



STATE COURT ADMINISTRATIVE OFFICE

REGIONAL QUICK TIP

Leading Change in Responding to Mental Illness

Leading Change: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders is a manual written to enable courts to lead the effort to improve court and community response to mental illness and co-occurring disorders.

It builds off the 2016-2017 COSCA Policy Paper, *Decriminalization of Mental Illness: Fixing a Broken System*, authored by our State Court Administrator, Milton Mack, Jr.

Judges are unique in their ability to convene stakeholders. We encourage you to review the attached papers and help your court and community improve the response to mental illness. For assistance and additional resources, please contact our office.

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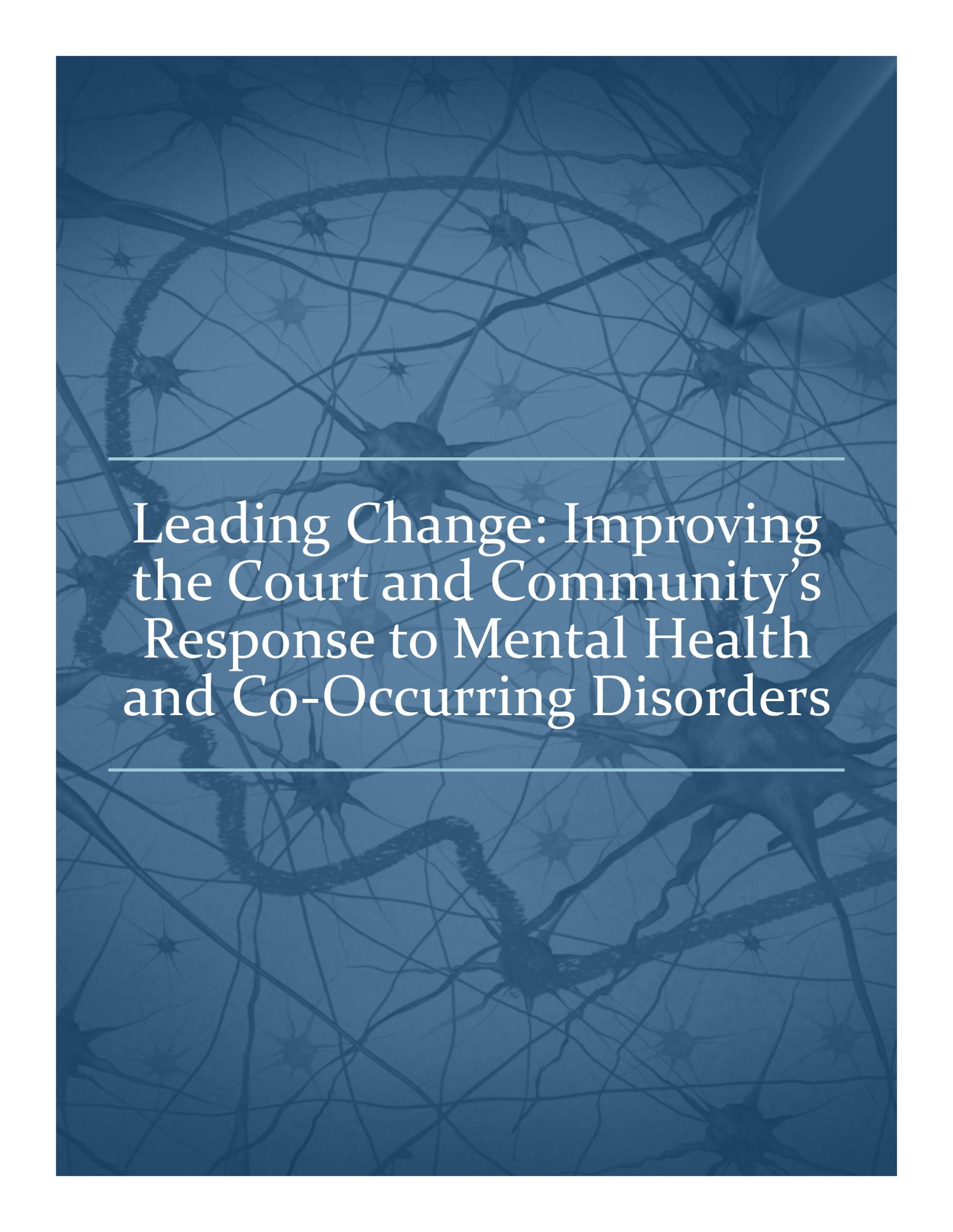
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Follow MSC on:



A microscopic view of neurons, showing a dense network of branching cell bodies and axons. The image is rendered in shades of blue, with a prominent neuron in the center-left. The background is a dark blue, and the overall texture is intricate and organic.

Leading Change: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders

A PROJECT ON BEHALF OF THE NATIONAL
INITIATIVE TO IMPROVE THE JUSTICE
SYSTEM REPOSENSE TO MENTAL ILLNESS



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Acknowledgments

In 2006, the Conference of Chief Justices (CCJ) published a resolution, *In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative*, which encouraged all chief justices to lead the movement to address the impact of mental illness on the court system.¹ In 2017, the Conference of State Court Administrators (COSCA) adopted a policy paper, *Decriminalization of Mental Illness: Fixing a Broken System*.² The policy paper, endorsed by CCJ in 2018, addresses the evolution of responses to those with mental illness, highlights key issues for successful responses, and makes explicit recommendations around developing a more robust, capacity-based response to those with mental health issues.

Recognizing the immediate importance of addressing mental health issues in state courts, Arizona established the Fair Justice Subcommittee on Mental Health and the Criminal Justice System.³ The Subcommittee developed “recommendations designed to promote a more efficient and effective justice system for those individuals who come to court and are in need of behavioral health services.”⁴ Those recommendations were incorporated into a *Guide for Arizona Presiding Judges: Improving Court's Response for Persons with Mental Illness (the Arizona Guide)*, an Arizona-specific guide for presiding judges to use to lead change around mental health issues in their communities.⁵

In the spring of 2019, the State Justice Initiative (SJI) awarded a grant to the National Center for State Courts (NCSC) for a national three-year initiative to improve the justice system response to those with mental health issues. The *Improving the Justice System Response to Mental Illness Initiative* (National Initiative) focuses on developing resources, best practices, and recommended standards in a variety of mental health areas, improving caseload management, building capacity of state and national court leaders to implement reforms, and promoting education for national and state court leaders. As a part of that initiative, the *Arizona Guide* was adapted into this national guide. This guide will provide a national perspective for mental health responses at the local as well as the state court level by providing judges across the country with a guide to developing mental health plans for their local jurisdictions.

This guide is one tool developed within the National Initiative to help court leaders create community by community change in how mental health issues are addressed. The National Initiative also includes an interactive website,⁶ regional summits,⁷ and workshops.⁸

1 Conference of Chief Justices, *Resolution 11: In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative*, 2006, <https://ccj.ncsc.org/~media/Microsites/Files/CCJ/Resolutions/01182006-In-Support-of-the-Judicial-Criminal-Justice-Mental-Health-Leadership-Initiative.ashx>.

2 Conference of State Court Administrators, *Decriminalization of Mental Illness: Fixing a Broken System*, 2017, <http://cosca.ncsc.org/~media/Microsites/Files/COSCA/Policy%20Papers/2016-2017-Decriminalization-of-Mental-Illness-Fixing-a-Broken-System.ashx>. COSCA expressly advocates for “1) an Intercept 0 capacity based standard for court-ordered treatment as used in court-ordered treatment of other illnesses to replace the dangerousness standard now applied, 2) Assisted Outpatient Treatment (AOT) under a capacity-based standard, and 3) robust implementation of Intercepts 1 through 5 of the Sequential Intercept Model.”

3 Subcommittee meeting materials and member information can be found at <https://www.azcourts.gov/cscommittees/Task-Force-on-Fair-Justice-for-All/Subcommittee/Mental-Health-and-Criminal-Justice>.

4 Report and Recommendations of the Fair Justice Taskforce's Subcommittee on Mental Health and the Criminal Justice System, May 2018, <https://www.azcourts.gov/Portals/74/TFFAIR/Subcommittee/FJ-MHCJ/Resources/Report042618TFFAIRMHCJ.pdf>.

5 *Guide for Arizona Presiding Judges: Improving Court's Response for Persons with Mental Illness*, October 2018. For a complete list of the names of many invaluable contributors to the Arizona Guide that could not be included here, please refer to the Acknowledgements section.

6 <http://www.ncsc.org/mentalhealth>

7 <http://www.ncsc.org/mentalhealth>

8 <http://www.ncsc.org/mentalhealth>

NCSC would like to thank the Arizona Administrative Office of Courts and the many professionals in multiple counties who have shared their time and expertise with the project team.⁹ Significant input from the following agencies and individuals were instrumental in the revision of the Arizona Guide into this national guide:

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⁹ Arizona Guide, *supra* note 4. For a complete list of the names of many invaluable contributors to the *Arizona Guide* that could not be included here, please refer to the Acknowledgements section of the *Arizona Guide*.

The National Guide

Trial courts have increasingly become the default system for addressing the needs of those with mental and behavioral health issues. Sixty-four percent of people in local jails suffer from mental illness.¹⁰ The rate of serious mental illness is four to six times higher in jail than in the general population,¹¹ and the rate of substance use disorders is seven times higher among those in jail than in the general population.¹² Failure to respond to these issues invites a continuing public health crisis and the continued criminalization of mental health that has devastating effects to individuals, families, and society.

Mental health advocate Judge Steve Leifman claims that the “justice system is a repository for most failed public policy.”¹³ Over 57 percent of adults with mental illness did not receive mental health treatment in the previous year.¹⁴ Without access to social services, the answer to a mental health crisis is often police and justice-system involvement, which can have broad-reaching and lasting implications. Incarceration negatively affects mental health outcomes, housing stability, employment, and community integration. A robust community response can prevent justice-system involvement, recidivism, and the associated negative outcomes for many individuals with mental health issues.

“What you learn after several years on the bench is that the criminal justice system is the repository for most failed public policy. And there is no greater failed public policy than our treatment towards people with mental illnesses.”

- Judge Steve Leifman

As leaders of their courts and communities, judges are in a unique position to expand and improve the response to individuals with mental illness.¹⁵ The Conference of Chief Justices/Conference of State Court Administrators recognized the critical role of judges as leaders on this issue in Resolution 11, In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative, a national group co-chaired by Judge Leifman that includes judges and psychiatrists from across the country.¹⁶ For decades, courts have gained experience in convening diverse stakeholders to tackle complex problems both within and outside of the justice system. From the evolution of problem-solving courts to dependency dockets, courts are often at the vanguard of responding to societal issues. This reality has paved the way for an independent but involved judiciary. At the national level, state court leadership has recognized the important role courts play in addressing the mental health crisis. The Conference for State Court Administrators (COSCA) has adopted the stance that “court leaders can, and must, . . . address the impact of the broken mental health system on the nation’s courts—especially in partnership with behavioral health systems.”¹⁷

10 The White House, Fact Sheet: Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration (June 30, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>.

11 Vera Institute of Justice, Incarceration’s Front Door: The Misuse of Jails in America (February, 2015), <http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/01/incarcerations-front-door-report.pdf>.

12 The Council of State Governments Justice Center, *Health, Mental Health, and Substance Use Disorders FAQs*, <https://csgjusticecenter.org/substance-abuse/faqs/#q2>.

13 Judge Steve Leifman is an associate administrative judge on the county criminal division of the Eleventh Judicial Circuit Court of Florida and is the Special Advisor on Criminal Justice and Mental Health Reform for the Supreme Court of Florida, <https://www.jud11.flcourts.org/Judge-Details?judgeid=735§ionid=97>.

14 National Alliance on Mental Illness, *Mental Illness Statistics* (2017), https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154787.

15 Recent conferences have focused on providing leadership training and resources for judges. See National Association for Presiding Judges and Court Executive Officers, 2017 Leadership Conference, <http://napco4courtleaders.org/2017-conference/>.

16 Conference of Chief Justices, *Resolution 11: In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative*, 2006, <https://ccj.ncsc.org/~media/Microsites/Files/CCJ/Resolutions/01182006-In-Support-of-the-Judicial-Criminal-Justice-Mental-Health-Leadership-Initiative.ashx>.

17 COSCA, *supra* note 1 at 20.

An effective response to the needs of individuals with mental health and co-occurring disorders requires committed stakeholders across a spectrum of services and time. From screening and assessment to diagnosis, emergency health responses, probation and beyond, effective mental health responses must be appropriately tailored to the individual as well as available services in the community. This guide is intended to be a practical tool for convening stakeholders across systems and developing a plan to address mental health needs in your community.

Over 70 percent of individuals with serious mental illness in jails also have a co-occurring substance use disorder. As such, this guide can and should be extended to those individuals with a co-occurring disorders. In fact, this guide should be applied to the full spectrum of individuals with mental health issues, from those with emerging mental health concerns to those with serious mental illness. A comprehensive response must also consider the role of trauma, traumatic brain injury, and developmental disabilities.¹⁸ In addition, court leaders should contemplate how to address the intersectionality between mental illness and special populations, such as juveniles, emerging adults, women, people of color, veterans, and those who are LGBTQ+.¹⁹

“Court leaders can, and must . . . address the impact of the broken mental health system on the nation’s courts—especially in partnership with behavioral health systems.”

- Conference for State Court Administrators

Court and behavioral health structures differ between states, but the advice in this guide is designed to apply universally. This guide emphasizes a community-by-community approach, but that action is best coupled with statewide leadership. Engaging state agencies in the process will help with alignment of local and state-level efforts and goals. The recommended checklist of action steps incorporates plan development considerations across a diverse set of jurisdictions. While these action steps provide the “backbone,” specific strategies will vary from jurisdiction to jurisdiction depending on existing efforts, available resources, and community infrastructure.

Where possible, this guide contains Local Considerations that reflect these considerations.

Addressing the mental health needs in your community is an important but weighty undertaking that will require sustained effort and time. Resources are often siloed, and it will take time to identify and untangle them. Because of your unique position as a judge and a leader, you are an optimal convener of these diverse stakeholders. This guide will help you get started and provide information about what to consider during the beginning stages of the process. The guide describes the important steps of convening stakeholders, assessing the mental health landscape in your community, and implementing court and community responses and strategies. Any steps forward will be positive and will make a difference in the community.

¹⁸ <http://www.ncsc.org/mentalhealth>

¹⁹ Topic papers covering issues specific to special populations will be posted on the National Initiative's webpage, <http://www.ncsc.org/mentalhealth>.

Coordinated Court and Community Responses

In order to address mental health needs in your community, certain court and community responses must be developed early on. The most effective approach is to design responses that are engaged in by community collaborators *early* and *often*.

As a starting place, COSCA recommends using the Sequential Intercept Model (SIM), which identifies appropriate responses at several intercept points that can keep an individual from continuing to penetrate the criminal justice system.²⁰ Nevertheless, effective court and community responses require interventions prior to engagement in the criminal justice system. As such, this guide recommends several additional areas of focus that, if engaged in proactively, can create necessary support structures and prevent justice system involvement for those with mental health disorders. These additional practices address physical and behavioral health needs, pre-crisis community resources, family and public outreach, and civil justice needs. Additionally, a focus should be placed on the role of court leaders and the importance of data and information sharing. This model is visualized in Figure 3.

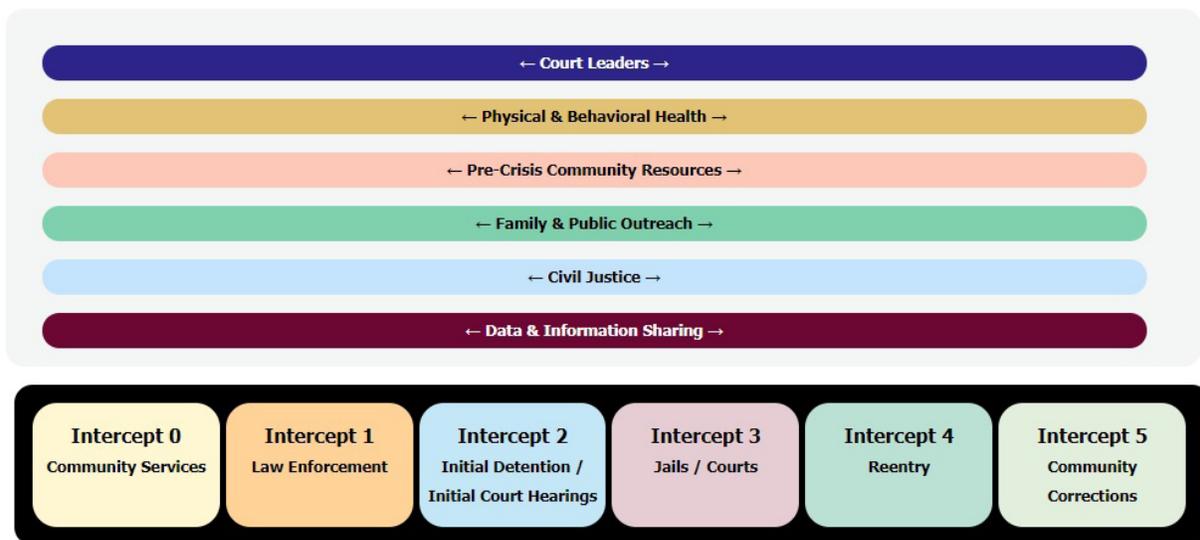


Figure 3. The Sequential Intercept Model and additional areas of focus for coordinated court and community responses.

Every community will be at a different place with its response to mental health and co-occurring disorders. As you look through the various recommendations in this guide, consider your own community and the best way to use these tools to build a structure of support for mental health issues within it. More information about recommended practices for each part of the model can be found on the National Initiative's web page.²¹

²⁰ The Sequential Intercept Model is a community strategic planning tool that helps communities assess available resources and determine gaps in services. The goal is to develop priorities and create a plan to improve the response to mental and substance use disorders. See Policy Resource Associates, *The Sequential Intercept Model* (2019), <https://www.prainc.com/sim/>.
²¹ <http://www.ncsc.org/mentalhealth>

Getting Started

- Consider the many stakeholders who could be involved and identify stakeholders relevant for your jurisdiction. See the list of potential stakeholders in Table 1.
- Plan a first meeting, create an agenda, and invite stakeholders.
- Convene the workgroup of stakeholders to assist you in this important effort.

This entire guide has been developed for leaders in the court community. As a first step, review the guide in its entirety and ask others in your jurisdiction to do the same. After you have all read the guide, discuss your preliminary thoughts on the best way to proceed in your community. This discussion should include a conversation on existing court and community mental health responses. Laying these out in a preliminary manner will provide context on the community's size, infrastructure, and resources that shape the most appropriate approach to this effort. For example, a jurisdiction with numerous treatment providers and many stakeholders might tackle protocol development in more manageable working groups that report back to a main development group. A jurisdiction with fewer key stakeholders might develop protocols as an entire group.

Local Considerations

Existing councils and committees can be leveraged as a starting point and backbone support for your efforts.

Also, consider prior multi-disciplinary efforts that may have been undertaken in the last few years. Has your court and/or the community participated in the *Stepping Up Initiative*²² or the *Safety and Justice Challenge*?²³ Have you participated in any "mapping" exercises designed to identify existing resources, gaps in services and community priorities? Do you have a criminal justice coordinating council or other group of stakeholders that meets periodically? Think about the leaders in your court and in the community. Like any successful effort, you will need "champions" to contribute to the work ahead.

The *Stepping Up Initiative* led by the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation, provides a framework for convening stakeholders and gathering appropriate data to inform a system-wide planning process (See Box on Six Questions County Leaders Need to Ask). While judges appropriately lead court response efforts, they are one piece of the mental

²² For more information, including a list of participating counties, visit <http://stepuptogether.org>.

²³ For more information, visit <http://www.safetyandjusticechallenge.org>.

health system responses; effective community-based mental health responses require buy-in and action from local elected officials. *Six Questions County Leaders Need to Ask*, developed by the Stepping Up Initiative, is an excellent resource for framing assessment at the systems level.²⁴ In particular, the *Stepping Up* website includes a detailed *Project Coordinator's Handbook* with exercises to walk an interagency group through the *Six Questions*²⁵ and a Self-Assessment Tool.²⁶ As you begin this effort, you should make a commitment to be conscious of your choice of language and ask the others joining you to do the same. Avoid stigmatizing language. Person-first language helps keep conversations person-centered rather than focused on issues to be managed. Whenever possible, defer to the preferences of individuals for how they choose to identify themselves (e.g., person with lived experiences, survivor, person in recovery, etc.).²⁷

Six Questions County Leaders Need to Ask *The Stepping Up Initiative*

1. *Is our leadership committed?*
2. *Do we collect timely screening assessments?*
3. *Do we have baseline data?*
4. *Have we conducted a comprehensive process analysis and inventory of services?*
5. *Have we prioritized policy, practice and funding improvements?*
6. *Do we track progress?*

Either prior to the first meeting or with your stakeholder group, a developmental plan should be established. Developing any effective collaborative response to a complex issue requires first understanding the available resources. Simply put, you must first understand where you are before you can determine where you want and need to go. Figure 4 outlines the mapping process that informs effective and appropriate judicial and community responses.²⁸ All five phases (assessment, gap determination, plan development, implementation, and sustainability) are necessary to develop a comprehensive community response to mental and behavioral health issues.



Figure 4. The Community-Based Mental Health Response Mapping Process

24 National Judicial Opioid Task Force, *The Court's Role in Combating the Opioid Crisis: Using the Sequential Intercept (SIM) as a Place to Start* (2019), <https://www.ncsc.org/~media/Files/PDF/Topics/Opioids-and-the-Courts/NJOTF%20Resources/The%20Courts%20Role%20in%20Combating%20the%20Opioid%20Crisis-Using%20the%20SIM%20Final.ashx>; The Stepping Up Initiative, *County Election Official's Guide to the Six Questions County Leaders Need to Ask* (2018) <https://stepuptogether.org/wp-content/uploads/2018/04/Elected-Officials-Guide%E2%80%9393to%E2%80%934-4-18.pdf>. A more robust guide describes why each question matters and what the best practices around the questions look like. Risè Haneberg et al., *Reducing the Number of People with Mental Illness in Jail: Six Questions County Leaders Need to Ask* (2017), https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illness-es-in-Jail_Six-Questions.pdf; The Stepping Up initiative, *Stepping Up Strategy Lab*, <https://lab.stepuptogether.org/database/results/>.

25 Available online at: <https://stepuptogether.org/products>

26 Available online at: <https://tool.stepuptogether.org/>

27 For more information, see Jensen et al., *Championing Person-First Language: A Call to Psychiatric Mental Health Nurses*, 19 J. Am. Psych. Nurses Ass'n 146 (2013), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.898.78&rep=rep1&type=pdf>; City of Philadelphia, Department of Behavioral Health and Intellectual disAbility Services, *Person First Guidelines*, <https://dbhids.org/wp-content/uploads/2015/09/Person-First-Initiative-Guidelines.pdf>; ADA National Network, *Guidelines for Writing about People with Disabilities*, https://adata.org/sites/adata.org/files/files/ADANN_writing_guidelines_2015-FINAL.pdf.

28 This process is similar to other court-led reform efforts in the access to justice and civil justice reform arenas. The Civil Justice Initiative provides a roadmap for implementing change in the civil justice system. See *Transforming Our Civil Justice System for the 21st Century: A Roadmap for Implementation*, <http://www.ncsc.org/~media/Microsites/Files/Civil-Justice/CJI%20Implementation%20Roadmap.ashx>. The Justice for All project lays out the process for an integrated, action-driven assessment and planning process. See *Justice for All Guidance Materials 2016*, <http://www.ncsc.org/~media/Microsites/Files/access/Justice%20for%20All%20Guidance%20Materials%20Final.ashx>.



Convene Stakeholders

- Consider the many stakeholders who could be involved and identify stakeholders relevant for your jurisdiction. See the list of potential stakeholders in Table 1.
- Plan a first meeting, create an agenda, and invite stakeholders.
- Convene the workgroup of stakeholders to assist you in this important effort.

For this endeavor, it will be important to have strong community collaboration, as well as judicial investment. Table 1 identifies the many stakeholders who should be included in a task force or community meetings.

Community meetings are more inclusive than an appointed task force and do not limit the number of people involved. When determining which stakeholders to invite, consider broad involvement in the work ahead and consider gender, racial, ethnic and geographic diversity across all spectrums of responsibility. This might include bringing new stakeholders to the table and developing new relationships through the task force effort.

Think about the roles each task force member will play. For example, someone on the task force should understand funding opportunities and others should know the available community resources. You should be looking for both champions of the cause and people who can span boundaries across the justice, community, court, and behavioral and mental health systems. Some community resources may be siloed, so it is important to identify diverse stakeholders who can make sure the whole spectrum of available resources is identified. Invite people who know the local landscape as well as those who know state-level resources. Extend invitations to leaders from other courts in your community. Stakeholders should have a working knowledge of the challenges of mental health issues, and you should include stakeholders who cover all needs of a person with a mental health disorder.

Local Considerations

Judges should consider a jurisdiction's available resources and infrastructure when identifying stakeholders and the protocol development structure. If a jurisdiction's effort does not include a sufficient number of stakeholders to form meaningful working groups, the group should work as a whole on each intercept.

You should consider implementation and sustainability strategies when convening participants. This includes ensuring stakeholder leadership representation and buy-in to execute developed plans. You should also consider the importance of soliciting a range of viewpoints from state leadership to “front-line” employees who directly interact with affected individuals. Inclusion of individuals with lived experiences and their family members is critical to understanding the specific challenges involved with navigating the systems. The importance of buy-in cannot be overstated in the development process. As leaders, judges should endeavor to ensure the participants feel heard and are offered an opportunity to meaningfully contribute to the process.

Table 1. Potential Stakeholders

✓ Judges	✓ Jail mental health staff
✓ Court administrators	✓ Probation and parole officers
✓ Law enforcement (Sheriff, local police)	✓ Pre-trial officers
✓ Bailiffs	✓ Disability/Physical brain disorder advocates
✓ Prosecutors	✓ Civil commitment personnel
✓ County attorneys	✓ Mobile crisis units
✓ Private counsel	✓ Crisis units
✓ Public defenders	✓ Benefits representatives
✓ Former system-involved individuals/Persons with lived experiences	✓ Tribal representatives
✓ City Council	✓ Competency evaluators
✓ County Board/Board of Supervisors members	✓ Competency restoration treatment providers
✓ School board members	✓ Disability law groups
✓ Criminal justice commissions	✓ Social security/Disability representatives
✓ Legislators	✓ Faith-based organizations
✓ Family members	✓ Emergency room personnel
✓ Direct treatment providers (public and private)	✓ Emergency medical technicians
✓ National Alliance on Mental Illness	✓ Public advocates/Public fiduciaries
✓ Psychiatrists	✓ Pediatricians and physicians
✓ Supported employment specialists	✓ Project coordinator
✓ Housing specialists	✓ Local business leaders
✓ Peer and self-advocacy organizations	✓ Local researchers and academics
✓ Jail administrators	✓ Data quality and integrity contacts
✓ Domestic violence services	✓ Victim rights advocates
✓ Mental health hotlines	✓ Guardianship and conservatorship groups
✓ Residential unit staff	✓ Food banks
✓ Mental health boards	✓ Transportation services
	✓ Community foundations
	✓ Substance use treatment and services

Consider the appropriate number of stakeholders to invite to participate as well as strategies to ensure that everyone’s perspectives are heard and incorporated in a manageable way. This decision will depend on the number of providers and interested parties in your community. You may want to invite different stakeholders to join the discussion at various stages.

It is critical that court and community responses to mental health issues are viewed in a holistic manner to avoid narrow and siloed responses. Development efforts should include creation of individual working groups to develop plans across each point of the justice system, from before a crisis occurs to probation and beyond. Nevertheless, to ensure a comprehensive response, there should also be a mechanism for bringing the entire development group together to review findings and develop a plan that spans across intercepts.

You should think about:

1. The purpose of the group (e.g., develop policies, communication strategies, funding coalitions);
2. Whether the group is a standing committee or convened for a limited duration; and
3. Who is best suited to serve in this capacity (i.e., top leadership or those with in-depth knowledge about the resources and programs)?

To ensure inclusion, you should ask those participating in the first meeting if you have missed other important roles to include in the effort.

After you have considered who to invite to contribute to this effort, you will plan the first meeting agenda. Sample meeting agendas are included in this guide for your reference and adaptation to the needs of your court and the community (see Appendix A).

Once you have identified those you want to invite and drafted an initial agenda, issue the invitations. Personally reaching out to invitees through a phone call can help emphasize the importance of this effort. Consider the budgets of your stakeholders and make an effort to provide housing, transportation, or other arrangements as needed. Set the meeting date sufficiently in advance to maximize participation. A minimum of four to six weeks in advance is recommended.



At Your First Meeting

- Engage your stakeholders; do a lot of active listening. Ask stakeholders how to think outside the box to find solutions.
- Propose a process to “map” the resources in your community to understand where you are and where you need to go to improve court and community responses.
- If not already completed, map your community's resources. Recognize that completing the mapping process may take a number of meetings and effort by separate workgroups.
- Decide the frequency of meetings to lead change in your community and choose a date for the next meeting.
- Create a communication plan for sustained collaboration with stakeholders.

Make sure your stakeholders feel welcome. There should be food and drinks provided. Print out copies of the meeting agenda and the invitation. Engage your stakeholders and thank them for their time. Share with them why this effort is important to you and what you hope to accomplish through this effort. Do a lot of listening. Ask each person to introduce themselves, share his or her role and responsibilities and why the work is important to them. Later in the agenda you will ask each participant if they are willing to work with you in the months and year(s) ahead to improve the court and community response to those with mental health issues.

You should elect a co-chair from outside the court community to help spearhead the effort. The co-chair will bring a different perspective of the mental health landscape in your community, and their involvement will reinforce the importance of collaboration throughout this process.

You will then either propose a plan and/or invite the participants to offer their suggestions, or both. Mapping to the Sequential Intercept Model (SIM) or a similar resource mapping exercise²⁹ is recommended as a key initial planning tool, if a resource map has not already been completed in your community (See Appendix C for sample planning materials for SIM). You can propose to conduct the National Initiative's workshops,³⁰ a SIM workshop

29 The Stepping Up initiative has an *In Focus* brief on *Conducting a Comprehensive Process Analysis*, which includes several sample system maps, available online at: https://stepuptogether.org/wp-content/uploads/JC_Stepping-Up-In-Focus_Conducting-a-Comprehensive-Process-Analysis.pdf .

30 Reference the workshop

model with a facilitator, or an abbreviated mapping process. Any of these methods will help stakeholders understand where the community is in terms of resources, what the gaps are, and what needs to be accomplished in order to improve court and community responses.

At this first organizational meeting you will also want to decide how best to move forward, i.e., how to organize yourself within workgroups or meetings of the whole body and decide the frequency of meetings. Meeting at least monthly or every other month is recommended to build and maintain momentum.

Ongoing communications both within the workgroup or task force and throughout the community are critical to the success of the ongoing efforts. You will want to develop a plan to maintain active communication with your stakeholders. Later as you proceed you will want to expand the communication of plans and strategies throughout your communities.

Local Considerations

Jurisdictions without dedicated communications staff/support can explore tailoring communication plans that reflect jurisdiction capacity and explore coordinated communication partnerships with other jurisdictions or agencies.



Assess the Mental Health Landscape

- Inventory the mental health landscape in your community.
- Examine the existing responses at each intercept point; document those responses.
- Identify any gaps in the community and court processes for those with mental health issues.
- Consider adapting protocols that have been developed in other counties and states to meet your needs.
- Identify potential solutions and set priorities to address identified gaps. Develop an action plan.
- Solicit viewpoints and ensure “buy-in” of all stakeholders at every step.

Completing a collaborative and candid assessment of the mental health landscape will secure buy-in from stakeholders. You should encourage direct observations and analysis at each intercept regarding contact between an individual with mental health issues, the justice system, and the community broadly. Understanding the landscape is the foundation on which informed and targeted action is based. Each community is at a different stage in the process of addressing mental health needs and has a unique mental health system. It will take time to understand how the mental health system is structured within your community. As a first step, you can talk with mental health and other stakeholders about the types of treatment and supports available in your community.³¹

Local Considerations

Jurisdictions that have already completed SIM mapping should complete an abbreviated review (and update) of their mapping process.

A comprehensive assessment requires input from all stakeholders and will allow you to identify ways to “intercept” persons with mental health and co-occurring disorders to ensure prompt access to treatment; opportunities for redirection or diversion; timely movement through the justice system; and linkage to community resources.³² Each point in the model in Figure 3 provides opportunities for intervention as early as possible and allows you and the community to develop targeted strategies.

³¹The Judges' and Psychiatrists' Leadership Initiative has developed a worksheet for judges to use to identify community-based treatments and supports, available online at: <https://csgjustice-center.org/wp-content/uploads/2019/07/My-Community-Resources-JPLI.pdf>.

³² Opportunities to “intercept” persons with mental health disorders are referred to as “intercepts” in the SIM model. For example, law enforcement could intercept a person with a mental health disorder during a call for service by diverting the individual to a stabilization unit rather than jail. Law enforcement is one of six intercepts in the SIM model. Policy Resource Associates, The Sequential Intercept Model (2019), <https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf>.

A comprehensive assessment should consist of the following steps:

1. **Convene** stakeholders;
2. Discuss and **decide** on how to approach the assessment (working groups, evaluations, reports, etc.);
3. **Investigate** the existing response at each intercept and data collection opportunities;
4. **Document** responses and effectiveness as well as resources/gaps; and
5. **Identify** accompanying evidence-based, best, and promising practices.

Depending on your community's experience with resource mapping, you will either schedule a separate mapping workshop or use the results of previous mappings to build upon. Mapping provides you the best tool to inventory community services and collaborative efforts, assess gaps and opportunities, identify where to begin interventions, and help you to examine, plan, and implement priority action plans to improve your community and court responses.³³

A one to two-day mapping workshop will generally include the following agenda items:

1. Description of the mapping workshop.
2. Evidence-based, best, and promising practices and national trends across intercepts.
3. Mapping of cross systems (court, community, civil, criminal, law enforcement, behavioral health, etc.).
4. Identification of gaps and opportunities.
5. Setting of priorities.
6. Action planning based upon priorities and developing specific plans for taking action.
7. Next steps, moving forward.
8. Assessment goals should frame the work of the group.

Assessment approaches and strategies require an action plan and timeline.³⁴ Investigating existing responses, both qualitatively and quantitatively, will provide the current mental health response "landscape." For an idea of possible response strategies, the Stepping Up initiative has a database of different tools alongside descriptions.³⁵

Six Questions County Leaders Need to Ask *The Stepping Up Initiative*

1. *Is our leadership committed?*
2. *Do we collect timely screening assessments?*
3. *Do we have baseline data?*
4. *Have we conducted a comprehensive process analysis and inventory of services?*
5. *Have we prioritized policy, practice and funding improvements?*
6. *Do we track progress?*

³³ See The Sequential Intercept Model as a Framework Video.

³⁴ For an example, see a variety of reports on community action plans from Massachusetts as a part of the Massachusetts Community Justice Project, <https://www.mass.gov/lists/massachusetts-community-justice-project-reports>.

³⁵ The Stepping Up initiative, Stepping Up Strategy Lab, <https://lab.stepuptogether.org/database/results/>.

You can find suggestions of assessment questions at each intercept in Appendix D. Assessment inquiries should target a response from a multi-agency perspective in addition to a response from an individual perspective. Effective individual responses are impossible if they are not backed by supportive systems.

The workgroup should document existing responses and resources at each intercept to allow for meaningful synthesis of existing gaps. When documenting the current status, discuss the *quality* and *breadth* of existing responses in addition to their existence.³⁶ For example, what type of treatment is available for individuals with mental health disorders? How accessible is that treatment?

36 The Justice for All Strategic Action Planning guidance materials, developed in 2016 to help courts and other access to justice stakeholders meaningfully assess their access to justice ecosystem provides templates and questions that help drive a quality-driven inquiry. See Justice for All Guidance Inventory Assessment Guide, Appendix A (2016), <http://www.ncsc.org/~media/Microsites/Files/access/Justice%20for%20All%20Guidance%20Materials%20Final.ashx>. Toolkits for collaborative educational teams also implicitly incorporate this concept in self-assessment. See New Jersey Department of Education, Collaborative Teams Toolkit, 5 (2015), <https://www.state.nj.us/education/AchieveNJ/teams/Toolkit.pdf>



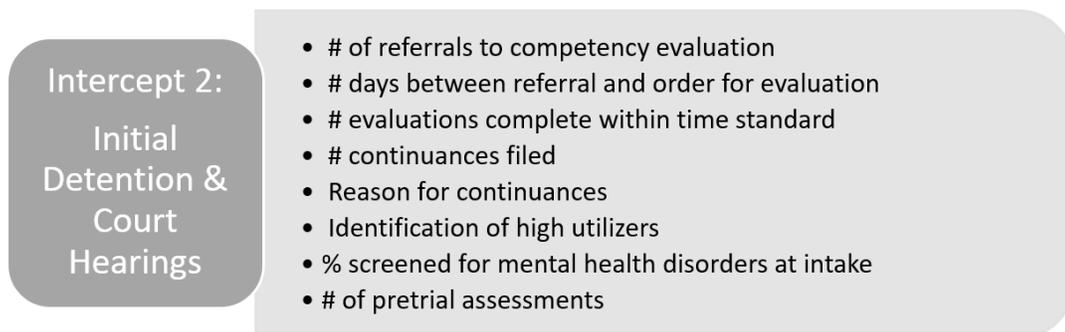
Collect Data

- Decide what data are important to collect to measure and assess effective responses.
- Identify which agency(ies) will be responsible for the collection of the data and reporting to the workgroup.
- Secure necessary data sharing agreements.
- Leverage technology whenever possible.

Existing data collection strategies inform many justice and public safety programs.³⁷ The development of comprehensive community-based mental and behavioral health responses is no different. Data collection is critical for enabling outcome tracking and conducting the initial mapping assessment. Therefore, data collection opportunities and strategies should be discussed at every intercept and across both civil and criminal matters. For example, the Stepping Up initiative focuses on four key outcomes related to its goal of reducing prevalence in jails: admissions, average length of stay, connections to treatment in the community, and recidivism.³⁸

The data to be collected should be discussed and determined at the beginning of the process and then used to inform the mapping procedure. As the work continues, you should continue to discuss what additional data need to be collected to ensure effective responses and best practices. A sample of data elements related to Intercept 2 are shown in Figure 5. The data elements listed are not exhaustive and should be identified by the stakeholders.

Figure 5. Sample Data Collection Opportunities



³⁷ States courts are now embracing evidence-based and data-informed strategies. There are a number of resources that provide informative data as well as questions to ask around data. See National Association of Counties, County Explorer: Mapping County Data, <http://explorer.naco.org/> (mapping numerous county indicators), Council of State Governments Justice Center, 50-State Data on Public Safety, Arizona Workbook: Analyses to Inform Public Safety Strategies, 31 (March 2018), https://50statespublicsafety.us/app/uploads/2018/06/AZ_FINAL.pdf (outlining key questions about state data for public safety strategies); Urban Institute, Justice Reinvestment at the Local Level: Planning and Implementation Guide (October 14, 2010), <https://www.urban.org/sites/default/files/publication/71341/412233-Justice-Reinvestment.pdf> (discussing the collection of data and how to use data to inform the selection of interventions).

³⁸ The Stepping Up Initiative, In Focus: Collecting and Analyzing Baseline Data, https://steptuptogether.org/wp-content/uploads/In-Focus_Collecting-and-Analyzing-Baseline-Data.pdf

Many agencies and organizations won't have much available data. Work with the data that are readily available and then determine how to enable the collection of additional data moving forward.

Data collection opportunities often require data sharing agreements between agencies. For example, if a defendant is booked into jail but was receiving mental health treatment through a local behavioral health center, it is critical to share status notifications. You should first look to see what data sharing agreements already exist. Stakeholder organizations should work collectively to identify additional data sharing opportunities. Once those opportunities are identified, stakeholders should enter into an agreement that delineates the events that trigger data sharing and who has access to what information. The agreement should consider data retention and timing for receiving data updates, as well as confidentiality.³⁹ This agreement should be in writing to establish stability throughout leadership and staffing transitions.

Data collection opportunities should be identified throughout the mapping process as well as throughout the planning process.

³⁹ See Summary of the HIPAA Privacy Rule: <https://multco.us/file/75791/download>.



Implement Improved Responses

- Develop an action plan, strategies, and timelines for implementation of responses.
- Identify plans to secure full leadership support.
- Identify strategies to overcome barriers, including a need for financial support.
- Discuss and document shared goals. Use these as a starting point for implementing strategies toward solutions.
- Consider grant, other funding, and technical assistance opportunities to enable you to accomplish your goals and action plans.

Following a workshop or similar mapping exercise(s), stakeholders should begin to refine the list of priorities identified and action plans developed. This further action planning should define the responses desired; identify necessary leadership support; prioritize the order for implementation starting with foundational steps first; and identify constraints, strategies to overcome barriers, and financial support to move forward.

This detailed action plan will include strategies and timelines for implementation of responses. You will also need to discuss funding needs and whether any funding could be obtained from grants, local or state funds, and other opportunities.⁴⁰ You should reach out to city, county, or state contacts to develop a plan to sustain funding for any developed responses. The stakeholders, with your leadership and encouragement and that of the court administrator, should make every effort to leverage technology to improve court and community responses to those with mental health issues.

Local Considerations

Jurisdictions can partner to leverage technology capacity and seek funding opportunities to overcome sparse resources.

⁴⁰ A list of funding resources to address substance use disorder and opioid misuse is available through the Office of National Drug Control Policy and U.S. Department of Agriculture: <https://www.rd.usda.gov/files/RuralResourceGuide.pdf>.

The potential for leveraging technology in mental health responses is immense and should support the entire response process. Automated messaging can be used at virtually every intercept, whether raising awareness, prompting action, or enabling informed monitoring. Video appearances enable remote participation. Remote appearances and telehealth enable individuals with mental health issues to overcome many impediments to successful court hearings including social anxiety and navigating scheduling or transportation challenges for receiving services. Technology can also facilitate the participation of remote stakeholders to overcome access issues often experienced in remote locations and for those without reliable access to transportation.⁴¹

⁴¹ Courts should consult with mental and behavioral clinicians to carefully consider which individuals may have deleterious reactions to remote technologies (e.g., individuals suffering from paranoid disorders).



Sustain Your Efforts

- Conduct regular reviews through workgroup meeting agendas, adjust plans if necessary.
- Identify and implement outcome measures relevant to data collection.
- Reach out to the community on an ongoing basis through an established communication plan.
- Continue to engage your stakeholders; regularly review list of stakeholders for additions/adjustments.
- Discuss and agree upon effective communication strategies, such as enlisting leadership support and identifying a point of contact for regular communication.
- Establish a regular schedule to assess and reassess your response efforts.
- Facilitate necessary training (and cross-training) for the workgroup members and others involved in improving responses.

Once the plan has been implemented, it is important to sustain your efforts. This will require continued funding, persistence, and time. Throughout the developmental process, you should work to gain an understanding of how systems and services are funded and the opportunities that may provide support for this endeavor. One of your roles is to bring stakeholders together and build lasting relationships. Think about yourself as a broker for change, but also be mindful of judicial ethical considerations and your comfort level at trying to implement policy. Advocating for resources is not the same thing as advocating for a particular entity.⁴²

Various organizations provide resources and tools to help drive and sustain change.⁴³ There are also new national and statewide efforts and taskforces aimed specifically at addressing mental health in the state courts.⁴⁴ These efforts should be leveraged as support for implementation.

To ensure sustainability, you must:

1. Measure impact, document results, and make adjustments;
2. Secure stable funding strategies; and
3. Establish leadership support.

⁴² See National Judicial Opioid Task Force, *Judicial Leadership in Creating and Leading a Multidisciplinary Team to Address Substance Use Disorders* (2019), <https://www.ncsc.org/~media/Files/PDF/Topics/Opioids-and-the-Courts/NJOTF%20Resources/Judicial%20Leadership%20of%20MDT%20Final.ashx> (discussing how judicial ethics can be upheld while convening a multidisciplinary team).

⁴³ Numerous federal and private funders support work in this area, including the Bureau of Justice Assistance (U.S. Department of Justice), the Substance Abuse and Mental Health Services Administration (U.S. Health and Human Services), and the MacArthur Foundation. Online resources are also for free through the Center for Court Innovation, the Council of State Governments Justice Center, The Judges' and Psychiatrists' Leadership Initiative, the National Association of Counties, Policy Research Associates, and the Stepping Up Initiative.

⁴⁴ Add references to new website address, regional workshops, opioid website, and state efforts

An important component for sustainability that informs regular reviews and targets appropriate responses and adjustments is evaluation. Evaluation should be built into the protocols. A successful strategy will document the intervention's desired impact on stated objectives and outcomes.

You should use data from evaluations to secure stable funding allocations. As an example, researchers have noted the importance and impact of using data (e.g., impact of housing stabilization on arrests) to inform crisis response system reform.⁴⁵ Creating outcome measures, evaluation frameworks, and carrying out evaluations is critical.

You should explore funding strategies and grant opportunities to help support development efforts. National efforts in place to support and sustain local efforts include the *Improving the Justice System Response to Mental Illness* National Initiative, Substance Abuse and Mental Health Services Administration (SAMSHA), *Stepping Up Initiative*, and the *MacArthur Safety and Justice Challenge*. In recent years, state responses have moved to the forefront. These also include state efforts, including ones in Arizona, Texas, and Ohio,⁴⁶ which have built on the experiences of states like California,⁴⁷ Delaware,⁴⁸ and Wisconsin⁴⁹ that have done earlier state-wide planning.

Dedicated mental health liaisons can also help ensure continued attention to mental health responses in your community. Cross-agency coalitions, as used in Minnesota, may be a worthwhile strategy for securing funding from the legislature.⁵⁰

Effective training and coordination ensure support by leadership and improves chances of successful implementation. For example, Virginia and Massachusetts have successfully implemented “train-the-trainer” approaches to mental health responses.

There are various forums at the national level to elevate mental and behavioral health issues and share solutions at the national level. For example, the National Association for Court Management (NACM) and the National Association of Presiding Judges and Court Executive Officers (NAPCO) host annual conferences. The Substance Abuse and Mental Health Services Administration (SAMSHA) also provides trainings that are designed for addressing substance abuse and mental health issues at the local level.⁵¹

Local Considerations

Obtaining stakeholder feedback is an important part of protocol evaluation. Jurisdictions with fewer stakeholders might find more informal feedback channels more effective and timely.

45 Lyn Overman, Angela LaScala-Greunewald and Ashley Winstead, MODERN JUSTICE: USING DATA TO REINVENT AMERICA'S CRISIS RESPONSE SYSTEMS, May 2018 (provides examples where data is used to track the impact of reforms (e.g., impact of housing stabilization on arrests in San Diego and New York) as well as the benefit of data sharing).

46 Arizona's Task Force on Fair Justice for All has a committee specifically focused on mental health issues in the justice system, <https://www.azcourts.gov/cscommittees/Mental-Health-and-the-Justice-System>. Texas recently started a Commission to mental health issues in civil, criminal courts. See Judicial Commission on Mental Health, <http://www.txcourts.gov/supreme/news/commission-to-address-mental-health-issues-in-civil-criminal-courts/>. Ohio has a standing taskforce on criminal justice and mental illness, <https://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Task-Force-on-Criminal-Justice-and-Mental-Illness>.

47 <https://www.courts.ca.gov/mhiitf.htm>

48 <https://courts.delaware.gov/AOC/MHTF/index.aspx>

49 <https://www.wicourts.gov/courts/programs/docs/alltaskforcereport.pdf>

50 See Report: <https://ncsc.contentdm.oclc.org/digital/collection/spcts/id/303/>

51 SAMSHA, *Empowering Communities to Address Health Disparities: Practical Steps to Take at the Local Level* (October 2016), <https://www.samhsa.gov/capt/tools-learning-resources/empowering-communities-address-health-disparities-practical-steps-take>

Central to securing leadership support, funding, and sustainable collaborative responses is communication and outreach. You should carefully consider how best to communicate response plans. There are several national resources available to help guide and inform communication efforts.⁵² This may include asking stakeholders to submit pieces to relevant newsletters or listservs and reaching out to local media contacts for press releases. The court's website is also a great place to get the word out.

One national resource comes from efforts to achieve legislative reform. The *Toolkit for Legislative Reform: Improving Criminal Justice Responses to Mental Illness in Rural States* provides a number of excellent references and tools to consider for group composition, identifying problems, communications needs and strategies, stakeholder engagement, and setting the stage for sustainability.⁵³

⁵² See *Stepping Up Initiative*, Talking to the Media and the Public about People with Mental Illness in their Jail (2018), https://stepuptogether.org/wp-content/uploads/2018/04/Elected-Officials-Guide-to-Talking-to-the-Media_4-10-18.pdf; Barbara Peirce, A Toolkit for Legislative Reform: Improving Criminal Justice Responses to Mental Illness in Rural States, http://www.crj.org/assets/2017/10/CJ-Responses-to-MH-Toolkit-Sept-2017_Final.pdf (2017).

⁵³ Id.

A Concluding Reminder

Improving the court and community's response to mental health needs is a difficult but rewarding undertaking. This guide is designed to help you start the conversation and begin the movement towards change, but this effort will take hard work and perseverance that will likely continue for many years. These issues will not be resolved after one meeting with stakeholders or one assessment of the community's needs. Nevertheless, every effort you and your community partners make will benefit your community.

For additional guidance, please refer to the National Initiative's website.⁵⁴ There you will find links to state-specific and national resources, an assessment tool to further help you decide where to begin your efforts, workshops, and much more.⁵⁵

Finally, please share your challenges and successes with NCSC through the National Initiative website. Together, state by state and community by community, we will learn to improve our court and community responses to those with mental health and co-occurring disorders.



⁵⁴ <http://www.ncsc.org/mentalhealth>

⁵⁵ <http://www.ncsc.org/mentalhealth>

Appendix A. Draft Invitation and Agendas

Judicial Letterhead

Dear _____,

As you might know, I am currently participating in an effort to convene and engage key community members in identifying strategies and ideas to improve our court and community responses to those with mental health issues. This effort is very important to me because

_____.

You have been identified as/ I know you are an important person to involve in this effort and would make significant contributions given your

_____.

I am convening a first meeting of community members _____ at _____ am/pm at the _____ County Courthouse (Address) and I am hoping you can join me. Please RSVP to Court Administrator _____ at

_____.

Thank you for your consideration and please call me or the Court Administrator if we can answer any questions that you might have.

Sincerely,

Judge

CC: Court Administrator

Appendix A. Draft Invitation and Agendas

Sample Agenda for a First Meeting

Expanding the Court and Community Response to Mental Health Issues

_____ County

[Date]

[Time]

[Location]

1. Welcome Remarks and Introductions

Hon. _____, Judge

(The Judge will welcome all the participants/stakeholders and describe the purpose of the effort and why it is important to the Judge. The Judge should convey the status of statewide efforts and the development of the Guide. Next, the Judge should ask each participant to introduce themselves and describe his or role and responsibilities.)

2. Purpose of the Meeting/Committee/Task Force

Goal (The Judge and Court Administrator should articulate in writing a goal for the Meeting/Committee/Task Force and include it here.)

Invite Feedback (The Judge should engage the stakeholders in the purpose of the effort and invite their feedback.)

Anyone Missing? (The Judge should ask the stakeholders if any community members are missing and if any additional members should be added.)

3. How Should Our Work Be Organized?

Proposal (The Judge and Court Administrator should articulate in writing a proposed approach and strategy to move forward. Consider coordination/differentiation of related ongoing efforts. For example, is a separate mapping workshop advisable or can you build on prior mapping efforts? Is there already an established working group to improve responses to those with mental health issues or some sort of multi-disciplinary workgroup that could be expanded?)

4. Moving Forward

(The Judge should lead a discussion about the frequency of meetings and a potential meeting schedule. Most importantly, the Judge should obtain a commitment from each stakeholder.)

Appendix A. Draft Invitation and Agendas

Sample Agenda for Subsequent Meetings

Expanding the Court and Community Response to Mental Health Issues

_____ County

[Date]

[Time]

[Location]

1. Welcome Remarks and Introductions

Hon. _____, *Judge*

(A second and subsequent meeting agendas will vary depending upon the extent of community “mapping” that may have already occurred. Generally, either a separate Sequential Intercept Mapping (SIM) workshop will be scheduled or you will build upon prior mapping efforts.)

2. Mapping the System

(The “mapping exercise” facilitates collaboration and what is called cross-system communication. An experienced facilitator is recommended to promote communication and to strengthen local strategies. The mapping exercise is generally scheduled for at least a day if it has not been completed before.)

3. Prioritizing the Gaps and Opportunities

(As you “map” each of the intercepts, you will identify gaps in the community and court response. Talk about what ideas and strategies could be implemented in your community. Turn the gaps into opportunities based upon your discussions.)

4. Action Planning

(The action planning will identify both short- and long-range goals. Action plans will identify priority areas, strategic objectives, and action steps, and also identify the who and the when.)

5. Recommendations

(In addition to the action plans, the participants will identify next steps and other recommendations for moving forward. A summary of the mapping exercise and a list of participants is recommended to accurately document the workshop or planning activity.)

Appendix B. Checklist of Judge Action Steps

GETTING STARTED

- Review this guide and talk with your court administrator.
- Together, discuss the status of your court and community response to those with mental health issues.
- What is the status of any other prior efforts undertaken in your county?
- Who has been involved and provided leadership on key efforts in this area?

CONVENE STAKEHOLDERS

- Consider the many stakeholders who could be involved and identify stakeholders relevant to your jurisdiction. See the list of potential stakeholders included in this Guide.
- Plan a first meeting, create an agenda, and invite stakeholders. Sample agenda(s) are included in this guide.
- Convene the workgroup of stakeholders to assist you in this important effort.

AT YOUR FIRST MEETING

- Engage your stakeholders; do a lot of active listening. Ask stakeholders how to think outside the box to find solutions.
- Propose a “mapping process” with your stakeholders to understand where you are and where you need to go to improve court and community responses.
- If not already completed in your county, map your community’s resources. Recognize that completing the mapping process may take a number of meetings and effort by separate workgroups.

<ul style="list-style-type: none"> <input type="checkbox"/> Decide the frequency of agendas and meetings to lead change in your community. <input type="checkbox"/> Create a communication plan for sustained collaboration with stakeholders. 	
--	--

ASSESS THE LANDSCAPE

<ul style="list-style-type: none"> <input type="checkbox"/> Examine the existing responses at each intercept point; document those responses. <input type="checkbox"/> Identify any gaps in the community and court processes for those with mental health issues. <input type="checkbox"/> Consider adapting protocols that have been developed in other counties and states to meet your needs. <input type="checkbox"/> Develop protocols to address identified gaps. <input type="checkbox"/> Solicit viewpoints and ensure “buy-in” of all stakeholders at every step. 	
--	--

COLLECT DATA

<ul style="list-style-type: none"> <input type="checkbox"/> Decide what data are important to collect to measure and assess effective responses. <input type="checkbox"/> Identify which agency(cies) will be responsible for the collection of the data and reporting to the workgroup. <input type="checkbox"/> Secure necessary data sharing agreements. <input type="checkbox"/> Leverage technology whenever possible. 	
---	--

IMPLEMENT IMPROVED RESPONSES

<ul style="list-style-type: none"> <input type="checkbox"/> Develop an action plan, strategies, and timelines for implementation of responses. <input type="checkbox"/> Identify plans to secure full leadership support. <input type="checkbox"/> Identify strategies to overcome substantial barriers, including a need for financial support. 	
---	--

<ul style="list-style-type: none"> <input type="checkbox"/> Discuss and document shared goals. Use these as a starting point for implementing strategies toward solutions. <input type="checkbox"/> Consider grant and funding opportunities to enable you to accomplish your goals and action plans. 	
---	--

SUSTAIN YOUR EFFORTS

<ul style="list-style-type: none"> <input type="checkbox"/> Conduct regular reviews through workgroup meeting agendas, adjust plans if necessary. <input type="checkbox"/> Identify and implement outcome measures relevant to data collection <input type="checkbox"/> Reach out to the community on an ongoing basis through an established communication plan. <input type="checkbox"/> Continue to engage your stakeholders; regularly review list of stakeholders for additions/adjustments. <input type="checkbox"/> Discuss and agree upon effective communication strategies, such as enlisting leadership support and identifying a point of contact for regular communication. <input type="checkbox"/> Establish a regular schedule to assess and reassess your response efforts. <input type="checkbox"/> Facilitate necessary training (and cross-training) for the workgroup members and others involved in improving responses. 	
---	--

Appendix C. Sample Planning Materials for Sequential Intercept Mapping



**SAMHSA'S
GAINS
Center for
Behavioral Health and
Justice Transformation**

Planning for *Sequential Intercept Mapping Workshop*

GAINS Center Sequential Intercept Mapping Planning Kit

A successful *Sequential Intercept Mapping* program begins with the planning process. For maximum benefit, use this Planning Kit for suggestions, a checklist, and materials to help plan the entire program. The program consists of a pre-workshop consultation conference call, the workshop, and a summary report with recommendations. All aspects of the program are conducted by experts from SAMHSA's GAINS Center.

<i>Sequential Intercept Mapping</i>	- 1 -
<i>Program Description: Sequential Intercept Mapping</i>	- 2 -
Specific Services Provided by SAMHSA's GAINS Center	- 4 -
Agency / Community Services	- 4 -
Planning for <i>Sequential Intercept Mapping</i>	- 5 -
<i>The Planning Group</i>	- 5 -
<i>The Consultation Call</i>	- 5 -
<i>Participants</i>	- 6 -
<i>The Space</i>	- 8 -
<i>Amenities</i>	- 10 -
<i>Additional Planning Issues</i>	- 10 -
Planning Checklist	- 11 -
Who to Invite.....	- 12 -
<i>Who to Invite – Sample Services and Roles</i>	- 14 -
Preparing for the <i>Sequential Intercept Mapping Workshop</i>	- 15 -
<i>Sequential Intercept Mapping Pre-Workshop Data Collection</i>	- 17 -
<i>Community Collaboration Questionnaire</i>	- 18 -
The Planning Tools.....	- 21 -
<i>Save the Date!</i>	- 22 -
<i>You are Cordially Invited</i>	- 23 -
<i>Reminder!</i>	- 24 -
<i>Press Release</i>	- 25 -

Appendix C. Sample Planning Materials for Sequential Intercept Mapping



Sequential Intercept Mapping Workshop

AGENDA

County, State

Date

8:00	Registration
8:30	Opening <ul style="list-style-type: none">■ Welcome and Introductions■ Overview of the Workshop■ Workshop Focus, Goals, and Tasks■ Collaboration: What's Happening Locally What Works! <ul style="list-style-type: none">■ Keys to Success The Sequential Intercept Model <ul style="list-style-type: none">■ The Basis of Cross-Systems Mapping■ Six Key Points for Interception Cross-Systems Mapping <ul style="list-style-type: none">■ Creating a Local Map■ Examining the Gaps and Opportunities Establishing Priorities <ul style="list-style-type: none">■ Identify Potential, Promising Areas for Modification Within the Existing System■ Top Five List■ Collaborating for Progress Wrap Up <ul style="list-style-type: none">■ Review
3:30	Adjourn

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

Appendix C. Sample Planning Materials for Sequential Intercept Mapping



Sequential Intercept Mapping Workshop

AGENDA

County, State
Date |

8:00	Registration and Networking
8:30	Opening <ul style="list-style-type: none">■ Remarks■ Preview of the Day
	Review <ul style="list-style-type: none">■ Day 1 Accomplishments■ Local County Priorities■ Keys to Success in Community
	Action Planning
	Finalizing the Action Plan
	Next Steps
	Summary and Closing
12:30	Adjourn

There will be a 15 minute break mid-morning.

Appendix C. Sample Planning Materials for Sequential Intercept Mapping

**Boston Community Justice Project
Strategic Plan [DRAFT]
April 2019**

Vision: We envision a City of Boston where people have access to treatment and support that meets them where they are, promotes recovery, enhances public safety and improves lives.

Mission: Our mission is to reduce justice involvement among people with addiction and mental health challenges, through collective action across systems, in the City of Boston.

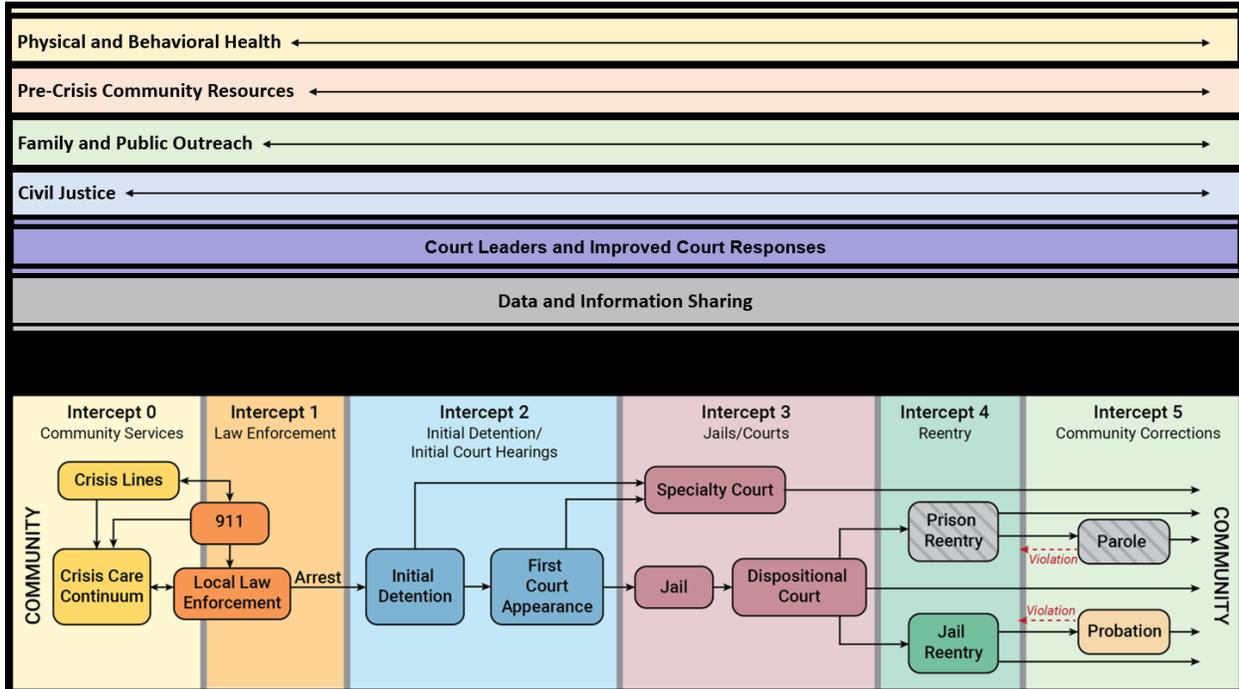
Goal #1: Increase coordinated planning and collective action within and between justice and community systems		
Objectives	Strategies	Committee(s)
Increase and maximize opportunities for cross-system coordination	<ul style="list-style-type: none"> • Implement Sequential Intercept Mapping workshops • Develop coalition to increase opportunities for collaboration between intervening systems and agencies <ul style="list-style-type: none"> ◦ Secure funding to support a coalition Coordinator • Increase information and data sharing across agencies to ensure efficiencies of care and measure change • Create/strengthen/optimize coordination of care processes to ensure smooth transitions and wrap-around care for individuals with complex needs 	<ul style="list-style-type: none"> • Planning • Steering

Goal #2: Increase knowledge and skills regarding behavioral health and justice involvement		
Objectives	Strategies	Committee(s)
Increase training and education opportunities about behavioral health among criminal justice system partners	<ul style="list-style-type: none"> • Law Enforcement: CIT, MHFA, academy and annual training • Court Staff and Partners (Attorneys, Probation, Judges, Clerks, Court Officers): model training • Corrections: academy and annual training 	<ul style="list-style-type: none"> • Model Training
Increase training and education opportunities about justice-involvement among key community partners	<ul style="list-style-type: none"> • Treatment Providers • Emergency Services • Homeless Shelters • Social Services 	<ul style="list-style-type: none"> • Model Training?

Goal #3: Improve behavioral health outcomes with high quality and evidence-based assessment, treatment and recovery support		
Objectives	Strategies	Committee(s)
Increase and maximize opportunities for identification of behavioral health issues (screening and assessment)	<ul style="list-style-type: none"> • Crisis team: mobile and walk-in • Law enforcement: Co-Response team, CIT, Hub Tables, Post-Crisis outreach • Court-based: Court Clinic (Section 15 and 35), CPCS Social Service Advocate, Bar Advocate Social Worker, Probation, Specialty Courts, Court Advocate • Corrections • Community: Healthcare, Public Health, Homeless 	<ul style="list-style-type: none"> • Co-Response
Increase access to evidence-based treatment	<ul style="list-style-type: none"> • Ensure health insurance and benefits enrollment • Create/optimize care transition processes between justice facilities and community providers that ensure timely access to care <ul style="list-style-type: none"> ◦ Psychiatric care and medication transitions ◦ Medication Assisted Treatment ◦ Co-Occurring Disorders Treatment ◦ Cognitive behavioral health interventions for criminogenic risk 	<ul style="list-style-type: none"> • Access to Treatment • Reentry
Increase access to recovery support services	<ul style="list-style-type: none"> • Peer Support • Comprehensive Case Management • Housing • Workforce Development and Supportive Employment 	<ul style="list-style-type: none"> • Peer Support • Reentry
Increase coordinated care for high utilizers of justice, treatment and healthcare systems	<ul style="list-style-type: none"> • Connect with high utilizer and data-driven justice initiatives 	<ul style="list-style-type: none"> • Steering • Co-Response • Access to Tx

Partners: Boston Municipal Court, BMC Probation, Office of Community Correction, Boston Police, Suffolk District Attorney's Office, Suffolk Sheriff's Office, Suffolk Law, Committee for Public Counsel Services, BMC BEST Team, Boston EMS, Mayor's Office of Recovery Services, Boston City Council, Massachusetts Organization for Addiction Recovery, JRI, Pine Street Inn, Rosie's Place, Boston Public Health Commission (AHOPE and PAATHS), Gavin Foundation, Arbor House, MassHealth, Boston Medical Center, Mass General Hospital, Community Resources for Justice, DPH: BSAS, DMH, DDS, East Boston Neighborhood Health, North Suffolk Mental Health, Boston Healthcare for the Homeless

Appendix D. Sample Assessment Questions



Physical and Behavioral Health

- What resources are available in the community to provide behavioral health services?
- What mental health awareness information is provided during routine medical visits?
- What types of mental health or co-occurring disorder screenings are done during routine medical visits?
- What public benefit assistance is available for behavioral health services? What assistance exists for obtaining and maintaining it?
- What practices are in place to identify individuals with behavioral health needs?
- What screening or assessment tools are used to identify behavioral health needs? Are these tools validated on the population of those with mental health issues?

Pre-Crisis Community Resources

- What organizations are working with people with a mental health or co-occurring disorder (e.g., syringe exchanges, business community, faith-based community, homeless shelters, food banks)?

- What housing resources are available in the jurisdiction?
- Does the community have adequate, affordable, and convenient transportation services?
- Does the community have food banks? Supported employment services? Education services?
- Is information available to the public about what resources are available in the community and how to access those services?
- Are services co-located?

Family and Public Outreach

- What public outreach on mental health currently exists (e.g. awareness campaigns, hotlines, health fairs)?
- Does your community have a local National Alliance on Mental Illness chapter? Do they provide training, classes, or support groups?
- What resources and treatment are available for families? Are there residential programs that allow parents to bring their children?

Civil Justice

- What resources are available on advanced directives, power of attorney, and other prospective legal planning? Where is this information provided? Is legal aid assistance available? Are private attorneys trained?
- What options exist for establishing advanced directives (e.g., guardianships) for individuals at risk for mental crises?
- What proactive measures are available to establish advanced directives/guardianship?
- What processes are in place to initiate a civil commitment? Are family and the public made aware of these processes and accompanying services?

Data and Information Sharing

- Are relevant providers aware of and trained on data-sharing best practices, including applicable federal and state laws on privacy?
- What data sharing practices currently exist? What are additional data sharing priorities?
- What, if any, data are collected on mental health issues during law enforcement responses? How are such data shared across agencies?

- What information sharing protocols and agreements are established to access mental health information (e.g., past evaluations) across agencies?
- What protocols are established to reduce redundancy in conducting and maintaining assessment and evaluation results?

INTERCEPT 0: COMMUNITY SERVICES

- Are in-custody or inpatient beds available if required? What are the discharge practices? Who is notified, when, and what resources are in place upon discharge (e.g., plans for medication continuity, housing, transportation, clothing)?
- What are the potential referral sources for individuals seeking behavioral health treatment and services?
- What efforts are in place to increase public and referral source awareness of treatment and service options?
- Are service providers trained in de-escalation techniques and tactics? Are community resources aware of and trained on appropriate practices for responding to individuals with mental or behavioral health needs?
- Are any organizations working to identify high utilizers of the justice, healthcare, and/or behavioral health systems and provide coordinated care management?
- What training do emergency room staff have regarding mental health, substance use disorders, and trauma?

INTERCEPT 1: CONTACT WITH LAW ENFORCEMENT

- What pre-arrest diversion, deflection, or redirection options are available in the community?
- What law enforcement and first responder training and efforts are available and offered for effective responses to crisis intervention (e.g., CIT, mental health first aid)?
- Are dedicated stabilization units established in the community to handle mental and behavioral crises? Are there stabilization units dedicated to co-occurring substance abuse/mental health crises?

INTERCEPT 2: INITIAL DETENTION AND COURT HEARINGS

- What protocols are in place to identify mental and behavioral health needs upon intake to detention?

- What screening or assessment tools are used to identify mental or behavioral health needs? Are these tools validated on the population of those with mental health issues?
- How and when do courts identify individuals with mental or behavioral health needs?
- How are mental and behavioral health needs communicated to providers? How are individuals connected to providers?
- Has your community planned and established co-located services? What (additional) opportunities exist for co-locating services?
- How can justice stakeholders identify high system utilizers? What criteria should be applied to identify high utilizers?
- How are justice system stakeholders and individuals informed of diversion options?
- What services are available to law enforcement for someone who is in a behavioral health crisis while detained?

INTERCEPT 3: COURTS AND JAILS

- Is there a mental health liaison position in the courts to connect with detention facilities and/or conduct evaluations?
- Who are the referral sources (e.g., prosecutors, defense attorneys, judges)? Are they familiar with identification of individuals with mental health issues, and do they understand potential judicial responses?
- Does a mental health court operate in your community? Are referral sources informed about eligibility criteria?
- Is the referral process to a mental health court established in writing and shared with referral sources?
- Are judges aware of alternative sentencing options?
- How are individuals identified and referred for competency evaluations? Are the processes efficient? What competency restoration, treatment, and education services are provided?
- What outpatient restoration services are available? What, if any, restoration processes differ for lower level offenses?
- What mental health information is provided to judges for pretrial release or sentencing decisions?
- Are mental health screens presented to the judge as part of the pre-sentence investigations?
- Is prescription continuity ensured during incarceration and while awaiting disposition? This includes from the community to jail, from jail to competency restoration, from competency restoration back to jail, and from jail to the community.

- Do people participating in problem-solving/treatment courts have to plead guilty to felony offenses to participate? If yes, what rights are in jeopardy for that individual (e.g., voting, housing, employment, etc.)?
- Do problem-solving courts utilize graduated sanctions to assist persons in getting needed treatment and assistance after a rule or law violation?
- What mental health and co-occurring disorder assessment and treatment is provided during incarceration?

INTERCEPT 4: RE-ENTRY

- Are individualized re-entry plans developed that include treatment and social services? Do individuals actively participate in the development of plans?
- What is done to facilitate benefit (re)enrollment upon re-entry?
- Have you worked with the state Medicaid system to ensure that a person's Medicaid status is only suspended and not terminated upon incarceration?
- What community-based treatment resources are available to sustain long-term support for individuals with mental health issues?
- What are potential remote service opportunities?
- Are wrap-around services coordinated for individuals? Are "warm hand-offs" available upon release?
- What strategies and supports are available upon re-entry to improve long-term outcomes (e.g., employment, education, or pro-social activities)?
- How are medication transitions into the community handled? What services are available for someone who needs to refill a prescription quickly (e.g., a bridge clinic)?
- For someone leaving incarceration with probation conditions, is the reentry plan shared with the probation officer? Is the probation officer involved in reentry planning?

INTERCEPT 5: PAROLE AND PROBATION

- Does probation offer a specialized caseload or specialized probation officers to be assigned to work with individuals with mental health issues?
- What screening and treatment/service coordination is conducted by probation? Does probation have specialized units with probation officers trained to work with individuals with mental health issues?

- What pro-social behaviors or wellness indicators are monitored by supervision agencies (e.g., housing, health, peer support)?
- Are there specialized units or trained probation/parole officers to assign individuals to with mental health issues?
- Are parole/probation officers trained on risk/needs models and responsivity?
- Do community-based treatment providers understand criminogenic risk and evidence-based strategies to address risk factors?
- How are transportation issues addressed for individuals who are required to go to treatment and services as conditions of their probation or parole?

Appendix E. Glossary

Co-location of services: Co-location occurs when several service or resource providers are housed in the same physical space. An example of this is a jail giving satellite office space to housing, employment, and education service providers for the accessibility of recently discharged individuals.

Co-occurring disorder: Co-occurring disorders refers to an individual diagnosed with both a mental health disorder and a substance use disorder.

Intercept: In the Sequential Intercept Model, intercept or intercept point refer to the particular points where an individual with mental health needs can be intercepted and prevented from continuing to penetrate the criminal justice system. The intercepts include community services, law enforcement, initial detention and court hearing, jail and courts, reentry, and community corrections.

Mapping: Resource mapping is a tool for identifying available resources and gaps within a community while also encouraging collaboration and priority planning.

Person-first language: A way of acknowledging mental health disorders and other disabilities by referring to the individual first and the disorder second (e.g., “a person living with schizophrenia” as opposed to “a schizophrenic”). This is the preferred method for communicating about mental health needs.

Sequential Intercept Model: A conceptual model developed to inform community-based response to the involvement of people with mental and substance use disorders in the criminal justice system. See <https://www.prainc.com/sim/>.

2016-2017 Policy Paper

Decriminalization of Mental Illness: Fixing a Broken System



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I. Introduction

*Waiting four months for a state psychiatric hospital bed to become available, Jamecheal Mitchell died of a heart attack after starving himself in a Virginia jail cell. He had been arrested for stealing \$5.05 worth of snacks from a 7-Eleven. He had a mental illness and had thought he was in a relative's store. He was arrested, jailed, found incompetent to stand trial, and ordered into a state hospital to restore competency. No bed was available, so he waited in jail until he died. He was 24.*¹

As tragic as Jamecheal Mitchell's story is, it is not uncommon for those suffering from serious mental illnesses to languish in jails or hospital emergency rooms. Jails and prisons have replaced mental health facilities as the primary institutions for housing persons suffering from mental illness. Our criminal justice system has become a revolving door for persons with mental illness, with the same persons cycling through the system again and again at great cost.²

With timely and appropriate services and support, most mental illnesses are treatable, and recovery is possible, reducing the likelihood of behavior that can lead to incarceration. However, outdated and untimely responses to mental illness now

block treatment and services that can prevent crime and lead to recovery.³ Rigid legal standards for involuntary treatment and the lack of an adequately funded community-based mental health system have led to a public safety crisis. Instead, the criminal justice system is systematically being used to criminalize mental illness and re-institutionalize persons with mental illnesses into jails and prisons.

For people suffering from serious mental illness, many state court systems are currently unable to order needed treatment as an alternative to incarceration. Judges and court personnel are in a unique position to describe to policymakers what they see in their courtrooms every day – a broken system, leading to compromised public safety, excessive incarceration, and damaged lives.

Policy makers need to provide our courts with better tools to meet this challenge. New legal standards that promote early intervention, combined with easily accessible assisted outpatient community-based treatment, will create the best opportunity to begin to reduce the use of jails and prisons as the *de facto* mental health system.⁴

COSCA advocates (1) An "Intercept 0" capacity based standard for court-ordered treatment as used in court-ordered treatment

¹ Treatment Advocacy Ctr., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds 4* (2016), <http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf> [<http://perma.cc/HFW9-GQUM>]; see also June W. Jennings, Office of the State Inspector General, Report to Governor Terence R. McAuliffe, Investigation of Critical Incident at Hampton Roads Regional Jail (2016), <https://osig.virginia.gov/media/5749/2016-bhds-002-hrrj-death-final-sig-approved.pdf> [<http://perma.cc/Z946-6PG4>].

² The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*

7 (2002), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf> [<http://perma.cc/4R6X-NFRE>].

³ Mich. Mental Health Comm'n, Part I: Final Report 16-17 (2004), http://www.michigan.gov/documents/FINAL_MHC_REPORT_PART_1_107061_7.pdf [<http://perma.cc/9H47-94XN>].

⁴ Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. Am. Acad. Psychiatry & L. 406, 406 (2007).

of other illnesses to replace the dangerousness standard now applied, (2) Assisted Outpatient Treatment (AOT) under a capacity based standard, and (3) robust implementation of Intercepts 1 through 5 of the Sequential Intercept Model. COSCA supports court leadership to convene parties interested in mental health issues to address more effective court involvement with these issues in the three ways advocated in this paper.

II. Jails and Prisons: The New Institutions for Persons with Mental Illness

“[W]hen mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system, with dire consequences to us all.”⁵
Chief Judge Judith S. Kaye

In nearly every state, jails and prisons are now the primary institutions for housing persons with mental illness.⁶

Over the course of the year, approximately two million adults suffering from serious mental illnesses will spend time in our

nation’s jails.⁷ While many thousands receive mental health treatment in custody, many do not. Even if treatment is available, jails and prisons are not therapeutic environments, leading to increased symptoms and diminished quality of life following release.⁸ For persons who enter the jail on a regimen of psychotropic medications, this regimen often cannot be sustained because of inadequate access in the jail to prescription medication. Often, inmates experience a delay between entry to the jail and provision of medication (which may not be their regularly prescribed medication, but a substitution based on availability or cost). Interruptions in the continuity of a medication regimen are detrimental to establishing stability.⁹

Current estimates are that over 383,000 people with serious mental illnesses are residing in our nation’s jails and prisons while fewer than 40,000 people with mental illnesses are being treated in state-funded hospitals.¹⁰ Ironically, the movement to provide state psychiatric hospitals, also known as “mental institutions”, was a reform movement that began over 150 years ago to end inhumane conditions of incarceration.¹¹

⁵ Matthew J. D’Emic, *The Promise of Mental Health Courts: Brooklyn Criminal Justice System Experiments with Treatment as an Alternative to Prison*, 22 *Crim. Just.* 24, 28 (2007) (quoting a November 25, 2002 press release from the New York State Office of Mental Health).

⁶ Treatment Advocacy Ctr., *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States* (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf [<http://perma.cc/XV5L-9YD6>].

⁷ Henry Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 *Psychiatric Servs.* 761, 764 (2009).

⁸ See Anasseril, *supra* note 4; see also Beatrice Coulter, *My Turn: The Trouble with New Hampshire’s Secure Psychiatric Unit*, *The Concord Monitor* (Feb. 28, 2016),

<http://www.concordmonitor.com/Archive/2016/02/my-turncoulter-cmforum-022716> [<http://perma.cc/L5L6-PJS4>].

⁹ Kavita Patel et al., *Integrating Correctional and Community Health for Formerly Incarcerated People Who Are Eligible for Medicaid*, 33 *Health Aff.* 468 (2014).

¹⁰ *Fast Facts*, Treatment Advocacy Ctr., <http://www.treatmentadvocacycenter.org/evidence-and-research/fast-facts> (last visited Jan. 31, 2017) [<http://perma.cc/ED22-KNDS>].

¹¹ See Manon S. Parry, *Dorothea Dix (1802-1887)*, 96 *Am. J. Pub. Health* 624, 624-25 (2006); see also Dorothea L. Dix, *Memorial to the Legislature of Massachusetts*, 1843, <http://www.archive.org/stream/memorialtolegisl00dix/d#page/n3/mode/2up> [<http://perma.cc/Z733-L2P2>].

In 44 states, a jail or prison holds more prisoners with mental illness than the largest state psychiatric hospital.¹² In a 2009 study, nearly two-thirds of all prisoners with mental illness were off their medications at the time of arrest.¹³ Estimates are that 25% to 40% of individuals with serious mental illness have been in jail or prison at some time in their lives.¹⁴

Incarceration of persons with mental illness has been a growing problem for several years and shows no signs of abating. A 2002 report warned of the growing population shift of persons with mental illness from psychiatric hospitals to prisons.¹⁵ Fifteen years later, that trend continues to grow. For example, in Michigan, although the total number of prisoners is declining, the number of prisoners with serious mental illness has increased 14% since 2012 and now comprises 23% of the total prison population while those with the most severe mental illnesses annually cost \$95,233 per inmate to house and treat compared with an average cost of \$35,253 for other inmates.¹⁶ On the other hand, Michigan spends an average of

\$5,741 annually on unincarcerated adults with mental illness.¹⁷

Virginia has had a similar experience. The closure of state hospitals was not accompanied by an adequate increase in community-based services, resulting in an increase in the number of people with mental illness in Virginia's jails. Between 2005 and 2012, Virginia's share of inmates with mental illness went from 16% to 23.7%.¹⁸

Prisoners with mental illness are also more likely to have experienced homelessness and prior incarceration, and they are known to have other criminogenic risk factors, including substance use disorders.¹⁹ Studies of prisoners with mental illness in Texas, Utah, Maryland, Illinois, and Ohio found that the likelihood of returning to prison dramatically increased for inmates with major psychiatric disorders.²⁰ Prisoners with mental illness in the criminal justice system serve longer sentences, receive more

¹² *Criminalization of Mental Illness*, Treatment Advocacy Ctr., <http://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness> (last visited Jan. 31, 2017) [<http://perma.cc/V4EM-9GV3>].

¹³ Andrew P. Wilper et al., *The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey*, 99 Am. J. Pub. Health 666, 666 (2009).

¹⁴ See Jeffrey W. Swanson et al., *Costs of Criminal Justice Involvement Among Persons with Serious Mental Illness in Connecticut*, 64 Psychiatric Servs. 630 (2013); More Mentally Ill Persons are in Jails and Prisons than Hospitals, *supra* note 6, at 1.

¹⁵ Mentally Ill Offenders in the Criminal Justice System, *supra* note 2, at 3.

¹⁶ Michael Gerstein & Jonathan Oosting, *Growth of Mentally Ill Inmates Raises Concern in Mich.*, The Detroit News (Dec. 28, 2016, 12:03 AM), <http://www.detroitnews.com/story/news/local/michigan/2016/12/28/growth-mentally-inmates-raises->

[concern-mich/95897544/ \[http://perma.cc/V7GH-U77G\]](http://perma.cc/V7GH-U77G) (referencing a Michigan Department of Corrections report).

¹⁷ Mich. Dep't of Health & Human Servs., Report on CMHSPs, PIHPs, Regional Entities, at 904(2)(b), p. 1 (2016), http://www.michigan.gov/documents/mdhhs/Section_904_2015_530673_7.pdf [<http://perma.cc/RRD8-KJSM>].

¹⁸ Mira E. Signer, *Virginia's Mental Health System: How It Has Evolved and What Remains To Be Improved*, 90 Va News Letter 1, 10 (2014).

¹⁹ KiDeuk Kim et al., Urban Inst., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* 9-10 (2015), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf> [<http://perma.cc/KYN2-5KRV>].

²⁰ *Id.* at 11-12.

probation and parole violations, and have higher rates of recidivism.²¹

Prisoners with mental illness remain incarcerated much longer than other inmates largely because many find it difficult to follow and understand jail and prison rules.²² For example, in Washington State, prisoners with mental illness accounted for 41% of prison rule infractions but only 19% of the prison population.²³ Prisoners with mental illness are more likely to be placed in solitary confinement and commit suicide.²⁴ All of this is at great expense to taxpayers and great human cost to affected inmates and their families.

The cost for psychiatric services spent in correctional environments, combined with the increased rate of recidivism for those with mental illness who are not appropriately supported means that these societal fiscal and human expenditures must be made again and again with no measurable benefit.

III. The Forces that Shaped this Outcome

The Community Mental Health Act (CMHA) of 1963 created a financial incentive for states to close state-funded

mental hospitals while promising to fund community-based outpatient treatment and community mental health centers to replace the services provided by hospitals. However, the community mental health centers that were to be the backbone of the promised community treatment system failed to materialize.²⁵ The absence of the promised community treatment system, the lack of adequate funding, and the inability to intervene except in the event of a crisis have led to the dramatic increase in the incarceration of persons with mental illness.²⁶

Under the CMHA, the federal government agreed to help states pay for the treatment of indigent persons with mental illness. In 1965, Congress excluded the use of federal funds for hospitalization in state hospitals. This restriction, known as the Institution for Mental Diseases (IMD) exclusion was the “stick” used by the federal government to disincentivize the treatment of persons with mental illness in large institutions.²⁷ This created a strong impetus for states to close hospitals.²⁸

In 1975, the United States Supreme Court ruled in *O'Connor v. Donaldson* that persons could not be held in mental hospitals solely due to mental illness if they

²¹ Doris J. James & Lauren E. Glaze, U.S. Dep’t of Justice, Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates* (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<http://perma.cc/G7K9-2UTK>].

²² Treatment Advocacy Ctr., *Serious Mental Illness (SMI) Prevalence in Jails and Prisons 2* (2016), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf> [<http://perma.cc/YBF4-3CFJ>].

²³ *Id.*

²⁴ *Id.* at 3-4.

²⁵ Michelle R. Smith, *50 Years Later, Kennedy’s Vision for Mental Health Not Realized*, The Seattle

Times (October 21, 2013, 8:28 PM), <http://www.seattletimes.com/nation-world/50-years-later-kennedys-vision-for-mental-health-not-realized/> [<http://perma.cc/ART8-JF5Y>].

²⁶ More Mentally Ill Persons are in Jails and Prisons than Hospitals, *supra* note 6.

²⁷ Treatment Advocacy Ctr., *The Medicaid IMD Exclusion and Mental Illness Discrimination 2* (2016), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/imd-exclusion-and-discrimination.pdf> [<http://perma.cc/E376-KTDK>].

²⁸ Part I: Final Report, *supra* note 3, at 9.

were capable of living safely outside the hospital.²⁹ In reaction to this decision and the financial incentives in the CMHA, state legislatures adopted mental health codes that severely restricted the ability of courts to order inpatient treatment without the consent of the person with mental illness.³⁰

The codes were designed to make it very difficult to order hospitalization, thereby helping to facilitate the deinstitutionalization³¹ of persons with mental illness and the closing of psychiatric hospitals.³² “The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community and on the willingness of patients to accept treatment voluntarily.”³³ While most people who suffer from mental illness who would have been institutionalized in the past are able to live independently, for far too many, the system is inadequate to prevent homelessness, incarceration, and impoverishment.

The mental health codes of the 1970s established important due process rights in involuntary mental health proceedings. Those safeguards, such as the right to counsel at state expense, the right to a trial by jury, and the right to an independent medical examination at state expense, were important reforms that should continue.

In addition to due process protections, these laws limited the basis upon which mental health treatment could be ordered. Over the years, there have been some modifications to these laws, but generally, three standards for involuntary mental health treatment are in use by all of the states. They include: (1) dangerousness, (2) gravely disabled, and (3) need-for-treatment.³⁴ However, all of the standards require a substantial probability of harm or dangerousness. The result is that civil courts can only intervene when an individual is in crisis and poses a clear risk of harm.³⁵ For example, Wisconsin, in its need-for-treatment standard, requires that an individual’s lack of capacity be accompanied by a substantial probability of severe mental, physical, or emotional harm based on a history of actions by that individual that supports that expectation. Even then, if there is a substantial probability that the individual may be provided protective placement or services, involuntary treatment cannot be ordered.³⁶ These codes also created complex processes to secure treatment. A request for treatment is initiated by petition. In most states, a family member can initiate the proceeding, but in some states, only a professional can initiate proceedings. Most states require that multiple physicians participate in the process to secure treatment. For many

²⁹ O’Connor v. Donaldson, 422 U.S. 563, 575 (1975).

³⁰ Treatment Advocacy Ctr., Mental Health Commitment Laws: A Survey of the States 5-6 (2014), <http://www.treatmentadvocacycenter.org/storage/documents/2014-state-survey-abridged.pdf> [<http://perma.cc/U9CB-C9HU>].

³¹ “Deinstitutionalization” is moving psychiatric patients from hospital settings into less restrictive settings in the community.

³² Am. Psychiatric Ass’n, Mandatory Outpatient Treatment Resource Document 2 (1999), https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/rd1999_MandatoryOutpatient.pdf [<http://perma.cc/GLE6-SHFS>]. See also Richard D. Lyons, *How Release of Mental Patients Began*, N.Y. Times (Oct. 30, 1984), <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all> [<http://perma.cc/K9RP-VLJD>].

³³ See Mandatory Outpatient Treatment Resource Document, *supra* note 32, at 2.

³⁴ Mental Health Commitment Laws, *supra* note 30, at 7-8.

³⁵ *Id.* at 4-8.

³⁶ Wis. Stat. § 51.20(1)(a)2(e) (2016).

family members, the process is too complicated and too late.

States should be given greater flexibility to use federal funds to address the mental health needs of the general population. Today, with less than 38,000 psychiatric beds available in the United States, the goal of the IMD to reduce the use of hospitalization for treatment has long been met. The IMD exclusion has greatly contributed to the nation's shortage of psychiatric hospital beds and should be eliminated.

The risk of unnecessary or inappropriate hospitalization has vanished. While hospitalization is sometimes necessary, mental health systems, like medical systems in general, will remain financially incentivized to use hospitalization as a last resort, even without the IMD exclusion, in order to maximize the allocation of scarce resources. "In fact, longer hospital stay[s] may nowadays imply poor mental health care and support in the community."³⁷ Funding decisions have also contributed to the crisis by converting state mental health systems that once served the general public into systems that primarily serve only those who qualify for Medicaid. Following adoption of the CMHA, states began reducing funding for mental health.³⁸

Therefore, for those not eligible for Medicaid, safety net resources are hard to find,³⁹ resulting in delays in treatment and increasing the risk of adverse consequences. More recently, during the 2007-2009 recession, state funding for mental health dropped by \$4.35 billion.⁴⁰ Many states also cut back services for uninsured people who were not Medicaid-eligible, leaving them without access to care.⁴¹

A study of state spending on mental health systems for fiscal year 2002 established a very strong correlation between those states having more persons with mental illness in jails and prisons and those states spending less on mental health services. The states spending more on mental health services were less reliant on jails and prisons while those spending less on mental health tended to rely more heavily on jails and prisons.⁴²

Compounding this problem, the promised comprehensive community-based treatment services that were to replace hospitalization did not materialize. "Unfortunately, community resources have not been adequate to serve the needs of many chronic patients, and large numbers of patients have failed to become engaged with the community treatment system."⁴³

³⁷ Athanassios Douzenis et al., *Factors Affecting Hospital Stay in Psychiatric Patients: The Role of Active Comorbidity*, 12:166 *BMC Health Servs. Res.* 1, 3 (2012), <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-166> [<http://perma.cc/GTB9-KFJP>].

³⁸ Judge David L. Bazelon Ctr. for Mental Health Law, *Funding for Mental Health Services and Programs 1-2* (2011), <http://www.bazelon.org/LinkClick.aspx?fileticket=GzmAbAweikQ%3D&tabid=436> [<http://perma.cc/ESC6-VURZ>].

³⁹ Part 1: Final Report, *supra* note 3, at 9.

⁴⁰ Nat'l All. on Mental Illness, *State Mental Health Legislation 2015: Trends, Themes & Effective Practices 1* (2015), <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf> [<http://perma.cc/6KY8-87BJ>].

⁴¹ *Funding for Mental Health Services and Programs*, *supra* note 38, at 2-3.

⁴² *More Mentally Ill Persons Are in Jail and Prisons than Hospitals*, *supra* note 6, at 8.

⁴³ *Mandatory Outpatient Treatment Resource Document*, *supra* note 31, at 2 (citations omitted).

The closure of most psychiatric hospitals in response to the CMHA and the enactment of laws limiting involuntary treatment have resulted in an apparent shortage of psychiatric hospital beds.⁴⁴ This shortage, along with insurance limits, has created an incentive to release patients as quickly as possible to create more bed capacity without adding more beds. There is also a shortage of psychiatrists for adults⁴⁵ and an even greater shortage for children.⁴⁶ As a result of these shortages and changing practices, length of stay (LOS) in the hospital has been steadily shrinking. The median LOS for an acute episode of schizophrenia went from 42 days in 1980 to 7 days by 2013.⁴⁷

The shortage of hospital beds and psychiatrists is also affecting the criminal justice system. Forensic centers that house and treat persons found not guilty by reason of insanity and those found incompetent to stand trial are full, and these persons are now filling state psychiatric hospital beds.⁴⁸ In Maryland, 80% of those admitted to state facilities are arriving via the criminal justice system.⁴⁹

The shortage of space is causing long delays in conducting competency evaluations and placement for those ultimately found incompetent to stand trial. These prisoners languish in jail awaiting their evaluation or placement, too often with tragic results, like the senseless death of Jamycheal Mitchell.

The shortage of hospital beds has also led to the practice of “psychiatric boarding.” People experiencing mental health crises often appear in hospital emergency rooms, where they face prolonged waits for admission or placement. Psychiatric patients are boarded in hospital emergency departments longer than any other type of patient and experience poorer outcomes.⁵⁰ In West Virginia, “psychiatric boarding” may mean the back of a police cruiser; a person picked up on a mental hygiene order could potentially spend as many as eighteen hours in the back of the car waiting for a mental hygiene commissioner.⁵¹

Today, when a law enforcement officer encounters a person with mental illness who is creating a disturbance, the officer must

⁴⁴ The shortage has continued to grow. Bed capacity has declined from 70,000 in 2002 to less than 40,000 in 2017. *Mentally Ill Offenders in the Criminal Justice System*, *supra* note 2, at 3; E. Fuller Torrey, *A Dearth of Psychiatric Beds*, *Psychiatric Times* (Feb. 25, 2016), <http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds> [<http://perma.cc/SX9B-XFVN>].

⁴⁵ Jonathan Block, *Shortage of Psychiatrists Only Getting Worse*, *Psychiatry Advisor* (Sept. 8, 2015), <http://www.psychiatryadvisor.com/practice-management/psychiatrist-psychiatry-shortage-few-stigma/article/437233> [<http://perma.cc/PF39-DQ3N>].

⁴⁶ *Workforce Maps by State: Practicing Child and Adolescent Psychiatrists by State 2015*, *Am. Acad. Child & Adolescent Psychiatry*, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx (last visited Jan. 31, 2017) [<http://perma.cc/4WKW-Y8ZR>].

⁴⁷ Treatment Advocacy Ctr., *Released, Relapsed, Rehospitalized: Length of Stay and Readmission Rates*

in *State Hospitals 1* (2016), <http://www.treatmentadvocacycenter.org/storage/documents/released-relapsed-rehospitalized.pdf> [<http://perma.cc/T2U7-73FQ>].

⁴⁸ Forensic patients now occupy almost half of state hospital beds nationwide. *Going, Going, Gone*, *supra* note 1, at 1-2.

⁴⁹ Michael Dresser, *With Psychiatric Beds Full, Mentally Ill in Maryland are Stuck in Jails*, *The Balt. Sun* (June 8, 2016, 8:43 PM), <http://www.baltimoresun.com/health/bs-md-mental-health-beds-20160608-story.html> [<http://perma.cc/GP7C-DWJT>].

⁵⁰ John E. Oliver, *Mental Health Crises and Hospital Emergency Departments*, 34 *U. Va. Inst. L., Psychiatry & Pub. Pol’y* 6, 6 (2015).

⁵¹ E-mail from Steve Canterbury, State Court Administrator (Ret), West Virginia, to author (Jan. 27, 2017, 1:49 AM).

decide between arrest and referral to a psychiatric facility for mental health treatment. In practice, officers know that access to care is limited, so the default option to resolve the immediate problem is often arrest or no action at all.⁵²

IV. More Effective Tools Exist for Courts to Address Mental Illness and its Impact on the Court System and the Community

What should courts do to address this complex issue? The overuse of jails and prisons to house persons with serious mental illnesses has broad impact and should be addressed systematically.⁵³

A. Overview of the Sequential Intercept Model

A promising approach is the Sequential Intercept Model. The model provides a conceptual framework for states and communities to use when constructing the interface between the criminal justice and mental health communities to use as they address the criminalization of people with mental illness.

“The Sequential Intercept Model ... can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as

they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision-makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time.”⁵⁴

The model contemplates diversion programs to keep people with serious mental illness in the community and not in the criminal justice system, providing constitutionally adequate institutional services in correctional facilities and the establishment of reentry transition programs to link those inmates with serious mental illness to community-based services when they are released.

The CMHS National GAINS Center⁵⁵ has developed a comprehensive sequential model for people with serious mental illness caught up in the criminal justice system. It provides for five intercept points: Intercept 1—contact with law enforcement, Intercept 2—initial detention and court hearing, Intercept 3—after incarceration, including mental health court and jail-based services; Intercept 4—reentry, and Intercept 5—parole or probation.

⁵² Mentally Ill Offenders in the Criminal Justice System, *supra* note 2, at 14.

⁵³ Adults with a serious mental illness (SMI) are defined by the Substance Abuse and Mental Health Services Administration as persons age 18 or over with a diagnosable mental illness of sufficient duration to meet diagnostic criteria with the DSM-IV, resulting in functional impairment which substantially interferes with or limits one or more major life activities. See Substance Abuse & Mental Health Admin. Ctr., Definitions and Terms Relating to Co-Occurring Disorders: COCE Overview Paper 1, at 2 (2006),

<https://store.samhsa.gov/shin/content/PHD1130/PHD1130.pdf> [<http://perma.cc/GA9J-EEQY>].

⁵⁴ Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 *Psychiatric Servs.* 544, 547-48 (2006).

⁵⁵ The Gains Center is a part of the Substance Abuse and Mental Health Services Administration (SAMHSA) and is focused on expanding access to services for people with mental illness who come into contact with the criminal justice system.

COSCA supports the sequential intercept model and encourages its adoption. COSCA also supports the addition of an Intercept 0 that addresses what can be done prior to contact with law enforcement. The new Intercept 0 should enable the civil justice system to help persons with mental illness secure earlier treatment in order to avoid behavior that may lead to contact with the criminal justice system.

Accomplishing this requires modifying mental health codes to permit timely, court-ordered treatment for persons with mental illness, before and after contact with law enforcement. This requires the conversion of mental health codes from current “inpatient” models to “outpatient” models focused on delivering timely treatment in the community.

If we are to be successful in reducing our reliance on jails and prisons, the courts would do best if they could address the needs of individuals with mental illness prior to their involvement with the criminal justice system. Modern mental health codes that will permit earlier intervention and promote the use of assisted outpatient treatment (AOT) will help persons with serious mental illness recover, exercise meaningful self-determination and avoid contact with law enforcement.

1. Capacity-Based Standard for Intervention

State mental health codes adopted in the 1970s in response to the Supreme Court’s decision in *O’Connor* were modeled to only address involuntary hospitalization. Court-

ordered community-based treatment did not exist and therefore was not addressed.

The late 1990s saw the emergence of the “recovery model” in guiding mental health policy and practice. The emphasis of this model was on the ability of a person with severe mental illness to develop a sense of identity and regain control over his or her life.⁵⁶ This model offered the hope of restoring the capacity to exercise self-determination. The recovery model recognizes that early intervention is preferred to secure the likelihood of a successful recovery. However, the recovery model is not reflected in the old mental health codes, which are “inpatient” models in an “outpatient” world.⁵⁷ The old codes focus on preventing hospitalization unless an individual is in crisis.

Modern brain research and the development of effective treatment have demonstrated the value of early intervention in recovery and resiliency.⁵⁸ What is needed are mental health codes based on the current outpatient model of treatment. That begins with changing the standard for intervention in the course of a person’s mental illness. Since *O’Connor* was decided, most mental health treatment is now provided on an outpatient basis. Recognizing this fact, states have begun using court-ordered Assisted Outpatient Treatment (AOT) instead of hospitalization for those who do not recognize their need for treatment. AOT is court-supervised treatment within the community. A treatment plan is developed that is highly individualized. These plans typically include case management, personal therapy, medication, and other services

⁵⁶ The President’s New Freedom Comm’n on Mental Health, Final Report 4-5, 57, 60 (2003), <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf> [<http://perma.cc/TEV5-BVVF>].

⁵⁷ Part I: Final Report, *supra* note 3, at 30.

⁵⁸ *Id.* at 12, 14.

designed to promote recovery. Noncompliance with the plan can lead to immediate hospitalization.⁵⁹

The Agency for Healthcare Research and Quality and the Substance Abuse and Mental Health Services Administration have both recognized AOT as an effective treatment option that has now been added to the National Registry of Evidence-Based Programs and Practices.⁶⁰

AOT enables people with mental illness to recover from their symptoms and lead productive lives. *AOT is not confinement*. It is most useful when used before an individual with mental illness is in crisis. AOT reduces hospitalization, arrests, incarceration, poverty, and homelessness. It would be difficult to imagine a more significant array of legitimate state interests that would justify ordering outpatient treatment. There is nothing in *O'Connor* that requires a showing of dangerousness before ordering AOT for a person suffering from mental illness in order to alleviate the symptoms of mental illness.

Currently, the standards for court-ordered treatment focus on a person's *future conduct* (the likelihood of causing harm), not *capacity*. This requires predictive ability as opposed to a present assessment. Assessing

a person's present capacity is far less problematic than predicting future conduct. The person may be incapacitated and unable to make informed decisions about his or her mental illness, but, unless the person can be predicted to be currently dangerous enough to be expected to seriously injure someone, nothing can be done. The *lack of capacity to make an informed decision* alone is not sufficient to secure court-ordered treatment for mental illness in any state.

Even in those states⁶¹ that appear to have a capacity-oriented standard, also known as the "need-for-treatment standard," the law still requires that there also be a substantial probability of severe mental, emotional, or physical harm without the treatment.⁶² A person that lacks the capacity to make an informed decision about his/her illness is simply not enough. The law requires waiting for crisis before acting.

Comparing the evolution of the law with respect to adult guardianship proceedings is helpful. Years ago, most states moved from a conduct-based standard to a capacity-based standard when deciding whether to appoint a guardian for an incapacitated adult. The old standard focused on whether the person was making responsible decisions.⁶³ The modern standard for appointing a guardian focuses on whether the person lacks the capacity to make or communicate informed decisions about him/herself. Unlike a petition seeking

⁵⁹ Treatment Advocacy Ctr., *A Guide for Implementing Assisted Outpatient Treatment 9* (2012), <http://www.treatmentadvocacycenter.org/storage/documents/aot-implementation-guide.pdf> [<http://perma.cc/N2GC-UL53>].

⁶⁰ *Assisted Outpatient Treatment (AOT)*, Substance Abuse & Mental Health Servs. Admin., Nat'l Registry of Evidence-Based Programs & Practices, <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=401> (last visited Jan. 31, 2017) [<http://perma.cc/A923-S8BM>].

⁶¹ Alabama, Arizona, Colorado, Kansas, Mississippi, Texas, Utah and Wisconsin.

⁶² *Mental Health Commitment Laws*, *supra* note 30, at 7.

⁶³ See Mich. State Representative Perry Bullard, Chair, House Judiciary Comm., *Michigan Guardianship Reform Act Handbook* (1991).

involuntary mental health treatment, there is no requirement of a threat of imminent harm or danger before a guardian can be appointed for someone who is incapacitated.

The same standard should be used when deciding whether to order mental health treatment. Mental illness should be treated the same as any other illness. For someone incapacitated by mental illness, current law makes it more difficult to secure involuntary mental health treatment than for almost any other illness.

For example, if a person has a guardian due to mental illness, the guardian could, over the ward's objection, consent to treatment of a leg infection that could include amputation. However, unless danger is imminent (i.e., the person was threatening to harm himself or others), the guardian would be unable to secure court-ordered mental health treatment for that same person, even though that treatment may restore the person's capacity to make his/her own decisions.

In most states, the same court that can appoint a guardian for a person with mental illness if that person lacks the capacity to make informed decisions cannot grant authority to the guardian to consent to mental health treatment that would restore that person's capacity and terminate the guardianship. To rectify this issue, at least four states have implemented some statutory authority to permit guardians to consent to mental health treatment over the ward's

objection. North Dakota made that change this year.⁶⁴

Waiting to intervene until a crisis exists damages a person's resiliency, the ability to recover from a psychotic episode.⁶⁵ There is often adequate time between the onset of incapacity and crisis to secure the treatment necessary to prevent the crisis and avoid the consequences of untreated mental illness. For too long, family members of persons with mental illness have endured the frustration of attempting to secure treatment for family members unable to help themselves only to be turned away because the person was not yet in crisis.⁶⁶

Complicating the problem is the fact that many individuals with serious mental illness, like schizophrenia, lack insight into their illness due to anosognosia, a functional and structural abnormality of the brain. In these cases, poor insight is a function of the illness rather than a coping mechanism.⁶⁷

A more appropriate standard for ordering involuntary mental health treatment would be: *When a person's judgment is so impaired by mental illness that he or she is unable to make informed decisions about that mental illness.* This is the standard used for all other illnesses. This is the standard generally used to appoint a guardian to consent to treatment for all other ailments. Such a standard would permit earlier intervention—intervention before a crisis occurs. This intervention would also present a better opportunity for an earlier recovery that would preserve that person's ability to

⁶⁴ H.B. 1365, 65th Legis. Assemb., Reg. Sess. (N.D. 2017), <http://www.legis.nd.gov/assembly/65-2017/documents/17-0901-04000.pdf> [<http://perma.cc/TH7S-X2TX>]. Wisconsin, Florida and Massachusetts have taken similar action.

⁶⁵ Am. Psychiatric Ass'n, Practice Guidelines for the Treatment of Psychiatric Disorders 256-61 (2004).

⁶⁶ See generally Pete Earley, *Crazy: A Father's Search Through America's Mental Health Madness* (2006).

⁶⁷ See generally Xavier Amador, *I Am Not Sick I Don't Need Help!: How to Help Someone with Mental Illness Accept Treatment* (2012).

bounce back from a future episode and avoid permanent incapacity. Most significantly, it would create the opportunity to restore the person's capacity and liberty to make his or her own choices.

2. Expanded Use of Assisted Outpatient Treatment

New York State has led the way in implementing AOT. A study of New York State's AOT program found that court-ordered AOT was effective at increasing medication adherence, reducing hospital readmission, and promoting recovery. AOT patients had a substantially higher level of personal engagement in their treatment, and they were no more likely to feel coerced by the mental health system than voluntary patients. The best predictor of perceived coercion or stigma was the patient's perception of being treated with dignity and respect by mental health professionals. The study found that increased services available under AOT clearly improved recipient outcomes. The court order itself, and its monitoring, appeared to offer additional benefits in improving outcomes.⁶⁸ Other states, including California, Florida, and Ohio have also found that the use of AOT reduces hospitalization, incarceration, and cost.

However, despite its effectiveness, in many states, the standard that must be used to order AOT is often stricter than the standard for ordering hospitalization. States often

require that a person have a history of recent involuntary hospitalization, serious violent behavior, or incarceration before AOT can be ordered. AOT is not used to prevent crisis; it is used only after the adverse consequences of a crisis have occurred.⁶⁹ Recently, Michigan joined Arizona and modified its law to permit courts to order AOT in all proceedings seeking involuntary mental health treatment.⁷⁰ Michigan no longer requires a history of recent involuntary hospitalization, serious violent behavior, or incarceration to order AOT. This policy change will permit the use of AOT whenever treatment is ordered.

AOT has been referred to as "outpatient commitment." This term reflects the ethical tension in the psychiatric community between principles of self-determination and promotion of the patient's medical best interest.⁷¹ However, AOT is less likely to impair self-determination than detention in a prison or psychiatric hospital and is an opportunity to restore the person's meaningful exercise of self-determination.

Dr. Alexander Simpson, Chief of Forensic Psychiatry at the Center for Addiction and Mental Health in Toronto, Ontario, Canada, wrote that the international evidence of the effectiveness of AOT supports the conclusion that it provides treatment in a deinstitutionalized environment for those who would otherwise refuse it and for whom

⁶⁸ Sharon E. Carpinello, N.Y. State Office of Mental Health, *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment 20-21* (2005), https://www.omh.ny.gov/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf [<http://perma.cc/JF3K-JB33>].

⁶⁹ Mental Health Commitment Laws, *supra* note 30, at 14-18.

⁷⁰ Mich. Comp. Laws 330.1468(2)(e), as enacted by 2016 PA 320 (effective Feb. 14, 2017).

⁷¹ Am. Psychiatric Ass'n, *Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment 1* (2015), <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2015-Involuntary-Outpatient-Commitment.pdf> [<http://perma.cc/CKS6-NQZY>].

adverse events would otherwise occur.⁷² He added that limiting the use of compulsory treatment increases the likelihood that treatment will occur late in the course of a relapse, too late to be used as a risk management tool.⁷³ He observed that these compulsory treatment laws require that the risk be manifested, not anticipated, which results in intervention that is too late.⁷⁴ It means that people suffering from serious mental illness will be at risk of living in the community with more acute symptoms and functional impairment, leading to homelessness, self-harm, criminalization, and incarceration. He added that too many limits on intervention make it harder for families to cope with major ongoing symptoms.⁷⁵

Where AOT has been used, it has been effective in reducing homelessness, psychiatric hospitalization, violent behavior, arrest, and incarceration.⁷⁶ Unfortunately, AOT has not been widely used in most states. Just as courts can order hospitalization without a history of violence or incarceration, courts should be able to order AOT before people are in crisis rather than require that they suffer the consequences of untreated mental illness before receiving help.

AOT, rather than being a rarely used special sort of relief, should be the cornerstone of the community treatment program promised by the CMHA. Some states use AOT as a

discharge planning tool following treatment in a hospital.⁷⁷ AOT should be used as a discharge planning tool from jails and prisons as well as hospitals for those who fail to recognize their need for ongoing treatment.

The current model of hospitalization until stabilization is expensive. Short stays mean that release, relapse, and then rehospitalization occur far too often.⁷⁸ AOT, on the other hand, is a less restrictive, evidence-based practice that improves self-care, reduces harmful behavior, and offers results that are sustainable. Persons who have been the subject of AOT orders report high levels of satisfaction, including gaining control over their lives, getting well and staying well, and being more likely to keep appointments and take medication.⁷⁹

Instead of wasting scarce resources by repeatedly incarcerating or hospitalizing people with mental illness, it would be much better policy, at far less cost, to provide AOT early in the course of a person's mental illness. This would promote recovery and avoid criminal behavior that could result in incarceration as well as creating avoidable victims of criminal behavior. This is particularly evident when the crime is a minor one, such as shoplifting snacks worth \$5.05.⁸⁰ If Jamycheal Mitchell had received outpatient treatment through an AOT, he might be alive today.

⁷² Alexander Simpson, *Mental Health Law in Ontario: Challenges for Reform*, 31 Health L. in Can. 65, 69 (2011).

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Marvin S. Swartz et al., Duke Univ. Sch. of Med., New York State Assisted Outpatient Treatment Program Evaluation (2009), <https://www.omh.ny.gov/omhweb/resources/publicati>

ons/aot_program_evaluation/report.pdf [<http://perma.cc/K84P-DZ8M>].

⁷⁷ *See id.*

⁷⁸ *See* Released, Relapsed, Rehospitalization, *supra* note 47.

⁷⁹ Sharon E. Carpinello, N.Y. State Office of Mental Health, *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment 20-21* (2005), https://www.omh.ny.gov/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf [<http://perma.cc/JF3K-JB33>].

⁸⁰ *See supra* text accompanying note 1.

There are significant up-front costs in establishing AOT programs.⁸¹ However, states that use AOT have found that the cost of mental health services for those being served has been reduced, primarily due to the effectiveness of AOT in reducing rehospitalization rates,⁸² reduced length of stay, and less expenditures of tax dollars per person.⁸³

More access to care as well as earlier intervention would increase the number of people being served. This could result in a short-term increase in cost. However, the cost over time, and the burden on other entities like jails, prisons, and hospitals would decrease; and the quality of the lives of persons with mental illness would improve.⁸⁴

Modifying mental health codes to permit ordering treatment, including AOT, when a person's mental illness robs them of the capacity to make informed decisions would be an effective addition that would reduce contact with law enforcement and reliance on jails and prisons. It would also permit the civil justice system to intervene earlier and order a mental health evaluation and either AOT or hospitalization.

B. Use of the Sequential Intercept Model

The Sequential Intercept Model, as described below, should be implemented throughout the country.

⁸¹ Jeffrey W. Swanson et al., *The Cost of Assisted Outpatient Treatment: Can It Save States Money?*, 170 *Am. J. Psychiatry* 1423, 1423 (2013).

⁸² *Id.* at 1430.

⁸³ *Id.* at 1426.

⁸⁴ Caroline M. Sallee & Erin M. Agemy, Anderson Econ. Grp., *Costs and Benefits of Investing in Mental Health Services in Michigan* 4-6 (2011), <http://www.andersoneconomicgroup.com/Portals/0/upl>

1. Intercept “0”

Intercept 0 is prior to contact with law enforcement. This contact should permit the civil justice system to intervene early in the course of a person's mental illness in order to treat the illness and avoid contact with law enforcement. Changing the standard for court-ordered treatment to permit earlier intervention and providing assisted outpatient treatment as described in earlier sections of this paper will create the best opportunity to help someone recover in the course of their mental illness and avoid behavior that might lead to contact with the criminal justice system and other consequences of untreated mental illness.

2. Intercept 1

Intercept 1 is the first contact with law enforcement. Action steps in Intercept 1 include training police officers and 911 operators to recognize mental illness and providing a police-friendly drop-off at local hospitals or crisis centers.

About one in ten police calls across the nation now involve mental health situations.⁸⁵ People with mental illness are 16 times more likely to be killed than any other civilians approached or stopped by law enforcement.⁸⁶

oad/AEG_MACMHB_Final%20Full%20Report.pdf [<http://perma.cc/6BAK-UQDA>].

⁸⁵ Mike Maciag, *The Daily Crisis Cops Aren't Trained to Handle*, *Governing*, May 2016, at 55, <http://www.governing.com/topics/public-justice-safety/gov-mental-health-crisis-training-police.html> [<http://perma.cc/Z6XM-FBFB>].

⁸⁶ Treatment Advocacy Ctr., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* 1 (2015),

Crisis Intervention Training (CIT) for law enforcement is effective in reducing violent incidents involving police and persons with mental illness. This program originated in Memphis, Tennessee, and is now promoted by a national CIT training curriculum developed through a partnership between the National Alliance on Mental Illness, the University of Memphis CIT Center, CIT International, and the International Association of Chiefs of Police. The curriculum is designed to give officers more tools to do their jobs safely and effectively and help people with mental illness stay out of jail and get on the road to recovery.⁸⁷

In a recent study, officers who received CIT training believed that the training not only increased their knowledge and understanding of mental illness, but also gave them the skills to identify possible mental illness, de-escalate the situation, listen actively, and build trust. Following training, there was a significant and constant increase in drop offs at the mental health crisis center as opposed to jail.⁸⁸ More CIT training would improve law enforcement's response to mental health situations and help divert people from the criminal justice system. CIT training would also help probation officers who work closely with the courts, emergency room personnel unfamiliar with mental health issues, jail personnel, and others called upon to intervene in crisis situations.

<http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf> [<http://perma.cc/SR7S-WPEM>].

⁸⁷ *What is CIT?*, Nat'l All. on Mental Health, <http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT> (last visited Feb. 1, 2017) [<http://perma.cc/6ZNK-YPRF>].

⁸⁸ Sheryl Kubiak et al., Mich. State Univ., *Statewide Jail Diversion Pilot Program Implementation Process Report*, at I-G4 and I-G5 (2015), http://www.michigan.gov/documents/snyder/MSU_Im

As an example, Oakland County, Michigan, in partnership with its community mental health agency began CIT training of officers from across the county in 2015. In the previous five years, 51 individuals had been diverted to treatment in lieu of incarceration. Since then, over 300 persons per year have been diverted to treatment. The de-escalation skills learned by officers have improved the handling of other potentially hazardous situations such as domestic disputes.⁸⁹

Even with a civil justice intervention system that has the tools to handle mental health cases effectively and efficiently, there will still be a need for the criminal justice system to be able to effectively respond. This includes not only law enforcement, but all the participants in the criminal justice system. This means using effective screening tools to divert persons with mental illness into treatment, training judges and staff, and expanding the use of mental health courts and diversion programs.

There is evidence that well planned diversion programs that include jail-based interventions and CIT training can substantially reduce the rate of incarceration of people with serious mental illness. Aggregate findings for eight counties in Michigan with diversion programs found a 25% reduction in the number of inmates with serious mental illness between 2015 and 2016.⁹⁰

plementation_Process_Report_FINAL_033016_526665_7.pdf [<http://perma.cc/DS7H-838E>].

⁸⁹ Testimony of Lieutenant Steven Schneider to the Michigan House Law and Justice Committee on May 23, 2017.

⁹⁰ Sheryl Kubiak et al., Mich. State Univ., *Diversion Pilots: Planning for the Future with Baseline Data 5* (2017), http://www.michigan.gov/documents/mentalhealth/Aggregate_Report_NO_Appendices_1.5.17_568762_7.pdf [<http://perma.cc/2PYN-A723>].

Miami-Dade County in Florida has developed a remarkably successful pre-arrest diversion program under the leadership of Judge Steven Leifman. Over the past seven years law enforcement has responded to 71,628 mental health crisis calls resulting in almost 16,000 diversions to crisis units and only 138 arrests. The daily census in the county jail system has dropped from well over 7,000 to 4,000 inmates and the county has closed an entire jail facility representing cost-savings of \$12 million per year.⁹¹

3. Intercept 2

Intercept 2 is the initial detention and initial court hearing. Action steps at Intercept 2 include screening, assessments, pretrial diversion, and service linkage.

The courts should use their convening power to set up an interagency commission to study expediting time to disposition for cases where mental illness has been identified as a factor in the alleged crime. The courts should also provide education and training to court personnel in pretrial services to help them work effectively with defendants who have been identified as having a serious mental illness as well as education on community resources and how to link defendants with them.

Assessments should be used to determine appropriateness for diversion decisions, such as bond release programs, pretrial services, and by prosecutors in pre- or post-plea diversion programs. Identifying criminogenic risk is one critical component,

but the assessment should also include mental health screening. Mental health screens and assessments identify an individual's needs for services and provide the best placement and treatment plan for providing support, services, and stability.

In a typical pre-adjudication diversion program, a person with mental illness who has committed a crime would be offered the opportunity to have potential charges dismissed if he or she submits to mental health treatment and other conditions. There is usually some type of supervision similar to probation to ensure the conditions are met. Once conditions are met, the prosecutor or judge dismisses the charges.⁹²

4. Intercept 3

Intercept 3 usually occurs after incarceration and includes problem solving courts designed to divert persons with mental illness. The action steps include screening, referral to a mental health court and jail-based services.

Mental health courts are a type of problem solving court. They represent a dynamic partnership between the criminal justice system and community mental health providers. Mental health court is usually a form of intensive probation after a criminal charge is made and the defendant pleads guilty or is found guilty by a judge or jury. Nationally, the majority (73%) of mental health courts allow participants to enter post-plea, but there are also a significant number who also accept participants post-sentence (41%). The trend is that more

⁹¹ Judge Steven Leifman. Decriminalizing Mental Illness - Applying Lessons Learned in Miami-Dade County, paper delivered at the Arizona Court Leadership Conference in Flagstaff, Arizona, on October 13, 2017

⁹² Ctr. for Health & Justice at TASC, No Entry: A National Survey of Criminal Justice Diversion

Programs and Initiatives 20 (2013), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/CHJ%20Diversion%20Report_web.pdf [<http://perma.cc/8V76-DBHT>].

mental health courts are trying to divert individuals sooner in the adjudicative process.⁹³

Potential participants must meet certain eligibility requirements and agree to participate and comply with their treatment plans. Once admitted into the program, they appear regularly at status hearings before the judge, where their accomplishments and setbacks from the date of the last status hearing are discussed. Accomplishments are rewarded with incentives, and setbacks are punished by sanctions.⁹⁴ Typically, mental health courts adopt the Ten Essential Elements of Mental Health Courts. Some also apply case management through the Assertive Community Treatment (ACT) model, which provides wraparound services to meet an array of treatment and social service needs.

Nationally, mental health courts have become an effective way to address individuals with mental illness who face criminal charges. They have increased in number by 36% between 2009 and 2014.⁹⁵

Several research findings have supported positive outcomes with regard to reductions in recidivism and less time in custody and have found lasting results for at least two years after discharge; results extend beyond just the provision of treatment and services.⁹⁶

A statewide comparison of Michigan mental health courts found a significant difference in recidivism based on the structure of the program. Mental health courts with higher levels of integration performed better, meaning that, the case manager and the clinician participate on the treatment team and attend status conferences.⁹⁷

There is evidence that it is difficult to sustain reductions in recidivism over time for those who participate in these programs. For example, in one statewide study, recidivism rates for mental health court participants four years after graduation rose to 23%, only slightly better than the comparison group recidivism rate of 26% after two years, although still better than the nonparticipants after four years.⁹⁸ It may be

⁹³ Suzanne M. Strong, Ramona R. Rantala & Tracey Kyckelhahn, U.S. Dep't of Justice, *Census of Problem-Solving Courts*, 2012 (2016), <https://www.bjs.gov/content/pub/pdf/cpsc12.pdf> [<http://perma.cc/A3N8-MK8M>].

⁹⁴ Sheryl Kubiak et al., Mich. State Univ., *Statewide Mental Health Court Outcome Evaluation Aggregate Report* (2012), https://www.michigan.gov/documents/mdch/Statewide_MHC_Evaluation_-_Aggregate_Report_Final_103112_w_seal_407300_7.pdf [<http://perma.cc/RT2S-52BR>].

⁹⁵ Douglas B. Marlowe, Carolyn D. Hardin & Carson L. Fox, Nat'l Drug Court Inst., *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States* (2016), <http://www.nadcp.org/sites/default/files/2014/Painting%20the%20Current%20Picture%202016.pdf> [<http://perma.cc/J6M3-DE3L>].

⁹⁶ Christine M. Sarteschi, Michael G. Vaughn & Kevin Kim, *Assessing the Effectiveness of Mental Health*

Courts: A Quantitative Review, 39 J. Crim. Just. 12 (2011); H.J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study*, 68 *Archives of Gen. Psychiatry* 167 (2011); Virginia Aldigé Hiday, Bradley Ray & Heathcote W. Wales, *Predictors of Mental Health Court Graduation*, 20 *Psychol., Pub. Pol'y & Law* 191 (2014); Shelli B. Rossman et al., U.S. Dep't of Justice, *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York, Final Report* (2012), <https://www.ncjrs.gov/pdffiles1/nij/grants/238264.pdf> [<http://perma.cc/6VVW-AHNB>]; Virginia Aldigé Hiday, Bradley Ray & Heathcote W. Wales, *Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit*, 67 *Psychiatric Servs.* 378 (2016).

⁹⁷ Kubiak et al., *supra* note 94, at 60-62.

⁹⁸ Mich. Supreme Court, State Court Admin. Office, *Michigan's Problem-Solving Courts: Solving Problems Saving Lives* 42 (2015), [17](http://courts.mi.gov/administration/admin/op/problem-</p></div><div data-bbox=)

that participation in the program only defers recidivism.

Recidivism for participants may increase over time due to a lack of adequate community treatment and support. Once a person completes the program, he or she may lack access to continuing treatment and may decompensate. Unless the person poses an immediate danger to self or others, involuntary treatment cannot be ordered, and it is necessary to wait until the recurrence of the behavior that led to arrest in the first place. Linking the person to continuing community treatment may be necessary to achieve sustainable, long-term improvement in recidivism and mental health. More research is needed to measure the impact of different mental health court practices in reducing recidivism.⁹⁹ Research should include whether mental health courts have an impact on involuntary treatment orders and on why rates of recidivism increase over time. For example: What intervening variables might be influencing this and can they be addressed while the defendant is still subject to the jurisdiction of the mental health court?

In addition, mental health courts often have constraints that limit their use. Participation is usually voluntary, so those who do not understand their need for treatment are less likely to participate. This excludes the highest need defendants. And these courts usually require a guilty plea before the defendant can participate. This results in a criminal record and the negative

consequences that flow from a conviction, including social stigma and its effect on a person's well-being.¹⁰⁰

Many diversion programs and mental health courts exclude those who have been charged with a violent crime, although inclusion could very well help avoid future violence. Since almost half of all state prisoners had a violent offense as their most serious offense, this exclusion can also be a significant limitation on the scope and usefulness of these programs.¹⁰¹ Federal grant programs have exacerbated the problem by restricting the use of those funds for nonviolent offenses. COSCA has previously recommended that federal law automatic exclusion of certain categories of persons and other state law or practice automatic exclusions be eliminated.¹⁰²

The level of supervision needed for mental health courts is time intensive and costly. With prosecutor and court budgets strained, sustainability is a significant challenge. For all of these reasons, diversion programs and mental health courts reach only a small percentage of the severely mentally ill defendants in the criminal justice system.

Expanding the continuum of criminal justice alternatives, including diversion programs and mental health courts, coupled with ensuring community-based treatment and support for each participant after completion of diversion or probation, would likely be most effective at securing long-term

solving-courts/documents/psc%202015%20report%20final_4-7-16.pdf [http://perma.cc/PMM5-8648].

⁹⁹ Kim et al., *supra* note 19, at 40.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 9.

¹⁰² Conf. of State Court Adm'rs, 2014-2015 Policy Paper: Problem-Solving Courts in the 21st Century (2015), <http://cosca.nesc.org/~media/Microsites/Files/COSCA/Policy%20Papers/Problem-Solving-Courts-in-the-21st-Century-Final.ashx> [http://perma.cc/MC44-6X97].

recovery for participants and achieving long-term reductions in recidivism.

5. Intercept 4

Intercept 4 occurs at reentry to society following discharge from incarceration and should include a plan for treatment and services and coordination with community programs to avoid gaps in service. It has been demonstrated that people with medical care and health insurance at reentry experience reduced rates of recidivism.¹⁰³

The Substance Abuse and Mental Health Services Administration (SAMHSA) has noted that transition planning is the least developed jail-based service and has developed a comprehensive implementation guide to help transition persons with mental illness or substance use disorders from institutional correctional settings into the community.¹⁰⁴

SAMHSA found that upon release from jail or prison, persons with mental illness or substance use disorders often lack access to services while at a time of heightened vulnerability. A formalized continuity of services from institution to community settings offers better outcomes and reduced recidivism. This is necessary to ensure adherence to treatment plans and avoid gaps in care. Coordination between corrections departments, mental health agencies, and the courts, could result in the use of court-ordered AOT to encourage compliance and improve treatment outcomes.

¹⁰³ See *supra* note 100 and accompanying text.

¹⁰⁴ Substance Abuse & Mental Health Servs. Admin., Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide 4 (2017), <https://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf> [http://perma.cc/YFW2-7344].

6. Intercept 5

Intercept 5 occurs at parole or probation and includes screening and maintaining a community of care. It also includes connecting individuals to employment and housing. Courts should adopt specialized dockets to provide supervision after release. This could be accomplished with AOT orders.

Housing is the number one critical resource lacking for persons with mental illness. A meta-analysis of controlled outcome evaluations on effectiveness of housing and support interventions and assertive community treatment found support for such programs.¹⁰⁵

V. State Court Judges as Conveners

Because of the unique vantage point of the judiciary at the front and back doors of the civil commitment and criminal justice systems, state courts judges, particularly presiding judges or those that hold administrative leadership positions in the courts, are the ideal organizing force to convene the entities that must come together to develop better protocols to evaluate the impact of the mental health crisis on our criminal justice system and devise solutions. The courts are found at nearly every step of the Sequential Intercept Model. In order to integrate that model, it is necessary that all the stakeholders are brought together, and state court judges are in the best position to make that happen.

¹⁰⁵ See Geoffrey Neslon, Tim Aubry & Adele Lafrance, *A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness Who Have Been Homeless*, 77 Am. J. Orthopsychiatry 350 (2007).

Juvenile, criminal, civil, and family courts all face this crisis as well as all the various parties interested in the outcome of these proceedings. They include the mental health system, National Alliance on Mental Illness (NAMI), law enforcement, prosecutors, public defenders, public health agencies, healthcare providers such as doctors, emergency room physicians, therapists, and case workers, as well as correction agencies and state and local government. State courts are in the best position to convene these groups, because they have frequent and collegial contact with many officials from the executive branch. They are in the best position to convene the relevant interested parties and design a comprehensive, collaborative approach to provide treatment instead of incarceration for persons with mental illness.

Judge Leifman is the perfect example of the effectiveness of the judge as a convening force. Prior to becoming a judge, he was in charge of the public defender office. He attempted but was unsuccessful in convening the necessary parties to address jail conditions for persons with mental illness. Once he became a judge and sent the same invitation out on judicial stationary, he had no trouble convening the necessary parties.

A series of public policy decisions has caused a shift in addressing mental health issues from the civil justice side of the judiciary to the criminal justice side. This has come at great human and monetary cost. Institutions were developed in the mid-nineteenth century as a reform effort to stop warehousing people with mental illness in jails. One hundred fifty years later, we are

once again confronted with the same dilemma.

Court leaders cannot solve the “chaos and heartbreak of mental health in America.”¹⁰⁶ Court leaders can, and must, however, address the impact of the broken mental health system on the nation’s courts—especially in partnership with behavioral health systems. The broken system too often negatively impacts court cases involving those with mental illness, especially in competency proceedings, criminal and juvenile cases, civil commitment cases, guardianship proceedings for adults and juveniles, and oftentimes family law cases. Each state court, as well as CCJ and COSCA, are urged to initiate a thorough examination of the mental health crisis and its impact on fair justice.

VI. Conclusion

The tools currently available to the judiciary fail to meet the challenge of dealing with persons with mental illness. The public safety of our citizens is as much at stake with the improper handling of such cases as is the fair treatment of individuals who have mental illness.

State courts should encourage policy makers to make changes in the court-ordered treatment standard and to use their convening power to bring stakeholders to the table to work on correcting problems and developing better tools for addressing mental health issues. COSCA advocates for judges to convene all parties interested in mental health issues to support these actions:

¹⁰⁶ Ron Powers, *No One Cares About Crazy People: The Chaos and Heartbreak of Mental Health in America* (2017).

1. Encourage policy makers to modify mental health codes to adopt a standard based on *capacity* and not *conduct* for ordering involuntary mental health treatment similar to the standard for court-ordered treatment of other illnesses.
2. Expand the use of Assisted Outpatient Treatment (AOT).
3. Encourage law enforcement agencies to train their officers in the use of CIT.
4. Support the adoption of the Sequential Intercept Model.
5. Chief Justices and State Court Administrators should encourage and assist local judges to convene stakeholders to develop plans and protocols for their local jurisdiction.
6. Provide information to policymakers that demonstrates how increased funding for mental health treatment can reduce jail and prison cost as has been demonstrated in Miami Dade County.

These recommendations, if implemented, will enable the courts to do a better job of effectively managing mental health cases. Courts can help forge a path toward policies and practices that treat those with mental illness more effectively and justly.