Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report

RECOMMENDATIONS FOR CHANGING THE PARADIGM FOR PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

APRIL 2011

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

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CENTER FOR FAMILIES, CHILDREN
& THE COURTS

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Contents

Introduction 1

Background 2

Task Force Charge 6

Guiding Principles 8

Report and Recommendation Development 9

- The Role of the Courts in Addressing the Needs of Offenders with Mental Illness 9
- Recommendation Development Process 9
- Lanterman-Petris-Short Act 9
- Implementation of Recommendations 11
- Target Population 12
- Services 13
- Organization of Recommendations 14

Section 1: Prevention, Early Intervention, and Diversion Programs 16

- Coordination of Community Services 17
- Early Interventions/Prearrest Diversion Programs 18

Section 2: Court Responses 21

- Judicial Leadership 23
- Case Processing 24
- Coordination of Civil and Criminal Proceedings 26
- Competence to Stand Trial 27
- Additional Court Resources 29

Section 3: Incarceration 31

- The Booking/Admission Process: Early Identification and Continuity of Care 32
- Custody Mental Health Treatment and Services 33

Section 4: Probation and Parole 35

- Coordination of Mental Health Treatment and Supervision 36
- Alternative Reponses to Probation/Parole Violations 38

Section 5: Community Reentry 40

- Preparation for Release 41
- Implementation of the Discharge Plan 42
- Housing Upon Release 43

Section 6: Juvenile Offenders 45

- Juvenile Probation and Court Responses 46

Competence to Stand Trial 48
Juvenile Reentry 49
Collaboration 50
Education and Training 50
Research 51
Section 7: Education, Training, and Research 53
Education and Training for Judicial Officers, Attorneys, and Criminal Justice Partners 53
Collaboration With California Law Schools 56
Research 57
Conclusion 59
Appendices 60
Appendix A: Glossary of Terms 60
Appendix B: Mental Health Court Fact Sheet 67
Appendix C: Mental Health Court Research Brief 70
Appendix D: Sample Discharge Plan 77
Appendix E: Sample Inmate Mental Health Information Form 82
Appendix F: Juvenile Competency Issues in California Educational Session 83
Appendix G: Mental Health Treatment Issues in California Educational Session 84
Appendix H: California Counties With Collaborative Justice Courts 85

Introduction

The Task Force for Criminal Justice Collaboration on Mental Health Issues was established by former Chief Justice Ronald M. George and its members were appointed in February 2008 as part of a national project designed to assist state judicial leaders in their efforts to improve responses to people with mental illnesses in the criminal justice system. The task force was charged to explore ways to improve practices and procedures in cases involving adult and juvenile offenders with mental illness, to ensure the fair and expeditious administration of justice, and to promote improved access to treatment for defendants with mental illness in the criminal justice system. The court's position of leadership and neutrality makes the judicial branch uniquely situated to convene criminal justice partners and other stakeholders, and to facilitate interagency and interbranch efforts to improve outcomes for people with mental illness in the criminal justice system. The task force created recommendations that address all facets of the criminal justice system and provide guidelines for developing effective responses to people with mental illness in the criminal justice system. The recommendations focus on the following areas:

- Community-based services and early intervention strategies that reduce the number of individuals with mental illness who enter the criminal justice system;

- Court responses that enhance case processing practices for cases of defendants with mental illness and reduce recidivism for this population;

- Policies and procedures of correctional facilities that ensure appropriate mental health treatment for inmates with mental illness;

- Community supervision strategies that support mental health treatment goals and aim to maintain probationers and parolees in the community;

- Practices that prepare incarcerated individuals with mental illness for successful reintegration into the community;

- Practices that improve outcomes for juveniles who are involved in the delinquency court system; and

- Education, training, and research initiatives that support the improvement of criminal justice responses to people with mental illness.

Background

The judicial system is uniquely positioned to take a leadership role in coordinating an appropriate response to the disproportionate number of people with mental illness[1] in the criminal justice system. According to the Bureau of Justice Statistics, 56 percent of state prisoners and 64 percent of jail inmates nationwide were clinically diagnosed as having a mental disorder, received treatment by a mental health professional, or experienced symptoms of a mental disorder in the previous 12 months.[2] A significant portion of this population has a serious mental illness,[3] which is usually defined to include mental disorders that cause the most serious impairment, such as schizophrenia and other psychotic disorders, bipolar disorder, other severe forms of depression, and some anxiety disorders. Although only 5.7 percent of the general population has a serious mental illness,[4] 14.5 percent of male and 31 percent of female jail inmates have a serious mental illness.[5] Similar to jail populations, approximately 23 percent of California's prison inmates have a serious mental illness.[6] It is noted that inmates with serious mental illness often need the most resources and can be the most challenging to serve while incarcerated.[7]

Sadly, many experts in the field refer to jails and prisons as today's de facto mental health treatment facilities. The Los Angeles County Jail is often cited as housing more people with mental illness than the largest psychiatric treatment facilities in the country. A recent study reported that in California there are almost four times more people with mental illness in jails and prisons than in state and private psychiatric hospitals.[8] Furthermore, California's state psychiatric hospitals currently provide treatment primarily to a forensic population. California's forensic state hospital population of approximately 4,600 includes mostly individuals who have been found Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST) or who are categorized as Mentally Disordered Offenders (MDO) and Sexually Violent Predators (SVP).[9]

Persons with mental illness are also overrepresented in the courtroom. One study found that 31 percent of arraigned defendants met criteria for a psychiatric diagnosis at some point in their

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[1] See Appendix A: Glossary of Terms (glossary).
[2] Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates* (September 2006), *www.nami.org/Content/ContentGroups/Press_Room1/2006/Press_September_2006/DOJ_report_mental_illness_in_prison.pdf.*
[3] See glossary.
[4] Ronald Kessler, Wai Tat Chiu, Olga Demler, and Ellen Walters, "Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)," *Archives of General Psychiatry* 62(6) (2005), pp. 617–627.
[5] Henry J. Steadman, Fred C. Osher, Pamela C. Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60 (2009), pp. 761–765.
[6] Per e-mail correspondence with Division of Correctional Health Care Services, California Department of Corrections and Rehabilitation, May 24, 2009.
[7] Treatment Advocacy Center and the National Sheriffs' Association, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (May 2010).
[8] *Ibid.*
[9] Per e-mail correspondence with Long Term Care Services Division, California Department of Mental Health, January 13, 2009.

lives and 18.5 percent had a current diagnosis of serious mental illness.[10] In many instances, the traditional adversarial approach is ineffective when processing cases in which the defendant has a mental illness. Connecting the defendant to mental health treatment and support services is often essential to changing behavior and reducing recidivism. This, in turn, may require courts to adopt new collaborative approaches in working more closely with criminal justice partners and other community agencies if outcomes for offenders with mental illness are to be improved.

Once this population is released back to the community from either jail or prison, it is difficult to secure housing, treatment, and other necessary support services. In part, this is because many community agencies are hesitant to serve those with a criminal history and because services are often uncoordinated and supported by different funding sources. Many federal, state, county, and city government programs have complicated, overlapping, and sometimes conflicting eligibility requirements and fiscal restraints that can serve as barriers to accessing needed services and supports such as health coverage, housing, and employment. Large numbers of people with mental illness are released back to the community on probation[11] or parole[12] only to recidivate and return to the criminal justice system often because they lack access to services that support a smooth transition back into the community.

One study found that recidivism rates for probationers with mental illness are nearly double that of those without mental illness (54 percent compared to 30 percent). In addition, probationers with mental illness are significantly more likely to have their probation revoked than those without mental illness (37 percent compared to 24 percent).[13] Similarly, parolees with mental health issues are at a much higher risk of committing violations than those without mental health issues (36 percent higher risk of all types of violations and 70 percent higher risk of technical violations other than absconding).[14]

Not only does the current criminal justice system have high recidivism rates, it is also a costly system. The average annual cost per California prison inmate in 2008–09 was about $51,000.[15] Annual California jail bed costs in 2008–09 ranged from $25,000 to $55,000;[16] however, annual costs for inmates with mental illness are typically higher due to additional costs related to mental health staff, psychiatric medications, and other services that are associated with these inmates. For example, according to a 2007 survey of 18 California county probation departments,

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[10]Nahama Broner, Stacy Lamon, Damon Mayrl, and Martin Karopkin, "Arrested Adults Awaiting Arraignment: Mental Health, Substance Abuse, and Criminal Justice Characteristics and Needs," *Fordham Urban Law Review 30* (2002–2003), pp. 663–721.
[11] See glossary.
[12] See glossary.
[13]Lorena L. Dauphinot, "The efficacy of community correctional supervision for offenders with severe mental illness," 57(9-B) Dissertation Abstracts International: Section B: The Sciences and Engineering 5912 (March 1997).
[14] Ryken Grattet, Joan Petersilia, and Jeffrey Lin, *Parole Violations and Revocations in California* (Washington, DC: National Institute of Justice, October 2008), *www.ncjrs.gov/pdffiles1/nij/grants/224521.pdf.*
[15] California Legislative Analyst's Office, Overview of Adult Correctional Health Care Spending, March 18, 2010.
[16] Jail unit costs from the California Drug Court Cost Analysis Phase 3 Site Specific Reports, Administrative Office of the Courts and NPC Research, 2009.

detained youth with mental illness can cost at least $18,800 more than other youth.[17] Furthermore, costs can be extremely high for inmates who are in need of intensive psychiatric treatment. For example, in 2008 the cost of a bed for acute mental health services in a psychiatric unit of a county jail in California was $1,350 per day.[18] Treatment in state hospitals is also costly. In 2007–08, the average cost per patient in a state hospital was $194,732.[19]

Housing and treating people with mental illness in such institutions is often more costly than if these individuals were to be treated in community-based outpatient mental health treatment programs. A 2009 study found that the yearly cost for an individual with mental illness in a supportive housing program[20] in Los Angeles was $20,412.[21] Furthermore, housing and providing services to this population can greatly reduce incarceration costs. For example, a study of AB 2034[22] mental health programs servicing individuals with mental illness who were previously homeless or incarcerated found that such programs were associated with an 81 percent decrease in the number of incarceration days.[23]

Outpatient Services Are Less Costly

- *Annual prison cost for general population = $51,000*
- *Annual jail cost for general population = $25,000–$55,000*
- *Annual state hospital cost per patient = $194,732*
- *Annual community housing and treatment cost for persons with mental illness = $20,412*

Jail diversion and reentry programs for persons with mental illness are an additional source of cost savings. A 2004 study of three postbooking programs and one prebooking program found that criminal justice costs were significantly lower ($184–$1,956 less) for those who participated in a diversion program compared to those who were not diverted over a 12-month period.[24] Savings are typically associated with the avoidance of costs related to jail and prison stays, court cases, and probation and parole. A 2010 multisite mental health court (MHC) study found that compared to members of a treatment-as-usual group, MHC participants had a lower number of subsequent arrests, lower subsequent arrest rates, and a lower number of subsequent days spent

[17] Edward Cohen and Jane Pfeifer, *Costs of Incarcerating Youth with Mental Illness—Final Report* (Chief Probation Officers of California and California Mental Health Directors Association, study conducted from 2005 to 2007), www.cdcr.ca.gov/COMIO/docs/Costs_of_Incarcerating_Youth_with_Mental_Illness.pdf
[18] Agreement between the County of San Mateo and the County of Santa Clara for Acute Inpatient Mental Health Services for Inmates, July 1, 2008.
[19] Office of State Audits and Evaluations, *California Department of Mental Health State Hospital Budget Estimate Review* (November 2008).
[20] See glossary.
[21] Daniel Flaming, Michael Matsunaga, and Patrick Burns, *Where We Sleep: The Cost of Housing and Homelessness in Los Angeles* (Economic Roundtable, November 2009).
[22] See glossary.
[23] Shannon Mong, Beth Conley, and Dave Pilon, *Lessons Learned From California's AB 2034 Programs* (March 2009).
[24] Alexander J. Cowell, Nahama Broner, and Randolph Dupont, "The Cost-Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse," *Journal of Contemporary Criminal Justice* 20(3) (2004), pp. 292–314.

incarcerated.[25] A RAND evaluation of a mental health court found that the mental health court program was associated with a decrease in jail expenditures ($5,948 per person over two years).[26] It is also important to note that numbers of arrests can be used as indicators of public safety. Therefore, in addition to being associated with cost savings, MHCs and other diversion programs may also increase public safety by reducing criminal behavior as reflected in a reduction in arrests.

In addition to costs, issues related to civil rights, quality of life, service accessibility, interbranch and interagency collaboration, and training and research needs must be considered when addressing the overrepresentation of persons with mental illness in the criminal justice system. Because the criminal justice system is often where social and criminal problems intersect, courts are uniquely positioned to convene stakeholders to address the issues that surface when people with mental illness enter the criminal justice system. With the recognition that the judicial system can play a facilitative role in supporting the community safety net for people with mental illness, the Task Force for Criminal Justice Collaboration on Mental Health Issues was created.

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[25] Henry J. Steadman, Allison Redlich, Lisa Callahan, Pamela Clark Robbins, and Roumen Vesselinov, "Effect of Mental Health Courts on Arrests and Jail Days," *Archives of General Psychiatry* (October 4, 2010), *http://archpsyc.ama-assn.org/cgi/content/short/archgenpsychiatry.2010.134v1?rss=1* (as of Feb. 23, 2011).

[26] Susan Ridgely, John Engberg, Michael D. Greenberg, Susan Turner, Christine DeMartini, and Jacob W. Dembosky, *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court* (RAND, 2007).

Task Force Charge

In 2007, the Council of State Governments (CSG) selected California as one of seven states to receive funding to establish a task force that would develop recommendations for policymakers related to the improvement of systemwide responses to offenders with mental illness. As a result, former Chief Justice Ronald M. George established the Task Force for Criminal Justice Collaboration on Mental Health Issues and appointed Justice Brad R. Hill of the Court of Appeal, Fifth Appellate District as task force chair. Task force members were appointed in 2008 and include representatives from all three branches of government and a variety of stakeholders involved at the interface of the mental health and criminal justice systems, including legislators, judicial officers, directors of state and local mental health and drug and alcohol programs, attorneys, consumer[27] and family mental health advocates, corrections administrators, researchers, and law enforcement personnel.

In establishing the Task Force for Criminal Justice Collaboration on Mental Health Issues, California builds upon previous efforts by judicial leaders nationwide in addressing issues related to people with mental illness in the criminal justice system. In July 2004, the Conference of Chief Justices and Conference of State Court Administrators adopted Resolution 22, which encourages states to expand the use of problem-solving court principles and methods. In January 2006, the Conference of Chief Justices adopted Resolution 11 in support of the Criminal Justice/Mental Health Leadership Initiative of the Council of State Governments, which urges chief justices to assume a leadership role in addressing criminal justice and mental health issues through the use of problem-solving court principles.

California's Task Force for Criminal Justice Collaboration on Mental Health Issues was established to explore ways to improve practices and procedures in cases involving adult and juvenile offenders with mental illness, to ensure the fair and expeditious administration of justice, and to promote improved access to treatment for defendants with mental illness in the criminal justice system.

The task force was charged with developing recommendations for policymakers, including the Judicial Council and its advisory committees, to improve systemwide responses to offenders with mental illness. Specifically, the task force was charged to do the following:

- Identify needs for court-related programs and services that address offenders with mental illness in adult and juvenile courts;
- Promote interbranch and interagency collaboration at state and local levels to identify barriers and create opportunities to improve case processing and outcomes;
- Disseminate locally generated best practices to trial courts and partner agencies;

[27] See glossary.

- Identify methods for evaluating the long-term effectiveness of mental health programs in the courts and for identifying best or promising practices that improve case processing and outcomes;
- Provide policymakers with recommendations to improve services and case processing for cases involving offenders with mental illness;
- Advise the Judicial Council and its advisory committees of funding needs and potential resources;
- Provide access to education and outreach programs designed to enhance the effectiveness of case processing and outcomes for cases that involve offenders with mental illness in adult and juvenile courts; and
- Serve as a clearinghouse for ideas, questions, and comments generated in the course of preparing recommendations.

Guiding Principles

Early on, task force members discussed principles that subsequently focused the work of the task force and the formulation of its recommendations. These guiding principles include the following:

- Courts should take a leadership role in convening stakeholders to improve the options and outcomes for those who have a mental illness and are at risk of entering or have entered the criminal justice system.
- Resources must be put toward identifying individuals with mental illness who are involved or who are likely to become involved with the criminal justice system. Interventions and diversion possibilities must be developed and utilized at the earliest possible opportunity.
- Diversion opportunities should exist for defendants with mental illness as they move through the criminal justice system.
- Treatment and disposition alternatives should be encouraged for individuals who are detained, arrested, or incarcerated primarily because of actions resulting from a mental illness or lack of appropriate treatment.
- Effective responses to this population require the collaboration of multiple systems and stakeholders because offenders with mental illness interface with numerous systems and agencies as they move through the criminal justice system.
- Flexible and integrated funding is necessary to facilitate collaboration between the various agencies that interact with offenders with mental illness.
- Offenders with mental illness must receive continuity of care as they move through the criminal justice system in order to achieve psychiatric stability.
- Information sharing across jurisdictions and agencies is necessary to promote continuity of care and appropriate levels of supervision for offenders with mental illness.
- Individuals with mental illness who have previously gone through the criminal justice system, and family members of criminally involved persons with mental illness, should be involved in all stages of planning and implementation of services for offenders with mental illness.
- Programs and practices considered best practice models should be adopted in an effort to effectively utilize diminishing resources and improve outcomes.

Report and Recommendation Development

The Role of the Courts in Addressing the Needs of Offenders with Mental Illness

A systemic approach that brings together stakeholders in the justice system with mental health treatment providers and social service agencies is required to address the needs of offenders with mental illness. Courts are uniquely positioned to take a leadership role in forging collaborative solutions by bringing together these stakeholders.

The work of the Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues hinges upon the judicial branch's unique capacity to facilitate collaboration among the system partners involved. Task force membership represents the full array of stakeholders who were charged with developing systemwide responses to offenders with mental illness. The task force acknowledges the interrelated functions of different parts of the system. While some of the recommendations presented by the task force may initially appear to be outside of the domain of the judicial branch, it is recognized that not addressing particular areas of the system could have a deleterious impact on the branch and be antithetical to the charge of the task force.

Recommendation Development Process

The Task Force for Criminal Justice Collaboration on Mental Health Issues held its first meeting on April 23, 2008. Over the next three years, the task force held 8 public meetings, 2 special educational sessions, over 40 subcommittee meetings, and 2 public hearings.

The task force looked at evidence-based practices as the foundation for the development of recommendations, and task force members took part in numerous activities to inform their discussions while crafting the recommendations. They reviewed current research findings, invited representatives from innovative programs from across the state to share best or promising practices, participated in conferences related to the work of the task force, and took part in site visits at courts operating programs for defendants with mental illness. In addition, task force members met with key stakeholders, including state hospital administrators, Mental Health Services Act (MHSA/Proposition 63) interagency partners, youth advocates, and other constituencies not directly represented on the task force.

Lanterman-Petris-Short Act

During the recommendation development process, the task force spent a significant amount of time discussing issues related to the Lanterman-Petris-Short (LPS) Act,[28] Laura's Law,[29] and other legislation related to involuntary treatment. Involuntary treatment is a sensitive topic that has long been debated in the mental health field. The diverse perspectives found within the field on this topic were reflected in task force members' viewpoints. To highlight some of the significant issues related to involuntary treatment, the Administrative Office of the Courts hosted

[28] See glossary.
[29] See glossary.

an education session for task force members on voluntary and involuntary mental health treatment in California in January 2010.[30]

During the public comment period, several individuals and agencies submitted comments about the LPS Act. Some encouraged the task force to aggressively address issues outlined in the LPS Act, such as involuntary treatment and conservatorships, whereas other commentators asked the task force to remove all recommendations that touched upon such issues. Because LPS is a sensitive issue that was raised by several commentators and which the task force members discussed at length, a discussion of broad issues related to LPS and the task force's approach are outlined below.

The Lanterman-Petris-Short Act was passed in 1967 primarily in response to concerns about the inappropriate involuntary commitment of individuals with mental illness to mental institutions.[31] At the time the LPS Act was passed, the conditions in state hospitals were of serious concern and such facilities were becoming an unsustainable cost to the state. Prior to passage of the law, persons with mental illness could essentially be committed involuntarily upon the referral of a clinician and could be committed for indefinite periods of time. The act had an enormous impact on the mental health service delivery system by facilitating a shift from state hospitals as the focal point of care to community-based programs, and also significantly changed the conditions under which persons may be treated involuntarily for mental illness.[32] Under LPS, treatment may not be provided involuntarily unless it is proven that the individual is gravely disabled or is considered a danger to themselves or others.

Most mental health practitioners and policymakers agree that reform of the mental health system of during the 1950s and1960s was badly needed; however, some believe the reforms enacted are excessively restrictive and impede the system's ability to provide needed services to persons experiencing psychiatric distress. Critics often state that highly symptomatic persons with mental illness may not have the capacity to make treatment decisions for themselves but do not meet criteria for involuntary commitment and, therefore, go untreated. These untreated individuals can become involved in the criminal justice system due to behaviors that might have been managed with proper treatment. Many critics of LPS believe that modifying the legislation to facilitate the provision of treatment to those they consider most in need will result in reducing the number of individuals with mental illness involved in the criminal justice system.

Others believe that the current commitment criteria outlined in the LPS Act are adequate and provide necessary safeguards of individual rights through judicial review. Proponents of maintaining current LPS protections believe that LPS rightfully upholds an individual's freedom and preserves an individual's right to manage his or her health care. It is often asserted that there

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[30] See Appendix F for the agenda of the educational session.
[31] Cal. Welf. & Inst. Code, § 5001.
[32] Harry R. Brickman, "Government and Medicine II: California's Short-Doyle Program, The New Mental Health System: Changes in Procedure, Implications for Family Physicians," *California Medicine* 109(5) (1968), pp. 403–408.

are legitimate reasons why a person would want to opt out of treatment, including that side effects of psychiatric medications can be severely uncomfortable and can involve serious health risks. Many believe that informed choice in regard to treatment is essential to recovery and maintaining one's mental health. Furthermore, negative experiences with involuntary treatment may make people more hesitant to access any form of treatment at a later point in time. Proponents of current LPS criteria often state that persons with mental illness are overrepresented in the criminal justice system not because of this legislation, but because of the dearth of voluntary community-based mental health services.

Ultimately, upon review of its charge, the task force decided that it would not address involuntary commitment criteria as outlined in the LPS Act. However, some recommendations that refer to other matters outlined under the LPS Act, such as the initiation of conservatorship proceedings, were developed. It is important to note that there was not unanimous agreement among task force members on recommendations about conservatorship proceedings.

Most experts in the mental health field and members of the task force agree that the array of community-based mental health services outlined in the LPS Act were never established and that the development and sustainment of a continuum of voluntary community-based mental health services is essential. If more mental health treatment and other support services were made available and easily accessible, the topic of involuntary treatment would perhaps be less on the forefront. In summary, task force members were profoundly interested in these topics and expressed a desire to continue a productive dialogue.

Implementation of Recommendations

Task force members recognize that some of the recommendations may require additional funding, legislative changes, or changes in the culture and practices of systems involved in responding to people with mental illness in the criminal justice system. Many of the original draft recommendations included qualifying statements such as "to the extent possible" or "as funding permits." Ultimately the task force removed such language after reaching a consensus that, in addition to recommendations that can be implemented immediately, the report should contain aspirational recommendations that serve as a blueprint for the best possible response to criminally involved people with mental illness.

During the development of recommendations, members of the task force were sensitive to the current economic climate and the fiscal difficulties faced by state and local government and community-based programs. As the task force was developing its report and recommendations, California was in the midst of the worst economic crisis since the Great Depression. This crisis had significant ramifications on California's ability to provide an adequate level of mental health services. In addition, the mental health system is still recovering from the loss of the Mentally Ill Offender Crime Reduction (MIOCR) grant program, eliminated by the California Legislature in 2009. In difficult economic times, it is imperative that courts and counties jointly develop and pursue programs, services, and interventions that will best maximize resources to improve outcomes for offenders with mental illness. The task force acknowledges that smaller counties

may have limited resources to implement some of the more costly or resource intensive recommendations and, therefore, encourages such counties to explore collaborative partnerships as a method for implementing many of the recommendations without additional funding.

It is important to note that task force members also put forward many cost-neutral recommendations that do not require additional funding. Even in the current fiscal environment, many recommendations can be implemented at little or no cost through cooperative ventures and through innovative collaborative efforts with state and local criminal justice and mental health partners. In fact, many of the recommendations are associated with cost savings as they often focus on ways to maintain offenders with mental illness in the community through connections to treatment services as an alternative to costly state hospital stays or incarceration in local or state facilities.

Recommendations were developed to provide a general guideline, acknowledging that courts and county partners may require flexibility in developing appropriate local responses to improving outcomes for people with mental illness in the criminal justice system. Although some recommendations are detailed and specific, many of the recommendations were written broadly to allow for flexibility regarding implementation. For example, various recommendations were created to be applicable to both jails and prisons as well as to both probation and parole, recognizing that the implementation of such recommendations will look different depending on the jurisdiction. Similarly, task force members were sensitive to the differences between California's counties and courts, recognizing that county size, county resources, and local county culture will influence what type of collaborative efforts would be most effective.

It is important to note that as task force members were finalizing recommendations, President Barack Obama signed health insurance reform into law. Early analyses suggest that implementation of this legislation could increase resources for mental health providers and expand coverage for many people with mental illness in California. Under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, basic benefit packages for all health plans are required to cover mental health and substance use disorder services; Medicaid eligibility will be expanded and benefits must include coverage of mental health services covered at actuarial equivalence; a three-year Medicaid emergency psychiatric demonstration project will be implemented; and grants will be awarded to programs that colocate primary and specialty care in community-based mental health settings, and to programs that demonstrate excellence in the treatment of depressive disorders.[33]

Target Population

The work of this task force, per its charge, focused on offenders with mental illness or those with a mental illness who are at risk of committing crimes and becoming involved in the criminal

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[33] Congressional Research Service, public law summary of the Patient Protection and Affordable Care Act; Democratic Policy Committee, "Affordable Care Act: Section-by-Section Analysis with Changes Made by Title X and Reconciliation," http://dpc.senate.gov/healthreformbill/healthbill96.pdf.

justice system. There is great diversity in the way mental illness and serious mental illness is defined. For purposes of this report, "mental illness" is used as a collective term for all diagnosable mental disorders; "serious mental illness" is defined to include schizophrenia and other psychotic disorders, bipolar disorder, other severe forms of depression, and some anxiety disorders, such as obsessive compulsive disorder, that cause serious impairment. The recommendations in this report primarily focus on individuals with diagnoses that fall within the scope of serious mental illness. Although some recommendations specifically mention co-occurring disorders,[34] the terms "mental illness" or "offenders/people with mental illness" throughout the report should be understood to include co-occurring disorders, as approximately 50 percent of those with a mental illness also have a co-occurring substance use disorder.[35] Furthermore, studies show that incarcerated individuals with a severe mental illness have a 72 percent rate of co-occurring substance use disorder.[36]

Throughout the report several terms are used to describe the population noted in the task force charge, depending on the status of the individual and where he or she is in the criminal justice system. For example, when referring to those who are in the process of case adjudication, the term "defendant with mental illness" is used, whereas those recommendations concerning postadjudication matters may use the term "offender with mental illness."

Services

The task force discussed the unique needs of subpopulations of persons with mental illness who are at risk of entering or who have already entered the criminal justice system. The experiences and needs of persons with mental illness who are elderly; women; veterans; transition age youth;[37] lesbian, gay, bisexual, or transgender (LGBT); whose first language is not English; who are from diverse cultures; and who are from minority and underserved populations must be considered and incorporated into the development of programs and services.[38] For example, persons from underserved populations often reside in communities that lack mental health services, making service availability and access a priority for these communities. Gender-specific and trauma-informed services are essential as incarcerated women with mental illness often have histories of trauma. Similarly, girls in the juvenile justice system have experienced higher rates of physical neglect and higher rates of physical, sexual, and emotional abuse than boys.[39] For elderly incarcerated individuals with mental illness, the coordination of medical and mental health services is essential to effectively manage medication needs and to prevent

[34] See glossary.
[35] California Department of Alcohol and Drug Programs, Co-Occurring Disorders Information *(Co-Occurring Disorders Fact Sheet)* www.adp.state.ca.us/COD/documents.shtml *(as of December 2010)*
[36] Karen M. Abram and Linda A. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46(10) (1991), pp. 1036–1045; the CMHS National GAINS Center, *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails* (2002), www.gainscenter.samhsa.gov/html/resources/publications.asp.
[37] See glossary.
[38] This list is not intended to be exhaustive.
[39] Kristen M. McCabe, Amy E. Lansing, Ann Garland, and Richard Hough, "Gender Differences in Psychopathology, Functional Impairment, and Familial Risk Factors Among Adjudicated Delinquents," *Journal of the American Academy of Child and Adolescent Psychiatry* 41(7) (2002), pp. 860–867.

unnecessary and harmful polypharmacy.[40] Veterans have unique experiences and needs often related to post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI), making it essential to connect veterans with veteran-specific resources and programs. Because it was not possible to tailor recommendations to each possibly relevant subpopulation, it should be understood that when services or programs are recommended within this report, it is anticipated that such services and programs must be developed to meet the unique needs of the specific population.

The task force intends for all services and programs described in the recommendations to support a recovery philosophy (in that they promote hope, personal empowerment, respect, social connections, self-responsibility, and self-determination), to be culturally and linguistically competent, and, whenever possible, to be informed by mental health clients who have had experiences with the criminal justice system. Furthermore, peer-run programs and services, such as self-help and wellness centers, warm lines, and crisis respite programs are encouraged and should always be considered as a possible option if available in the community.

It is also important to note that when the term "treatment" or "mental health treatment" is used in this report, it refers to the array of interventions and services that may be needed to promote client wellness and recovery. The term treatment should be understood to include, but not be limited to, behavioral counseling, including counseling that focuses on criminogenic risk factors and peer-provided counseling, support groups, case management, vocational services, supportive housing, medications, and medication management support.

Organization of Recommendations

The task force used the Sequential Intercept Model (SIM)[41] as a framework for formulating and organizing its recommendations. The SIM illustrates various points along the criminal justice continuum where interventions may be utilized to prevent individuals from entering the criminal justice system or from becoming more deeply involved in the system. Ideally, most people will be diverted before entering the criminal justice system, with decreasing numbers at each subsequent point along the criminal justice continuum.[42]

Similar to the SIM framework, this report begins with recommendations that aim to make evidence-based community mental health services more accessible to prevent people with mental illness from entering the criminal justice system. Recommendations regarding initial contact with law enforcement are also included in the first set of recommendations, recognizing that this is an important opportunity for diversion. The second set of recommendations is applicable for those who were not initially diverted from the criminal justice system and focuses on court-based strategies and responses. The third and fourth sets of recommendations outline responses related

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[40] Judith F. Cox and James E. Lawrence, "Planning Services for Elderly Inmates With Mental Illness," *Corrections Today* (June 1, 2010).
[41] Created by Summit County, Ohio, and the National GAINS Center.
[42] Mark R. Munetz and Patricia A. Griffin, "Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness," *Psychiatric Services* 57 (April 2006), pp. 544–549.

to individuals in custody or on probation or parole. The fifth set of recommendations focuses on reducing recidivism and ensuring successful community reentry for offenders with mental illness. The sixth set of recommendations focuses exclusively on juveniles with mental health issues in the delinquency system. The final sections of the report highlight the education, training, and research necessary to effectively implement the recommendations and to measure the effectiveness of practices targeting offenders with mental illness.

Section 1: Prevention, Early Intervention, and Diversion Programs

There are several factors believed to contribute to the prevalence of people with mental illness in the criminal justice system. These include, but are not limited to, the nature of the illness, negative stigmatization, homelessness, and decentralized and often underfunded mental health service delivery systems.

When mental illness is not effectively managed, it can be extremely difficult to maintain a stable lifestyle and living situation, leaving a substantial number of people with mental illness homeless. Research shows that as many as 46 percent of those who are homeless have a mental illness.[43] The New Freedom Commission on Mental Health reports that "the lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, institutions, shelters, and the streets."[44] People who live on the street often come into contact with law enforcement for quality-of-life crimes such as disturbing the peace and public intoxication. In addition, homeless people with mental illness often use drugs and alcohol, further exposing this population to interaction with law enforcement.

People with mental illness are more likely to be arrested than those in the general population for similar offenses.[45] This might be attributed to negative stigmas associated with mental illness or to "compassionate arrests" where an officer makes an arrest in order to secure services for the individual or to remove him or her from the street. Although law enforcement has frequent contact with people with mental illness and many departments have instituted specialized mental health training, officers may not have adequate education or training about mental illness and how to react to symptomatic behaviors. Furthermore, officers frequently don't have places other than jail to bring an individual in need of immediate attention. Contact with law enforcement can serve as a critical opportunity for diverting individuals with mental illness from the criminal justice system and connecting these individuals to appropriate mental health and social services. In the recommendations that follow, such opportunities for diversion are referred to as "prearrest diversion"[46] opportunities.

People with mental illness or co-occurring disorders are often in need of a multitude of resources, including, but not limited to, housing, income maintenance programs (e.g., Supplemental Security Income, Social Security Disability Insurance, and CalWORKs), medical insurance, vocational services, a variety of mental health treatments, and drug and alcohol services. These services are provided by different systems, and the coordination of such services can be overwhelming. The absence of standardized information-sharing systems further

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[43] Martha Burt, "What will it take to end homelessness?" (2001) Urban Institute Brief.
[44] New Freedom Commission on Mental Health, "Subcommittee on Housing and Homelessness: Background Paper" (June 2004).
[45] Judith F. Cox, Pamela C. Morschauser, Steven Banks, and James L. Stone, "A five year population study of people involved in the mental health and local correctional systems: Implications for service planning," *The Journal of Behavioral Health Services and Research* 28(2) (2001), pp. 177–187.
[46] See glossary.

complicates the coordination of services, while issues of confidentiality can pose problems for intersystem collaboration and continuity of care. Finally, in challenging fiscal times many mental health and other supportive services are cut, making it difficult for this population to receive the services they need and are entitled to.

In addition to being adequate and available, mental health services must also be easily accessible, with eligibility and enrollment procedures that are clear and streamlined, outreach that is performed to an adequate extent, and services that are sensitive and tailored to the population in need. According to the U.S. Surgeon General's report on mental health, most people with mental disorders do not seek treatment, due to a multiplicity of reasons related to demographic factors, patient attitudes toward a service system that often neglects the special needs of racial and ethnic minorities, finances, and the organization of service systems. [47]

The recommendations below may be best addressed through local task forces as the recommendations focus on community agencies serving people with mental illness and on local law enforcement. By improving access to local services, and by training law enforcement to capitalize on opportunities for diversion, there will likely be fewer individuals with mental illness entering the justice system.

Coordination of Community Services

To prevent entry or reduce the number of people with mental illness entering the criminal justice system, both public and private services that support this population should be expanded and coordinated. Having a range of available and effective mental health treatment options can help prevent people with mental illness from entering the criminal justice system.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

1. Community partners should collaborate to ensure that community-based mental health services are available and accessible. Community services should include, but are not limited to, income maintenance programs,[48] supportive housing[49] or other housing assistance, transportation, health care, mental health and substance abuse treatment, vocational rehabilitation, and veterans' services. Strategies should be developed for coordinating such services, such as colocation of agencies and the provision of interagency case management services. Services should be client centered, recovery based, and culturally appropriate.

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[47] U.S. Department of Health and Human Services, "The Fundamentals of Mental Health and Mental Illness: Overview of Treatment," part of chapter 2 in *Mental Health: A Report of the Surgeon General* (1999), http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec6.html#issues (as of Feb. 24, 2011).
[48] See glossary.
[49] See glossary.

2. State and county departments of mental health and drug and alcohol should design and adopt integrated approaches to delivering services to people with co-occurring disorders that cross traditional boundaries between the two service delivery systems and their funding structures. Resources and training should be provided to support the adoption of evidence-based integrated co-occurring disorder treatment, and information from existing co-occurring disorder work groups (e.g., Co-Occurring Joint Action Council and Mental Health Services Oversight and Accountability Commission) should inform the development of integrated service delivery systems.

3. Mental health programs, including both voluntary and involuntary services, should be funded at consistent and sustainable levels. Funding should be allocated to programs serving people with mental illness that utilize evidence based practices (e.g., programs established under AB 2034[50] that serve homeless individuals with mental illness).

4. Community mental health agencies should utilize resources such as the California Network of Mental Health Clients;[51] National Alliance on Mental Illness, California (NAMI CA);[52] the United Advocates for Children and Families;[53] local community-based programs that interact with populations most in need; and peer networks to perform outreach and education about local mental health services, drug and alcohol programs, and other programs that serve individuals with mental illness in order to improve service access.

A program, run by the City Attorney's Office in Los Angeles, helps homeless individuals, many of whom have mental illnesses and/or substance abuse problems, obtain a clean criminal record and receive housing and services. The Homeless Alternatives to Living on the Street (HALO) program has several components, including a prefiling jail diversion program (previously called Streets or Services); a postfiling diversion program where defendants are placed in housing and services and may have their cases dismissed upon successful completion of the program; a citation clinic where citations and warrants are dismissed if the individual participates in four hours of community service or treatment; and a Homeless Court.

Early Interventions/Prearrest Diversion Programs

Criminal justice partners, local mental health agencies, other service providers, and mental health clients and family members should collaborate to create early intervention strategies, including prebooking diversion programs to prevent people with mental illness from entering the criminal justice system.

[50] See glossary.
[51] See glossary.
[52] See glossary.
[53] See glossary.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

5. Local task force or work groups composed of representatives from criminal justice and mental health systems should be created to evaluate the local needs of people with mental illness or co-occurring disorders at risk of entering the criminal justice system, to identify and evaluate available resources, and to develop coordinated responses.

6. Local mental health agencies should coordinate and provide education and training to first responders about mental illness and available community services as options for diversion (e.g., detoxification and inpatient facilities, crisis centers, homeless shelters, etc.).

7. Law enforcement and local mental health organizations should continue to expand the development and utilization of Crisis Intervention Teams (CIT),[54] Mobile Crisis Teams (MCT),[55] and Psychiatric Emergency Response Teams (PERT)[56] to effectively manage incidents that require responses by law enforcement officers. Such teams provide mental health expertise through specially trained police officers or through mental health professionals who accompany officers to the scene. Smaller counties unable to assemble response teams should consider alternative options such as a mental health training module for all cadets and officers.

8. Community-based crisis centers that operate 24 hours daily, 7 days a week, should be designated or created to ensure that law enforcement officers have increased options for people with suspected mental illness in need of timely evaluation and psychiatric stabilization. Local mental health providers, hospitals, and law enforcement agencies should collaborate to designate or create such crisis centers so that individuals are appropriately assessed in the least restrictive setting.

The Restorative Policing Program in San Rafael *is an interagency collaboration specializing in the treatment of people with mental illness who frequently have contact with law enforcement. Each month, social service, criminal justice, and treatment-providing agencies meet to develop individualized case management plans for each client referred by law enforcement. The partnership allows community service providers to utilize law enforcement to gain the outreach and community presence required to intervene with those with mental illness at risk of entering the criminal justice system. Furthermore, the partnership also assists police departments with difficult cases or situations involving people with mental illness.*

[54] See glossary.
[55] See glossary.
[56] See glossary.

9. People with mental illness, working with their mental health care providers, should be encouraged to create Psychiatric Advance Directives (PADs)[57] to distribute to family members or members of their support system so that vital treatment information can be provided to law enforcement officers and other first responders in times of crisis. The development of PADs should be encouraged for persons discharged from correctional or inpatient facilities. PADs should be included in clients' personal health records and abbreviated PADs could be made available in the form of a wallet card.

10. Discharge planning protocols should be created for people released from state and local psychiatric hospitals and other residential facilities through collaborations among the hospitals, community-based agencies, and pharmacies to ensure that no one is released to the streets without linkage to community services and stable housing. Discharge planning should begin upon facility entry to support a successful transition to the community that may prevent or minimize future interactions with the criminal justice system. Clients, as well as family members when appropriate, should be involved in the development of discharge plans.

Psychiatric advance directives *express an individual's preferences and instructions for treatment in the event that he or she is unable to consent to care. Such directives may provide information about the effectiveness or ineffectiveness of current or past treatment as well as provider contact information. Finally, PADs can relay information about contraindications for particular treatments considered. As a result, PADs can beneficially inform treatment providers, support the efficacy of treatments chosen, and prevent adverse treatment incidents. They may also address issues related to non-consent including the absence of consent or refusal to consent in the midst of a mental health crisis. Consequently, determining the existence of and implementing PADs can support effective jail-based mental health care and facilitate the implementation of court-ordered treatment.*

[57] See glossary.

Section 2: Court Responses

Once people with mental illness enter the criminal justice system and are involved in the court process, they face a new set of complications and difficulties. The negotiation of dispositions may require more time for cases involving defendants with mental illness. In some instances, defendants with mental illness are not granted the same opportunities for pretrial release and deferred prosecution programs as are defendants with similar cases who do not have a mental illness.[58] The quality of representation that defendants with mental illness receive is dependent on their attorneys' knowledge about mental illness and its impact on behavior. Defense attorneys often do not have information related to their client's current mental health status or their mental health history, and may not be aware of community mental health services available to the client. In summary, judicial officers and counsel need specialized knowledge to address the issues that often surface when adjudicating cases of defendants with mental illness.

In some instances having a mental illness can interfere with a defendant's ability to understand and participate in the adjudication of his or her case. Defendants with mental illness may be found incompetent to stand trial due to their mental disorder, resulting in the suspension of case proceedings until competency is restored. The restoration process, which usually involves the provision of psychiatric medications, must take place in a state hospital or a public or private treatment facility approved by the community program director. Restoration of competency is often a lengthy process as local facilities and state hospitals are constantly at capacity. The wait time for state hospital admission can sometimes last up to six months. Although defendants can be restored in the community (depending on the charge), many counties don't have the resources for outpatient placement, and judicial officers, staff of Conditional Release Programs (CONREP),[59]and county mental health directors may be hesitant to utilize this option as it requires closer supervision, and community mental health providers might not be experienced in serving forensic clients.

In 2007, California Senate Bill 568 was passed, designating jails as treatment facilities for the purpose of administering antipsychotic medications to defendants found incompetent to stand trial due to a mental disorder (Pen. Code, § 1369.1). This bill was passed as an interim measure to address the long waiting periods for state hospital admission due to inadequate bed space and a lack of community alternatives. However, treatment in a jail with antipsychotic medication is not a substitute for timely transfer to and appropriate treatment in a state hospital.[60] Many jails do not have expertise or resources to be considered treatment facilities. Furthermore, task force members expressed concerns about the use of jails as treatment facilities when the overrepresentation of people with mental illness in correctional facilities is already a problem. Because interim measures often become the status quo, there is an urgent need to utilize and expand alternatives that provide competency restoration outside of jails.

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[58] John Clark, *Non-Specialty First Appearance Court Models for Diverting People with Mental Illness: Alternatives to Mental Health Courts* (Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion, 2004).
[59] See glossary.
[60] *In Re Mille* (2010) 182 Cal.App.4th 635.

Another challenge regarding competency restoration procedures is the frequency with which individuals returned to jail after restoration of mental competency do not obtain appropriate treatment, suffer remission, and are again determined incompetent to stand trial, thereby restarting the restoration process. Procedures to address this phenomenon need to be created.

Some criminal defendants with mental illness may be conserved or may be involved in conservatorship proceedings at the same time that their criminal case is being processed. Because these cases are currently heard by different judicial officers on different calendars, judicial officers hearing either the civil or criminal case often do not have all applicable information, which can result in conflicting orders and other complications for the defendant. An additional challenge regarding conservatorships is that judicial officers are unable to initiate conservatorship proceedings even if there is reasonable cause to believe that the defendant is gravely disabled and counsel agrees that conservatorship may be an appropriate part of disposition for the criminal case.

Finally, people with mental illness who have become involved in the criminal justice system are often clients of other public systems, making collaboration between the courts and community partners essential. For example, the disposition of a case may require the defendant to receive mental health treatment. However, without established methods for communication and information-sharing procedures in place, collaboration between courts and local mental health and social service systems can be difficult.

Solutions to these court-based problems can often be found in collaboration with criminal justice and mental health partners and by applying collaborative justice/problem-solving approaches that have been demonstrated to be effective. Many of the recommendations discussed in the following section are based on collaborative justice court principles,[61] which emphasize partnerships with stakeholders in and outside the courts. These principles can be applied, when appropriate, in cases heard outside of the intensive and specialized collaborative justice court calendar, though it is noted that mental health courts have shown to be effective, cost-efficient approaches in many jurisdictions.[62] For example, local evaluations have found that mental health court participants have significantly lower rearrest rates (26–47% lower) compared to similar defendants in traditional court.[63] Lower rearrest rates translate into cost savings as costs associated with a new arrest (e.g., arrest, booking, jail stay, and court costs) are avoided.

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[61] See glossary.

[62] Susan M. Ridgely, John Engberg, Michael D. Greenberg, Susan Turner, Christine DeMartini, and Jacob W. Dembosky, "Justice, treatment, and cost: An evaluation of the fiscal impact of Allegheny County Mental Health Court" (Santa Monica, Calif.: RAND Corporation, 2007).

[63] Dale McNiel and Renee Binder, "Effectiveness of a mental health court in reducing criminal recidivism and violence," *American Journal of Psychiatry* 164 (2007), pp. 1395–1403; Marlee Moore and Virginia Hiday, "Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants," *Law and Human Behavior* 30 (2006), pp. 659–674.

Judicial Leadership

Courts should provide judicial leadership in facilitating an interbranch and interagency coordinated response to people with mental illness who have entered the criminal justice system.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

11. California Rule of Court 10.952 (Meetings concerning the criminal court system) should be amended to include participants from parole, the police department, the sheriff's department, and Conditional Release Programs (CONREP), the County Mental Health Director or his or her designee, and the County Director of Alcohol and Drug Programs or his or her designee.

12. Courts and court partners identified under the proposed amendment of California Rule of Court 10.952 should develop local responses for offenders with mental illness or co-occurring disorders to ensure early identification and appropriate treatment. The goals are to provide better outcomes for this population, reduce recidivism, and respond to public safety concerns.

13. Courts and court partners identified under the proposed amendment of California Rule of Court 10.952 should identify information-sharing barriers that complicate collaborations, service delivery, and continuity of care for people with mental illness involved in the criminal justice system. Protocols, based on best or promising practices, and in compliance with Health Insurance Portability and Accountability Act (HIPAA),[64] and other federal and state privacy protection statutes, rules, and regulations, should be developed to facilitate effective sharing of mental health–related information across agencies and systems.[65] Agencies should be encouraged to maintain mental health records electronically and to ensure compatibility between systems.

14. The presiding judge, or the judge designated under California Rule of Court 10.952, should obtain from county mental health departments a regularly updated list of local agencies that utilize accepted and effective practices to serve defendants with mental illness or co-occurring disorders and should distribute this list to all judicial officers and appropriate court personnel.

15. Courts should become involved with local Mental Health Services Act stakeholder teams in order to promote greater collaboration between the courts and local mental health agencies and to support services for people with mental illness involved in the criminal justice system.

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[64] See glossary.
[65] See 2007 GAINS article, "Dispelling the Myths about Information Sharing Between Mental Health and Criminal Justice Systems" by John Petrila, *www.gainscenter.samhsa.gov/text/integrated/Dispelling_Myths.asp.*

Case Processing

Courts should use collaborative methods for processing cases involving defendants with mental illness or co-occurring disorders. By adopting problem-solving approaches and employing collaborative justice principles, courts can connect defendants with mental illness to treatment, reduce recidivism, and protect public safety.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

16. Each California trial court should have a specialized method based upon collaborative justice principles for adjudicating cases of defendants with mental illness, such as a mental health court, a co-occurring disorders court, or a specialized calendar or procedures that promote treatment for the defendant and address public safety concerns. Judicial leadership is essential to the success of these efforts.

17. Information concerning a defendant's mental illness should guide case processing (including assignment to a mental health court or specialized calendar program) and disposition of criminal charges consistent with public safety and the defendant's constitutional rights.

18. Local courts, probation, and mental health professionals should collaborate to develop supervised release programs to reduce incarceration for defendants with mental illness or co-occurring disorders, consistent with public safety.[66]

19. Prosecutors should utilize, as appropriate, disposition alternatives for defendants with mental illness or co-occurring disorders.

20. In accordance with the Victim's Bill of Rights Act of 2008 (Marsy's Law), judicial officers should consider direct input from victims in cases involving

There are over 40 ***mental health courts*** *in 27 counties in California. Although mental health courts vary across jurisdictions, common elements include a separate docket for people with mental illness, collaboration between criminal justice and mental health professionals, judicial supervision of required mental health treatment and other services in lieu of jail time, provision of intensive case management, and voluntary participation. Local evaluations have found that mental health court participants have significantly lower rearrest rates compared to similar defendants in traditional court.*

The Superior Court of Orange County operates ***a collaborative justice court program*** *that is a postadjudication alternative serving individuals with serious mental illness who are homeless or at risk of becoming homeless and have pending criminal charges. Participants are provided intensive mental health or substance abuse treatment, case management, and intense judicial and probation supervision and monitoring.*

[66] Postbooking diversion (see glossary).

defendants with mental illness or co-occurring disorders to inform disposition or sentencing decisions, recognizing that many victims in such cases are family members, friends, or associates.

21. The court system and the California Department of Mental Health cooperatively should develop and implement video-based linkages between the courts and the state hospitals to avoid delays in case processing for defendants being treated in state hospitals and to prevent the adverse consequences of repeated transfers between hospitals and jails. The use of video-based procedures is to be voluntary, and clients should retain the right to request live hearings. Policies and procedures should be in place to ensure that clients have adequate access to private conversations with defense counsel.

22. Judicial officers should require the development of a discharge plan[67] for defendants with mental illness as a part of disposition and sentencing. Discharge plans should be developed by custody mental health staff, pretrial services, or probation, depending on the status and location of the defendant, in collaboration with county departments of mental health and drug and alcohol or other designated service providers. Discharge plans must include arrangements for housing and ongoing treatment and support in the community for offenders with mental illness.

23. Court administrators should develop local policies and procedures to ensure that medical and mental health information deemed confidential by law is maintained in the nonpublic portion of the court file. Mental health information not otherwise a part of the public record, but shared among collaborative court partners, should be treated with

Increasing numbers of veterans are entering the criminal justice system with charges often related to substance abuse or combat-related mental illness. A 2000 Bureau of Justice Statistics report found that 25 percent of all justice-involved veterans were identified as mentally ill. Twenty percent of all veterans from Iraq and Afghanistan report symptoms of post-traumatic stress disorder or major depression. Diversion programs tailored to this population are necessary to connect veterans with needed services.*

As of November 2010, eight ***veterans courts*** *had been established in California.* ***Veterans courts*** *are a type of collaborative justice court that connect veterans to services while providing judicial supervision.*

Penal Code section 1170.9 allows the court, under certain circumstances and if the defendant consents, to substitute treatment for incarceration for veterans suffering from combat-related mental health disorders.

* Terri Tanielian, Lisa H. Jaycox, Terry L. Schell, Grant N. Marshall, M. Audrey Burnam, Christine Eibner, Benjamin R. Karney, Lisa S. Meredith, Jeanne S. Ringel, Mary E. Vaiana, and the invisible wounds study team. *Invisible Wounds of War: Summary and Recommendations for Addressing Psychological and Cognitive Injuries* (RAND, 2008).

[67] See glossary. Discharge plans are also discussed in greater detail in recommendations 46, 47, and 76–81.

sensitivity in recognition of an individual's rights to confidentiality.

Coordination of Civil and Criminal Proceedings

Courts should develop protocols that ensure the coordination of conservatorship and criminal proceedings for defendants with mental illness.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

24. Conservatorship proceedings and criminal proceedings should be coordinated where a defendant is conserved and has a pending criminal case or a defendant has a pending criminal case and is then conserved. Such coordination could include designating a single judicial officer to preside over both the civil and criminal proceedings, when all parties agree, or a protocol for how such proceedings can be coordinated when heard by different judicial officers. If a judicial officer presides over both civil and criminal proceedings, he or she should have training in each area.

25. Legislation should be enacted that allows judicial officers to join the county conservatorship investigator (Welf. & Inst. Code, § 5351), the public guardian (Gov. Code, § 27430), private conservators, and any agency or person serving as public conservator to criminal proceedings when the defendant is conserved or is being considered for conservatorship.

26. Existing legislation should be modified and new legislation should be created where necessary to give judicial officers hearing criminal proceedings involving defendants with mental illness the authority to order a conservatorship evaluation and the filing of a petition when there is reasonable cause to believe that a defendant is gravely disabled within the meaning of Welfare and Institutions Code section 5008(h). The conservatorship proceedings may be held before the referring court if all parties agree.[68] Judicial officers should have training in the area of LPS law if ordering the initiation of conservatorship proceedings.

27. When the criminal court has ordered the initiation of conservatorship proceedings, the conservatorship investigation report should provide recommendations that include appropriate alternatives to conservatorship if a conservatorship is not granted.[69]

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[68] There is precedence for allowing such coordination in section 241.1 of the Welfare and Institutions Code, which requires coordination and communication between the dependency and delinquency courts when a child appears to come within the description of both section 300 and section 601 or 602.

[69] Nevada and Los Angeles counties have implemented Assisted Outpatient Treatment programs (Laura's Law/AB 1421 [see glossary]), which provide intensive court-ordered treatment in the community and may be utilized as an alternative to LPS conservatorship (see glossary).

Competence to Stand Trial

Courts, in collaboration with state hospitals and local mental health treatment facilities, should create and employ methods that prevent prolonged delays in case processing and ensure timely access to restoration programs for defendants found incompetent to stand trial.[70]

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

28. There should be a dedicated court or calendar where a specially trained judicial officer handles all competency matters. Competency proceedings should be initiated and conducted in accordance with California Rule of Court 4.130 and relevant statutory and case law.[71]

29. Each court should develop its own panel of experts who demonstrate training and expertise in competency evaluations.

30. Mental health professionals should be compensated for competency evaluations in an amount that will encourage in-depth reports.

31. California Rule of Court 4.130(d)(2) should be amended to delineate the information included in the court-appointed expert report in addition to information required by Penal Code section 1369. The report should include the following:[72]

    a. A brief statement of the examiner's training and previous experience as it relates to examining the competence of a criminal defendant to stand trial and preparing a resulting report;
    b. A summary of the examination conducted by the examiner on the defendant, including a current diagnosis, if any, of the defendant's mental disorder and a summary of the defendant's mental status;
    c. A detailed analysis of the competence of the defendant to stand trial using California's current legal standard, including the defendant's ability or inability to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense in a rational manner as a result of a mental disorder;

[70] The task force examined the difficult problem of the defendant who may not have "a sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and . . . a rational as well as factual understanding of the proceedings against him" (*Dusky v. U.S.* (1960) 362 U.S. 402), but not as a result of a mental disorder or developmental disability as currently required by Penal Code section 1367. Judges often encounter defendants who seem to lack these abilities as a result of cognitive impairments resulting from organic brain damage, fetal alcohol syndrome, or other causes, which have not been formally diagnosed as developmental disabilities. This is an area that requires further research.

[71] See also Center for Judicial Education and Research (CJER) Benchguide #63 (revised 2010).

[72] A preliminary draft of information that should be included in expert reports originally came from the Council on Mentally Ill Offenders (see glossary).

d. A summary of an assessment conducted for malingering, or feigning symptoms, which may include, but need not be limited to, psychological testing;
e. Pursuant to Penal Code section 1369, a statement on whether treatment with antipsychotic medication is medically appropriate for the defendant, whether the treatment is likely to restore the defendant to mental competence, a list of likely or potential side effects of the medication, the expected efficacy of the medication, possible alternative treatments, whether it is medically appropriate to administer antipsychotic medication in the county jail, and whether the defendant has capacity to make decisions regarding antipsychotic medication;
f. A list of all sources of information considered by the examiner, including, but not limited to, legal, medical, school, military, employment, hospital, and psychiatric records; the evaluations of other experts; the results of psychological testing; and any other collateral sources considered in reaching his or her conclusion;
g. A statement on whether the examiner reviewed the police reports, criminal history, statement of the defendant, and statements of any witness to the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency;
h. A statement on whether the examiner reviewed the booking information, including the information from any booking, mental health screening, and mental health records following the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency; and
i. A summary of the examiner's consultation with the prosecutor and defendant's attorney, and of their impressions of the defendant's competence-related strengths and weaknesses.

32. An ongoing statewide working group of judicial officers, the Administrative Office of the Courts, Department of Mental Health, CONREP, and other stakeholders should

***CONREP has established a pilot program** in collaboration with Napa State Hospital to improve CONREP's ability to accurately identify individuals who can be safely and effectively restored to competence for trial in an outpatient setting rather than the state hospital. San Francisco and Sacramento CONREP program officers will be trained in the use of a preplacement assessment protocol.*

The protocol assesses severity of psychiatric symptoms, the defendant's ability to understand court procedures and charges, and the possibility that the defendant is feigning mental illness (malingering). The protocol also includes an actuarial assessment of risk for violence. It is anticipated that with the successful implementation of these practices, CONREP will be able to place more defendants in the community for competency restoration, identify inmates who might be malingering, and identify inmates who have become almost or fully competent since the initial competency evaluation.

be established to collaborate and resolve issues of mutual concern regarding defendants found incompetent to stand trial.

33. State hospitals and mental health outpatient programs should be adequately funded to ensure effective and timely restoration of competency for defendants found incompetent to stand trial in order to eliminate the need to designate jails as treatment facilities (Pen. Code §1369.1).

34. There should be more options for community placement through CONREP and other community-based programs for felony defendants found incompetent to stand trial on nonviolent charges so that not all such defendants need be committed to a state hospital for competency restoration.

35. Courts are encouraged to reopen a finding of incompetence to stand trial when new evidence is presented that the person is no longer incompetent. If the defendant is re-evaluated and deemed competent he or she should not be transferred to a state hospital.

36. Existing legislation should be modified or new legislation be created to give judicial officers hearing competency matters access to a variety of alternative procedural and dispositional tools, such as the jurisdiction to conditionally release a defendant found incompetent to stand trial to the community, where appropriate, rather than in a custodial or hospital setting, to receive mental health treatment with supervision until competency is restored.

37. Care and treatment of defendants with mental illness should be continued after restoration of competence. Penal Code section 1372(e) should be expanded, consistent with *Sell v. United States,* to ensure that competence is maintained once restored and that medically appropriate care is provided to defendants until such time that a defendant's incompetent-to-stand-trial status is no longer relevant to the proceedings. In an effort to maintain a defendant's competence once restored, courts, state hospitals, and the California State Sheriff's Association should collaborate to develop common formularies to ensure that medications administered in state hospitals are also available in jails.

Additional Court Resources

Courts are encouraged to provide additional supports to defendants with mental illness.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

38. Forensic Peer Specialist Programs[73] should be utilized within the courts, particularly in mental health courts to assist defendants with mental illness in navigating the criminal justice system.

39. Court Self-Help Centers should provide materials to defendants with mental illness, family members, and mental health advocates about general court processes, mental health courts or other court-based programs and services for defendants with mental illness, and community and legal resources.

[73] See glossary.

Section 3: Incarceration

As stated earlier, jails and prisons have reluctantly become de facto mental health treatment facilities. Correctional facilities, however, are not appropriate places to provide treatment, and incarceration often exacerbates symptoms of an inmate's mental illness. Functional impairments can make it difficult for inmates with mental illness to abide by the myriad jail and prison rules. Not surprisingly, these individuals are often at higher risk for being charged with facility rule violations and prison infractions.[74] In addition, individuals with mental illness are often more vulnerable to the hostile incarceration culture. For example, prisoners with mental illness are more likely to be physically and sexually assaulted and exploited by other inmates.[75] As a result, prisoners with mental illness are more likely to be placed in administrative segregation than the general inmate population.[76] Isolation and segregation can exacerbate symptoms of mental illness, however.

Jails and prisons in California are overcrowded and have a shortage of qualified mental health professionals, both of which can contribute to substandard care of inmates with mental illness. Booking and receiving staff are often not able to adequately screen incoming people for mental illness. Therefore, many prisoners and jail inmates are not appropriately placed and may not receive sufficient treatment until they decompensate to the point where an emergency response is required. In addition, prisons, jails, and county mental health departments usually have different drug formularies, meaning the inmate will likely have to switch psychiatric medications upon transfers, which can result in further destabilization as abrupt withdrawal from and sometimes changes in psychiatric medications can lead to relapses and psychosis.[77]

The inadequacy of treatment for people with mental illness in jails and prisons has been litigated many times. In 1995, in *Coleman v. Wilson,* it was found that treatment of California prisoners with mental illness violated the Eighth Amendment's prohibition of cruel and unusual punishment because of a lack of screening mechanisms, inadequate mental health staffing levels, delays and denial of medical attention, and inappropriate use of punitive measures.[78]

Although a primary goal of the task force is to find ways to divert this population from jail and prison when appropriate, the following recommendations address ways to provide appropriate care to those people with mental illness who are incarcerated.

The task force crafted many of the recommendations below with county jails in mind; however, the general principles described in the recommendations below may be applied to California prisons as well.

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[74] Treatment Advocacy Center and the National Sheriffs' Association, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (May 2010).
[75] Human Rights Watch, "Ill-equipped: US Prisons and Offenders with Mental Illness" (2003).
[76] *Ibid.*
[77] *Ibid.*
[78] *Coleman v. Wilson* (9th Cir. 1996) 101 F.3d 705.

The Booking/Admission Process: Early Identification and Continuity of Care

As part of the county jail booking and prison admission process, individuals with mental illness should be identified and assessed, and procedures and services that prepare defendants for their eventual release should be initiated.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

40. At the time of initial booking or admission, all individuals should be screened for mental illness and co-occurring disorders through a culturally competent[79] and validated mental health screening tool to increase the early identification of mental health and co-occurring substance use problems of incarcerated individuals.

41. The California State Sheriff's Association, California Department of Corrections and Rehabilitation, Corrections Standards Authority, California Department of Mental Health, California Department of Alcohol and Drug Programs, County Alcohol and Drug Program Administrators in California, California Mental Health Directors Association, and the Chief Probation Officers of California should collaborate to develop and validate core questions for a Mental Health and Co-occurring Disorder Initial Screening instrument based on evidence based practices and consistent with the defendant's constitutional rights. All jails and prisons in California should adopt the screening instrument to standardize procedures statewide and to promote consistency and quality of information across counties. The content of such a screening instrument can be expanded upon or automated by local programs.

42. The adopted screening instrument should inquire about the individual's mental health and substance use history, history of trauma, other co-occurring conditions (including physical and metabolic conditions), and military service status, as well as his or her current housing status and any history of homelessness. The screening should be conducted in the incarcerated individual's spoken language whenever possible, the instrument must be sensitive to cultural variations, and staff administering the tool must understand inherent cultural biases.

43. If the initial screening indicates that an individual in custody has a mental illness or co-occurring disorder, a formal mental health assessment should be administered to determine the level of need for treatment and services while in custody. The assessment should be conducted by a qualified mental health practitioner as close to the date of the initial screening as possible.

44. Mental health staff should be available at jail-booking and prison admission facilities at all times.

[79] See glossary.

45. Upon booking or admission, individuals with mental illness should be housed in an appropriate setting within the jail or prison based on their medical and mental health needs as identified in the mental health screening and evaluation.

46. A discharge plan should be developed for incarcerated individuals with mental illness or co-occurring disorders. The discharge plan will build upon information gathered from the mental health screening and assessment instruments and will document prior mental health treatment and prescribed psychiatric medications to ensure continuity of essential mental health and substance abuse services in order to maximize psychiatric stability while incarcerated as well as after being released. Treatment and services outlined in the discharge plan should be culturally appropriate (e.g., according to ethnicity, race, age, gender) for the individual with mental illness.

47. Discharge plans should follow the individual across multiple jurisdictions, including local and state correctional systems and mental health and justice agencies to ensure continuity of care. Information sharing across agencies and jurisdictions must follow criminal justice, HIPAA, and other federal and state privacy protection statutes, rules, and regulations.

Custody Mental Health Treatment and Services

Jails and prisons should address the mental health needs of offenders with mental illness. Practices and protocols should be established to coordinate continuity of care while the offender is incarcerated and after being released.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

48. Jails and prisons should have sufficient resources and staff to ensure access to mental health treatment services. Assessment and treatment services must begin immediately upon entry into jail or prison and should include, but not be limited to, the following: an assessment and discharge plan developed by custody mental health and psychiatric staff, appropriate psychotherapeutic medications, psychiatric

> ***The Men's Psychiatric Sheltered Living Unit (PSLU),*** *located in the San Francisco County Jail, prepares clients to reenter the community and increases clients' probability of retention and treatment success in community programs. Clients are seen weekly for individual therapy and attend a variety of groups that emphasize their strengths and are most relevant to their treatment goals, including Expressive Arts, Medication Education, Men's Health, Conflict Resolution, and Restorative Justice. Clients have an active role in operating the program; clients lead various groups, facilitate weekly PSLU community meetings, and organize various peer activities and projects such as a biannual newsletter in which they publish their writings, articles, poems, and artwork.*
>
> **See glossary.*

follow up, custody mental health staff to monitor treatment progress, and behavioral and counseling interventions,
including peer-based services.

49. Jails and prisons should implement therapeutic communities or other evidence based programming for incarcerated individuals with mental illness or co-occurring disorders where clinically appropriate.

50. Custody nursing and mental health staff should be available 24 hours a day in order to sufficiently respond to the needs of incarcerated individuals with mental illness or co-occurring disorders.

51. Custody mental health staff should continue the treating community physician's regimen in order to prevent relapse and exacerbation of psychiatric symptoms for incarcerated individuals assessed as having a mental illness, unless a change in treatment regimen is necessary to improve or maintain mental health stability.

52. The California Department of Mental Health, California Department of Corrections and Rehabilitation, California State Sheriff's Association, and California Department of Health Care Services — Medi-Cal should coordinate, to the greatest extent possible, drug formularies among jail, prison, parole, state hospitals, and community mental health agencies and establish a common purchasing pool to ensure continuity of appropriate care for incarcerated individuals with mental illness. The coordination of formularies should not further restrict the availability of medications.

53. In the absence of a common drug formulary, jails, prisons, parole, state hospitals, and community mental health agencies should obtain expedited treatment authorizations for off-formulary medication to ensure psychiatric stabilization and continuity of care when necessary.

54. The California State Sheriff's Association and California Department of Corrections and Rehabilitation should consider utilizing the NAMI California Inmate Mental Health Information Form[80] for use in all California jails and prisons. Both the original jail form and its more recent adaptation by the prison system provide family members an opportunity to share diagnosis and historical treatment information with correctional clinical staff.

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[80] Inmate Mental Health Information Forms can be found at *www.namicalifornia.org/criminaljustice-arrested.aspx?tabb=arrested&lang =ENG*.

Section 4: Probation and Parole

People with mental illness are overrepresented among parole and probation populations, with estimates ranging from two to four times the general population.[81] In 2004, 13 percent of all adults released on parole in California were identified as having a mental disorder.[82] Probation officers and parole agents often find probationers and parolees with mental illness to be difficult to supervise as this population has diverse treatment and service needs. Probation officers and parole agents have increasingly large case loads and limited resources for probationers and parolees. Many supervision officers have not received specialized training about mental health issues, the needs of the population, or how mental disorders can interfere with the ability to adhere to supervision requirements. Finally, mental health treatment is often an essential component to living in the community and complying with community supervision requirements; however, representatives from treatment and supervision rarely collaborate to share necessary information or to synthesize treatment and supervision goals.

Many probationers and parolees with mental illness live in poverty, are unemployed, and have few social supports, which can make it difficult for this population to meet supervision requirements. In addition, people with mental illness may have functional impairments and may experience relapses that further complicate their ability to adhere to supervision conditions. Furthermore, many probationers and parolees have their public benefits such as Supplemental Security Income, Social Security Disability Insurance, and Medi-Cal terminated or suspended while incarcerated. Therefore, once released from either jail or prison, many are without benefits until applications are processed. Without public assistance and medical insurance, this population is not able to access community supports essential to successful supervision adherence. It is therefore not surprising that people with mental illness under community supervision are more likely to violate their terms of supervision and have their community supervision revoked.[83] Studies have reported that parolees with mental illness have a 70 percent higher risk of committing technical violations (excluding absconding) [84] and are twice as likely as parolees without mental illness to have their parole suspended.[85]

The recommendations below outline alternative supervision strategies that address public safety concerns while ensuring improved outcomes for this population. Many of the recommendations in this section target probationers under the jurisdiction of county probation departments. Although parolees are under the jurisdiction of the Department of Corrections and Rehabilitation

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[81] Seth J. Prins and Laura Draper, *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009), p. 11.

[82] Jennifer E. Louden, E. Dickinger, and Jennifer L. Skeem, “Parolees with mental disorder: Toward evidence-based practice” (in press).

[83] Lorena L. Dauphinot, “The efficacy of community correctional supervision for offenders with severe mental illness,” 57(9-B) Dissertation Abstracts International: Section B: The Sciences and Engineering 5912 (March 1997).

[84] Ryken Grattet, Joan Petersilia, and Jeffrey Lin, “Parole Violations and Revocations in California” (Washington, D.C.: National Institute of Justice, October 2008), *www.ncjrs.gov/pdffiles1/nij/grants/224521.pdf.*

[85] Frank J. Porporino and Laurence L. Motiuk, “The prison careers of mentally disordered offenders,” *International Journal of Law and Psychiatry* 18 (1995), pp. 29–44.

and usually receive mental health services from Parole Outpatient Clinics rather than local county mental health systems, the recommendations in this section, are, in principle, equally applicable to parolees with mental illness.

Coordination of Mental Health Treatment and Supervision

The following alternative supervision strategies and evidence-based practices that consider the treatment and service needs of probationers and parolees with mental illness should be utilized in order to improve outcomes for this population.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

55. The court should have jurisdiction to join to the proceedings those agencies and providers that already have legal obligations to provide services and support to probationers and parolees with mental illness. Before joinder, any agency or provider should have advance notice of and an opportunity to be heard on the issue.

56. In cases where the offense is committed and sentencing occurs in a county other than the probationer's county of residence, before the court grants a motion to transfer jurisdiction to that county (pursuant to Pen. Code, § 1203.9), judicial officers should give very careful consideration to the present mental stability of the probationer and determine whether or not the probationer will have immediate access to appropriate mental health treatment and other social service supports in the county of residence. The court must ensure that adequate discharge planning has taken place, including referral to a mental health court if appropriate, to ensure a direct and immediate connection with treatment and services in the county of residence.

57. Probation and parole supervision should follow the discharge plan approved by the judicial officer as part of the disposition of criminal charges or by California Department of Corrections and Rehabilitation at the time of release. The discharge plan should include probationers' or parolees' treatment and other service needs as well as risks associated with public safety, recidivism, and danger to self. Individuals with low risk or needs may require no supervision and early

The Mentally Ill Offender (MIO) Program in San Diego County *is a unit in the county's probation department that supervises a caseload of offenders with mental illness. Through a collaborative and client-centered approach, the program links offenders to community-based services and provides intensive case management. Initially, the probationer receives close supervision with a caseload ratio of 1 to 50. Standard probation conditions for the MIO program include that the probationer participate in treatment, therapy, and counseling as suggested by validated assessment tests; take psychotropic medications as prescribed; and provide written authorization for the probation officer to receive progress reports.*

termination of probation or parole, whereas individuals with high risk or needs may need to receive intensive supervision joined with intensive mental health case management.

58. Probation and parole conditions should be the least restrictive necessary and should be tailored to the probationers' or parolees' needs and capabilities, understanding that successful completion of a period of community supervision can be particularly difficult for offenders with mental illness.

59. Probationers and parolees with mental illness or co-occurring disorders should be supervised by probation officers and parole agents with specialized mental health training and reduced caseloads.

60. Specialized mental health probation officers and parole agents should utilize a range of graduated incentives and sanctions to compel and encourage compliance with conditions of release. Incentives and positive reinforcement can be effective in helping offenders with mental illness stay in treatment and follow conditions of probation or parole.[86]

61. Specialized mental health probation officers and parole agents should conduct their supervision and other monitoring responsibilities within the communities, homes, and community-based service programs where the offender with mental illness spends most of his or her time.[87] This approach should reorient the supervision process from enforcement to intervention.

Under Penal Code section 3015(b), the Department of Corrections and Rehabilitation must employ a ***parole violation decisionmaking instrument*** *to determine the most appropriate sanctions for parolees who violate their parole conditions. The violation decisionmaking instrument is a standardized tool that provides ranges of appropriate sanctions for parole violators, given relevant case factors, including, but not limited to, offense history, risk of reoffense based on a validated risk assessment tool, and need for treatment services.*

62. Specialized mental health probation officers and parole agents should work closely with mental health treatment providers and case managers to ensure that probationers and parolees with mental illness receive the services and resources specified in their discharge plans, and that released offenders are connected to a 24-hour crisis service.[88]

63. Working agreements and relationships should be developed between community-based service providers and probation and parole to increase understanding and coordination of

[86] Council of State Governments Justice Center, *The Criminal Justice/Mental Health Consensus Project Report*, Policy Statement #22 (2002).
[87] *Ibid.*
[88] *Ibid.*

supervision and treatment goals and to ensure continuity of care once supervision is terminated.

64. Probationers and parolees with mental illness or co-occurring disorders should receive mental health and substance abuse treatment that is considered an evidence based or promising practice.[89]

Alternative Reponses to Probation/Parole Violations

Traditional formal violation hearings for offenders with mental illness should be a last resort after alternative interventions have failed.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

65. Judicial officers should avoid stating fixed sentencing terms that mandate state prison for an offender with mental illness upon violation of probation conditions regardless of the seriousness of the violation.

66. Judicial officers hearing probation violation calendars and deputy commissioners of the Board of Parole Hearings should carefully review the offender's discharge plan and consider the seriousness of the alleged violation(s) as well as the offender's progress or lack thereof in mental health treatment. Absent new serious criminal behavior by the probationer or parolee, alternative responses short of reincarceration should be considered. Incarceration should be reserved for those violations that demonstrate a threat to public safety.

67. Specialized calendars or courts for probationers and parolees with mental illness at risk of returning to custody on a supervision violation should be established in every jurisdiction. Such courts (e.g., reentry courts[90]) or calendars should be modeled after collaborative drug and mental health courts. If an individual is a participant in a mental health court and violates probation, he or she should be returned to

*Penal Code section 3015(d) authorizes the Department of Corrections and Rehabilitation to refer parolees with a history of substance abuse or mental illness who violate their parole conditions, to a **reentry court program.** The purpose of a reentry court is to promote public safety, hold parolees accountable, reduce recidivism, and help parolees successfully transition back into the community.*

Key elements for effective reentry courts include court supervision, a team approach, accountability, and services that address substance abuse, mental health, housing, vocational needs, and family reunification. Reentry courts show promise as a strategy to maintain parolees in the community and avoid return to prison or jail.

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[89] The Council of State Governments Justice Center, *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives* (2009).
[90] See glossary.

the mental health court for adjudication of the violation.

68. Immediate treatment interventions should be made available to a probationer or parolee with mental illness who considerably decompensates after his or her release or appears to be failing in community treatment.

69. Probation officers and parole agents should utilize graduated sanctions and positive incentives and work with mental health treatment providers to increase the level of treatment or intervention or initiate new treatment approaches when probationers and parolees with mental illness violate conditions of supervision.

70. Probation officers, parole agents, and treatment providers should provide pertinent treatment information to custody staff for those probationers or parolees with mental illness who are returned to jail or prison to ensure continuity of care.[91]

[91] The Council of State Governments Justice Center. *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives* (2009).

Section 5: Community Reentry

California's prisons release nearly 120,000 prisoners each year. Roughly two-thirds will be back in prison within three years (27 percent for a new criminal conviction and 39 percent for a technical or administrative violation)—the highest return-to-prison rate in the nation.[92] On any given day, six out of ten admissions to California prisons are returning parolees.[93] Parolees with mental illness are more likely than other populations to face possible revocation since this population has a 36 percent higher risk of committing all violation types and a 70 percent higher risk of committing technical violations (excluding absconding).[94]

Although reentry is often discussed in terms of prisoners being released back to the community, reentry can happen at many different points after an individual with mental illness has entered the criminal justice system. People can reenter the community through jail diversion programs, through mental health courts, from state hospitals, from jail after serving a sentence, and through probation.

Offenders with mental illness experience many barriers and obstacles to successfully transitioning to the community. Offenders' federal and state benefits are revoked or suspended while they are incarcerated. In many cases offenders cannot reinstate or apply for benefits until they are released, resulting inevitably in a period of time (often several months) when these individuals are without health insurance (through Medi-Cal or Medicare) or income supports such as Supplemental Security Income. Even when offenders are released with the means to access necessary psychiatric medications, they are often not able to receive the same medications administered in jail or prison under their insurance plan. Having a criminal history further complicates obtaining mental health treatment and other scarce community services that enable a successful transition back to the community. Parolees, in particular, are underserved. Mental Health Services Act funds can't be allocated toward parolees, meaning this population is excluded from many county and other community-based programs. Furthermore, it is difficult for parolees to access mental health services at California Department of Corrections and Rehabilitation's Parole Outpatient Clinics if they were not given particular mental health designations while in prison.

Many individuals with mental illness are released from jail and prison without housing arrangements, making it nearly impossible to succeed in managing their mental illness. The California Department of Corrections and Rehabilitation (CDCR) reports that, at any given time, 10 percent of the state's parolees are homeless. Furthermore, the percentage of parolees who are homeless ranges from 30 percent to 50 percent in major urban areas such as San Francisco and Los Angeles.[95]

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[92] Ryken Grattet, Joan Petersilia, and Jeffrey Lin, "Parole Violations and Revocations in California" (Washington, DC: National Institute of Justice, October 2008),, *www.ncjrs.gov/pdffiles1/nij/grants/224521.pdf.*
[93] *Ibid.*
[94] *Ibid.*
[95] California State Department of Corrections, "Prevention Parolee Failure Program: An Evaluation" (National Criminal Justice Reference Service, 1997).

Central to successful community reentry is the creation and implementation of discharge plans. Discharge plans decrease the chance of recidivating for offenders with mental illness by identifying and arranging services needed in order to live successfully in the community. According to the Bazelon Center for Mental Health Law, however, only one third of inmates with mental illnesses receive discharge planning services. Furthermore, successful implementation of discharge plans depends on the level and quality of communication between correctional staff and community service providers.

The recommendations below highlight actions that can be taken while the offender is incarcerated to ensure successful reentry; they also outline crucial steps for linking offenders to services immediately following release and emphasize the essential role that stable housing plays in promoting improved outcomes for this population. The following recommendations are related primarily to county jails and superior courts rather than the prison and parole systems, which are the responsibility of CDCR. In principle, however, the recommendations in this section are equally applicable for prisoners with mental illness released into the community.

Preparation for Release

Procedures and services that prepare people with mental illness for release should be provided or established while the individual is still in custody.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

71. A community mental health care manager should initiate person-to-person contact with the incarcerated individual in jail who has a mental illness prior to his or her release from custody through an in-reach[96] process in order to engage the individual in the development of his or her community treatment plan, and to provide a "bridge" to the community, thereby increasing the probability that the individual will follow up with treatment upon release. The community health care manager should also work with those involved in the development of the discharge plan to find appropriate stable housing for the incarcerated individual upon release.

72. A formal jail liaison[97] should be designated by local mental health departments and local correctional facilities to improve communication and coordination between agencies involved in the discharge planning and postadjudication services for offenders with mental illness. Jail liaisons provide a single point of access within each system for problem identification and resolution regarding care of specific individuals as well as coordination of systems.

[96] See glossary.
[97] See glossary.

73. Peer support services, through an in-reach process, should be offered to offenders in jail with mental illness while incarcerated and upon release to help ensure successful community reentry.

74. Legislation and regulations, as well as local rules and procedures, should be modified or enacted to ensure that federal and state benefits are suspended rather than terminated while offenders with mental illness are in custody. Administrative procedures should be streamlined to ensure that benefits are reinstated immediately after offenders with mental illness are released from jail or prison.

75. Offenders with mental illness who do not have federal and state benefits, or have lost them due to the length of their incarceration, should receive assistance from jail or prison staff or in-reach care managers in preparing and submitting the necessary forms and documentation to obtain benefits immediately upon reentry into the community.

Implementation of the Discharge Plan

Successful implementation of the discharge plan requires close coordination of the court, custody staff, probation, parole, the community mental health system, family members where appropriate, and all necessary supportive services.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

76. The discharge plan for release from jail, approved by the judicial officer as part of the disposition of criminal charges, should be implemented immediately upon release. The discharge plan should include arrangements for mental health treatment (including medication), drug and alcohol treatment, case management services, housing, applicable benefits, food, clothing, health care, and transportation.

77. Offenders with mental illness should be released during daytime business hours rather than late at night or in the early morning hours to ensure that offenders can be

Senate Bill 618–San Diego Prison Reentry Program, *which became effective in January of 2006, prepares prisoners for successful community reentry by conducting assessments, creating discharge plans, and providing services prior to, during, and following release from prison. Participants' needs are assessed before their sentence begins, and a life plan is created by a multidisciplinary team that is modified as the participant's needs change. Participants receive services, including case management, while in prison and are connected to community services upon release. Once the client is released, a Community Roundtable made up of various stakeholders identified by the client, including his or her community case manager, meet regularly to ensure that community reentry challenges are successfully addressed.*

*San Diego Association of Governments, *Improving Reentryfor Ex-Offenders in San Diego County: SB 618, Second Evaluation Report* (February 2009).

directly connected to critical treatment and support systems.

78. Upon release from jail, the sheriff's department should provide or arrange the offender's transportation to the location designated in the discharge plan. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.

79. Upon release from jail, the sheriff's department should facilitate access to an appropriate supply of medication as ordered in the discharge plan, a prescription, and a list of pharmacies accepting the issued prescription. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.

80. Upon release from jail, the care manager who engaged the offender through in-reach services[98] while in custody should facilitate timely follow-up care, including psychiatric appointments as outlined in the discharge plan. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender to parole.

81. The sheriff's department should give advanced notice of the offender's release date and time from jail to the offender's community treatment coordinator as specified in the discharge plan as well as to members of his or her family, as appropriate, and others in his or her support system. CDCR should utilize similar procedures, to the greatest extent possible, when releasing an offender.

Housing Upon Release

Appropriate housing in the community at the time of release is critical for successful reentry for offenders with mental illness since it serves as the foundation from which this population can access treatment and supportive services. Every offender with mental illness leaving jail or prison should, as a part of his or her discharge plan, have in place an arrangement for safe housing.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

82. Offenders with mental illness should be released with arrangements for appropriate safe and stable housing in the community as provided in the discharge plan.

83. Courts, prisons, jails, probation, parole, and community partners, including CONREP, should be prepared to assume the role of housing advocate for the releasee, recognizing that there are explicit as well as implicit prejudices and exclusions based on either mental illness or the criminal history of the releasee.

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[98] See glossary.

84. Courts, prisons, jails, and community partners, including law enforcement, discharge planners, service providers, probation, and parole, should establish agreements with housing programs, including supportive housing, to develop a housing referral network to coordinate stable housing placements for offenders with mental illness who are returning to the community.

85. Need-based housing options should be available, recognizing that offenders with mental illness and co-occurring disorders require different levels of housing at release that may change over time.

86. Legislation should be enacted to provide incentives (e.g., funding, tax credits) to housing developers; providers of supportive housing, including peer-run organizations; and owners of rental units, to support the development and availability of housing to incarcerated offenders with mental illness when they are released to reenter the community.

87. Mental Health Services Act (MHSA)[99] funding dedicated to housing, per the local stakeholder process, should be leveraged with other funding sources to ensure equal access to housing for offenders with mental illness, including those on probation. The state Director of Mental Health and the Mental Health Oversight and Accountability Commission (MHSOAC) should ensure that county plans include provisions to secure equal access to housing paid for with MHSA funding for offenders with mental illness.

Project 50 *is a demonstration program in Los Angeles to identify, engage, house, and provide integrated supportive services to the most vulnerable, long-term chronically homeless adults living on the streets of Skid Row, many of whom have a mental illness.*

In phase one of the program, 50 of the most vulnerable persons eligible for the program were identified. In phase two of the program, an outreach team assessed the needs of these individuals and engaged them in services, including transitional and permanent housing. In the final phase of the program, multidisciplinary teams are providing intensive integrated health, mental health, and substance abuse services to clients once they are placed in housing. Other supportive services provided to participants include money-management services, around-the-clock crisis services, recovery-based self-help and support groups, employment services, transportation services, education opportunities, medication management services, and benefit (re)establishment.

[99] See glossary.

Section 6: Juvenile Offenders

The large number of youth with mental health disorders involved in the juvenile justice system is a significant concern. According to a 2006 study, 70.4 percent of youth in the juvenile justice system meet criteria for at least one mental health disorder. When conduct disorder and substance use disorders (common disorders among delinquent youth) were excluded from the analysis, 45.5 percent of youth were identified as having a mental disorder.[100] Approximately 27 percent of these youth had a severe mental disorder (i.e., met criteria for certain severe disorders, or had been hospitalized for a mental disorder), which suggests that more than a quarter of youth should be receiving some form of mental health services while involved in the juvenile justice system.[101]

Several key issues recur as challenges or barriers to providing effective services to juvenile offenders with mental health issues. These challenges include connecting juveniles to appropriate and available services and resources, both while under the jurisdiction of the court and after reentering the community. Other challenges include establishing procedures and infrastructure to deal with juveniles who may be incompetent to stand trial, encouraging collaboration among stakeholders, providing sufficient education and training about juvenile mental health issues for stakeholders, and conducting necessary research to utilize evidence based practices.

In spite of the challenges, addressing the mental health issues of juveniles in the delinquency system is important. Early recognition and treatment of mental health issues can prevent these individuals from later entering the adult criminal justice system. Juveniles need to be screened and assessed for mental health problems so that appropriate services are offered, particularly if the juvenile will be in detention or placement. For example, if a juvenile is severely depressed or has a mental illness, putting him or her in isolation can significantly increase the risk of suicide. Risks can also be exacerbated if the juvenile does not have access to prescribed medications. Often, it takes time for psychiatrists in detention facilities to see a juvenile who has entered the facility, and mental health symptoms can increase during this time that the juvenile is not taking prescribed medication. Appropriate services and resources are equally important when juveniles are leaving the jurisdiction of the juvenile court and reentering the community.

A growing concern in the juvenile delinquency court is the insufficient guidelines, procedures, and infrastructure for dealing with juveniles who may be incompetent to stand trial. Although case law and recently enacted legislation address this issue to some extent, procedures must be further outlined, and the lack of infrastructure to treat and restore juveniles found incompetent to stand trial must be addressed.

Since juveniles may be involved with several agencies (e.g., schools, probation, mental health, etc.), collaboration among key stakeholders is essential to ensuring that juveniles are receiving

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[100] Jennie Shufelt and Joseph Cocozza, "Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study," *Research and Program Brief* (Delmar, NY: National Center for Mental Health and Juvenile Justice, 2006).
[101] *Ibid.*

appropriate services. In addition, since mental illnesses can manifest different symptoms in juveniles than in adults, specialized education and training are necessary so that individuals working across multiple systems with juveniles are aware of potentially dangerous indicators of mental health problems. It is equally important for these individuals and agency stakeholders to know what services are best for certain populations as well as what services are available for the juveniles with whom they work. In order to know what the best services are for particular populations, more research must be conducted to identify best and promising practices for juveniles with mental health issues who are in the delinquency system.

Several reports were considered in the development of recommendations within this section, including the *Juvenile Delinquency Court Assessment (JDCA)*,[102] the first-ever comprehensive assessment of California's delinquency court system; the State Commission on Juvenile Justice's *Juvenile Justice Operational Master Plan: Blueprint for an Outcome Oriented Juvenile Justice System*; and the California Endowment's report *Promising Practices from the Healthy Returns Initiative: Building Connections to Health, Mental Health, and Family Support Services in Juvenile Justice.*

This section includes recommendations regarding the recurring issues surrounding delinquency matters. Some recommendations address issues related to juvenile offenders with developmental disabilities and developmental immaturity as it is difficult to differentiate these conditions from mental illness in youth. Although there may be overlap with other sections of this report, the uniqueness of juvenile mental health and the juvenile court system necessitates an independent discussion.

Issues related to criminally involved transition age youth were not addressed in the following recommendations. Because the needs and experiences of transition age youth are uniquely different from those of adults and juveniles, the task force believes that a separate effort is necessary to adequately explore these issues.

Juvenile Probation and Court Responses

Juveniles with mental illness involved in the delinquency court system should be identified, assessed, and connected to appropriate services.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

88. Each presiding judge of the juvenile court should work with relevant stakeholders, including family members, to develop procedures and processes to provide appropriate services to youth in the delinquency system who have a diagnosable mental illness or a developmental disability, including developmental immaturity, or a co-occurring

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[102] Center for Families, Children & the Courts, Administrative Office of the Courts, *Juvenile Delinquency Court Assessment* (2008), *www.courtinfo.ca.gov/programs/cfcc/resources/publications/JuvenileDelinquency.htm*.

disorder. These procedures should include collaboration with mental health systems, probation departments, and other community resources.

89. Every juvenile who has been referred to the probation department pursuant to Welfare and Institutions Code section 602 should be screened or assessed for mental health issues as appropriate.

90. Protocols should be developed for obtaining information regarding a child's mental health diagnosis and medical history. Emphasis should be placed on acquiring thorough information in an expedited manner. Memorandums of understanding should be utilized to control the use and communication of information.

91. Juveniles in detention should have a medication evaluation upon intake into the detention center. Any psychotropic medication that a juvenile in detention is currently prescribed should be available to that juvenile within 24 hours of intake into detention unless an evaluating psychiatrist determines that it is no longer in the child's best interest.

92. Each court should have informational and educational resources for juveniles and their families, in multiple languages if needed, to learn about juveniles' rights, resources available, and how to qualify for services and benefits as they relate to issues of mental health. Those resources could include specially trained personnel, written materials, or any other sources of information. Each local jurisdiction should develop listings of available support and educational nonprofit organizations to assist families in need.

93. Mental health services should continue to be available to youth upon completion of their involvement with the delinquency system. Specifically, services should be extended in a manner consistent with the extension of

Use of CASA: *El Dorado Superior Court often assigns Court Appointed Special Advocates (CASAs) to juveniles with mental health issues in the delinquency system. CASAs are appointed to the case at the earliest point possible and help communicate the needs of the youth to the various partners involved with the case. The advocate is involved in meetings with juvenile hall staff, court-appointed mental health experts, treatment providers, school officials, etc., and do everything from coordinate access to pharmaceutical needs once the child leaves custody, to helping the child transition back into school, home, and the community at large. If a problem develops, the CASA will contact probation or the court to convene a meeting with all relevant players to coordinate services and an appropriate response.*

services to dependent youth after they turn 18. [103] This includes services provided for systemically appropriate transition age youth (18–25 years of age) who were formerly adjudicated as delinquent wards.

94. Communication between the delinquency system and the adult criminal justice system should be improved to ensure that if a person once received mental health treatment as a juvenile, the information regarding that treatment is provided in a timely and appropriate fashion if they enter the adult criminal justice system. Information sharing must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy protection statutes, rules, and regulations. When deemed appropriate upon assessment, treatment should continue in a consistent fashion if a minor transitions into the adult criminal justice system.

> ***The Court for the Individualized Treatment of Adolescents (CITA),*** *Santa Clara County Superior Court, Juvenile Delinquency Division, was the first juvenile mental health court in the country and was developed with no additional funding. CITA has developed an evolving set of graduation criteria that now have been replicated by other courts throughout the country. CITA holds the juvenile accountable, attempts to treat the underlying causes of the juvenile's behavior in a collaborative manner, and aims to reduce recidivism through approaches that are community based, family centered, culturally appropriate, and supportive of the individual. Approximately 67 percent of participants successfully complete the one-year program.*

Competence to Stand Trial

It is critical that procedures to determine a juvenile's competence to stand trial be clarified and improved. They need to take into consideration the cognitive abilities and the differences separating juveniles from adult offenders. Reformed standards should be supported with a developmentally appropriate infrastructure and services such that children subject to a competency hearing will have a timely resolution of the issue and appropriate services and procedural protections whether they are found competent or incompetent to stand trial.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends that:

95. Experts in juvenile law, psychology, and psychiatry should further study the issue of juvenile competence, including the need for appropriate treatment facilities and services, for the purpose of improving the systemic response to youth found incompetent to stand trial in the delinquency court.

[103] Extension of services beyond the age of 18 for dependent youth is discussed in the California Blue Ribbon Commission on Children in Foster Care's final report and action plan at the following citation: Center for Families, Children & the Courts, Administrative Office of the Courts, "A New Future for California's Children: Ensuring Every Child a Safe, Secure, and Permanent Home" (May 2009), *www.courtinfo.ca.gov/jc/tflists/documents/brc-finalreport.pdf* (as of Feb. 25, 2011).

96. Existing legislation should be modified[104] or new legislation should be created to refine definitions of competency to stand trial for juveniles in delinquency matters and outline legal procedures and processes. Legislation should be separate from the statutes related to competency in adult criminal court and should be based on scientific information about adolescent cognitive and neurological development and should allow for appropriate system responses for children who are found incompetent as well as those remaining under the delinquency court jurisdiction.

Juvenile Reentry

The juvenile court and probation should work together to ensure that juveniles have a plan for treatment, necessary medication, and other necessary services when they reenter the community after being in detention or placement.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

97. Youth exiting the juvenile delinquency system, including those returning from out-of-state placements, should receive appropriate reentry and aftercare services, including, but not limited to, stable housing, and a discharge plan that addresses mental health, education, and other needs.

98. Upon release from detention or placement, the probation department should facilitate access to an adequate supply of medication to fill any gap in time before having a prescription filled as ordered in the discharge plan. Upon release juveniles should have a scheduled appointment with a mental health agency.

99. The presiding judge of the juvenile court, working with the probation department, should create memoranda of understanding with local pharmacies and mental health service providers to ensure that juveniles leaving detention or placement have a reasonable distance to travel to fill prescriptions and obtain other necessary mental health services.

100. Administrative procedures should be revised and streamlined to ensure that benefits of youth with mental illness are suspended instead of terminated during any period in detention and that those benefits are reinstated upon an individual’s release from detention or placement. A youth’s probation officer or mental health case manager should assist youth and their families with any associated paperwork.

[104] While the task force received public comment on this report, California Assembly Bill 2212 was passed (2010) adding section 709 to the Welfare and Institutions Code regarding the mental competency of juveniles in juvenile court. However, it’s the belief of the committee that this legislation doesn’t adequately address the issue.

Collaboration

Juvenile courts should collaborate with community agency partners to coordinate resources for juveniles with mental illnesses who are involved in the delinquency court system.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

101. The presiding judge of the juvenile court should work collaboratively with relevant local stakeholders to ensure that mental health services are available for all juveniles in the juvenile court system who need such services, including facilitating the delivery of culturally competent and age appropriate psychological and psychiatric services.

102. The presiding judge of the juvenile court of each county should work collaboratively with relevant agencies to ensure that youth in detention receive adequate and appropriate mental health treatment.

103. The presiding judge of the juvenile court should establish an interagency work group to identify and access local, state, and national resources for juveniles with mental health issues. This work group might include, but is not limited to, stakeholders such as schools, mental health, health care, social services, local regional centers, juvenile probation, juvenile prosecutors, juvenile defense attorneys, and others.

104. Guidelines for processes and procedures should be created for information sharing among institutions that protects juveniles' right to privacy, privilege, confidentiality, and due process.

105. Counties should uniformly apply standards of care for youth in detention who have mental illness or developmental disabilities. Local jurisdictions should collaborate to develop strategies and solutions for providing services to youth with mental health issues that meet this minimum statewide standard of care utilizing available local and state resources.

106. The presiding judge of the juvenile court of each county should work collaboratively with relevant local stakeholders to ensure that out-of-custody youth with co-occurring disorders are obtaining community-based mental health services. These stakeholders can include, but are not limited to, schools, mental health, social services, local regional center, juvenile probation, juvenile defense attorneys, drug and alcohol programs, family members, and others.

Education and Training

The Administrative Office of the Courts should provide training and education about juvenile mental health issues to individuals and agencies who work with children in accordance with California Government Code section 68553.5. This section of the Government Code stipulates,

in part, that “to the extent resources are available, the Judicial Council shall provide education on mental health and developmental disability issues affecting juveniles in delinquency proceedings . . . to judicial officers and, as appropriate, to other public officers and entities that may be involved in the arrest, evaluation, prosecution, defense, disposition, and post disposition or placement phases of delinquency proceedings.”

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

107. Education and training related to juvenile development, mental health issues, co-occurring disorders, developmental disabilities, special education, and cultural competency related to these topics should be provided to all judicial officers, probation officers, law enforcement, prosecutors, defense attorneys, court evaluators, school personnel, and social workers. This education and training should include information about the identification, assessment, and provision of mental health, developmental disability, and special education services, as well as funding for those services.

108. Education and training that is culturally competent should be provided to judicial officers, juvenile defense attorneys and prosecutors, court evaluators, probation officers, school personnel, and family members on how to assist juveniles and their families in qualifying for appropriate mental health treatment services for youth under the jurisdiction of the juvenile delinquency court (e.g., Medi-Cal, housing, SSI).

109. The Administrative Office of the Courts should disseminate information to the courts regarding evidence-based collaborative programs or services that target juvenile defendants with mental illness or co-occurring disorders.

Research

Research should be conducted to determine the number of juveniles and transition age youth in the delinquency system who have a mental illness; to assess and evaluate how mental illness affects juvenile offenders; to identify services available to juvenile offenders; and to evaluate programs targeted at this population in order to inform current and future efforts.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

110. The California Courts website should include links to national and international research on collaborative justice and juvenile mental health issues, as well as information on juvenile mental health courts, promising case processing practices, and subject matter experts available to assist the courts.

111. Assessments and evaluations of the current data, processes, and outcomes of juvenile competence to stand trial in California should be conducted. This research should

include, but is not limited to, an assessment of the number of cases in which the issue of competence is raised, the number of youth found incompetent versus competent, and what happens when a youth is found to be incompetent to stand trial.

112. Additional research should be conducted related to juvenile mental health issues, including assessments and evaluations of the following:

   a. The mental health services available to juveniles and transition age youth in each county; and
   b. Any overlap between youth who enter the delinquency system and youth who are eligible to receive mental health services under a special education program provided by the Individuals with Disabilities Education Act[105] (IDEA, in accordance with AB 3632).
   c. The prevalence of youth with disabilities or mental illness who enter the criminal justice system later as adults.

113. Ongoing data should be collected about juveniles diverted from the juvenile delinquency court to other systems, including, but not limited to, the mental health system or juvenile mental health court.

[105] See glossary.

Section 7: Education, Training, and Research

Education and training for judicial officers, court staff, and mental health and criminal justice partners are critical components of any program or response designed to improve outcomes for people with mental illness involved in the criminal justice system. Planning and implementation of education and training programs should incorporate legal and mental health perspectives and reflect a multidisciplinary and multisystem approach to ensure that evidence based practices are included as well as current information about mental health treatment and research findings that may impact criminal justice and court responses to people with mental illness.

Training programs should include, at a minimum, information about mental illness (diagnosis and treatment), the impact of mental illness on individuals and families, indicators of mental illness, stabilization and deescalation strategies, legal issues related to mental illness, and community resources (public and private). Training for judicial officers should include additional information about strategies for developing effective court responses for defendants with mental illness. Cross-training between criminal justice, mental health, and drug and alcohol services partners, and training in developing effective collaborations between the courts and mental health and criminal justice partners is critical if effective practices are to be designed and implemented to improve outcomes for individuals with mental illness in courts, jails, and prisons. All training initiatives should be designed to include mental health consumers and family members.

Additional research is needed to identify best practices in California as well as the costs associated with traditional and alternate responses to people with mental illness in the criminal justice system. This information will help programs become more effective and will assist California's judicial, executive, and legislative branch leaders in crafting public policy to improve outcomes for criminally involved persons with mental illness.

The recommendations below highlight actions that can be taken to heighten awareness and to provide the information and knowledge base necessary for improving outcomes for people with mental illness in the criminal justice system.

Education and Training for Judicial Officers, Attorneys, and Criminal Justice Partners

Judicial officers, counsel, and criminal justice partners should receive ongoing mental health education and training in strategies for working effectively with defendants with mental illness.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

114. Funding for education on collaborative justice principles and mental health issues should be sought from local, state, federal, and private sources.

115. The Administrative Office of the Courts should disseminate to the courts, using advanced technology, information regarding evidence-based collaborative programs or services that target defendants with mental illness or co-occurring disorders.

116. The Administrative Office of the Courts, in collaboration with consumer and family groups, the Forensic Mental Health Association, California Institute of Mental Health (CIMH), California Mental Health Directors Association (CMHDA), and other professional mental health organizations, should develop and provide ongoing education for judicial officers, appropriate court staff, and collaborative partners on mental health issues and strategies for responding to people with mental illness or co-occurring disorders in the criminal justice system. Education should include information on diversion programs and community services that target this population.

117. Judicial officers should participate in ongoing education on mental illness and best practices for adjudicating cases involving defendants who have a mental illness or co-occurring disorder. An overview of such information should be provided to all judges during judicial orientation and/or judicial college and should be included in a variety of venues for ongoing education.

> ***Crisis Intervention Team (CIT) training*** *for law enforcement usually consists of a 40-hour training program designed to improve outcomes of interactions between law enforcement and people with mental illness. Specialized training includes basic information about mental illnesses, instruction on how to recognize signs of psychiatric distress, verbal de-escalation training, role playing, information about local mental health systems and local laws, and participation from mental health clients and family members.*

118. Ongoing training should be provided to judicial officers and attorneys with assignments in collaborative justice courts on collaborative justice principles and all areas related to defendants with mental illness or co-occurring disorders, including diagnoses, communication techniques, and treatment options. Training should include recent outcome research on collaborative court programs.

119. Continuing Legal Education (CLE) courses focusing on mental health law and participation by mental health professionals in the criminal process should be developed.[106]

120. Pretrial services and probation personnel should receive training regarding symptoms of mental illness so that they can refer, or recommend that a judicial officer refer, people

[106] Council of State Governments Justice Center, *The Criminal Justice/MentalHealth Consensus Project Report*, Policy Statement #29 (2002).

who may suffer from a mental illness to trained mental health clinicians for a complete mental health assessment.[107]

121. Probation officers and parole agents should receive education and training about mental illness to increase understanding of the unique challenges facing these offenders and to obtain better outcomes for this population. Education and training should promote a problem-solving approach to community supervision that balances both therapeutic and surveillance goals and includes information regarding communication techniques, treatment options, and criminogenic risk factors.

122. Deputy commissioners of the Board of Parole Hearings who are responsible for hearing parole violations should receive education about mental illness and effective methods for addressing violations of supervision conditions by parolees with mental illness.

123. Crisis intervention training and suicide prevention training should be provided to law enforcement, including jail custody personnel and correctional officers, on an ongoing basis to increase understanding of mental illness and to improve outcomes for and responses to people with mental illness. CIT training and suicide prevention training should also be part of the standard academy training provided to new officers.

124. All mental health training and education should include information on cultural issues relevant to the treatment and supervision of people with mental illness. Custodial facilities, courts, probation, parole, and treatment agencies should be encouraged to actively seek practitioners who have the cultural and language skills to directly relate to people with mental illness.

125. Education and training programs for criminal justice partners should utilize mental health advocacy organizations and include presentations by mental health consumers and family members.

In September 2010, the County of San Diego Health and Human Services Agency launched the **"It's Up to Us" campaign** to empower San Diegans to talk openly about mental illness, recognize symptoms, utilize local resources and seek help. The campaign aims to eliminate negative stigma associated with mental illness and to inspire wellness and recovery by raising awareness, educating the community, and facilitating easy access to local services. The five-year campaign, funded by the County of San Diego Mental Health Services Act, provides messages about mental illness in both English and Spanish on the Internet, television, radio, billboards, buses, and bus shelters, as well as in newspapers and movie theaters.

[107] (*Ibid.*)

126. Mental Health Services Act funding should be actively utilized, per the local stakeholder process as applicable, for state and local educational campaigns and training programs for the general public that reduce stigma and discrimination toward those with mental illness. Educational campaigns and training programs should incorporate the recommendations of the California Strategic Plan on Reducing Mental Health Stigma and Discrimination.[108]

Collaboration With California Law Schools

The Administrative Office of the Courts, California law schools, and the State Bar of California should collaborate to promote collaborative justice principles and expand knowledge of issues that arise at the interface of the criminal justice and mental health systems.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

127. All accredited law schools in California should expand their curricula to include collaborative justice principles and methods, including those focused on defendants with mental health issues.

128. The Administrative Director of the Courts should transmit this report to California law school deans and urge them to consider the following strategies:

    a. Develop effective strategies to institutionalize collaborative justice principles and methods in training programs for law school faculty and staff;
    b. Provide faculty with access to periodic training that focuses on understanding mental illness and how to best represent those with mental illness based on collaborative justice principles and methods; and
    c. Encourage faculty to develop teaching methods and engage speakers who can integrate the practical aspects of how collaborative justice principles and methods relate to the reality of legal practice in the substantive areas being taught.

129. The State Bar of California admissions exam should be expanded to include questions testing knowledge of collaborative justice principles and methods, including those focused on defendants with mental health issues. The Board of Governors and the Committee of Bar Examiners of the State Bar of California should collaborate, as appropriate, with law school deans regarding the inclusion of collaborative justice principles and methods into bar examination questions.

130. The Administrative Director of the Courts should transmit this report to the Law School Admissions Council (LSAC) and the Board of Governors of the State Bar of California for its information and consideration.

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[108] See glossary.

Research

Research should be conducted to evaluate practices aimed at improving outcomes for people with a mental illness involved in the criminal justice system. Research findings should be distributed to courts and court partners and should inform the expansion of such interventions.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

131. Funding for research initiatives outlined in this report should be sought from local, state, federal, and private sources.

132. The California Courts website should include links to national and international research on collaborative justice and mental health issues, as well as information regarding mental health court and calendar best practices and subject matter experts available to assist the courts.

133. There should be further research on the effectiveness of programs that serve people with mental illness involved in the criminal justice system, such as crisis intervention teams, mental health courts, reentry courts, and specialized mental health probation programs. Research should analyze mental health, recidivism, and criminal case outcomes, costs, and savings, as well as the elements of such programs that have the most impact. Research should evaluate outcomes for different subgroups (e.g., according to race, gender, diagnosis, etc.) within the participant population.

134. Programs targeting offenders with mental illness should track outcome data. Although programmatic goals will determine the data collected, key data elements should include the following:

    a. Participant data (e.g., number served and relevant characteristics, such as diagnosis and criminal history);
    b. Service data (e.g., type of service received, frequency of service, length of service provision);
    c. Criminal justice outcomes (e.g., number of arrests, types of charges, jail days);

> ***The Council of State Governments' Criminal Justice/Mental Health Consensus Project*** *has an online accessible research and document library. Many of the reports published on this site help courts and local programs translate research into practice. Recent reports include "Improving Responses to People with Mental Illness: The Essential Elements of Specialized Probation Initiatives"; "Mental Health Courts: A Guide to Research Informed Policy and Practice"; and "The Advocacy Handbook: A Guide to Implementing Recommendations of the Criminal Justice/Mental Health Consensus Project."*

d. Mental health outcomes (e.g., number of inpatient hospitalizations and lengths of stay, number of days homeless);[109] and
e. Program costs and savings data.

135. Statewide evaluations should be conducted to identify and study the effectiveness of inpatient and outpatient programs that regularly accept forensic mental health clients. Barriers to the placement of individuals under forensic mental health commitments should be identified.

136. Independent researchers should evaluate the effectiveness of competency restoration programs.

137. Local public agencies, including law enforcement, should collaborate to create a system, in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations, that identifies individuals involved in the criminal justice system who frequently access services in multiple public systems in order to distinguish those most in need of integrated interventions, such as permanent supportive housing. Public agencies can use this system to achieve cost savings by stabilizing the most frequent and expensive clients.

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[109] Henry J. Steadman, *A Guide to Collecting Mental Health Court Outcome Data* (Council of State Governments Justice Center, 2005), *http://consensusproject.org/mhcp/MHC-Outcome-Data.pdf*.

Conclusion

When members of the Task Force for Criminal Justice Collaboration on Mental Health Issues met for the first time in April 2008, it was noted that this task force had a unique opportunity to impact the future of people with mental illness in the criminal justice system. It was agreed that, in spite of organizational and fiscal challenges, resolutions to long-standing problems are possible through collaborative and innovative efforts that strengthen and expand relationships between the courts and their mental health and criminal justice partners.

Through their individual and collective efforts to learn more about the problems of the traditional response to criminally involved persons with mental illness, task force members reached a fuller understanding of the issues associated with the overrepresentation of persons with mental illness in the criminal justice system. The comprehensive nature of this report is attributable to the collective knowledge and experiences of task force members. Members brought to the table diverse perspectives on the nature of the problem, contributing factors, and approaches for tackling these complex issues. By drawing upon each other's differences in experiences and ideologies, as well as their shared dedication and passion for changing the status quo, task force members outlined a blueprint to vastly improve responses to criminally involved persons with mental illness.

Before the report was finalized, task force members had already begun working collaboratively to implement some of the recommendations. Many task force members expressed a strong willingness to continue to assist with implementation efforts at both the state and local levels. With their enthusiasm and commitment and with judicial branch leaders uniquely positioned to continue to lead such efforts, it is possible to proceed on the actions proposed in this report and make a real and lasting difference in the lives of people with mental illness in our courts, our jails and prisons, and our communities.

Appendices

Appendix A: Glossary of Terms

AB 2034 Initiative: In 1999, the California State Legislature passed Assembly Bill 34 (AB34), which provided $10 million in funding for pilot programs addressing the needs of homeless people with serious mental illness in Stanislaus, Los Angeles, and Sacramento Counties. Assembly Bill 2034, passed in 2000, sustained the initial AB34 programs and created additional programs statewide. AB 2034 programs were successful in reducing days spent homeless, in jail, and in psychiatric hospitals through cost-efficient methods. Funding for AB 2034 programs was eliminated in 2007.[110]

California Network of Mental Health Clients: The California Network of Mental Health Clients (CNMHC) is a solely consumer-run organization whose membership consists of affiliates and individuals throughout California. It provides a statewide advocacy voice for California's mental health consumers.[111]

California Strategic Plan on Reducing Mental Health Stigma and Discrimination: In collaboration with the Mental Health Services Oversight and Accountability Commission, the Department of Mental Health convened the Stigma and Discrimination Advisory Committee, which developed a strategic plan with input from other community leaders, researchers, advocates, and the public at large to reduce mental health stigma and discrimination in systems throughout the state of California.[112]

Collaborative justice court principles: Collaborative justice courts (also known as problem-solving courts) promote accountability by combining judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery. These courts are distinguished by the following elements: a problem-solving focus, a team approach to decision making, integration of social and treatment services, judicial supervision of the treatment process, community outreach, direct interaction between defendants and judicial officers, and a proactive role for the judicial officer inside and outside the courtroom. Collaborative justice courts adhere to the following principles:

- Collaborative justice courts integrate services with justice-system processing;
- Collaborative justice courts emphasize achieving desired goals without using the traditional adversarial process;
- Eligible participants are identified early and promptly placed in the collaborative justice court program;

[110] U.S. Psychiatric Rehabilitation Association, *Lessons Learned from California's AB 2034 Programs* (2009).
[111] California Network of Mental Health Clients website, *www.californiaclients.org* (as of March 1, 2010).
[112] California Department of Mental Health, *Stigma and Discrimination Reduction Advisory Committee—Strategic Plan*, *www.dmh.ca.gov/PEIStatewideProjects/StrategicPLan.asp*

- Collaborative justice courts provide access to a continuum of services, including treatment and rehabilitation services;
- Compliance is monitored frequently;
- A coordinated strategy governs the court's responses to participants' compliance, using a system of sanctions and incentives to foster compliance;
- Ongoing judicial interaction with each collaborative justice court participant is essential;
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness;
- Effective collaborative justice court operations require continuing interdisciplinary education;
- Forging partnerships between collaborative justice courts, public agencies, and community-based organizations increases the availability of services, enhances the program's effectiveness, and generates local support; and
- Effective collaborative justice courts emphasize a team and individual commitment to cultural competency. Awareness of and responsiveness to diversity and cultural issues help ensure an attitude of respect within the collaborative justice court setting. [113]

Conditional Release Program (CONREP): The Department of Mental Health's statewide system of community-based services for specified forensic patients. CONREP is charged with the treatment and supervision in community settings of people referred by criminal courts or by the Board of Prison Terms to the Department of Mental Health. People served by CONREP include those found by the courts to be Not Guilty by Reason of Insanity (Pen. Code, § 1026 or Welf. & Inst. Code, § 702.3) and Incompetent to Stand Trial (Pen. Code, § 1370); those committed as Mentally Disordered Sex Offenders under the provisions of Penal Code section 6316 (repealed in 1981); Mentally Disordered Offenders (Pen. Code, § 2962); prison inmates required to receive mental health treatment as a condition of parole; and civilly committed Mentally Disordered Offenders (MDO) (Pen. Code, § 2972) or MDO parolees in CONREP who have completed their sentence but remain severely mentally ill.[114]

Consumer: An individual with mental illness who may utilize mental health services. The term consumer is sometimes synonymous with the terms "mental health client" or "mental health service user."

Co-occurring disorder: The task force defines this term as a disorder in which an individual has a mental illness and an accompanying disorder, such as a substance use disorder, a developmental disability, or conditions that are physical or metabolic in nature. Traditionally, this term refers to an individual with one or more substance use disorders and one or more psychiatric disorders.

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[113] Judicial Council of California website, "Collaborative Justice Programs," *www.courtinfo.ca.gov/programs/collab* (as of March 1, 2010).
[114] California Department of Mental Health, *Forensic Conditional Release Program (CONREP)*, *www.dmh.ca.gov/Services_and_Programs/Forensic_Services/CONREP/default.asp* (as of March 1, 2010).

Council on Mentally Ill Offenders (COMIO): On October 12, 2001, former Governor Gray Davis signed Senate Bill No. 1059 (Chapter 860, Statutes of 2001) (Perata) creating the Council on Mentally Ill Offenders (COMIO). The Legislature identified that the primary purpose of the Council is to "investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending."[115]

Crisis Intervention Teams (CIT): Police officers who have received specialized mental health training act as primary or secondary responders to every call involving people with mental illnesses. CIT is a type of prebooking jail diversion program designed to improve the outcomes of interactions between law enforcement and people with mental illnesses. The CIT approach was developed by the Memphis (TN) Police Department.

Cultural competence: A set of skills, behaviors, attitudes, and policies in a system, an agency, or among people providing services that enables the system, agency, or service providers to work effectively in cross-cultural situations.[116]

Discharge plan: A document that builds upon jail mental health screening and evaluation information and outlines the care and services an individual with mental illness is to receive upon release. Discharge plans should arrange for transportation, housing, food, mental and physical health care, and other necessary services.

Dual diagnosis: See co-occurring disorders.

Evidence-based practice: A practice that has been demonstrated by research to be associated with positive outcomes, such as reduced recidivism, reduced substance use, or improved psychosocial functioning.

Forensic Peer Specialist Programs: Peers are individuals with a mental illness or co-occurring disorder who have experienced past involvement in the criminal justice system. Peer specialists provide recovery-oriented direct services to their peers currently involved in the criminal justice system. Forensic Peer Specialist Programs can provide services in a variety of settings, including jail or prison, upon discharge, during the proceedings of a mental health court, and in working with probation and parole. Effective peer support requires that peer staff (and volunteers) be provided with training and ongoing supervision and support.

Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules: The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule permits the disclosure of personal health information needed for patient

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[115] Department of Corrections and Rehabilitation, *COMIO: Council on Mentally Ill Offenders*, *www.cdcr.ca.gov/COMIO*.
[116] Title 9 of the California Code of Regulations section 1810.211.

care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to ensure the confidentiality, integrity, and availability of electronic protected health information.[117]

Income maintenance programs: Social welfare programs or services that provide financial resources for people who are unable to provide for themselves (e.g., Supplemental Security Income, CalWORKs, General Assistance, etc.).

Individuals with Disabilities Education Act: The Individuals with Disabilities Education Act (IDEA) is a United States federal law, 20 U.S.C. §1400 et seq., most recently amended in 2004, meant to ensure "a free appropriate public education" for students with disabilities, designed to meet the individual needs of each student in the Least Restrictive Environment. The act requires that public schools provide necessary learning aids, testing modifications, and other educational accommodations to children with disabilities. The act also establishes due process in providing these accommodations.[118]

In-reach services: Services provided to jail or prison inmates with mental illness that prepare them for release and connect them to needed services in the community.

Jail liaison: Jail liaisons are designated staff who serve as boundary spanners between local mental health systems and correctional facilities. Jail liaisons improve communication between systems and address and resolve problems that arise in the planning and coordination of services for offenders with mental illness during incarceration and upon release into the community. The designation of formal liaisons provides a single point of access within each system for problem identification and resolution regarding care of specific individuals as well as coordination between systems.

Lanterman-Petris-Short (LPS) Act: California legislation passed in 1967, which changed the conditions under which persons may be treated involuntarily for mental illness. The legislation aimed to end indefinite involuntary commitment, establish the due process rights of individuals for whom commitment was being sought, and provide for a system of prompt evaluation and treatment of persons with serious mental illness.[119]

Laura's Law (AB 1421): Assembly Bill 1421, passed in California in 2002, gives counties the option to implement assisted outpatient treatment programs. Assisted outpatient treatment programs provide intensive court-ordered treatment in the community to those who have a

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[117] U.S. Department of Health and Human Services, *Understanding Health Information Privacy*, *www.hhs.gov/ocr/privacy/hipaa/understanding/index.html* (as of March 1, 2010).
[118] K12 Academics, U.S. Education Legislation, *Individuals with Disabilities Education Act*, *www.k12academics.com/us-education-legislation/individuals-disabilities-education-act-idea* (as of March 1, 2010).
[119] Harry R. Brickman, "Government and Medicine II: California's Short-Doyle Program, The New Mental Health System: Changes in Procedure, Implications for Family Physicians," *California Medicine* 109(5) (1968), pp. 403–408.

mental illness, are unlikely to survive safely in the community without supervision, have a history of mental health treatment noncompliance, and whose mental illness has either been a significant factor in the individual's hospitalization or incarceration within the last 36 months or has resulted in one or more acts, attempts, or threats of serious violent behavior toward self or others within the last 48 months.[120]

Mental Health Services Act (MHSA): The MHSA, passed in November 2004, imposes a one-percent income tax on personal income in excess of $1 million. The majority of the funding is provided to county mental health programs to fund programs consistent with their local plans. The Act addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that will effectively support California's mental health system.[121]

Mental illness: A collective term for all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[122] (Also see serious mental illness.)

Mobile Crisis Teams (MCT): A mobile crisis team is an interdisciplinary team of mental health professionals who provide a range of services, including assessment, crisis intervention, information and referrals, linkage with appropriate community-based mental health services for ongoing treatment, and follow-up. Mobile crisis teams provide consultation to police and may respond to psychiatric emergency calls initially handled by other police units or may accompany police officers to the scene.

National Alliance on Mental Illness, California (NAMI CA): A nonprofit charitable grassroots organization of families and individuals whose lives have been affected by serious mental illness. NAMI CA advocates for lives of quality and respect, without discrimination or stigma, for all of their constituents and provides leadership in advocacy, legislation, policy development, education, and support throughout California.

Parole: Parole is the legal status of all prisoners upon release from a California prison after serving their sentence. Upon release from prison, most parolees are supervised in the community by parole agents of the California Department of Corrections and Rehabilitation.

Postbooking diversion programs: Postbooking diversion programs identify and divert individuals with mental illness from the criminal justice systems after they have been arrested. Points at which individuals may be diverted postbooking include (1) at or immediately after

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[120] California Welf. and Inst. Code, § 5346.
[121] California Department of Mental Health, *Mental Health Services Act (Proposition 63), www.dmh.ca.gov/prop_63/MHSA/default.asp* (as of March 1, 2010).
[122] U.S. Department of Health and Human Services, "Introduction and Themes," part of chapter 1 in *Mental Health: A Report of the Surgeon General* (1999), *www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html.*

booking into jail, before the formal filing of charges; (2) upon release from pretrial detention, with the condition of participation in treatment; (3) prior to disposition, for example, upon the prosecutor's offer of deferred prosecution; (4) at disposition or sentencing (this may include deferred sentencing or release on probation with conditions that include participation in treatment); and (5) when at risk of, or following, a violation of probation related to a prior conviction.[123]

Prearrest or prebooking diversion programs: Prearrest or prebooking diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health and substance abuse services. Most prebooking programs are characterized by specialized training for police officers and a 24-hour crisis drop-off center with a no-refusal policy for people brought in by the police.[124]

Probation: Probation is the community supervision of criminal offenders. The court may sentence criminal offenders to probation instead of or in addition to jail time. In California, community supervision of probationers is conducted by county departments of probation. County probation officers work with probationers on their caseload to ensure compliance with conditions of probation, to protect the community, and to help reduce risk and recidivism.

Psychiatric advance directives (PADs): Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. Typically, these instruments authorize a surrogate decision maker with Durable Power of Attorney for Healthcare to act in accordance with an incapacitated patient's previously expressed wishes or known values or to act in the patient's best interest if the patient's preferences are unknown.[125] Information about PADs in California can be found at *www.nrc-pad.org/content/view/67/54/*.

Psychiatric Emergency Response Teams (PERT): A licensed mental health clinician is paired with an officer or deputy to respond to situations determined by the dispatcher or another officer to involve a person suspected of having a mental illness. These teams conduct mental health assessments and process referrals to county providers if appropriate.[126]

Reentry courts: According to Penal Code section 3015(e)(1), reentry courts are a type of collaborative justice court that use a highly structured model, including close judicial supervision and monitoring, dedicated calendars, nonadversarial proceedings, frequent drug and alcohol

[123] National GAINS Center, *Types of Jail Diversion Programs*, *www.gainscenter.samhsa.gov/html/jail_diversion/types.asp* (as of March 1, 2010).
[124] *Ibid.*
[125] National Resource Center on Psychiatric Advance Directives, *www.nrc-pad.org/content/section/6/41* (as of March 1, 2010).
[126] Council of State Governments Justice Center, *The Criminal Justice/Mental Health Consensus Project Report*, Policy Statement 3: On-Scene Assessment (2002).

testing, and close collaboration between the respective entities involved to improve the parolee's likelihood of success on parole. Parolees with a history of substance abuse or mental illness who violate their conditions of parole may be referred to a reentry court program by the California Department of Corrections and Rehabilitation.

Serious mental illness: Serious mental illness is defined differently across programs, policies, and in research literature. Serious mental illness is usually defined by the type of diagnosis, the duration of the illness, and the level of impairment. The definition of serious mental illness as stated in Public Law 102-321, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act requires the person to have at least one 12-month disorder, other than a substance use disorder, that met criteria described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, and to have serious impairment as determined by a Global Assessment of Functioning score. Much of the research literature defines serious mental illness to include schizophrenia and other psychotic disorders, bipolar disorder, other severe forms of depression, and sometimes anxiety disorders, such as obsessive compulsive disorder, that cause serious impairment.

Supportive housing: Supportive housing for persons with mental illness is designed to provide safe, permanent, and affordable housing in combination with social services that help these individuals live in the community.

Transition age youth: Youth typically between the ages of 18 and 25. The term often refers to youth in public systems, such as the foster care system or the juvenile justice system.

United Advocates for Children and Families (UACF): An agency dedicated to improving the quality of life for all children and youth with mental, emotional, and behavioral challenges and to eliminate institutional discrimination and social stigma. UACF currently operates three programs to meet its mission, a direct service program in two California counties, a statewide advocacy and training program, and a national training and technical assistance center. With the passing of the Mental Health Services Act, UACF's primary goal in California is to assist independent family organizations at the county level to identify their missions and incorporate and build intentional and effective strategies to transform California's mental health service delivery system for children.[127]

[127] United Advocates for Children and Families, *UACF History*, *www.uacf4hope.org/au_history.htm* (as of June 3, 2010).

Appendix B: Mental Health Court Fact Sheet

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FACT SHEET

April 2008

Mental Health Courts

"People with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate."

Council of State Governments,
Criminal Justice/Mental Health Consensus Project, June 2002

What Are Collaborative Justice Mental Health Courts?

Like drug courts, collaborative justice mental health courts focus on treatment to restore health and reduce criminal activity. They focus on providing mentally ill offenders with better access to treatment, consistent supervision, and support to reconnect with their families. The primary goal is to reduce episodes of incarceration and recidivism by linking mentally ill offenders to an array of local service and support options.

A quick review of the literature reveals the following facts about mental illness and its impact on the criminal justice system:

- Of the nearly 11 million people arrested each year in the United States, at least 600,000 have an acute mental illness while another 7 million have substance abuse and/or mental disorders;
- Nearly half the inmates in prison with a mental illness are incarcerated for committing a nonviolent crime; and
- Studies indicate that offenders with mental illness have three or more prior probations, incarcerations, or arrests as compared to those without mental illness.

Crises in community mental health care and the long-term effects of de-institutionalization, the drug epidemic of the 1980s and 1990s, the dramatic increase in homelessness over the last two decades, and widespread jail overcrowding have all led to an increase in mental health courts. As of 2008, California trial courts reported having approximately 40 mental health courts operating statewide, serving adult and juvenile populations.

Common Elements in Mental Health Courts

Several types of mental health court models have developed throughout the state, but courts in general apply the following common elements.

- Participation in a mental health court is voluntary. The defendant must consent to participation before being placed in the program.
- Each jurisdiction accepts only persons whose involvement with the criminal justice system can be attributed to a demonstrable mental illnesses.
- The key objective of a mental health court is to either prevent the jailing of mentally ill offenders or to secure their release from jail for appropriate community services.
- Public safety is a high priority, and mentally ill offenders are carefully screened for appropriate inclusion in the program.
- Early intervention is essential, with screening and referral occurring either immediately after arrest or up to a maximum of three weeks after arrest.
- A multidisciplinary team approach is used, with the involvement of justice system representatives, mental health providers, and other support systems.
- Intensive case management includes supervision of participants, with a focus on accountability and monitoring of each participant's performance.
- The judge is the center of the treatment and supervision process.

Benefits of Mental Health Court

Although research on mental health courts (MHCs) is emerging, individual research conducted on mental health court programs across the nation has produced some promising findings:

- MHCs can provide greater access to treatment than traditional court. Defendants in treatment prior to appearing before a mental health court may be more likely to stay in treatment than those in treatment whose cases are handled by a traditional court.
- MHCs can play a productive role in a comprehensive strategy to break the cycle of poor treatment, worsening mental illness, escalating criminal behavior, and increasing arrest and incarceration.

- MHC participants demonstrated significant improvements in global functioning and quality of life, as well as reductions in the psychological distress and drug and alcohol problems.
- A juvenile MHC resulted in a dramatic decrease in the need for residential and inpatient care, resulting in an ability to serve twice the number of juvenile clients.

Evaluation of Mental Health Courts

Local evaluations show reduced recidivism overall, though results and research quality vary. An evaluation in Seattle found a 27 percent lower rate of recidivism for mental health court participants, as compared to participants in traditional court.

A study conducted in Broward County, Florida, found a reduction in the number of violent acts after eight months of mental health court compared to the group in traditional court.

A 2007 study by the RAND Corporation found significant cost savings in a mental health court in Allegheny County, Pennsylvania.

Mental Health Court Resources

Bernstein, R. (2003). *Criminalization of people with mental illnesses: The role of mental health courts in system reform*. Washington, DC: Judge David L. Bazelon Center for Mental Health Law.

Council of State Governments (2005). *A guide to mental health court design and implementation.* New York, NY: Council of State Governments. Retrieved April 15, 2008, from http://consensusproject.org/mhcp/Guide-MHC-Design.pdf

Denckla, D., and Berman, G. (2001). *Rethinking the revolving door: A look at mental illness in the courts.* New York, NY: Center for Court Innovation.

Judges' Criminal Justice/Mental Health Leadership Initiative (JLI). *Judges' guide to mental health jargon: A quick reference for justice system practitioners.* Retrieved April 15, 2008, from http://www.prainc.com/xml/services/popups/judges_guide.html.

Steadman, H. J. (2005). *A guide to collecting mental health court outcome data.* New York, NY: Council of State Governments. Retrieved April 15, 2008, from http://www.consensusproject.org/mhcourts/MHC-Outcome-Data.pdf

Appendix C: Mental Health Court Research Brief

Mental illness is a considerable problem within U.S. jails and prisons, with many arguing that jails and prisons are the new asylums for the mentally ill and that correctional institutions are now the primary providers of services for the mentally ill (Lamb, Weinberger, & Reston-Parham, 1996; Moore & Hiday, 2006; Robison, 2005). James and Glaze of the Bureau of Justice Statistics (2006) reported that 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates had a mental health diagnosis or symptoms of mental health problems in the previous 12 months. Despite this prevalence, only about half of state prisons provide 24-hour mental health care (Beck & Maruschak, 2001). The most common mental health problems found in forensic settings include major depression, bipolar disorder, schizophrenia, and other psychoses (James & Glaze; Lurigio, Rollins, & Fallon, 2004). The prevalence of these illnesses is approximately three to four times higher than that of the general public (Ditton, 1999). In addition, Ditton estimated that 1 in 10 inmates take psychotropic medication and only 1 in 8 receives mental health counseling.

One strategy for addressing the issues and challenges of mentally ill offenders is through a mental health court, a criminal court that has a dedicated calendar and judge for offenders with mental illness. Mental health courts apply collaborative justice principles to combine judicial supervision with intensive social and treatment services to offenders in lieu of jail or prison. These collaborative justice principles include a multidisciplinary, nonadversarial team approach with involvement from justice system representatives, mental health providers, and other support systems in the community. Mentally ill offenders are carefully screened for inclusion in mental health courts, with screening and referral occurring as soon as possible after arrest. Each offender who consents to participate receives intensive case management that includes supervision focused on accountability and treatment monitoring. Across the country there are now more than 200 mental health courts, and in California there are more than 40 mental health courts in 30 counties. Across the country and in California, evaluations have been conducted on mental health courts to determine their outcomes and cost effectiveness. A nonexhaustive list of relevant studies and their results can be found at the end of this document.

Evaluation of Mental Health Courts

Since mental health courts first emerged in the 1990s, researchers have been examining whether mental health courts reduce recidivism among its participants. An additional factor in evaluations is whether these courts save money for the jurisdictions in which they are located. Although few rigorous evaluations have been conducted, all show promising results, including increased utilization of treatment services, reduced recidivism, and cost savings.

Utilization of Treatment Services

An early study conducted on Seattle's mental health court showed that the mental health court is effectively linking mentally ill offenders with the necessary treatment services and that mental health court participants have a greater likelihood of treatment success and access to housing and

critical supports compared to mentally ill offenders in traditional court (Trupin, Richards, Wertheimer, & Bruschi, 2001). Another evaluation of one of the country's first mental health courts in Florida also showed that participation in the mental health court increases the likelihood of participants' engaging in treatment (Boothroyd, Poythress, McGaha, & Petrila, 2003).

Recidivism

Several evaluations have also illustrated mental health courts' impact on reducing recidivism. In one early study, researchers found that one year after sentencing, offenders who were court mandated to complete judicially monitored mental health treatment had significantly better outcomes than those who were merely recommended to receive treatment (Lamb et al., 1996). Outcome were defined as avoiding hospitalizations, rearrests, violence against others, and homelessness. Other researchers found similar outcomes for mental health courts. In the evaluation of Seattle's mental health court, Trupin et al. (2001) found that participants' arrests significantly decreased—by nearly half—between the time they entered the program and a year after they entered the program. Herinckx, Swart, Ama, Dolezal, and King (2005) also found that mental health court participants' number of arrests was significantly reduced between 12 months prior to enrolling and 12 months after enrolling. In the 12 months after enrollment, there was also a significant reduction in probation violations.

In an evaluation of one of the first mental health courts in the country, Broward County, Florida, Christy, Poythress, Boothroyd, Petrila, and Mehra (2005) found that participants' average number of arrests significantly decreased between one year before participating and one year after entering the mental health court program. When compared to arrest rates of those who went through traditional case processing, however, there were no significant differences. Christy et al. did find, though, that mental health court participants spent significantly fewer days in jail compared to the comparison group.

More recently, Moore and Hiday (2006) found that mental health court participants in another Southeastern state were rearrested significantly less often than were those in a comparison group of traditional criminal court defendants; the mental health court participants had a rearrest rate of about half that of the comparison group. The researchers also found that a "full dose" of mental health court, or completion, had a significant effect on recidivism. In a follow-up study, Hiday and Ray (2009) followed mental health court graduates for two years and found that their proportion and number of arrests continued to be significantly lower than in the two years prior to entering the mental health court. In addition, those who completed the mental health court program had fewer arrests and a longer time to rearrest than did noncompleters of the program.

In California, Cosden, Ellens, Shnell, and Yamini-Diouf (2005) compared mental health court participants to a "treatment as usual" comparison group two years after participants entered the program. They found that both participants and those in the comparison group had a significant decrease in the number of jail days between the times, although those with a dual diagnosis were less affected by treatment than were others. The researchers concluded that judicial training and

changes in community practice affected both participants in the program and those who were receiving "treatment as usual" since that usual treatment changed as well. A more recent study in California also showed the effectiveness of mental health courts on recidivism. McNeil and Binder (2007) compared mental health court participants to defendants in traditional court who also had a mental illness in San Francisco and found that mental health court participants were 26 percent less likely to be charged with new crimes and 55 percent less likely to be charged with violent crimes than were those in the comparison group. In addition, the researchers found that after 18 months, the risk of mental health court graduates was about half of that of the comparison group. In a recent study of four mental health courts—two in California, one in Minnesota, and one is Indiana—researchers found that mental health court participants had a lower rearrest rate and fewer incarceration days than did a "treatment as usual" group (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2010). In addition, those who graduated from a mental health court program had lower rearrest rates than those whose participation was terminated before graduation. The researchers noted that "the appropriate question for mental health courts is not 'do they work?' but 'for whom, and under what circumstances do they work?'" (p. E5). They found that having a diagnosis of schizophrenia or depression rather than bipolar disorder and having used illegal drugs in the past 30 days were associated with more incarceration days during the follow-up period. They also found that longer exposure to the mental health court program is associated with better improvement after leaving the program.

Cost Savings

Research on cost savings of mental health courts is limited; however, Ridgely, Greenberg, DeMartini, and Dembosky of RAND (2007) have looked at the cost effectiveness of mental health courts. The researchers examined the fiscal impact of a mental health court and found that the mental health court did not result in substantial short-term costs over traditional case processing. However, they suggested that there could be substantial long-term savings due to reductions in recidivism as well as reductions in utilizing expensive, intensive treatment such as hospitalization.

Conclusion

Evidence shows that jails and prisons have become the new institutions for the mentally ill. With such a large proportion of offenders having a mental illness, mental health courts have become a useful tool in providing the appropriate treatment to these offenders. Numerous evaluations over the last decade have shown promising results for mental health courts in several areas, including participants' utilization of services, reduced recidivism, and cost savings to counties and states.

Despite the promising results shown thus far, continued research with strong and rigorous designs is recommended. These would include studies with equivalent comparison groups, extended follow-up to determine how long the mental health court's effect lasts, and large sample sizes.

Nonexhaustive List of Relevant Studies and Their Findings

Author (Year)	Study	Findings
Boothroyd, Poythress, McGaha, & Petrila (2003)	The Broward mental health court: Process, outcomes, and service utilization	Participation in mental health court increases the likelihood of participants' engaging in treatment.
Christy, Poythress, Boothroyd, Petrila, & Mehra (2005)	Evaluating the efficiency and community safety goals of the Broward County mental health court	Mental health court participants spent fewer days in jail for the index arrest than did a comparison group. There was no difference in re-arrests up to one year after enrollment between participants and comparison group. Participants reported fewer acts of violence than did the comparison group at 8 months.
Cosden, Ellens, Shnell, & Yamini-Diouf (2005)	Efficacy of a mental health treatment court with assertive community treatment	There was reduced recidivism and improved psychosocial functioning for mental health court participants compared to a treatment-as-usual group. Mental health court was not as effective for participants with serious drug and alcohol problems, or dual-diagnoses.
Cuellar, McReynolds, & Wasserman (2006)	A cure for crime: Can mental health treatment diversion reduce crime among youth?	Youth who participated in a juvenile mental health diversion program were significantly less likely to be rearrested than a comparison group.
Herinckx, Swart, Ama, Dolezal, & King (2005)	Rearrest and linkage to mental health services among clients of the Clark County mental health court program	The number of arrests for mental health court participants was significantly reduced between 12 months prior to enrolling and 12 months after enrolling. In the 12 months after enrollment, there was also a significant reduction in probation violations.
Hiday & Ray (2009)	Arrests after exiting mental health court	The proportion and number of arrests of mental health court graduates continued to be significantly lower two years after entering the mental health court. In addition, those who completed the mental health court program had fewer arrests and a longer time to rearrest than did noncompleters of the program.

Author (Year)	Study	Findings
McNeil & Binder (2007)	Effectiveness of a mental health court in reducing criminal recidivism and violence	At 18 months, the likelihood of mental health court participants being charged with any new crimes was 26% lower than for individuals receiving treatment as usual, and graduates of mental health court maintained reduced recidivism after they were no longer under court supervision.
Moore & Hiday (2006)	Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants	Mental health court participants had a rearrest rate of about half that of a comparison group. Also, a "full dose" of mental health court, or completion, had a significant effect on recidivism.
Ridgely, Greenberg, DeMartini, & Dembosky (2007)	Justice, treatment, and cost: An evaluation of the fiscal impact of Allegheny County Mental Health Court	Fiscal impact analyses showed that entry into the mental health court program leads to an increase in the use of treatment services in the first year as well as a decrease in jail time for program participants during both the first and second years after entry. The decrease in jail expenditures mostly offsets the cost of the treatment services.
Steadman, Redlich, Callahan, Robbins, & Vesselinov (2010)	Effect of mental health courts on arrests and jail days: A multisite study.	Mental health court participants in four sites had significantly lower rearrest rate and fewer incarceration days than did a "treatment as usual" group. Those who graduated from a mental health court program had lower rearrest rates than those whose participation was terminated before graduation. Those who had a diagnosis of schizophrenia or depression rather than bipolar disorder and who had used illegal drugs in the past 30 days were associated with more incarceration days during the follow-up period. Longer exposure to the mental health court program is associated with better improvement after leaving the program.

Author (Year)	Study	Findings
Sullivan, Veysey, Hamilton, & Grillo (2007)	Reducing out-of-community placement and recidivism: Diversion of delinquent youth with mental health and substance use problems from the justice system	A juvenile mental health diversion program significantly reduced recidivism among participants 120 days after referral to the program. Recidivism continued to decrease during the two-year study period. Participants also had a decreased rate of out-of-community placement.
Trupin, Richards, Wertheimer, & Bruschi (2001)	City of Seattle mental health court evaluation report	Mental health court participants' arrest rates significantly decreased between the time they entered the program and a year after they entered the program. The mental health court also effectively links mentally ill offenders with services.

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Appendix D: Sample Discharge Plan

Jail Discharge and Community Reentry Plan (JD/CRP)

Introduction

The following are key activities and elements that must be addressed in a Jail Discharge/ Community Reentry Plan (JD/CRP). A JD/CRP that is initiated as early as possible during incarceration is widely understood as key to ensuring a successful transition and return of an offender with mental illness to his or her community.[128] The sample JD/CRP, outlined on pages 75–78, is not all-inclusive; it is intended as a template to identify critical needs and issues that must be addressed prior to release from jails or other correctional facilities.

Recommended Process:

1. At the earliest time feasible after booking into jail, custody mental health staff or other designated professionals administer a risk/needs assessment of the offender with mental illness. Evidence based assessment instruments should be utilized. It is important to note that the assessment may need to be administered more than once if the offender remains in custody for an extended period of time. Assessments should always be re-administered if an offender with mental illness is released and subsequently returns to custody.

2. The community supervision agency (probation/parole) and the community mental health services agency designee, after reviewing the risk/needs assessment and all other relevant and available information, are to develop a JD/CRP prior to release for offenders who are the most seriously mentally ill. The JD/CRP development should be initiated as early as possible during the time of incarceration and should involve the offender's counsel if possible. Every effort shall be made to engage the offender with mental illness, and where appropriate (and feasible) the offender's family members, in developing the JD/CRP.

3. The JD/CRP shall be submitted to the court for consideration, modification as needed, and adoption at the time of sentencing, or at any other court proceeding or hearing where a judge will consider the possible release of an offender with mental illness from custody into the community.

4. Whenever feasible, the JD/CRP will indicate agreements by participating community supervision agents (probation/parole) and service providers regarding the type, intensity, and frequency of services to be provided during the initial reentry period.

5. The JD/CRP should follow the offender with mental illness from the correctional facility to the community. In the event of a re-offense, this plan should be reviewed and updated for subsequent release planning.

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[128] Each county should designate an entity, depending on local agencies and partnerships, that is responsible for ensuring that the discharge plan is completed and delivered to appropriate staff in partnering agencies.

Jail Discharge and Community Reentry Plan

Client name: ______________________________

Contact information: ______________________________

____

Family/Others contact information:

1. ______________________________
2. ______________________________

Staff/Person(s) completing the JD/CRP:

Name: ______________________________

Agency: ______________________________

1. Community Supervision

Judicial Supervision

a) Judge and court: ______________________________

____

Probation/Parole program

a) Supervising agent name and unit: ______________________________

b) Phone and e-mail contact: ______________________________

c) After-hours/emergency contact: ______________________________

Community Supervision Plan

a) Describe prerelease contact with supervising probation officer, parole agent, or other person designated to monitor offender on release: ______________________________

____

b) Anticipated type and frequency of contact postrelease
Within 72 hours postrelease: ______________________________

First 30 days postrelease: ______________________________

c) First supervision appointment
Date: ______________________________

Time: ______________________________

Address: ______________________________

Name of supervising agent/agency: ______________________________

2. Postrelease Housing/Living Arrangement

a) Type of housing or facility *(Indicate type of housing, including if temporary shelter, supervised/treatment facility, family residence, etc.)*: ____________________

____

b) Address: ____________________

c) Phone: ____________________

d) Staff contact if supervised housing: ____________________

3. Transportation

a) Describe immediate postrelease transportation needs and arrangements: ____________________

____

____

____

4. Benefits

a) Describe financial and health benefit status
- Income/financial: ____________________
- Health coverage: ____________________

b) Plan for follow-up to apply or reinstate benefits *(including contact information for the individual who will assist the offender and any actions the offender is to take immediately upon release)* ____________________

____

____

5. Community Services Plan

Services Coordination and Plan

a) Services coordinator name and agency: ____________________

b) Phone and e-mail contact: ____________________

c) After-hours/emergency contact: ____________________

d) Has a services coordinator met with offender? YES ❑ NO ❑

e) Immediate postrelease services coordination plan: ____________________

____

____

Medications ____

a) Number of days of medications provided on release: ____________________

b) Prescription(s) to be filled by date: ____________________________

c) Name and location of pharmacy: ____________________________

d) List of current medications and directions attached? YES ❑ NO ❑

Psychiatric Services

a) Name of provider: ____________________________________

b) Appointment date: ____________________________________

c) Contact information: ____________________________________

Mental Health, Substance Abuse Treatment, and Other Services *(Describe service, program location, appointment information, etc.)*

- ____
- ____
- ____

Daily Activity *(Employment, job training, school, etc.)*

- ____
- ____
- ____

Health Care: Indicate any known health-care providers and needs for follow-up referrals and appointments.

- ____
- ____
- ____
- ____

6. **Recovery Plan:** Strengths, Triggers for Relapse and/or Decompensation, and Actions to Address Triggers.

a) Strengths:

- ____
- ____
- ____

b) Triggers—Indicators of Risk of Relapse/Decompensation:

- ____
- ____

c) Actions to Address Triggers and Utilize Strengths:

- ____________________
- ____________________
- ____________________

7. **Other needs:** Indicate if the individual has needs or requires additional support not reflected above.
   - ____________________
   - ____________________

Individual to be Released

Name: ____________________

I have discussed___ and agree___ with this JC/CRP for my release.

Signature: ____________________

Staff/Person(s) completing the JD/CRP

Name: ____________________

I have discussed this JC/CRP with ____________________ (*client name*) on ________ (*date*)

Signature: ____________________

Appendix E: Sample Inmate Mental Health Information Form

INMATE MENTAL HEALTH INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: ____________________

STREET ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP CODE: __________

DOB: __________ BOOKING #: ____________________

JAIL LOCATION: TOWER: __________ FLOOR: __________ POD#: __________

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: ____________________ RELATIONSHIP __________

STREET ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP CODE: __________

DAYTIME PHONE: ____________________ EVENING PHONE: ____________________

CONTACT SIGNATURE: x____________________

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST/LAST TREATMENT FACILITY: ____________________ DATE LAST TREATED: __________

STREET ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP CODE: __________

PHONE: ____________________ FAX: ____________________

MEDICAL INFORMATION

DIAGNOSIS: ____________________

DAYTIME MEDICATIONS: ____________________

____

NIGHTTIME MEDICATIONS: ____________________

____

PRIOR ADVERSE MEDICATION EFFECTS (i.e. side effects, allergies, poor efficacy): ____________________

____

____

IS SUICIDE A CONCERN? NO _____ YES _____ IF YES, WHY? ____________________

____

____

____

OTHER MEDICAL CONCERNS: ____________________

____

____

____

MEDICAL DOCTOR'S NAME: ____________________ OFFICE PHONE: ____________________

STREET ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP CODE: __________

JAIL MENTAL HEALTH SERVICE FAX NUMBERS

MEN'S FAX: WOMEN'S FAX:

SHERIFF'S MEDICAL SERVICES BUREAU – MEN'S FAX: WOMEN'S FAX:

FAX TO BOTH NUMBERS WHEN OTHER MEDICAL CONDITIONS APPLY

Appendix F: Juvenile Competency Issues in California Educational Session

Task Force for Criminal Justice Collaboration on Mental Health Issues

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

Juvenile Subcommittee

April 28, 2009
Administrative Office of the Courts
San Francisco, California

Agenda

TUESDAY, APRIL 28

10:00 – 10:30 a.m.	Welcome *Judge Christina L. Hill, Chair, Superior Court of Los Angeles County*
10:30 - 11:30 a.m.	30 minute presentation, 30 minute discussion *Sue Burrell, Attorney, Youth Law Center, San Francisco*
11:30 – 12:20 p.m.	Discussion over lunch – Subcommittee
12:20 – 12:50 p.m.	20 minute presentation, 10 minute discussion *Arthur Bowie, Supervising Assistant Public Defender, County of Sacramento*
12:50 – 1:00 p.m.	Discussion – Subcommittee
1:00 – 1:30 p.m.	20 minute presentation, 10 minute discussion *Jim Salio, Assistant Chief Probation Officer, San Luis Obispo Probation Department*
1:30 – 1:40 p.m.	Break
1:40 – 2:10 p.m.	20 minute presentation, 10 minute discussion *Jim Salio, Assistant Chief Probation Officer, San Luis Obispo Probation Department*
2:10 – 2:20 p.m.	Discussion – Subcommittee
2:20 - 2:50 p.m.	20 minute presentation, 10 minute discussion *Rick Lewkowitz, Supervising Deputy District Attorney, County of Sacramento*
2:50 - 3:00 p.m.	Break
3:00 - 3:50 p.m.	Discussion and recommendations – Subcommittee
3:50 - 4:00 p.m.	Wrap up
4:00 p.m.	Adjourn

Task Force for Criminal Justice Collaboration on Mental Health Issues

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

Educational Session: Voluntary and Involuntary Mental Health Treatment in California

January 29, 2010

Judicial Council Conference Center
Catalina A and B

San Francisco, California

Agenda

FRIDAY, JANUARY 29

9:00 – 9:30 a.m. Registration, Review of Materials

9:30 – 9:45 a.m. Welcome and Introductions

- Agenda Review
- Overview of Goals and Objectives
- Administrative Matters

Hon. Brad R. Hill, Chair

9:45 – 10:15 a.m. Historical Overview of Voluntary/Involuntary Treatment Issues in California

Dr. Sandra Goodwin, President and CEO, California Institute of Mental Health (CIMH)

10:15 – 11:15 a.m. Consumer/Survivor Perspectives

Ms. Sally Zinman, former Executive Director of the California Network of Mental Health Clients; Member, Client and Family Leadership Committee of the Mental Health Services Oversight and Accountability Commission

11:15. – 12:15 p.m. Alternatives for Access to Care and Treatment

Dr. Cameron Quanbeck, Associate Clinical Professor, University of California San Francisco, School of Medicine, Department of Psychiatry, San Francisco General Hospital

Mr. Randall Hagar, Director of Government Affairs for the California Psychiatric Association

12:15 – 12:45 p.m. Lunch *(task force members and presenters)*

12:45 – 2:00 p.m. Experiences With AB 1421/Laura's Law: Views and Experiences From Two California Counties

Hon. Thomas M. Anderson, Superior Court of Nevada County

Ms. Mary Marx, Los Angeles Mental Health Clinical District Chief; Los Angeles County AB 1421 Representative

2:00 – 3:30 p.m. Task Force Member Discussion

Appendix H: California Counties With Collaborative Justice Courts

Superior Court of California, County of	COMMUNITY	DRUG - ADULT	DRUG - JUVENILE DELINQUENCY	DRUG - DEPENDENCY	DUI	ELDER	HOMELESS/ STAND-DOWN	MENTAL HEALTH - ADULT	MENTAL HEALTH - JUVENILE	REENTRY	TRUANCY	VETERANS	YOUTH/PEER
Alameda		X		X		X	X	X	X	X	X		X
Alpine													
Amador		X	X										X
Butte		X	X	X	X								X
Calaveras		X											X
Colusa													X
Contra Costa		X	X			X	X	X					X
Del Norte		X		X									
El Dorado		X	X	X	X			X					X
Fresno		X	X	X			X	X	X				X
Glenn		X	X	X									
Humboldt		X	X	X			X	X					X
Imperial													X
Inyo		X											
Kern		X	X				X	X					X
Kings		X											
Lake		X	X	X									
Lassen		X											X
Los Angeles		X	X	X			X	X	X	X		X	X
Madera		X	X										
Marin		X	X					X					X
Mariposa		X											
Mendocino		X	X	X									X
Merced		X	X	X									
Modoc		X	X	X									X
Mono													
Monterey		X	X					X	X				
Napa		X	X	X				X					X

Superior Court of California, County of	COMMUNITY	DRUG - ADULT	DRUG - JUVENILE DELINQUENCY	DRUG - DEPENDENCY	DUI	ELDER	HOMELESS/ STAND-DOWN	MENTAL HEALTH - ADULT	MENTAL HEALTH - JUVENILE	REENTRY	TRUANCY	VETERANS	YOUTH/PEER
Nevada		X	X	X				X					X
Orange	X	X	X	X	X		X	X			X	X	X
Placer		X	X	X	X			X					X
Plumas		X											
Riverside		X		X				X					X
Sacramento		X	X	X			X	X					X
San Benito		X											
San Bernardino		X	X	X			X	X	X			X	X
San Diego		X	X	X			X	X	X	X		X	X
San Francisco	X	X	X	X			X	X	X	X			X
San Joaquin		X	X	X	X		X	X	X	X	X		X
San Luis Obispo		X	X	X				X					
San Mateo		X	X					X					
Santa Barbara		X	X				X	X					X
Santa Clara		X	X	X			X	X	X	X	X	X	
Santa Cruz		X		X									X
Shasta		X	X										X
Sierra		X											X
Siskiyou		X	X	X									
Solano		X	X	X	X								
Sonoma		X	X	X	X		X	X	X			X	X
Stanislaus		X		X				X					X
Sutter		X											
Tehama		X		X									X
Trinity			X										
Tulare		X	X					X				X	X
Tuolumne		X		X									X
Ventura		X	X	X			X		X			X	X
Yolo		X	X				X						
Yuba		X											