EFFECTIVE COURT RESPONSES TO PERSONS WITH MENTAL DISORDERS

UNDERSTANDING THE PROBLEM: MENTAL DISORDERS

Arrest rates for persons with mental disorders are 3 to 4 times higher than for persons without mental disorders. Arrest rates for persons with a mental disorder (MD) and a substance use disorder (SUD) are 13 to 14 times higher than for persons without either disorder.[1] Jails and prisons are now the primary institutions for housing persons with MD.[2] A number of factors contribute to the over-representation of persons with MD in the criminal justice system such as their likelihood of coming into contact with law enforcement because of their symptomatic public behaviors, SUD, and homelessness. Persons with MD tend to stay in jail longer, are less likely to secure pretrial release, less likely to be granted probation in lieu of incarceration, and more likely to be revoked on probation.[3] The lack of sufficient community-based treatment opportunities and the functional impairments that impede access to treatment, result in decompensation and public behaviors leading to re-arrests and/or probation revocation, and interfere with compliance with standard conditions of probation.[4] Persons with MD often also lack the financial and social supports that may provide a safety net to compensate for their functional impairments.[5] As summarized by the Council of State Governments:

> *Many individuals with mental illnesses who wind up in jails have committed low-level, nonviolent crimes, often because of their untreated mental illnesses or co-occurring substance use disorders. For these individuals, contact with the criminal justice system starts a cycle of arrest, incarceration, release, and re-arrest that poses nearly insurmountable challenges to recovering from their mental illnesses. Furthermore, many jail officials agree with community-based treatment providers that the jail environment is not the best treatment setting for individuals with mental illnesses—in fact, this environment can exacerbate mental illnesses in a manner that poses risks to the individuals, the general jail population, and jail staff.*[6]

Efforts to reduce recidivism among persons with MD have had only a "mixed or modest impact."[7] A primary reason for this is the lack of a causal relationship between crime and MD.[8] To succeed, interventions need to address both the criminogenic risk factors[9] common among persons with MD and simultaneously promote recovery to relieve the homelessness, symptomatic public behaviors, and other environmental factors that bring persons with MD into contact with the criminal justice system.[10]

The broadly-accepted Sequential Intercept Model, first developed by Policy Research Associates (PRA), is the framework for intervention used by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) criminal justice reform work. SAMSHA recognizes that state municipal courts are "by far, the primary case resolution forum in the United States" for individuals with mental and substance abuse disorders[11] and identifies five key potential points of intervention to address the needs of people with mental and substance use disorders in the criminal justice system: 1) law enforcement, 2) initial detention/first court appearance, 3) jails/courts, 4) reentry from detention into the community, and 5) community corrections, probation, and parole.[12]

KEY FINDINGS: ELEMENTS OF EFFECTIVE RESPONSES

As part of the development of a curriculum for judges, the National Center for State Courts reviewed the literature and interviewed researchers and practitioners regarding effective court responses to address persons with MD at three of SAMHSA's five key potential intercept points: pretrial, sentencing, and probation supervision.[13] This brief summarizes nine key conclusions that emerged from the review.

1. **Use validated pretrial risk assessment and mental/substance use disorder screening tools to assess pretrial risk.[14]**

   Pretrial detention of persons with MD should be minimized because detention is detrimental to the person, costly, and fails to improve outcomes.[15] Return to custody also should be a last resort.[16] Because MD is not itself a criminogenic risk factor, the risk of recidivism among persons with MD can most accurately be measured by standard risk and needs assessment tools measuring underlying criminogenic risk factors. The risk of failure to appear, however, may also be affected by MD-related functional impairments.[17] At pretrial, the court can use validated screening tools such as the Brief Jail Mental Health Screen and the Texas Christian University Drug Screen V screening instruments to screen for MD and SUD

issues. Housing and Medicaid screening and support are also important. Information collected for making pretrial decisions should be limited to use at pretrial.[18]

2. **Ensure pretrial diversion includes an effective mental health (MH) services component.[19]**

 43 states have pretrial diversion statutes, and 17 have specific diversion options for persons with MD.[20] As noted by Dr. Henry Steadman, however, the critical question is "divert to what?" Standing alone, diversion may reduce jail bed days, but it does not necessarily reduce recidivism; and, depending upon supervision costs, it may not reduce overall costs. To reduce recidivism, diversion must also include an effective services or treatment component.[21] The judge can be an influential champion of additional diversion resources, even for basic help such as connecting persons with peer support services or available human services offices which provide food, clothing, shelter, or mediation.

3. **Create effective MH diversion programs by adopting early screening and MH assessment, and making referrals to effective, low-demand, recovery-based services.[22]**

 SAMHSA has identified four key elements of successful misdemeanor MH diversion programs:[23]

 1) Early identification and screening to reduce length of incarceration to bare minimum required. Pretrial services agencies, defense counsel, court-based clinicians, or even judges and court staff can perform the identification and screening role;

 2) Clinical assessment is required to identify clinical eligibility and treatment needs; court-based or defense-based clinicians are a key tool;

 3) Identification of treatment resources, referral, and linkage/engagement. Peer specialists can often be very helpful in promoting treatment engagement; and

 4) Low demand, recovery–based engagement strategies that focus on the person's multiple needs and provide a "warm handoff" to low-demand and accessible services. The use of pretrial services, and/or clinical monitoring can be helpful.

 Examples of successful pretrial diversion programs are:[24]

 1) The Manhattan Transitional Case Management [later called START] program, which requires participation in 3 to 5 short conferences with social service providers upon release and offers subsequent voluntary services;

 2)The New York Misdemeanor Arraignment Project (MAP) that pairs a Legal Aid Society attorney and a licensed clinical social worker and "targets people with co-occurring disorders and others who are at risk of being arraigned and released without supportive services, or with a jail sentence, or being held in jail pending a court appearance."[25] It provides MH services, housing, and other support services both pre-arraignment and post-arraignment.[26]

 3) A Community Reintegration Program at an undisclosed site that diverts non-violent misdemeanor defendants with severe MD from jail within 24 hours to an outpatient MH services program with two social workers and a cognitive behavioral therapist who provides stability, maintains medications, and ensures court obligations are met.[27]

4. **Establish relationships with behavioral health treatment providers in the community; and establish engaging, firm, and fair relationships with persons with MD in the courtroom.**

 In 2017 The Council of State Governments Justice Center and American Psychiatric Association Foundation published a judicial bench card "Practical Considerations Related to Release and Sentencing for Defendants Who Have Behavioral Health Needs." The publication echoes many of the recommendations contained in this brief and emphasizes the two specific recommendations described above as well.[28]

5. **Focus supervision and treatment of persons with MD on the twin goals of recidivism reduction and recovery, and use criminogenic risk needs assessment and clinical psychosocial screening and assessment as key tools to identify and achieve supervision and treatment goals.**

 Resources on the effective supervision of persons with MD overlap significantly in their recommendations. One of the key points of agreement is the pursuit of two primary goals: "recidivism reduction" (focusing on effective probation supervision using RNR principles of risk, needs, and responsivity, and addressing the offender's criminogenic needs and responsivity factors) and "recovery" (focusing on effective mental health services addressing the functional impairments of a person with MD). Recidivism reduction services focus on public safety objectives, whereas mental health services focus on public health objectives. Traditionally, public safety and criminal risk have not been significant factors (except in cases of overt threats to self or others) in prioritizing MH treatment.[29] PRA has reviewed and recommended several specific substance abuse and mental disorder screening and assessment tools.[30]

6. **Increase the intensity of supervision and integration of probation and mental health services as criminal risk and functional impairment increase. Avoid threats and sanctions as they increase the risk of recidivism.[31]**

 "Integrated Services" refers to models where supervision services are integrated with mental

health services. Integrated services are especially recommended in the supervision of high risk/high need (significantly impaired) persons.[32] Three examples of integrated services programs are:

- Specialized caseloads average 45 persons per probation officer and are composed exclusively of persons with MD. Probation officers supervising these caseloads: receive 20 to 40 hours of specialized training each year; collaborate extensively with community service providers; and use a problem-solving approach, not threats, to address noncompliance issues.
- FACT (Forensic Assertive Community Treatment) provides intensive, supervised, team-based (often residential) treatment.[33]
- FICM (Forensic Intensive Case Management) is similar to FACT but is less resource-intensive because it is not team-based, and services are not available 24/7and are brokered rather than provided in-house.

The low risk/high need person, on the other hand, requires routine supervision and intensive MH case management services.

7. Use promising and evidence-based clinical practices: Assertive Community Treatment; illness self-management & recovery (i.e., the skills to monitor one's own well-being); supported employment and housing; medications; family psychoeducation; integration of families, peers, and pro-social individuals into treatment services; motivation to remain in the community; and trauma-informed care (TIC).[34]

The appropriate "level" of behavioral health care depends on the intensity of assessed clinical need. Levels of appropriate care are classified by the American Association of Community Psychiatrists (AACP) "Level of Care Utilization System (LOCUS) and American Society of Addiction Medicine (ASAM) criteria.[35]

TIC includes the use of screening & assessment tools,[36] and strength–based interventions promoting resilience; providing safety and peer support; recognition that healing happens through relationships; and avoiding secondary trauma to staff and patients.[37]

8. When available, refer persons with MD to well-run mental health courts which have been proven to reduce recidivism.

MH courts adapt the key elements of successful drug courts to the supervision and treatment of persons with MD. MH courts are especially effective when they include the following features: housing resources; recognition that mental illness, unlike substance abuse, is not a crime; the use of peers; and the use of procedural fairness.[38] MH courts can also improve their effectiveness by better addressing persons' criminogenic needs.[39]

MH courts are considered an evidence-based practice, i.e. virtually all meta-analyses of well-run MH courts, including felony MH courts, misdemeanor MH courts, and those courts serving both felons and misdemeanants, have found statistically significant reductions in recidivism and substantial cost savings, especially for completers.[40]

There is evidence, however, that it is difficult to sustain reductions in recidivism more than 2 to 4 years after program completion, and linking offenders after completion to on-going community-based treatment may be necessary to sustain long-term recidivism reduction.[41] Several studies also find that treatment of persons with co-occurring disorders (CODs) in MH courts is particularly challenging.[42]

9. Recognize that the supervision and treatment of persons with CODs is particularly challenging because the treatment modalities are different for each disorder.

A COD is defined as one DSM-5 mental disorder co-occurring with one DSM-5 substance use disorder (SUD).[43] In determining the existence of a COD, it is important to determine if mental health symptoms appeared before or after engaging in substance use and whether there is a causal relationship between the mental and substance use disorders.[44]

A hallmark of CODs is the highly interactive nature of mental and substance use disorders and how each disorder affects the symptoms, course, and treatment of the other disorder.[45] Those with MD are more likely to have SUD than those without MD; those with SUD are more likely to have MD than those without SUD. MD is a responsivity issue, while SUD is both a risk and responsivity issue. Motivation is not a good criterion for treatment because it prioritizes the inclusion of low risk offenders. Effective motivation enhancement interventions are available. Although integrated SUD and MD care is preferred for treatment of COD, few treatment providers offer such services.[46]

In addition to utilizing relevant risk/needs and COD screening and assessment tools, it is important to cross-train probation, MH and SUD agency personnel, and integrate MH, SUD, and cognitive behavioral therapy services. The effective supervision and treatment of persons with COD differs in significant ways from the supervision and treatment of persons with SUD. The supervision and treatment of persons with MD is less confrontational; more flexible on violations; recognizes relapse as a step in the recovery process; more dependent on motivation

enhancement; more likely to incorporate peer & family support groups; more likely to emphasize medication compliance; more likely to promote independent living skills; and more likely to provide supported housing, social skills training, benefits management, vocation rehabilitation, and primary health care.[47]

ABOUT THIS BRIEF

This brief was created with support from the John D. and Catherine T. MacArthur Foundation as part of the Safety and Justice Challenge, which seeks to reduce over-incarceration by changing the way America thinks about and uses jails. The Safety and Justice Challenge supports a network of competitively selected local jurisdictions committed to identifying and addressing local drivers of over-incarceration to improve the justice system as a whole. More information is available at www.SafetyandJusticeChallenge.org.

This brief was authored by Judge Roger K. Warren (Ret.) in collaboration with Dr. Pamela Casey and Ms. Sara Ward-Cassady as part of the National Center for State Courts' work on the Safety and Justice Challenge. The authors gratefully acknowledge Ms. Lisa Callahan, Policy Research Associates; Judge Jeffrey A. Kremers (Ret.), Milwaukee County Circuit Court; Dr. John Monahan, University of Virginia School of Law; and Mr. Travis Parker, Policy Research Associates, for their helpful information and suggestions in preparing this brief. For more information on the NCSC's work on the Safety and Justice Challenge, including additional briefs and a curriculum on evidence-based sentencing practices for judges hearing cases involving potential jail incarceration, see http://www.ncsc.org/Topics/Criminal/Courts-and-Jails/Safety-and-Justice-Challenge.aspx. Points of view or opinions expressed in the brief are those of the authors and do not necessarily represent the official position of the MacArthur Foundation or the National Center for State Courts.

ENDNOTES

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5. Ibid

6. See p. 3 in The Council of State Governments Justice Center (2009, June) at endnote 3. There is little association between mental disorder and violence. Less than 5% of violence towards others can be attributed to persons with mental illness. Psychosis may have a slight association with violence, but 80% of violent incidents committed by persons with psychosis are the result not of acute psychotic events but from a history of antisocial behaviors that often started in childhood and pre-dates the onset of psychosis. Substance use or abuse is a significant additional risk factor for such persons. Skeem, J., Kennealy, P., Monahan, J., Peterson, J., & Applebaum, P. (2016). Psychosis uncommonly and inconsistently precedes violence among high-risk individuals. Clinical Psychological Science, 4, 40-49. DOI 10.1177/2167702615575879. Also see Swanson, J. W., Van Dorn, R. A., Swartz, M. A., Smith, A., Elbogen, E. B., & Monahan, J. (2008). Alternative pathways to violence in persons with schizophrenia: The role of childhood antisocial behavior problems. Law and Human Behavior, 32, 228-240. DOI 10.1007/s10979-007-9095-7.

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8. The research indicates that mental illness is not in itself a risk factor for recidivism, but that those with mental illness are likely to have more of the criminogenic needs that are associated with criminality, including prior arrest history, anti-social factors, and substance abuse, than those without mental illness. Skeem, J. L., Winter, E., Kennealy, P. J., Louden, J. E., & Tatar, J. R. (2014). Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. Law and Human Behavior, 38(3), 212-224. DOI: 10.1037/lhb0000054. Also see Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. Law and Human Behavior, 35, 110-26. DOI 10.1007/s10979-010-9223-7.

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10. See Pope et al. (2016) at endnote 7.

11. See p. 12 in Substance Abuse and Mental Health Services Administration (2015a) at endnote 1.

12. Substance Abuse and Mental Health Services Administration. (2017, December 11). SAMHSA's efforts on criminal and juvenile justice issues [Webpage]. Retrieved from https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts. Policy Research Associates has recently introduced an Intercept "0", even earlier interventions including crisis lines and a crisis care continuum of services for persons with mental health and substance use disorders before they are placed under arrest. Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behavioral Sciences and the Law, 35, 380-395. DOI: 10.1002/bsl.2300. The Conference of Chief Justices and Conference of State Court Administrators have formally supported the Sequential Intercept Model and advocate a similar Intercept "0" and modifications to the civil justice system to allow court-ordered and supervised Assisted Outpatient Treatment (AOT) based on a lack of capacity standard in lieu of current reliance on in-patient treatment based on a risk of future harm standard. See Conference of State Court Administrators (2017) at endnote 2.

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16. Ibid. Also see Osher, F., D'Amora, D. A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). Adults with behavioral health needs under correctional supervision. New York, NY: Council of State Governments Justice Center. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral-Health-Framework-final.pdf.

17. See Fader-Towe & Osher (2015) at endnote 14.

18. Ibid

19. See Pope et al. (2016) at endnote 7.

20. See Fader-Towe & Osher (2015) at endnote 14

21. See Pope et al. (2016) at endnote 7.

22. See Substance Abuse and Mental Health Services Administration (2015a) at endnote 1

23. Ibid

24. Ibid

25. Ibid., p. 12

26. Ibid. Nearly 60% of the 223 offenders assessed (149) were diverted. Fifty percent of those were released on their own recognizance, and the remaining received conditional discharges or had charges dismissed. Follow-up data showed that the MAP cohort had a 24% reduction in arrest when compared to non-MAP diverted clients.

27. A pre-post design found that the program reduced re-arrests and jail days, especially for persons in the co-occurring disorder group. Alarid, L. F., Rubin, M. (2018). Misdemeanor arrestees with mental health needs: Diversion and outpatient services as a recidivism reduction strategy. International Journal of Offender Therapy and Comparative Criminology, 62, 575-590. DOI: 10.1177/0306624X16652892.

28. Judges and Psychiatrists Leadership Initiative. (2017). Practical considerations related to release and sentencing for defendants who have behavioral health needs: A judicial bench card. New York: Council for State Governments. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2017/11/11.10.17_JC_BenchCard.pdf.

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30. Recommended screening instruments for mental disorders include the Correctional Mental Health Screen (CMHS-F; CMHS-M), the Mental Health Screening Form-III (MHSF-III), or the Brief Jail Mental Health Screen. Recommended screening instruments for substance use disorders include the Texas Christian University Drug Screen V (TCUDS V), the Simple Screening Instrument (SSI), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), the Alcohol Use Disorders Identification Test (AUDIT), or the Simple Screening Instrument (SSI). Recommended instruments for assessment of substance use disorders and treatment matching are the TCUDS V, the TCU Client Evaluation of Self and Treatment (TCU CEST), the TCU Mental Trauma and PTSD Screen (TCU TRMA), the TCU Physical and Mental Health Status Screen (TCU HLTH), and the TCU Criminal Justice Comprehensive Intake (TCU CJ CI). A recommended assessment instrument for mental disorders is the Personality Assessment Inventory (PAI). See Substance Abuse and Mental Health Services Administration (2015b) at endnote 1

31. See Prins & Draper (2009) at endnote 3 and Lamberti (2016) at endnote 29.

32. Ibid., Prins & Draper, pp. 26-28

33. The Rochester FACT model operates much like a mental health court and serves high-risk, high-need persons with a team-based approach to case management services. A randomized control group study found that the program reduced recidivism, as well as jail and hospital stays. Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., . . . Caine, E. D. (2017). A randomized controlled trial of the Rochester forensic assertive community treatment model. Psychiatric Services, 68, 1016-1024. DOI: 10.1176/appi.ps.201600329.

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39. Some mental health court practitioners stress the importance of getting representatives of all the relevant community resources, including housing, employment, public benefits, and pharmacology, at the table. J. Kremers, personal communications, June 14, 2018.

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42. See Callahan & Wales (2013) at endnote 40.

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45. See Steadman et al. (2013) at endnote 1.

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47. See Steadman et al. (2013) at endnote 1.