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-REPORT TO THE OFFICE OF THE BUCKS COUNTY DISTRICT ATTORNEY-

Improving Criminal Justice Outcomes through Mental Health Court Development

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EXECUTIVE SUMMARY

Improving Criminal Justice Outcomes through Mental Health Court Development was developed by researchers with the Quattrone Center for the Fair Administration of Justice at the University of Pennsylvania Carey School of Law and prepared in response to Bucks County's intention to develop a mental health court. The report provides important background and a set of recommendations Bucks County might consider in designing and implementing a mental health court.

In sum, through the creation of a mental health court, Bucks County can improve both clinical and criminal justice outcomes for people living with mental illness. A mental health court would operate as a form of judicially supervised probation, diverting defendants from incarceration to the community, where they can access both treatment and social supports. As the report describes, mental health courts contribute to reductions in time offenders with mental illness spend in jail, improve public safety by reducing rates of re-offending, and lead to improvements in quality of life among participants. Furthermore, a mental health court would draw from existing resources in Bucks County to provide it with a new set of tools to tackle the challenges posed by people with mental illness who come into contact with the criminal justice system.

Recommendations span the following conceptual and practical considerations:

1. Target Population

- The mental health court should seek to assist people with serious psychiatric disorders (*e.g.,* major depression disorder, bipolar disorder, schizophrenia) as well as people with co-occurring mental health and substance abuse disorders
- Mental health court planners should consider including both misdemeanor and felony offenders if they have the capacity to do so

2. Admissions Process

- Multiple agencies may function as referral sources, each provided with a clear manual that will include criteria necessary for admission to the program
- "Filtering" parties, including the Public Defender and District Attorney, screen referrals
- Applications that pass these filters are vetted by mental health court team members
- Admissions decisions must be made within two weeks of the date of an individual's referral to the mental health court
- Candidates must provide informed consent to participate and must sign releases to facilitate transition and linkage to community-based services,

and key terms of participation are confirmed by the candidate's signature of a written contract

- An important consideration involves the County's approach to individuals who are deemed not competent to participate in the criminal courts. When possible, the use of the penal system to restore competency during a "pause" of the traditional criminal judicial process should be avoided, and mental health courts can be deployed as a tool to restore competency such that individuals can more rapidly engage in the judicial system in ways that promote their constitutional rights

3. Program Entry

- Mental health court staff should identify service needs through standardized screening instruments to design entry plan
- The staff should coordinate entry with criminal justice professionals and community-based providers in implementing plan
- The staff should provide prompt access to services, prioritizing service goals based on need and capability
- The staff should make sure to integrate victims and their loved ones in the mental health court decision-making

4. Treatment and Community Supports

- Services may include individual and group counseling, peer support, medication management and compliance, community support services, and case management
- The participant should be an active member of the treatment planning, but also must agree to the planning of the most clinically appropriate treatment
- Ideally, the mental health court should connect participants with community-based agencies that could help with the provision of housing and transportation supports

5. Supervision Conditions

- Participants must follow the conditions required by the Adult Probation and Parole Department and those of an individualized treatment plan designed to coordinate mental health treatment and services under the supervision of the criminal court
- Participants are required to make court appearances to monitor the status of their compliance and must court-imposed rules. Initially, participants will be required to come to court on a weekly basis. Court requirements will lessen with phase promotion
- These meetings are designed to review cases scheduled for the court docket the following day. The treatment team provides a clinical report, the probation officer provides a supervision report, and additional team members may provide other relevant information

6. Program Completion

- When completion is successful, charges may be expunged or lessened. If the person is unsuccessful at completing the program, the specific reason for the unsuccessful completion should be identified. If it is due to frequent decompensation, refusal to take medication, etc., then a person should be given other clinical treatment opportunities
- A strong, structured transition/discharge plan from the mental health court to less intense/structured treatment and supervision will be developed including appropriate referrals for housing options, treatment team, and other community supports services

7. Staff Team

- Judge: leads collaborative team and implements rewards and sanctions discussed by team
- District Attorney: filters all cases for legal eligibility and provides feedback to clients about potential consequences of noncompliance, as well as encouragement and praise
- Public Defender: filters cases for legal eligibility, represents participants in court proceedings, and consults with participant to find best legal and treatment solutions
- Jail Representative: organizes and generates list of referrals on a biweekly basis
- Human Services Department Representative: provides clinical oversight, assessment, treatment planning, linkage, and referral
  Probation Officer(s): supervises participants, serving a case management function, and participates in all team meetings to provide timely case review

1. Report Overview

This report addresses how Bucks County, Pennsylvania can improve the outcomes of those with serious mental illness (SMI) who come into contact with the criminal justice system through the development of a mental health court.

Like counties across the United States, Bucks County criminal justice agencies routinely process individuals with SMI. Many of these individuals endure a persistent struggle for stability in communities that provide a dearth of services and fail to use what services exist effectively. They cycle through different government agencies and institutions, such as emergency medical facilities, social welfare offices, and treatment centers without deriving lasting benefit—or fail to access services entirely. Contact with the criminal justice system often becomes a part of this trajectory when they struggle to meet their needs, decompensate in the community, and engage in criminal offending. Given both the social and economic costs associated with dealing with this population through the criminal justice system, as well as the existence of better alternatives, this status quo was untenable even before the groundswell of recent protests nationwide that passionately call for "defunding" police and reallocating government and community funds to social services, including prominently support for mental health services not linked to law enforcement or criminal justice agencies.

Bucks County has been aware of these issues and has taken the following steps to provide better alternatives:

- Joined the Council of State Government's *Stepping Up Initiative* with a focus on scaling up innovative and evidence-based practices geared at addressing mental illness in the criminal justice system;[1] and
- Gathered stakeholder bodies to coordinate efforts between the criminal justice and behavioral health systems such as the Bucks County Criminal Justice Advisory Board and the Forensic Executive Committee (who hosted a workshop to map out gaps, opportunities, and barriers in these two systems in 2010 and again in 2016).

Bucks County also developed and expanded many promising interventions at every stage of criminal justice processing. Examples of this include:

- Providing increased **Crisis Intervention Team (CIT) training** opportunities for law enforcement, aiming to ensure police are equipped to address mental illness when they confront it in the community;
- Developing court-based interventions with a problem-solving approach, including **Drug Court**, **Veteran's Diversion Program**, **District Court Diversion**, and a dedicated track within **Drug Court** targeting people with co-occurring mental illness and substance abuse disorders;

[1] For more information, visit https://stepuptogether.org/.

- Developing supportive efforts in the community in the forms of a **Forensic Response Team** and **Mobile Engagement Program** to which Magisterial District Judges can refer defendants when issues of mental illness, substance abuse, or co-occurring disorders are suspected;
- Addressing issues associated with mental illness in correctional facilities through screening and service provision, as well as monthly **Severe and Persistent Mental Illness Meetings** to coordinate service needs of inmates upon release, **Boundary-Spanner positions** that facilitate reentry and aftercare, and **National Alliance on Mental Illness peer support specialists** for inmates; and
- Increasing linkages to services in the community through programming such as **Forensic Assertive Community Treatment** and **Recovery Housing for co-occurring disorders**, as well as **specialized training for probation officers** to respond to the needs of probationers with mental illness.

These efforts demonstrate the County's significant commitment to tackling the problems associated with SMI in the criminal justice system. At the same time, the complex challenges in optimizing clinical and legal outcomes for individuals with SMI have developed over decades, and no single solution exists. Hence, despite the committed efforts of Bucks County stakeholders, it is important to continue to work towards identifying effective practices that will help reduce criminal justice contact of individuals with SMI.

A mental health court offers the County one such opportunity. A significant innovation in court practice, these courts operate as a form of judicially supervised probation, diverting defendants from incarceration to the community in ways that increase the likelihood that they can gain the support they need. As discussed below, mental health courts can contribute to reductions in time that offenders with mental illness spend in jail, improve public safety by reducing rates of re-offending, and lead to improvements in quality of life among participants (Berman and Feinblatt 2005; Higgins and Mackinem 2009). Moreover, mental health courts specifically can help the County build on its strengths and shore up gaps in meaningful ways. For example, a mental health court could:

- Identify individuals who currently do not meet eligibility criteria for other programming and yet are identified by criminal justice and/or behavioral health professionals as ideal candidates for supervised community diversion
- Build on efforts of the Severe and Persistent Mental Illness Meeting Group and Boundary-Spanner positions to ensure structured releases of these individuals (under court supervision);
- Employ the skills, expertise, and resources of a judge in innovative ways to motivate and monitor individuals who might otherwise be treatment noncompliant and decompensate in the community; and
- Increase collaboration between existing committed staff members from different criminal justice and behavioral health agencies in coordinating

service provision and supervision for those who could significantly benefit from these efforts but are currently falling through the cracks of these systems.

In other words, a mental health court would draw upon many existing resources to provide the County with a new set of tools to tackle the challenges posed by SMI individuals who come into contact with the criminal justice system.

Mental health courts are relatively new and vary considerably in form. As such, questions remain about the most effective ways to design a mental health court to produce the best possible outcomes. Moreover, how mental health courts are designed ultimately depends on local resources.

To understand how Bucks County can design and implement an effective mental health court, it is necessary to consider what we know to date about issues related to mental health court design and implementation that could be sustainable in Bucks County. Moreover, it is critical to recognize that while Bucks County can draw upon existing resources, a mental health court will ultimately be more effective the degree to which it can provide its participants with appropriate resources in the community (as detailed in this report), which will inevitably require funding.

This report proceeds in two parts. First, it begins with background information for those less familiar with the mental health court model and interventions for those with SMI in the criminal justice system.

Second, it examines different aspects and operations of the mental health court model, drawing on empirical research when and where possible to demonstrate how mental health courts can work. Given that research on mental health courts is still developing, research on related interventions—particularly drug courts—is also used to help elucidate different possibilities for design.

Ultimately, this report demonstrates that a well-designed mental health court can play an important role in helping Bucks County improve its responses to individuals with SMI in the criminal justice system, building on its strong foundation of collaboration between the criminal justice and behavioral health systems.

2. Mental Health Courts

2.1. Brief History

The last few decades have seen unprecedented levels of imprisonment and supervision in the United States. As of 2016, jails and prisons nationwide housed around 2.1 million adult inmates (Kaeble and Cowhig 2018). An additional 4.6 million adults were either under probation or parole (Kaeble and Cowhig 2018). An additional 60,000 youths were under detention in juvenile correctional facilities (Barnert et al. 2015). With more than 6.7 million people supervised in some way by the criminal justice system, the United States has the highest per capita prison population in the world (Walmsley 2018).

In response to this trend, criminal justice professionals, policymakers, and advocates increasingly are seeking ways to stem the tide. One group of interventions that has been developed within the judicial system in an effort to reduce the social and economic costs associated with mass incarceration and supervision has been the creation of "problem-solving courts," including mental health courts.

Problem-solving courts represent a significant innovation in criminal justice practice (Berman and Feinblatt 2005; Higgins and Mackinem 2009). They developed in criminal courts, but they differ significantly from them. Mental health courts are not traditional spaces for adjudicating cases. Rather, they can best be understood as a form of judicially supervised probation aimed at addressing the root causes associated with participating offenders' criminal behavior, thereby reducing the possibility of future reoffending. They link participants who have mental illness or addiction to community-based services (e.g., treatment and employment) tailored to their condition. The authority of the court is used to monitor and motivate engagement in services, helping participants reach service goals across time such as achieving greater mental stability and reducing substance use.

Starting as a grassroots initiative in different courtrooms across the country, problem-solving courts vary significantly in form and function. Different models include (but are not limited to) drug courts, domestic violence courts, community courts, veterans treatment courts, driving-under-the-influence courts, tribal wellness courts, and human trafficking courts (Huddleston, Hardin, and Fox 2011).

Problem-solving courts typically coalesce around a similar set of features. They create a specialty docket (ranging in size from, for example, 10 to 75 participants) focused around a specific issue (such as addiction or mental illness) and work to identify eligible defendants awaiting traditional prosecution. Requirements for participation vary, but candidates typically must plead guilty to a criminal charge as a condition of participation; the plea is held in abeyance pending program completion. If candidates voluntarily agree to participate, they begin engaging in services and submit to supervision by court staff, including appearing in court to review their progress with the judge.

Meanwhile, court staff, which include treatment and criminal justice professionals, regularly meet as a "treatment team" headed by a judge to develop, monitor, and adjust the treatment plans of participants on a case-by-case basis, allotting rewards and

sanctions to motivate behavior changes. If staff deem that participants have met requirements across their participation (which, for example, can last from one to two years), they can successfully "graduate," fulfilling their obligation to the criminal justice system. Those who fail to meet these requirements face increasing sanctions and eventually can be transitioned out of the program to conventional adjudication.

In short, problem-solving courts offer criminal justice participants an alternative to traditional criminal adjudication processes—most notably incarceration—to support a goal of treatment and community reintegration (Miller 2017).

2.2. Mental Health Courts: A Promising Response to a Complex Social Problem

Drug courts, which began to emerge In the United States In the 1980s, are the longest running and most prevalent type of problem-solving court. However, after these courts showed utility in reducing recidivism and improving treatment outcomes (Marlowe 2010; Rossman et al. 2011), many other types of problem-solving court programs have been created.

Among these, mental health courts began developing in the late 1990s in response to the unique issues mental illness posed within the criminal justice system (Redlich et al. 2006). Mental health courts derive in part from a theory of law and policy called *therapeutic jurisprudence*, which focuses on how the administration of justice impacts people's physical and psychological well-being (Winick 1997). Fundamentally, models based on therapeutic jurisprudence provide harm reduction interventions that seek to reform punitive systems and, instead, offer rehabilitative services to vulnerable individuals (Winick and Wexler 2001). It recognizes the importance of assessing the interaction between law and policymaking and their real-world health outcomes.

Beyond its theoretical foundations, therapeutic jurisprudence has emerged as an important agent of real-world change. As of 2009, there were more than 470 adult mental health courts across the country seeking to address the troubling overrepresentation of people with mental illness involved in the criminal justice system (Steadman et al. 2009). The need is substantially greater than these courts can address, however; according to the Bureau of Justice Statistics, more than half of the country's inmate population suffers from mental illness (James and Glaze 2006). Substance use among inmates is also a well-documented phenomenon: more than 50 percent of the inmate population has reported some type of substance use before their offense (Mumola and Karberg 2006). Research has found a high prevalence of mental health and substance abuse comorbidity among inmates in the United States (Sung, Mellow, and Mahoney 2010).

As a result, jails and prisons are routinely forced to provide both incarceration and mental health treatment, leading experts to conclude that the criminal justice system is the largest mental health care provider in the United States (Clark 2018). The causes behind this trend are complex, including changes in mental health, drug, and social policy, as well as the increasing reliance on incarceration to resolve social problems. However, regardless of the cause, it is clear that the current response to this population is designed for failure if the goal is to reduce the justice involvement of SMI individuals.

Most obviously, the criminal justice system is ill-equipped to manage this population. Judges and lawyers frequently do not have meaningful recourse to respond to SMI individuals' unique problems. Judges also routinely fail to consider the mental health history of defendants as a mitigating factor at the sentencing stage; in fact, many judges have interpreted mental illness as an aggravating factor leading to increased criminal sanctions (Perlin 2015).

This is both unfortunate and unwise, as incarceration can exacerbate symptoms of SMI and disrupt treatment regimens, and contribute to victimization and even suicide (Ditton 1999). A lack of access to appropriate treatment and other basic human services post-release can lead to decompensation in the community, resulting in further criminal justice contact (Baillargeon et al. 2010). Moreover, SMI individuals are more likely to be over-detained, denied probation or parole, and placed in isolation as criminal justice practitioners struggle to manage their issues with only the hammer of the justice system (Castellano and Leon 2012).

With their underlying clinical needs ignored by the courts, many among this SMI population cycle not only through the criminal justice system but a variety of other public agencies—including community mental health centers, hospitals, emergency medical facilities, substance abuse treatment programs, and social welfare agencies—while failing to derive lasting benefit because they do not follow through with service goals (Monahan et al. 2003). This disengagement is directly linked to a paucity of effective services and residence in communities without adequate supports. But it also reveals that poor adherence to scarce services is a problem contributing to the "revolving door" of SMI individuals through the criminal justice system and other public agencies (Monahan et al. 2003).

Mental health courts offer an innovative solution to these issues, providing a way to stop this revolving door in two ways. First, they break the link to the criminal justice system, diverting SMI individuals to programming that addresses the root causes of their problems. And second, they increase the linkages to programming through equipping participants with the motivation, skills, and supports to derive meaningful benefit from it across time

Already, there are signs that mental health courts can generate positive outcomes for institutions, communities, and participants. Specifically, researchers indicate that these courts can:

- Provide better tools to the court system for dealing with SMI defendants (Winick 2003)
- Reduce time SMI individuals spend in jail (Steadman et al. 2010)
- Reduce recidivism (Hiday and Ray 2010; Steadman et al. 2011; Dirks-Linhorst and Linhorst 2012)
- Improve treatment engagement (Boothroyd et al. 2003; Henrinckx et al. 2005; Steadman et al. 2011)
- Improve quality of life of SMI individuals (Cosden et al. 2003)
- Reduce costs for taxpayers through more effectively employing resources (Henrinckx et al. 2005)

Yet, given their grassroots antecedents, mental health courts vary significantly. Even if studies have shown positive outcomes, some others have shown that they can lead to limited and even worse outcomes than traditional incarceration (Honegger 2015). These mixed findings indicate that the outcomes mental health courts produce depend on how they are designed and the resources available in their local jurisdiction. To achieve the best possible outcomes, it is important to critically dissect what we know about the different aspects of court design and operation—the focus of the second part of this report—and how Bucks County is equipped to implement a court.

It is useful to first examine more closely the range of the problems mental health courts address.

2.3. How to Design and Meet Mental Health Court Goals that Improve Treatment *and* Criminal Justice Outcomes

Early interventions targeting the overrepresentation of SMI adults in the criminal justice system were united by a common philosophy: criminal justice involvement of this population could be reduced primarily by strengthening linkages to mental health treatment (Epperson et al. 2014). Mental health treatment plays a critical role in improving outcomes for SMI individuals. However, research both within the mental health and criminal justice domains reveals that the problems of this population require a more comprehensive response than simply providing mental health treatment alone (Keator et al. 2013).

Problems requiring intervention are complex

Untreated mental health symptoms can directly cause criminal behavior. For example, an individual may hear voices or experience delusions that motivate them to engage in theft or assault another person. Likewise, symptoms associated with bipolar disorder can intensify impulsivity and aggression, increasing the likelihood of criminal behavior. While popular beliefs about the relationship between violence and mental illness tend to be significantly exaggerated, research shows that persons with serious mental illness display somewhat higher rates of violent behavior than those without (Monahan et al. 2001), particularly due to psychosis or when comorbid with substance abuse (Douglas, Guy, and Hart 2009). In such cases, treating psychiatric symptoms will likely directly impact the propensity towards criminal behavior.

However, most individuals with mental illness engage in criminal behavior for the same reasons that people without mental illness do so (Andrews, Bonta, and Wormith 2006; Epperson et al. 2014). Further, even those whose behavior is motivated directly by symptoms commonly struggle with a host of factors that are known to increase risk of criminal behavior. As Epperson et al. (2014) outline, these include:

- *Individual-level factors* such as antisocial history and personality pattern, lack of success in education and employment, lack of positive leisure activities and prosocial relationships, and substance use; and

- *Structural-level factors* such as social and environmental disadvantage that generate greater exposure to racism, violence, trauma, drug use, and policing, as well as reduce educational and employment opportunities and access to resources that can mediate the more deleterious effects of community environments.

Mental illness certainly can exacerbate these risk factors, shaping the functioning of individuals in their families and communities. For example, it can create strain on social relationships, disrupt the development of educational and employment skills, contribute to status loss and discrimination, lead to self-medicating with illicit substances, and result in "downward drift" as SMI individuals are marginalized and move to increasingly disadvantaged neighborhoods (Faris and Dunham 1939; Silver et al. 2002). Still, for many individuals with criminal justice involvement, mental illness is not the *sole* cause of their criminal behavior.

- Mental health courts should be designed to employ a multidimensional approach to participants. Interventions should be comprehensive, including as deemed necessary: psychiatric and psychosocial treatment, substance use treatment, transportation support, housing services, employment and educational services, family services, and medical care. Further, interventions should be integrated where possible to combat any negative interactions existing among the multiple, simultaneously presenting problems.

Problems requiring intervention are heterogeneous

Not only do SMI individuals become involved in the criminal justice system due to complex and interacting factors, but also through diverse pathways that require tailored intervention. Hiday and Wales (2009) offer a typology for thinking through key pathways into the criminal justice system. They describe SMI individuals arrested for:

- *Nuisance behaviors* (e.g., loitering and disturbing the peace) because they spend a great deal of time in public spaces where they face greater public scrutiny and police surveillance.

- *Survival behaviors* (e.g., shoplifting or failure to pay for a taxi ride) generally caused by social background as well as mental illness.

- *Co-occurring substance use issues* that result in individuals engaging not just in nuisance and survival crimes, but also behavior connected to substance use (e.g., theft to support a habit).

- *Anti-social disorders* (often coupled with substance use) that drive aggressive, threatening, and/or violent behavior.

- *Severe symptoms such as delusions and hallucinations* that drive individuals to commit criminal offenses.

These categories demonstrate the diverse problems mental health courts may be tasked with addressing depending on their eligibility criteria and admissions process. For certain participants, medication adherence—and increasing the knowledge and skills associated with adherence—should remain the primary goal, whereas for other participants, housing and income needs must also be addressed in tandem to reduce future contact with the criminal justice system. Other participants will need special assistance understanding factors that contribute to their criminal behaviors (such as criminal thinking), developing coping skills to deal with trauma, and/or access to substance use treatment.

- Mental health courts should be designed to tailor programming to the varied needs of the targeted participant base. Mental health court practitioners should be equipped to apply different intervention modules to participants as deemed necessary. Community-based service providers will be critical in helping to ensure appropriate problem-specific programming is available.

Problems requiring intervention take time to address

As recognized in the mental health system, recovery is a long-term process. SMI individuals with co-occurring disorders in particular typically do not develop stability and functional improvements quickly, even in intensive treatment programs, unless they enter at advanced stages in the recovery process (Drake et al. 1998). Hence, effective treatment programs progress in stages that can take months to years in the community depending on the sub-population (Drake et al. 2004). Moreover, SMI individuals also frequently must be supported in meeting basic needs that can take time to achieve, including gaining access to identification cards, housing, income, and medical care. This may be particularly true for justice-involved individuals who are at higher risk of losing access to resources due to bouts of incarceration and the problems that contributed to incarceration, and who commonly experience delays in accessing needed services due to obstacles such as loss of identification cards.

As a result, mental health court participation will typically require multiple stages. For example, early on, securing identification cards and housing, participating in intensive substance use treatment, stabilizing on medications, and/or building relationships with case managers and other service providers will be critical. As participants achieve greater stability, they can focus on employment, education, and other forms of activity, as well as engage in psychosocial interventions to better develop coping skills. Importantly, participants will not necessarily progress in a linear fashion. Setbacks can emerge and lead to renewed attention on specific needs, such as the loss of housing or employment.

- Mental health courts should be designed to adapt the programming to the evolving needs of the participant base. Commonly, courts structure program phases associated with different benchmarks through which participants can progress, while recognizing that participants will vary in their capacity to progress through stages and setbacks can occur along the way.

3. Elements of Mental Health Court Design and Implementation

3.1. Target Population

The clinical and criminal justice criteria set forth below and currently being discussed by agencies in Bucks County are supported by available research and practice, so long as appropriate supports are provided through the court to meet the needs of this population.

Clinical criteria

Mental health courts typically handle serious psychiatric disorders like major depression disorder, bipolar disorder, and schizophrenia. A study found that participant outcomes are not associated with psychiatric diagnoses, supporting the need for such inclusive diagnosis criteria (Comartin et al. 2015). However, many among this population also have co-occurring substance use issues. Research has long documented a relationship between substance use and offending. Moreover, studies show that substance use plays a key role in recidivism among the SMI population (Bonta et al. 1998; Swartz and Lurigio 2007) and can impact recidivism rates among mental health court participants specifically (Dirks-Linhorst and Linhorst 2012). Still, recent studies demonstrate that mental health courts can positively impact the rates of recidivism of those with co-occurring substance abuse and dependence issues (Gallagher et al. 2018).

Although most mental health courts require participants to have serious psychiatric disorders, many also accept participants with co-occurring personality disorder diagnoses (Lurigio and Snowden 2009; Wolff, Fabrikant, and Belenko 2011). These disorders include antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders (American Psychiatric Association 2013). That said, the number of mental health courts that handle serious psychiatric disorders exclusively appear to outnumber those that accept personality disorders (Lurigio and Snowden 2009). One reason is that personality disorder diagnoses are more common than serious psychiatric disorder diagnoses. Mental health courts might not have the capacity to adequately serve individuals with personality disorders if another, more serious psychiatric diagnosis is not co-occurring (McNiel and Binder 2010).

Finally, functional level is an important eligibility criterion to consider that does not map neatly onto diagnostic labels. The National Institute of Mental Health defines serious mental illnesses are those that by definition "substantially interfere with or limit one or more major life activities." However, even those diagnosed with serious mental illnesses can vary in terms of how such conditions affect their daily functioning. Some candidates for mental health court will face significant functional disabilities that can impede their ability to make decisions about their care and thus fall in a subgroup of individuals commonly acknowledged as requiring more comprehensive state interventions (Monahan et al. 2003; Frank and Glied 2006).

Developmental disabilities, traumatic brain injuries, dementia, and other cognitive and behavioral impairments can also influence functioning. Individuals with significant functional disabilities will require greater supports and accommodations in a mental health court setting. Hence, mental health court planners should consider the degree to

which the court they are designing can meet these needs, relying on local mental health providers and administrators to provide guidance in determining the breadth of eligibility.

Criminal charge criteria

Mental health courts typically consider the severity of the charge in establishing eligibility criteria. However, in some cases, the line between misdemeanors and felonies can be difficult to draw. Defendants might have criminal histories involving both types of charges and whether defendants are charged with a misdemeanor or felony is partly a product of the discretion of criminal justice professionals. Further, in some cases, more serious charges are a product of the onset of symptoms that can be addressed through interventions such as a mental health court. Most importantly perhaps, mental health courts have documented success in targeting both types of offenses (Fisler 2005). As a result, mental health court planners should consider including both types of offenses among their eligibility criteria if they have the capacity to do so.

Mental health courts also typically consider the relationship between the candidate's charge and mental illness in eligibility criteria, although how this standard is applied varies widely in practice (BJA 2005). Critically, there is no recognized measure to assess the degree to which mental illness caused an alleged offense (BJA 2005) and the causal factors that drive criminal behavior even among SMI individuals can be very complex (Epperson et al. 2014). As a result, as mental health court planners receive referrals from stakeholders in the community and process them through the admissions process (explained in fuller detail below), they should provide space for flexibility in how court administrators evaluate the relationship between a candidate's mental illness and charge in their admissions decisions.

Finally, mental health courts also design eligibility criteria around violent offenses due to public safety concerns. Notably, as (BJA 2005) makes clear, some charges involving violence may be more complicated than they first appear. For example, in arrests where police officers are less familiar with techniques of de-escalation, a trespassing charge can quickly deteriorate into a shoving match. Similarly, domestic violence charges involving SMI individuals can result from minimal behaviors such as pushing, shoving, and agitation against family members and caretakers. While research in this domain is still in development, one study showed that recidivism outcomes of mental health court participants did not differ between violent and nonviolent offenders in one program and were lower among violent offenders in two programs (Anestis and Carbonell 2014). These initial findings indicate that mental health courts should evaluate candidates based on the facts and circumstances underlying their specific cases as opposed to excluding violent offenses outright.

Additional criminal justice criteria

Mental health court planners also must determine how they will handle candidates sentenced in other courtrooms. For example, some candidates are referred to mental health court after violating the terms of their probation. Moreover, some candidates accrue multiple charges across jurisdictions before being arrested, incarcerated, and referred to mental health court. While issues of public safety should factor into how

administrators evaluate such cases, these outcomes can be related to a person's mental health and thus should not necessarily be a cause for automatic exclusion. In fact, candidates with greater criminal justice involvement—sometimes referred to as "revolving door" defendants—might particularly benefit from participation in mental health court, which could serve to disrupt the cycle and generate the greatest savings of criminal justice resources.

Mental health court planners also must determine how they will handle candidates with a prior history of participation in the mental health court. Due to the complex problems of the participant base, it is not unusual for a select number of former participants—both those with records of mental health court success and failure—to accrue a new charge that could make them eligible for reentry into the mental health court program. The degree to which individuals can benefit from more than one dose of mental health court is not well-researched. However, given that mental health courts can provide definite benefits that might require significant time to fully realize, it is likely useful for courts to not unilaterally close the door on readmittance, providing opportunity for administrators and candidates to assess this on a case-by-case basis.

3.2. Admissions Process

The proposed admissions process is supported by available research and practice, with recommendations to adhere to proposed time limits and utilize a written contract to ensure candidates understand the terms of participation.

Proposed process:

a. Multiple agencies may function as referral sources, each provided with a clear manual that will include criteria necessary for admission to the program
b. "Filtering" parties, including the Public Defender and District Attorney, screen referrals
c. Applications that pass these filters are further vetted by mental health court team members
d. Admissions decisions must be made within two (2) weeks of the date of an individual's referral to the mental health court
e. Candidates must provide informed consent to participate and must sign releases to facilitate transition and linkage to community-based services, and key terms of participation are confirmed by the candidate's signature of a written contract

As the above procedures indicate, admission into mental health court is frequently based on a multi-stage, complex decision-making process that involves different parties representing diverse expertise and interests (Wolff et al. 2011; Luskin and Ray 2015). While mental health courts vary in their admissions process, (Wolff et al. 2011) identified common stages:

1. *Referral*: Multiple parties refer potential candidates to the court. These parties include, for example, service providers, law enforcement, judges, attorneys, probation and parole officers, jail personnel, family members, and candidates. Courts with greater system-wide support and that are more integrated with referral sources (such as jail personnel, pretrial service programs, and the public

defender's office) are more likely to have greater referral flow. Educating these parties about the mental health court and its admissions process can increase referral flow across time, as well as reduce the work burden associated with referrals that fail to meet the court's eligibility criteria.

2. *Filtering*: "Filtering" parties—including the Public Defender, the District Attorney, and mental health court coordinators—provide an initial screening to determine whether candidates are appropriate for the program (e.g., based on clinical and criminal charge criteria). Dedicating specific individuals to these roles can both increase consistency in how cases are filtered and provide clear communication pathways between the mental health court team and filtering parties to enhance the efficiency of the admissions process.

3. *Screening*: Court-affiliated staff engage in a more thorough screening process. This process can include: (a) gathering information from candidates (or about candidates through pre-existing information from the mental health and criminal justice systems) to more closely review clinical criteria, service needs, treatability, motivation, and potential risk factors and (b) providing information to candidates to educate them on the nuts and bolts of participation. Mental health courts typically require that candidates either have a recent mental health evaluation record available or are newly assessed as part of their screening. How courts design this process will depend on available resources, but it can be systematized through designating specific court staff as screening agents and relying on standardized screening instruments. Courts that use both mental health and addiction assessment tools in their screening process typically see improved outcomes (Bullard and Thrasher 2014).

4. *Reviewing*: In some jurisdictions, judges further require a first meeting with candidates in which the judge retains the right to veto participation in the court and candidates are provided a final opportunity to refuse participation (after the judge further explains the conditions of participation). This process can provide the opportunity to further make clear the nuts and bolts of court participation (including via direct observation of court processes prior to the participant's appearance with the judge). It also can provide a routine opportunity for defense attorneys to review the court contract with all incoming candidates (prior to the appearance with the judge).

Referral-to-admissions time limits

The admissions process to mental health court can be lengthy, resulting in candidates spending greater time in jail than they would have through traditional prosecution (Redlich et al. 2005). To reduce this likelihood, time limits for these stages should be established and followed. Time limits are especially important for misdemeanor cases, in which defendants could spend more time in jail awaiting admission and diversion into the community than they would have in traditional case processing (BJA 2005).

Informed consent and a written contract

Participation in the mental health court program must be voluntary. Or else, "singling out defendants with mental illnesses for separate and different treatment by the courts would violate the equal protection guarantee of the 14th Amendment and would likely violate the 6th Amendment right to a trial by jury and the prohibition against discrimination by a state program found in the Americans with Disabilities Act" (Bornstein and Seltzer 2004).

During the admissions process, therefore, candidates must fully understand the terms of participation and agree to participate (BJA 2005; Redlich 2005). Concretely, this involves establishing procedures to ensure that candidates are legally competent. This procedure needs to minimize the potential for individuals to be caught in a criminal justice/mental health "purgatory."

Situations can arise in which an individual experiences anosognosia, that is, they reject their psychiatric diagnosis or lack awareness of the true severity of their disorder. Anosognosia undermines capacity, and the person experiencing it will often not be competent to be adjudicated in the criminal justice system, or to voluntarily participate in the mental health court. In such cases, a pre-admission stage to the mental health court may offer a way of providing competency restoration treatment, after which the voluntariness of the individual's continued participation in the mental health court can be re-evaluated.

Given that competency decisions can be lengthy, courts should develop guidelines for the identification and expeditious resolution of competency concerns. That said, Stafford and Wygant (2005) have identified the following basic guidelines on how to establish competency:

- *Compare.* Prospective participants must have the ability to compare the duration and requirements of the mental health court with the sentence and probationary period associated with their offense.

- *Nature of Treatment.* Prospective participants must receive information about the nature of the treatment programs that the program will require, specifically whether the use of coercive treatment methods, such as involuntary medication, will be used. Prospective participants must also be aware of the types of mental health care and community-based services needed to graduate from the program.

- *Privacy.* Mental health court staff must explain to prospective participants whether the staff will need to have access to privileged information that would typically be applicable in traditional mental health care settings. For instance, the mental health court may need to gain access to personal health care data, which would typically raise issues under privacy laws (e.g., HIPAA) in non-clinical settings.

- *Disposition.* Prospective participants must know what effect participation will have on their criminal justice record. For instance, they must know whether completion of the program will result in the dismissal of the charge against them, and whether participation will count as time served.

Once competency is established, candidates then need to be educated about available legal options, including both entering mental health court *and* how their case is likely to be processed through the traditional court system. This process should be thorough, lengthy, and provide an exhaustive overview of mental health court requirements. This includes sharing potential legal rewards of court participation such as dismissal or reduction of charges and/or reductions in fines and fees (if they are provided through participation). However, it also involves explaining potential sanctions, in cases of non-compliance. After all, in some cases, candidates may face more lenient alternatives through traditional prosecution (i.e., less intensive probation requirements, less intensive specialized programming, or a short stint in jail). These least restrictive alternatives should be made readily apparent to prospective participants.

Despite a goal of promoting voluntary choice, it is important to emphasize that candidates are making decisions about participation in jail and/or while awaiting criminal justice processing. These contextual factors can lead candidates to gloss over aspects of mental health court participation that they later recognize do not work for them. To maximize the voluntariness of this process (as well as enroll participants who are motivated to engage in the program), court staff should clearly spell out the terms of participation with candidates. Critically, this would involve explicit discussion of potentially negative aspects of participation such as its intensity and duration (including the possibility for extension if it exists), the consequences of failing to abide by court terms, and the implications of a guilty plea (if required for participation). At every step of the conversation, staff should note whether the applicant understands the demands of the mental health court and is committed to fulfilling them.

To facilitate informed and voluntary choice, the Bureau of Justice Assistance (BJA) recommends that court staff provide candidates with a list of all court terms in a written, formal contract that is concrete, easy-to-read, and free of jargon (BJA 2005). Candidates should review the contract with defense attorneys before accepting entry into the court. Such a contract can serve as an important communication tool between the court program and candidates, ensuring key terms are uniformly reviewed with all candidates. It also can provide new participants with the opportunity to review court terms further independently of court-affiliated professionals, maximizing the likelihood that participants will enter the program understanding and recalling the terms by which they must abide.

Communicating with victims and their family about mental health diversion

Mental health diversion programs are fundamentally aimed at harm reduction and rehabilitation. As such, they function in a non-adversarial and non-retributive manner. Such a paradigm shift may elicit concern, skeptism, or opposition from victims and/or their families who may feel punishment and/or incarceration are more appropriate. From the standpoint of therapeutic jurisprudence, such forms of opposition are not only justifiable, but are also necessary factors to take into account throughout the diversion

process (Winick 2009). Indeed, mental health courts should not focus exclusively on the therapeutic and rehabilitation prospects of participants; they should look to balance these priorities with the "emotional well-being of the victim" as well (Winick 2009). Under this orientation, therefore, mental health court planners should seek to maximize input from victims and their loved ones as they screen prospective participants and shepherd them through the program.

One way to put this proposal into effect is by requiring the consent of the victim when a prospective mental health court participant was charged with a violent offense (e.g., assault) (Poythress et al. 2002). At least one mental health court—in Broward County, Florida—has used this approach (Poythress et al. 2002). A second approach is offering victims a voice in the diversion process, but not a veto (Winick 2009). Concretely, doing so could entail asking the victim to fill out an intake form at the beginning of the mental health court selection and screening process that would detail their perceptions about the offender's entitlement to a diversion program (Winick 2009). With this intake on hand, the mental health court team will benefit from a broader understanding of the offender's characteristics, while creating a pathway through which to integrate victims in the program's decision-making process.

In addition to inviting participation on the part of victims and their loved ones, victims should be provided psychosocial support and education about the disposition of the defendant and the rationale for offering the defendant the option of mental health court. In cases where victims express discomfort or objection to mental health diversion, it will be important to reiterate the harm reduction aims of the program, emphasizing the potential benefits to all parties.

Furthermore, more broadly, it will be critical victims rights advocates and other important community stakeholders be included in the process as the program is developed. The broader community should be educated about the aims, goals, and function of the program. We recommend a series workshops and town hall forums to describe the programs overall aims, procedures, and, importantly, the ethical underpinnings of mental health courts: therapeutic jurisprudence and of harm reduction.

3.3. Program Entry

The Bucks County's mental health court will need a program entry plan that involves both timely identification of service needs and linkages to services in the community.

Proposed process:

a. Mental health court staff should identify service needs through standardized screening instruments to design entry plan
b. The staff should coordinate entry with criminal justice professionals and community-based providers in implementing plan
c. The staff should prompt access to services, prioritizing service goals based on need and capability

Decisions to admit participants to the program should be promptly followed by implementing a structured plan for program entry. This plan should include

identification of service needs (which can be part of the admissions process as described above), coordinated release into the program, and timely access to needed services. As part of this process, court staff should recognize stage-based progression, prioritizing service goals based on participant need and capability.

1. *Identification of service needs and designing tailored plan*. As part of the screening process for eligibility, service needs (e.g., mental health care, substance abuse treatment, crisis intervention services, housing and employment resources) should be identified so that staff can create a tailored plan for program entry (Goldkamp and Irons-Guynn 2000; Boothroyd et al. 2005). Court participants may require an array of services and supports. For example, participants suffering from a combination of mental health and substance abuse disorders may not respond adequately to traditional treatment forms (SAHMSA 2012).

2. *Coordinated release*. Once service needs are identified and a tailored plan is established, court staff should work with relevant stakeholders including attorneys, judges, correctional staff, and community-based providers to ensure that the plan can be implemented effectively. Breakdowns in communication between any of these stakeholders can result in failure to appropriately link participants to the services they need upon program entry—for example, through an unplanned release from the jail—and, potentially, decompensation in the community. Mental health courts can avoid such outcomes through establishing open communication channels between stakeholders. Communication channels can be achieved through assigning a court staff member to serve the role of "boundary spanner" (Steadman 1992), a dedicated individual responsible for providing regular updates among key stakeholder bodies on the status of incoming program participants. Communication channels can also be formalized through data systems, where they exist, in which the participant's status is flagged as a special release.

3. *Timely access to services*. The effectiveness of prescribed plans will necessarily depend on the availability of services in the community (Grudzinskas et al. 2005). Service plans must match the community's capacity to deliver. As such, through prompt connection to mental health services, mental health court staff will need to foster continuity of care or jumpstart mental health treatment regimen. Doing so will require that those responsible for the intake and admissions process take note of the mental health care services that participants have received at or before the time of the offense. It will also require coordination between staff and community-based providers and agencies to ensure that room and resources are available for continued care and rehabilitation.

Importance of phasing participants into the program and its challenges

Program terms should reflect that participants needs will vary across the course of participation. The period of program entry should focus on fostering stability in the participant's life and helping participants adjust to the program.

Stability involves different components. Most obviously, participants will need help with treatment and management of their condition(s). A first set of requirements may

simply involve mandating connection with treatment services and appearing at court. This mandate can include substance use treatment for those who need it. (Some court programs additionally employ drug testing and prescription monitoring plans.)

Participants also frequently require a stable and safe place to live, as well as access to transportation. Without these foundational resources, participants will have difficulty meeting other court terms. The court program should draw insights from other indigent criminal justice programs (e.g., Bronx Defenders, Legal Aid Society of New York) that have successful track records in reintegrating defendants into their communities. For instance, the Bronx Defenders commonly uses a checklist system at the very outset of the criminal adjudication process to understand the needs of their clients, including employment, housing, immigration, student loans, and public benefits (Anderson, Buenaventura, and Heaton 2019). In the same way, the mental health court should identify participant needs early in the program process and help participants gain access to them. Many of these services require forms of government-issued identification, so the mental health court staff should assist participants in obtaining such identification.

Program entry also involves recognition that participants will need to learn the rules of the program, and that participants enter the program on a different footing. Some participants might have prior experience with correctional supervision, and even problem-solving courts, while others may have little to no experience with the criminal justice system. Similarly, participants will vary in terms of their experience with services, as well as their functioning. As such, participants might vary in how quickly they adjust to program guidelines.

In elaborating this plan, the mental health court should take particular note of whether one or many of the participants have a co-occurring substance abuse disorder (Hills 2000). Participants suffering from a combination of mental health and substance abuse disorders may not respond adequately to traditional treatment forms (SAHMSA 2012). These are participants also frequently require costly services (e.g., emergency rooms, inpatient treatment facilities, outreach services) to address their vulnerabilities (Grudzinskas et al. 2005).

This recommendation dovetails into another crucial aspect of early diversion: ensuring that participants have appropriate linkages with mental health and community service providers such that participants can readily engage in mental health treatment. Stated differently, the effectiveness of prescribed plans will necessarily depend on the availability of services in the community (Grudzinskas et al. 2005). In this way, many participants will require transportation support and housing placement to meet court requirements (Council of State Governments 2002). Participants must also, with the help of the mental health court team, ensure that they have in their possession specific resources before they begin the program, including pieces of identification, health insurance, and sufficient financial resources (Human Rights Watch 2003). Access to these resources will decrease, and hopefully eliminate, service delivery friction with community-based providers and agencies.

In addition to ensuring that participants have access to appropriate linkages with community support systems, mental health courts should coordinate with the law

enforcement community to ensure that its personnel has appropriate training and resources to intervene in crisis situations (Grudzinskas et al. 2005; Lamb, Weinberger, & DeCuir Jr 2014). This is because law enforcement officers are often responsible for the management of mental health crisis situations (Finn & Sullivan 1988). Research has shown, however, that these officers feel ill-equipped and at times even alienated when handling the task (Borum 2000). We thus recommend the implementation of policy measures that not only equip law enforcement with a crisis toolkit that they can deploy when handling an emergency situation involving a court participant, but also enable efficiency coordination between the on-the-ground officers and community service providers. One example of such a model is Crisis Intervention Team Programs, which aim to train front-line responders to redirect people in mental health crises toward sources of treatment and rehabilitation rather than the criminal justice system (Compton et al. 2008).

That said, because law enforcement officers are commonly ill-equipped to respond to mental health crises, we caution against over-reliance on police interventions and recommend instead the widespread deployment of non-police strategies designed to provide frictionless diversion into the community (Lamb, Weinberger, and DeCuir 2002) . These strategies, the scope of which goes beyond this report, deserve sustained attention and further research. But, preliminarily, we recommend that mental health personnel coordinate with community agencies and mental health providers at the front end of the diversion process to equip participants with a support system and emergency resources if problems were to arise. Participants will have better opportunities to engage in treatment and rehabilitation if contact with punitive law enforcement interventions is kept to the very minimum (Wells and Schafer 2006).

3.4. Treatment and Community Supports

The services proposed by Bucks County are supported by available research and practice. However what services Bucks County provides will ultimately depend on its target population, as well as available resources in the community.

Proposed services:

a. Services may include individual and group counseling, peer support, medication management and compliance, community support services, and case management
b. The participant should be an active member of the treatment planning, but also must agree to the planning of the most clinically appropriate treatment

Further recommendations:

a. The mental health court should connect participants with community-based agencies that could help with the provision of housing and transportation supports

Comprehensive, tailored, and culturally competent treatment is key

Adequate access to mental health services—including psychiatric care, psychotherapy, substance abuse treatment, and crisis intervention services—is but one component of the success of mental health courts (Boothroyd et al. 2005). Participants should also

have access to robust, evidence-based, and culturally competent services that are tailored to their needs (Boldt 1998; Linhorst et al. 2009). No one-size-fits-all solution exists for providing adequate treatment and community supports for participants. But mental health courts that have a track record in integrating best practices have generally adopted a phase-by-phase process in connecting participants with community stakeholders (King 2008).

Take, for instance, the mental health court in Ramsey County, Minnesota, which has around the same population as Bucks County and includes Minnesota's capital, St. Paul. The Ramsey County court divides its program in four different phases (Guthmann 2015):

1. *Engagement.* The participant and their team create a crisis plan and an individualized treatment plan, and they identify the mental health and substance abuse services that the participant needs.

2. *Active Treatment.* The team helps to connect the participant with mental health and substance abuse services in the community. The participant's case manager also sets recommendations for prosocial activities—which include physical activity, community service, and other kinds of community-based engagement—to optimize the participant's quality of life.

3. *Stabilization.* The team continues to oversee the participant's development in the program, focusing on the participant's decision-making and lifestyle. They also ensure that the participant has access to stable housing along with mental health and substance abuse services.

4. *Program Completion and Graduation*. The participant has completed and graduated from the program. The judge relieves the participant from the program's court-ordered conditions.

These phases emphasize connecting participants with government and community-based services. And as the participant progresses from one phase to the next, they are more autonomous in using these services to accommodate their particular needs. That said, given the close relationship between housing and rehabilitation, we do recommend placing particular emphasis on access to housing throughout the program (Goldkamp and Irons-Guynn 2000).

In addition to connecting participants with available mental health and substance abuse services, supports, and housing services, mental health courts should equally prioritize the provision of culturally competent services (Thompson, Osher, and Tomasini-Joshi 2007). Culturally competent services require that mental health courts design their programs around an appreciation of and knowledge about the role of age, gender, race, and religion in the criminal justice system (Kapoor et al. 2013). What works for one participant may not work for another, and teams must realize that empirical research supporting treatment modalities remain in progress (Boldt 1998; Baker 2013). We recommend that teams balance evidence-based measures with a realistic plan that accounts for participant characteristics that may elicit prejudice in the community.

For example, teams should receive training on the stigma associated with both incarceration and mental illness. Research has shown that community mental health agencies are frequently reluctant to offer services to people involved in the criminal justice system (Primm, Osher, and Gomez 2005). Teams should thus ensure that participants have access to adequate services and advocate on behalf of participants if the participants face, and have to overcome, community-based barriers and stigma.

Coerced or mandated treatment: opportunities and pitfalls

Mental health courts are structured such that participation is voluntary, but engagement in key requirements—particularly those focused around treatment—are mandatory. Judges typically delegate treatment decisions to treatment providers (such as psychiatrists or counselors) and allow for second opinions but make clear to participants that they must attend treatment appointments and follow the recommendations of treatment providers. In some cases, judges may further mandate (following the recommendation of court staff) that participants attend additional treatment programming such as self-help recovery groups as issues like substance use emerge. Judges frequently are explicit that participation in such treatment programming is compulsory.

Mandating treatment serves a purpose. Ideally, it provides participants with a sustained opportunity to experience the benefits of treatment in ways they would not otherwise experience because they would not consistently engage in treatment if not coerced. In this vein, coercion serves a jumpstart function: it engages participants in treatment, allows them to experience the benefits of treatment consistently across time, and thus leads them to pursue treatment long after it is no longer coerced because they recognize the benefits of doing so. Yet, coercion might not work as intended. Instead, it can serve as a temporary fix, with participants disengaging from treatment immediately after program completion when they are no longer under the court's control. Moreover, some participants may be even less likely to seek out treatment as it is now directly associated with coercion.

The degree to which mental health court participants experience long-term treatment benefits due to mandated treatment has not been fully examined. Some studies demonstrate that voluntary treatment—in contrast to compulsory treatment—is associated with reduced rates of recidivism (Parhar et al. 2008). Such findings are in line with a recovery logic that extols the virtue of including consumers of mental health services directly in treatment decision-making.

However, other researchers argue that some degree of compulsion is necessary to promote better outcomes for those at the intersection of criminal justice and mental health systems (Monahan et al. 2005) and find that outcomes for mental health court participants under legal pressure are better than outcomes for those not under legal pressure (Goldkamp and Irons-Guynn 2000). These conflicting viewpoints and findings indicate that further research is required.

Participants of interventions like mental health court will not have a singular experience of compulsory treatment. Some individuals describe benefitting from supervision and compulsion, while others experience it as a form of subjugation and control—often tied

to broader experiences of oppression in their daily lives (Leon and Shdaimah 2012). In addition, the way that participants experience treatment pressure is likely to be moderated by their relationship with court staff (Canada and Hiday 2014). In other words, some staff members (e.g., judges, probation officers) may embrace more forceful strategies, while others favor more lenient approaches—dispositions that likely affect the degree to which participants experience treatment in the court as coercive or not.

The variability of success rates and of treatment scenarios makes it challenging to propose a universal best practice for when and how mental health courts should mandate involvement in certain treatments when participants express resistance. Instead, court staff will need to be closely attuned to balancing input from participants with their recommendations on a case-by-case basis, with a recognition of the diversity of their participant base. Some participants may appreciate supervision and judicial mandate as a source of accountability and support. For others, compulsion may have less to do with accountability and more to do with undesired control that leads to disengagement from the court and treatment. Rather than amplifying coercion in all cases (which could adversely affect treatment engagement in some cases), staff will need to find diverse ways of engaging participants in the treatment process that match participants' diverse needs.

3.5. Supervision Conditions

The supervision conditions proposed by Bucks County are supported by available research and practice.

Proposed conditions:

a. Participants are required to follow both the conditions required by the Adult Probation and Parole Department and also the conditions of an individualized treatment plan designed to coordinate mental health treatment and services under the supervision of the criminal court
b. Participants are required to make court appearances to monitor the status of their compliance and must follow any additional rules the court may impose. Initially, participants will be required to come to court on a weekly basis. Court requirements will lessen with phase promotion
c. These meetings are designed to review all cases scheduled for the court docket the following day. The treatment team provides a clinical report, the probation officer provides a supervision report, and additional team members may provide any other relevant information

Although most, if not all, supervision models rely on active participation from judges, these models nonetheless vary across jurisdictions.[2]

1. *Case manager model.* One model involves active monitoring on the part of community treatment providers who usually act as case managers. These case managers are typically either part of the court staff or employees of community

[2] In this section, we apply insights provided by the Bureau of Justice Assistance's *A Guide to Mental Health Court Design and Implementation* (Council of State Governments 2005).

agencies. Under this model, the case manager may need to report progress to the court, either on a regular basis or upon instances when the participant has experienced difficulties (Griffin, Steadman, and Petrila 2014). The current consensus suggests that this model is efficient. Having a case manager serve as the principal point of contact substantially decreases risks of miscommunication between the participant and the court. The biggest potential downside, however, is that the case manager can play conflicting roles. On the one hand, they serve to encourage participants to adhere to and benefit from the program. On the other hand, they are responsible for administering sanctions when participants do not comply with plan conditions.

2. *Probation or parole office model.* Another model relies on mental health court staff (or probation or parole office staff) to ensure that participants adhere to treatment and resort to government and community-based services that meet their needs. Under this model, the criminal justice staff member frequently consults with participants and those engaged with the participant's progress through the program, including family members, friends, and employers. One benefit of this model is that, by involving a criminal justice staff member, participants will have less incentive to deviate from court-imposed conditions. This model is also focused on promoting public safety and ensuring that law enforcement responses are quickly dispatched if the need arises. That said, criminal justice staff may lack the mental health expertise that a case manager would. This issue may become particularly relevant if a participant requires specialized community mental health treatment or closer attention by mental health professionals.

3. *Hybrid model.* A final model is a hybrid between the case manager model and probation or parole office model, using both community treatment providers with the probation or parole office to monitor participant progress. One benefit of the hybrid model is that the involvement of multiple stakeholders will ensure that participants benefit from multifaceted expertise. But one downside is that involving multiple stakeholders increases the need for proactive coordination and, by extension, increases the risk of miscommunication. Another downside is that the hybrid model will increase the cost per participant of operating a mental health court.

Regardless of the chosen model, mental health courts will need to devise a particular timeline for their programs. Most programs in the country span 12 to 24 months, which generally tracks with the maximum sentences for misdemeanors (Griffin, Steadman, and Petrila 2014). Some existing programs, however, span only six months while others last more than three years (Council of State Governments 2005). We thus recommend that Bucks County establish the duration of its mental health court program according to the maximum sentence associated with a misdemeanor violation. We would also recommend that the extension of up to six months if a participant has difficulty completing the program in the initially allotted time or requires more oversight by their team. But these recommendations will depend on whether Bucks County limits eligibility to people who have committed misdemeanors. If people who have committed felonies are also eligible, Bucks County may want to track how other, similar courts have designed their program length.

Mental health courts should also impose the least restrictive supervision conditions for participants (Thompson, Osher, and Tomasini-Joshi 2007). The logic behind this principle is that harsh supervision conditions will increase the occurrence of minor condition violations, putting participants at an even greater risk of involvement with the criminal justice system. In addition (and especially when probation or parole officers play an active role in supervising participant progress), mental health courts should ensure that these officers go through robust mental health training. Research has shown that so-called specialty probation—that is, probation services that integrate mental health best practices—decreases the risk of recidivism because specialty officers tend to have firm, fair, and caring relationships with probationers (Skeem, Manchak, and Peters 2011).

3.6. Program Completion

The program completion process proposed by Bucks County is supported by available research and practice.

Proposed process:

a. When completion is successful, charges may be expunged or lessened. If the person is unsuccessful at completing the program, the specific reason for the unsuccessful completion should be identified. If it is due to frequent decompensation, refusal to take medication, etc., then a person should be given other clinical treatment opportunities
b. A strong, structured transition/discharge plan from the mental health court to less intense/structured treatment and supervision will be developed including appropriate referrals for housing options, treatment team, and other community supports services

Discharge requirements (e.g., treatment attendance consistency, drug use abstinence, reaching educational or vocational goals, and feed payment) vary from one mental health court to another (Fisler 2015). The same goes with the disposition of cases upon program completion (e.g., charge dismissal or reduction versus probation) (Fisler 2015). But research has established several guidelines that programs should follow before discharging participants. First, research conducted in the drug court context has shown that rigorous structure and establishing clear behavioral requirements for graduation leads to superior outcomes for participants (Carey, Mackin, & Finigan, 2012). We thus recommend that graduation hinge on a realistic and pre-established set of requirements that participants achieve during their participation in the program.

Second, advancing through and graduating from the mental health court program should depend on more than the time of participation. Research in the drug court context has shown that the ability of participants to successfully navigate the program's phases and accomplish its requirements is what drives program success (National Association Of Drug Court Professionals). Third, participants should be able to demonstrate that they have abstained from drug use during the program. Research has shown that a 90-day clean time has led to recidivism rates that are far lower than programs that require less clean time (Carey, Mackin, & Finigan, 2012). Finally, as described in more detail below, participants should have access to a robust transition

plan. Having an established support network is critical to ensure that participants feel confident when they graduate and to decrease the likelihood that participants have future encounters with the criminal justice system.

Importance of reducing and/or expunging criminal charges

Criminal records are associated with multiple collateral consequences that often cause greater harm than good. These include disqualifications from public aid such as welfare benefits, rental subsidies, and education grants, restrictions on occupational licensures and government positions, termination of custody rights, and disenfranchisement (Wheelock 2005). Moreover, beyond formal policies, criminal records result in durable stigma, shaping employment, education, and housing opportunities as employers, educational institutions, and landlords winnow out applicants by their criminal history even when no such selection process is required (Pager and Shepherd 2008). Importantly, a similar process may also unfold in some behavioral health treatment agencies, where providers are concerned about minimizing any liabilities they associate with criminal histories (Pogorzelski et al. 2005).

These collateral consequences tend to be particularly devastating for those with serious mental illness (Pogorzelski et al. 2005). Further, a high prevalence of substance abuse among this population creates additional burdens to accessing needed supports due to formal restrictions tied to drug offenses, the added stigma associated with drug use, and the difficulties of accessing integrated treatment. These barriers rest on top of the additional hurdles caused by disrupted treatment plans and loss of insurance (due to incarceration), insufficient mental health treatment linkages in the community upon release, and the stigma of mental illness (Baillargeon et al. 2010).

As such, mental health courts should work to reduce and expunge criminal records when and where possible. These records make the already herculean task of achieving and maintaining mental and material stability in the community even more difficult. Moreover, critically, reducing and expunging charges need not risk public safety. Prosecutors will employ their expertise to determine on a case-by-case basis which participants can be eligible for reduction and expungement of criminal charges.

3.7. Staff Team

The court team proposed by Bucks County is generally supported by available research and practice. However, mental health court team composition varies significantly, which makes it difficult to provide empirical recommendations about which composition works best. Rather than focusing first on who should be included, Bucks County should consider what they need the court team to do and, then, who best can serve that function in their jurisdiction.

Proposed team members:

a. Judge: leads collaborative team and implements rewards and sanctions as discussed by team
b. District Attorney: filters all cases for legal eligibility and provides feedback to clients about potential consequences of noncompliance, as well as encouragement and praise

c. Public Defender: filters all cases for legal eligibility, represents participants in court proceedings, and consults directly with participant to find best legal and treatment solutions
d. Jail Representative: organizes and generates list of referrals on a biweekly basis
e. Human Services Department Representative: provides clinical oversight, assessment, treatment planning, linkage, and referral
f. Probation Officer(s): supervises participants, serving a case management function, and participates in all team meetings to provide timely case reviews

The mental health court "treatment team" is a distinguishing feature of the mental health court model. The team ensures that previously siloed (and, in some cases, adversarial) parties work together to provide coordinated, comprehensive and rapid responses to the problems facing their participants. The team typically includes a diverse set of actors, such as a judge, treatment providers, attorneys, and probation officers. Some mental health courts are entirely court-based with treatment supervised by court personnel, but many mental health court teams are comprised of a mixture of criminal justice and mental health treatment personnel (e.g., case managers and counselors). These team members meet on a routine basis to collectively discuss how to process participant cases, as well as screen new referrals and discuss administrative issues. In some jurisdictions, they also participate in separate steering committees to address overarching issues around court administration and implementation.

The team model is designed to serve two primary functions in the routine operations of the court (beyond screening):

1. *Increase knowledge of problems facing participants and solutions*. In real time, the probation officer can report a participant's positive drug test directly to a treatment provider, who in turn can explain how this drug test relates to the participant's recovery process and life circumstances. These two team members can further draw on their unique interactions with the participant to create a fuller picture of how the participant is doing. With this shared knowledge, they can think critically about possible interventions. The value of a jail sanction versus treatment adjustment can be evaluated from their distinct points of expertise and each might propose other alternatives the court could use to respond to the participant.

2. *Increase capacity to efficiently respond to problems*. If participants incur a crisis in the community and require immediate attention, staff can intervene swiftly. Interventions are certain and targeted. Judges can readily impose a sanction or offer a reward. A probation officer can directly communicate a gap in treatment to a treatment provider, who then can quickly ensure a new linkage is established. Conversely, a treatment provider can note a pending legal issue that the probation officer or a lawyer can assist the participant in addressing in ways that best minimize disruptions to the current treatment plan. Moreover, the team can provide oversight not just to participants, but to service providers as well, ensuring that participants receive the services they need and are not falling in the cracks of any service system.

To carry out these functions effectively, mental health courts generally require the fulfillment of certain roles:

1. *Case management and supervision*. Mental health courts must ensure participants are connected to appropriate services and their service engagement is monitored. This role can be carried out by employees of the court, treatment providers, and/or community corrections officers. In some contexts, courts rely on a single team member to provide these services. In other contexts, courts may rely on multiple different professionals to provide overlapping forms of support, such as treatment case managers and probation officers.

   Research to date suggests that effective case management requires caps on caseloads. Research has found, for example, that probationers on specialized community corrections caseloads of 45:1 received significantly more mental health services, were less likely to be arrested, and were less likely to have their probation revoked when compared to those under traditional probation (Prins and Draper 2009). In the mental health court context, caps are important because they create the capacity for case managers to provide: the participant with timely linkages to services and the court team with up-to-date information about service engagement that provides the team with the data they need to tailor the intervention to the participant.

   The latter is important. Mental health courts were developed under the logic that behavior patterns can be changed through rapid, graduated court response. Delayed updates undermine this goal. Further, uneven access to and reporting on participant service engagement can lead to inconsistent court responses *between* participants. This happens, for example, as the court responds more punitively towards one participant over another not due to differences in their behavior but due to differences in what the court *knows* about their behavior.

   Mental health courts can improve the capacity of case managers to consistently track participants through enhancing key communication pathways (in compliance with privacy laws and regulations). Treatment case managers, for example, may not be able to regularly attend team meetings, but could check in with the court's case manager prior to meetings or be prepared to take phone calls during the meeting period. Treatment administrators could also serve as a conduit for updates from multiple treatment case managers at their agency. Further, timely updating of and access to service records can assist court case managers in reviewing a participant's progress.

2. *Provision of substantive expertise on intervention*. Mental health courts must ensure that treatment plans are informed by relevant expertise. However, given resource constraints, it is generally not possible to include key experts such as psychiatrists, counselors, and medical doctors in routine team meetings. Instead, courts must rely on a few different mechanisms to ensure that clinical expertise appropriately factors into decision-making.

   First, treatment providers such as treatment administrators, treatment case managers, and/or nurses can serve directly as team members. These treatment

providers can both (a) provide necessary clinical expertise to help the team better understand the problems of participants and potential solutions and (b) serve as conduits for the reports of other experts such as psychiatrists and doctors who cannot be present.

Second, treatment records can be used to shape case processing (in compliance with privacy laws and regulations). For example, some mental health courts require a list of psychiatric medications for those on the docket to help understand the kinds of physical, psychological, and behavioral effects participants may be experiencing that shapes their conduct. Of course, such records will have little utility for decision-making without the presence of a team member with expertise on psychiatric treatments. However, other records—such as therapists' updates written for the mental health court or doctors' notes—can provide mental health court teams with basic information on participants' clinical limitations, strengths, and progress.

Third, team members generally can be selected for their expertise and increase their expertise through training. More specifically, team members can be selected to participate in the court based on prior expertise working with SMI populations. Team members also should participate in cross-training before the court is launched and ongoing training throughout their participation on the court, with court administrators working to identify education and training resources (BJA 2005, 2007).

Two interrelated issues are critical to emphasize when it comes to incorporating clinical expertise into court processes. First, given resource constraints, it might be difficult to ensure that the treatment team has the requisite knowledge to both understand the ways in which psychiatric and substance use disorders influence conduct and choose between different kinds of treatment options (as well as sanctions) in routine case processing—a feat made more difficult by time limitations structured into the decision-making process and treatment constraints in the community.

Second, staff may be susceptible to filling gaps in knowledge with personal beliefs and commonly accepted (but not empirically supported) societal beliefs about disorders and interventions. Already researchers show that in contexts like mental health courts staff can turn to blaming participants for their problems rather than trying to understand the clinical and/or contextual factors that produce them (Gowan and Whetstone 2012). This happens even in contexts where staff are deeply committed to and compassionate about helping participants given how entrenched notions of individual responsibility are in the U.S. and criminal justice system specifically, as well as resource constraints that limit education and training.

No quick fixes exist to remedy constraints that courts may face in incorporating clinical expertise into their routine interventions. However, staff should be made aware of the possibility of conflating beliefs and moral judgements with expertise. When and where possible, they should defer to treatment experts to

better understand each participant's case and pursue educational and training opportunities to increase their expertise.

3. *Provision of substantive expertise on systems*. Mental health courts must ensure the complex needs of participants are met by multiple different systems, such as correctional and court systems, mental health and substance use treatment agencies, and government benefit programs. Each of these systems have distinct capabilities and capacities, as well as norms and rules that must be navigated. To ensure the capabilities and capacities of systems are brought to bear efficiently and effectively on participant needs, it is important to include team members who are well-versed in how such diverse systems operate. Mental health courts frequently rely on representatives from key systems—such as mental health treatment providers for the mental health system and judges and lawyers for the court system—to provide such distinct expertise, but team members can also develop cross-system expertise.

4. *Judicial oversight*. Mental health courts rely on a judge to serve as team leader. The judge typically serves a steering function for the program overall, ensures that legal codes are followed, and acts as a final arbitrator in routine decision-making. The judge considers the perspectives of all team members before making decisions about how to process a participant's case or adjust how the mental health court is implemented.[3]

While these roles will be filled by diverse team members, a single team member may be able to fill multiple roles. For example, a probation officer may serve as a case manager as well as provide substantive expertise on systems participants must navigate to access needed services (given a history of working with this population in the jurisdiction). To effectively target human resources, the court should consider the degree to which these roles (and/or other roles) are critical and in what processes and assign professionals to them accordingly. For example, it may be useful to have a prosecutor serve as a filtering agent in the referral process and participate on the steering committee, but unnecessary to have them attend routine team meetings if they are not regularly interacting with participants. Alternatively, the court may determine the substantive expertise of the District Attorney plays an important role in case processing and effectively managing screening decisions, necessitating their attendance at routine team meetings.

Decisions about team configuration can be refined across time, as the needs of the court evolve and/or new funding opportunities emerge. For example, it might become increasingly clear that including a housing coordinator directly in team meetings is critical for improving housing service linkages. Conversely, the team may find that they can achieve their housing goals by contacting a housing coordinator as needed or through a coordinator presenting on how housing services work at a single team meeting and no longer expect the housing coordinator attend all team meetings.

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[3] The Supreme Court of Ohio has developed *A Handbook for Developing a Mental Health Court Docket*, which provides guidance to judges on how to design dockets, identify key personnel, and spotlight resources to ameliorate the functioning of the mental health court. For more information, visit http://www.supremecourt.ohio.gov/JCS/specDockets/MHCourts/handbook.asp.

A study of multiple mental health courts indicated that a large, diverse group of team members contributes to program success, as team members efficiently divide the workload and provide varied expertise (Bullard and Thrasher 2014). This study also found that some successful courts mandated that all court team members attend routine team meetings regardless of their contact with participants (although it is unclear if mandated attendance specifically contributed to success or was correlated with success in these select courts). However, in contexts of limited human resources, mental health court planners ultimately should focus on prioritizing filling key roles they determine crucial to achieving court goals.

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