is warranted for all specialty court participants. This is typically provided twice weekly during early, more intensive phases of treatment, and once weekly or biweekly during later stages of treatment.

Graduated Sanctions As is the case among other specialty court participants, those with co-occurring disorders will benefit from implementation of graduated sanctions that are imposed swiftly, that establish a clear and measured connection between the behavioral infraction and the response, and that are applied consistently over time. It is generally useful to employ a team approach in developing effective sanctions for specialty court participants with co-occurring disorders, with staff included on the team who are trained in both mental health and substance abuse issues.

Flexibility is needed in responding to behaviors that may be affected by the co-occurring disorders, such as missed appointments due to the sedative effects of psychotropic medications or agitation due to withdrawal from street drugs. Thus, judges, supervision staff, treatment staff, and other specialty court staff must be aware of changes in the participant's living arrangements, treatment plan, medications, and in other treatment services. Incarceration should be used sparingly as a specialty court sanction for participants with co-occurring disorders. Unless there are major public safety risks present, these participants should be incarcerated for only brief periods, and should be rapidly involved in jail mental health and other related services to insure adequate continuity of medication and to address other treatment needs.

Liaison with Community Treatment Agencies In many cases, specialty courts will not be able to provide a full set of on-site integrated mental health and substance abuse services for participants who have co-occurring disorders, and these services will be provided by other community treatment agencies or individual practitioners. Specialty courts will need to establish contact with these agencies and practitioners to routinely obtain results of assessment and court evaluations, and to monitor progress in treatment. Specialty courts have often found it useful to include these ancillary treatment providers in treatment team meetings. Memoranda of agreement and other affiliation arrangements can be developed between specialty courts and other community treatment providers to facilitate open communication and information exchange.

Court Hearings and Judicial Monitoring Specialty court status hearings and related treatment team meetings may need to be conducted more frequently for participants who have co-occurring disorders, in order to respond quickly to changes in mental health symptoms and in patterns of medication adherence and involvement in treatment. Following an initial hearing to establish conditions of specialty court participation, another hearing may be needed to impose more specific components of the treatment plan, such as requirements to obtain mental health services. Court hearings provide a good opportunity to recognize and reward even small positive changes in behavior, such as attendance at treatment activities, improvements in personal hygiene, increased periods of abstinence, and involvement in work or vocational training. With the consent of the specialty court participant, family members should be engaged in the treatment process and encouraged to assist the court in monitoring the participant's behavior. Family members may also be recognized during hearings for their contributions to assist specialty court participants.

Conditions of participation in specialty court programs are useful in defining program expectations and promoting successful completion of co-occurring disorders treatment services. These conditions optimally provide a blend of specific requirements (e.g., drug testing twice weekly) and more general guidelines (e.g., complete a mental health and/or substance abuse assessment and enroll in treatment as required by the treatment provider), to enhance the flexibility of community treatment agencies and supervision staff in developing recommendations based on information that may not be available at the time of matriculation to the program. Conditions of specialty court involvement should specify that participants regularly report to supervision staff and/or the court, who can monitor their progress and "flag" any problems that occur.

Structural Enhancements to Co-Occurring Disorders Services

Specific *structural program enhancements* for individuals with co-occurring disorders include the following:

- A higher staff-to-client ratio is used, with more mental health staff integrated into treatment groups. Treatment staff have smaller caseloads.
- Staff provide significant monitoring and coordination of treatment activities.
- All staff are cross-trained, with mental health staff trained in self-help approaches and stages of recovery, and reoriented to the role of staff as guides or facilitators rather than "treatment" providers. Substance abuse staff are trained in mental disorders and diagnoses, pharmacotherapy, and in adjusting their treatment approaches to accommodate slower rates of behavior change, lower motivation and commitment to treatment, and reduced responsivity to interventions.
- At least one year of treatment services is provided, with the potential for ongoing involvement in treatment.
- Movement through the program and specific treatment activities is more individualized.
- Rewards (e.g., verbal praise, privileges) are delivered more frequently. The pace of treatment activities is slower.
- Treatment groups and other activities are of shorter duration, and more breaks are provided.
- Information is provided more gradually, and supplemental group or individual sessions are used to consolidate information.
- There is more overlap in activities, with planned repetition of material both within and between groups.

Clinical Enhancements to Co-Occurring Disorders Services

Specific *clinical program enhancements* for individuals with co-occurring disorders include the following:[2]

- More emphasis is placed on psychoeducational and supportive approaches than on confrontation and compliance. However, as the court is ultimately responsible to protect the public safety, the specialty court participant is informed that he or she has the primary responsibility for compliance with program requirements.
- Groups that include significant confrontation are replaced by conflict resolution or "community" groups, with more emphasis on affirmation of progress and individual change efforts.
- More individual counseling is provided.
- Exercises, skills training, and didactic activities tend to minimize the need for abstraction and are presented using basic concepts and terminology.
- Outlines are used for all treatment sessions and include explicit learning objectives.
- Instructions provided to guide homework, exercises, and other activities are brief.
- Frequent testing is provided to assess knowledge acquisition.
- Participants engage in "role preparation" to help prepare for unexpected circumstances.
- Participants demonstrate the ability to perform skills during staff-supervised sessions.
- Role-play activities are typically brief and focused on specific situations or scenarios.
- Staff provide specific feedback regarding how to apply treatment principles and techniques.
- Audiovisual aids are used frequently in groups, including illustrations and "concept mapping."
- Memory enhancement strategies are provided, including use of notes, tapes, and mnemonic devices.

Enhancements to Specialty Courts for Co-Occurring Disorders

Specialty courts interested in a more active service role can consider the following program enhancements to supplement the "core" set of modified services described in the previous section. These changes do not always require additional staff or financial resources. For example, specialty courts may consider redirecting resources to more efficiently address the treatment needs of participants with co-occurring disorders through implementation of co-occurring disorder groups, case management services, or other types of interventions. Alternatively, specialty courts may elect to augment existing services to provide additional "tracks," "groups," psychiatric consultation, case management, or counseling services. The following section describes several different approaches to enhance or modify specialty courts to better address the needs of participants with co-occurring disorders.

Specialty courts may need to be flexible in the amount of time allowed . . . [and] to allow participants with co-occurring disorders to exit the program and re-enter as needed

Several program enhancements have been developed for individuals with co-occurring disorders who are participating in specialty courts and other types of forensic/justice services. These enhancements are quite consistent with principles of effective correctional treatment programs (Gendreau & Ross, 1984; Gendreau, 1996), and have been applied successfully with individuals who have co-occurring disorders in various treatment settings.

Treatment Services Specialty court programs for participants who have co-occurring disorders may require more than a year of involvement in services. This extended period may be needed to provide for adequate engagement in treatment, stabilization on medications, linkage with ancillary community services, and to achieve sustained abstinence.

Specialty courts may need to be flexible in the amount of time allowed participants to progress to different phases of treatment and in criteria for graduation to different phases. Specialty courts that are not able to provide extended program involvement for individuals with co-occurring disorders may elect to provide extended tracking and case monitoring (e.g., through specialized case management services) to insure that participants are engaged in community services, are taking prescribed medication, and remain abstinent. Specialty courts may also need to provide some flexibility to allow participants with co-occurring disorders to exit the program and re-enter as needed, following periods of more intensive mental health treatment or hospitalization.

Where supplemental services are available for participants with co-occurring disorders, specialty courts should, at minimum, accommodate the needs of these individuals through modifying existing services, as described in the previous section. Depending on the level of symptom severity, it may not be necessary for participants to leave the specialty court treatment setting to receive these services. For example, if cross-program consultation services are provided, supplemental needs (e.g., mental health counseling) may be addressed effectively within the specialty court setting. Similar collaborative arrangements can be made for individuals who are identified during the course of mental health treatment as having a serious substance abuse problem.

Group Treatment Components Group treatment components for specialty court participants with co-occurring disorders include education about their diagnoses and disorders, including review of biological, risk, and protective factors related to these disorders; discussion of key psychotropic medications, side effects, and interactions with the use of alcohol and illicit drugs; review of the interdependent nature of mental and substance use disorders; motives and consequences related to substance abuse; and relapse prevention approaches and techniques.

A range of cognitive and behavioral skills are also commonly taught in group treatment settings, including problem solving skills, communication skills, anger management, stress management, drug coping skills (e.g., dealing with active users, drug refusal skills), and effective strategies for collaborating with mental health professionals. Relapse prevention approaches that have been developed within substance abuse treatment settings can be readily adapted for treatment of co-occurring disorders. Strategies include identification of "red flags" for substance abuse relapse and recurrence of mental health symptoms and strategies to respond to these relapse warning signs.

More intensive specialty court programs for co-occurring disorders are likely to include several phases, or stages of treatment. The scope, frequency, and duration of these program phases will vary according to available resources, although most existing programs provide the following general sequence of phased activities:

- Orientation
- Intensive treatment
- Relapse prevention and transition

More intensive specialty court programs for co-occurring disorders are likely to include several phases, or stages of treatment. Most programs provide the following:

- *Orientation*
- *Intensive treatment*
- *Relapse prevention and transition*

Key Features of Group Treatment

Group treatment for co-occurring disorders tend to share the following substantive features:

- A *highly structured therapeutic approach* is used, that includes significant staff supervision and involvement, and a highly organized and focused daily schedule of activities.
- Attempts are made throughout treatment activities to *destigmatize mental illness*. Mental and substance use disorders are presented as manageable life problems that are experienced by many individuals. Biological, emotional/ psychological, and behavioral aspects of the disorders are reviewed to "demystify" mental disorders.
- Treatment groups *focus on symptom management versus "cure,"* presenting recovery as a long-term process. Relapse prevention approaches provide a useful model to conceptualize management of the co-occurring disorders, similar to approaches used with other health disorders (e.g., diabetes, heart disease).
- *Education* is provided regarding participant's mental disorders, diagnoses, and the interactive effects of co-occurring disorders. Attempts are made to "normalize" the fact that participants have a mental disorder, and key information is provided about medications and medication side effects, and effects of substance use on medications and mental disorders.
- For participants with ingrained criminal belief systems, some programs have offered *"criminal thinking" groups* that are useful to assist participants in identifying maladaptive "criminogenic" beliefs and to learn cognitive strategies to modify these beliefs and associated behaviors.
- Basic *life management and problem-solving skills* are provided to address a range of psychosocial deficits in areas of social skills and communications skills, anger management, assertiveness, leisure skills, stress management, nutrition, and managing personal finances.

An assumption underlying orientation activities is that specialty court participants have not yet committed themselves to making major lifestyle change. As a result, the orientation phase should include a comprehensive assessment of co-occurring disorders and other related psychosocial areas (including motivation and commitment to the recovery process) and a focus on persuasion and engagement interventions, development of a treatment plan or contract, introduction to the recovery process, and frequent appearances before the court.

Intensive treatment phases include individual and group activities that use a supportive and psychoeducational approach and that have a focus on life skills and other important coping and self-management skills. Participants in this phase are expected to take "action steps" towards lifestyle change and recovery goals. In the final phase of program activities, participants receive advanced skills in relapse prevention and often help to develop a relapse prevention plan (or "contingency" or "emergency" plan). A transition plan is also developed to help guide linkages to community treatment, engagement with the self-help community, and to mobilize resources to assist with housing, employment, and economic support. Case managers or transition coordinators are often actively involved in these activities, and work closely with community supervision staff in developing the transition plan.

Families and Treatment Family members often welcome the leverage provided by the court in engaging participants in structured treatment and supervision activities. Specialty courts can provide counseling and support services to family members to assist them in monitoring participant's medication use and signs of relapse, and in managing crisis situations.

Group and individual treatment interventions should reflect the unique styles and concerns of cultural and ethnic groups that participate in the specialty court, particularly as the styles and concerns relate to mental health treatment; involvement of the family in treatment; and issues related to shame, guilt,

and self-disclosure of mental health and substance abuse symptoms. Specialty courts can also provide education for family members about co-occurring mental and substance use disorders, and should, with the participant's consent, attempt to involve family members or significant others (e.g., those residing with the participant) in treatment planning and monitoring. Group dynamics may be disrupted if participants with co-occurring disorders are perceived as receiving "favored" treatment by the court. For this reason, all participants should be advised of the unique needs of their peers who have co-occurring disorders and the unique treatment, supervision, or sanction approaches that have been developed by the specialty court for use with individuals who have these disorders.

Co-Occurring Disorder Groups and Program Tracks Although some specialty courts have attempted to exclude those with co-occurring disorders, in reality, a large proportion of specialty court participants have co-occurring disorders that may often go undetected and that may not be addressed in treatment. In order to best meet the needs of this population, specialty courts would optimally develop focused co-occurring disorder services or "tracks," requiring additional planning, staff resources, training, supervision, and space, in many cases. These tracks may include several variations: 1) mental health services that are provided concurrently with other specialty court services; 2) "parallel" sets of services, or "transition" tracks, in which participants receive specialized mental health services for a period of time, and then are "mainstreamed" with other specialty court participants; and 3) supplemental or "booster" services that include individual counseling, psychiatric consultation, and other mental health supports to participants. These tracks have been developed in both mental health courts and drug courts. In some cases, freestanding specialty court programs have been developed for individuals with co-occurring disorders. For specialty courts that contract with community agencies to provide treatment services, co-occurring disorder tracks can be embedded in existing mental health or substance abuse programs.

Motivational Interventions Research indicates that persons with co-occurring disorders experience considerable fluctuation in their motivation and commitment to lifestyle and behavior change, particularly during early phases of treatment. Despite their attendance in treatment, specialty court participants and others with co-occurring disorders are often not fully committed to the idea of becoming abstinent during early stages of treatment (Drake, Rosenberg, & Mueser, 1996), and require involvement in ongoing activities to promote motivation. If unaddressed, these issues are likely to lead to non-adherence to treatment and dropout from specialty court programs.

Early phases of specialty court treatment should be designed to enhance motivation for treatment, and motivation levels should be monitored periodically over an extended period of time. The provision of adjunctive services (e.g., economic assistance, housing, employment, child care), the removal of other barriers to participation in treatment, and leveraging involvement in treatment through the courts, where appropriate, can all serve to encourage participant's engagement in specialty court programs. During initial phases of specialty court programs, strategies to address motivation and engagement will often be the primary focus of treatment, particularly for participants with co-occurring disorders. These include Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) approaches or groups, and "persuasion groups" that examine the interactions between co-occurring disorders and promote motivation to address substance use disorders (Mueser, et al., 2003). Several MET curricula are described in the resource section of this monograph.

Contingency contracting and related "voucher" approaches have been used successfully to engage and retain individuals in treatment who are at high risk for dropout (Onken, Blaine, & Boren, 1993). These approaches often use non-cash items of value to reward specific treatment-related behaviors, such as maintaining clean drug test or attending treatment groups. Rewards can be tapered off as individual treatment goals are met.

Individual Counseling Specialty court participants who have co-occurring disorders may need more frequent involvement in individual counseling to address negative moods, personal stressors, and recurrence of mental health or substance abuse

symptoms. Individual counseling may also provide an opportunity to explore in more detail issues that were originally addressed in group treatment, such as "high risk situations" for relapse, and development of life skills or cognitive-behavioral skills. Individual sessions can also provide a useful forum to discuss progress and participation in specialized services (e.g., use of medications, involvement in peer recovery groups).

Medication Monitoring and Drug Testing Psychotherapeutic medications are quite effective in reducing the symptoms of major mental disorders such as depression, bipolar disorder, and schizophrenia. Most of the currently prescribed medications have few serious side effects when combined with alcohol or drug use, and generally do not affect drug test results. Use of psychotherapeutic medication does not violate abstinence-based treatment policies, and self-help groups such as AA/NA have explicit policies that support the use of such medication by those in recovery.

Psychiatric consultation should be provided during the initial assessment to examine the need for psychotropic medication and to determine if the effects of medication may be compromised by current or recent patterns of substance abuse or if medications may be contraindicated by these potential interactions. Specialty court participants who have co-occurring mental disorders often require periodic evaluation by a psychiatrist to examine adherence to medication, to determine whether their medication should be continued, and if so, to determine whether the dosage should be modified. Peer support and counseling services may also be quite useful in managing medication adherence.

Over the course of treatment, specialty court participants should be educated about their need for medication, the rationale for being prescribed specific medications, potential side effects, and about the effects of continued substance abuse on their use of medication. Education and training is also needed for specialty court staff and participants regarding:

- the nature of co-occurring disorders
- mental health diagnoses and symptoms
- the purpose and use of psychotherapeutic medication
- the difference between medication and street drugs
- the need to preserve confidentiality, and
- strategies for handling confrontation related to medication use that may occur within community self-help groups.

Information is also needed regarding the effects (e.g., addictive) of psychotropic medications prescribed for specialty court participants, differences between psychotherapeutic medications and narcotics/illicit drugs, and the effects of prescribed medication on drug test results.

Frequent and random drug testing is an important component of treatment for specialty court participants who have co-occurring disorders and can provide early detection of substance abuse problems before they result in a full-blown relapse. Specialty courts frequently provide testing through either the collaborating treatment or supervision agency, and some courts have on-site testing labs or other testing capability (e.g., via quick screens) in the courtroom. Specialty court participants often report that the presence of drug testing enhances their motivation to remain abstinent and provides tangible evidence to the court of their continuing sobriety.

Case Management and Outreach Services Case management services are particularly useful in working with specialty court participants who have co-occurring disorders and other individuals who are at "high risk" for homelessness, unemployment, chronic health problems, and criminal recidivism. Case managers often negotiate contact across various service systems and link together services that are not addressed in other treatments, including housing, vocational rehabilitation, community mental health services, and evaluation of eligibility for Medicaid/SSI or other financial entitlements.

Case managers are also well positioned to coordinate and monitor scheduled appointments and provide important linkages with the court and community supervision. Another important responsibility is coordination with family members or other

care providers to ensure that basic needs (e.g., housing, transportation) are met and to monitor medication use, symptoms of co-occurring disorders, and other behavior problems.

TASC (Treatment Alternatives for Special Clients) programs have provided offender case management and linkage services in many jurisdictions and have worked effectively with specialty courts and offenders. Case managers working with participants with co-occurring disorders generally are assigned smaller caseloads and have the capability of tracking participants through different phases of the specialty court program and during the transition to follow-up community services.

Community Supervision: Supervision of specialty court participants with co-occurring disorders involves monitoring active symptoms and high risk situations related to both disorders, responding to infractions and violations, referral to treatment, and monitoring involvement in treatment and other services. In general, supervision of specialty court participants who have mental health problems is likely to require smaller caseloads and more intensive services. This will include more frequent monitoring of their functional status, mental health symptoms, motivation and commitment to treatment, and adherence to medications and other treatment requirements. This intensive monitoring will need to include frequent contact with family members, friends, and other collaterals, particularly those who live and work with the specialty court participant. Consent should always be obtained from the specialty court participant prior to contacting any supports.

Supervision staff should carefully monitor even moderate levels of alcohol or drug use, which may trigger recurrence of mental health symptoms and behavior problems (e.g., criminal behavior) among individuals who have co-occurring disorders. Supervision staff should also be familiar with co-occurring disorders treatment approaches, including integrated treatment models, cognitive-behavioral and skills-building approaches, and common psychotropic medications and their side effects. Supervision staff can play a pivotal role in monitoring medication compliance and communicating with both the participant and the psychiatrist about medication issues.

At the procedural level, outstanding or "fugitive" warrants issued for specialty court participants with mental disorders should receive priority for enforcement by local law enforcement officers. Warrants should be flagged to alert the arresting officer that participants have a history of co-occurring disorders, and of

Conflicts sometimes arise between court, treatment, and supervision staff . . . that can be addressed through treatment teams and other regular meetings [with] representation from all participating agencies.

Summary of Effective Supervision Strategies

Effective supervision approaches with specialty court participants who have co-occurring disorders include the following:

- Dedicated specialty court supervision caseloads are provided that consist of participants who have mental and substance use disorders. Caseloads should be smaller than ordinary to accommodate the need for more intensive supervision, monitoring, and ongoing contact.
- Use of multidisciplinary teams to monitor progress towards supervision and treatment goals and to respond to infractions and other offenses.
- Ongoing monitoring is provided of mental health and substance abuse symptoms through observation, contact with the participant and collaterals (e.g., family members), and frequent drug testing.
- Ongoing monitoring is provided to assess adherence to prescribed medication. Liaison is provided with the psychiatrist and other mental health and treatment staff regarding symptoms and behaviors related to mental disorders, adherence to medication, and to assist in evaluating the effectiveness of medications and to request information regarding prescribed medication and changes in medication.
- Regular updates are provided to the specialty court regarding participant progress and deviation from program rules and guidelines.
- Participants are referred to a psychiatrist when undesirable behaviors, moods, or thought patterns are detected that may be responsive to medication.
- Supervision staff reinforces the importance of medication compliance with participants.
- Staff have the ability to schedule hearings before the court to address concerns related to treatment and supervision.
- A proactive role is taken in scheduling court and supervision appointments.
- Supervision staff promote the participant's involvement in a highly structured set of daily activities and development of planning skills to organize daily activities.
- Special service needs (e.g., individual counseling, transportation, housing, medical care, vocational support) are recognized and addressed.
- Clear and concrete directives are provided regarding specialty court guidelines, with frequent repetition and monitoring to determine the participant's level of understanding.
- A supportive rather than confrontative approach is used in addressing mental health and substance abuse problems, and in monitoring adherence to program guidelines. Verbal praise and other support is provided for small successes and indicators of progress.
- Expectations are adjusted regarding the response to supervision to reflect the potentially disruptive effects of mental health symptoms, with flexibility provided in responding to infractions (e.g., missed appointments).

the presence of related behavioral problems. This will allow the officer to take preventive steps (e.g., arranging for backup support), particularly if there is a history of violence related to the co-occurring disorders.

Specialty court participants with co-occurring disorders are likely to have some level of cognitive impairment (e.g., difficulties in attention and concentration, memory, abstract reasoning, problem solving, and planning ability) that affects their level of engagement in treatment and supervision. For example, these participants may not understand or remember critical information regarding their treatment requirements, or obligations related to their court and community supervision (e.g., dates of hearings or appointments), and may not recognize the full range of consequences resulting from violations and other criminal behavior. As a result, instructions may need to be repeated several times and regular written reminders provided of upcoming appointments and consequences of

Key Training Issues Related to Co-Occurring Disorders

Key training issues related to co-occurring disorders that should be addressed for specialty court staff include the following:

- Identification of signs and symptoms of mental illness and substance abuse.
- Awareness of the range and scope of mental disorders (e.g., diagnostic categories and definitions, course of disorders, cognitive symptoms).
- Strategies for treating and managing participants who have personality disorders (e.g., Borderline Personality Disorder)
- Treatment and supervision approaches for participants with a history of trauma and physical, sexual, or emotional abuse.
- When and how to arrange for mental health evaluation.
- Characteristics of psychotropic medications (e.g., commonmedications for different disorders, side effects), interactive effects of medications with drugs and alcohol, and effects of medications on drug testing.
- Identification of existing community treatment resources and ancillary services.
- Strategies for accessing community treatment resources and ancillary services.
- Use of supportive rather than confrontative treatment and supervision approaches.
- Development and use of an integrated system of sanctions and treatment to respond to critical incidents.
- Adjusting expectations regarding outcomes of supervision (e.g., developing long-term goals of abstinence).
- Flexibility in responding to noncompliance with community supervision rules (e.g., missed appointments).
- Strategies to avoid staff burnout.

infractions and noncompliance with treatment requirements. Specialty court participants with co-occurring disorders are likely to be more disorganized than other participants and would benefit from considerable daily structure and external monitoring to insure adherence to rules and regulations.

Specialty court participants who have co-occurring disorders may not respond favorably to confrontation, and judicial, treatment, and supervision approaches should focus on goals of engagement rather than on punishment. In general, treatment and supervision requirements should reflect the participant's level of functioning, with flexibility provided to adjust these requirements according to demonstrated abilities to handle confrontation, group interaction, and to provide sustained attention during treatment and other required activities (Pepper & Hendrickson, 1996).

Conflicts sometimes arise between court, treatment, and supervision staff related to sharing of information, critical incidents, and progress in treatment. Specialty court participants who have personality disorders may attempt to augment these tensions and conflicts through their interaction with various staff to obtain less restrictive sanctions, privileges or special consideration, or other favorable disposition of incidents that may occur. These potential areas of conflict can be addressed productively through use of treatment teams and other regular meetings that include representation from all participating agencies.

These meetings provide a vehicle to share information about the participant's status, level of engagement in treatment, to review critical incidents, to develop appropriate sanctions, and to update the treatment and

supervision plan. Relapse prevention approaches often provide a unifying organizational structure, theme, and vocabulary for these treatment teams (Clear, Byrne, & Dvoskin, 1993; Peters, 1994), and are particularly helpful in developing strategies to address specialty court participants who have co-occurring disorders.

Staff Training Treatment, court, and supervision staff working in specialty courts should receive training in issues related to co-occurring disorders, including issues related to medication management, abuse and trauma issues (particularly salient for female participants), community outreach and crisis stabilization services, and linkage to community treatment. In the absence of advanced training, staff may interpret unusual and unpredictable behaviors related to mental disorders as noncompliance with treatment or supervision rather than as indicating the need for mental health treatment.

Judicial training should address the types of questions related to mental health issues to ask participants at court hearings. Additional judicial training should be provided regarding the types of problems that are typically encountered by individuals with various types of mental disorders and how different levels of cognitive and physical functioning may influence behavior in treatment, supervision, and in status hearings. Supervision staff should have significant prior work experience with traditional probation caseloads to work effectively with participants who have co-occurring disorders.

Cross-training should be provided for community supervision staff, case managers, treatment staff, and others who provide services for specialty court participants with co-occurring disorders. Through this process, the different professional disciplines can advise each other of key strategies for supervision, management, and treatment of participants who have co-occurring disorders. For example, community supervision staff can review the type of information related to critical incidents (e.g., positive drug screens, recurrence of mental health symptoms) that should be reported to the court. Cross-training also provides an opportunity to understand the goals and missions of cooperating agencies, and to develop strategies for sharing information and accessing services. Whenever possible, training should also be provided to family members or other care providers who work with specialty court participants.

All specialty courts will need to address critical issues related to the treatment, management, and supervision of participants with co-occurring disorders, whether these are addressed early and in a planned manner, or later, during periods of crisis.

Conclusion

A significant number of individuals in the justice system have co-occurring mental and substance use disorders, including many participants in specialty court programs. Although some specialty courts attempt to exclude these individuals, co-occurring disorders are often undetected for a period of time before coming to the attention of court personnel. Mental health and substance abuse problems that are not initially addressed tend to worsen over time and require far greater program resources if dealt with during periods of acute crisis rather than as an integrated, ongoing part of specialty court programs. In reality, all specialty courts will need to address critical issues related to the treatment, management, and supervision of participants with co-occurring disorders, whether these are addressed early and in a planned manner, or later, during periods of crisis.

Although the ability of specialty courts to address these issues will vary according to the functioning level of participants with co-occurring disorders and the level of program resources, all specialty courts should provide several "core" services for this population that address their unique needs. A number of evidence-based practices have been established that can help guide specialty courts in designing program modifications to provide these basic services. Key areas for specialty court modification include the following:

- Screening and assessment approaches that examine both mental health and substance abuse content.
- Education regarding mental and substance use disorders.
- Medication monitoring and drug testing.
- Flexible application of graduated sanctions to accommodate the effects of mental disorders and other individual needs of program participants.
- Liaison with other community mental health and substance abuse treatment providers.
- Court hearings and judicial monitoring approaches that provide a rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.

For specialty courts that elect to provide more intensive program enhancements to address the unique needs of participants with co-occurring disorders, a number of structural and clinical approaches are available that have been used effectively in justice settings. Many of these enhancements do not require new program resources and can be accomplished through reorganizing existing services.

In general, both supervision and treatment approaches are longer, more intensive, slower paced, more flexible, and accommodate various cognitive impairments in implementing sanctions, treatment groups, and other services.

Several specialty courts have successfully implemented separate program "tracks" for participants who have co-occurring disorders or have developed separate programs for this population. These enhanced programs provide a blended set of mental health and substance abuse services and use a "phased" approach that includes sequenced interventions focusing on orientation, intensive treatment, and relapse prevention and transition.

Other major program enhancements for specialty courts include enriched motivational interventions, greater use of individual counseling, on-site psychiatric consultation, intensive case management and outreach services, and community supervision teams that include smaller case loads and staff who are trained in co-occurring disorders.

Specialty courts have emerged in the past decade to provide significant national leadership in developing treatment and supervision approaches that reduce criminal recidivism, engage individuals in the recovery process, and that safely retain people in their communities rather than in jails or prison.

The spirit of innovation embodied by specialty courts and the unique coordination and partnership between courts, treatment, and supervision that has been applied so successfully to assist individuals with mental or substance use disorders can also be

effectively applied on behalf of those with co-occurring disorders. The National GAINS Center and federal agencies that support the Center are committed to assist the pioneering efforts of specialty courts in developing program modifications and enhancements for participants with co-occurring disorders, and look forward to collaborating with specialty courts in pursuit of these goals. Specialty courts are encouraged to contact the National GAINS Center and related federal agencies to obtain information, technical assistance, and other resources to assist in developing program services for participants who have co-occurring disorders.

References

Abram, K.M., & Teplin L.A. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for Public Policy. *American Psychologist*, 46(10): 1036-45.

Bartels, S.J., Drake, R.E., & McHugo, G.J. (1992). Alcohol abuse, depression, and suicidal behavior in schizophrenia. *American Journal of Psychiatry*, 149, 394-395.

Bartels, S.J., Teague, G.B., Drake, R.E., Clark, R.E., Bush, P., & Noordsy, D.L. (1993). Substance abuse in schizophrenia: Service utilization and costs. *Journal of Nervous and Mental Disease*, 181, 227-232.

Bellack, A.S., Bennett, M.E., Gearon, J.S., & Alexander, M.A. (2000). *Behavioral treatment for substance abuse in schizophrenia: A training manual for mental health professionals.* Baltimore, MD: University of Maryland.

Bureau of Justice Statistics (2000). *Prison and jail inmates at midyear 2000.* U.S. Department of Justice Statistics, Washington, D.C., NCJ-185989.

Carey, M.P., Carey, K.B., & Meisler, A.W. (1991). Psychiatric symptoms in mentally ill chemical abusers. *Journal of Nervous and Mental Disease*, 179, 136-138.

Caton, C.L.M., Wyatt, R.J., Felix, A., Grunberg, J., & Dominguez, B. (1993). Follow-up of chronically homeless mentally ill men. *American Journal of Psychiatry*, 150, 1639-1642.

Caton, C.L.M., Shrout, P.E., Eagle, P.F., Opler, L.A., Felix, A., & Dominguez, B. (1994). Risk factors for homelessness among schizophrenic men: A case-control study. *American Journal of Public Health*, 84, 265-270.

Center for Mental Health Services (1997). *Addressing the Needs of Homeless Persons with Co-Occurring Mental Illness and Substance Use Disorders.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Clark, R.E. (1994). Family costs associated with severe mental illness and substance use: A comparison of families with and without dual disorders. *Hospital and Community Psychiatry*, 45, 808-813.

Clear, T.R., Byrne, J.M., & Dvoskin, J.A. (1993). The transition from being an inmate: Discharge planning, parole, and community-based services for offenders with mental illness. In Steadman, H.J., and Cocozza, J.J. (Eds.), *Providing services for offenders with mental illness and related disorders in prisons* (pp. 131-157). Washington, D.C.: The National Coalition for the Mentally Ill in the Criminal Justice System.

Cournos, F., Empfield, M., Horwath, E., McKinnon, K., Meyer, I., Schrage, H., Currie, C., & Agosin, B. (1991). HIV seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry*, 148, 1225-1230.

Cournos, F., & McKinnon, K. (1997) HIV Seroprevalence among people with severe mental illness in the United States: A critical review. *Clinical Psychology Review*, 17, 259-269.

Cuffel, B.J., Shumway, M., & Chouljian, T.L. (1994). A longitudinal study of substance use and community violence in schizophrenia. *Journal of Nervous and Mental Disease*, 182, 342-348.

Denckla D, & Berman, G. (2001). Rethinking the Revolving Door: A Look at Mental Illness in the Courts. New York, NY, Center for Court Innovation.

Dickey, B., & Azeni, H. (1996). Persons with dual diagnosis of substance abuse and major mental illness: Their excess costs of psychiatric care. *American Journal of Public Health*, 86:973-977.

Dixon, L., McNary, S., & Lehman, A. (1995). Substance abuse and family relationships of persons with severe mental illness. *American Journal of Psychiatry*, 152, 456-458.

Drake, R.E., Essock, S., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., Lynde, L., Osher, F.C., Clark, R.E., & Rickards, L. (2001). Implementing Dual Diagnosis Services for Clients with Severe Mental Illness, *Psychiatric Services*, 4(52), 469-476.

Drake R.E., Mercer-McFadden, C., & Mueser, K.T. (1998). A review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24: 589-608.

Drake, R.E., Osher, F.C., & Wallach, M.A. (1989). Alcohol use and abuse in schizophrenia: A prospective community study. *Journal of Nervous and Mental Disease*, 177, 408-414.

Drake, R.E., Rosenberg, S.D., & Mueser, K.T. (1996). Assessing substance use disorder in persons with severe mental illness. In R.E. Drake and K.T. Mueser (Eds.), *Dual diagnosis of major mental illness and substance abuse*, Vol. 2: Recent Research and Clinical Implications (pp. 3-17). San Francisco: Jossey-Bass.

Drake, R.E., & Wallach, M.A. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry*, 40, 1041-1046.

Edens, J.F., Peters, R.H., & Hills, H.A. (1997). Treating prison inmates with co-occurring disorders: An integrative review of existing programs. *Behavioral Sciences and the Law*, 15, 439-457.

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. Harland (Ed.), *Choosing correctional options that work.* Newbury Park, CA: Sage Publications.

Gendreau, P., & Ross, R.R. (1984). Correctional treatment: Some recommendations for successful intervention. *Juvenile and Family Court Journal*, 34, 31-40.

Haywood, T.W., Kravitz, H.M., Gorssman, J.L., Davis, J.M., & Lewis, D.A. (1995). Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. *American Journal of Psychiatry*, 152:856-861.

Justice Policy Institute (2000). U.S. Imprisoned Population May Hit 2 Million in 2000, Washington Post, A4, January, 1, 2000.

Lamb H.R., & Weinberger L.E. (1998). Persons with Severe Mental Illness in Jails and Prisons: A Review. *Psychiatric Services*, 49(4):483-492.

Lehman A.F., Myers C.P., & Corty E. (1989). Assessment and classification of patients with psychiatric and substance abuse syndromes. *Hospital and Community Psychiatry*, 40: 1019-30.

Mueser, K.T., & Fox, L. (1998). *Stagewise family treatment for dual disorders treatment manual.* Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice.* New York: Guilford Press.

NASMHPD & NASADAD (1999). National Dialogue on Co-occurring Mental Health and Substance Use Disorders, Washington, D.C..

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2001). The Prevalence of Co-Occurring Mental Health and Substance Use Disorders in Jails, Fact Sheet Series: Delmar, NY: The National GAINS Center.

Onken, L.S., Blaine, J.D., & Boren, J.J. (Eds.) (1993). *Behavioral treatments for drug abuse and dependence.* National Institute on Drug Abuse Monograph Series #137. Rockville, MD: National Institutes of Health.

Osher, F.C., & Kofoed, L.L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry*, 40, 1025-1030.

Osher, F.C., Drake, R.E., Noordsy, D.L., Teague, G.B., Hurlbut, S.C., Biesanz, J.C., & Beaudett, M.S. (1994). Correlates and outcomes of alcohol use disorder among rural outpatients with schizophrenia. *Journal of Clinical Psychiatry*, 55, 109-113.

Owen, R.R., Fischer, EP, & Booth BM. (1996). Medication noncompliance and substance abuse among patients with schizophrenia. *Psychiatric Services*, 47:853-858.

Pepper, B., & Hendrickson, E. (1996). Working with seriously mentally ill substance abusers (pp. 78-93). In Lurigio, A.J. (Ed.), *Community corrections in America: New directions and sound investments for persons with mental illness and codisorders.* Seattle, WA: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Peters, R.H. (1994). Relapse prevention approaches in the criminal justice system. In Gorski, T.T., Kelly, J.M., Havens, L., & Peters, R.H. (Eds.), *Relapse prevention and the substance-abusing criminal offender: An executive briefing* (pp. 19-30). Rockville, MD: Center for Substance Abuse Treatment.

Peters, R.H., & Bartoi, M.G. (1997). *Screening and assessment of co-occurring disorders in the justice system.* Delmar N.Y: The National GAINS Center.

Peters, R.H., & Hills, H.A._(1997). *Intervention strategies for offenders with co-occurring disorders: What works?*_Delmar N.Y: The National GAINS Center.

Peters, R.H., Hills, H.A., Moore, K.A., Matthews, C.O., Hunt, W.M. (2002). *Co-occurring Disorders Treatment Manual.* Tampa, Florida: Louis de la Parte Florida Mental Health Institute.

Peters, R.H., & Peyton, E. (1998). *Guideline for drug courts on screening and assessment.* Washington, D.C: U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office.

Rosenberg S.D., Goodman L.A., Osher F.C., Swartz M., Essock S.M., Butterfield M.I., Constantine N., Wolford G.L., Salyers, M. (2001). Prevalence of HIV, Hepatitis B and Hepatitis C in People with Severe Mental Illness, *American Journal of Public Health*, 91(1), 31-36.

Seibel, J.P., Satel, S.L., Anthony, D., Southwick, S.M., Krystal, J.H., & Charney, D.S. (1993). Effects of cocaine on hospital course in schizophrenia. *Journal of Nervous and Mental Disease*, 181, 31-37.

Steadman, H.J., Deane M.W., Morrissey J.P., Westcott M.L., Salasin S., & Shapiro, S. A. (1999). SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons, *Psychiatric Services*, 50(12), 1630-1624.

Stephan, J.J. (2001). *Census of jails, 1999.* NCJ 186633. Washington D.C.: U.S. Department of Justice Programs, Bureau of Justice Statistics.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD. (1999). U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Rockville, MD: Author.

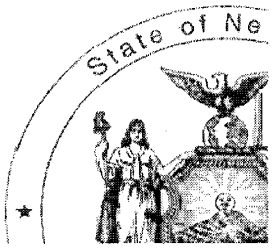
CENTER
FOR
COURT
INNOVATION

A Public/Private Partnership with the
New York State Unified Court System

THINK PIECE

Rethinking the Revolving Door

A Look at Mental Illness in the Courts



SJI

A Look at Mental Illness in the Courts

Introduction

Each day, a disturbingly large number of people with mental illness cycle through the criminal justice system across the nation. While it is difficult to get an accurate read of exact numbers — many defendants are never properly diagnosed — a recent study found that about 16 percent of the national prison and jail population suffer from some form of mental illness (U.S. Department of Justice, 1999). Before arriving in the criminal justice system, these individuals have frequently fallen through the "safety net" of families, hospitals and community-based treatment providers.

Once they reach the courts, defendants with mental illness pose significant challenges for judges. Judges typically lack both the tools necessary to perform meaningful assessments and the connections with mental health service providers necessary to know what kinds of treatment options are available. Given these realities — and given concerns for public safety — judges find that in many cases the safest choice is to sentence mentally ill offenders to jail or prison. The calculus is simple: while incarcerated, there's at least a chance that an offender will receive some form of medication and assistance.

Incarceration may in fact be the right outcome for some mentally ill offenders who pose a serious threat to individual victims or the public welfare. But for many others, particularly those without violent histories, incarceration makes little sense. The drawbacks are obvious. It's expensive both on the front end and the back end. State and local governments incur significant costs when they incarcerate people. Just as significantly, prisons and jails are not designed to be therapeutic environments. All too often, the condition of mentally ill individuals seriously deteriorates in custody. They are then released to the streets with little or no discharge planning. No one links them to needed treatment, housing and other services. And no one checks to make sure they take advantage of these services. Unsurprisingly, many mentally ill defendants find themselves back before the courts in short order, repeating the same process. Everyone loses in this scenario. Defendants with mental illness fail to receive the help they need. The justice system fails to deploy resources either efficiently or effectively. And the community at large fails to address a serious public safety problem.

This study takes a closer look at these challenges. Along the way, it seeks to answer a set of basic questions about defendants with mental illness. How big is the problem? What do judges, attorneys, service providers and other stakeholders

think about the ways that courts currently handle cases involving defendants with mental illness? What efforts have been made to improve the situation? And what kinds of obstacles have these efforts confronted? In answering these questions, this study seeks to provide judges, attorneys and court administrators across the country with new ideas, new tools and new strategies as they grapple with some of the most difficult cases that ever appear in court.

"Rethinking the Revolving Door" is the product of a year-long study performed by the New York State Unified Court System in conjunction with its independent research and development arm, the Center for Court Innovation. The methodology for this research effort was fairly straightforward; it included reviewing the current literature in the field, attending relevant conferences and workshops, making site visits to promising programs and conducting dozens of stakeholder interviews.

The purpose of the study, which was underwritten by a grant from the State Justice Institute, was not to create a work of original scholarship. Nor was it to determine whether specialized "mental health courts" are a good thing or a bad thing. The aspirations for the feasibility study were rather more modest: to provide practitioners with an overview of mental health and the courts, a description of the model projects currently being tested in a number of jurisdictions and an outline of some of the concerns that have been raised by various stakeholders. The findings in this report have already served as the foundation for a proposed mental health court in Brooklyn, providing the planning team with a sense of context and a guide to issues that are worthy of deeper exploration. With any luck, in the days ahead it will continue to provide helpful background information to those with an interest in this field.

Scope of the Problem

Over the last few years, the number of people with mental illness in the criminal justice system has increased steadily. This phenomenon can be traced to various intersecting causes, including law enforcement strategies targeting drugs and low-level, "quality-of-life" offenses and the long-term effects of de-institutionalization (Marasso & Pepper, 2001; Health Foundation of Greater Cincinnati, 2000).

"De-institutionalization" is a term that describes a systematic shift in resources for treating people with mental illness — from large, residential, state-run psychiatric hospitals to community-based treatment (Department of Health & Human Services, 1999). Advances in the effectiveness of psychiatric medications since the 1950s have allowed even the most severe mental disorders to be treated on an outpatient basis, decreasing the need for inpatient institutionalization. And starting in the 1970s, civil libertarians and legislative reformers sought changes in civil commitment statutes and regulations to make it more difficult to place a person with mental illness in a psychiatric hospital involuntarily. In general, the guiding principle of de-institutionalization reformers was to offer appropriate treatment in the least restrictive environment possible (Torrey & Zdanowicz, 1998).

One unintended consequence of this shift in public policy has been that it has become far more difficult for many people with mental illness to access the mental health system. Many states closed or shrank their state psychiatric hospitals without adequately funding community treatment (Kupers, 1999). Accordingly, all too many people with mental illness live in the community, but they do so without adequate support services or medication.

While the number of people with mental illness in state psychiatric hospitals has decreased precipitously over the last thirty years, the number of mentally-ill people in jails and prisons has steadily increased. In 1955, there were 560,000 individuals hospitalized with mental illness in the United States. By 1999, there were less than 80,000 (Kupers, 1999). By contrast, since 1970, the U.S. jail and prison populations have increased fivefold to a total of about 1.6 million people (Bureau of Justice Statistics, 1999). And a recent Department of Justice survey found that 16 percent of the inmates in United States prisons and jails reported having a mental condition or mental health hospitalization. That translates to about a quarter-of-a-million inmates with mental illness (Ditton, 1999). Some critics, drawing a causal link between the rise of incarcerated mentally ill individuals and the decline in mental health hospitals, have labeled this phenomenon "transinstitutionalization" (Torrey & Zdanowicz, 2000; Massaro & Pepper, 2001).

Treatment in the Criminal Justice System

So if jails and prisons have become — de facto — "hospitals of last resort" for people with mental illness, the next question is: What kind of treatment do they receive while they are there?

Jails and prisons offer 24-hour, 7-day-a-week supervision and housing, but they were never intended to be psychiatric hospitals. And they are not typically institutionally equipped, trained or staffed to address the treatment needs of people with mental illness. Of the inmates who report mental illness, only 17 percent of state prisoners and 11 percent of jail inmates receive treatment for mental illness while incarcerated (Ditton, 1999). [A similar story can be told for substance abuse treatment in jail and prison. Of the estimated 70-85 percent of all state inmates who need substance abuse treatment, only 12 percent of them receive some form of treatment (CASA, 1998).]

These statistics are just the tip of the iceberg. The bottom line is that there is a severe shortage of treatment for people with mental illness while they are incarcerated. Even when treatment programs are available, their effectiveness is limited by long waiting lists, lack of incentives to participate, a dearth of trained counselors and the stigmatization of those who participate (CASA, 1998).

The inadequacy of treatment for mental illness and substance abuse in jails and prisons is exacerbated by the lack of adequate discharge planning and aftercare services. (This is a problem that has been the subject of litigation by advocates seeking to improve conditions for the mentally ill — see, for example, the "Brad H." lawsuit in New York City.) The result is that many offenders with mental illnesses

leave jail and prison no better — and sometimes quite worse — than when they were first incarcerated.

Revolving Doors

It comes as little surprise that many ex-offenders with mental illness find themselves back in the criminal justice system again in short order (Barr, 1999). Forty-nine percent of federal prisoners with mental illnesses have three or more prior probations, incarcerations or arrests, compared to 28 percent without mental illnesses (Ditton, 1999). Family members report that the average number of arrests for their relative with mental illness is more than three (McFarland, Faulkner, Bloom & Hallaux, 1989).

Mentally ill individuals with a criminal record are often placed in a lose-lose situation. While incarcerated, their condition tends to worsen (Belcher, 1988). And upon release, they are often unable to access available community treatment because of providers' reluctance to serve them (Lamb & Weinberger, 1998). Many community mental health centers are unprepared or unwilling to treat people who have criminal records (Jemelka, et al., 1989).

The results are painfully clear: many defendants with mental illness churn through the criminal justice again and again, going through a "revolving door" from street to court to cell and back again without ever receiving the support and structure they need (Finkelstein & Brawley, 1997). It is fair to say that no one wins when this happens — not defendants, not police, not courts, not victims and not communities.

Co-Occurring Disorders

One of the factors that complicates any effort to address the problems faced by criminal defendants with mental illness is the prevalence of co-occurring disorders among this population. A diagnosis of "co-occurring disorder" (also known as "dual diagnosis" or "dual recovery") describes the presence of both a mental disorder and a substance abuse disorder (American Psychiatric Association, 1994).

National research suggests that as many as three out of every four defendants in major cities test positive for drugs at the time of arrest (National Institute of Justice, 1998). Mental illness and substance abuse have a symbiotic relationship: people with substance abuse disorders are more likely to develop mental illness and people with mental illness are more likely to develop a substance abuse disorder (Peters & Hills, 1997; Massaro & Pepper, 1994). And people with mental illness who have significant criminal justice histories are more likely to have a co-occurring substance abuse problem than the general population of people with mental illness (Peters & Hills, 1997; GAINS Center, 1997).

Research indicates that people with co-occurring disorders have lower rates of treatment compliance, more severe symptoms and higher relapse rates than those treated for a single disorder (Peters & Hills, 1997). They are three times more likely to be arrested than others with mental disorders (Borum, et al., 1997). And without effective and appropriate treatment, they are more likely to be jailed again and again (Draine & Solomon, 1994).

Why is this? What exactly is the relationship between mental illness and substance abuse? People with mental illness often take alcohol or other drugs to temporarily reduce their symptoms (Peters & Hills, 1997). Using drugs and alcohol to alleviate psychiatric symptoms is at best a short-term solution. Alcohol and drugs can cause significant health consequences. They can also precipitate certain psychiatric symptoms, including anxiety, depression and confusion. Together, mental illness and substance abuse can lead to an ever-intensifying cycle of abuse as relief for symptoms is sought through consuming more and more drugs or alcohol (Pepper, 1992). This cycle is known as "self-medication."

There is a growing recognition among researchers and policymakers that the problem of co-occurring disorders is one that requires significant attention. One sign of this is the creation of a new federal partnership of mental health, substance abuse and justice agencies, called the National GAINS Center for Persons with Co-Occurring Disorders in the Justice System.

Among the issues that the GAINS Center has examined is how to assess people with co-occurring disorders. The reality is that co-occurring disorders are not easy to identify. The residual effects of substance abuse may "mask or mimic psychiatric symptoms such as depression" (Peters & Hills, 1997). And acute psychiatric symptoms may interfere with substance abuse treatment (ibid.). Another complicating factor is the reality that people with co-occurring disorders tend to suffer from a whole host of collateral problems including homelessness, HIV, violent behavior, trauma, and difficulties with employment, social and family relationships (Peters & Hills, 1997; Broner, et al., 2000).

But assessment is far from the only obstacle. More significant is the lack of effective treatment designed to address both mental health and substance abuse disorders in one therapeutic setting. Traditionally, services for mental health and substance abuse have been kept separate (Peters & Hills, 1997). Most programs treat co-occurring disorders sequentially, which means that patients must complete one form of treatment before engaging in another. There is a good deal of evidence that suggests that sequential treatment has proven ineffective for people with co-occurring disorders. Another approach is "parallel" treatment, in which a patient attends mental health and substance abuse treatment simultaneously but with different providers. While parallel treatment is an improvement over sequential treatment, it is far from perfect (Peters & Hills, 1997; GAINS Center, 2001).

In recent years, "integrated" treatment services for co-occurring disorders that address both substance abuse and mental health simultaneously in a continuous and comprehensive fashion have been developed, evaluated, and found to be more effective than nonintegrated programs (Drake, et al., 2001). For example, the New Hampshire-Dartmouth Research Center has created a model for integrated treatment that emphasizes the following elements: case management, group interventions, assertive outreach, education, development of long-term perspective, relapse prevention, family support, and progressive levels of treatment (Mueser, et al., 1997).

Effective integrated treatment must also incorporate a vast array of other supportive services such as health, financial aid and housing (Pepper & Hendrickson, 1996).

While many experts argue that integrated treatment is a promising approach to treating co-occurring disorders, it is rarely used by treatment providers. (Peters & Hills, 1997, GAINS Center, 2001). Why? State and local governments often have separate and inconsistent structures for licensing, regulating and financing mental health and substance abuse treatment services. Service standards, administrative guidelines and quality assurance procedures for integrated treatment have not yet been widely incorporated by public mental health and substance abuse authorities or adopted by service providers, so that many treatment providers are simply not up-to-date on the methodology and potential benefits of this approach. Even where clinicians are interested in moving beyond the traditions of their separate mental health and substance abuse systems, opportunities for cross-training and credentialing have been limited (Drake, et al., 2001; Quadrant IV Task Force, 2001). The result is that there is a genuine scarcity of the kind of treatment most needed by a substantial number of offenders with mental illness.

Mental Health and the Courts

It is difficult to get an accurate read on exactly how many people with mental illness come before the courts each day. The recent Department of Justice survey of inmates with mental illness was based on self-reporting rather than the diagnoses of mental health professionals. And studies of the mentally ill in jails and prisons miss defendants with mental illness who make their way through the court system but whose cases are ultimately dismissed or who receive sentences other than incarceration. Preliminary results from a recent study in Brooklyn suggest that as many as 30 percent of all arraigned defendants may have a serious mental illness (Broner, Owen, Lamon & Karopkin, 2000).

How have courts dealt with mental illness in the past? Not particularly well. Historically, courts have a handful of methods to address problems associated with defendants who appear to be mentally ill. These include pleas of "not guilty by reason of insanity" and "guilty but mentally ill" as well as rulings that a defendant is not competent to stand trial (Parry, et al., 1998). These tools are used very infrequently. For instance, an eight-state study showed that the insanity defense was used in less than 1 percent of all cases and was successful only 26 percent of the time despite the fact that 90 percent of those invoking the defense had been diagnosed with a mental illness (American Psychiatric Association, 2001). On the civil side, judges may order involuntary treatment for people with severe mental illness who are found to be a danger to themselves or others. However, the impact of civil commitment proceedings is sharply limited by the tiny numbers of inpatient beds available and the many procedural safeguards that permit patients to obtain their own release after a short time.

More often than not, defendants with mental illness receive no special treatment whatsoever from the court — they are treated just like any other defendant. In fact, many are treated worse, because they are stigmatized by criminal justice officials

with little experience dealing with mental illness. It should come as no surprise that the existing approaches have not been effective in reducing recidivism, improving the health of defendants with mental illness or protecting communities.

New Directions

In recent years, many state courts have come to realize that business as usual isn't working. Out of this recognition has come a wave of new criminal justice interventions for defendants with mental illness, including post-booking diversion programs, enhanced mental health services in jails and programs that link participants to intensive treatment after release (Watson, et. al., 2001).

One judicial experiment in particular has attracted a great deal of attention: the development of specialized "mental health courts" that seek to link defendants to long-term treatment as an alternative to incarceration. The goal of these new model courts --- which, along with drug courts, community courts, domestic violence courts and re-entry courts, are often called "problem-solving courts" --- is to move beyond standard case processing to address the underlying problems that bring people to court. In the process, they seek to shift the focus of the courtroom from weighing past facts to changing the future behavior of defendants (Feinblatt, et al., 2000-A).

In many respects, mental health courts are built on the foundation of an earlier problem-solving court model: drug courts. In 1989, Dade County, Florida created the first drug court in the country. The drug court sentences addicted defendants to long-term, judicially-supervised drug treatment instead of incarceration. Participation in treatment is closely monitored by the drug court judge, who responds to progress or failure with a system of graduated rewards and sanctions, including short-term jail sentences. If a participant successfully completes treatment, the judge will reduce the charges or dismiss the case (Drug Courts Program Office, 1997).

The results of the Dade County experiment have attracted national attention --- and for good reason. A study by the National Institute of Justice revealed that Dade County drug court defendants had fewer re-arrests than comparable non-drug court defendants (U.S. Department of Justice, 1993). Based on these kinds of results, drug courts have become an increasingly standard feature of the judicial landscape across the country (Feinblatt, et al., 2000-B). At last count, there were more than a thousand drug courts nationwide, including ones in operation or being planned in every state (Drug Court Clearinghouse and Technical Assistance Project, 2001). In addition, several states, including New York and California, have begun to look at how some of the principles of drug courts might be institutionalized throughout a state court system (New York State Commission on Drugs and the Courts, 2000; Kaye, 2001; Feinblatt, et al., 2000-B).

Based on the success of the drug court model, a handful of jurisdictions across the country have developed specialized courts to address mental illness. Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment. The first of these courts opened in June 1997 in Broward County, Florida.

There are many points of entry into the Broward County Mental Health Court, but primarily candidates are identified during intake by jail staff within 24 hours of arrest. Jail psychiatrists evaluate each defendant's mental health. If a defendant is found to pose a danger to himself or others, the psychiatrist will seek a judge's order to transport the defendant to a crisis center for symptom stabilization. Defendants charged with misdemeanor offenses who are found to have mental health problems and who are deemed stable are referred to clinicians from the public defender's office who perform an additional screening. If symptoms of mental illness are again found during this second screening, the defense attorney informs a magistrate presiding over the bail hearing, who refers the case to Mental Health Court.

At the Mental Health Court, the judge will recommend pre-adjudication diversion into treatment. The judge will monitor defendants in treatment for up to one year. The length of judicial supervision and level of treatment vary depending on the treatment needs of the individual defendant. For defendants who agree to participate in treatment diversion, the State's Attorney may either dismiss charges immediately or hold prosecution in abeyance, depending on the seriousness of the offense. Upon completion of the treatment, the charges held in abeyance will be dismissed or reduced. However, certain defendants with serious criminal histories may be required to plead guilty and get credit for time served in treatment in lieu of incarceration.

Proliferation of Mental Health Courts

Shortly after Broward opened its doors, several other municipalities began to plan mental health courts. Today, there are mental health courts in Seattle and Vancouver, Washington; San Bernardino, Santa Barbara and Santa Clara, California; Anchorage, Alaska; Marion County, Indiana; St. Louis, Missouri; Akron, Ohio; and Jefferson County, Alabama. A number of other mental health courts are in the planning stages. A recent study by the Crime and Justice Research Institute documented the practices of the first four mental health courts — Broward, King County (Seattle), San Bernardino and Anchorage (Goldkamp & Irons-Guynn, 2000). While each mental health court is unique, this study — and independent research on the other mental health courts — highlighted a set of common procedures and goals that typify the mental health court approach:

Problem-Solving Mental health courts mark an attempt by court systems to address a systemic problem, taking a critical look at the issues that defendants with mental illness pose for the courts and crafting a new set of responses. Put simply, these courts are not satisfied with continuing with business as usual — standard case processing or out-sourcing the solution to some other agency. (Finkelstein & Brawley, 1997).

Public Safety By responding to widespread concerns about how courts deal with defendants with mental illness, mental health courts attempt to shore up public trust and confidence in the justice system. Indeed, many mental health courts have been created in response to a specific local crisis involving mentally ill defendants — for

instance, the murder of a retired firefighter in Seattle, Washington by a person with mental illness (Goldkamp & Irons-Guynn, 2000).

Therapeutic Jurisprudence In linking defendants with mental illness to treatment alternatives, many mental health courts see themselves as practicing "therapeutic jurisprudence" (Lurigio et al., 2001; Lerner-Wren, 2001; Wexler & Winnick, 1996). In one way or another, mental health courts are testing the extent to which the law can be a therapeutic agent --- a social force producing positive life changes for defendants.

Identification Mental health courts develop new systems to identify defendants with mental illness. The point in the criminal justice process at which this intervention occurs varies by jurisdiction. Usually, identification takes place within 24 hours of arrest while defendants are still in custody. The primary sources of identification are jail staff, family members and defense attorneys.

Targeting After identification, each court has created eligibility criteria that target a certain type of defendant. Almost all programs require that defendants have symptoms of severe mental illness and face non-violent, misdemeanor charges. San Bernardino's court has handled some non-violent felonies on a case-by-case basis. In general, mental health courts specify that the defendants' mental illnesses must be "Axis I disorders" as designated in the Diagnostic Statistics Manual IV (American Psychiatric Association, 1994).

Dedicated Staff Each mental health court has a dedicated judge and some additional specialized staff. The specialized staff are usually mental health clinicians who screen cases for eligibility, prepare treatment plans, and report to the judge on defendants' progress in treatment. In some cases, this staff is hired by the court system using new funding sources. In other cases, this staff is assigned from a collaborative government agency or from a local treatment provider. In general, mental health courts have been planned and overseen by interdisciplinary teams composed of a variety of criminal justice and behavioral health stakeholders. For instance, the Santa Clara Mental Health Court "team" includes the judge, district attorney, public defender, and mental health caseworkers (Santa Clara Bar Association, 2001). The team meets to discuss every case, with each representative providing input from their unique institutional perspective.

Non-Traditional Roles Mental health courts --- like drug courts before them --- have altered the dynamics of the courtroom, including, at times, certain features of the adversarial process. For example, in some courts defenders and prosecutors come together to discuss their common goals for each defendant. Mental health courts may engage judges in unfamiliar roles as well, asking them to convene meetings and broker relationships with service providers.

Voluntariness Participation in mental health court is voluntary — defendants must affirmatively "opt-in" to receive treatment. For instance, the King County Mental Health Court in Washington gives defendants two weeks in a treatment placement to help them decide whether to participate in the program or not (during this time, their attorneys can also investigate the strength of the case against their client) (Goldkamp & Irons-Guynn, 2000).

Plea Structure Once a defendant opts into a mental health court, one of two things happens: either prosecution is "frozen" and charges are dropped after the defendant successfully completes treatment, or a plea is taken and later vacated (or charges reduced) after treatment is completed. All of the mental health courts require a longer period of time in treatment than the defendant would have served in jail or prison if they had plead guilty to the crime charged, and most courts require participating defendants to spend a minimum of one year in treatment. The rationale behind this is two-fold. First, mandated treatment involves many fewer restrictions than being incarcerated (many defendants are even released to their own residences). Second, mental health courts are willing to invest in treatment only if there is real promise of reducing symptom severity (and thereby reducing recidivism). Experience indicates that it takes at least a year to successfully engage people with mental illness in treatment. Accordingly, many mental health courts reserve the right to extend offenders' period of treatment in the event of non-compliance.

Judicial Monitoring Mental health courts require participants to return frequently to court to enable the judge to monitor the progress of treatment. Court appearances are made less frequently as participants demonstrate consistent compliance over a sustained period of time.

System Integration Mental health courts seek to promote reform with partners outside of the courthouse as well as within. For instance, mental health courts have encouraged mental health and drug treatment providers to come together to improve service delivery for offenders.

Results

What does the record show about mental health courts? Are they working? The short answer is that it is too early in the development of mental health courts to say whether they are achieving their goal of reducing the recidivism of participating defendants — there's simply not enough evidence to make the case one way or another.

At this point, most of the available evidence about mental health courts comes from a University of South Florida evaluation of the Broward County Mental Health Court and an evaluation of the first two years of the King County Mental Health Court performed by the University of Washington.

From July 1997 to June 2000, the Broward Mental Health Court evaluated 1,530 defendants for participation, 652 of whom were found to be eligible. While long-

term treatment results are not yet available, researchers have documented some basic information about participants:

- Fifty-four percent of defendants presented with mental illness only, 16 percent with co-occurring disorders, 2 percent with substance abuse disorders alone, 2 percent with development disabilities and 26 percent with an undetermined diagnosis (but still believed to be mentally ill).
- Thirty-six percent of defendants reported one or more psychiatric hospitalizations in the past.
- About 26 percent of defendants were homeless.
- Sixty-nine percent of defendants were male. The average age was about 40 years old. Fifty-five percent of defendants were white, 3 percent Black, 5 percent Hispanic, less than 1 percent Asian and 6 percent unspecified (Broward County 2000-A).

Meanwhile, an evaluation of the 236 defendants who have been referred to the King County Mental Health Court over the last two years revealed that:

- Forty-one percent of defendants referred to the King County Mental Health Court opted to participate.
- Eighty-five percent of those referred were diagnosed with severe mental disorders such as psychotic disorders, bipolar disorder, major depression, and organic brain dysfunction.
- Those defendants who opted into the King County Mental Health Court received more hours of treatment per month after contact with the court than they had received in the past.
- Participants in the program spent fewer days in detention than those who did not participate.
- Most significantly, researchers found that there was a sharp drop in the rate of new arrests for opt-in defendants compared to those who chose not to participate (Trupin, et al., 2001).

More substantial information from the independent evaluations of King County and Broward should become available in the months ahead. In the meantime, it is possible to look at the self-reported results from the first wave of mental health courts. Perhaps predictably, these results are almost uniformly encouraging. For example, the Santa Clara Mental Health Court had graduated 56 participants as of January 1, 2001. During the 2 years prior to their entry into the Santa Clara Mental Health Court, these 56 graduates were held in custody for a total of 19,040 days, at a cost of approximately $1,252,832. Court officials estimate that the effect of moving these 56 clients from jail custody into community treatment over a one-year period saved 6,013 jail days, for a cost savings of approximately $395,655. And during the

period of involvement with the court, there were no new arrests for this first group of graduates (Santa Clara Bar Association, 2001).

While these results are promising, there is a need for more rigorous research about the impacts of mental health courts. This is especially true given that the proliferation of these experiments shows no sign of slowing down any time soon.

Challenges, Questions and Tensions

Perhaps because they offer a provocative new approach to defendants with mental illness, mental health courts have attracted a fair amount of scrutiny from judges, prosecutors, defenders, mental health advocates and others with an interest in what happens to mentally-ill offenders. What follows is a brief overview of some of the concerns and questions these experiments have generated:

Defining Success How do you define success in a mental health court? How realistic are the goals of reduced recidivism and stable community living when working with offenders who are severely ill? Some offenders with serious mental illnesses will need treatment throughout their lives. At what point can the court say that treatment has been successful? When should the involvement of the court begin and end?

Proportionality Traditionally, the gravity of an offender's crime determines how much leverage the court has to impose conditions for release or probation. This poses a dilemma for mental health courts, which tend to focus on low-level cases involving defendants who require long-term therapeutic interventions. How do mental health courts determine the right proportion between charge severity and the length of mandated treatment? Finding this balance is crucial to winning the support of both prosecutors and defenders.

Case Targeting Mental health courts have used various criteria for determining eligibility. Some exclude offenders with histories of violence. Others exclude offenders with co-occurring disorders. Still others exclude defendants charged with felonies or violent crimes. Targeting misdemeanors may make political sense, particularly during a project's pilot phase, but this approach does little to address the problem of "transinstitutionalization" for the more serious offenders who are headed for longer stays in jails and prisons. And it runs the risk of lower success rates due to proportionality problems. What approach to case targeting makes the most sense given the goals of mental health courts?

Sanctions and Rewards Building on the drug court model, some mental health courts apply a series of graduated sanctions and rewards to help improve compliance with treatment mandates. Does this structure work with mentally ill defendants? Do some mentally ill defendants lack the capacity for consequential thinking that is required for this approach to work? If so, what sanctions and rewards are most effective in promoting compliance?

Use of Jail Many mental health court practitioners struggle with the issue of whether it is ever appropriate to use jail as a sanction for defendants who fail to take their medications or participate in treatment. In drug court, there's a certain logic to sending offenders to jail for dirty urine because they're violating the law — there's a clear connection between the incarceration and the violation. When a mentally ill defendant stops taking his medications, he may have violated the court's order but no law has been broken. What kinds of sanctions are appropriate in this case? And apart from appropriateness, there are questions about the effectiveness of jail for offenders with mental illness. For instance, the King County Mental Health Court tries to avoid using jail sanctions because offenders' mental condition often deteriorates in jail, making it harder for them to re-engage in treatment upon release (Cayce, 2000). The San Bernardino Mental Health Court also seeks to avoid the use of jail, but for a different reason. Interestingly, they found that offenders with mental illness were simply not motivated by the threat of jail. Many regarded a stay in jail as a welcome relief from the difficulties of life in treatment or in the community (Morris, 2000). As a result, San Bernardino has aggressively employed community service sanctions instead.

Beyond Legal Competency Legal competency statutes and rulings set a very low standard for participation in criminal proceedings. Even if defendants meet the standard for legal competency to stand trial, their mental disorders may impair their abilities to make effective treatment decisions (Grisso & Applebaum, 1998). Given this, what expectations of competency should mental health courts adopt? One approach to this difficult question is offered by King County, which permits defendants to enter treatment for a short period of time pre-plea to stabilize their condition and maximize their ability to make competent decisions about their legal and treatment options.

Treatment Availability/Effectiveness Mental illnesses are various and complicated. Are certain mental illnesses less susceptible to treatment than others? How do you handle defendants for whom medication simply has no effect? Are there some illnesses for which treatment will have no impact on recidivism? Is there enough "integrated" treatment available for defendants with co-occurring disorders?

Public Safety A single sensational story about a participant committing a violent act could be enough to sink the entire mental health court movement. Courts must always balance the desire to rehabilitate with the need to preserve public safety. How can mental health courts quickly and effectively assess the public safety risks posed by defendants with mental illness? How reliable are the available risk assessment instruments? How should they be used?

Stigma and Confidentiality Do mental health courts run the danger of stigmatizing defendants with mental illness? What happens if a defendant decides not to opt in

to mental health court and the case is transferred to a conventional court? What information should the new judge and prosecutor receive about that defendant's mental illness, if any? And would this information have the potential to prejudice the way that the prosecutor and judge treated the defendant in subsequent proceedings? More generally, what kinds of confidentiality protections are appropriate for the information that defendants reveal as part of their involvement with mental health court?

Housing Many defendants with mental illness are homeless — they need housing in addition to treatment. And the effectiveness of treatment may be seriously compromised without adequate housing (Ades, 2001). How will mental health courts ensure access to housing for those defendants who require it?

Public Benefits The vast majority of participants in mental health courts will require public benefits — Medicaid, Social Security Insurance or Social Security Disability Insurance — for their subsistence and treatment. These federal benefits are often terminated or suspended when a person is jailed. As a result, when defendants are released, they must re-apply for benefits. It often takes several weeks before benefits applications are processed and payments begin. This leaves many defendants with mental illness in limbo, unable to meet their basic support and health needs (GAINS Center, 1999). What, if anything, can mental health courts do to address this problem?

The Role of the Courts Many individuals who end up in mental health courts have already been in the mental health system at some point in their lives. What evidence is there that courts can bring about different results? What do they bring to the table that's unique? Is it simply coercion? Or is it something else? Can courts promote enhanced system integration, bringing together criminal justice, mental health and drug treatment agencies?

Answering these questions will go a long way toward coming to terms with a more fundamental question: Are mental health courts a good thing or a bad thing? This is a question that can only be answered over time, with the help of solid, independent research and more practice on the ground.

While mental health courts have raised difficult legal, ethical, practical and therapeutic concerns, it is important to note that many of these issues are not entirely new. Drug courts, community courts, domestic violence courts and other problem-solving courts have been grappling with these issues for years. And the record has shown that on a local level, many problem-solving courts have managed to figure out answers to thorny issues of confidentiality, proportionality, case targeting and public safety. Mental health courts must figure out how to build on the best of the existing problem-solving courts while formulating new responses to issues that are unique to the mental health field.

Stakeholders

Mental health courts have not emerged in a vacuum, of course. To forge a new response to mentally-ill offenders inevitably requires the active engagement of a variety of stakeholders — judges, defenders, prosecutors, mental health advocacy groups and others. What do each of these groups think about the way that courts have traditionally handled cases involving mentally ill defendants? What would they do differently if they could? What do they think of the mental health court experiment? What are their primary concerns with this new model?

The following pages sketch out answers to these questions based on the results of dozens of interviews with each of these stakeholder groups. It is important to note that these sections are not intended to provide a definitive look at what these groups think about mental illness in the courts. Rather, the goal is to take a snapshot of a moment in time, offering impressions gleaned from months of interviews and focus group research.

Judges

Interviews with criminal court judges around the country reveal a consistent theme: defendants with mental illness pose special problems.

In general, judges feel that the standard options available in the criminal justice system are not a good fit for the majority of cases involving people with mental illness (Karopkin, 2000; Cayce, 2000). Judges in arraignment parts and courts that deal with misdemeanors and violations say that a substantial portion of their core business involves repeat offenders who appear to have mental illness (Broward County, 2000-B; Karopkin, 2000; Cayce, 2000; Norko, 2000; Rosenberg, 2001). The same holds true in lesser volume in courts that deal with felonies (Ferdinand, 2000; Morris, 2000; Leventhal, 2000). For this reason, one judge dubbed defendants who appeared to have mental illness as "frequent flyers" (Cayce, 2000).

Judges say that defendants "appear" to have mental illness because, in most circumstances, they do not really know for sure (Karopkin, 2000; Landsberg et al., 2000). Judges report that they usually lack the capacity to identify whether defendants have mental illness in any kind of systematic way (Anderson, 2000). More often than not, a judge will receive information from jail staff, defense attorneys or prosecutors about the possibility of a defendant's mental illness based on signs of strange behavior. According to James Cayce, the first presiding judge at the King County Mental Health Court: "This ad hoc approach certainly misses many defendants who suffer from mental illnesses but who do not have florid and obvious symptoms" (Cayce, 2000).

Even if judges in conventional courts could identify defendants with mental illness, they still lack the kinds of connections with community-based service providers that are necessary to place people in appropriate treatment programs (Broward County, 2000-B). According to Martin G. Karopkin, a judge in Brooklyn's criminal court, "Without a mental health professional they can turn to for reliable information, judges don't have any confidence that treatment is going to be effective for any

given defendant, so they won't risk it. Simply put, it's a frustrating situation that makes sense to no one" (Karopkin, 2000).

Problem-Solving Judges

In contrast, judges in problem-solving courts report that they have more time and resources to address the underlying problems of defendants. This includes staff to perform meaningful assessments, connections with treatment providers, and procedures for monitoring defendants in treatment. Despite these advantages, problem-solving judges say that defendants with mental illness often don't fit the mold. Some drug courts have simply excluded defendants with co-occurring disorders from program participation (Anderson, 2000). For drug courts that do accept defendants with co-occurring mental illness, it is estimated that these cases account for about one-third of their total caseload (Ferdinand, 2000). Domestic violence courts judges estimate that about one in ten defendants suffer from a mental illness (Leventhal, 2000). And much of the core business of community courts involves defendants with mental illness and substance abuse problems who are homeless (Koretz, 2000; Norko, 2000). In all of these settings, judges have noticed that defendants with mental illnesses tend to fail to satisfy the court's requirements at a higher rate than those without such problems.

In drug courts, judges have found that "defendants with co-occurring disorders are harder to place in treatment than defendants with a single disorder" (Ferdinand, 2000). Choosing the appropriate mode of treatment is also difficult for judges, even when relying on expert advice. First of all, co-occurring disorders are not easy to diagnose properly. Especially at or near the time of arrest, identifying a co-occurring disorder often requires a subtle differential diagnosis that is capable of separating out symptoms (Broner, et al., 2000). And mental illness is not a one-size-fits-all problem — not all mentally ill defendants are alike. Some have thought disorders like schizophrenia that can cause delusions. Others suffer from mood disorders like severe depression. Making an accurate diagnosis for placement in treatment requires a highly-trained mental health professional that even most drug courts do not have on staff and could not afford to retain.

In domestic violence courts, defendants with mental illness are often involved in crimes against their parents with whom they reside (Leventhal, 2000). Usually, parents do not want to cooperate with prosecution of the case, fearing it will result in punishment of their child (ibid.). But they have been scared by their child's violent behavior. They often implore the judge to use his or her powers to leverage and mandate treatment. The problem for domestic violence courts is that linking defendants to mental health treatment is not part of their core business (ibid.). Diagnosing a defendant, finding appropriate treatment and monitoring his or her progress is time-consuming, requires additional expertise and reduces the number of cases a judge can handle. Judges in domestic violence courts expressed a desire to be able to refer these defendants to a court that specializes in addressing mental health issues (ibid.).

Community courts handle a steady stream of low-level, quality-of-life offenses. Defendants are often repeat offenders who have co-occurring disorders (Koretz, 2000; Norko, 2000). Community courts emphasize neighborhood restoration through community service while helping defendants access basic services to address their underlying problems. This program design does not work very well with defendants suffering from serious mental illnesses (Koretz, 2000). Many defendants with mental illness are disorganized and confused, especially after being arrested and jailed pending arraignment. "They tend to miss court appointments to perform community service or to attend short-term treatment readiness programs" says Eileen Koretz, the presiding judge of the Midtown Community Court in New York. As a result, many community courts are searching for new approaches to defendants with mental illness.

By contrast, judges presiding in mental health courts feel like they have finally gotten a chance to address the issues of defendants with mental illness in an appropriate manner (Cayce, 2000; Anderson, 2000). Judge Ginger Lerner-Wren of the Broward County Mental Health Court has described her experience this way: "We view the Mental Health Court as a 'strategy' to bring fairness to the administration of justice for persons being arrested on minor offenses who suffer from major mental disability. We have seen time and time again true successes. Persons with major psychiatric disorders and/or mental disabilities can live and thrive in the community with individualized care, treatment and community support" (Lerner-Wren, 2001). Similarly, Judge Cayce has written about the King County Mental Health Court: "We see a positive difference in the defendants' personal level of satisfaction with their role in the system, the use of our limited jail resources, and in protecting public safety" (Cayce & Burrell, 1999).

Defense Attorneys

In many cases, defense attorneys are the first to discover that a client suffers from mental illness when they interview them after arrest (Saucedo, 2001). Defenders report a variety of challenges that accompany these clients. For instance, impaired mental functioning may make it much more difficult for clients to understand their attorneys' advice or for attorneys to clearly discern their clients' wishes (Bock, 2000).

Many defenders believe that their clients' mental illness drives their criminal conduct (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000; Finkelstein & Brawley, 1997). Some defenders believe that the system "criminalizes" mental illness — arresting people with mental illness for quality-of-life crimes, like disorderly conduct, that are the direct result of symptoms of their untreated illness (Schreibersdorf, 2001). "If they're acting 'weird' in the opinion of the police, then they get arrested. That 'weird' is a symptom of mental illness not criminal conduct," explains Lisa Schreibersdorf of Brooklyn Defender Service. And in the past, many people with mental illness would have been taken by the police for inpatient hospitalization rather than being arrested, booked and jailed (Finkelstein & Brawley, 1997). As a result, defenders tend to think that charges against their mentally ill clients are unfair and should be dismissed (Saucedo, 2001; Schreibersdorf, 2001).

What happens when a defender believes that his or her client with mental illness would benefit from treatment? Defenders talk about some daunting obstacles that they must then face. Their clients may not be "clean" enough or rational enough to accept that they are suffering from a mental illness. In this state, clients often won't accept the necessity of treatment (Bock, 2000). Or even if clients accept that they are ill, they may not want to engage in treatment, having become so used to serving short terms in jail or prison and so averse to treatment with its medications and their potentially negative side effects (Saucedo, 2001). Clients' resistance to treatment complicates defenders' ability to act in those clients' best interest. Finally, defenders worry about setting their clients up for failure by entrusting them to a behavioral health system that has failed to adequately treat and monitor people with mental illness who end up in the criminal justice system (Finkelstein & Brawley, 1997; Schreibersdorf, 2001).

In addition, defenders are not satisfied with the standard plea options available to their clients with mental illness. For instance, defenders almost never recommend the defense of "not guilty by reason of insanity" (Bock, 2000). They only recommend seeking this verdict in serious felonies, usually murders, which make up a minute amount of their overall caseload (Schreibersdorf, 2001). Defense attorneys explain that defendants will serve less time behind bars in most cases than they would spend hospitalized under an insanity defense, except when facing a sentence of death or life in prison (ibid.).

The same logic usually applies to seeking a ruling of incompetency. In misdemeanors, defense attorneys may raise incompetency if the charges will be dropped (ibid.). But not in all cases. Defendants found guilty of misdemeanors are usually given time served, probation or very short jail sentences, all of which may be shorter than the hospitalization required under competency regimes. In felony cases, defenders may seek a ruling of incompetency as a strategic device to buy time or to improve their ability to communicate with a difficult client (ibid.). For a felony charge, incompetency usually means staying in a hospital until the defendant stabilizes enough to return to court and face trial. Finally, defense attorneys are mixed on the defense of guilty but mentally ill because it often requires inpatient treatment only. This leads defenders to recommend this plea only in cases involving serious charges.

Across the board, defense attorneys expressed reluctance to employ these traditional judicial solutions out of concern over the intense negative stigma placed upon criminal defendants with mental illness (Schreibersdorf, 2001; Saucedo, 2001). This fear of stigma extended to their perceptions about mental health courts as well. Defense attorneys believe that prosecutors, judges, juries and some of their own colleagues need to become better educated about mental illness. They point to the fact that prosecutors may seek and judges may agree to withhold bail, increase sentences and extend probation for defendants with mental illness (Schreibersdorf, 2001; Finkelstein & Brawley, 1997). Some defenders may even see this reaction as understandable and fail to protest. Some defenders have expressed concern that the deci-

sions by these system actors are often based on myths about mental illness rather than any individualized assessment of the defendant in front of them. This concern leads many defendants to keep their client's mental illness to themselves whenever possible (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Defenders expressed a cautious optimism about mental health courts and mental health treatment diversion. After all, obtaining treatment as an alternative to incarceration is something that many defenders have wanted for years (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000) Some defenders hope mental health courts will act as a kind of catalyst "to spotlight the paucity of treatment in the community and... spark an interest in creating the treatment programs for the mentally ill that the law mandates as a matter of right, which up until now have been denied them" (Finkelstein & Brawley, 1997).

In assessing the mental health court model, defenders' opinions vary based on whether participation takes place pre- or post-plea. Defenders are concerned that courts mandating treatment prior to adjudicating guilt could be too coercive. Some feel that the charges should be dropped after a client is diverted into treatment, in recognition of the fact that a client lacks culpability for an offense fueled by symptoms of an untreated mental illness. In addition, some defenders contend that holding the threat of prosecution over a client's head while in treatment is unfair and potentially a violation of due process principles (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Many of these arguments drop away in the post-plea context. Once the issue of guilt has been adjudicated, defenders agree that the court may exercise broad sentencing authority and mandate defendants into treatment (Schreibersdorf, 2001; Feinblatt & Denckla, 2001). Some mental health court pleas explicitly lay out the defendants' potential exposure to jail in the event of consistently failing to comply with program requirements. While defenders think this approach is fair in the post-plea context, they are concerned about how much jail time would be faced by their clients (Schreibersdorf, 2001). For instance, defenders think it is unfair to make offenders who fail out of a treatment program serve a longer sentence than they would have served under a standard plea agreement (Feinblatt & Denckla, 2001). Other defenders believe that the "back-up time" for failure should decrease as the offenders' time in treatment increases, giving them credit for time served.

A general concern voiced by defenders about problem-solving courts involves how much authority judges will exercise over treatment decisions (Feinblatt & Denckla, 2001). Defenders like the idea that judges are becoming more educated about mental illness, but they fear that judges might be tempted to become "psychologists with black robes" (ibid.).

Prosecutors

Chief among prosecutors' concerns about defendants with mental illness is public safety. Mentally ill offenders tend to be repeat offenders. Consequently, some prosecutors have been attracted to alternatives in these cases, hoping that new solutions

might help reduce recidivism (Newman, 2001; Schrunk, 2001; Hynes, 2001; Clark, 2000; Raybon, 1997).

Unfortunately, many prosecutors who support alternatives to incarceration are often frustrated with the limits of treatment providers' capacity and willingness to treat defendants with mental illness. Some prosecutors complain that admissions standards are used to reject more defendants than they include. (Swern, 2000; Landsberg, et al., 2000). Given their mission to protect the public, prosecutors are particularly interested in residential treatment for offenders with mental illness. Many express concern about the dearth of residential treatment slots (Clark, 2000; Swern, 2000; Landsberg, et al., 2000).

Put simply, prosecutors want mental health courts to ensure the accountability of defendants linked to treatment. Prosecutors fear that a defendant with mental illness who is released for treatment will commit a violent crime (Clark, 2000). "Not only would this be tragic for potential victims but it could attract negative media attention that might be used to shut down alternative programs like the mental health court," says Daniel Clark, a prosecutor from King County (Clark, 2000). Given this concern, prosecutors focus a great deal of attention on risk assessment and case targeting (Swern, 2000, Monahan, 2001). "We have a responsibility to the public to assess the risk of violence and assure ourselves that the risk is as little as possible," says Anne Swern of the Brooklyn District Attorney's Office. "We are making an investment in treatment in order to prevent the re-occurrence of crime — particularly violent crime — by offenders with mental illness." Defining who is and is not eligible for a mental health court based on the risk of violence may be crucial to addressing prosecutorial priorities.

Defendants and Ex-Offenders with Mental Illness

In general, ex-offenders and defendants with mental illness who were interviewed at Howie the Harp Advocacy Center, Pathways to Housing, Odyssey House, Harbor House and the Brooklyn Arraignment Part in New York City Criminal Court thought that they had not been served well by the standard case processing of the criminal justice system. Ex-offenders baldly state that their mental illness (and, in many cases, their substance abuse) helped drive their criminal activity. Many reported that they committed their crimes under the influence of drugs or alcohol during a period in which they also failed to take prescribed psychiatric medications. Most had been arrested more than once. Many had served time in jail or prison.

Interestingly, ex-offenders expressed a good deal of ambivalence about their defense attorneys. While many had positive things to say about the legal counsel they had received, others felt that their attorneys were more focused on pursuing short-term strategies necessary to close the case than in preventing their return to the criminal justice system. One ex-offender put it this way: "Defense attorneys aren't thinking about me as an individual who has a mental illness. They're not thinking about my best interests, my need for long-term treatment or how to keep me from coming back to court tomorrow. They are thinking about the short-term of this case. If they knew more about mental illness, they would do things differently." This criti-

cism was fueled by the fact that the ex-offenders interviewed for this study had managed to stay out of the criminal justice system once they obtained treatment. (Many admitted that they had to try a number of different treatment modalities — and get arrested again — before they were able to stabilize.)

None of the ex-offenders interviewed had ever sought a verdict of "not guilty by reason of insanity" or "guilty but mentally ill." Some of them had been referred by their defense attorneys for a competency hearing. Some had also taken advantage of substance abuse treatment as an alternative to incarceration. It had worked for only a few of them because the treatment offered failed to address their mental illness as well.

While none of the ex-offenders interviewed had participated in a mental health court, most of them thought that this type of program was a good way to prevent recidivism. While many said that they would be willing to accept services at the time of arrest, there were some who, even with the benefit of hindsight, stated that would not avail themselves of treatment. Clearly, overcoming resistance to treatment is an issue that any mental health court must take seriously.

Ex-offenders thought that any treatment alternative should be mandated for a period of time longer than what a defendant would face in jail or prison. They repeated stories about how they and others like them didn't realize their own need for treatment even after they were arrested or incarcerated. They would resist treatment, especially if it involved psychiatric medications which carried negative side effects. And repeat offenders stressed that even several months in jail was considered a "skid bid" that was easier to serve rather than enter unwanted treatment.

As to case targeting, some ex-offenders thought that misdemeanor charges did not carry enough of a threat of incarceration to deliver long-term engagement in treatment. One ex-offender explained it in the following fashion:

> *Look, misdemeanors aren't going to be enough to get these guys [with mental illness] into treatment. If you're facing a misdemeanor, you're not going to do more than a year. Now, for most guys who've been through the system, they can do [that time] standing on their head. It's nothing. It's a 'skid bid' — fast and smooth. So they are not going to take treatment unless it is less than [a year], especially if they don't think they have a mental illness. And your program isn't going to want them to go to three months or six months or even a year of treatment. It takes a minimum of two years — maybe three — for treatment to work. So, I think you've got to take felons only. If you're facing a [sentence of] three-to-five [years in prison], two years in treatment is going to sound good.*

Ex-offenders offered suggestions about how to engage defendants with mental illness in treatment: "They are not going to listen to anybody except someone who has been through what they've been through and changed. That's why you need peer educators. It's the only way you'll get through to them." When asked about their experiences with judges, court officers, clerks and district attorneys, ex-offenders reported that these court personnel could benefit from training in the the mental

health recovery process ("relapse is part of recovery"). The ex-offenders also pointed to the need for training about the dangers of free time: "If I'm just sitting around in my house, watching the TV, that's when I start to get into trouble. My thoughts wander to the drugs, to the street, to whatever. Really, I'm just bored. But when I'm doing something all day — volunteering, working, even sightseeing — I'm not going to get into trouble."

What sanctions and rewards would be effective with defendants with mental illness? Interviewees stated that treatment plans should be re-evaluated to see if noncompliance is due to either an inappropriate treatment modality or truly willful behavior. One consumer put it this way: "You want [defendants] to think about the consequences — stay on track, you get a reward; mess up, you get punished. But what if they're confused and can't think straight because their medication is wrong? That's not their fault. It's not right to punish them then." They expressed the need to separate legal issues from treatment issues. The ex-offenders also suggested that a defendant's failure to comply should trigger the court to review whether the provider delivered the agreed upon services. And one consumer urged courts to use privacy as a sanction and reward: "Take away their [defendants'] privacy or give them more privacy. Everyone wants to be left alone. Reward them with more privacy."

The ex-offenders suggested various ways to reward/sanction with privacy. The consumers believed that increasing monitoring visits and calls, particularly at home, would be more effective than increased office visits, which can be easily ignored. They noted that privacy can be increased or decreased within a treatment facility (e.g., sharing a room with one person versus ten). However, they did not think short terms in jail would be effective as a sanction. Why? "In jail you lose the progress you made in treatment. Your self-esteem goes down. You think you can't get well. And you're afraid for your life. You don't want to go to the MO [Mental Observation Unit]. They dope you up on the wrong drugs. You fall apart." The consumers also proposed taking control of a defendant's income as another sanction. "Without spending money, you can't get into much more trouble."

Families

What about the families of criminal defendants with mental illness? In many cases, family members have been victimized by mentally ill offenders, suffering abuse, theft and harassment. Nevertheless, many families are extremely concerned over the incarceration of their relatives (Finkelstein, 2001; Saler, 2001). Organizations such as the National Alliance for the Mentally Ill (NAMI) have begun to explore solutions to this problem (Honberg, 2000; Corliss, 2000; Flynn, 1999). Family members feel trapped by unappealing alternatives. On the one hand, there is the mental health treatment system, which has failed to engage their relative in effective treatment. And on the other hand, there is the criminal justice system, which is certain to punish their relative for behavior that stems from their untreated illness (Corliss, 2000). But at least in jail or prison, their relative will be restrained from hurting themselves or others. And many offenders with mental illness have long, complex histories of resisting treatment, including failing to take their prescribed psychiatric

medications (Saler, 2001). Families want their mentally-ill relatives to get help, but in many cases they don't know how to do it (ibid.).

Families of mentally ill defendants are divided over the use of coercion to engage their relatives in treatment. Many lean towards the use of coercion because they have often been victimized by their relatives' criminal activity and their failure to remain in treatment (Saler, 2001; Corliss, 2000; Landsberg, et al., 2000). As a result, many families support outpatient civil commitment statutes, such as "Kendra's Law" in New York State, as a way to promote treatment compliance (Corliss, 2000). Similarly, many families have reacted positively to mental health courts (Finkelstein, 2001; Saler, 2001; Honberg, 2000; Corliss, 2000). They see these new experiments as providing their relative with a powerful incentive to remain engaged in treatment (Honberg, 2000; Corliss, 2000).

Mental Health Advocacy Groups

Mental health advocacy groups such as the Urban Justice Center's Mental Health Project in New York City and the Bazelon Center for Mental Health Law in Washington, D.C., engage in lobbying, public education and litigation on behalf of people with mental illness. Similar to defense attorneys, these advocacy groups believe that over the last decade or so law enforcement priorities combined with the effects of significant gaps in community mental health services have resulted in a "criminalization" of people with mental illness. (Barr, 2001; Bernstein, 2000).

Mental health advocates believe many defendants with mental illness commit crimes because their illness has not been effectively treated (Barr, 2001; Bernstein, 2000). Accordingly, advocates argue that defendants with mental illness should be diverted out of the criminal justice system and into treatment as early as possible. They believe that prosecuting most defendants with mental illness is fundamentally unfair. These advocates favor pre-booking diversion programs (sometimes called Crisis Intervention Teams) like the one employed with the police in Memphis, Tennessee (Barr, 2001). "The mental health system needs to develop more appropriate responses to people in psychological crises that will help avoid any criminal justice involvement," says Heather Barr, a staff attorney at the Urban Justice Center. If a defendant must go to court, they favor a diversion to treatment at arraignment and a dismissal of charges (Barr, 2001; Bernstein, 2000).

Mental health advocates are not very favorably inclined towards certain attributes of mental health courts. They share many of the same concerns voiced by defense attorneys. They see court-mandated treatment as an invasion of defendant's liberty and privacy (Barr, 2001; Bernstein, 2000). "Coercion by the courts," explains Barr, "is only appropriate when a defendant chooses that option freely and the offense is one that would lead to a substantial period of incarceration in the normal sentencing marketplace of the criminal justice system" (Barr, 2001). As a matter of principle, advocates tend to believe that individuals with mental illness should access treatment voluntarily on their own after charges against them have been dismissed.

In addition, mental health advocates are concerned about the use of confidential treatment information by prosecutors and judges in mental health courts (Bernstein,

2000). They describe occasions when prosecutors and judges have used psychiatric information disclosed in the course of advocating for a treatment disposition to justify a greater period of incarceration (Barr, 2001). They also fear that prosecutors (or other government agencies) will collaterally prosecute or impeach a witness on cross-examination using information obtained by the court during its mental health evaluation of the defendant (ibid.).

The Treatment Community

The behavioral health "treatment community" consists of state and county agencies of mental health, mental retardation and substance abuse and the programs they fund, including psychiatric hospitals and community-based service providers. Historically, the treatment community has been reluctant to address the issue of people with mental illness who have repeated contacts with the criminal justice system (Osher, 2001). Recently, that has begun to change. For one thing, research has documented that a significant number of people with mental illness cycle back and forth from treatment to incarceration. Even though the treatment community is starting to come to grips with this issue, the solutions are not easy ones. Addressing the needs of defendants with mental illness requires intricate cooperation among government agencies not used to collaboration with each other (ibid.).

Even though many of their clients have had criminal justice contacts in the past, many treatment providers do not have an expertise in treating these clients (often known as "forensic" clients). In general, where treatment providers are able to choose their clients, they tend to select clients who do not pose the kinds of treatment challenges associated with forensic clients (McCormick, 2000). Treatment providers often associate forensic clients with disruptive or violent behavior (Tsemberis, 2000; McCormick, 2000). As a result, many treatment providers will not treat people coming directly from the criminal justice system, fearing for the safety of their own staff and other clients (Tsemberis 2000). Further, some treatment providers also express concern about the complexity of forensic cases, explaining that clients from the criminal justice system usually have a host of very severe problems that are very difficult to treat effectively (Wertheimer, 2000).

In addition, many community treatment providers are concerned that forensic clients may require more frequent hospitalizations because of the severity of their mental health issues, thus impairing the provider's overall treatment performance statistics (there is even the potential that the failures of forensic clients will jeopardize funding from government sources that require performance-based contracts). "Evaluations of mental health services often regard hospitalization as a negative outcome when it may actually be a positive outcome when compared to being inappropriately placed in jail or prison," says C. Terence McCormick of the New York State Office of Mental Health (McCormick, 2000).

Hospitalization is a tricky problem. In jurisdictions that use a managed care system to deliver mental health services, psychiatric hospitalization initiated by community treatment providers is sometimes discouraged because of its expense (McCormick, 2000). Hospitals have an impact on the front end as well. Many

refuse to admit forensic patients, which makes it more likely that a police or parole officer will exercise his discretion to detain that person in the criminal justice system (Landsberg, et al. 2000).

Treatment providers share the view of many defenders and mental health advocates that mental illness has been "criminalized" in recent years, resulting in more and more criminal justice contacts for their clients (Wertheimer, 2000; Tsemberis, 2000). They also report that people with mental illness do not respond well to the stresses associated with arrest, courtroom appearances and incarceration (Tsemberis, 2000).

Treatment providers have mixed responses to the mental health court model. Some like it because it guarantees on-going court involvement with difficult clients. It gives them a greater sense of assurance that they can call upon the court to help engage forensic clients in treatment (Unterbach, 2001; Wertheimer, 2000). "Treatment outcomes are usually much better when the client, case managers and treatment staff maintain a close relationship with the court" explains Arnold Unterbach, director of mental health services at Odyssey House in New York City (Unterbach, 2001). Indeed, despite their concerns with forensic clients, treatment providers tend to believe that treatment works or can be made to work for just about any person with mental illness. Moreover, many believe that effective treatment can prevent recidivism (Wertheimer, 2000).

Some mental health service providers are encouraged that the courts have begun to realize that their conventional responses to defendants with mental illness are not working. Some believe that the courts may be taking the lead — ahead of the treatment community — in pushing for integrated treatment for co-occurring disorders (Osher, 2001). Other treatment providers express doubts. They worry that courts will intrude into the treatment process without developing a real understanding of either the day-to-day realities of providers' work or the challenges that people face in treatment (Stoller, 2000). And they fear that their need to report confidential information to the court could jeopardize their ability to gain clients' trust, reducing the chances that treatment will be successful (Tsemberis, 2000). "Our concern is that mental health courts may perpetuate the public's unrealistic expectation that when a court mandates someone to do something they actually do it. In reality, when people are told that they have to do something, paradoxically, they often do the opposite. That's human nature — whether you have a mental illness or not." says Ellen Stoller of FEGS, the largest community mental health treatment provider in New York City (Stoller, 2000). Finally treatment providers worry that without specific relationships with treatment providers and priority access to services, mental health courts will face difficulties placing forensic clients in treatment (McCormick, 2000).

Conclusion

While judges, attorneys, service providers and defendants with mental illness come at the issue from different perspectives, there is a consensus that criminal defendants with mental illness pose a major problem for courts in the United States. Standard case processing methods have proven to be neither efficient nor effective in dealing

with these defendants. Given this reality, state court systems have begun to test new approaches in an effort to protect communities and prevent defendants with mental illness from returning to court over and over again at great cost. Most notable among these approaches are mental health courts.

Mental health courts are creating a great deal of discussion around the country. They have provoked a surprising variety of responses from stakeholders in the criminal justice system and the mental health system. For instance, offenders with mental illness and their families appear to differ from defense attorneys and mental health advocates about whether or not coerced treatment is ever appropriate. Further, offenders with mental illness report that their attorneys sometimes fail to pursue case outcomes (e.g., treatment alternatives) that might involve the short-term loss of liberty but might also keep them out of the criminal justice system over the long haul. Defenders and mental health advocates have responded with ambivalence to mental health courts — worrying over the possibility of increased state coercion while applauding the system's interest in expanding access to treatment.

Meanwhile, many prosecutors and judges seem willing to risk the possibility of failure to test whether treating symptoms of mental illness will reduce recidivism and improve public safety. Strikingly, they have encountered some of the most solid resistance from treatment providers, who lack the capacity (and, in many cases, the knowledge about effective treatment regimes) to serve this difficult population. Courts are not an institution known for innovation. But if mental health courts are to succeed, it is clear that they will have to take a leadership role, both in building public support for treatment an alternative to incarceration and in encouraging treatment providers to work with forensic clients.

As mental health courts move forward, they will test three ideas. Primarily, mental health courts explore the connection between defendants' symptoms of mental illness and their criminal conduct, asking whether intensively monitored treatment can reduce recidivism. They also aim to evaluate whether coercion helps improve accountability by engaging defendants with mental illness in long-term treatment. And they tackle the question of system integration: Can the systems of mental health and criminal justice craft collaborative approaches to mental illness and in the process improve the delivery of services to defendants with mental illness and co-occurring disorders? In the years ahead, the answers to these questions will go a long way towards determining both the course of mental health treatment and the future of individuals with mental illness in the criminal justice system.

References

Ades, Y. (2001). Interview with Yves Ades, Director, Mental Health Programs, Center for Alternative Sentences and Employment Services, New York, NY.

American Psychiatric Association (2001). *The Insanity Defense*. Public Information. Washington, D.C. Available: http://www.psych.org/public_info/insanity.cfm

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Washington, D.C.

America's Law Enforcement and Mental Health Project (2000). Public Law 106-515 signed November 13, 2000, formerly S. 1865 (De Wine, M.).
Available: http://thomas.loc.gov/cgi-bin/bdquery/z?d106:SN01865:|TOM:/bss/d106query.html|

Anderson, C. (2000). Interview with Hon. Clifford Anderson, Judge of the Superior Court of California, County of Santa Barbara who presides over the Mental Health Treatment Court there.

Barr, H. (2001). Interview with Heather Barr, Staff Attorney, Urban Justice Center, New York, NY.

Barr, H. (1999). *Prisons and Jails: Hospitals of Last Resort — The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York*. New York, NY: Correctional Association and Urban Justice Center.
Available: http://www.soros.org/crime/MIReport.htm

Belcher, J. (1988). *Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?* Community Mental Health Journal, 24(3), 185-95.

Bernstein, R. (2000). Remarks of Robert Bernstein, Executive Director, Bazelon Center for Mental Health Law. *Mental Health Courts: A Jurisprudent Therapy Perspective*. 2000 New York American Bar Association Annual Meeting, Commission on Mental & Physical Disability, Panel Discussion, July 10, 2000. New York, NY.

Borum, R., Swanson, J., Swartz, M., and Hiday, V. (1997). *Substance Abuse, Violent Behavior, and Police Encounters Among Persons with Severe Mental Disorder*. Journal of Contemporary Criminal Justice, 13 (3) 236-250. Thousands Oaks, CA: Sage Publications.

Broner, N., Owen, E., Lamon, S., Kuropkin, M. (2000). *Mental Illness and Substance Use of Pre-Arraignment Detainees: Population Characteristics and Service Needs*. Presented at American Psychological Association, American Psychology Law Society. New Orleans, LA, March 2000.

Bock, B. (2000). Interview with R. Stewart Bock, Attorney, The Defender Association, Seattle, Washington who works in the King County Mental Health Court.

Broward County (1998). *Mental Health Court Report: The Nation's First Mental Health Court Progress Report*. Ft. Lauderdale, FL: Circuit Court of 17th Judicial Circuit, Broward County, FL.
Available: http://www.co.broward.fl.us/ojss/jsl00500.html

Broward County (2000-A). *Third Annual Mental Health Court Progress Report*. Ft. Lauderdale, FL: Circuit Court of 17th Judicial Circuit, Broward County, FL.
Available: http://www.sunny.org/ojss/jsl00700.html

Broward County (2000-B). *In Re: Creation of a Mental Health Court Subdivision Within the County Criminal Division, Administrative Order-VI-00-1-1*. Ft. Lauderdale, FL: Circuit Court of the 17th Judicial District, Broward County, FL.
Available: http://www.17th.flcourts.org/VI-00-1-1_Mental_Health_Amended_8-4-00_Disk__30.pdf

Bureau of Justice Statistics (1999). *Correctional Populations in the United States* (NCJ 170013). Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

Cayce, J. (2000). Interview with Hon. James D. Cayce, Presiding Judge of the King County District Court, who planned and presided over the King County Mental Health Court located in Seattle, WA.

Cayce, J. & Burrell, K. (1999). *King County's Mental Health Court: An Innovative Approach for Coordinating Justice Services.* Washington State Bar News (June).
Available: http://www.wsba.org/barnews/1999/06/mentalhealth.html

Center on Addiction and Substance Abuse (CASA) (1998). *Behind Bars: Substance Abuse and America's Prison Population.* Prepared by Belenko, S. New York, NY: Columbia University.

Clark, D. (2000). Interview with Daniel Clark, Deputy Prosecuting Attorney, Office of the Prosecuting Attorney, King County, WA.

Codiss, B. (2000). Interview with Robert Codiss, Criminal Justice Coordinator, New York State NAMI, Albany, NY.

D'Emic, M. (2000). Interview with Hon. Matthew D'Emic, Justice of New York State Supreme Court, Kings County who presides over one part of the Brooklyn Felony Domestic Violence Court.

Ditton, P.M. (1999). *Mental Health and Treatment of Inmates and Probationers* (Bureau of Justice Statistics, NCJ-174463). Washington, D.C.: U.S. Department of Justice.
Available: http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf

Draine, J. & Solomon, P. (1994). *Jail Recidivism and the Intensity of Case Management Services Among Homeless Persons with Mental Illness Leaving Jail.* Journal of Psychiatry and Law, 22, 245-60.

Drake, R.E., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E., and Rickards, L. (2001). *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness.* Psychiatric Services, 52 (4), 469-476.

Drug Court Clearinghouse and Technical Assistance Project (2001). *Summary of Drug Court Activity by State & County.* Washington, D.C.: American University and U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office.
Available: http://www.american.edu/academic.depts/spa/justice/publications/ drgchartak.pdf

Drug Courts Program Office (1997). *Defining Drug Courts: The Key Components.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs.
Available: http://www.ojp.usdoj.gov/dcpo/Define/welcome.html

Feinblatt, J. & Denckla, D. (eds. 2001). *What Does It Mean To Be an Effective Lawyer?: Prosecutors, Attorneys and Problem-Solving Courts,* Judicature, 84(4).

Feinblatt, J., Berman, G., & Denckla, D. (2000-A). *Judicial Innovation at the Crossroads: The Future of Problem-Solving Courts.* The Court Manager, 15(3), 28-34.

Feinblatt, J., Berman, G. and Fox, A. (2000-B). *Institutionalizing Innovation: The New York Drug Court Story.* Fordham Urban Law Journal, 28(1), 277-292.

Ferdinand, J. (2000). Interview with Hon. Jo-Ann Ferdinand, Justice of the New York State Supreme Court, Kings County who presides over the Brooklyn Treatment Court.

Finkelstein, H. & Brawley, D. (1997). *Introduction. Broward County Mental Health Court Status Report, 1(1).* Ft. Lauderdale, FL: Broward County Public Defender. (Both authors are Chief Assistant Public Defenders).
Available: http://www.browarddefender.com/mhealth/volume_i_mental_health.htm#Vol I, No. 1

Finkelstein, R. (2001). Interview with Rena Finkelstein, Co-Chair, Rockland County Criminal Justice Task Force, NAMI, Rockland County, NY.

Flynn, L. (1999). *Mentally Ill Need More Than Cells: Jails and Prisons are Ill-Equipped to Help Disturbed Inmates.* Dayton Daily News, July 18, 1999 at 12B.

GAINS Center (2001). *Screening and Assessment of People with Co-Occurring Disorders in the Justice System.* Prepared by Peters, R. & Bartoi, M. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.
Available: http://www.prainc.com/gains/publications/screening.htm

GAINS Center (2001). *Treatment of People with Co-Occurring Disorders in the Justice System.* Prepared by Hills, H. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.
Available: http://www.prainc.com/gains/publications/treatment.htm

GAINS Center (1999). *Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders.* Prepared by Sherman, R. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.
Available: http://www.prainc.com/gains/publications/medicaid.htm

GAINS Center (1997). *Just the Facts: The Prevalence of Co-occurring Mental and Substance Abuse Disorders in the Criminal Justice System.* Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.
Available: http://www.prainc.com/gains/publications/just_the_facts.htm

Goldkamp, J. (2000). *The Drug Court Response: Issues and Implication for Justice Change.* Symposium on Drug Crimes: Penal Jurisprudence in Punishment and Treatment, Albany Law Review, 63, 923-961.

Goldkamp, J. & Irons-Guynn, S. (2000). *Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office.
Available: http://www.ncjrs.org/html/bja/mentalhealth/contents.html

Grisso, T. & Applebaum, P. (1998). *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals.* New York: Oxford University Press.
Summary available: http://macarthur.virginia.edu/treatment.html#N_1_

Health Foundation of Greater Cincinnati (2000). *Mental Illness and Substance Abuse in the Criminal Justice System.*

Honberg, R. (2000). Interview with Ronald S. Honberg, Deputy Executive Director for Legal Services, National Alliance for the Mentally Ill (NAMI), Alexandria, Virginia.

Hynes, C. (2001). Interview with Charles Hynes, District Attorney for Kings County (Brooklyn), NY.

Jemelka, R., Trupin, E., & Chiles, J. (1989). *The mentally ill in prisons: A review.* Hospital and Community Psychology 40, 481- 491.

Kaye, I. (1999). *Making the Case for Hands-On Courts.* Newsweek, 11 October: 13.

Kaye, J. (2001). *The State of the Judiciary 2001 by Chief Judge of the State of New York.* Albany, NY: New York State Unified Court System, New York State Court of Appeals.
Available: http://www.courts.state.ny.us/NYStateofJudiciary2001.pdf

Karopkin, M. (2000). Interview with Judge Martin G. Karopkin, New York City Criminal Court, Arraignment Part, Kings County.

Kluger, J. (2000). Interview with Hon. Judy Harris Kluger, Administrative Judge of the New York City Criminal Court who once presided over the Midtown Community Court.

Koretz, E. (2000). Interview with Hon. Eileen Koretz, Judge of the New York City Criminal Court, New York County who presides over the Midtown Community Court.

Kupers, T.A. (1999). *Prison madness: The mental health crisis behind bars and what we must do about it.* (Jossey-Bass Publishers).

LaFave, W. & Scott, A. (1986). *Criminal Law, Second Edition.* Minneapolis, MN: West Publishing.

Landsberg, G., Rock, M., & Broner, N. (2000). *Pathways of the Mentally Ill into the Criminal Justice System: Initial Findings and Recommendations.* New York, NY: New York University, School of Social Work, Institute Against Violence.

Lamb, H. & Weinberger, L. (1998). *Persons with severe mental illness in jails and prisons: A review.* Psychiatric Services, 49, 483-492.

Lerner-Wren, G. (2001). *Letter from the Mental Health Court Judge.* Third Annual Mental Health Court Progress Report. Ft. Lauderdale, FL: 17th Judicial Circuit, Broward County, Florida.
Available: http://www.co.broward.fl.us/ojss/jsi00500.html

Leventhal, J. (2000). Interview with Hon. John M. Leventhal, Justice of the New York State Supreme Court, Kings County who presides over one part of the Brooklyn Felony Domestic Violence Court.

Luigio, A., Watson, A., Luchins, D., Hanrahan, P. (2001). *Therapeutic Jurisprudence in Action: Specialized Courts and the Mentally Ill.* Judicature, 84(4), 184-189.

Massaro, J. & Pepper, B. (1994). *The Relationship of Addiction to Crime, Health, and Other Social Problems.* Technical Assistance Publication 11: Treatment for Alcohol and Other Drug Abuse; Opportunities for Coordination, ch. 2. Rockville, MD: Treatment Improvement Exchange, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration, Pubic Health Service, U.S. Department of Health and Human Services.
Available: http://www.treatment.org/Taps/Tap11/TAP11toc.html/toc.html

McCormick, T. (2000). Interview with C. Terence McCormick, Program Specialist for Community Services, New York State Office of Mental Health, Albany, NY.

McFarland, B., Faulkner, L., Bloom, J., Hallaux, R., Bray, J. (1989). *Chronic Mental Illness and the Criminal Justice System.* Hospital and Community Psychiatry, 40(7): 718- 723.

Monahan, J., Steadman, H., Silver, E., Applebaum, P.S. (2001). *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence.* Oxford University Press.

Morris, P. (2000). Interview with Hon. Patrick Morris of the Superior Court in the City of San Bernadino, California about the Mental Health Comprehensive Offender Umbrella for Release and Treatment program.

National Institute of Justice (1998). *ADAM 1997 Annual Report on Adult and Juvenile Arrestees.* Washington, D.C.: U.S. Department of Justice.

Newman, S. (2001). Interview with Scott Newman, Marion County Prosecutor, Indianapolis, Indiana who has helped plan and implement several problem-solving courts.

New York State Commission on Drugs and the Courts (2000). *Confronting the Cycle of Addiction and Recidivism: A Report to Chief Judge Judith S. Kaye.* Albany, NY: New York State Unified Court System.

Norko, R. (2000). Interview with the Hon. Raymond Norko, Judge of the Hartford Community Court.

Osher, F. (2001). Interview with Fred Osher, M.D., Director, Center for Behavioral Health, Justice and Public Policy, University of Maryland who is conducting an on-line conversation about system integration.

Parry, J., Hounlnik, D., Skoler, G., Altschwager, H. (1998). *National Benchbook on Psychiatric and Psychological Evidence and Testimony.* Washington, D.C.: American Bar Association, Commission on Mental and Physical Disability Law and State Justice Institute.

Pepper, B. (1992). *Interfaces Between Criminal Behavior, Alcohol and Other Drug Abuse, and Psychiatric Disorders.* Treatment Improvement Exchange --- Forging Links to Treat the Substance-Abusing Offender, ch. 3. Rockville, MD: Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration, Public Health Service, U.S. Department of Health and Human Services. Available: http://www.treatment.org/Communique/Comm93/toc.html

Pepper, B. & Hendrickson, E. (1996). *Developing A Cross Training Project For Substance Abuse, Mental Health And Criminal Justice Professionals Working With Offenders With Co-Existing Disorders (Substance Abuse/Mental Illness).* New City, NY: The Information Exchange, Inc.
Available: http://www.toad.net/~arcturus/dd/ddhome.htm

Peters, R.H. (2001). Unpublished and untitled manuscript detailing the results of a one-day meeting on May 14, 1997 in Los Angeles, California to develop strategies for working with drug court participants who have co-occurring mental health and substance abuse disorders. Convened by National Association of Drug Court Professionals and National GAINS Center.

Peters, R.H., & Hills, H.A. (1997). *Intervention strategies for offenders with co-occurring disorders: What works?* Delmar N.Y: The National GAINS Center.
Available: http://www.prainc.com/gains/publications/intervention.htm

Quadrant IV ask Force (2001). *Treating Co-Occuring Mental Health and Addictive Disorders in New York State: A Comprehensive View.* New York, NY: New York State Office of Mental Health and New York State Office of Alcohol and Substance Abuse Services.

Raybon, K. (1997). *State Attorney Perspective.* Broward County Mental Health Court Status Report, 1(1). Ft. Lauderdale, FL: Broward County Public Defender. (Author is Assistant State Attorney Supervisor).
Available: http://www.browarddefender.com/mhealth/volume_1_mental_health.htm#Vol I, No. 1

Ridgely, M.S., Borum, R., Petrila, J. (2000). *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States.* Santa Monica, CA: RAND. RAND Health & RAND Institute for Civil Justice.

Rosenberg, L. (2001). *Report of the Psychiatric Assertive Identification and Response (PAIR) Mental Health Diversion Program for County Year 2000.* Indianapolis, IN: Marion County Superior Court.

Saler, S. (2001). Interview with Susan Saler, Director of Services, NAMI-Metro New York City, NY.

Santa Clara Bar Association (2001). *Time for a Change: The Mental Health Court of the County of Santa Clara* (Press Release of April 3, 2001) reprinted in Santa Clara Bar Association Legal Links. Santa Clara, CA: Superior Court of California, County of Santa Clara. Available:
http://www.sccba.org/whats_new.htm#MENTAL HEALTH COURT

Saucedo, B. (2001). Interview with Bernie Saucedo, Attorney with the Office of the Public Defender, Santa Clara, California who works in the Santa Clara Mental Health Court.

Schreibersdorf, L. (2001). Interview with Lisa Schreibersdorf, Executive Director, Brooklyn Defender Services, Brooklyn, NY.

Schrunk, M. (2001). Remarks of Michael Schrunk, District Attorney, Multnomah County, Portland, Oregon. *Drug Courts and Mental Illness.* Roundtable Discussion held on May 24, 2001. Washington, D.C.: Center for Court Innovation and Office of Justice Programs, U.S. Department of Justice.

Stoller, E. (2001). Interview with Ellen Stoller, Director of Staff Training and Consumer Affairs, FEGS, New York, NY

Swern, A. (2000). Interview with Anne Swern, Deputy District Attorney, District Attorney's Office, Kings County, NY.

Torrey, E.F. & Zdanowicz, M. (1998). *Why Deinstitutionalization Turned Deadly.* Wall Street Journal. August 4, 1998.
Available: http://www.psychlaws.org/GeneralResources/Articles.htm.

Center for Court Innovation

The winner of an Innovations in American Government Award from the Ford Foundation and Harvard's John F. Kennedy School of Government, the Center for Court Innovation is a unique public-private partnership that promotes new thinking about how courts can solve difficult problems like addiction, quality-of-life crime, domestic violence and child neglect. The Center functions as the New York State Unified Court System's independent research and development arm, creating demonstration projects that test new approaches to problems that have resisted conventional solutions. The Center's problem-solving courts include the nation's first community court (Midtown Community Court), as well as drug courts, domestic violence courts, youth courts, family treatment courts and others.

Nationally, the Center disseminates the lessons learned from its experiments in New York, helping courts across the country launch their own problem-solving innovations. The Center contributes to the national conversation about justice by convening roundtable conversations that bring together leading academics and practitioners and by contributing to policy and professional journals. The Center also provides hands-on technical assistance, advising court and criminal justice planners throughout the country about program and technology design.

For more information, call 212 397 3050 or e-mail info@courtinnovation.org.

Center for Court Innovation
520 Eighth Avenue, 18th Floor
New York, New York 10018
212 397 3050 Fax 212 397 0985
www.courtinnovation.org

CENTER
FOR
COURT
INNOVATION

A Public/Private Partnership with the
New York State Unified Court System

State of New York Unified Court System
23 Beaver Street
New York, New York 10004
212 428 2111 Fax 212 428 2188
www.courts.state.ny.us

State Justice Institute
1650 King Street, Suite 600
Alexandria, Virginia 22314
703 684 6100 Fax 703 684 7618
www.statejustice.org

SJI

Written by

Derek Denckla
Greg Berman

2001

This study was developed under grant number SJI-00-N-109 from the State Justice Institute. The points of view expressed are those of the authors and do not necessarily represent the official position or policies of the State Justice Institute, the New York State Unified Court System or the Center for Court Innovation.

About the Authors

Derek Denckla is a senior planner at the Center for Court Innovation. Greg Berman is deputy director of the Center for Court Innovation.

mental health courts satellite broadcast

nov 14 2002

Judicial Council of California

Administrative Office of the Courts

Executive Office Programs Division,
Center for Court Research, Innovation, and Planning

Center for Judicial Education and Research

For additional information:

Administrative Office of the Courts
455 Golden Gate Avenue
San Francisco, California 94102-3688
415-865-4200

mental health courts satellite broadcast

Contents

1 Broadcast Materials

Mental Health Courts Satellite Broadcast
Schedule
Thursday, November 14, 2002
12:15–2:45 p.m.

Introductory Video

Welcoming Remarks

Hon. Darrell W. Stevens
Judge of the Superior Court of Butte County
Chair, Collaborative Justice Courts Advisory Committee

Moderator
Michael P. Judge
Los Angeles County Public Defender

Introduction of In-Studio Panel

Hon. Becky Dugan
Judge of the Superior Court of Riverside County

Emily A. Keram, M.D.
University of California at San Francisco

Hon. Stephen V. Manley
Judge of the Superior Court of Santa Clara County

Hon. Patrick J. Morris
Judge of the Superior Court of San Bernardino County

Overview of Mental Illness

Emily A. Keram, M.D.
Assistant Clinical Professor of Psychiatry
Associate Director, Psychiatry and the Law Program
University of California at San Francisco

Local Activity 1

Panelists' Responses to Faxed Questions on Mental Illness

Introduction to Pharmacology

Jeff Gould, M.D.
Staff Psychiatrist
San Mateo County Jail

Local Activity 2

Panelists' Responses to Faxed Questions on Pharmacology—Includes Panel Discussion

Local Activity 3

Panelists Discuss Local Mobilization Plans

Closing Video

Mental Health Courts Satellite Broadcast
Introduction

Welcome to the Mental Health Courts Satellite Broadcast. This broadcast is a joint project of the Executive Office Programs Division's Center for Court Research, Innovation, and Planning and the Center for Judicial Education and Research—two divisions within the Administrative Office of the Courts. This broadcast may be the first in a series of educational programs on problem-solving courts.

Satellite broadcasts deliver information in real time to facilitate learning experiences for the viewer. The intent of this broadcast is to not only educate but to help you begin a planning process for the development of specialized procedures for mentally ill offenders or for starting a mental health court in your community. Real-time viewer interactivity is available through the faxing of questions to panel experts and through supplemental printed, electronic, and Web-based materials. During the local activity breaks, viewers will interact with each other to discuss presentations and to begin a mobilization plan.

Assigning a Facilitator and Recorder

The goal of the broadcast is to maximize learning through discussion and "action steps." The participants at each court site should designate a facilitator and a recorder for the three local activity breaks—two after the mental illness and pharmacology presentations and one for the development of a mobilization plan. Remember that you have the option of faxing questions to the panelists throughout the broadcast, using the form supplied with this booklet.

A few suggestions for the facilitator

- If time permits, welcome and introduce the participants.
- Stay focused and on track. Remain operationally neutral while utilizing your facilitator's prerogative, if required.

- Establish clear objectives for the broadcast. For your group, this broadcast may combine several of the following objectives: problem solving, decision making, planning, reporting, and evaluating.

- Review all agreements: who will do what by when?

- Set the date and time of your next meeting, if appropriate.

- Follow up on the action items determined by your group.

Local Activity 1

Mental Illness

Questions for Discussion

- How does your court identify defendants who have a mental illness?

- What problems do mentally ill defendants present to criminal courts?

- What problems do incarcerated mentally ill persons create for sheriffs' departments and other community agencies?

Local Activity 2
Pharmacology

Questions for Discussion

- What treatments and interventions are available to mentally ill defendants in your court?

- What methods of treatment do jails and prisons provide for mentally ill inmates?

Local Activity 3
Mental Health Court
Mobilization Plan

	Issues to Consider	
	Consensus building. Identify the key decision-makers. How will you get their support for a mental health court?	**Staffing.** Will new staff members be needed? Will current staff members need to be re-allocated? What kind of specialized training is needed for a mental health court staff?
Plans or strategies to address issues		
Departments or individuals involved		
Next steps		

	Issues to Consider	
	Structure. Will this be a separate, specialized court? What are the methods of identifying defendants with mental illness? What are the eligibility criteria, plea structure, monitoring, etc.?	**Funding.** Are additional funds needed? Where will they come from? How will they be spent?
Plans or strategies to address issues		
Departments or individuals involved		
Next steps		

	Issues to Consider	
	Coordination. What other agencies need to be involved? How will the mental health court coordinate with these agencies to provide services?	**Other issues.**
Plans or strategies to address issues		
Departments or individuals involved		
Next steps		

2 Organizing in Your Community

Success Factors for Change

Obstacles to Change

- Failure to create a strategic vision and plan.
- Failure to communicate the vision to key stakeholders.
- Failure to build commitment of key stakeholders.
- Failure to build capacity of staff to support change.
- Failure to conduct ongoing assessment.
- Failure to create short-term wins—not benchmarking.
- Failure to empower others to assume leadership roles.
- Failure to "pull up the anchor"—staying entrenched.

Consequences

- Mentally ill offenders are caught in the system.
- New strategies aren't implemented well.
- Staff is unclear about how the change supports offenders with mental illness.
- Staff becomes more resistant to change.
- Obstacles become ingrained in the culture.
- Key stakeholders lose trust in the leadership.

Strategies for Overcoming "Change Failure"

Communicate clearly

- Provide a clear picture of the change, with details about the future.
- Share information about a change in plans with key stakeholders to the greatest extent possible.
- Minimize surprise; give your staff advance warning about new requirements.
- Repeatedly demonstrate your own commitment to the change.
- Make standards and requirements clear; communicate exactly what is expected of your staff in the change.

Build support

- Allow time for staff members to become accustomed to the idea of change.
- Build a commitment to change.
- Allow room for participation in the planning of change.
- Leave some choices open within the overall decision to change.
- Create an environment that builds trust and fosters risk taking.
- Allow mistakes to become learning opportunities.

Develop capability

- Divide a big change into more manageable and familiar steps that are measurable. Let your staff take a small step first.
- Help your staff find the extra time and energy that change requires.
- Prepare your staff for the change through professional development.

- Offer positive reinforcement for competence; let your staff know you trust their ability to accomplish the change.
- Avoid creating obvious "losers" from the change.

Reward achievement

- Look for and reward pioneers, innovators, and early successes to serve as models.
- Allow expression of nostalgia and grief for the past—then create excitement about the future.
- Celebrate the small wins.

Collaboration—
Challenges and Strategies

Challenge: Collaboration takes time

Strategies

- Plan your meeting time well.
- Have an agenda and stick to it.
- Build commitment and action plans.
- Monitor your progress rigorously.
- Make sure staff members feel valued for spending time as part of the collaborative.

Challenge: Collaboration is messy

Strategies

- Make sure you are managing the situation closely.
- Give team members the freedom to explore new ideas and take risks.
- Follow the "rule of no surprises": Do not hold any meetings where people will hear something they are not prepared for.
- Break the "mess" into smaller components, which are more manageable and have identified short-term rewards.
- Build humor into your process, acknowledging that a mess exists but affirming that together you can work through the situation.

Challenge: Collaboration is tense

Strategies

- Stay focused on the vision.
- Acknowledge the tension in the group.
- Be prepared to discuss the tension and try to identify the root cause.
- Take a break, but don't quit.
- Give collaborative participants time to reflect.

Challenge: Getting requires giving

Strategies

- "What's in it for me?" Make sure you have identified some of the "wins" for each member of the collaborative.
- Compromise, but do not lose focus.
- Acknowledge the contributions of each member.
- Incorporate the group's ideas and suggestions into the overall plan.

Challenge: Collaboration is held together by relationships

Strategies

- Build team spirit through celebratory events.
- Organize for success by including those who will readily support the collaborative effort.
- Encourage relationship building by working in small groups.
- Take time to reflect on the working relationship and the fruits of everyone's efforts.

Project Management Process

Guiding Questions

Vision

- Where are we headed?
- What will our mental health court look like when we attain our goals?

Measurable objectives

- What positive outcome will be achieved?
- Who will benefit, and how?
- What will I measure to know we have achieved success?

Strategic plan and activities

- What, specifically, are we going to do to achieve the objective?
- Who does what—when, where, and how?
- How will the activity lead to the achievement of the objective?

Monitoring and assessing

- What concrete, observable indicators will we check to see whether we are making progress toward the desired outcome?
- What evidence will we collect to demonstrate that we are making progress?
- What tools will be used to collect and measure the evidence?
- Who will collect the data, and how often?
- How will the collected data shape our course of action and our vision for the future?

3 Models of Mental Health Courts

Common Elements in Mental Health Courts

- 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 with demonstrable mental illnesses to which their involvement in the criminal justice system can be attributed.
- 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 immediately after arrest 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 the participant's performance.
- The judge is the center of the treatment and supervision process.

Brooklyn Mental Health Court
Introduction

The Brooklyn Mental Health Court is a demonstration project that seeks to craft a meaningful response to the problems posed by defendants with mental illness in the criminal justice system. Addressing both the treatment needs of defendants with mental illness and the public safety concerns of the community, the Brooklyn Mental Health Court will link defendants with serious and persistent mental illnesses (such as schizophrenia and bipolar disorder) who would ordinarily be jail- or prison-bound to long-term treatment as an alternative to incarceration. The goals of the Brooklyn Mental Health Court, which will operate out of a dedicated courtroom in Kings County Supreme Court, are to:

- Improve the court system's ability to identify, assess, and evaluate mentally ill offenders;
- Provide judges, prosecutors, and defense attorneys with better information so they can make more informed decisions about how to balance the individual treatment needs of offenders with the need to preserve public safety;
- Use the authority of the court to link mentally ill offenders to appropriate mental health treatment and motivate them to engage in treatment;
- Reduce recidivism among mentally ill offenders; and
- Enhance effectiveness and efficiency by facilitating coordination between the criminal justice system and the mental health system and improving the accountability of mental health and social service providers.

To achieve these goals, the court will adapt several operating principles that have proven successful at existing problem-solving courts, such as the Brooklyn Treatment Court, the Brooklyn Domestic Violence Court, the Red Hook Community Justice Center, and others:

- **Screening and assessment.** The court's clinical team will perform detailed psychosocial assessments of defendants and craft individualized treatment plans that match defendants to appropriate mental health, housing, and other social services.

- **Judicial monitoring.** Each defendant will be required to return to court regularly to meet with case managers and appear before the judge to report on his or her progress in treatment. This will keep the judge engaged with the defendant for the life of the case and emphasize for the defendant the seriousness of the process.

- **Accountability.** The court will use an array of graduated rewards and sanctions to respond to compliance or noncompliance with treatment. Regular monitoring of progress in treatment will also hold service providers accountable to the judge.

- **Coordinated services.** The Mental Health Court will work with a broad network of government and not-for-profit service providers to address interrelated problems that defendants face, including substance abuse, homelessness, joblessness, and serious health problems.

The Brooklyn Mental Health Court is being developed as a joint project of the New York State Office of Mental Health; the New York State Unified Court System; and the Unified Court System's research and development arm, the Center for Court Innovation. Other government and nonprofit partners involved in planning the Mental Health Court include the Kings County District Attorney's Office, The Legal Aid Society, the Brooklyn Defenders Service, the New York City Department of Mental Health, and numerous representatives of the mental health treatment community. The New York Community Trust, the United Hospital Fund, and the Ittleson Foundation have also provided support for this project.

Development of the Brooklyn Mental Health Court

Goals

- Improve the court system's ability to identify, assess, and evaluate offenders with mental illness
- Use the authority of the court:
  - >To link offenders with mental illness to appropriate mental health treatment and supports
  - >To ensure that participants receive high-quality community-based services
  - >To engage participants in treatment
  - >To hold participants accountable for their actions
- Create effective linkages between the criminal justice system and the mental health system
- Improve public safety by reducing the recidivism of offenders with mental illness
- Develop new community-based strategies for services for offenders with mental illness

Planning and Implementation Issues

Planning partners

- Core members: court system, prosecutor, defense bar, corrections, public mental health and substance abuse agencies, mental health and substance abuse treatment providers, other service providers (housing, case management, education, employment, etc.), probation

Eligibility

- Criminal justice criteria: current charges, prior convictions, exclusions
  - >Felony vs. misdemeanor

> Include or exclude violent offenses

- Clinical criteria: diagnosis, risk assessment, functioning level

Identification and screening of cases

- Referral sources and procedures—identify all possible points of entry:

  > Referrals from judges, defense attorneys, prosecutor

  > Defendants whose competence to stand trial has been put at issue

  > Referrals from jail, police, emergency medical services

- Screening and assessment tools and procedures: How will clinical eligibility be determined?

Critical information and confidentiality

- Categories of required information

  > Information to be obtained during screening and assessment

  > Information provided by treatment and other service providers

- Confidentiality of information: federal and state laws; ethical standards for mental health and legal professionals

  > Identities of defendants referred for screening

  > Information generated during screening and assessment

  > Information about participants' progress in treatment

- Who will have access to which information: court clinical staff, judge, D.A., defense attorney, treatment/service providers, others

- Consents and waivers

Plea and court contract

- Plea: Is a guilty plea required in all cases?

- Opt-in

> Voluntary participation

> Length of opt-in period

- Length of treatment mandate
- Requirements for graduation
- Rewards for successful completion
- Back-end punishment for program failure

Treatment mandate

- Treatment plan and expectations
- Treatment/supervision categories (based on clinical assessment, criminal history, and other community ties and supports)
- Phases

Compliance and monitoring

- Frequency of appointments and court appearances
- Infractions
- Clinical responses and sanctions
- Rewards
- Right to refuse treatment or medication: procedures regarding exercise or waiver of right
- Urine testing protocols

Advisory committees

- Steering committee
- Treatment advisory board
- Consumer advisory group

Linkage agreements (including access to services and enhanced services)

- Case management agencies (short- and long-term)
- Treatment providers

- Housing providers
- Short-term crisis beds or immediate placement beds
- Medium-term transitional beds

Psychiatric services

- Scope of services: assessment and evaluations, medications, hospitalizations, consultation with Mental Health Court clinical team
- Agreements with providers

Agreements with government agencies

- Health & Hospitals Corporation Correctional Health Services: quality of treatment for candidates/participants while incarcerated; access to treatment information
- New York City Human Resource Administration (welfare benefits agency): processing of applications for Medicaid and subsidized housing
- New York State Office of Mental Health: assignment of case managers and wrap-around funds
- New York City Department of Health and Mental Hygiene: service utilization information; access to discharge planning and transitional case management services under LINK program
- Department of Corrections: access to defendants in pens at courthouse; production of defendants for assessment/evaluation
- New York State Office of Alcoholism and Substance Abuse Services: general support
- New York City Department of Probation: general support; agreement on protocols when someone on probation reoffends; use of interim probation supervision before sentencing

Miscellaneous supports

- Escorts
- Transportation
- Personal supplies for defendants

Research and evaluation

- Scope of evaluation; research design
- Who will perform

Technology

- Interim system
- Adaptation of justice center application
- Staff hires and selection and engagement of consultants

Funding

- Government sources
- Private foundations
- In-kind contributions

Training

- Judge and court staff (clerks, court officers, etc.): basics of mental illness and treatment
- Mental health court clinical team: basics of criminal justice and court system
- Planning group
    - > Basics of mental illness, treatment, and community resources
    - > Risk assessment
    - > Assisted outpatient treatment (Kendra's law)
    - > Community supervision

Brooklyn Mental Health Court
Program Participation Guidelines

Welcome to the Brooklyn Mental Health Court!

This handbook is designed to:

- Answer questions
- Address concerns
- Provide information about the Mental Health Court

As a participant in the Brooklyn Mental Health Court, you will be required to follow the instructions given in court by the judge and comply with the treatment plan developed for you by the Mental Health Court staff. This handbook will explain what is expected of you. It will also provide general program information.

Ask your Mental Health Court case manager or your defense attorney to explain anything in this handbook that you do not understand!

What is the Brooklyn Mental Health Court?

The Brooklyn Mental Health Court is a special part of the Kings County Supreme Court. It is a court-supervised program for those arrested in Brooklyn who have mental health issues, who need treatment and other services, and who choose to participate in the court program instead of having their cases proceed in the regular court process.

What do I have to do?

The Brooklyn Mental Health Court has prepared a treatment plan for you based on an assessment of your needs for mental health treatment, substance abuse or alcohol treatment, case management services, and housing. In order to participate in the court, you must agree to comply with this treatment plan and to sign a contract in court, which is an agreement between you and the judge. This contract explains what is expected of you and what will happen if you

do not follow the rules. The judge will also sign the contract, which is written specifically for you based on your current charges, your prior criminal history, and your treatment plan. Before you sign the contract, you will have an opportunity to review it with your defense attorney and have your questions answered.

How long will I be involved in the Mental Health Court?

The Brooklyn Mental Health Court is a four-phase program that lasts from 12 to 24 months. The amount of time you spend in the Mental Health Court is determined by your plea and by your individual progress in treatment. While you are participating in the Mental Health Court, the judge and your court case manager will monitor your participation and progress in treatment.

Discharge, termination, or voluntary withdrawal from the Mental Health Court will result in sentencing on the charges to which you pled at the time you signed your contract.

What's in it for me?

- **Services.** The staff of the Mental Health Court will help you get case management services, mental health treatment, and, if your treatment plans calls for it, substance abuse or alcohol treatment and supported housing.
- **Recognition of progress.** As you progress through the phases of your treatment plan, your achievements will be publicly recognized by the Mental Health Court judge and you will receive certificates to acknowledge your accomplishments.
- **Dismissal or reduction of your charges.** If you successfully complete your mandated treatment plan, your criminal charges will be either dismissed or reduced. Your Court contract will specify what will happen when you complete the Brooklyn Mental Health Court program.
- **Opportunity.** The Mental Health Court offers you a chance to avoid jail or prison on your current charges and to move forward in your life.

Remember that there are many people who make up the Brooklyn Mental Health Court team, and they all want to see you succeed. If you take advantage of the assistance offered, you can discover many ways to make a better life for yourself.

What are the rules of the Mental Health Court?

To remain in the Brooklyn Mental Health Court, you must follow these rules:

1. Appear in court as scheduled

You will be required to appear in front of the Mental Health Court judge on a regular basis. The judge will be given progress reports regarding your attendance and participation in your treatment program and the other components of your treatment plan. The judge will ask you about your progress and discuss any problems you may be having.

You will be required to meet with your Mental Health Court case manager each time you have a court appearance before the judge, and you may also be required to attend additional appointments with your case manager on days when you do not have a court appearance before the judge.

You must attend all scheduled court appearances and all scheduled appointments with your Mental Health Court case manager. Depending on your situation, you may have to come to court several times a month. As you make progress, the frequency of your court appearance and appointments will be reduced.

2. Follow your treatment plan

Your treatment plan will include some or all of the following components:

> Medications

> Regular appointments with a psychiatrist

> Participation in a mental health treatment program, such as a day treatment program

> Participation in substance abuse or alcohol treatment

> Intensive or supported case management services

> Housing with social services provided

Your treatment plan may include additional components as well, such as participation in educational or vocational programs or in self-help or support groups.

Specific rules about some treatment plan components are discussed below.

Medications. It is extremely important that you take the medications that your treating psychiatrist prescribes for you! The judge and staff of the Brooklyn Mental Health Court recognize that many medications have very unpleasant side effects, that many medications do not work equally well for all patients, and that it can be very difficult for a doctor and a patient to find the best combination of medications for that patient. But for most participants in the Mental Health Court, medications will be essential for managing symptoms of illness and living successfully in the community.

If you have complaints about the medications your treating psychiatrist has prescribed for you, you must tell your psychiatrist, who may be able to prescribe a different medication or additional medications to treat side effects. If you continue to have complaints about your medications and feel that your psychiatrist is not responding to your concerns, you should tell your Mental Health Court case manager, who will discuss your concerns with your psychiatrist and see whether any acceptable alternatives are available.

Refusal or repeated failure to take medications may result in sanctions being imposed by the Mental Health Court judge. Before any sanctions are imposed, you will have an opportunity to explain your reasons for not taking medications to your Mental Health Court case manager and the judge.

Mental health treatment program. Your treatment plan will require that you participate in a mental health treatment program. Your treatment provider will tell the Mental Health Court when you are attending, when you are absent, and how you are doing in your program. You must attend all scheduled treatment appointments and follow all the rules of your treatment program.

Substance abuse or alcohol treatment. All candidates for the Mental Health Court will be asked about their history of substance or alcohol abuse, and all participants in the Mental Health Court will be required to give urine samples when they first enter the Mental

Health Court program. Participants may be required to participate in drug or alcohol treatment and to submit regular urine samples, both at court and at their treatment program, if they:

> Have a history of substance or alcohol abuse,

> Have current charges or previous convictions involving drug-related offenses,

> Have positive results in a urine test, or

> While participating in the Mental Health Court program, show signs of possible drug use.

As with your mental health treatment, you must attend all scheduled substance abuse or alcohol treatment appointments and follow all the rules of your treatment program. Your substance abuse or alcohol treatment provider will tell the Mental Health Court how your attendance is and how well you are doing.

Case management services. Community-based intensive and supportive case managers help consumers to coordinate the services they need in the community. Your treatment plan may require you to accept the services of a community-based case manager, who will visit you at your home and at your treatment program and will assist you with getting a variety of services. Your community-based case manager will also provide information to the Mental Health Court on how well you are following your treatment plan and how you are doing in treatment.

Housing. Some participants in the Mental Health Court will be required to live in a particular type of housing or in a particular housing facility, which may offer an array of services for residents. If your treatment plan specifies the type of housing you must live in or a particular housing facility, you must live where specified and you must follow all of your housing provider's rules. Your housing provider will give information to the Mental Health Court about how well you are following your treatment plan.

Phases. Your treatment plan is divided into four phases:

Phase 1: Adjustment

Phase 2: Engagement in treatment

Phase 3: Progress in treatment

Phase 4: Preparation for graduation from Mental Health Court

You will receive a certificate upon completion of each phase.

3. Infractions, rewards, and sanctions

There are consequences—both good and bad—for your conduct while you are a participant in the Mental Health Court. If you comply with your treatment plan and live a crime-free life in the community, you will be acknowledged and rewarded in a number of different ways. Conversely, if you fail to comply with your treatment plan or commit any new offenses, you will be sanctioned. Ultimately, good participation and compliance with treatment will be rewarded by having your criminal charges reduced or dismissed, and failure in the program will result in serving the jail or prison sentence specified in your court contract.

Infractions. The following events will be treated as infractions of the Mental Health Court program:

> Missed treatment appointments

> Missed appointments with Mental Health Court case management staff

> Missed court appearances

> Failure or refusal to take medications

> Refusal to give urine sample

> Infractions of rules of treatment or rules of the housing provider, including verbal threat of violence

> Other noncompliance with treatment plan

> Abuse of drugs and/or alcohol

> Absconding from treatment program or supervised housing

> New criminal offenses

Clinical responses and sanctions. The Mental Health Court judge will respond to all infractions by imposing a sanction or requiring that you participate in a treatment-related activity. The judge may also mandate a change in your treatment plan. Examples of clinical responses and sanctions include the following:

> Reprimand

> Increased frequency of appointments with your Mental Health Court case manager

> Increased frequency of appearances before the Mental Health Court judge

> Penalty box (observing court activities from the jury box)

> Mandatory NA/AA/Double Trouble

> Mandatory group attendance (i.e., money management, anger management, family relations)

> Loss of privilege at your treatment or housing program

> Community service

> Unannounced visits by Mental Health Court staff

> Imposition or increase in frequency of urine testing

> Detox/drug rehab

> Transfer to a more restrictive housing or treatment program

> Hospitalization—voluntary

> Hospitalization—involuntary

> Bench warrant

> Jail sentence (1 to 28 days)

Rewards. In addition to advancing to the next phase and receiving a dismissal or reduction in charges upon graduation, demonstration of effort and progress in treatment will be acknowledged. Potential rewards include:

> Reduced frequency of appointments with your Mental Health Court case manager

> Reduced frequency of appearances before the Mental Health Court judge

> Transfer to a less restrictive housing or treatment program

> Suspension of urine testing requirements

> Certificates or other mementos of progress

> Phase advancement

> Participation in a court-sponsored social or cultural event

> Participation in a speakers' bureau

What else is expected of me?

The Brooklyn Mental Health Court expects you to:

- Treat others with respect.

You should respect the opinions and feelings of other participants in and staff of the Mental Health Court. Verbal or physical threats to

anyone will not be tolerated. Any inappropriate behavior will immediately be reported to the court and may result in a severe sanction or your termination from the program.

- Avoid all drug-related activity and abuse of alcohol.

You will not possess, sell, or use alcohol or illegal drugs. Any relapse by you involving drugs and/or alcohol must be reported to your court case manager immediately.

- Be law abiding.

You must refrain from any further violation of the law. Additional offenses may result in your being terminated from the Mental Health Court.

[Form A] Important Names and Numbers

Brooklyn Mental Health Court
360 Adams Street, Brooklyn, New York 11201

My attorney:
Name: _____
Telephone #: _____

My Mental Health Court case manager:
Name: _____
Telephone #: _____

My community-based case manager:
Name: _____
Telephone #: _____

My mental health treatment program:
Name: _____
Address: _____
Telephone #: _____

My substance abuse and/or alcohol treatment program:
Name: _____
Address: _____
Telephone #: _____

My housing program:
Name: _____
Address: _____
Telephone #: _____

[Form B] Treatment Plan

Name:_____

Date of treatment plan: _____

Goals

[Universal goals]

1. Achieve/maintain psychiatric stability
2. No new criminal offenses/arrests
3. Achieve/maintain sobriety

Objectives

[Universal objectives]

1. Client will take medication as prescribed by client's treating psychiatrist
2. Client will talk to Mental Health Court case manager before stopping or changing medications
3. Client will meet with community case manager at least once a week
4. Client will attend day treatment program ___ times per week
5. Client will meet with treating psychiatrist once a month
6. Client will reside in housing deemed appropriate by the Mental Health Court judge
7. Client will provide urine samples to Mental Health Court staff in accordance with Program Participation Agreement
8. Client will be on time for all scheduled court appearance with the presiding judge of the Mental Health Court
9. Client will be on time for all scheduled appointments with Mental Health Court clinical staff

10. Client will comply with all requirements of housing and/or treatment providers

[Individualized objectives]

1. Client will participate in substance abuse/alcohol treatment

Length of Mandated Treatment

____ months

Phases

Participation in treatment will be marked by four phases:

- Phase I: Adjustment
- Phase II: Engagement in treatment
- Phase III: Progress in treatment
- Phase IV: Continued progress in treatment and successful completion of the mandate

Compliance with treatment and positive reports from treatment and service providers will be marked by phase advancement.

Service Categories and Providers

Treatment program, including psychiatric care:

_____

Case management agency:

_____

Housing type and provider:

_____

Physician who developed treatment plan:

_____

Social worker who developed treatment plan:

_____

[Form C] Plea

Name: _____

Date: _____

Dkt/SCI/Ind. # _____

Defendant: By entering this plea of guilty and agreeing to participate in the Brooklyn Mental Health Court program, I understand and agree to the following:

1. I have reviewed the treatment plan prepared for me by the Brooklyn Mental Health Court and will comply with that plan.

2. I have reviewed the Brooklyn Mental Health Court Program Participation Guidelines and will comply with the rules and procedures set forth therein.

3. I will lead a law-abiding life until the successful completion of my Brooklyn Mental Health Court mandate.

4. I understand that failure to comply with the rules of the court, of my treatment program, or of my housing provider may result in sanctions by the court, which may include incarceration and/or a change in my treatment plan.

5. If I fail to complete my court mandate, I will receive a jail/prison sentence of _____.

6. Any new arrest may result in immediate termination from my housing program, my treatment program, and the Brooklyn Mental Health Court and the imposition of up to the maximum jail/prison sentence specified above.

_____

Brooklyn Mental Health Court Client

Judge: By accepting your plea of guilty and your promise to comply with your treatment plan, the Brooklyn Mental Health Court agrees to the following:

1. The Brooklyn Mental Health Court will help you get treatment, case management, and/or housing services as described in your treatment plan.

2. A Mental Health Court case manager will meet with you regularly to discuss your participation and progress in treatment.

3. The Brooklyn Mental Health Court will hold you accountable for your actions. Successful compliance with your treatment mandate will be rewarded and acknowledged through the different phases of treatment. Sanctions, including jail time, will be imposed for failure to comply with your treatment plan or with the court's rules and directions as outlined in the Brooklyn Mental Health Court Program Participation Guidelines.

4. The court will impose the agreed-upon jail/prison sentence if you fail to complete your treatment mandate.

5. If you successfully complete your treatment mandate, the Brooklyn Mental Health Court will:

   - Dismiss the charges against you and seal the record of those charges.

   - Reduce the charges to a misdemeanor with no further sentence imposed.

   - Reduce the charges to a misdemeanor with a sentence of probation for _____.

_____

Judge, Brooklyn Mental Health Court

Riverside County Mental Health Court

Hon. Becky L. Dugan

On January 4, 2001, Riverside County began a mental health court in the Hall of Justice in downtown Riverside. The purpose of the court is the proper treatment and placement of criminal defendants with mental health issues upon a plea of guilty, with the aims of reducing recidivism, relieving jail overcrowding, and treating the mentally ill more appropriately. The court also addresses issues of criminal incompetence and LPS (Lanterman-Petris-Short Act) conservatorships or probate conservatorships if those options pertain to a criminal matter.

As those who work in the criminal justice system know all too well, many defendants with mental health problems continue to cycle through the system after incarceration, committing new offenses. Up to 25 percent of the inmates in both county jails and state prisons have mental illnesses. Many of them also have severe substance abuse problems.

Although the mental health system attempts to treat these defendants in a variety of ways, the doctors and social workers in that system have no leverage with which to force a client to remain on prescribed medication and comply with a treatment program. The treatment programs are strictly voluntary. On the other side, the criminal system often ignores mental health issues when setting probation terms.

In a mental health court, the two systems work together to ensure that each defendant has the best possible opportunity to comply with his or her terms and stay with the medical treatment program. Mental health terms—such as medication, substance abuse placement, psychiatric visits, and counseling—are made mandatory probation terms. The defendant is made aware that failure to comply means further incarceration. All defendants are placed on formal probation, and the probation officer is aware of all the mental health terms and has received a copy of the defendant's mental health evaluation.

The Riverside County Mental Health Court operates out of two courtrooms, Departments 33 and 34. Department 33 is Domestic Violence Court, and Department 34 is Drug Court. These courts were chosen because of the correlation among domestic violence, drug abuse, and mental illness. Together, these courts are referred to as the C.A.F. (crimes affecting families) courts.

The Process

1. Any party can request that a criminal defendant be evaluated in Mental Health Court. It does not matter what the charge is (except in the cases of those who are statutorily ineligible for probation). It can be a misdemeanor or a felony.

2. If the case has an odd number, it goes to Department 33; if it has an even number, to Department 34. Once in that court, the defendant is referred to the forensic mental health team in the jail, and the case is set over for two weeks so that the assessment can be completed. The assessment includes any diagnosed mental illness the defendant has, the medications the defendant is on or should be on, a suggested treatment plan, a confirmed place for the defendant to live, and whether the defendant is willing to comply with the mental health terms suggested.

3. Upon consideration of the assessment, the parties can either enter an agreement—including up to one year of custody time and formal probation—or the defendant can plead to the court if the court is willing to accept the plea. If there is still doubt about the proper disposition of the case, a request for a pre-plea report is sent to the probation department, with the mental health assessment attached for the department's review. The case is continued for 30 days, for the consideration of the report.

4. If the defendant is rejected for treatment, he or she returns to the court from which the file originally came. Rejection can be caused by statutory ineligibility, excessive criminality, refusal to agree to mental health treatment, or physical volatility or explosiveness (danger to staff.)

   Generally, many defendants who have been denied participation in Mental Health Court remain in local custody while awaiting placement in drug treatment or dual diagnosis facilities such as Whiteside Manor or Cedar House; intensive, year-long day treat-

ment plans; Regional Center (for the developmentally disabled); housing; or probate or LPS conservatorships.

All of the usual probation terms are included along with the mental health terms. What increases the likelihood of success is the individual attention these defendants get upon release from jail. Their appointments are prearranged before release, and they are give a two-week supply of medication, a prescription, a doctor's appointment, and a ride to the treatment facility. They have a verified place to live or are connected to county homeless services. Instead of waiting out a six-week delay to see a probation officer, they are seen when they first report to probation after residential treatment.

Profile of the Mental Health Defendant

As of September 1, 2002, 511 defendants have been referred to Mental Health Court. Of those:

- 130 have been rejected and returned to the originating court or sentenced, for reasons ranging from inability to place to defendant's refusal;
- 50 are doing residential dual-diagnosis drug treatment before starting outpatient mental health services;
- 16 are developmentally disabled and in placement through Inland Regional Center;
- 17 are on probate or LPS conservatorship;
- 3 are on "diversion," with the case to be dismissed if defendant stays on meds and does not reoffend;
- 151 are in outpatient treatment;
- 40 remain trial-incompetent and are housed at Patton State Hospital; and
- The remainder are awaiting disposition of their cases.

There have been 79 defendants who have violated their probations, most for leaving the program, not taking medications, or "testing dirty." Seventeen have been sentenced to state prison; 15 of those committed a new offense while on probation.

Most defendants are schizophrenics, and many have borderline intelligence. The great majority are "dual diagnosis"—mentally ill substance abusers. Of all the defendants referred, 81 are misdemeanants having multiple cases; 430 are felons with crimes ranging from attempted murder and child molestation to drug possession. The great majority of cases involve assaults, usually on family members.

Funding

The Riverside County Mental Health Court exists because of the cooperation of the Mental Health, Sheriff's, and Probation Departments and the courts. Several grants have made it possible for the court to impose a network of treatment:

1. *California Board of Corrections' Mentally Ill Offender Crime Reduction (MIOCR) grant:* The jail has a five-year, $5 million grant that is in its last year. With that grant, the jail has created a fully staffed psychiatric unit, a day treatment program, and aggressive discharge planning that provides transportation and medication for mentally ill defendants leaving the jail.

2. *California Assembly Bill 2134 grant:* The Mental Health Department has a three-year multimillion-dollar grant, now in its second year, to provide housing and treatment to the homeless mentally ill. This grant supplies room and board, board and care, and augmented board and care to the homeless population, including mentally ill defendants leaving custody.

3. *Federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant:* The Mental Health Department has a $400,000-per-year, three-year grant, now in its second year, dedicated to providing services to the defendants in Mental Health Court. This grant increased the staff for evaluation, case management, and coordination of services.

4. *California Administrative Office of the Courts grant:* The court received a one-time $50,000 grant to hire a liaison, who tracks data, defendants, placements, provider concerns, etc.

All of these grants, working together, enable the complete treatment of the defendant, including housing, job training, education counseling, doctor visits, and medication. The obvious problem is that

they all expire. Additionally, with the federal and state deficits, there is a threat that the last year of funding for these grants will be cut.

If the concept of mental health courts is valued, then these courts must be budgeted consistently so that their staffs will not have to constantly chase after money and reconfigure programs under the threat of loss of funds.

Conclusion

The Riverside County Mental Health Court is successful in safeguarding the public and in returning functioning adults to the community. To date, with over 200 supervised defendants, we have a 35 percent probation violation rate, but less than 10 percent have committed new offenses. The great majority of clients do very well. We have defendants working, in college, completing their GEDs, and raising their children. Violations are dealt with immediately so that the defendant is redirected back into his or her program. Considering that most of our defendants have substantial criminal histories, this outcome is nothing short of amazing.

San Bernardino Mental Health Court Procedure

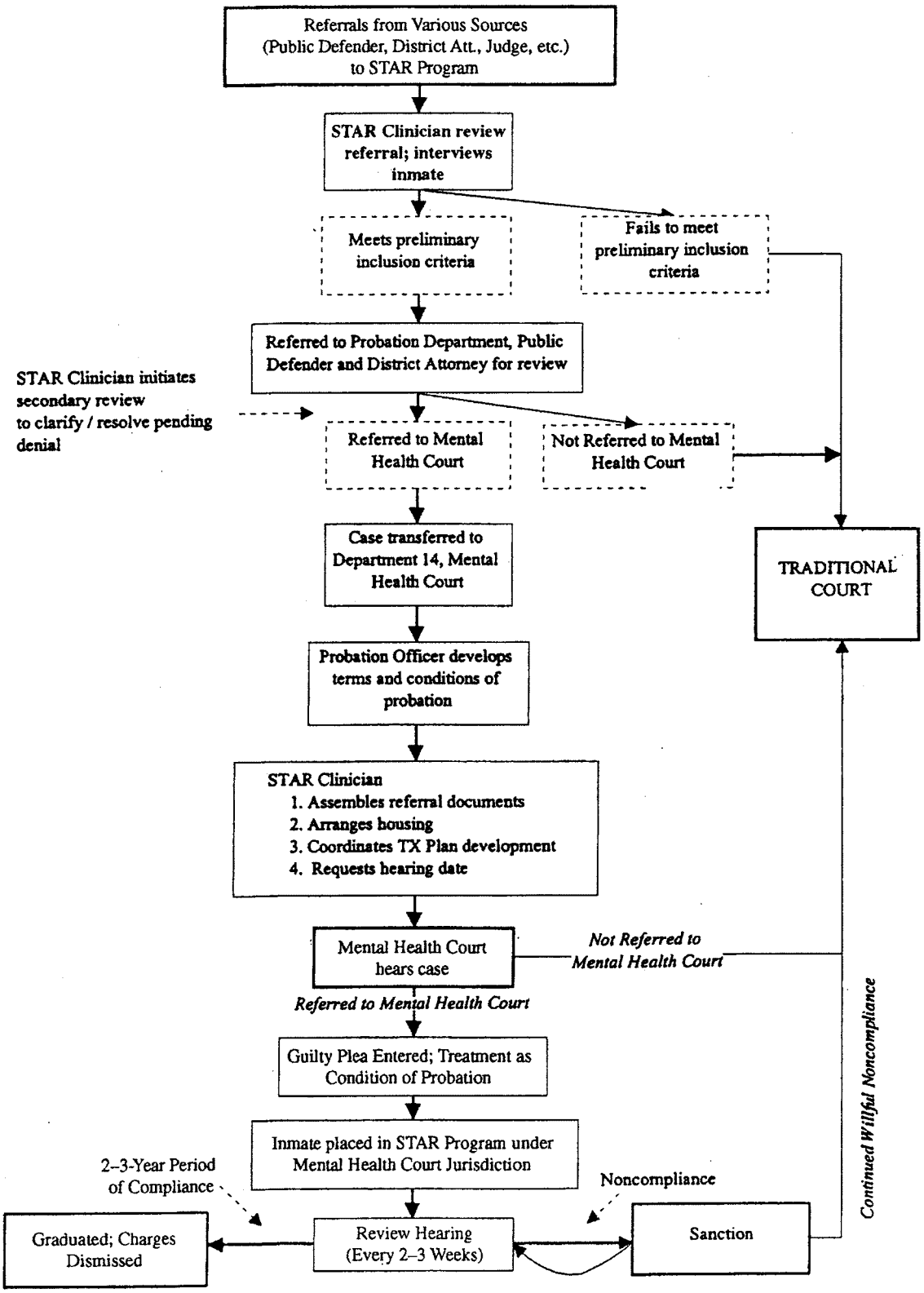
Most potential candidates are identified for the San Bernardino Mental Health Court while in detention in the West Valley Detention Center by jail mental health staff, subsequent to arraignment, which must occur within 48 hours of arrest. (For an overview of the San Bernardino Court procedure, see Figure 4.) The staff consists of two clinicians with PhDs in psychology, and one licensed clinical social worker. These clinicians also function as case managers, who provide supervision for the participants who are admitted into the program. At that time, they are interviewed and screened by a mental health clinician who explains the Mental Health Court program and confirms that the defendant has been diagnosed as having a history of an Axis I category of mental illness.[22] Candidates who appear eligible for the Mental Health Court sign a waiver permitting information to be conveyed to the court relating to the mental illness and indicate they wish to participate in the treatment process. Once candidates request admission to the program, screening information is passed on to the probation officer, the prosecutor and the public defender assigned Mental Health Court duties. The practice of considering only candidates who have requested admission to the treatment program helps ensure that resources are focused on persons who will enter the program and engage in treatment once admitted.

The defendant-candidate will make a first appearance in Mental Health Court about 2 or 3 weeks after arraignment. The period between referral (after arraignment) and first hearing in Mental Health Court is used to develop background information about the candidate's mental health and criminal history and to stabilize the individual on medication, if necessary. This is done so that participation is meaningful in the first hearing, and the candidate can comprehend the proceedings and make an informed acceptance of the program conditions. Because the Mental Health Court purposely targets persons who would be spending time in jail upon conviction, the criminal histories of participants are often significant, although violent prior offenses might preclude participation in the program.

[22] Axis I is primary mental heath diagnosis that is usually first diagnosed in childhood, including schizophrenia, mood or anxiety disorders, certain impulse control disorders, and major depression. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. Washington, DC: American Psychiatric Association, 1994.

Taken from U.S. Department of Justice, Bureau of Justice Assistance, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts*. NCJ 182504 Monograph, April 2000.

Figure 4. San Bernardino County Mental Health Court Referral Process



Admission to the Mental Health Court requires consensus of all members of the court team. If any member of the team, including the defender, the prosecutor, the mental health caseworker, or the judge objects, the defendant will not be accepted into the program. The probation officer performs an intensive interview of the defendant and reviews his prior criminal record. If the defendant is believed to be appropriate for the program, the probation officer will complete a pre-sentence investigation and prepare written terms and conditions that outline specific requirements that the defendant must adhere to for his treatment to be effective. The prosecutor also checks into the defendant's criminal history. Crimes of violence are checked to ascertain their actual circumstances and seriousness. True violent offenders are not eligible for the program. If a consensus is reached and the defendant is approved, the case is listed for Mental Health Court. Prior to the hearing, the prosecutor and the defense attorney engage in plea negotiations, so that they are prepared to present an agreement to the court at the defendant's first appearance, assuming the defendant is competent.

San Bernardino Mental Health Court hearings are held once a week on Wednesdays. The court team meets to discuss the case prior to the hearing, as well as any issues that should be addressed in court. As in the other courts, the first issue addressed in the San Bernardino court is competency. Felony defendants who are thought to be incompetent are returned to the jail and the court will order that they be assessed by a licensed psychologist or a psychiatrist for competency. A hearing on the issue will then be held. Defendants found to be incompetent are examined by a therapist from the county Department of Mental Health to determine appropriate placement. If hospitalization is deemed appropriate, the defendant may remain in the hospital while steps are taken to restore competency. In fact, that process may take up to 3 years, or the statutory maximum associated with the crime charged, whichever is less. In misdemeanor cases, the court will attempt to avoid hospitalization, which can cost approximately $350 per day. It is more likely that the misdemeanor defendant will be placed in a public or private treatment facility approved by the Department of Mental Health or in a community-based program, in an attempt to restore competency. The criminal proceedings are suspended pending the restoration of competency, up to a period not to exceed the statutory maximum.[23] Defendants who are unstable when they enter the jail are generally stabilized during the 2- to 3-week detention period while being considered for treatment court. Unstable defendants must consent to treatment while in jail in order to qualify for Mental Health Court, so that while they are housed in the psychiatric wing, they can be stabilized with therapy and medication. Most unstable defendants are ultimately denied program admission due to

their inability to cope with the highly structured nature of the treatment program.

Assuming that a defendant is competent, he or she enters a guilty plea as a condition of entry into the program. The defendant is placed on probation for a period of 2 years in misdemeanor cases or 3 years in felony cases, with participation in Mental Health Court treatment ordered as a condition of probation. Each participant must also sign an individualized treatment contract that specifies the mental health services to be provided, the frequency of those services (and the required attendance), and any other activities required of the participant. Upon successful completion of the program, the plea may be withdrawn, the charges against the defendant may be dismissed, and the participant may also petition the court to have the record expunged.

Once the treatment plan has been agreed to, most participants are released into an augmented board-and-care residential treatment facility. (There are presently 24 beds allotted to the Mental Health Court program.) The case managers transport the participant to the facility and then visits the client several times a week to ensure compliance, providing intensive supervision to assure that he is attending psychiatric counseling, stabilizing on medication and abiding by the terms of his probation. Upon request, the probation officer will intervene if the client becomes disruptive or uncontrollable at the facility, and will arrange for transport back to court for a hearing before the judge. Clients who fail to cooperate or comply with program standards, or who otherwise are in violation of probation, will have sanction recommendations made for them by the mental health clinicians.

A small number of participants may have the family support and stability to allow them to be supervised from their homes. The case manager will conduct home visits two times per week, to determine that the living conditions are appropriate, and that clients are not in possession of any illegal or inappropriate items that would impede their progress in treatment, and to perform urine analysis testing for illegal substances. When the conditions in the residence are found to be unsuitable, the officer will find new arrangements for the participant. When a participant is found to be in violation, the officer will recommend sanctions.

Status hearings are held every 3 to 4 weeks to track the level of compliance by the participant and to address any problems that may arise. Noncompliance sanctions range from an in-court reprimand from the judge and loss of privileges, to increased restrictiveness of placement that includes more meetings with the case manager and more meetings in the 12-step program, or community service, and even jail time (usually a weekend, or more for continued violations). The noncompliant participant will also be reevaluated to ascertain if changes in treatment and/or living arrangements are necessary to aid them in attending to program rules. Serious and

willful recurring violations may result in program termination and a return to traditional court. San Bernardino differs from the other early mental health courts in its close adaptation of the drug court model to the mental health court treatment process, including the use of jail as a sanction. If the defendant commits a new minor crime, he or she will probably be sanctioned with jail time, but may not be terminated from the program. An arrest for a new, more serious crime will result in termination. The benefits of compliance are privileges granted at the treatment facility.

The Treatment Approach in the San Bernardino Mental Health Court

The treatment process centers on the Mental Health Court judge and the court team. After the initial court session during which a participant formally enters the treatment program (STAR), participants attend court for status reviews as frequently as needed but average every 3 to 4 weeks. Prior to a court session, the treatment team reviews each case, including its problems and progress, with the judge who makes notes about the issues that need to be addressed. The team includes the judge, the prosecutor, the public defender, the probation officer, the case manager, the day treatment provider and sometimes the housing service manager. In the courtroom, the Mental Health Court resembles a drug court. The San Bernardino court sessions are very carefully organized and prepared. The judge discusses each participant's situation, problems and progress, and encourages, reprimands, sanctions or modifies the treatment plan. Participants are treated differently depending on their symptoms, illness or stage of treatment. For some, the judge's message is stern and a jail sanction may be applied. For others, the judge may be very supportive of small steps taken in a constructive direction. One of the reasons the Mental Health Court seems similar in style to the drug court is that most participants also suffer from serious substance abuse problems.

Nearly all of the participants in the San Bernardino Mental Health Court are initially placed in one of four augmented board-and-care facilities, the Redwood Guest Home, Fontana Board and Care, North End Board and Care and Linda Villa. These facilities receive funding that enables them to provide additional services tailored to the needs of the mentally ill offender. The facility supervisor must be at least a licensed clinician, who is qualified to dispense medications and provide individual and group treatment on site if necessary. These gateway facilities not only provide a temporary place to live, but also an array of supportive services to help the participant begin the treatment process. These include 24-hour supervision, group therapy, dispensation of client medications, assistance in helping with finances through the teaching of budgeting skills, assistance in spending money in appropriate ways, and transportation to the day treatment program that provides treatment services.

Because this type of care is expensive, the number of beds allotted to the treatment program is limited to 24 beds. As clients progress and become more stable, they are moved to one of the six regular licensed board-and-care facilities with which the court has contracted, and finally to basic room and board or other independent living situations. Only very stable clients are initially released into a regular, licensed board-and-care facility, where, in contrast to the augmented-care facilities supportive services, day treatment and dispensation of medications are not included in facility services (and the educational level required for staff is not as high). A small number of participants may be released directly to their family when family support is sufficient to facilitate the treatment process.

San Bernardino Mental Health Court participants generally receive day treatment from the Pegasus program which was run by Mental Health Systems, Inc., and tailored to fit the needs of the Mental Health Court. Pegasus began servicing the Mental Health Court in February 1999. Although Pegasus also takes referrals (of mainly individuals with some form of criminal justice involvement) from the other courts and agencies, the majority of its clients are participants in the Mental Health Court.

Defendants attend the day treatment program 5 days per week, from 8:30 a.m. until 1:00 p.m. The services provided include anger management, socialization skills, psychotherapy, medication therapy, and chemical dependency treatment, which includes a "12 + 5" step program specifically geared toward the dually diagnosed client, as well as drug testing. (Most San Bernardino Mental Health Court participants also have serious substance abuse and self-medication problems.) Pegasus also provides prevocational training, which is meant to prepare participants for educational or work programs. Participants also receive individual case management; regular conferences are held to discuss client needs and progress. The program will transport participants to scheduled doctor's appointments.

The day treatment component is intended to last for 1 year, at which point participants who have made satisfactory progress will be considered for vocational or educational training, or full- or part-time employment. Participants are referred to the state vocational rehabilitation department to receive training. Court (STAR) participants move from one level of care to another as a result of recommendations made by clinicians to the judge and the attorneys at periodic treatment meetings.

The mentally ill offenders grant is being used to fund two new programs: STAR LITE and SPAN. STAR LITE is an intermediate level treatment program designed to cover a similar mentally ill population to the one covered by STAR, but with *Less Intensive Treatment Episodes*. It offers services and case management for defendants who have less need for supervision; however, these participants will still be on supervised probation and be subject to specific medication and treatment requirements. They are also required to meet regularly with their case managers. Review hearings will

be held approximately every 3 months. SPAN, which stands for San Bernardino Partners for Aftercare Networking, was designed to provide case management and augmented services to in-custody defendants who had not been previously diagnosed, but rather were diagnosed with an Axis I illness in jail,[24] and who are not chronic offenders. Lower level services are offered to these defendants, and only regular board-and-care referrals are available for homeless participants. SPAN participants may not have probation terms and conditions relating to taking medications and treatment. There are no regularly scheduled review hearings required for them. Rather, they are tracked through brief meetings with a case manager and a counselor who will check in on them to assure that they are stable.

From the San Bernardino Mental Health Court's inception in January 1999 through November 16, 1999, 181 referrals were made to the Court. Of these, 106 were actually evaluated, resulting in the acceptance of 25 participants and the rejection of 81 candidates. The majority of the rejections came from the office of the District Attorney. Most of those accepted were placed in the Pegasus program, with the majority of these housed in augmented board-and-care facilities. Sixty percent of entering participants were remanded to jail at least once during their treatment period, with 40 percent remanded more than once. Six participants were terminated from the Mental Health Court program, half due to AWOL status, and half due to serious or persistent violation of terms and conditions. Nineteen participants were active in the program as of November 19, 1999.

Success and Failure in the San Bernardino Mental Health Court

The San Bernardino Mental Health Court accepts participants facing misdemeanor or felony charges who have serious mental health problems based on past history and current diagnosis of Axis I conditions. All participants plead guilty and are sentenced to probation for 2 or 3 years, depending on the offense. The STAR Program aims to place mentally ill offenders in appropriate services and to move them to different and less intensive levels of care when success is demonstrated in various stages. An overriding goal is to place participants in treatment programs and to link them with the appropriate services so that, when their participation is concluded, they continue to make use of these resources, which will assist them to function normally and not to return to the criminal justice system. A related goal is to maintain the mentally ill offenders in the community and to avoid their confinement in the local correctional facility. Participants who are successful move from intensive services to more independent and self-sufficient living situations, complete probation successfully

[24] Axis I is primary mental heath diagnosis that is usually first diagnosed in childhood, including schizophrenia, mood or anxiety disorders, certain impulse control disorders, and major depression. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. Washington, DC: American Psychiatric Association, 1994.

and have their pleas withdrawn, their charges dismissed, and their arrests expunged. The program's first graduation is expected to occur in June 2000, when it is anticipated that up to six participants will have successfully completed the program.

After entering the Mental Health Court, participants who cannot comply with the requirements of the treatment process are sanctioned, much as in Judge Morris' drug court. They often receive stern lectures and reprimands, sometimes resulting in sitting in the jury box during the court proceedings, possibly being placed in a more restrictive and structured treatment setting, and, occasionally, being returned to jail until further plans can be made. Court staff considers the use of the jail appropriate in a therapeutic not a punitive sense, helping some participants see the consequences of their actions and encouraging them to refocus their efforts. Unsuccessful participants may be terminated from the Mental Health Court, have probation revoked and face serving terms of confinement in jail or a state prison facility.

4 Resources

Resources

Government Agencies

Bureau of Justice Assistance Clearinghouse
P.O. Box 6000
Rockville, MD 20849-6000
800-688-4252
www.ncjrs.org/

Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts. NCJ 182504 Monograph, April 2000.

Center for Mental Health Services, SAMHSA
www.samhsa.gov/centers/cmhs/cmhs.html

Center for Substance Abuse Treatment, SAMHSA
www.samhsa.gov/centers/csat/csat.html

National Institute of Corrections/Jails Division
www.nicic.org/about/divisions/jails.htm

Nonprofit Advocacy Organizations

Bazelon Center for Mental Health Law
www.bazelon.org/

The Judge David L. Bazelon Center for Mental Health Law is a nonprofit legal advocacy organization based in Washington, D.C., and known until 1993 as the Mental Health Law Project. Its present name honors the federal appeals court judge whose landmark decisions made him a pioneer in the field of mental health law. The center's advocacy is based on the principle that every individual is entitled to choice and dignity.

Center for Problem Solving Courts
www.problemsolvingcourts.com/

The Center for Problem Solving Courts provides state-of-the-art information as well as the educational, training, and scholarly support necessary for problem-solving courts to succeed. Existing problem-solving courts include drug courts, DUI/drug courts, domestic violence courts, homeless courts, mental health courts, and re-entry courts.

National Alliance for the Mentally Ill
www.nami.org/

The National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots self-help, support, and advocacy organization of consumers, families, and friends of people with severe mental illnesses such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.

National GAINS Center
www.gainsctr.com/

The National GAINS Center for People With Co-Occurring Disorders in the Justice System was created in 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is funded by the Substance Abuse and Mental Health Services Administration's two centers—the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS).

National Mental Health Association
www.nmha.org/

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans—especially the 54 million individuals with mental disorders—through advocacy, education, research, and service.

Treatment Advocacy Center
psychlaws.org/

The Treatment Advocacy Center is a nonprofit organization working to eliminate barriers to the treatment of severe mental illness.

Urban Justice Center
www.urbanjustice.org/projects/

The Urban Justice Center was founded with two primary goals—to make legal services easily accessible to people living on the streets and in poverty, and to make social advocacy and law reform efforts directly responsive to the daily struggles of those individuals.

Mental Health Courts and Drug Courts

Grant Opportunities

Grant Program Name	Funding Agency	Program Purpose	Est. Due Date	Amount Available (per award)
FEDERAL				
Drug Court Implementation and Enhancement Grants	U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office *http://www.ojp.usdoj.gov/dcpo/*	DCPO funds the planning, implementation, and evaluation of drug courts.	January	$300,000 to $500,000
Grant to Provide Treatment Services for Family, Juvenile, and Adult Treatment Drug Courts	Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment *http://www.samhsa.gov/grants/grants.html*	Funding to expand substance abuse treatment services provided by family, juvenile, or adult treatment drug courts.	September	$300,000 to $400,000 per year for 2–3 years
Mental Health Courts (official title still TBD)	U.S. Department of Justice, Bureau of Justice Assistance *http://www.ojp.usdoj.gov/BJA/*	This program is new and still being formulated. Approximately $8 million was available in 2002 to fund mental health courts across the nation.	September	Approximately $500,000
Safe Schools/ Healthy Students	U.S. Department of Justice, Juvenile Justice and Delinquency Prevention; Department of Education; Health and Human Services *http://ojjdp.ncjrs.org/grants/current.html #011023*	Supports the implementation and enhancement of comprehensive communitywide strategies for creating safe and drug-free schools. School districts are to be the lead applicants, but some California courts have successfully partnered in these applications in the past.	June	$1 to $3 million per year

Mental Health Courts and Drug Courts
Grant Opportunities

Grant Program Name	Funding Agency	Program Purpose	Est. Due Date	Amount Available (per award)
STATE				
Juvenile Justice Crime Prevention Act	California Board of Corrections *http://www.bdcorr.ca.gov/cppd/cpa_2000/cpa_2000_page.htm*	$116.3 million has been budgeted for 2002–2003 programs. Funding eligibility under the act requires each county to submit to the BOC a comprehensive multiagency juvenile justice plan (CMJJP). Several California courts have received funding for drug and mental health courts programs in partnership with their counties.	Plans are usually submitted to the states by the counties in the early summer.	Varies depending on county size
Comprehensive Drug Court Implementation Act	California Legislature	$7 million has been passed this year for misdemeanants and felons with substance abuse.		
Drug Court Partnership Act	California Legislature	$7 million has been passed this year for felons with substance abuse.		

DIAGNOSTIC CATEGORIES TREATED WITH PSYCHIATRIC MEDICATIONS

Psychosis
Depression
Mania/bipolar disorder
Anxiety/panic
Insomnia
ADHD (attention deficit hyperactivity disorder)
Behavioral problems
Dementia
Chemical dependency

PSYCHOSIS

Psychosis is treated with antipsychotics. Psychosis occurs from:

- Schizophrenia
- Bipolar disorder
- Depression
- Drug or alcohol intoxication or withdrawal
- Medical conditions
- Dementia

RELAPSE RATES FOR SCHIZOPHRENIA

Taking antipsychotic medication:	30–50%
Not taking antispychotic medication:	70%

Typical Antipsychotic Medications

Haldol, Prolixin, Trilafon, Stelazine, Mellaril, Thorazine

SIDE EFFECTS **EPRs (extrapyramidal reactions)** include muscle tightening, tremors, a shuffling gait similar to that from Parkinson's disease, and an uncomfortable restless feeling in the body (akathisia). These side effects are treated with varying success with *Cogentin, Benadryl,* or *Artane* (antiparkinsonian drugs) and go away when the antipsychotic is stopped. EPRs are the primary reason patients stop their medicine.

Tardive dyskinesia is characterized by involuntary movement of part of the body (e.g., the mouth and tongue). It is caused by extended use of antipsychotics—which, unfortunately, many patients require. It often does not go away when the medication is stopped.

Atypical Antipsychotic Medications

Clozaril, Risperdal, Zyprexa, Seroquel, Geodon

These drugs cause considerably fewer EPR and tardive dyskinesia problems.

Clozaril (Clozapine) was the first of the atypical antipsychotic drugs and has been effective for people who are not helped by standard antipsychotics. It is the only one that has been proved effective for refractory psychosis.

SIDE EFFECTS One side effect is agranulocytic anemia, in which white cells or infection-fighting cells stop being produced—which can lead to fatal infections if not detected quickly. This is rare, but the white blood cell count must be checked each week. For this reason Clozaril is not used as a first choice but only after two other medicines have failed to work.

The remaining atypical antipsychotics have fewer side effects than Clozaril, and weekly blood draws are not necessary. None of them is as good as Clozaril for patients with refractory psychosis, however.

- *Risperidone (Risperdal)* can cause some EPR and is less sedating.
- *Olanzepine (Zyprexa)* is very effective but can cause weight gain, sedation, and diabetes.
- *Quetiapine (Seroquel)* is controversial as it can cause a bad side effect in the eyes. It is recommended that a special ophthalmology exam be performed before and periodically throughout treatment. It is not clear how often this is actually done in practice.
- *Ziprasidone (Geodon)* is the newest drug on the market. It does not cause weight gain but it is controversial if it causes problems with the beating rhythm of the heart.

DEPRESSION

Overall, approximately 70 percent of patients with depression respond to an adequate trial of antidepressants alone. The neurovegetative symptoms of depression (lack of energy, low motivation) often improve before the mood symptoms, which

usually don't improve for 2 to 4 weeks. This can be a potentially dangerous time for a patient prone to suicide because he or she experiences a return of energy and motivation while still experiencing feelings of worthlessness and guilt.

The general rule for an antidepressant trial is to start with one class of drug and try it for a minimum of 4 to 8 weeks before determining its effectiveness. All the classes discussed below have about equal effectiveness. When prescribing an antidepressant, it is very important to screen for bipolar (manic-depression) disorder. If a patient has a history of mania or is prone to it, the antidepressant may cause him or her to become manic very quickly even if he or she is depressed when the medicine is given.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Prozac, Zoloft, Paxil, Celexa

SSRIs increase the amount of serotonin in the brain, which is believed to affect mood. They are the most popular antidepressants as a first choice, since they work well with minimal side effects. Additionally, an overdose of an SSRI will not cause death. SSRIs have been researched extensively and are now used commonly and successfully for depression, anxiety, panic, obsessive-compulsive disorder, bulimia, and premenstrual dysphoric disorder (premenstrual syndrome, or PMS).

SIDE EFFECTS The main side effects of SSRIs occur at the outset of taking the medication and are usually transient. Side effects include headaches, upset stomach,diarrhea, weight gain, fatigue/apathy, and sweating. Some people experience chronic agitation, insomnia, or sexual problems. (Sexual problems are often not discussed by patients but are very common. Treatment strategies and medications are available to treat sexual side effects, but often with variable results.)

Luvox is an SSRI that has received FDA approval only for the treatment of obsessive-compulsive disorder but has been used for years in Europe for depression.

New Antidepressants

Wellbutrin, Serzone, Effexor, Remeron

Wellbutrin affects norepinephrine and dopamine levels in the brain and has mixed results.

SIDE EFFECTS There is an increased risk of seizures and insomnia, agitation is common, and the drug doesn't control anxiety or panic. However, it does not cause sexual dysfunction. It produces a lower incidence of mania.

Serzone affects serotonin in the brain. The drug has mixed results.

SIDE EFFECTS Serzone does not induce insomnia or create sexual side effects.

Effexor is like the SSRIs but also increases norepinephrine in the brain.

SIDE EFFECTS It has the same side effects as SSRIs and can also cause high blood pressure. New research claims that this is an effective medication for refractory depression (which does not get better with conventional treatments).

Remeron has a wide range of chemical effects, mainly through indirectly increasing norepinephrine.

SIDE EFFECTS It causes a lot of weight gain and sleepiness.

Tricyclics

Tricyclics (TCAs) affect other receptors in the brain related to mood, mainly norepinephrine, and were the most popular prior to SSRIs.

SIDE EFFECTS TCAs have worse side effects than SSRIs. Most commonly, they cause sleepiness and dry mouth. Similar sexual problems are evident, and an overdose can often be fatal. The best known TCAs are *Imipramine* and *Elavil.*

MAO Inhibitors

MAO Inhibitors Nardil (phenelzine) and Parnate (tranylcypromine) are extremely effective, but no one uses them anymore because they can be fatal when mixed with other medications or foods (e.g., wine and cheese).

MANIA / BIPOLAR DISORDER

Mood Stabilizers

Lithium, Depakote, Tegretol

Mood stabilizers prevent the fluctuating depression and mania seen in bipolar disorder.

SIDE EFFECTS These medications can be very dangerous due to potentially toxic side effects and drug interactions. Laboratory monitoring prior to and throughout therapy is required. All mood stabilizers cause significant fetal damage, so it is important to make sure the patient is not pregnant.

Lithium is the original mood stabilizing medication. It is an element on the periodic chart. It is effective 70 percent of the time for acute mania and 70 percent of the time for acute depression. It is being overtaken by Depakote because

Depakote works faster and lithium can "burn out" the thyroid and kidneys over the course of many years.

Depakote is as effective as lithium for mania and is more effective for rapid-cycling mania. It is only 30 percent effective for depression, however—the same as placebo. Depakote works faster than lithium and has fewer side effects (upset stomach and mild sedation are most common), but in very rare cases it can kill a patient's liver with no warning. This rare hepatic toxicity occurs predominantly in very young children.

Tegretol is slightly less effective than lithium and Depakote. It also has many drug interactions, which makes it difficult to give if patients are taking other medications. It has more cognitively related side effects (altered mental status), as well.

The above medications may be combined for refractory cases, but careful monitoring is essential.

Several new medications such as *Neurontin, Topomax,* and *Lomictal* are being studied for use in treating mania.

ANXIETY / PANIC

Benzodiazepines ("benzos")

Xanax, Valium, Ativan, Klonopin

These are calming drugs (similar to alcohol). They also cause sleepiness. They are very addictive, have a numbing effect on feelings similar to that of alcohol, and are recreationally abused for a high. With an acute panic attack, however, sometimes these medications are required.

Antidepressants *(SSRIs* and *tricyclics)* are helpful for anxiety or panic but may take weeks to take effect.

Buspar is an expensive medication and is useful only for low-level "neurotic anxiety."

Agoraphobia, panic, obsessive-compulsive disorder, social phobia, body dysmorphism, eating disorders, and post-traumatic stress disorder can be very broadly grouped together under generalized "anxiety disorder." SSRIs are commonly used for these disorders.

INSOMNIA

Benzodiazepines such as *Xanax, Valium, Ativan, Klonopin,* and *Restoril* are used but can cause addiction or abuse.

Chloral hydrate is also addictive.

Trazadone is nonaddictive. It is a preferred choice for women but can have dangerous side effects for men.

Benadryl and *Vistoril* are both antihistamines that are sedating enough for mild insomnia.

Ambien is a new and effective drug and has properties similar to those of benzodiazepines. It is also addictive and can cause rebound insomnia when discontinued.

DEMENTIA

There are no current medications that really help with dementia. Acetylcholine cholinesterase inhibitors, such as *Aricept*, produce some mild delay in cognitive decline.

Low-dose antipsychotics are often used to treat the behavior problems associated with end-stage dementia.

BEHAVIORAL PROBLEMS

Chronic behavioral problems can occur in Axis II (personality disorders), substance abuse disorders, and developmentally disabled/mentally retarded patients as well as psychotic patients. Axis II disorders are rarely helped with psychiatric medication. Mood stabilizers *(lithium, Depakote,* and *Neurontin)* are used to treat impulse control disorders.

Acute emergency (out-of-control, violent) patients are given high doses of antipsychotics and benzodiazepines.

ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER)

Children mainly get amphetamine medications such as *Ritalin, Cylert,* and *Dexedrine*. This helps them concentrate and decreases hyperactivity. Antidepressants and mild sedating medications are also used.

This diagnosis and treatment for adults is very actively debated.

CHEMICAL DEPENDENCY

Alcohol withdrawal and delirium tremors (DTs) are a very dangerous medical situation. Hundreds of people die from this every year, often in the hospital. Patients receive high doses of benzodiazepines when symptoms of withdrawal are present (tremor, increased blood pressure, increased heart rate, sweating, malaise, nausea, vomiting, anxiety, hallucinations) in order to prevent a seizure. Hallucinations are treated with an antipsychotic.

Folate and thiamine are also given to prevent medical conditions that often accompany alcoholism.