Either way, ambitious but realistic targets will help the court reduce the time spent in jail for people with mental illnesses who can be supervised safely and effectively in the community.

7. INTEGRATION OF TREATMENT AND COMMUNITY SUPPORTS

A mental health court's success is predicated on its participants receiving comprehensive treatment in the community. Unfortunately, this is not as simple as assessing a participant, making a diagnosis, and setting up an appointment for services. People with serious mental illnesses, particularly those who become involved in the criminal justice system, have extensive and complicated needs. Typically, they have co-occurring substance abuse disorders and complicating medical conditions. They are more likely than the general population to be homeless and may lack resources to pay for treatment and other basic needs.

A mental health court that has effectively defined its goals, established a target population, assured voluntariness and confidentiality, developed terms of participation, and identified eligible participants—in other words, a court that has addressed all of the elements discussed thus far—has achieved only the precursors to program success; it has yet to actually apply the intervention designed to produce positive outcomes. This section provides guidance on integrating treatment and related supports into the court process, including identifying the treatment needs of court participants, developing treatment plans, contending with the high prevalence of co-occurring disorders, and planning for the transition of participants out of the mental health court program.

To address these issues, court practitioners will need to understand basic information about mental illnesses and their treatment, subjects which are beyond the scope of this guide. For this reason, CSG has published *Navigating the Mental Health Maze: A Guide for Court Practitioners* as a companion to this document. *Navigating the Mental Health Maze* provides detailed information about the mental health service system, the types of mental illnesses that court participants have, how those illnesses are diagnosed, and the kinds of treatment and supports that participants require. Representatives of criminal justice agencies participating in mental health court programs are strongly encouraged to consult that guide.

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

Identifying treatment needs

Developing strategies to meet the treatment needs of mental health court participants requires in-depth discussions to answer questions such as the following:

- What are the expected treatment needs of the participants?
- Who is able to provide each type of treatment?
- How much will these services cost?
- How will treatment providers be compensated?

Obviously, these questions can only be answered with criminal justice and mental health representatives at the table together. Courts cannot simply expect treatment to be made available to their participants without the buy-in of community-based treatment providers. As many court officials have learned, this often requires reaching out to an array of agencies. For example, more than 75 community-based agencies have provided services to participants in the Brooklyn Mental Health Court.[54] In other jurisdictions, such as in the example below, service slots may be somewhat easier to identify.

EXAMPLE: Bonneville County Mental Health Court (Idaho)

The Bonneville County Mental Health Court relies on an existing Assertive Community Treatment (ACT) team to serve all court participants. Because of the low client-to-staff ratio of ACT programs, the mental health court accepts no more than 20 clients at any given time. The court chose to rely on an ACT Team to ensure public safety and to overcome the inherent difficulty of accessing treatment in a rural setting.

Recognizing the current gaps in the service system, some courts have secured resources and contracted with providers for a pre-determined number of beds or treatment slots. While this strategy may improve access to treatment for mental health court participants, it raises important philosophical and practical issues. One of the most trenchant criticisms of mental health courts is that they prioritize treatment for court-involved consumers above treatment for those who have not committed a crime.* Isolating treatment slots for mental health court participants contributes to the perception, and in some cases the reality, that becoming involved in the criminal justice system makes it easier to obtain services. In response to this criticism, mental health court planners should establish clear arrangements with mental health treatment providers that ensure treatment access for mental health court participants without jeopardizing treatment availability for the general public.

*"**Criminalization of** People with Mental Illnesses: The Role of Mental Health Courts in System Reform," by The Bazelon Center for Mental Health Law, offers a thorough discussion of this concern. Available at: www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/.

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

As discussed later in this section, mental health court participants are likely to require care long after judicially supervised treatment has ended and, as a result, are best served by linkages with community-based providers who are prepared to treat consumers regardless of their court status. When defendants receive services from one agency while under court supervision and from a separate agency after the program ends, continuity of care is hampered. One exception to this view is court-based case management. Court-based case managers perform essential planning and monitoring functions of court-ordered treatment and support and this function can be readily transferred to a community-based case manager upon program completion without disrupting the flow of treatment.

The mental health court planning committee should identify all available services, particularly those previously unknown to the court, and ensure that these programs are willing and able to accept court referrals. Estimated capacity needs for the various types of treatment should be informed by local data on the projected size of the target population and the types of diagnoses anticipated among court participants. As mentioned above, a complete discussion of the likely treatment needs of mental health court participants is included in *Navigating the Mental Health Maze: A Guide for Court Practitioners*. These needs include:

- Psychiatric hospitalization
- Inpatient mental health treatment (crisis stabilization)
- Outpatient mental health treatment

paying for services and supports: the role of benefits programs

Practitioners working at the intersection of the criminal justice and mental health systems, including those in mental health courts, are increasingly paying attention to the importance of federal benefit programs such as Medicaid and Social Security Insurance as funding sources for treatment and other supports. In general, federal funds cannot be accessed for people who are incarcerated, but steps can be taken to accelerate the reinstatement of benefits after incarceration, including the establishment of policies to suspend, rather than terminate, Medicaid benefits, and the development of prerelease application procedures with local, state, and federal benefit agencies. Mental health courts should take steps to ensure that eligible participants are connected as quickly as possible to federal benefit programs, and consult guides such as the Bazelon Center for Mental Health Law's "Arrested? What Happens to Your Benefits If You Go to Jail or Prison," and case studies recently developed by the Council of State Governments about efforts in four states to address these issues.[55]

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

- Substance abuse treatment
- Medication and symptoms management
- Housing (including supported housing)
- Benefits (e.g., Medicaid, SSI, SSDI, veterans)
- Transportation
- Supported employment

Some mental health providers may be reluctant or even unwilling to accept clients referred by the criminal justice system, especially those charged with felonies. Court officials should respect these concerns and provide information and consultation to mental health providers to help alleviate them. For example, courts can provide data to mental health providers demonstrating that many of their existing clients have been involved in the criminal justice system at some point in their lives. Emphasizing that the clinical requirements are comparable regardless of criminal justice involvement may make mental health treatment providers more amenable to serving court participants. Treatment providers can also be reminded that the addition of court

peer supports

One of the emerging practices in mental health treatment is the use of consumers to provide support to their peers to aid recovery. Some mental health courts are adapting this strategy to their programs. Consumers, whether or not they have been involved with the criminal justice system, are ideally suited to support mental health court participants because of their unique insight into the dynamics of recovery. Peer supports can be important components in helping mental health court participants remain in treatment and develop adaptive, crime-free lifestyles.

EXAMPLE: St. Louis County Mental Health Court (Missouri)

The St. Louis County Mental Health Court makes available a peer support specialist for all participants. This specialist provides one-on-one consultation, facilitates group meetings, introduces participants to consumer education, and provides other supports as needed. For some participants, the peer support specialist serves as an intermediary with his or her mental health treatment providers to ensure a collaborative treatment environment. The peer support specialist also provides trainings on the use of public transportation, household management, budgeting, and social networking, among other issues. The peer support specialist is not a full-time employee but receives a stipend to cover costs associated with this work.

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

leverage to a treatment regimen often creates better overall outcomes for both the treatment and criminal justice systems.

Developing treatment plans

Treatment plans provide the framework for services delivered to consumers; particularly when treatment is delivered by multiple providers and supervised by yet another agency, treatment plans are essential to ensure treatment integrity. The various court and mental health professionals involved with the participant should be involved in formulating the treatment plan, along with the participant himself, family and significant others, and other community supports (e.g., Alcoholics Anonymous sponsor, mentor). While language conventions and philosophical approaches will vary across providers, the end product should provide a framework for how the consumer will manage his or her issues and identify specific steps toward recovery. Treatment plans must be responsive to each consumer's individual needs, and should also provide specific benchmarks for progress. Treatment planning involves five basic steps:[56]

1. Identifying the Problem: clinicians must identify the most significant problems interfering with the consumer's functioning. Having a smaller, more manageable number of problems keeps the treatment plan focused.
2. Defining the Problem: the way in which the problems are manifested in terms of the consumer's behavior should be clearly articulated.
3. Setting Goals: broad, long-term goals should describe how the targeted problems will be resolved.
4. Specifying Objectives: specific and measurable steps for attaining each treatment goal should be listed, along with expected dates of completion. When appropriate, this section may also be used to discuss signs of relapse and to provide the consumer with specific strategies for resisting common triggers.
5. Identifying Interventions: specific interventions will vary according to the consumer's needs and the clinician's expertise, but will generally include a combination of cognitive, psychodynamic, behavioral, pharmacological, and family-oriented therapies; medical care; assistance with housing, employment, or education; peer-based supports; and concrete supports such as transportation and child-care. The people responsible for providing the various interventions should be clearly identified.

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

gender-specific and trauma-informed services

Women with mental illnesses involved in the criminal justice system have particular needs to which mental health courts should attend. For example, most women who are arrested have one or more children in their custody; maintaining custody and ensuring that their children are appropriately cared for may be primary concerns for female defendants. In addition, histories of trauma are considered the norm for women in the criminal justice system: 94 percent of incarcerated women report violence or sexual assault by intimates over the course of their lifetime. Mental health courts that do not consider these issues may inappropriately exclude some women (because of inaccurate diagnoses), apply sanctions ineffectively, or otherwise hamper the ability of female participants to adhere to court conditions. A recent monograph, *Special Needs of Women with Co-Occurring Disorders Diverted from the Criminal Justice System*, recommends that mental health courts and other diversion programs take the following steps to develop "gender-specific" and "trauma-informed" programs:[57]

- **Examine policies and procedures—**to ensure that gender and trauma issues are considered, particularly in staff training.
- **Adapt screening and assessment—**to account for histories of trauma and abuse and to determine whether female defendants have children in their custody.
- **Develop treatment plans—**that respond to the specific needs of women and their children, including trauma-specific services, parenting classes, sexual assault and domestic violence groups, and children's health care.
- **Link women to long-term services—**to ensure that women's involvement in treatment continues past their term of judicial supervision.

ensuring cultural competency

Mental health court planners must also take steps to ensure the cultural competence of their programs, particularly in light of the racial disparities in the criminal justice system. Consensus panels convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) have defined **cultural competency** as: "An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations." Examples of culturally competent program adaptations are the use of peer counselors and the availability of interpreters. Consumers can provide particularly valuable input on how courts can address these issues.

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

Treatment plans are not intended to be static documents, but rather living instruments that are reviewed and updated periodically. As court staff and treatment providers learn more about the participants and their strengths and resources, plans may be made more specific. Not only should the plan be used to track consumer progress or lack thereof, but also to hold court and treatment partners accountable for their commitments to provide services.

Co-occurring substance abuse disorders

Among mental health court participants, co-occurring psychiatric and substance abuse disorders are the rule, not the exception, a fact that must be considered in all aspects of the court's operation. Recent research on managing co-occurring disorders in the context of a specialty court (particularly drug courts) offers the following recommendations to enhance the quality of care:*

- Screen and assess potential participants for both mental health and substance abuse problems.
- Educate participants about both mental health and substance abuse disorders.
- Ensure access to both medication monitoring and drug testing.
- Work closely with both community mental health and substance abuse treatment providers.
- Include conditions, goals, and objectives related to mental health treatment and substance abuse treatment in treatment plans for all participants with co-occurring disorders.[58]

*_Co-Occurring_ *Disorders and Specialty Courts* was published by the National GAINS Center for People with Co-occurring Disorders in the Criminal Justice System and the TAPA Center for Jail Diversion, and is available at: http://www.gainsctr.com/pdfs/CoOccurringSpecialty04.pdf.

Of all the actions that mental health courts can take to ensure the success of participants with co-occurring disorders, perhaps the most important is identifying and promoting integrated treatment. Integrated treatment involves the simultaneous and coordinated treatment of both mental health and substance abuse disorders, as opposed to the sequential or parallel treatment strategies, which are common in most communities. Research has consistently demonstrated that integrated treatment leads to superior outcomes among people with co-occurring disorders.[59] In general, integrated treatment combines interventions targeting both the psychiatric and the substance abuse disorders within the same context, ideally delivered by cross-trained staff (see sidebar on next page).

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

EXAMPLE: The Substance Abuse and Mental Illness (SAMI) Court Program (Butler County, Ohio)

The SAMI Court Program in Butler County is based on the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model.[60] As its name suggests, the program serves persons with serious mental health *and* substance abuse disorders. Only defendants charged with felonies are eligible. All participants receive integrated treatment from a specially trained, dedicated team that includes an alcohol and drug abuse specialist, a psychiatrist, a case manager, and a probation officer. Integrated treatment is not generally available in Butler County, so the court has also conducted trainings on integrated treatment for mental health and substance abuse treatment providers across the county.

modes of treatment for co-occurring disorders

Sequential Treatment—the consumer with co-occurring disorders is not eligible for treatment for one disorder until the other problem is resolved or suitably stabilized.

Parallel Treatment—the consumer has both disorders treated simultaneously, but by different providers who have no formal relationship or shared treatment planning.

Integrated Treatment—the consumer has both disorders treated simultaneously by providers who develop a single treatment plan addressing both conditions.

High-quality Integrated Treatment Programs:

- Utilize a multidisciplinary team.
- Deliver treatment in sequential stages that correspond to the client's readiness (engagement, motivation, action, relapse prevention).
- Provide access to residential treatment, supported employment, family psychoeducation, illness management and recovery, and assertive community treatment.
- Deliver treatment over a long period, modifying intensity based on the client's degree of recovery.
- Provide information and offer practical assistance to the client during outreach.
- Use motivational interviewing techniques to express empathy and empower the client.
- Focus on relapse prevention strategies in counseling.
- Address both disorders in group treatment.
- Involve family members.
- Require clients to participate in self-help groups (e.g., AA or NA).
- Use psychotropic medications to address psychiatric symptoms.
- Target the full range of physical, social, and behavioral effects of substance abuse in counseling.
- Make secondary interventions available for those who do not respond to treatment initially.

SOURCE: SAMHSA. *Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Fidelity Scale*. Washington, DC, SAMHSA, 2003. Available at http://media.shs.net/ken/pdf/toolkits/cooccurring/IDDTFidelityScaleAJ1_04.pdf

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

Creating broad access to integrated treatment presents a significant challenge; integrated treatment is not widely available in most communities, and in some, not at all. The reasons for the dearth of integrated treatment slots are complex, relating to funding requirements, standard practices, and systemic inertia. While mental health courts cannot solve these problems on their own, they can become vocal advocates for expanding access to integrated treatment, both for court participants and for the community at large.

Transition Planning

As mental health courts mature and participants begin to successfully complete their term of treatment, the following scenario has become increasingly common. After a year of judicially supervised treatment during which several setbacks were overcome, a participant gets "back on her feet" and graduates from the court. Her life appears to be headed in a positive direction and the mental health court strategy appears vindicated. Six months later, she is back in the mental health court, having committed a crime similar to the one that precipitated her initial involvement. Even if this only happens to a few participants, the psychological impact on the court team's morale (not to mention that of the participants) can be significant, as the return of the participant to the court suggests that all the hard work of the consumer and those supporting her was for naught. Though frustrating, these situations offer valuable lessons.

The return to court of some proportion of "successful" graduates is inevitable. Serious mental illness is a lifelong ailment, and even with the good intentions and collaborative efforts of numerous people, psychiatric disorders often lead to behavior that brings people into repeated contact with the criminal justice system. Accepting this fact is an important step toward establishing realistic expectations at the outset of a mental health court project and toward deciding whether to re-accept graduates on new offenses.

Much can be learned from the mental health system's experience in this area. "Discharge planning begins on admission" is the mantra of inpatient psychiatric services, and should be adopted by mental health courts. In the early phases of participation, the court is appropriately focused on engaging the individual and ensuring that he or she understands the court's expectations. Mental health court practitioners must also recognize from the outset that the mental health court intervention is time-limited, while the individual's mental health problems may be chronic and ongoing. Mental health and court staff must attend to the inevitable end of judicial supervision

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.

from the date of admission and be prepared to address the client's concern, anxiety, or outright decompensation as graduation approaches.

One of the best ways to help people navigate this transition is to acknowledge, collectively, its potential difficulty. Reciprocal engagement between the consumer and treatment providers should be the focus; that is, the court participant must be engaged with her treatment providers, and the treatment providers must be prepared to continue working with the individual after the court mandate has been lifted.

For many participants, the structure provided by the mental health court is itself a clinical intervention; the clear expectations communicated by the court can be therapeutic. In some cases, the structure of the mental health court should be replaced by another structured intervention (e.g., day treatment, intensive case management, Assertive Community Treatment, etc.). For others, the increased intensity of court-brokered services during the transitional period may suffice. In addition, court and mental health providers should ensure that all participants have adequate housing and resources to pay for needed services, including access to Medicaid, cash and food stamps benefits, and SSI. Above all else, strong, collaborative relationships between court staff and the entire spectrum of community-based service providers is the best way to ensure that success in the mental health court breeds success in the community, over both the short and long term.

EXAMPLE: Washoe County Mental Health Court (Nevada)

The Washoe County Mental Health Court has taken steps to ensure a smooth transition for program participants ending their period of judicially supervised treatment. The court team is developing a system through which court participants maintain the same case manager, doctor, comprehensive service plan, and amount of contact after leaving the court program. This allows the treatment provider to mirror the structure and supervision provided by the court. The team is also identifying potential graduates three months in advance and working with the participants and mental health treatment providers to develop aftercare plans, to identify issues for concern during the transition period, and to promote continuity of care and engagement.

Collaborative advocacy

Even courts with strong mental health partnerships struggle to rectify the chronic limitations of the community treatment system. The inadequacies and fragmentation of the mental health system have been well documented in several recent major reports, most notably the report of the President's New Freedom Commission on Mental Health.[61] In the radical shift from a system of large, centrally-managed

Excerpt from Council of State Governments Justice Center, A Guide to Mental Health Court Design and Implementation, 2005.