

A MODEL FOR
CALIFORNIA
BEHAVIORAL HEALTH
COURTS

A Note from The Woozy:

Far too many Black Individuals, poor individuals, uneducated, mentally ill, developmentally delayed and drug addicted individuals find themselves incarcerated, and unable to find any way to mitigate the circumstances that have resulted in their having been incarcerated.

Increasingly, society has turned to law enforcement and incarceration as a solution to a whole host of societal ills. The costs associated with such a philosophical orientation are staggering

from 1984 when it costs California \$320 million to operate it's prisons, the costs was \$9.7 billion in 2007 with an additional \$3.8 billion on the Judiciary and \$514 million to provide health care services to the inmates. In addition, the state of California is proposing in 2008 to spend an additional \$7 billion dollars to overhaul the states prison health care system. The total of all of these prison related expenditures is \$14.5 billion for the states 172,000 inmates. Which amounts to \$84,302 per inmate

The Legislative Analyst Office has Debt service on just the \$7 billion to overhaul the health care system would amount to \$26 billion over the next 26 years.

In comparison the state of California spends \$2.1 billion on K-14 Education, \$11.2 billion on higher education

Behavioral health courts are an attempt to find community accountability for the treatable mental health issues that are left unaddressed, and result in individuals being arrested for behaviors that are carried out due to the effect of mental illness. With an estimated 16% of incarcerated (jail, prison) individuals suffering from mental illness, the use of behavioral health courts to divert treatable illness to the community, represents a significant opportunity to reduce the costs of incarceration by \$1-\$2 billion dollars or more. In addition, the ethical and human costs of relying on a system of punishment to deal with the issued caused by mental health must in someway, guide our actions to mitigate these circumstances in keeping with the founding principles of justice, liberty and freedom that our nation was founded on.

-The Woozy

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Section 1

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Courts Respond to System Overload of Defendants with Mental Illness

Mental health courts were modeled after the successful intervention of Drug Courts. Judge Herbert M. Klein of Dade California County, Florida implemented the first drug court in 1989 to deal with the crippling effect of the increase in drug offenders upon the Dade California County court system.

Partially due to the success of the Dade California County Drug court, by 1995 there was a newfound level of support for alternative disposition of drug offenses. The successes were able to serve as a platform for the understanding that (1) substance abuse is a major contributing factor to crime and social problems, and (2) traditional criminal justice system approaches were having little impact on substance abuse.

Substance abuse like mental illness is a complex disease that necessitated specialty treatment that was not successfully mitigated by incarceration. Armed with this understanding, a few pioneering mental health courts were created in the late 90's (Broward California County FL., King California County WA., San Diego California County, CA., etc) as a new way to approach the growing problem of mental illness in the criminal justice system using the lessons learned in the previous generations specialty drug courts.

The Broward California County, Florida mental health court was the first court of its kind in the United States. The impetus for it's creation were the findings of a Special Grand Jury convened in 1994 to investigate a series of high profile incidents in the criminal justice system involving mentally ill offenders, including several jail suicides.

Today, in addition to drug courts and behavioral health courts, there are many forms of alternative and collaborative justice courts across the nation that to deal with any number of issues where (1) gaps in service have been identified; i.e. re-entry court (from prison to the community) community issues court, family court, and others. The key element in all of the above named courts is that traditional criminal justice response, including incarceration, has been largely ineffective to deal with the issue and there has been the participation by the various stakeholders involved with the issue to create a specialty court.

All specialty courts base their success on collaboration with community expertise and focused adjudication where the sentencing and oversight of the release conditions, are designed to effectively address the underlying issue. As the expertise of the courts have increased, their ability to effectively monitor participants as well as to collaborate with community providers to structure effective interventions has increased. Today, established behavioral health courts through the nation are increasingly able to identify, retain and graduate larger numbers of participants by utilizing the collective wisdom generated by such courts. In the process the knowledge imparted to the community about the operations, possibilities and limitations of the court has allowed advocates to work together

with local, state and federal politicians to probe the criminal justice system for further opportunities as well as to advocate for supportive community services to support the work of the courts. Similarly, community advocates have been able to leverage their work with the courts to educate the criminal justice system as to ways in which to more pointedly address the underlying social issues which leads to criminal justice contacts.

Problems Identified between Criminal Justice and Mental Health

In numerous locals and jurisdictions, as committees, grand juries and task forces have lead investigations into the Criminal Justice system several key areas, or problems are routinely identified. One of the primary findings, replicated by pioneering courts in Broward California County Florida and King California County (Seattle) Washington has been that large numbers of mentally ill, (developmentally disabled and individuals with organic brain syndrome) individuals, disproportionate to their representation in the larger community, are currently in incarcerated settings.

These individuals place an exceptional burden upon court systems (in processing, identifying and in disposing of their cases) due to the influence, effect and labor intensive interventions necessitated by their conditions. Additionally, the burden placed upon incarcerated settings to provide mandated medical and psychological service to these individuals' further strains the resources of law enforcement, criminal justice mental health services. The underlying strain is that the criminal justice system has had to take on increasingly complex social service functions in order to simply move such specialty cases through the system. And as these individuals move through the court system, there is a dis-connect between their service needs, their illnesses, and how the two are considered within the system.

Traditionally, court personnel have little or no special training in mental health issues, or the dispositional alternatives available to those with mental illness within the larger social service system. As mentally ill individuals move through the system, serve their time and/or are released to the community, there is even less awareness among community providers that these individuals will be released. The complex interplay of legal mandates (probation & parole, future court visits, payment of fines, etc) and how these issues are impacted by mental health issues is often not translated to community providers simply due to the (often times) complete lack of knowledge of the legal mandates, or even the date of release. Additionally, most mental health treatment providers have very little knowledge as to the inner workings of the criminal justice process, from arrest, incarceration, legal wrangling, sentencing and release.

The tools typically available to the court for oversight of individuals on probation or parole, or other monitoring systems by themselves, have been proven to be ineffective in dealing with the root issues and needs of the mentally ill. Even in cases where mental health treatment is a requirement of probation or parole, the ability of the criminal justice system to broker and oversee such services, is mostly ineffective. A primary finding of the investigation of the mental health and criminal justice system, is that the imposition of treatment and probation requirements without accompanying community based assistance (whether from the family or an agency) ultimately serves as a 'set-up' for recidivism.

Outlined below are a number of other issues have also been identified as problematic in the delivery of effective services for mentally ill defendants in the criminal justice system.

- Mentally Ill offenders typically have multiple forensic and law enforcement contacts
- Once their charges are resolved, they "fall of the radar" to mental health and criminal justice personnel
- Mentally ill offenders spend more time incarcerated than non-mentally ill offenders who are charged with the same crimes
- The rate of severe mental illness in jails and prisons is roughly double that found in the general population (Incarcerated Settings =16-20% vs. General Population=6-8%)

- Law enforcement has little training in how to deal with mentally ill offenders, resulting in unnecessary injuries and deaths among mentally ill individuals
- Incarceration is the highest cost and least effective form of mental health treatment
- Neither mental health systems nor criminal justice systems are willing to take responsibility for persons with mental illness who are either incarcerated, on parole, or probation.
- Several areas in criminal justice processing appeared to contribute to recidivism
- Multiple judges, multiple DA's at each stage of the process as case moved through

Problems in Sentencing and Release

Two key areas identified as problematic in the disposition of mentally ill individuals in traditional courts are in sentencing and release. Oftentimes mentally ill individuals were released without referral or follow up appointments for mental health, thus left to their own to maintain compliance with their medications and their ability to understand the sentencing forms and recommendations.

In cases where follow up appointments were made, they were often 2-3 weeks post release, more than enough time for a chronically mentally ill individual to decompensate significantly.

Garnering medications can oftentimes be difficult because their income such as social security, etc, often lapses as a matter of statute 30-days after incarceration to incarceration (which is considered a provision of "room and board").

In cases where mentally ill individuals are released and there are community treatment providers involved, the release is oftentimes not coordinated, and can occur at any time within a 24 period. If the treatment provider can not be there for the release, the inmate can often times become lost, confused and disoriented prior to even finding their place of residence or picking up their medications.

Opportunities for Self-Empowerment

Another trait these specialty courts have in common is that by holding defendants accountable, the defendants are in fact empowered to become a responsible voice in their own rehabilitation. The very nature of the collaborative philosophy of the court necessitates that the participants must report to the court, address setbacks, blockages (as well as successes) and offer solutions to alter the release plan in order to address the setbacks. In fact, no success is possible in any of these courts without the participants motivation to comply, and acknowledgement of the need to be responsible and actively problem solve. In this way, drug courts and mental health courts in particular, represent a true coming together of consumer empowerment, and self-determination as an essential element of the rehabilitation.

The use of creative adjudication and case disposition such as withheld pleas, guilty & no-contest pleas, voluntary participation and frequent social service contacts in exchange for sentences that do not include incarceration, has made voluntary participation a reality for a population of individuals that had previously been resistant to engagement and participation. In fact, one of the most promising findings of the collaborative justice movement has been the creative use of the traditional tools of the court, at all points along the criminal justice continuum as the primary transformative tool.

Changing Society

Many cataclysmic societal shifts have taken place in the last and current century. Meanwhile, the American system of justice has changed relatively little since it was established. Health care costs have skyrocket, unions have evaporated, the costs of education and the grades needed to garner entrance have all become more highly marginalized. Along with this, the growing disconnect between the rich and poor, have combined with social events such as the drug crisis, deinstitutionalization of mentally ill, increased violence, homelessness, working parents, increasing urbanization,

overcrowding, youth violence, gangs proliferation and increasing environmental hazards. All of the above forces have combined to cause considerable social strain and marginalization for those with disabilities be they medical, physical, mental or otherwise. As can be seen by the 400% increase in incarcerations within the United States over the last 35 years. As society has become increasingly marginalized, it becomes easier for individuals who fall to the wayside to become entangled within the criminal justice system. This in turn has lead to an increased emphasis on law enforcements role to “police” society and weed out those who have become marginalized to the point of calling attention to themselves.

Deinstitutionalization, which occurred in two waves first in the early 60’s under President Kennedy, and the second more notable wave in the 80’s under Reagan caused social system effects which are still being felt and will continue to impact the social, legal and mental health system.

Deinstitutionalization, through displacement and lack of opportunity, placed hundreds of thousands of mentally ill individuals in homeless shelters, in the streets, in psychiatric emergency rooms, in skilled nursing facilities and more pointedly, within jails and prisons. What cannot be properly gauged is the number of individuals that previously would have had the option of institutionalization under the previous system and who now form a large percentage of the chronically mentally ill in urban populations. Once again, the lack of treatment options for the chronically mentally ill has caused system pressure at every level. Often by the time they enter the mental health system, other serious problems such as dual dx, housing, physical, etc, have also needed to be addressed.

Each of the mental health courts have identified a potentially large population of mentally ill and disabled defendants who are in need of mental health and treatment related supportive services. If the rationale for making use of these existing services is that the mental health court creates a new synergistic relationships that improves both court and treatment approaches, then the actual availability of these services and resources becomes of a critical concern in light of the increased pressure upon the mental health system explained above. Effective identification of candidates for specialty disposition within the criminal justice system, places a new enlarged demand on existing treatment resources that have already proven themselves to be strained beyond capacity. And so it is with an eye turned towards taking a hard look at the entire mental health continuum of care, that behavioral health courts must turn their attention to in pointing future directions for the overall system.

How Does the Mental Health Court Work?

Through a collaboration of dedicated courts with assigned Judges, Prosecutors and Defenders along with community treatment providers and case managers, the mental health court functions as a team with a single purpose with multiple areas of expertise. By working as a one stop clearing house where cases could be sentenced, monitored, intervened and resolved a criminal justice continuum of care is created, where before, many disparate elements functioned with little or no awareness of one another.

In successful mental health court teams, the mental health court team has been cross-trained, so that Legal workers gain knowledge of mental health and substance abuse issues and mental health and substance abuse workers gain knowledge of how the legal system operates. Training has been in the form of formal (scheduled trainings, conferences, in-service, guest speakers) and informal (education on the job, in court, in team sessions, and in policy discussions).

The labor intensiveness of the court has been justified financially through several cost effectiveness studies of costs as well as future savings in the form of decreased recidivism. There is also abundant anecdotal testimony of individuals who have been successful where in the past, they have served as examples of multiple system failures (criminal justice, social service, medical, housing, benefits, mental health, substance abuse, etc).

Mental health advocacy groups that have long touted new models of wellness and recovery and

advocated vigorously for consumer involvement have applauded the intervention of mental health courts. Mental illness is now recognized as a disease and not a crime, but until the creation of mental health courts, the functional reality of this awareness had no avenue move through. Mental health courts afforded those who suffered from it the opportunity for guidance and direction. What can not be measured tangibly in the evaluation of mental health court outcomes is the value of effectively providing compassion in action, facilitating the right to treatment and delivering appropriate care in the place of incarceration, punishment and inattention to the debilitating symptoms of mental illness.

Reward and Response vs. Reward and Punishment

In mental health court, successes are rewarded with decreased oversight, which in turn leads to increased motivation. Failures result in treatment plans being adjusted accordingly to effectively deal with the treatment relapse or failure. Sanctions could range from admonishment by the judge in open court, to something as powerful as a court participant being remanded to jail for anywhere from 1-several days. In this way, social rehabilitation is able to take place, with direct feedback through the experience of rewards, benefits, and behavior modification with the support of coordinated and effectively brokered services. In the end, Mental Health court is a collaboration of criminal justice and mental health professionals that work with a specific group of eligible individuals, with individualized treatment plans and supervision schedules focused to address their individual needs.

Relapse, failures and problems in the treatment are to be expected, and serve as an in vivo experience to be learned from, responded to and overcome along the ever hopeful pathway to rehabilitation. Behavior modification is the ultimate goal, where the incapable, unable and unwilling slowly learn to become the capable and, empowered and successful.

Court Schedule / Features of Behavioral Health Courts

- Judge presides
- Treatment team reviews each case including problems and progress prior to court session
- Judge takes notes for court
- In court judge discusses participants situation, problems, progress, reprimands, sanctions, modifies treatment
- Dedicated pd, da, probation, court coordinator, CJ, community providers
- Dedicated calendar
- Deal with other ongoing legal issues (referred back to the BHC)
- Resolve competency
- Deal with success and failure within the courtroom milieu
- Hold defendant, treatment providers accountable
- Problem solving approach, modeled on drug courts, domestic violence courts
- Last method tried should be jail

Provider Coordination

One of the important issues that need to be addressed when different agencies with differing missions, philosophies and professional standards come together to work across systems in new settings is taking the time to work out shared definitions of critical concepts such as “voluntary participation”, “competence”, “voluntary”, and “coercion. Other important vocabulary and cross-professional standards of practice such as issues related to confidentiality, how and when to share information, coordinating timetables, ethical standards of practice, the impact of legal statutes, local laws and codes as well as other issues. The larger point being, at some point these issues will arise, and then they do, they must be addressed in a collaborative fashion, taking all of the relevant parties and missions into account as the providers move forward towards the larger mission and goals

A Note About Beginning

A review of early evaluations of new mental health courts shows that of the total number of

individuals referred, result in a low level of “output” participants that make it through to graduation. Although the successes have been significant with a key target population that had shown previous histories of frequently revolving in and out of jail with little or no meaningful or effective intervention, the numbers, at least initially, have been low.

The understanding that the beginning mental health or behavioral health courts have been small in focus, and have slowly gained momentum is an understanding that all participants must be prepared for and accept from the outset. The goal at first is to implement the court and focus on coordination with a key, limited number of qualifying, high-need clients with identified, addressable (at least in theory) mental health and qualifying criminal justice issues. From that point the group can move on and build as they learn new skills and gain expertise and experience working with this new population of clients.

As these courts have matured in their ability to identify, enroll, treat, monitor and creatively dispose of their cases, the percentage of enrollees that make it to graduation and the effectiveness of the treatments and interventions have also slowly risen upwards. It is not long however, before significant cost savings and cost effectiveness can be demonstrated, if the target population falls in line with those identified within pioneering behavioral health court models.

Section 2

IMPLEMENTATION:

The formation of a Behavioral Health Court (BHC) Implementation Workgroup

Introduction

1. Recruitment / Selection of Agency Representatives
 2. Review and Approve a California county BHC Proposal
 3. Set the BHC Schedule
 4. Selection of the BHC Agency Participants and MOU Development (over time)
 5. Designate BHC Court Capacity, Expectations, Time Commitment
 6. Timetable for Implementation
 7. Development of a California county BHC Training Needs/Schedule
 8. Recruitment of the BHC Planning Committee & Advisory Work Group
 9. Funding & Recruitment of the Mental Health Court Coordinator Position
 10. Oversight & Development of an California County Mental Health Training Curriculum
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Introduction

Behavioral Health Court Implementation Workgroups are a time limited body, formed with the purpose of coordinating the administrative steps necessary to initiate commencement of the BHC as well as to facilitate selection of the ongoing BHC Planning Committee.

Once the BHC is operational and the BHC Planning Committee has been selected and has had it's first meeting, the BHC Implementation Workgroup will disband and Administrative functioning of the BHC will fall to the BHC participants under the guidance of the BHC Planning Committee.

The BHC Implementation Workgroup has several primary objectives, outlined below.

1. Recruitment of the Implementation Workgroup/ Selection of Agency Representatives from each of the following agencies

The Implementation Workgroup will have representation from the following agencies:

Superior Court Judge
District Attorney's Office
California County Sheriff's Command Staff
Probation
Public Defender's Office
Behavioral Health Care Services Administration
Criminal Justice Mental Health
The Court Advocacy Project
Mental Health Community Treatment Teams
California County Wellness & Recovery & Consumers Office
Court Administration
Administrative & Clerical Support personnel
Other identified representatives

2. Review and approve the BHC Proposal

The BHC proposal is attached and includes supporting documentation

3. Set the BHC Schedule

Considerations: Meeting days; Court Schedule; Interdisciplinary meeting; Designating the Dept the BHC will operate; Define Eligible California County Jurisdictions; Other as needed.

4. Selection of the BHC agency participants and MOU Development (over time)

Selection of Key Agency participants of the BHC, i.e.; District Attorney; Prosecutor; Judge; FORENSIC MENTAL HEALTH representative; Probation; Other as needed.

- Establishment of partnerships and formal memorandums of understanding between: a California county Superior Court; California County mental health; The District Attorney offices; The Sheriff's Department; Public Defender's office, Probation Department and local community based organizations; for the purpose of the formal establishment and commitment to the BHC process and services.
- Letters of agreement relevant to staffing justification
- Appropriate curriculum vitas and resumes for staff
- Continuous outreach and information to be posted and disseminated to stakeholder agencies in relation to the BHC

5. Designate BHC Court capacity, expectations, time commitment

6. Timetable for Implementation

Considerations:

Number of meetings needed to initiate court, (3-6 or more)

Mental Health Training of BHC Staff, Planning Committee, etc

Start Date (TBA)

Drafting and approval of needed forms

7. Development of the BHC Training Needs/Schedule

The BHC Planning Committee will have oversight of the development of the BHC Mental Health & Criminal Justice Training Needs.

Considerations:

Identify Mental Health Training needs

Identify Criminal Justice Training needs

Training schedule and curriculum

Coordination of training, days, times, equipment, etc

8. Recruitment of the BHC Planning Committee & Advisory Work Group

Proposed: Quarterly meeting of the BHC Planning Committee

The charge: of the BHC Planning Committee is the day to day operation of BHC, with a focus towards strategic problem solving of emergent administrative needs and to provide expertise, advocacy and guidance to BHC participating agencies.

One way to think about the BHC Planning Committee is as an entity that can provide group Administrative oversight of the BHC. Each agency that will have representatives in the BHC will have upper level administrative supervision. To pool the supervisory and administrative entities from the differing agencies into one room, named as the BHC Planning Committee will allow each agency to carry out it's needed administrative and supervisory oversight in a venue that has the maximum potential for enhancing communication, problem solving and coordination of the BHC. It could be argued that for each agency to engage in problem solving and to carry out administrative processes without consultation or cooperation with the other BHC agencies, as to how those decisions may best be carried out may lead to needless delays and unproductive efforts. Advocacy within and between all BHC agencies can be enhanced through a coordinated effort and support of multiple agencies.

It may be the case, and it should be expected that many agency representatives on the Implementation Workgroup, will become participants in the Planning Committee.

For the reasons stated above, the BHC Recommends the formation of a multi-disciplinary Planning Committee to exercise oversight, and to provide expertise and advocacy over all areas of operation

for the BHC.

In all matters, the Planning Committee will strive to provide articulate clear, specific and realizable goals for the BHC.

Primary Functions of the Planning Committee:

- Identify needs for court-related programs and services that address mentally ill offenders in adult and juvenile courts;
- Promote inter-branch and interagency collaboration at state and local levels to identify barriers and create opportunities to improve case processing and outcomes;
- Provide expertise and guidance in interagency MOU development
- Disseminate locally generated best practices to trial courts and partner agencies;
- Identify methods for evaluating the long-term effectiveness of mental health programs in the courts and identify the best or promising practices that improve case processing and outcomes.
- Provide policymakers with recommendations to improve services and case processing for cases involving mentally ill offenders;
- Advise the judicial council and its advisory committees of funding needs and potential resources;
Provide access to education and outreach programs designed to enhance the effectiveness of case processing and outcomes for cases that involve mentally ill offenders in adult and juvenile courts;
- Designating collaborative priorities for the Advisory Work Group.

In addition to the areas mentioned above, the Planning Committee may wish to explore other that are faced by the criminal justice and mental health system such as;

- Overcrowding in jails and prisons
- Disparity in jail and prison representation
- Issues of cultural awareness and cultural competency
- Public safety and high profile incidents
- Information from other counties and Behavioral Court systems
- Conference representation and presentation of findings
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To assist the Planning Committee, it is advised that there be an accompanying Advisory Work Group composed of non-professional representation and community leaders (management and administration) not directly involved in the day to day operations of the BHC.

The role of the Advisory Work Group will be to provide expertise, advice and feed back to the Planning Committee as to aspects of policy formation. It is suggested that the Advisory Work Group be composed of representation from the following groups; subsidized housing sources, mental health and substance abuse advocates & consumers, faith-based providers, community leaders, homeless service agencies and shelters, eligibility workers, crime victims/survivor groups, family and community members.

Having representation on multiple levels of involvement within the BHC will assure inclusion of the greatest possible sampling of community representation that will strengthen the ability of the BHC to move forward in its mission and objectives.

9. Funding & Recruitment of the Behavioral Health Court Coordinator Position

The high level of operational and administrative demands involved in the coordination of the BHC requires the services of a managerial position. The role of the BHC Court Coordinator position will primarily be dedicated to the functions of coordinating the information, the reports, the calendar, the

implementation of the Planning Committee policy and procedures in such a manner as to ensure the sustainability and oversight of the court.

Virtually all BHC's and Mental Health Courts nation-wide have a dedicated coordinator position, or a position created within one of the court organizational entities that is assigned the duties that are described below.

Definition: The incumbent in this position will develop, implement, coordinate, oversee, and evaluate a California county BHC.

Job description: The Behavioral Health Court Coordinator is responsible for the overall development, coordination and operation of a California county BHC and will serve as a permanent member of the BHC Planning Committee. The duties and responsibilities of the coordinator include but are not limited to the following:

Development:

- Research mental health court models and best practices.
- Participate in defining the mission and goals of the BHC and see that they are carried out.
- Obtain stakeholder support for the BHC including political partners.
- Assist in defining the scope (numbers served) and criteria for participants.
- Work with the judiciary, the District Attorney's Office, the Public Defender's Office, Probation, and Behavioral Health Care Services, jail psychiatric staff to solicit participation and identify staffing needs.
- Identify community resources needed for successful diversion and advocate for necessary programs, housing, etc.
- As needed, participate in the identification and recruitment of key BHC court members
- Disseminate information to stakeholders
- Identify and create forms: referral, progress reports, etc.
- Define procedures for referrals and follow-up.

Implementation:

- Serve as a member of the Implementation Workgroup
- Serve as a permanent member of the Planning Committee.
- Clarify mission and goals with court staff and facilitate collaboration for treatment outcomes
- Identify the start date
- Start small and with low profile cases
- Provide information to families and others
- Proactively engage community mental health services providers to proactively support the community treatment plans and provide progress reports back to the court.

Coordination:

- Schedule court sessions and the docket
- Ensure that the court is staffed each session
- Monitor scheduling of court dates for maximum efficiency.
- Solicit and engage community providers
- Assist staff with tools to do their jobs

Oversight:

- Monitor BHC to ensure that it is accomplishing its mission

Evaluation:

- Record data and evaluate The BHC's success in increasing community treatment participation and reducing overall jail time and recidivism.

10. Oversight & Development of a California County Mental Health Training Curriculum

The Objective of the Training Committee is to broaden the knowledge base of the individuals involved in the BHC. The training curriculum will also provides a mechanism through which criminal justice agencies and mental health practitioners, consumers, family members, and other stakeholders can collaborate to educate personnel in various departments on pertinent issues that arise within the BHC.

A key goal is to ensure that court staff is kept apprised of current mental health trends and that mental health staff is apprised of the legal process as well as to provide adequate training for court officials (including prosecutors and defense attorneys) about appropriate responses to criminal defendants who have a mental illness.

Training Topics:

- signs and symptoms of mental illness
- stigma associated with mental illness
- prevalence of substance abuse among individuals with mental illness and the effects of substance abuse on mental illness
- gender and cultural differences among people with mental illness and the potential impact on criminal case processing
- the mental health system and available community resources
- privacy rights and regulations relevant to mental illness
- Legal issues and blockages to treatment
- Court process and structure
- Legal requirements and mandates
- New laws and statutes that impact the work of the BHC
- Resources and funding available to the BHC
- Current trends in psychotropic medications
- Outpatient pharmacy and case management
- Social Justice advocacy
- Consumer issues and support
- California County social service issues.

Section 3

OPERATION:

A California county Behavioral Health Court

Behavioral Health Court Recommendations
Identification of Target Clients for the Behavioral Health Court (BHC)
Team Process
Determining Eligibility; Criminal & Mental Health
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Cultural Competency

Behavioral Health Court Recommendations

The pioneering behavioral health courts began usually in committees and specially formed task forces convened to investigate the issue of mentally ill individuals involved in the criminal justice system. Below is a summary of many of the common recommendations made by many of the committees and task forces formed to provide guidance and problem identification:

- Reduce times mentally ill come into contact with criminal justice in the future
- Reduce inappropriate use of institutionalization of mentally ill individuals
- Improve the mental health and well-being of mentally ill defendants in court
- Develop greater linkages between criminal justice and mental health
- Expedite case processing
- Protect public safety
- Establish linkages with programs that target mentally ill to maximize service delivery
- Team approach (Judge, PD, DA, Probation, Mental Health) to resolving mental health issues
- Court representation in mental health & Mental Health representation in court
- Strong and experienced team in mental health issues in courts to establish continuity of care
- Eliminate and resolve communications gaps and problems between agencies and organizations that serve mentally ill defendants
- High levels of co-occurring disorders (up to 75% of incarcerated mentally ill have substance abuse issue)
- Other issues impact mentally ill offenders; drugs, medical issues, dental, cultural issues, language barriers, immigration/residency issues, homelessness, deinstitutionalization, overcrowding, political pressure

Identification of Target Clients for the Behavioral Health Court (BHC)

The effectiveness of behavioral health courts to intervene in the cases of mentally ill individuals hinges on the ability of the system to quickly and effectively identify potential candidates. Many investigatory agencies have urged the quick identification of mentally ill defendants to mitigate the negative effects of incarceration and to avoid criminalization of mental illness.

One recommendation that has been made repeatedly is that behavioral health courts must have a mechanism in place for the earliest possible identification of mentally ill defendants. Oftentimes, once the mentally ill individual is in custody, they are prone to falling through the cracks. Quick identification of inmates with mental health needs is also precipitated by the need to get such defendants quickly back on their medications and stabilized so that the mitigating effects of their mental illness may be addressed, and the debilitating effects of the symptoms will not further negatively impact their court proceedings and the ability of participants to adhere to the terms of court involvement.

Police Departments, Sheriff's departments, Jail Intake, Jail Mental health and medical screeners, booking deputies, Prosecutors, Defense attorneys, Pre-trial release, Bail Bondsmen, Families, victims, witnesses, Judges are oftentimes the point of first contact/awareness of mental illness as a factor in individual cases as demonstrated by many mental health courts.

To allow any of the above parties to identify and alert mental health that there are potential candidates is the best practice in ensuring that all mentally ill defendants have the opportunity to utilize the services of the behavioral health court.

Almost all behavioral health courts began their referral mechanisms with a primary focus on defendants entering the criminal process shortly after arrest, but expanded to accept referrals from other courts, attorneys, police, friends, relatives or other community contacts aware of mentally ill or disabled persons caught up in the justice system.

The best/easiest form of diversion was from arrest to the mental health system, thereby bypassing the courts. In jurisdictions where law enforcement personnel have been trained to utilize mental health services when most appropriate this form of diversion has been very effective.

The findings on behavioral health courts regarding referral entities have been as follows:

Referral Entities for the Behavioral Health Court

- Arresting agencies (police and sheriff)
- Jail booking deputies
- Jail medical and mental health intake staff
- At cause/bail hearing
- Pre-trial services
- Community providers
- Family members
- District Attorney
- Public Defender
- Judge
- Housing Unit Deputies
- Inmates
- Parole agents
- Jail Chaplains
- Transportation Deputies

Determining Eligibility: Criminal & Mental Health

All mental health courts have target populations identified. These target populations are identified by two guiding factors of eligibility determination. One is the type of charges that are eligible for the mental health court. The second is the type of mental illness and diagnosis that the courts whose to intervene on.

Typically, it takes more than a diagnosable mental condition, or the fact that a defendant takes medications. It needs to be demonstrated that mental illness itself was a mitigating factor in the commission of the crime charged. It must also be shown that the mental condition is primary, and not secondary to the effects of drug use, or predominantly based upon drug intoxication, possession or use.

The type of charge is key in determining eligibility. The vast majority of mental health courts only deal with misdemeanors, or charges that are eligible for a term of 1 year or less. Some mental health courts also allow some selected felonies, but they are judged on a case-by-case basis. Sex offenses,

(eligible for pc290 registration if convicted), crimes of violence or serious injury are not eligible, similarly crimes of domestic violence, dui and other offenses which are eligible for other specialty courts are not typically under the purview of mental health courts.

All referrals, once investigated, assessed and competency, and the desire for voluntary participation is determined, must also have the approval of the court team members. The court team process is cooperative and a team approach, such that virtually all BHC teams have some leeway in terms of eligibility. BHC's are usually structured from the outset such that all BHC members may advocate for the inclusion of participants who may not fully meet criteria; however, most BHC's, in recognition of the public safety function of the Prosecutor's office, allow the Prosecutor's office to have final veto authority of referrals that they deem as too great of a risk to the public safety.

Eligible Criminal Offenses

- Misdemeanors
- Non-violent felonies (with approval from DA)
- Violent felonies (if investigation of the case facts demonstrates that no actual violence occurred)
- Some courts require the approval of the victim in crimes where there is a victim

Non-Eligible Criminal Offenses

- Pc 290 registration charges
- Pc1356, US code violations, 1368, SVP, NGI, Mentally incompetent to stand trial
- Pc 1026, 1368
- Pc 3056
- Vc23152, vc23153
- Pc 1192.7
- Violation of vc23152, 23153
- Violations of pc code section 192

Qualifying Mental Health Issues & Diagnosis (as a basis of criminal charges)

- Mental Illness must be a mitigating factor in the commission of the crime
- Psychosis must be a part of the mental illness
- Qualifying Mental Illnesses
- Schizophrenia
- Schizoaffective
- Delusional Disorder
- Major Depression (with psychosis)
- Bipolar Disorder (with psychosis)
- PTSD
- Pervasive Developmental Disorders or Regional Center Eligibility
- Dementia
- Organic Brain
- Head Injury

Other Qualifying/Mitigating Factors (determined at assessment)

- In custody defendants
- Competent
- Voluntary
- Motivated for treatment
- Public Safety not endangered
- Willingness to take prescribed medications
- History of mental health treatment or 1st break mental illness
- Insight into mental illness
- Success/failure of community treatment

- If not treated, great likelihood of re-offending
- Agreement of Court Team, Prosecutor/Defender has right of veto
- Substance use/abuse is not the primary condition, or major mitigating criminal factor
- Ability to abide by court conditions, or court conditions may be monitored

Court Responsibilities once potential individuals have been identified

- Court will notify mental health of all referrals notification will include current charges and limitation.
- Continue case for (15days) to allow mental health to complete the initial assessment
- Court will be provided with the proposed treatment plan and make a decision as to whether to accept, modify, or reject the plan.
- Treatment plan will include the terms and condition of probation and a set discharge date and time.
- Court will make disposition of cases returned by probation violation
- The court will work cooperatively with other participate to process all cases.

Confidentiality & Release of Information

The Issue of confidentiality and maintaining confidentiality of defendant and mental health client information presents specific challenges to behavioral health courts. On one hand, to identify and intervene on mental health issues of defendants in a timely fashion, it necessitates quick, thorough and accurate evaluation and assessment. For the assessment to be meaningful, background information needs to be gathered with regards to treatment history, medication history and community with providers and family members. Complicating this issue is the issue of confidentiality. Specific local, state and federal laws govern the handing of patient information. Confidentiality forms and release of information needs be obtained to enable not only the assessment to determine eligibility, but for court team members to be able to share information, conduct conferences and to develop a treatment plan.

Once mental health information is obtained by the court team, it must be kept separate from criminal case information so that inadvertent disclosure of confidential information does not occur when other parties not authorized to view client information get a hold of the criminal chart.

The guiding principle common to all mental health courts, is that at no time can the fact that the defendant released information, or considered participating in the BHC, or *has* participated in the BHC, negatively impact the defendants criminal proceedings *while* participating in the BHC, or if the defendant at some point decides to opt out of the BHC process.

On an ongoing basis, BHC's, through the collaborative process and expertise provided by the mental health liaisons and treatment teams, must be diligent in advising the court as to confidentiality issues and ensuring that inadvertent disclosures do not occur.

Caution: Release of Information

Even with a signed release of information, information can only be made available on the principle of 1. Right to know 2. Need to know. Non-essential information is not authorized for release at any time, for any reason.

All discussions of the defendant's information should only be conducted in closed sessions, court team discussions and never occur in open court. This last provision provides a challenge to behavioral health courts, seeing as a major therapeutic aspect of Mental Health courts is the open court discussion of defendant's progress in treatment and adherence to treatment plan goals. There is a way to discuss client updates, without the discussion of diagnosis, specific treatment interventions, sensitive case information, or information of a deeply personal nature, etc.

Issues that are generally free for discussion in open court without presenting a hazard to confidentiality, is compliance, made appointments, barriers to treatment, additional treatment plan needs and general assessment of the client's state of mind.

Communication, Confidentiality & Release of Information

- Court Team members must be able to communicate about the relevant issues related to disposition of the defendants case
- Court Team members must be able to address mental health issues related to 1. The underlying reasons for criminal justice intervention 2. Ensuring public safety
- Court Team members must be involved in the discussion of treatment plan and court requirements
- Confidential information will be released following the principles of 1. Need to know 2. Right to know
- Information needs to be protected in the case file for unauthorized disclosure pursuant to Hipa Regulation and CA W&I 5328

Laws and Regulations governing mental health patient information

- Mental Health patient bill of rights

Hippa Regulations:

The Hippa Privacy Rule ensures a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. Personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose.

- **California W&I 5328:**

All information and records obtained in the course of providing services shall also be confidential. Information and records shall be disclosed only in any of the following cases: (a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservator ship proceedings. (b) When the patient, with the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient, designates persons to whom information or records may be released. (c) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled. (d) If the recipient of services is a minor, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed (e) For research, provided that the Director of Mental Health or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards

Competency

Competency is a complex and complicated issue in criminal justice settings that is made more complicated by the impact of competency on possible disposition options for the behavioral health court. Behavioral Health courts have several options in determining competency, restoring competency and in involving or excluding defendants where competency is an overarching concern to the court process.

Many behavioral health courts have taken advantage of judicial powers to order restoration of competency as an entry point to needed mental health treatment for complicated, frequent criminal justice system involved defendants who have demonstrated failures in having their needs met in the community.

It behooves the behavioral health court to accurately assess competency seeing as the defendant's ability to adhere to the court designated treatment plan is going to be directly correlated to the defendant's competency. An incompetent defendant is more than likely not a good candidate for the specialty intensive services of the behavioral health court. On the other hand, the ability of a defendant to be restored to competency should be assessed by the court personnel, so that defendants that are able to take advantage of the court process have the opportunity to do so.

The fact that some defendants can be restored to competency quickly with proper treatment is an issue that an effective behavioral health court has the ability to positively affect through effective treatment plan requirements. Competency and the ability to meaningfully participate in behavioral health court go hand in hand.

Traditional Court Involvement in Competency

- Deferring proceedings to allow inmates to get stabilized on their medications
- For those too mentally ill to appear before court a hearing is held to determine competency
- Judge enters an order requiring competency restoration (with or without "forced medications")
- Order a pre-determined length of time in state hospital mental health treatment in order to restore competence (felonies)
- Order restoration of competence in community mental health facilities, or in the designated local correctional facility (misdemeanor)
- Order additional treatment up to, but not beyond statute (maximum length of time eligible with regards to sentencing guidelines for charges faced)
- Dismissal of charges once statute limitations have been reached and competency has failed to be restored

Primary Factors used in Determining Competency

- Ability to understand charges
- Ability to participate in defense
- Ability to understand court players and roles
- Ability to adhere to a highly structured treatment
- Judges agreement as to competency of the defendant
- Ability to comprehend consequences of the Criminal Justice Process
- Gross Disorganization
- Disoriented (not oriented to person, place and/or situation)
- Uncontrolled Hallucinations
- Fixed, irrational delusions impacting ability to participate meaningfully in court process
- Assessment outcome of court ordered alienist report
- State maintains jurisdiction over the criminal case for 12 months
- Evaluation for civil confinement
- If confirmed as incompetent, the court will order a conditional release subject to treatment and special provisions

Traditional Court Responses to Mentally Ill Defendants

- IST (Incompetent to stand trial)
- NGRI (Not guilty by reason of insanity)
- Guilty, but mentally ill
- Mitigation of guilt (diminished capacity)
- Mitigation of sentence
- Post sentence MDO and SVP
- 4011.6
- PC 1368/1370
- Murphy Conservatorship

Voluntary Participation

Once the issue of competency is resolved, in most behavioral health courts, a probable cause hearing is held in to review the basis of the charges. Defendants are advised in open court about the nature of the BHC and treatment process, what would be done, and what would be expected from them. Issues of housing, prior history and public safety as well as how the defendant feels and what they are looking for in community treatment. Families and advocates are encouraged to attend.

“Coerced” Treatment

The issue of “coerced treatment” has both favorable and negative connotations. The favorable side is where motivation derives from the avoidance of negative consequences (incarceration). Defendants who consciously and voluntarily choose to engage with the behavioral health court demonstrate a level of insight and awareness of the consequences of their actions. The avoidance of incarceration and the stigma of conviction increase motivation to participate in the behavioral health court program as does the opportunity for the defendant to seek resolution of the underlying causative factors (mental illness) for their involvement in the criminal justice system. When properly enacted this type of motivational awareness of the avoidance of negative consequences, “coercion” does not meet the definition of “coercion”, instead, it serves as an entry point for individuals to begin taking responsibility and to engage in a process whereby they are required to be an active participant in their recovery, to request treatment plan alterations and to discuss blockages and solutions with the judge and treatment team in a “live” court setting. Not to be forgotten, in most behavioral health courts, individuals are allowed to opt out at virtually any point within the proceedings and seek resolution of their legal issues in a traditional venue with no negative consequences for having utilized the behavioral health court option.

Many of the investigatory bodies of behavioral health courts have examined the issue of voluntary participation, and whereas the desire to avoid incarceration results in many convicts agreeing to the terms of parole and probation, the failing point has been the lack of available community programs, oversight of these programs and court supervision that a behavioral health court team approach is able to offer in assistance to such individuals. Many evaluations have made note to point out the transformative factors related to a coordinated approach to assisting court participants make a successful adaptation to the terms of release whereas in previous venues, they have failed. In cases where court participants are left to their own devices to fashion a plan of community rehabilitation, it has been tantamount to the criminal justice system actively contributing to recidivism.

The negative connotation of “coerced treatment” is in the case that the conditions of release are unwieldy, difficult to obtain, and multiple blockages are placed in the path of the client to meet the conditions of participation. As has been stated, for most behavioral health courts, competent, participants are usually allowed a minimum several week window to make up their minds, or opt out of the mental health court and return to original court of origin to face charges. The role of the defense attorney greatly mitigates the possibility of coercion through their mandate to zealously ensure that their client understands their legal options and the advantages and disadvantages of the various options presented.

Coercion, in its pure form is unavoidable in some scenarios involving mental health treatment. Some types of emergency mental health treatment are not voluntary. Namely, competency restoration under the statutes of 5150 “emergency treatment” and judgments arising from Capacity Hearings (Riese) have provisions for “forced treatment” deemed necessary for the restoration of competency. At no point and in no behavioral health court, is any individual forced to participate or to take medications, nor do they ever lose the right to refuse treatment or to choose to stop adhering with the terms of court participation in behavioral health court. This is owing to the fact that no individual lacking competency is eligible to participate in the mental health court, due to the complex nature and highly structured requirements of participation.

Pleas & Resolution of Charges

The type of pleas accepted and the alternatives in case resolution will depend on the requirements/restrictions of California statute and the goals of the behavioral health court; however, in the use of creative solutions to find the best possible solution to individual needs of court participants, there are many different dispositional alternatives available to behavioral health courts to implement, depending on their mission, the issues they face and the needs of their individual communities. Below are several of the common Plea and case resolution options utilized in mental health courts throughout the nation.

- **Guilty & No Contest**

The vast majority of mental health courts have adopted a conviction based approach to case disposition in deference to prosecutorial preference, but also, due to constraints of criminal procedure. Pre-plea courts generally require a plea of guilty or no contest (no lo contendre) in order to be eligible for mental health court case disposition. The agreement generally is understood that no jail time will result (except in the case of sanctions) if the conditions are successfully completed.

- **Delayed entry of Judgment/Deferred Prosecution**

In King California County, charges are resolved through deferred prosecution or deferred sentence, resulting in a high likelihood of dismissal of charges upon successful completion.

- **Waiver of Right to Trial**

In King California County, WA, the defendant must waive the right to trial in return for admission to the behavioral health court.

- **Not Guilty (rare)**

In some jurisdictions, when the case arises that a defendant who was previously determined to be eligible for behavioral health court chooses to go to trial, the mental health court maintains jurisdiction of the case and the trial occurs in the mental health court.

- **No Plea Required (Pre-adjudicatory)**

Broward California County Florida Mental Health court is pre-adjudicatory; defendants are not required to answer to their charges until their treatment is completed. Charges are held in abeyance for up to a year. At conclusion of treatment adjudication is often withheld, based upon the therapeutic rationale of behavioral health courts being non-penal and non-threatening. In some circles it is through that a pre-adjudicatory based system may go further to demonstrate the voluntary nature of the court seeing as no guilty or no-contest plea is required.

- **Charges held in abeyance**

- **Expunged record**

- **Dismissal of Charges**

- **Vacated Judgment**

- **Deferred Adjudication**

Texas law has a "deferred adjudication" provision. Under this provision, once the defendant enters a guilty plea, the judge may defer the proceedings without entering the adjudication of guilt and order the defendant to abide by certain conditions if the judge finds that doing so "is in the best interests of the victim." If the defendant successfully completes supervision, the charges are dismissed.

- **Withheld adjudication**

As a result of withheld adjudication, Broward California County FL successful completion of the Court Program can result in outright dismissal of charges with consent of prosecutor "if it appears to the court...that the defendant is not likely again to engage in a criminal course of conduct and that the ends of justice and the welfare of society do not require that the defendant presently suffer the penalty imposed by law." The court then orders the defendant to participate in what is called a "community control" program. If the defendant successfully completes the program there is no conviction.

- **Conviction (with or without successful completion of Mental Health Court)**

The Anchorage Mental Health Court requirement of guilty plea, ensures that a conviction results whether successful completion or not. This is referred to as a "Finding of Guilt." In the event that the defendant decides to proceed with trial instead of entering the behavioral health court and he/she is found guilty, there remains the possibility of entry to the mental health court (with approval of the behavioral health court team) at the level of case sentencing.

- **Withdrawal of Guilty or No Contest Plea**

In San Bernardino Mental Health Court, successful completion may result in withdrawal of plea (Guilty/No-Contest) and dismissal of charges.

- **Probation & Suspended Sentencing (for duration of program participation)**

Probation for Misdemeanors generally runs from 1-2 years, 3 years for a Felony. The length of a suspended sentence can be 1-2 years for a Misdemeanor.

Court Process: Identification to Treatment and Graduation

Below is a generalized description of various possible processing steps along the continuum of a California county BHC from identification to graduation/case disposition.

STEP 1: Identification & Initial contact with law enforcement

- Screened @ jail in ITR (Deputies, PHS, forensic mental health)

STEP 2: Referral

- Referred to forensic mental health
- Referral to/from Mental Health Court
- Email to court coordinator to notify of referral
- Court Coordinator notifies Behavioral Health Court Team (so they can be prepared for initial court appearance)
- Mental Health Worker meets with defendant/inmate, Consents obtained to share information
- Defendant/inmate assessed, BHC explained, history collected (criminal & mental health 3-days – 2 weeks)
- Probation conducts investigation/interview
- Competency addressed

STEP 3: Enrollment

- BHC Team meets prior to cause/bail hearing
- Case is discussed, concerns (mental health & criminal)
- Treatment plan reviewed: problems, goals, objectives, treatment plan
- Prosecutor and Defender enter into plea/sentencing negotiations
- Cause/Bail Hearing in BHC
- Mental Health Worker released proposed treatment plan: (Judge/Team reviews)
- Defendant/inmate pleads, is sentenced, released with conditions/treatment
- Upon completion of hearing and orders issued, defendant/inmate formally enrolled into the BHC program

STEP 4: Program Participation: Beginning Phase

- Once placement found, inmate linked with designated services, release order issued
- Community treatment provider transports defendant/inmate to program
- Participant placed on calendar for weekly-monthly review of treatment plan obligations
- Community treatment reports regularly submitted to BHC CAP worker or BHC Court Coordinator
- Problems/successes reviewed, rewards/sanctions issued, treatment plan adjusted accordingly

STEP 5: Program Participation: Middle Phase

- Prior to each court session/appearance Court Team gathers to discuss case (Judge takes notes)
- Reports from community treatment providers discussed
- Successes (rewards) and failures (sanctions) discussed
- Treatment plan adjusted accordingly
- Inmate allowed to speak and give report
- Given encouragement or admonishment (possible remanding to custody)
- Once inmate engages with treatment, court appearances can be bi-weekly, or monthly

STEP 6: Program Participation: Graduation Phase

- Regular Court Appearances as above
- Graduation after 12-18 months with substantial progress towards goals
- Probation continues according to statute 1-2 years depending on charges
- Graduation “Ceremony”

STEP 7: Graduation / Case Disposition

- Final Case Disposition dealt with
- Non-entry of judgment
- Delayed entry of judgment
- Dismissal of charges
- Charges expunged
- Conviction

Summary: Team Process

The Team process will use a collaborative, non-adversarial approach to the rehabilitation of participants. Under the BHC approach, the team will meet before each court session and discuss each client’s progress and compliance with probation. Based upon the community reports on individual court participants, the BHC team will discuss, develop and recommend a course of action which will be loosely “scripted” in cooperation with the Presiding Judge. There is a certain level of leeway given to the Judge for the live court session interaction with the participant.

In court, each case will be called individually. The judicial officer will discuss with the client his or her compliance. The client is required to disclose any police contacts, drug or alcohol use, attendance to treatment programs, and compliance with medication regimen. If the client is in compliance with his/her court-ordered treatment plan, the Judicial Officer acknowledges the client for his or her good work. If the client is not in compliance, the judicial officer may impose an immediate sanction or corrective action. Sanctions may include admonishment, remanding to custody, corrective counseling (by the judge in session), reinforcement of case management/court recommendations, inpatient treatment, etc. Psychiatric placement (when W&I 5150 code standard is present), further psychiatric evaluation, and possibly termination of the court agreement.

For BHC clients, each plan will vary considerably depending on relevant mental health and criminal justice variables with primary consideration as to the acuity of each individual participants illness, and the presence and severity of co-occurring disorders, as well as the available treatment programs and other factors.

Treatment Team & Treatment Plan Elements

- Multidisciplinary team
- Individual therapy
- Medication management
- Payee services
- Group therapy
- Family therapy
- Crisis intervention
- Case management
- Social activities
- Psychiatrist appointments
- Nurse appointments
- Occupational therapy
- Vocational specialist
- Peer advocacy

Terms of Participation / Terms of Continuing in Treatment

Behavioral health courts have general parameters for continuing treatment. Although treatment terms are clearly delineated, the goal is the effective treatment of the client's mental health issues. Treatment slip-ups and failures are to be expected, as are treatment successes.

Once a client agrees to work with the behavioral health court, there is a commitment by the court to work with the inmate though their gradual approximation towards the attainment of their stated treatment goals.

The onus is on the treatment team to devise a plan that addresses the primary issues in the clients life that have resulted in past failures be it drug use, housing, treatment, employment, medical treatment, domestic dysfunctional families or non-compliance with mediations. If the primary, underlying issues are not addressed in the treatment plan, then the client has an "easy out" to either coast through the court process, or to re-enter the cycle of recidivism. Supervision and oversight is key to providing the necessary support for clients to maintain their community placement.

The job of the court is to construct standard general parameters for plea agreements, program duration, supervised conditions and clear, definable, achievable goals for completion such that treatment failures and adjustments can be anticipated and addressed within the treatment plan, and guidance and support can be provided throughout the determined time of participation. It is not enough for the treatment plan to be thorough, the defendants need to be made aware of, and counseled as to the requirements and expectations, as well as the impact of non-compliance and impact/effects of a criminal conviction.

General points to be covered in the terms of participation

- Length of behavioral health court participation (should not be beyond probation and maximum incarceration)
- Completion should be tied to adherence to conditions and strength of community treatment/linkage
- Least restrictive supervision is a goal
- Should be a positive legal outcome for compliance/completion
- If pre-plea reduction or dismissal of charges can be considered
- If post-plea early terminations of supervision
- Vacated pleas
- Lifted fines, and fees can be considered
- Participants should have the option of withdrawing at any time from court and not have previous participation and/or failure in behavioral health court reflect negatively on their criminal case.

It should be generally expected that at a minimum, participants should be required to:

- Make all appointments
- Make court appearances
- Follow rules of programs referred to
- Take medications as prescribed, (and if there is a problem or concern with medications, the participant is required to address such issues with the psychiatrist, rather than to stop taking medications or decreasing or increasing dosages.)
- Sign an individualized treatment agreement (and all subsequent revisions)

In the case of New offenses and charges that arise in the course of BHC participation;

- Be held accountable for new offenses and expect that previous requirements can and will change in the case where new charges are related to underlying issues that are not being addressed.
- If new offenses occur that present a threat to public safety, termination from the behavioral health court will be at the discretion of the BHC team with deference to the Prosecutors

- office.
- Eligibility for the BHC will be reviewed for all new charges and offenses.

***Graduation requirements are usually a function of the following:**

- Required time of participation completed
- Adherence to treatment plan
- Minimum periods of testing negatively for drugs
- Completion of all treatment activities
- Payment of fees
- Compliance with meds
- Stabilization
- Decreasing need for oversight
- Demonstrated growth within the program

*There must be the understanding among BHC members and participants that in the realm of mental health as well as criminal justice involvement, there is a lack of a common starting point; therefore, the level at which one participant may achieve success and graduation may not be sufficient for another participant depending on their condition, functional impairment and severity of their mental illness. Each case must be dealt with according to its own merits, its particular eligibility and constraints and the assessed clinical need.

Cultural Competency

It is suggested that the California County BHC set as one of its goals the development of a California County and State approved, cultural competency plan which incorporates the needs cultures in a California county of, along with uniform methods of providing mental health services, staff deployment trainings, community awareness campaigns, service outreach procedures, staffing recruitment and document/information preparation, evaluation and community representation.

Some Considerations in the Development of a Cultural Competency Plan:

Creating a structure

A work group to serve as a primary body to plan, implement and provide oversight to the BHC should be convened with the purpose of addressing cultural and linguistic competency. The work groups should have representation from all levels of the BHC and Such groups reflect the diversity within the BHC and its participants as well as the community at large

Values and philosophy

Ensure that the BHC, and participating organizations and agencies have values, principles and/or mission that incorporate culture as an integral aspect of all of their endeavors.

Community Demographics

Identify the racially, ethnically, culturally and linguistically diverse populations served by the BHC and California County and determine and address any disparity in access and utilization of the BHC services.

Engaging the communities

Communities have the inherent ability to recognize their own problems, including the health of their members, and intervene appropriately on their own behalf (Goode, 2002). Expand collaborative relationships to include natural helpers, community informants, cultural brokers, faith-based organizations, ethnic-specific and advocacy organizations and local merchants.

Section 4

ROLES:

Roles of the Behavioral Health Court Team Members

Role of the Judge

Role of the Mental Health Court Worker

Role of the Court Probation Officer

Role of the Prosecutor

Role of the Public Defender

Role of the Judge

The BHC Judge Presides over court. The BHC Judge is the final legal authority of the Court. The Judge will preside and rule on all legal matters. The Judge will chair all BHC Court meetings, take notes, and develop the “script” of the issues that the BHC court team recommends as interventions for BHC court sessions.

In court the Judge addresses the clients directly about treatment issues, successes, failures. Offers suggestions, motivational insights, sanctions. The Judge also encourages progress and responds to poor performance. The Judge re-schedules the clients for future sessions. In court, the Judge plays all traditional courts, as well as additional informal roles of counselor, consultant, and case management broker.

The Judge has responsibility for all the legal actions and is the final authority for treatment. In the event that BHC court participants opt out of the program, the Judge adjudicates cases of participants. The Judge can order services and treatment agencies into the court and holds them accountable for their responsibilities formal and informal, in effecting the case management and treatment plan elements assigned.

The Judge holds all duties and obligations for the judgment of mentally ill offenders and as such, all judgments and decisions will coincide with current operating procedure mandates for Superior Court Judges in California County.

Role of the Mental Health Court Worker

The BHC mental health worker is a key individual. The mental health worker provides support, encouragement, advocacy and related services in order to assist the client’s case manager in coping with immediate situations that arise in the BHC. The mental health worker will have advanced education and experience in providing a wide range and variety of mental health services including assessment, competency determination, determination of primary psychiatric qualifying diagnosis; crisis intervention, court systems knowledge, jail psychiatric services knowledge, California County sheriff procedures, classification and records, case management, motivational interviewing and crisis intervention.

Duties will include meeting with other mental health professionals to determine the needs of the mentally ill offender; development of court case plan for release; telephone contacts; response to potential suicide or other emergency situations; answering questions and describing basic services to clients and family members of mentally ill defendant; assisting the clients in recognizing and solving issues within their lives that contribute to mental health problems as well as criminal justice involvement.

Other duties may include:

- Updates family members and case managers about client progress; receives updates from the community case managers and providers to get updates on client’s progress. Mental health

court workers in turn relate this information to the judge and treatment team during pre-court conference/updates.

- Assist and help inform PD, DA, Judge on mental health issues; coordinate with community treatment providers to consult with them regarding mental health issues, treatments, placements, and diagnosis/recommendations.
- Arranges for release (O.R.) of inmates with Jail records deputies and transportation to treatment/placement.
- Degree in psychology or social work, and have extensive experience in the mental health field.
- Review and alter treatment plans and make recommendations as to it's sufficiency with input from community treatment providers
- Monitor compliance through close supervision of BHC clients. This will include: checking with clients and/or their treatment providers weekly, or daily if necessary; assessment of mental health stabilization and substance use issues as necessary
- Advocacy for clients in resolving treatment plan successes and failures, in the garnering of benefits and mandated services, in resolving disputes with individuals, programs and in treatment plan conflicts, payment of fines, fees, etc.

Role of the Court Probation Officer

- Has a master's degree in social work, family counseling, psychology, or some other closely related social service field.
- Shall return cases to court for disposition if it's determined that the client has violated the terms and conditions of probation.

The Probation Officers duties are similar to that of other officers in that they monitor compliance. However the BHC Probation workers have extensive backgrounds in mental health that allow for a better understanding of treatment compliance, mediations and treatment issues. The BHC probation officer supervises clients closely, often checking in with them weekly or even daily, attends hearings with clients and establish and maintain a strong relationship with clients. The BHC probation caseloads will be matched with BHC cases. Probation officers will receive updates from treatment providers regarding treatment compliance and relay this information to the court. The Probation Officer provides probation expertise to the Judge and the BHC Team.

Role of the Prosecutor

The BHC Prosecutors generally do not prepare for trial in most BHC's seeing as defendants in most behavioral health courts opt-in to the program exchange for a diversion, a plea or deferred sentence. The BHC Prosecutor takes mental health illness into consideration in filing decisions and asking for sanctions.

- DA shall represent the community, public safety and accountability for crimes as it relates to mentally ill offenders processing through the BHC
- DA shall along with other court team members review the mental health treatment plan and make recommendations to the court on its sufficiency
- DA is the final authority in the acceptance of BHC clients based upon the need to maintain public safety

The general role of the prosecutor is similar to that in other courtrooms: to represent the community public safety and accountability for crimes. The philosophy seems to be somewhat unique in that the goals of the BHC are more long-term and the focus is on treatment compliances, as opposed to jail time. The prosecutor may consult with other BHC participants, specifically the mental health worker, in an attempt to understand the dynamics of a particular case.

Role of the Public Defender

- Shall represent the client and advocate for the client's position in court. The defender

assigned to BHC, shall only carry BHC cases.

- Defender shall along with the court, the DA and probation review the BHC treatment plan and make recommendations to the court on its sufficiency.
- Zealous representation of client rights; represents their clients in all legal matters; screens for potential BHC clients at the morning custody calendar at the jail facility. Before a potential participant opts into the BHC, the BHC Public Defender consults with their clients to determine whether the clients interest are better served by participation in the BHC or regular court. If the client opts in, the Public Defender continues to protect the client's legal interest while working with the BHC team to help their client to successfully complete treatment and probation

The main differences in the behavioral health court are the difficult and needy population of mentally ill defendants, and the need for the defense attorney to be very knowledgeable about mental health issues and resources, and to be able to continually gauge the impact of their client's mental illness in consideration of advocating for the the least restrictive monitoring possible. At times the public defender, the mental health worker and the community treatment provider will need to pool their knowledge to access appropriate treatment resources for the client. Despite the obvious team approach of the mental health court staff, it is still, at it's roots, an adversarial system. The BHC public defender carries only BHC cases.

Section 6

Articles:

Further Readings on Behavioral Health Courts

Early Mental Health Court Initiatives: Common Themes and Emerging Issues, U.S. Department of Justice
Decriminalizing Disease & Disability, Lenny Karpman, MD
San Francisco's New Behavioral Health Court-One solution to Helping the Underserved, J. Johnson, Deputy PD

Early Mental Health Court Initiatives: Common Themes and Emerging Issues

Common Origins and Objectives

From:

Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload:
Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.
U.S. Department of Justice, Office of Justice Programs, 810 Seventh Street NW. Washington DC 20531

The nation's first mental health courts have much in common with the problem-solving courts that preceded them. Drug courts, community courts, domestic violence courts and related court-centered treatment and social service strategies were motivated by similar problems, severe local correctional crowding and court delay, dramatically growing caseloads of substance abuse offenders, and a shared sense that traditional methods of case disposition were inadequate and unsatisfying. Drug courts "broke the mold" in searching for a more effective response to substance abuse in the criminal justice population, with subsequent problem-solving or specialized courts adding to the substantive agenda of problems, including domestic violence and community quality-of-life issues that could be addressed by adapting the drug court approach.

In part, the subject matter of special courts diversified as courts discovered first hand that substance abusers often suffered from co-occurring disorders or were struggling with other critical life problems linked to the substance abuse, such as housing, unemployment, domestic violence, educational, vocational and health issues. Thus, to succeed at restoring offenders to sobriety and functionality in the community, multifaceted treatment approaches were necessary and new service delivery partnerships were created. Special court approaches of the last decade prioritized different problems and different target populations and selectively adapted the methodology and lessons of the drug court model to address them and added unique new dimensions of intervention and operation. Each special court initiative has faced the challenge of dealing with participants who were mentally ill. The first mental health court initiatives took on that challenge.

The four pioneering mental health court initiatives described in this report grew from efforts to respond to three basic critical problems. These problems included: the public safety risk posed by mentally ill offenders; the difficulties associated with housing the mentally ill in local jails; and the inadequacy of the criminal process in dealing with mentally ill defendants in all matters. These judicial strategies were based on the recognition that mentally ill offenders were handled poorly in the criminal justice system generally, as well as in the criminal courts in particular. Many offenders— particularly mentally ill defendants charged with low-level offenses who were nevertheless competent—were routinely processed through the misdemeanor system with meaningless responses and ineffective penalties, including fines that would never be paid and time served for days already spent in jail.

A very clear aim in each site was to devise an alternative to holding and treating mentally ill defendants in jail. Although each jail was attentive to the issues of the mentally ill offender, the jails faced serious crowding problems and were ill-equipped to provide more than temporary care for the mentally ill. Resources were too scarce, facilities were inadequate, and the numbers of inmates were too great. Moreover, each mental health court strategy was premised on a belief that, in most cases, jail was the last method that should be employed to address the problems of the mentally ill offender. Not only were jails generally unable to provide adequate care, confinement was often a stressful ordeal for the mentally ill, causing crises and a variety of problems that might otherwise be avoided. The designers of these mental health court innovations saw the growing problem of the mentally ill in jails as evidence of the failure of mental health treatment and other social service systems in the community.

The early courts also share common origins and aims because they draw on the example and experience of the nation's first mental health court in Broward California County. Each of the succeeding efforts has considered

and adapted the pioneering Broward California County Mental Health Court model in some fashion. Once established, the early mental health courts have shared lessons and challenges among themselves and—as communication and geography would permit—have continued to learn from their different experiences. Moreover, each of the early courts now receives visitors from other courts interested in addressing the problems of the mentally ill in their justice systems.

Common Features

The four pioneering mental health courts we examined share a number of common attributes, some adapted from the earlier models of problem-solving courts, some unique to the mental health populations they address.

Target Problems and Populations

The early mental health courts focus their efforts on the relatively low-level mentally ill offender who is found in the criminal justice population. All of the courts place a primary emphasis on the mentally ill defendant or offender held in jail, seeking ways to find supportive treatment in the community as an alternative to confinement. The courts differ slightly in their criminal justice and mental health eligibility criteria. Each of the courts accepts misdemeanor defendants but has a varying period of court supervision. The Broward California County Mental Health Court is limited to 1 year of supervision of participants, the extent of misdemeanor jurisdiction in cases that are sentenced. (Broward defendants are not on probation during their participation in Mental Health Court.) The other sites require disposition of the charges prior to entering treatment.

In King California County, a guilty plea was required under the original program rules. Currently, however, charges are increasingly more likely to be resolved through deferred adjudication or a deferred sentence. The participant's period of probation is limited to 2 years, unless the defendant is charged with DUI, in which case probation may last up to 5 years. The Anchorage Court requires a guilty plea and, while the probationary term in Anchorage for the misdemeanor charges may extend to up to 10 years, the supervisory term is typically set at 3 to 5 years. In San Bernardino, misdemeanor probation is limited to 2 years; felony terms may last up to 6 years, but are generally limited to 3 years in the program. Despite the different periods of court supervision that are employed in each of the locations, a noncompliant misdemeanor participant who faces serving a term of confinement can serve no more than 1 year of jail time. Felony participants in San Bernardino can face considerably longer terms.

The mental health court approaches also differ with regard to the type of charges that are acceptable for entry into treatment court. The Broward Court excludes from Mental Health Court DUI and domestic violence charges, for which separate court programs exist; battery charges are acceptable only with the victim's consent. The King California County Mental Health Court, in contrast, does not limit the type of misdemeanor charge that is eligible. The Anchorage CCRP does not eliminate specific misdemeanors from consideration for program admission; instead, the screening element focuses more on prior record as an indicator of dangerousness to the public. San Bernardino is the only court to accept felony defendants, some facing relatively serious charges. There the prosecutor looks beyond the actual charges filed and into the facts of the case to determine the true seriousness of the criminal acts alleged, in addition to factoring in the mental illness as a cause of the act before making the eligibility decision. Truly violent criminal defendants are not eligible for program admission. In San Bernardino there is no limitation on admission based upon the type of misdemeanor charged.

All of the mental health courts accept individuals with extensive criminal histories, based on the knowledge that few mentally ill or disabled defendants will be first-time offenders and that many often find themselves in and out of the criminal justice system for a variety of usually minor offenses. San Bernardino is the only site that actually requires that the defendant have a criminal history in order to be admitted to the program. All of the other programs accept both new and repeat offenders, although the majority of the participants in each of the locations have had prior contacts with the criminal justice system.

Although each mental health court focuses on defendants who show signs of mental illness as they enter the process, the clinical eligibility criteria also differ slightly from court to court. In Broward California County, candidates must be diagnosed with an Axis I mental illness,²⁵ have an organic brain injury or head trauma, or be developmentally disabled. In King California County, misdemeanor candidates must be found to suffer from a significant mental illness, organic brain impairment, and/or a developmental disability that is directly or indirectly connected to the crime charged, and for which the person is in need of treatment and that, unless treated, greatly increases the probability of future criminal recurrence. The JAS Program in Anchorage and the

STAR court in San Bernardino have the strictest mental health criteria. In Anchorage, the JAS Program deals with defendants who have a major mental illness with a history of psychosis. (Eligibility requirements for CCRP are less stringent, requiring serious mental illness, developmental disability or organic impairment, but not psychosis.) The San Bernardino Court requires that participants have been previously diagnosed with one of the six Axis I illnesses. The defendant must have a documented history of mental illness to be eligible for treatment through the STAR Program. Both of these programs are relatively low volume, having access to a small number of treatment beds, and both focus on confined defendants who are seriously mentally ill.

Judge-Centered Court Treatment Process

Each of the mental health courts is built around the main feature of the problem-solving court strategy pioneered by the Miami Drug Court and carried over into other substantive areas, such as community courts and domestic violence courts. Under this approach, the judge sits at the center of the court treatment process and plays a variety of roles, formal and informal. The judge represents authority and has responsibility for all actions of both legal- and treatment-related natures to be taken. The judge presides formally over any legal matters at the entry and completion stages of the process and may adjudicate cases of participants who opt out or fail in the program. Perhaps most importantly, the judge plays a hands-on, therapeutically oriented and directive role at the center of the treatment process. The judge deals with problems, encourages progress and responds to poor performance by participants. The judge deals and interacts with the participant directly, and assigns rewards and sanctions as may be appropriate, including selective use of jail or changes in placement options.

New Working Relationship Between the Court and Mental Health Services

The new, multifaceted role of the judge and other courtroom actors is premised on the development and implementation of a new working relationship between the criminal court and mental health treatment and related support services. To the mental health court, the presence in criminal justice (and particularly in jail) of large numbers of mentally ill and disabled defendants is evidence that, on their own, community mental health services have failed to engage citizens in the treatment process. If they were effective in treating this population, such large numbers would not be in the criminal justice system. Following the drug court model, the mental health court redesigns the working relationship between the court and treatment services, brings the redesigned partnership into the courtroom and holds it accountable to the judge. The new working relationship is seen in the special teams of courtroom personnel dedicated to staffing the mental health courts, including the judge, probation officers, clinical supervisors or coordinators, case managers, defense attorneys, prosecuting attorneys, jail liaisons and other service providers dealing with the court participants. The new relationship is reflected in the pre-court case staffing discussions and the in-court collective problem-solving that assist the judge in directing appropriate actions in individual cases. The authority and final decision making responsibility of the judge holds the treatment process, as well as the participant, accountable and requires continual communication between members of the mental health court staff.

Special Courtroom Procedures, New Roles for Courtroom Staff

The special use of the courtroom associated with the early mental health courts is reminiscent of the drug court conceptualization of the courtroom as part of the therapeutic environment (a “theatre in the square”) (Goldkamp, 1994a, 1994b; Goldkamp et al., 2000; Hora et al., 1999). The courtroom environment differs in style in each of the settings studied, ranging from the full and busy meeting room with many consultations going on in Broward California County, to the quieter and slower proceedings in King California County Court, to the drug-court style of proceedings in San Bernardino. Each of the courtrooms shares in common the attempt to present a supportive environment in which participants have confidence that they can speak and have their problems addressed.

A full range of courtroom actors are called upon to participate at various stages of proceedings to report on progress, interpret evaluations, discuss treatment plans and help resolve problems. They include a mix of clinical and criminal justice staff. In addition to the clinical supervisors, case managers, and defense and prosecution attorneys, there is also a representative of the jail staff who provides a critical link for the mental health court.

The tempo of proceedings differs markedly from other courts. The mental health court judge allows time for participants to speak; in some instances, defendants may ramble and get confused in addressing the court, sometimes causing proceedings to progress slowly. The style of the courtroom varies as well in the size and

nature of the audience, often including people at various stages of treatment and processing who may be experiencing a variety of problems. The mental health court courtroom is intense, emotional and demanding of all staff, as problems are identified and solutions are devised.

Range of Treatment and Supportive Services

Each of the courts seeks to link their participants with appropriate treatment services, some in residential or other supportive housing placements, but most ultimately in the community. Thus, each mental health court approach has involved drawing together whatever appropriate services are available to assemble a network of services that can be responsible to the court. In Broward California County, this includes two mental health providers responsible for covering different parts of a California county with slightly different services available. Participants there are supervised by facility case-managers as well as the mental health court monitor. In Seattle, the King California County Court partners with a managed care provider who oversees a California county's mental health treatment programs. Participants are supervised by the probation department. In San Bernardino services are provided by private, nonprofit providers for augmented board and care facilities and a day treatment program that draws upon a range of services. Supervision is provided by jail mental health staff, who also function as case managers, and by the probation department. In Anchorage, the selected participants from the jail population are placed in residential settings with supervision provided by treatment facility case managers, with careful oversight by the JAS case coordinator. In the Anchorage CCRP, non-jail misdemeanor defendants are required to arrange adequate treatment services themselves through public and/or private means and are monitored only by facility case managers, who provide progress reports upon request to the Municipal Prosecutor, and the judge through in-court status reviews. The early mental health courts differ in the kinds of treatment resources they have available to serve their participants. The courts share common difficulties identifying sufficient treatment resources, because of limited local treatment capacity, and funding to support the needed services for the difficult populations they have engaged.

Multiagency and System Support

The four mental health courts described in this report are at various stages of development, ranging from the oldest and most established in Broward California County (about two and a half years of operation), to the newest in San Bernardino and King California County, opened in January and February 1999, respectively. Regardless of stage of development, however, a critical element in each of the strategies is multiagency and systemwide support in both planning and operation. This is reflected in the planning task forces producing the recommendations for the mental health courts and in the collaboration required in the day-to-day operation of the court and the work of the court team. In Broward, the Public Defender's office, State Attorney's office, Broward California County Sheriff's Office, community treatment providers, and the local hospital have supported the development and operation of the mental health court. In King California County, the court operates with the support and cooperation of the Prosecuting Attorney's office, the Public Defender's office, the Probation Department, the King California County Jail, and United Behavioral Health, which provides case management. In San Bernardino, participating agencies include the Department of Behavioral Health, the Public Defender's office, the District Attorney's office, the Probation Department, and private providers. In Anchorage, the court draws on the cooperation and support of the Department of Corrections, the Alaska Mental Health Trust Authority, the Municipal Prosecutor's office, the Public Defender's office, and treatment providers and is seeking to broaden its base of support and cooperation.

Differences in the Approaches of the Four Mental Health Courts

Although the four mental health courts we describe share common elements, they also differ in their adaptation of a problem-solving court model to their particular systems. These differences include the timing and method of resolving the underlying criminal charges, the responses to noncompliance by participants, and the effect of a defense request for a trial.

Stage of Intervention

As the first site to design a special court approach addressing the mentally ill and disabled in the criminal justice population, the Broward California County Mental Health Court laid the groundwork for the efforts that followed. One of the features of the Broward court that none of the other sites chose to adopt was its pre-adjudicatory emphasis. Defendants who choose to enter the Broward program are not required to answer to their charges until their treatment is completed. Criminal charges are held in abeyance for a period of up to a year, while the participant's mental health needs are addressed. At the conclusion of the treatment period, the

defendants' adjudication is often withheld, depending on the seriousness of the charges and their criminal histories. This approach was adopted in Broward California County based upon a therapeutic rationale that the mental health court should be as nonthreatening and nonpenal as possible. In addition, the Broward model seeks to divert the mentally ill person from the formal adjudication process. Other jurisdictions adopted a conviction-based approach, partly because of prosecutorial preferences and partly because of constraints of criminal procedure.

Mental Health Court Versus Normal Trial: Second Chances?

In each of the jurisdictions, a candidate's participation in the mental health court is based on a voluntary decision. The courts differ in their policies regarding mentally ill defendants who decline to enter mental health court and choose to have their charges adjudicated instead of either entering treatment prior to adjudication or pleading guilty and being placed on probation in the mental health court. In King California County, defendants must waive their rights to a trial in return for admission to the mental health court treatment process. Defendants who choose to go to trial and are then found guilty are not accepted back into the mental health court. None of the other sites has a strict policy against accepting individuals who have declined the program, chosen adjudication, been convicted and then requested admission to the mental health court. However, admission is far from ensured and is decided on a case-by-case basis. The San Bernardino, Anchorage and Seattle Mental Health Courts operate as sentencing courts, or at least as courts dealing with persons serving sentences but not as trial courts for practical and philosophical reasons. (They were seeking to concentrate resources on mental health treatment.) Thus, they may have little control over adjudication and sentencing in other courts, should candidates select the normal adjudication route.

Methods of Case Disposition

The four mental health court sites also differed in their methods of resolving the criminal charges. Successful participants in the Broward Mental Health Court may, as a result of withheld adjudication or an outright dismissal of charges with the consent of the prosecutor, have no conviction on their records. In King California County, there is an increasing likelihood that charges will be resolved through deferred prosecution or deferred sentence, resulting in a dismissal of the charges upon successful program completion. In Anchorage, however, the requirement of a guilty plea (or of a *nolo contendere* plea) ensures that a conviction generally results, whether or not the participant is successful. Withheld adjudication or deferred prosecution dispositions are only rarely employed in this location. In San Bernardino, where a plea is also required, successful completion may result in withdrawal of the plea and dismissal of charges. Because many of the mentally ill or disabled persons who enter the mental health courts may have fairly extensive records of prior convictions, the question of whether or not a conviction is recorded for the current offense may be of little practical significance. Defense counsel, especially in King California County, have expressed discomfort with the policy requiring conviction and suggested that the guilty plea requirement might serve as a disincentive to some eligible defendants wishing to enter treatment.

Use of Sanctions for Participant Noncompliance

The four mental health courts appear to differ as well in the way they respond to noncompliance by participants in the mental health treatment process. In designing its approach, each court has recognized the challenges associated with engaging and maintaining the target populations in the treatment process. Thus, while each court expects problems with compliance in its client population, they vary in the way they impose sanctions, a basic element of the drug court model adapted by each type of problem-solving court. Short of termination from the program (with the attendant legal consequences), one of the most severe sanctions is the imposition of jail confinement. The use of jail as a sanction seems least common in the Broward California County Mental Health Court and the Anchorage Mental Health Court, and somewhat more likely in the King California County Court. It is used most common in the San Bernardino Mental Health Court, which operates most closely to a drug court model.

This difference in the use of sanctions generally, and of jail in particular, is not explained mainly by judicial philosophy—which likely accounts for some differences—but may be linked instead to differences in the type of candidates admitted to the courts. For example, in contrast to its peer courts, the San Bernardino Mental Health Court focuses on felony defendants as well as misdemeanants and deals with serious substance abuse as a co-occurring disorder in most of its cases. Differences in target populations notwithstanding, officials interviewed in the King California County and San Bernardino Mental Health Courts acknowledge that the

threat of jail may serve as an important motivator for candidates considering whether to enter the mental health court and a useful tool for ensuring compliance among participants.

Emerging Issues

Early Identification of Mental Health Court Candidates

Problem-solving courts of different types share the need to identify their target population candidates as early in criminal processing as possible. The original drug court model was premised on the assumption that intervention with addicted offenders should occur shortly after arrest when individuals may be most open to the possibility to maximize the opportunity to begin treatment. In domestic violence courts, there is urgency to correctly assess the risks posed to victims and implement options for treating or otherwise dealing with the offenders before further harm can occur. To be effective, mental health courts share that critical need to identify mentally ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process.

Like the other types of courts, however, the mental health court model faces serious challenges in identifying appropriate candidates early through appropriate and effective screening and evaluation procedures. Collectively, the early mental health courts employ informal and formal methods for identifying possible candidates and assessing them in some depth before detouring them from the normal adjudication process. These methods may include informal referrals at arrest, arraignment or jail admission of persons appearing to suffer from mental illness or disabilities. They are followed by more in-depth clinical interviews at the jail or in court to assess the eligibility of defendants for the mental health court programs.

Fair, appropriate and effective screening procedures face three principal challenges: timeliness, accuracy, and confidentiality. Each of the courts has established procedures that identify mentally ill or disabled candidates as early as possible in the criminal process to maximize the opportunity to intervene and assist. The need to identify and assess the conditions of candidates quickly potentially conflicts with the need to conduct the thorough clinical assessment required for a reliable diagnosis on the basis of which processing in the mental health court can begin. To put it simply, it is hard to rush such an assessment and still have it be accurate and complete. This may be particularly true because of the difficulty associated with communicating with some mentally ill defendants.

Early intervention by the mental health court depends on timely and accurate information about the defendants' criminal justice and mental health backgrounds. However, the goal of early intervention and prompt treatment conflicts in part with the need for confidentiality and for consent by the defendants to share the mental health information with the court staff. Devising workable procedures that both enhance early intervention and enrollment of mentally ill offenders in the mental health courts and respect confidentiality pertaining to sensitive personal information represents one of the difficult challenges facing the mental health court approach.

Voluntariness

Some observers see special courts as vehicles for "coerced treatment," a term with favorable and unfavorable connotations. The favorable use of the term suggests that the judicial role and application of sanctions and rewards contribute a valuable tool for keeping participants in treatment and increasing the chances of successful outcomes (Anglin and Hser, 1990; Anglin, 1988). The unfavorable reference alludes to the problems associated with forcing treatment upon individuals who have not voluntarily consented, from a due process perspective and from the perspective that treatment cannot be effective unless it is wanted and the offender is "ready."²⁶ In fact, most problem-solving courts are premised on voluntary participation by candidates, with the exception of some sentenced-based approaches (in which judges may simply sentence a person to treatment in court). This is especially true in diversion-based courts. Certainly, courts requiring guilty pleas from participants for admission must demonstrate that a plea was made knowingly and voluntary on the record. Even when appropriate procedures are observed to safeguard voluntariness in special courts, some critics argue that the choice (between, for example, drug court and jail) is a coerced choice.

The question of voluntariness is even more difficult for mental health courts. Although all the same legal issues dealt with in drug courts, domestic violence courts and community courts exist for persons entering the mental health courts examined in this report, they must also confront questions about a person's mental capacity and ability to comprehend the proceedings and the options being provided. Competency is a threshold issue that

must be decided before an individual can be considered as a mental health court candidate in each of the courts. However, even among those deemed competent to stand trial, serious questions may be raised about the ability of persons really to understand the choices being presented and the consequences of those choices (e.g., going to trial or participating in the mental health court in one of several possible legal statuses).

If a requirement for voluntary participation in the special courts is not only competency as legally defined, but also an ability to understand and make reasonable decisions, then achieving voluntariness among mentally ill or disabled treatment candidates is a challenging proposition indeed. In the mental health courts, it means that sufficient time must be taken by defense counsel and by the court itself to make certain that the candidate's decision to enter the mental health court is in fact voluntary. This means having a grasp, beyond the threshold question of competency, of a defendant's mental condition. The potential fear is that defense counsel and/or the court may make decisions in the candidate's best interest when in fact the candidate, though competent, is thoroughly confused and afraid.

Conflict Between Criminal Justice and Mental Health Treatment Goals

A challenge in the design of each type of problem-solving court was the need to craft an approach that resolved conflicts in values and goals inherent in criminal justice and treatment orientations (Goldkamp, 1999). For example, when substance abuse treatment professionals might stress tolerance for relapse and erratic performance (or a positive drug test) by drug abusers as part of the therapeutic process, criminal courts might normally be inclined to revoke conditional release (probation) and impose sanctions. While the criminal process may need to proceed expeditiously to adjudicate criminal charges, mental health professionals require sufficient time to diagnose the mentally ill defendant's condition, take immediate steps to stabilize the defendant and then to place the defendant in appropriate supportive services so that treatment could then proceed. From the perspective of mental health treatment, potentially the worst experience for many mentally ill persons would be arrest, jail and formal proceedings in the criminal court. In short, these conflicts in method, aims, values and style pose a particular challenge in the emerging mental health court initiatives to produce a hybrid model that attends to the basic requirements of each.

Defining Success

Favorable progress in the drug court treatment process is measured by completion of successive phases of treatment by participants on their way to graduation. In the drug court instance, requirements for graduation were clearly specified and typically included minimum periods of testing negatively for drugs of abuse, completion of all treatment activities, payment of fees, etc. Drug court participants therefore were able to chart their progress against clear expectations and rules for completion of the program. When applying this kind of framework of favorable progress to the mental health court approach, however, setting a standard for success in treatment is more complex.

Participants may suffer from a variety of symptoms and illnesses and, thus, lack a common starting point. The steps necessary to stabilize participants and to situate them in living situations that will maximize their effective functioning are likely to differ considerably from individual to individual. While a goal for substance abusers can clearly and measurably be abstinence within the timeframe of the drug court treatment program, such a practical framework is not so readily available in the treatment of mental illness. Courts cannot say, "be cured within 12 months." They can expect that participants successfully follow the steps to improved functioning outlined in a treatment plan agreed upon by the participant and the mental health participants. Thus, the challenge for setting achievable milestones for mental health court professionals is more complex and the functional equivalent of graduation may differ considerably from individual to individual.

Range of Responses to Participant Behavior/Performance

To an observer of other problem-solving courts, particularly drug courts where some of the in-court techniques were first developed, the mental health court model faces special challenges in devising responses to participant performance in treatment. One might argue that the experience of drug courts in the United States suggests that drug abusers respond well to a very structured system of incentives and sanctions when moving through the treatment process toward sobriety and improved functionality. These approaches are crafted based on assumptions about the behaviors of addicted persons, including a belief that very basic lessons and behaviors may have to be taught and retaught for substance abuse treatment to be successful. Many drug courts have devised a rich range of responses rewarding participants for forward progress through treatment stages (until graduation). When these elements of the drug court model are applied to the mentally ill and disabled in the

criminal justice system, the translation of the “rewards and sanctions” approach to mental health courts raises some difficult challenges.

To promote progress through treatment, the drug court model rewards good behavior and discourages poor performance by participants through the use of various types of sanctions. It is apparent that, because of the nature of mental illness (as compared to substance abuse or domestic violence), judicial responses have to be more generally encouraging and supportive as the court process seeks to move mentally ill and disabled participants into treatment and supportive services. Thus, depending on a defendant’s illness, the judge’s repertoire may need to draw on a wider range of incentives and supportive responses to participant progress than other problem-solving courts.

The notion that mental health courts should also call upon sanctions for poor performance is more difficult. In some cases, it may be clinically appropriate to employ the kinds of sanctions employed by drug courts in responding to noncompliance in treatment, including returning participants to earlier and more restrictive treatment stages or, even, making use of jail in selective instances. In others types of cases, however, it may be questionable as to whether sanctions (based on assumptions of deterrence) are at all appropriate to produce the improved mental health outcomes desired. Real questions, therefore, are raised about how the coercive power of the courts can be channeled to promote the goals of mental health treatment. Can a court sanction a defendant who fails to take medication? Does a court sanction a defendant who has difficulty functioning and understands little of the current circumstances or expectations due to mental illness?

Community Linkage and Resources

A critical element of the emerging mental health court model involves identification of the necessary treatment and related services in the community, and the development of an effective working arrangement between the courts and the service providers that helps place participants in appropriate services and moves them out of jail. Moreover, the model is premised on a working relationship as represented by the dedicated team approach that facilitates ongoing supervision and case management. Courts considering a mental health court approach face two important problems.

First, if it is true that the court system finds itself having to address the needs of the mentally ill population, it is at least partly because existing institutions and services in the community (at least outside of criminal justice) have failed to serve this population. There is some irony, then, in designing a program that uses the court to place mentally ill and disabled participants in those very systems. Secondly, if the rationale for making use of these existing services is that the mental health court creates a new, synergistic relationship that improves both the court and treatment approaches, then the actual availability of these services and the resources to support them becomes a critical concern. A mental health court approach with a large population of persons in need of treatment but few services available in the area may have great difficulty in delivering treatment. Moreover, even when services are available and enthusiastic about the court-based mental health treatment approach, effective identification of candidates in the criminal justice population risks placing a new and large demand on existing treatment resources.

Each of the mental health courts described in this report has identified a potentially large population of mentally ill and disabled defendants who are in need of mental health and treatment-related supportive services. Each has also found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future. When resources exist, they do not adequately provide the type or range of services the mentally ill and disabled persons in the criminal justice population require.

Mental Health Courts as a Community Justice Initiative

The mental health court strategy shares with prior problem-solving court undertakings the fact that a difficult problem has not been adequately dealt with through community institutions and services. Presumptively, effective community interventions could prevent the need to find and treat mentally ill citizens in the criminal justice system. The crime behaviors of the mentally ill range from nuisance and quality-of-life levels to more serious offenses that endanger themselves or others. Although there are a range of behaviors associated with the mentally ill and disabled, it is highly unlikely that they have gone unnoticed in the community until their encounters with the criminal justice system.

Because other community networks or institutions have not effectively treated and supported the mentally ill—due to the failure of community based safety nets—they enter the justice system, usually involved in minor,

nuisance, and quality-of-life offenses. Often, by then, they have other serious problems—such as alcohol or other drug addiction, housing, employment and physical health problems—that also have not been addressed. In many instances, the mentally ill or disabled find themselves in criminal justice primarily because of their mental illness and their inability to connect with or stay in supportive community-based treatment services.

Like the other special court approaches, the mental health courts described in this report attempt to address the problems of their target populations on two levels:

- By dealing with their problems in the criminal justice system.
- By building linkages to community services and support structures that have for a variety of reasons failed to reach them prior to their criminal justice involvement.

Each of the mental health courts discussed has developed strategies for identifying mentally ill and disabled offenders at the earliest stages of processing, sometimes involving contacts from police officers at the arrest stage. Each jurisdiction has taken steps to implement early screening procedures to evaluate candidates for the court treatment process as soon as possible so that unnecessary delay, criminal justice processing, and jail confinement can be avoided. Each of the courts began with a primary focus on defendants entering the criminal process shortly after arrest and being held in jail. But they expanded to accept referrals from other courts, and other sources, such as attorneys, police, friends, relatives or other community contacts aware of individuals caught up in the justice system who were mentally ill or disabled. Each of the courts established a close link to the local jail, so that mentally ill inmates could be identified and admitted to the mental health court treatment process, at whatever stage of processing in the criminal justice system. In short, consolidating justice procedures to identify and enroll candidates in treatment has been an aim of these first pioneering mental health courts.

In each case, the in-house approach is closely tied to a focus on community treatment resources and linkages. Depending on the kinds of illnesses evidenced and the types of resources available in their locales, each of the early mental health courts takes steps to place participants in community based treatment services, either immediately or after initial crises are addressed and individuals are stabilized. Each court emphasizes the importance of proper and timely diagnosis and of placement in proper treatment and supportive care services, where they exist. Each court builds the treatment process around court supervision as a critical, core element ensuring both that enrolling participants cooperate and that appropriate services are indeed provided. At the core of the mental health court approach is a newly established working relationship between the supervising court and community mental health treatment and related services.

Mental health courts, in this regard, represent important court-based community justice initiatives. They are strengthening the effectiveness of community mental health treatment approaches by offering their close attention and supervision. They are returning mentally ill persons from custody and processing in the criminal justice system to the community to function there. They are encouraging community-based justice and health approaches that would prevent mentally ill and disabled individuals from entering the justice system in the first place. Thus, successful court strategies would ideally put themselves out of business: they would find far fewer mentally ill persons in criminal justice, because such persons would be more effectively and appropriately dealt with through improved community intervention, services and support mechanisms.

Decriminalizing Disease & Disability

Lenny Karpman, MD

The ideas explored in this issue of San Francisco Medicine are based on the following premises:

1. there are two classes of disease and one class of disability which are very prevalent in homeless and incarcerated populations
2. individuals with any combination of these conditions are more often put behind bars than into appropriate treatment programs,
3. aggressive outcome-proven treatments are available for all three,
4. treatment, although costly, would save our society billions of dollars, and
5. we, the medical profession, need to take a leadership role in the transformation of attitudes and approaches toward people with these conditions.

What follows is an introductory overview, a series of illustrative literature excerpts and commentary by experts in the various fields that examine the validity of these premises.

TWO CLASSES OF DISEASE AND A CLASS OF DISABILITY

Mental Illness: _The largest center for treatment of people with mental illness in Marin California County, where I live, is a California county jail. Twenty-five percent of all inmates are on psychotropic medications. The primary inpatient alcohol detox facility in a California county is only funded for eight hours of nursing service per day. Since this level of staffing precludes medication schedules for agents given more than once a day, they have a de facto policy excluding most mental patients on medication.

Mr. Jones (fictional name) urinates on the front of businesses in downtown San Rafael when he runs out of his medications. Local business people clamor for his arrest. Local homeless advocates argue that he is ill and not a criminal. With the support of Police Chief Cam Sanchez, Mental Health Liason Officer Joel Fay or his surrogate spend a few minutes each day ensuring that Mr. Jones is taking his medicines and seeing his doctor regularly. Everyone benefits and the overall cost to the community is substantially reduced.

Addiction: _In 1970, there were 200,000 incarcerated people in America. By 1990, we had exceeded a million. We have a higher percentage of people in jails and prisons than any other country on earth. About 60 percent of all the people behind bars are there for drug offenses. For those with addictions, drug-seeking behavior is as symptomatic of their disease as a cough is symptomatic of bronchitis. The excellent article by Smith and Heilig in the November-December issue of San Francisco Medicine makes a compelling case for appropriate treatment, based on outcome evidence and free of traditional prejudices.

Learning Disabilities: _Since 1975, the Individuals With Disabilities Education Act (IDEA), and, in 1990, the Americans With Disabilities Act (ADA) have guaranteed special education programs for individuals with learning disabilities, to help them acquire the skills to cope independently in our society. In February 1998, the U.S. Supreme Court reaffirmed the legal obligation of school districts to provide such education. In California, federal guidelines for compliance have not been met in any single year in the past ten. Without such remedial education, individuals with learning disorders have an astronomically augmented likelihood of ending up unsheltered or incarcerated, except for the few fortunate enough to be born into affluent, caring families. Because the mandate to provide special education has been underfunded by both the state and federal governments, local school authorities have tried to under diagnose affected individuals and stonewall dissatisfied parents.

Punishment and Treatment _Inability to cope often leads to socially unacceptable and/or criminal behavior. In those cases (the majority) where behavior does not include violent acts or dissemination of addicting substances, a stint behind bars without altering the individual's ability to cope, changes nothing. A very expensive revolving door of apprehension, indictment, incarceration, release, reaprehension etc., for repeat "violations" ensues.

Evidence-based Treatment Data _A group of nationally prominent physicians called Physician Leadership on National Drug Policy (PLNDP) have issued reports and consensus policy statements distilling fact from fiction.

Their activities were supported by the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, and Brown University's Center for Alcohol and Addiction Studies.

One of the programs they studied was the Richmond, Virginia Drug Court. It was a carrot and a stick program. Adult offenders chose from straight jail time or a very strictly disciplined drug treatment program, which was often longer than the jail sentence. The treated group had a 50 percent decrease in recidivism. Similar reductions in recidivism have been reported from studies in California, Illinois and Missouri. They looked at many different problems and offered many new directions for our country's leadership, all concordant with a shift in emphasis away from punishment and criminal justice toward treatment and prevention.

Costs of Treating vs. Cost of Incarcerating _

The Richmond, Virginia intensive treatment program costs about \$3,000 to \$4,000 a year per individual, compared to \$20,000 a year for incarceration. The treatment program was saving money by the second year. Not even factored in are the savings in police costs, the benefits to the population at large from decreased crime, and the obvious benefit to the individual restored to health. An addict in recovery ceases to commit felonies to support a habit. A person with schizophrenia or bipolar disorder is less likely to end up in the emergency department of the hospital or in jail for disorderly behavior, if there is a California County or local support system which helps him stay on his meds and keep his appointments. The recipient of special education can recover from the stigma that he or she is stupid and /or lazy with the acquisition of skills to become self-sufficient and out of the criminal justice system revolving door. Special education pilot programs in penal institutions have comparable successes to intensive drug treatment programs in decreasing recidivism.

Maintaining Community Safety _

Sanctions against violent offenders are not altered by treatment or education programs. Reducing risks that lead to criminal behavior does not diminish public safety, it enhances it. Treating disease and disability is not akin to being soft on crime.

Political Inertia _

We have a long political tradition that all candidates try to appear to be hard on crime at election time. To do otherwise is considered political suicide. As a result, crime bills that are poorly constructed and do more harm than good, multiply like fruit flies before elections, with little or no opposition. Politicians avoid any stances that can be misrepresented by opponents as "soft on crime" and misconstrued as such by voters. Any approach other than more jails and more incarceration dies on the political vine for lack of support. With all the negative stereotypes associated with these three groups, the voters seldom support funding for new or expanded treatment programs. They get to see only an isolated piece of the picture.

Source of Funds _

We saw a comparable model in the seventies. There was no political will and very little public will to spend tax dollars on prenatal care and reproductive choice for indigent women. It was clear to us and to a number of advocacy groups that dollars spent on prenatal care and choice in high-risk communities saved many more dollars down the road. It took about a dozen victories in the California Supreme Court to get the governors of our state to include funding in the annual budget. Without the support of the California Medical Association, the American College of Obstetrics and Gynecology, the American Pediatrics Association, Planned Parenthood, and the ACLU, it might never have happened.

Similarly, effective programs which help individuals with mental illnesses, addictions, and learning disabilities to survive, off the streets and outside the criminal justice system, will save our society billions. Think of the extraordinary sums we spend on new jails and prisons to house even more people who don't belong there. There must be a rational way to transfer those energies and funds away from human warehousing, toward risk reduction and rehabilitation.

Medical Leadership _

Once again, there is a barrier against providing needed services to the underserved for their benefit and for ours. The barrier is a lack of vision of the whole picture. We have to show the public an integrated program of education, prevention, early treatment of high risk individuals and treatment of people already on the streets or behind bars. We, the medical community, can enter a coalition with the police, public health and mental health departments, the courts, boards of supervisors, non-profit advocacy groups and tax-payer groups. We can help to make the case that well-spent funds ultimately save money and enhance quality of life for the under-served and the entire community.

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As physicians and physicians' groups, we need to define for the courts, the school systems and the legislature these diseases and disabilities and their symptoms, as they occur alone and in combination with each other, to enhance identification and referral into effective evidence based programs. We need to support such programs at California County, state and federal levels. We need to keep the focus on the rational, compassionate and cost-effective approach to the whole picture.

Dr. Karpman is a member of the SFMS delegation to CMA, the Council on Legislation of CMA, the editorial board of San Francisco Medicine, the Legislative Forum of Kaiser Permanente, the Legislative Policy Committee of the ACLU of Northern California, the Law Enforcement Committee of the Marin California County Human Rights Commission, and the Advisory Committee to the Chief of Police for San Rafael.

San Francisco's New Behavioral Health Court-One Solution to Helping the Underserved

Jennifer Johnson, Deputy Public Defender

The criminal courts in San Francisco are faced with increasing numbers of mentally ill defendants. The criminal justice system is becoming the default solution for dealing with the larger societal problems of mental illness and homelessness. As a result, the responsibility of recognizing and dealing with mental illness falls on lawyers and judges who are not trained in psychology. A population of offenders who should be in mental health programs is cycling through the court system, where mental illness often goes ignored, untreated, or worse yet, unnoticed.

The Creation of Behavioral Health Court

In late 2002, Superior Court Judge Ksenia Tsenin decided to address the problem. In conjunction with a number of other city departments, Judge Tsenin instituted the Behavioral Health Court (BHC). The court has three main objectives: first, to connect criminal defendants who suffer from serious mental illness to treatment services in the community; second, to find creative and appropriate dispositions to the criminal charges that take the mental illness and the seriousness of the offense into consideration; and third, to decrease recidivism in this defined population of offenders.

The court has a team approach. The BHC team is led by retired Judge Herbert Donaldson and consists of mental health providers in the community, Jail Psychiatric Services, volunteer psychiatrists, the Adult Probation Department, the Office of the District Attorney, and the Office of the Public Defender.

The Population

In order to qualify for Behavioral Health Court, defendants must have an Axis I Mental Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, IV. The most common diagnoses in BHC are schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and post-traumatic stress disorder. Clients with developmental disabilities and mental retardation are also accepted into the program. In addition to the primary mental health diagnosis, participants must be amenable to treatment in the community mental health system.

Behavioral Health Court is currently treating clients charged both with felonies and misdemeanors, as well as clients who are on probation. We have established some general guidelines about which criminal charges are appropriate for BHC. For example, crimes of violence involving great bodily injury, sex crimes, domestic violence and arson are presumptively excluded from consideration for BHC. In certain limited circumstances, these types of cases are presented to the court. The judge, conferring with the prosecution and defense, examines the facts carefully and may decide to accept an individual whose criminal behavior falls outside of the guidelines. For those clients, the court considers the risks to the community and the likelihood of that particular person reoffending upon release.

The court also looks carefully at the nexus between the mental illness and the behavior that led to the arrest. In almost all cases, clients who participate in the court were not on any psychiatric medication or actively participating in treatment at the time of the incident.

The Procedure

Most clients are accepted into Behavioral Health Court while they are still in custody in a California county jail. The first step is to find a program in the community that is appropriate for the individual. In some cases, clients are referred to Acute Diversion Units where they graduate to progressively less restrictive levels of care. In other cases, clients are housed in residential hotels with supportive services, and connected to community mental health programs on an outpatient basis. The placement is dependent upon that person's needs and capabilities.

Upon each client's release from custody, progress is closely monitored. Participants appear in court regularly and the team works together to create a treatment plan that includes access to intensive case management, counseling, medication and housing. Based on the person's adherence to the treatment plan, the district attorney, public defender and judge find an appropriate resolution for the criminal charges. There is no set standard for successful completion of the program because each case is dealt with on an individual basis.

Behavioral Health Court is a voluntary program and clients are free to return to the criminal process at any stage of treatment. They are encouraged, not forced, to comply with treatment and are given multiple chances to cooperate with a treatment plan. The court has a progressive understanding of the complexity of mental illness, the lack of insight that often accompanies a psychotic disorder, and the reality that many clients have concurring substance abuse problems that complicate treatment.

The Research

Because Behavioral Health Court is still evolving, there is no outcome data to show the success of the program. We are in the process of implementing the first phase of a three-phase study proposed by Dr. Dale McNiel and Dr. Renee Binder of the University of California, San Francisco, entitled "Processes and Outcomes of the San Francisco Behavioral Health Court."

Phase I is a descriptive study, designed to provide preliminary information about the court. The first phase will be hypothesis-generating and depend largely on anecdotal information provided by the members of the court. Phase II of the study is retrospective. The goal of this phase is to obtain objective data about outcomes for the participants in the court to date. This phase will focus on all of the clients who have been presented to the Behavioral Health Court team since its inception to look for patterns. Have these clients been referred to Psychiatric Emergency Services fewer times in the last year than in the past? Have they continued a pattern of arrests or has that behavior stopped? Are they more compliant with mental health treatment than before entering the court? Why were certain clients rejected from BHC?

Finally, Phase III is a long-term prospective study that will evaluate BHC on a broad array of outcome measures. We intend to assess 100 defendants upon entry into the program, and assess a comparison group of 100 other mentally disordered defendants.

The Results

While there is insufficient scientific data to prove that this court is a success, the players involved in the creation and implementation of Behavioral Health Court are overwhelmingly convinced that the program is necessary and successful and has extraordinary potential.

For the first time in San Francisco, the mental health system and the criminal justice system are working together and concentrating experience and knowledge to negotiate clients through a system that can be callous regarding the needs of the mentally ill. Public defenders, district attorneys, and judges in the court have the opportunity to share information with psychologists, psychiatrists and social workers to find solutions for clients that have a greater chance of long-term success. Also, clients are encouraged to contribute and to help direct the course of their own treatment.

The team meets in private in the morning to discuss each case and to work out any disagreements. By the afternoon when clients appear in court, we address them with a uniform, clear message. Clients see the same defense lawyer, the same prosecutor and the same judge week after week. This continuity eliminates confusion and alienation that criminal defendants often feel in court. In creating this environment, the hope is that clients will not be afraid to return to court.

Another unusual aspect of Behavioral Health Court is the fact that clients communicate freely with the judge about their treatment without fear of reprisal. Clients are encouraged to be honest with the court about both successes and failures in treatment. The atmosphere in court is positive, the judge talks directly to each individual and clients receive positive reinforcement from the team.

The Future

By establishing a mental health court, San Francisco is on the forefront of a nationwide trend. Cities and counties everywhere are faced with dwindling resources for the mental health community and corresponding increases in jail populations. With support for Behavioral Health Court, we hope to expand the program to encompass more mentally ill clients who would be better served by treatment than incarceration. Our community deserves a criminal justice system that recognizes and addresses the needs of its most vulnerable citizens.

Jennifer Johnson is a deputy public defender in San Francisco and represents the majority of indigent clients in Behavior Health Court. She can be reached at Jennifer_Johnson@ci.sf.ca.us.

