke, Hancock, Marshall, and Ohio Counties)	WV	(304) 558-0145
Yavapai-Apache Mental Health Court	AZ	(928) 567-1033

Appendix B Conference of Chief Justices / Conference of State Court Administrators Resolution in Support of Problem-Solving Courts

CCJ Resolution 22

COSCA Resolution 4

WHEREAS, the Conference of Chief Justices and the Conference of State Court Administrators appointed a Joint Task Force to consider the policy and administrative implications of the courts and special calendars that utilize the principles of therapeutic jurisprudence and to advance strategies, policies and recommendations on the future of these courts; and

WHEREAS, these courts and special calendars have been referred to by various names, including problem-solving, accountability, behavior justice, therapeutic, problem-oriented, collaborative justice, outcome-oriented and constructive intervention courts; and

WHEREAS, the findings of the Joint Task Force include the following:

- The public and other branches of government are looking to courts to address certain complex social issues and problems, such as recidivism, that they feel are not most effectively addressed by the traditional legal process;
- A set of procedures and processes is required to address these issues and problems that are distinct from traditional civil and criminal adjudication;
- A focus on remedies is required to address these issues and problems in addition to the determination of fact and issues of law;

- The unique nature of the procedures and processes encourages the establishment of dedicated court calendars;
- There has been a rapid proliferation of drug courts and calendars throughout most of the various states;
- There is now evidence of broad community and political support and increasing state and local government funding for these initiatives;
- There are principles and methods grounded in therapeutic jurisprudence, including integration of treatment services with judicial case processing, ongoing judicial intervention, close monitoring of and immediate response to behavior, multidisciplinary involvement, and collaboration with community-based and government organizations. These principles and methods are now being employed in these newly arising courts and calendars, and they advance the application of the trial court performance standards and the public trust and confidence initiative; and
- Well-functioning drug courts represent the best practice of these principles and methods;

NOW, THEREFORE, BE IT RESOLVED that the Conference of Chief Justices and the Conference of State Court Administrators hereby agree to:

1. Call these new courts and calendars "Problem-Solving Courts," recognizing that courts have always been involved in attempting to resolve disputes and problems in society, but understanding that the collaborative nature of these new efforts deserves recognition.
2. Take steps, nationally and locally, to expand the principles and methods of well-functioning drug courts into ongoing court operations.
3. Advance the careful study and evaluation of the principles and methods employed in problem-solving courts and their application to other significant issues facing state courts.
4. Encourage, where appropriate, the broad integration over the next decade of the principles and methods employed in the problem-solving courts into the administration of justice to improve court processes and outcomes while

preserving the rule of law, enhancing judicial effectiveness, and meeting the needs and expectations of litigants, victims and the community.

5. Support national and local education and training on the principles and methods employed in problem-solving courts and on collaboration with other community and government agencies and organizations.
6. Advocate for the resources necessary to advance and apply the principles and methods of problem-solving courts in the general court systems of the various states.
7. Establish a National Agenda consistent with this resolution that includes the following actions;
    a. Request that the CCJ/COSCA Government Affairs Committee work with the Department of Health and Human Services to direct treatment funds to the state courts.
    b. Request that the National Center for State Courts initiate with other organizations and associations a collaborative process to develop principles and methods for other types of courts and calendars similar to the *10 Key Drug Court Components,* published by the Drug Courts Program Office, which defines effective drug courts.
    c. Encourage the National Center for State Courts Best Practices Institute to examine the principles and methods of these problem-solving courts.
    d. Convene a national conference or regional conferences to educate the Conference of Chief Justices and Conference of State Court Administrators and, if appropriate, other policy leaders on the issues raised by the growing problem-solving court movement.
    e. Continue a Task Force to oversee and advise on the implementation of this resolution, suggest action steps, and model the collaborative process by including other associations and interested groups.

Appendix C Sample referral form

MENTAL HEALTH COURT SCREENING AND REFERRAL FORM

MENTAL HEALTH COURT MONITOR
PHONE: (412) 350-4393
FAX: (412) 350-4395

DATE OF REFERRAL:_____

Client's Name:_____**AKA**_____

DOB: ___/_____/_____ **Gender:** _____ **Race:** _____

Social Security Number: _____-_____-_____

Allegheny County Jail (ACJ)? □ Yes □ No If yes, Date of Admittance: _____/_____/_____

If not in ACJ, where does client reside?_____

Phone Number: _____

Criminal Charge(s): _____

CC #(s) _____

Trial Status: □ Preliminary Hearing □ Formal Arraignment □ Pre-trial Conf. □ Trial

Probation Officer: _____ Phone Number _____

Mental Health Diagnosis: _____

Drug and Alcohol Use: □ Yes □ No

Referral Source: _____**Relationship to Client:** _____

Referral Source Phone Number: _____

A. Who is **ELIGIBLE** for Allegheny County Mental Health Court?
- Any client who voluntarily expresses an interest in Mental Health Court.
- A client who is currently charged with committing a misdemeanor and/or felony in Allegheny County.
- An adult male or female in Allegheny County awaiting a trial.
- A client who has a documented diagnosis of a mental illness, mental disability or is dually diagnosed with a mental illness in conjunction with drug and alcohol.

B. Who is **NOT ELIGIBLE** for Mental Health Court?
- Those who have committed the following crimes:
  - ∞ Assault by prisoner
  - ∞ Drug Trafficking
  - ∞ DUI
  - ∞ Homicide Offenses
  - ∞ Sexual Offenses
  - ∞ Theft by extortion with threats of violence
- Those who have an out of County or State Detainer.
- Those who only have Probation Violation Cases.

(Aggravated Assault, Arson, Burglary, Robbery & VUFA offenses may be reviewed on a case by case basis).

Revised 18-May-04

Appendix D Sample information release form

CITY OF BUFFALO C.O.U.R.T.S. PROGRAM/ BUFFALO CITY COURT/ BUFFALO DRUG COURT

****

CRIMINAL JUSTICE CONSENT TO RELEASE INFORMATION

****

I, _____ hereby consent to
(Name of Defendant/Client)
communication between The City Of Buffalo C.O.U.R.T.S. Program (Court Outreach Unit Referral and Treatment Services) Buffalo City Court and: _____
_____
_____
_____
_____
(Name all Persons and Agencies to which disclosure is to be made- i.e., Court/Prosecuting Agency/ Probation Agency)

The purpose of the disclosure and need for the disclosure is to inform the above named Criminal Justice Agency(ies)/ Person (s) of my attendance at, progress in and attitude toward my evaluation and treatment, results of urine toxicology and participation/cooperations
_____
_____

The extend of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, my prognosis and current status with the agency (ies)
_____
_____
_____

I understand that my participation in treatment is a condition of (check all that apply):

_____ My release from confinement.
_____ The execution of a sentence imposed upon me.
_____ The disposition of a criminal justice proceeding against me.
_____ The suspension of a sentence imposed upon me.
_____ Other action (specify): Condition of continued release

I understand that, until the Court sees fit, this consent will remain in effect and may not be revoked by me.

I understand that any disclosure made is bound by the Code of Federal Regulations Title 42, Part 2, governing confidentiality of alcohol and drug abuse patient records and the Code of Federal Regulations Part 45, Parts 160 and 164 (HIPAA), governing protected health information. any further disclosure of information pertinent to Drug or Alcohol user or must not be made unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part2.

_____ _____
(Signature of Defendant/Client) (Date)

_____
(Parent/Legal Guardian)

Appendix E Sample contract for participation

OKLAHOMA COUNTY MENTAL HEALTH COURT
PARTICIPANT PERFORMANCE CONTRACT

PARTICIPANT: _____ **CASE NO:** _____

DATE: _____ **CASE NO:** _____

I, agree to enter the Oklahoma County Mental Health Court. I understand and agree that I have certain obligations and responsibilities and will have to follow orders from the Judge, Mental Health Court Team and others involved in the Mental Health Court Program.

MY RESPONSIBILITIES ARE:

1. I will report as directed. I will keep all appointments for:
   - ☐ Court
   - ☐ Treatment
   - ☐ Case Management
   - ☐ Probation
   - ☐ Classes
   - ☐ Support Groups
   - ☐ All other appointments ordered by the Court.
2. I will take my medication as prescribed.
3. I will not leave Oklahoma County without a travel permit from my probation officer.
4. I will allow and cooperate with home visits from my probation officer, intensive case manager and any other designated Mental Health Court team member or designated representative.
5. I understand that my probation officer can search me, my vehicle, and any property under my control or my residence within the policy of the Department of Corrections.
6. I will obey all city, state, and federal laws. If I take part in any criminal act, I may be revoked from Mental Health Court. I will tell my probation officer immediately if I have any law enforcement contact.
7. I will not use alcohol, marijuana or other illegal drugs. I will submit to drug testing when instructed.
8. I will not associate with any known felon unless the felon is a family member. I will tell my probation officer if I have a family member who has a felony record. It is my responsibility to know if someone I associate with has a criminal record.
9. ***I will talk to my Probation Officer and Mental Health Court Intensive Case Manager before I make any changes in address, phone number or employment.***
10. I will not own or carry weapons of any kind. I will not be in a vehicle containing any weapon. I will not commit or threaten to commit any acts of violence.
11. I will pay all fees ordered by the court.
12. I will follow any rehabilitation, educational, vocational, medical, psychiatric, or substance abuse treatment program assigned by the Court.
13. I will sign all authorizations for release of information needed by the Mental Health Court, treatment provider(s) and other resource providers. If I choose not to sign these authorizations I may not be able to take part in the Mental Health Court program.

12

14. I understand that immediate action may be taken before the weekly staffing if I:
    - ❑ Don't keep an appointment ordered by the court (unexcused absence)
    - ❑ Don't comply with instructions from treatment providers or Mental Health Court team members
    - ❑ Test positive for alcohol or any non-prescribed drug
    - ❑ Violate court orders or break the law.

15. When I am in the court room:
    - ❑ I will dress appropriately
    - ❑ I will not talk during Court proceedings
    - ❑ I will not bring food or drink into the Courtroom
    - ❑ I will stay until the Judge dismisses me
    - ❑ I will not use profanity
    - ❑ I will be on time.

16. I will be supervised by the Mental Health Court Program UNTIL FURTHER ORDERED BY THIS COURT.

17. I agree to the special conditions as follows:

_____
_____
_____

I hereby acknowledge that I have read and understand my responsibilities as set forth her in above, and I have agreed to abide by each and every rule. With all present, this _____ day of _____ _____,20____.

_____ Mental Health Court Judge

_____ Participant

_____ Defense Attorney

_____ Assistant District Attorney

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About the Mental Health Courts Program

The Bureau of Justice Assistance administers the Mental Health Courts Program (MHCP), which has awarded grants to 37 mental health court projects nationwide since 2002. The MHCP funds projects that seek to improve the response to adult and juvenile offenders with mental illnesses through continuing judicial supervision and the coordinated delivery of mental health and related services. **www.ojp.usdoj.gov/BJA/grant/mentalhealth.html**

The program also provides technical assistance, coordinated by the Council of State Governments (CSG), to grantee courts and other jurisdictions. As part of its technical assistance effort CSG has developed four publications to aid communities considering or implementing a mental health court:

THIS GUIDE:

A Guide to Mental Health Court Design and Implementation provides detailed guidance on critical issues such as determining whether to establish a mental health court, selecting the target population, ensuring confidentiality, sustaining the court, and many others. Examples from existing mental health courts illustrate key points.

OTHER GUIDES IN THE SERIES:

What Is a Mental Health Court? introduces the mental health court concept, including the reasons why communities establish such courts, how they differ from drug courts, recent research, and concerns that these courts have raised.

Navigating the Mental Health Maze: A Guide for Court Practitioners offers a basic overview of mental illnesses, including their symptoms, diagnosis, and treatment, and discusses the coordination of treatment and court-based services.

A Guide to Collecting Mental Health Court Outcome Data provides practical strategies to both well-established and newly operating courts for deciding which data to collect; obtaining, evaluating, and comparing the data; and overcoming common challenges.

The Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system. BJA provides leadership, services, and funding to America's communities by emphasizing local control; building relationships in the field; developing collaborations and partnerships; promoting capacity building through planning; streamlining the administration of grants; increasing training and technical assistance; creating accountability of projects; encouraging innovation; and ultimately communicating the value of justice efforts to decisionmakers at every level.

810 Seventh Street, NW
Fourth Floor
Washington, DC 20531
Tel: (202) 616-6500 | Fax: (202) 305-1367
www.ojp.usdoj.gov/BJA/

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40 Broad Street
Suite 2050
New York, NY 10004
Tel: (212) 482-2320
Fax: (212) 482-2344
www.csgeast.org

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For more information please contact
editors@consensusproject.org

www.consensusproject.org/mhcourts/