

Briefing Report



Mental Health, Mental Health Courts and the Criminal Legal System

A Report of the District of Columbia Advisory Committee

to the U.S. Commission on Civil Rights

(September 2020)

Advisory Committees to the U.S. Commission on Civil Rights

By law, the U.S. Commission on Civil Rights has established an advisory committee in each of the 50 states and the District of Columbia. The committees are composed of state citizens who serve without compensation. The committees advise the Commission of civil rights issues in their states that are within the Commission's jurisdiction. More specifically, they are authorized to advise the Commission in writing of any knowledge or information they have of any alleged deprivation of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, national origin, or in the administration of justice; advise the Commission on matters of their state's concern in the preparation of Commission reports to the President and the Congress; receive reports, suggestions, and recommendations from individuals, public officials, and representatives of public and private organizations to committee inquiries; forward advice and recommendations to the Commission, as requested; and observe any open hearing or conference conducted by the Commission in their states.

This report is the work of the District of Columbia Advisory Committee to the U.S. Commission on Civil Rights. The report may rely on testimony, studies, and data generated from third parties. Advisory reports are reviewed by Commission staff only for legal sufficiency and procedural compliance with Commission policies. The views, findings, and recommendations expressed in this report are those of a majority of the District of Columbia Advisory Committee, and do not necessarily represent the views of the Commission, nor do they represent the policies of the U.S. Government.

Letter of Transmittal

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U.S. Commission on Civil Rights

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The District of Columbia Advisory Committee, as part of its responsibility to advise the Commission about civil rights issues within the District, submits this report, *Mental Health, Mental Health Courts and the Criminal Legal System*. The report was adopted unanimously by all nine DC Advisory Committee members on June 11, 2020.

Sincerely,

John G. Malcolm, Chairman
District of Columbia Advisory Committee

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* Marcos Mullin worked under the direction of Committee Chairman, John G. Malcolm. Marcos is a 2020 graduate of the University of Texas at San Antonio. He majored in Economics and Public Administration.

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Introduction

In 1957, President Dwight D. Eisenhower signed into law the Civil Rights Act of 1957, which, among other things, created the U.S. Commission on Civil Rights.¹ The Commission is an independent, bipartisan federal agency charged with studying alleged discrimination or deprivations of civil rights and enhancing the enforcement of the equal protection of the laws because of race, color, religion, sex, age, disability, or national origin, or in the administration of justice.² Congress charged the Commission to “establish at least one such [advisory] committee in each State and the District of Columbia composed of citizens of that State or District” to collect and provide information, findings, and recommendations to the Commission about issues of civil rights in their respective states.³

On November 7, 2019, the District of Columbia Advisory Committee convened for a public hearing to consider the intersection of mental health and criminal justice and to evaluate the effectiveness of the District of Columbia Superior Court Mental Health Community Court (DCMHCC), one of several diversion programs provided by the D.C. court system. The Committee heard from the following mental health court experts, which included academics and practitioners, and D.C. stakeholders:

Prof. Richard Boldt, University of Maryland Carey School of Law

Prof. Kelli Canada, Associate Director of Research School of Social Work, University of Missouri

Prof. E. Lea Johnston, University of Florida Levin College of Law

Prof. Susan McMahon, Georgetown University Law Center

Mr. Terrence D. Walton, Chief Operating Officer, National Association of Drug Court Professionals

Ms. Kelly O’Meara, Executive Director, Strategic Change Division, Metropolitan Police Department

Mr. Stephen Rickard, Chief, General Crimes Section, D.C. U.S. Attorney’s Office
Laura L. Rose, Esq., Mental Health Specialist for the Trial Division, Public Defender Service for DC

Gregg Baron, Esq., Defense Counsel

Hon. Ann O’Regan Keary, Senior Judge, DC Superior Court
Ms. Cleonia Terry, Coordinator, Mental Health Community Court, DC Superior Court

¹ Civil Rights Act of 1957, Pub. L. No. 85-315, 71 Stat. 634.

² 42 U.S.C. §1975a.

³ 42 U.S.C. §1975a(d).

Mr. Jeffrey Wright, Treatment Program Manager, Pretrial Services for the District of Columbia

Dr. David Freeman, Chief Clinical Officer, Community Connections, Inc.

Ms. Christy Respress, Executive Director, Pathways to Housing DC

Mr. Andre Gray, Peer Navigator, Disability Rights DC's DC Jail and Prison Advocacy Project at University Legal Services

Additionally, Prof. Allison Redlich, Professor of Criminology, Law & Society, George Mason University, submitted written testimony which was read into the record but was unable to attend the public hearing.

The Committee also heard from Anthony Ellis and Tania Taylor; two members of the public who were graduates of the DCMHCC.

Prior to the November hearing, several members of the Advisory Committee went to the D.C. Superior Court to observe some proceedings before the DC Mental Health Community Court (DCMHCC). During that time, the Committee observed some participants graduate from the program after successfully completing all the requirements, others who were remanded to Superior Court having been unsuccessful in completing the program, and one participant who needed medical attention immediately prior to his hearing.

This report will provide relevant background information about the issue and the DCMHCC, describe the relatively new pre-arrest program that has been instituted by the Metropolitan Police Department (MPD), detail how the DCMHCC works, consider criticisms of mental health courts offered by some experts, analyze how the DCMHCC is doing, examine service providers' perspectives, and offer some recommendations by the Committee.

Background: Defining the Problem

Prof. McMahon began her testimony by recounting the story of 24-year-old Virginia resident Jamycheal Mitchell, who was diagnosed with bipolar disorder and schizophrenia in his youth. He was arrested for minor theft when he stole a \$5 bag of potato chips from the corner store and then sent to a mental health facility for a competency evaluation. The facility was, unfortunately, overbooked. For four months, he waited in an isolation cell at Hampton Road Jail, began to wipe feces on the walls, and eventually starved to death.⁴ Tragedies like these are unfortunate and more common than one might imagine. Jamycheal's story illustrates a problem that is also all too real—the disproportionate representation of individuals diagnosed with a mental disorder in the criminal justice system.

⁴ Susan McMahon, Professor of Law, Georgetown University Law Center, Washington, D.C., testimony, *Briefing Before the District of Columbia Advisory Committee to the U.S. Commission on Civil Rights, Washington D.C.*, Nov. 7, 2019, pp. 34-36 (hereafter *DC Briefing*).

Prof. Boldt noted that there has been a significant decline over the last half-century in the reliance on large state hospitals to care for persons diagnosed with a severe mental illness.⁵ Unfortunately, a large portion of these individuals, who otherwise would have been hospitalized, end up in the criminal justice system.⁶ The criminal justice system, however, is not well-prepared to care for the needs of this vulnerable population.⁷

Prof. Canada testified that according to the National Alliance of Mental Illness (NAMI), “when a person in the U.S. has a mental health crisis, they are more likely to encounter law enforcement than a mental health professional.”⁸ The National Institute of Mental Health reports that 18.9% of adults in the United States possess a mental illness, and over half of all prisoners are reported to possess some form of mental illness.⁹ Estimates show “56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates” in localities have a mental illness.¹⁰ The District of Columbia is not an exception to this rule. According to Prof. McMahon, citing a 2013 *Washington Post* article, “as of 2013, forty percent of incarcerated people at DC’s Central Detention Facility... suffered from some form of mental illness.”¹¹

Ms. Rose, a mental health specialist for the agency charged with maintaining and monitoring federal prisons and inmates, stated that three percent of their current inmates require regular mental health treatment, compared to 30 percent in California, 20 percent in Texas, and 34 percent in the DC jail and correction treatment facility.¹² In 2015, the Chief Psychiatrist for the Federal Bureau of Prisons (BOP, Bureau), after discussions with the in-residence psychiatry services at multiple prisons, estimated that around 40 percent of federal inmates have some form of mental illness.¹³

⁵ Richard Boldt, T. Carroll Brown Professor of Law, University of Maryland Carey School of Law, Baltimore, MD, Testimony, *DC Briefing*, pp. 14-15.

⁶ *Ibid.*

⁷ *Ibid.*

⁸ Kelli Canada, Associate Professor and Associate Director of Research, School of Social Work, University of Missouri, Columbia, MO, *DC Briefing*, p. 21.

⁹ “Prevalence of Any Mental Illness.” *National Institute of Mental Health*, last modified February 2019, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (accessed September 2, 2020).

¹⁰ Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, D.C.: Bureau of Justice Statistics, 2006) (The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002).

¹¹ Susan McMahon, Written Statement for the *DC Briefing*, at 2 (hereafter McMahon Statement), citing Aaron C. Davis, *Report: Rash of Suicides at D.C. Jail Points to Deep Problems with Inmate’s Mental Health Care*, WASH. POST, Nov. 7, 2013.

¹² Laura L. Rose, Esq., Mental Health Specialist for the Trial Division of the Public Defender Service for D.C., Washington, D.C., Testimony, *DC Briefing*, p. 120.

¹³ U.S. Department of Justice, Office of the Inspector General, *Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness*, July, 2017, pp. i-iii, <https://oig.justice.gov/reports/2017/e1705.pdf>.

In addition to the Bureau's underreporting of inmates with a mental health condition, the BOP is underfunded in providing the services that are required for this vulnerable population.¹⁴ In 2014, a new mental health treatment policy required the BOP to increase its mental health care standards.¹⁵ Since the implementation of that policy, the number of inmates receiving mental health treatment has declined by 30 percent.¹⁶ Local jails usually don't perform much better; a study demonstrated that in local jails across the country, only one-third of inmates who require mental health treatment receive it.¹⁷

The problem of the "revolving-door" of defendants with mental health conditions cycling in and out of the criminal justice system is quite common. Mr. Wright reported that 62 percent of defendants in the DC system with a self-reported mental illness pose a high or very high-risk of re-arrest or failure to appear in court.¹⁸ Only 31% of all other defendants pose that same risk.¹⁹ Defendants with mental health conditions usually require more resources and additional contact with case managers to follow their probationary or court-ordered tasks and are also significantly more likely to violate their terms of probation, which leads them back into the criminal justice system.²⁰ Unfortunately, defendants with a mental health condition are at a higher risk for recidivating, usually for reasons directly and indirectly related to their mental health condition.

Unfortunately, people who suffer from mental illness have become residents of our criminal justice institutions, and the criminal justice system has a particularly detrimental effect on incarcerated individuals with a mental health diagnosis. According to Prof. Canada, correctional officers generally report that they don't have adequate knowledge or training to monitor inmates with mental illness, and the general "command and control" structure that is typically used is problematic for people in crisis.²¹ This leads to a heightened risk for inmates with mental illness who do not receive adequate treatment as they are more likely than other inmates to be placed into solitary confinement, and to suffer abuse and neglect from correctional officers and other inmates.²² For example, in Pennsylvania and South Carolina, "a prisoner with a mental health

¹⁴ Rose Testimony, DC Briefing, pp. 126-27; *see also*, Christie Thompson Eldridge and Taylor Elizabeth Eldridge, *Mental Health Crisis in Federal Prisons*, The Marshall Project (Nov. 21, 2018), <https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons>.

¹⁵ U.S. Department of Justice, Federal Bureau of Prisons, *Treatment and Care of Inmates with Mental Illness*, May, 2014, https://www.bop.gov/policy/progstat/5310_16.pdf.

¹⁶ U.S. Department of Justice, *Review of the Federal Bureau of Prisons*, p. iii.

¹⁷ Canada Testimony, *DC Briefing*, p. 22.

¹⁸ Jeffrey Wright, Treatment Program Manager, Pretrial Services for the District of Columbia, Washington, D.C., Testimony, *DC Briefing*, pp. 205-06.

¹⁹ *Ibid*.

²⁰ *Ibid*; *see also* Canada Testimony, *DC Briefing*, p. 23.

²¹ Canada Statement, at 3.

²² McMahon Testimony, *DC Briefing*, pp. 23-24.

condition is twice as likely to be placed in solitary confinement” than a prisoner without one.²³ While in solitary confinement, one prisoner mutilated his genitals and another smeared feces on himself.²⁴ As Prof. McMahon emphasized, “jail is possibly the worst place for a person living with a mental illness to be.”²⁵

Pre-arrest Diversion PROGRAM

As stated above, according to the National Alliance on Mental Illness (NAMI), a person having a mental health crisis in the U.S. is more likely to encounter a law enforcement officer than a mental health professional.²⁶ How police officers interact with someone in crisis and what resources are available to officers to assist such persons can affect the quality and outcome of that interaction. Prof. Johnston suggested, for instance, that following a Crisis-Intervention-Training model that “emphasized de-escalation rather than establishing control over the individual” could be a helpful step to ensure that the individual in crisis doesn’t overact and become violent or worrisome with the officer.²⁷ This training should include educating officers on different forms and symptoms of mental illnesses, how to identify them, and the best de-escalation techniques to use for someone in crisis.²⁸

Likewise, more education on mental illnesses and de-escalation techniques should not be the only resources law enforcement authorities have to address these issues.²⁹ Several panelists also suggested alternative destinations for officers to transfer an individual in crisis, rather than to the police station or the emergency room. This alternative could divert the number of people in crisis from becoming involved with the criminal justice system.³⁰

The Metropolitan Police Department (MPD) has, in fact, been providing Crisis Intervention Training (CIT) to its officers and implementing the Sequential Intercept Model (SIM), a method for law enforcement and practitioners to divert people with mental illness from becoming justice-involved, D.C. area. Ms. O’Meara testified that “[y]ear after year, MPD interacts with hundreds or

²³ McMahon Statement, at 3, *citing* “Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons,” Human Rights Watch, <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and#>.

²⁴ McMahon Statement, at 3.

²⁵ McMahon Testimony, *DC Briefing*, p. 35.

²⁶ Canada Testimony, *DC Briefing*, p. 21.

²⁷ E. Lea Johnston, Professor of Law, University of Florida Levin College of Law, Gainesville, FL, Testimony, *DC Briefing*, p. 83.

²⁸ *Ibid.*

²⁹ Boldt Testimony, *DC Briefing*, p. 85.

³⁰ Ann O’Regan Keary, Senior Judge, DC Superior Court, Washington, D.C., Testimony, *DC Briefing*, pp. 242-43.

even thousands of individuals facing persistent and severe mental health issues.”³¹ She added, “[m]any encounters do not end in arrest, while others result in arrest for low-level offenses with a low probability of prosecution.”³² Further, MPD would have no way of knowing what had happened after the initial arrest until the person would end up back on the street.³³ Regardless of the outcome, these individuals were no closer to receiving the mental health treatment they needed and consequently, a cycle ensued where people with mental illness were frequently criminally involved and released back onto the streets.

Realizing that there were few options for low-level offenses committed by individuals suffering from severe mental illness, in 2018, MPD, in partnership with the Department of Behavioral Health (DBH) and the Department of Human Services (DHS), launched its pre-arrest diversion program, which helps to provide behavioral health services, improvements in housing stability, access to other supportive services, and education and employment support.³⁴ The program intends to provide a “one-stop-shop” for officers, so they don’t have to go through the additional hassle of calling Behavior Health or other agencies to attempt to help people whom they encounter who are in crisis.³⁵ So far, the program has been successful,³⁶ and it is expanding.³⁷

In addition to creating and offering the pre-arrest diversion program services, MPD has trained more officers utilizing the crisis intervention model of training.³⁸ Currently, MPD has over 800 officers trained in the model.³⁹ One impediment to training more officers is that time dedicated to training officers is time they are off the streets, temporarily reducing the MPD’s headcount.⁴⁰ Additional police departments with overlapping jurisdiction in the District of Columbia, such as the D.C. Housing Police, have also participated in the training.⁴¹

³¹ Kelly O’Meara, Executive Director, Strategic Change Division, Metropolitan Police Department, Washington, D.C., Testimony, *DC Briefing*, p. 109.

³² *Ibid.*

³³ *Ibid.*, 116.

³⁴ *Ibid.*, 110-11.

³⁵ *Ibid.*, 141.

³⁶ O’Meara stated that as of December 31, 2018, two-thirds of participants had been reconnected to treatment or provided a higher level of care, one-third were provided housing, and one-half were able to secure documentation they needed for other services. She added that over 200 individuals who were initially unwilling to enroll in the program had changed their minds and been helped, and that their response has been “extremely positive.” *Ibid.*, 112-13.

³⁷ *Ibid.*, 139-41.

³⁸ *Ibid.*, 164.

³⁹ *Ibid.*, 173.

⁴⁰ *Ibid.*, 166-67.

⁴¹ *Ibid.*, 169.

In a letter dated April 27, 2020, Dr. Richard Bebout, the Deputy Director of Adult Services for DBH, provided additional information about the pre-arrest diversion program. He wrote: “In 2019, DBH created a new, consolidated Community Response Team (CRT) that consisted of DBH’s homeless outreach team, a pilot pre-arrest diversion (PAD), and the mobile crisis team. [omitted] DBH is cognizant that mental illness is a risk factor for homelessness and criminal justice involvement. Consequently, DBH prioritizes funding housing development for consumers (capital), supportive services in Permanent Supportive Housing, and roughly \$10,000,000.00 annually in rental assistance. DBH is working to align its housing investments with Homeward DC 2.0, the Mayor’s strategic plan to end chronic homelessness in the District. DBH is also coordinating with the District of Columbia Interagency Council Agency on Homelessness and government and non-government partners to leverage appropriate housing resources for DBH consumers.”⁴²

He continued: “The PAD function is integrated into the CRT. As such, the CRT staff co-respond with police to identify and divert individuals engaged in petty criminal offenses into needed behavioral health care. Additionally, DBH contracts with Pathways to Housing DC to provide urgent psychiatric care at the D.C. Superior Court. [omitted] DBH also provides training and education to its provider network on evidence-based practices for individuals with behavioral health issues and criminal justice involvement to address risk factors known as criminogenic needs, including thought patterns that can be modified through highly targeted cognitive behavioral therapy strategies. Data are not yet available.”⁴³

Dr. Bebout further stated: “DBH’s CRT responds to emergency calls for psychiatric evaluation or support twenty-four (24) hours a day, seven (7) days a week both with and without co-responders from MPD. DBH also operates a call center known as the Access Help Line (1-888-7WE-HELP) that is open twenty-four (24) hours per day, seven (7) days per week to provide crisis counseling and linkage to the provider network. Finally, DBH trains MPD officers in CIT, the national best practice model, so that officers may become certified Crisis Intervention Officers (CIO) and can be deployed to 911 calls where there is a suspected psychiatric component. CIO officers respond across precincts, are trained to recognize signs and symptoms of mental illness and to use specialized communication and de-escalation strategies.”⁴⁴

⁴² Dr. Bebout also addressed some of the efforts undertaken by Behavioral Health to address the housing needs of those who are being released from jail, stating: “DBH houses three (3) staff in the READY Center, an inter-agency resource center anchored at the Department of Corrections (DOC) and located outside of the D.C. Jail. At the READY Center, DBH staff contact all jail residents on the short-term release list during the thirty (30) days prior to their release to assess their behavioral health needs and to link individuals to CSAs and Substance Use Disorder (SUD) treatment resources upon release. DBH staff also review the daily intake list provided by DOC to advise Unity Health Care, the DOC Comprehensive Health Services Contractor, about which individuals were previously connected to a DBH provider to ensure continuity of care.” See Letter of April 27,2020 from Dr. Richard Bebout, Deputy Director, Adult Services, Department of Behavioral Health, District of Columbia. See Appendix 4.c of this Report.

⁴³ Ibid.

⁴⁴ Ibid.

When measures fail to divert the person with mental illness from becoming justice-involved, the mental health courts function as an alternative to a traditional court with the aim of providing treatment for the people with mental illness, which, in turn, will hopefully keep them from becoming justice-involved in the future. The next section will cover how the mental health court operates in the District of Columbia.

DC Mental Health Court: How the Process Works

In 2007, attempting to address the growing problem of people with severe mental illness becoming involved in the criminal justice system, the Superior Court of the District of Columbia implemented a new treatment court, the DC Mental Health Community Court (DCMHCC).⁴⁵ Judge Keary, one of the co-founders of the DCMHCC, described it as originally a “predisposition program only and it was aimed at diverting seriously and persistently mentally ill persons out of the misdemeanor calendar... and getting individuals engaged in mental health treatment.”⁴⁶

The DCMHCC operates similarly to other special treatment courts, such as juvenile or drug courts, and has been, according to Judge Keary, a great success, benefitting thousands of defendants who have participated and completed the program.⁴⁷ Judge Keary stated that the initial focus of the program was on misdemeanor offenders because many of them had “a high volume of arrests” and the “revolving door” for such offenders was “very high.”⁴⁸

In 2011, the Pretrial Services Agency (PSA), in partnership with the DC Superior Court, the U.S. Attorney’s Office (USAO), and the defense bar, expanded the eligibility of the DCMHCC to include certain non-violent felony offenders, who were previously barred from participation.⁴⁹ Although exceptions can be made, “absent extraordinary circumstance,”⁵⁰ individuals charged with violent felony offenses are generally ineligible for participation.⁵¹ However, as of 2017,

⁴⁵ Keary Testimony, *DC Briefing*, p. 184.

⁴⁶ *Ibid.*, 195-96.

⁴⁷ *Ibid.*, 185.

⁴⁸ Judge Keary, citing Ms. Terry, added, “you could go into mental health court with up to six cases. It is not unusual that a misdemeanor defendant who picks up one theft charge then misses a court hearing and then gets a separate charge of failure to appear, or they go back to the CVS where they committed the theft and they get a contempt charge for violating a stay-away [order] that might have been imposed when they were released, or they pick up another theft charge.” Moreover, she stated, “many people feel that misdemeanor offenses are gateway offenses to more serious offenses.” Keary Testimony, *DC Briefing*, pp. 237-38.

⁴⁹ “Mental Health Community Court.” *Pretrial Services Agency for the District of Columbia*, 2014, https://www.bop.gov/policy/progstat/5310_16.pdf.

⁵⁰ Stephen Rickard, Chief, General Crimes Section, The United States Attorney’s Office for the District of Columbia, Testimony, *DC Briefing*, p. 143.

⁵¹ *Ibid.*, 152.

Superior Court judges can include treatment and supervision administered by the DCMHCC as part of the sentence imposed on such offenders.⁵²

The process begins once a defendant has been charged with a crime. The U.S. Attorney's Office determines if the defendant is eligible to be transferred from either the U.S. Misdemeanor Community Court calendar or the Felony 2 criminal calendar to the DCMHCC calendar.⁵³ The U.S. Attorney uses specific criteria to determine a defendant's eligibility.⁵⁴ The defendant must be charged with a misdemeanor offense or certain non-violent felony offenses; be under supervision by the Specialized Services Unit (SSU), a specially trained subgroup of the Pretrial Services Agency⁵⁵; have a verified "serious and persistent" mental illness; be connected to mental health treatment; receive drug testing and treatment, at the direction of PSA, test negative for all drugs including marijuana; be "competent"; have the approval of the U.S. Attorney; and enter into a Deferred Plea or Prosecution Agreement, aka Deferred Sentencing Agreement (DSA), or Amended Sentencing Agreement (ASA) as determined by the U.S. Attorney.⁵⁶

In the case of a DPA, a defendant is not required to enter a guilty plea to participate in the program, and the case is dismissed upon successful completion.⁵⁷ In the case of a DSA, a defendant is required to enter a guilty plea, but the plea is vacated and the charges are dismissed if the defendant successfully completes the program.⁵⁸ In the case of ASA, which is usually required in all felony cases, a defendant must enter a guilty plea, but with an agreement that if the defendant successfully completes the program, the charge will be reduced to a misdemeanor, and the defendant will be sentenced to probation.⁵⁹ Defendants who enter into a DPA who fail to complete the program are

⁵² *Ibid.*, 175-76; *see also* Cleonia Terry, Coordinator, Mental Health Community Court, D.C. Superior Court, Testimony, *DC Briefing*, pp. 322-24.

⁵³ "Mental Health Community Court Case Management Plan." *D.C. Courts*, p. 2, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁵⁴ *Ibid.*

⁵⁵ As Mr. Wright testified, "[w]e have three specialized supervision teams and they're comprised of officer who have had special training on dealing with the mentally ill, along with three licensed independent social workers who are available to consult with our team members relating to substance use disorder issues, so that's how the teams are broken down." Wright Testimony, *DC Briefing*, p. 216.

⁵⁶ *Ibid.*; *see also* "Mental Health Community Court Case Management Plan," p. 3, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁵⁷ "Mental Health Community Court Case Management Plan," p. 3, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

referred to the regular criminal court for further proceedings, and defendants who enter into either a DSA or an ASA and who fail to complete the program are referred for sentencing by the DCMHCC judge assigned to the case.⁶⁰ As Mr. Rickard explained, the DCMHCC is a diversion program, but, if the defendant does not wish to follow through on his commitment to use the provided services and comply with the terms of the agreement, the U.S. Attorney has no other choice but to prosecute the case.⁶¹

If the defendant fails to meet all of these criteria or has a pending domestic violence or dangerous felony charge, is in jail or prison, or has certain disqualifying convictions in the past decade or is on parole or probation for a violent felony charge, he or she will not be eligible to enroll in the DCMHCC.⁶² Mr. Baron testified, though, that there is frequent interaction between defense attorneys and prosecutors discussing client eligibility for the DCMHCC program and that defense attorneys occasionally ask the judge to have the defendant screened for enrollment into Specialized Supervision Unit supervision, so that the defendant may then become eligible for the DCMHCC.⁶³ Mr. Rickard agreed and added someone from Pretrial Services Agency will contact the prosecutor and suggest that a defendant is eligible for supervision by the Specialized Supervision Unit and should be referred to the DCMHCC.⁶⁴ Mr. Rickard also stressed that the opinions of victims are taken into consideration before a referral to the DCMHCC is made.⁶⁵

Once the U.S. Attorney deems the defendant eligible, the defendant must then demonstrate to the judge that he is linked to, and actively engaged in, mental health treatment, and has tested negative for drug use.⁶⁶ Although the defendant does not have to pass the initial drug test to enroll in the DCMHCC, the defendant must pass a drug test to qualify for any benefits from the agreement, including having a charge reduced or dismissed.⁶⁷ The defendant will then be offered an

⁶⁰ *Ibid.*, 3-4.

⁶¹ Rickard Testimony, *DC Briefing*, p. 180.

⁶² *Ibid.*; *see also* “Mental Health Community Court Case Management Plan,” p. 3, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁶³ Gregg Baron, Esq., Defense Counsel, Testimony, *DC Briefing*, pp. 134-35.

⁶⁴ Rickard Testimony, *DC Briefing*, p. 144.

⁶⁵ *Ibid.*, 153.

⁶⁶ Canada Testimony, *DC Briefing*, p. 22; *see also* “Mental Health Community Court Case Management Plan,” p. 3., <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁶⁷ Terry Testimony, *DC Briefing*, p. 243; *see also*, “Mental Health Community Court Case Management Plan,” p. 3, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

opportunity to enter into a treatment program.⁶⁸ If the defendant agrees, he or she must remain in the program for at least four months and appear before the judge approximately every 30 days to monitor progress.⁶⁹ While in the DCMHCC, the defendant is also expected to meet weekly with a DCMHCC case manager to review the defendant’s progress and to become better connected with mental health facilities and treatment centers offered by DBH.⁷⁰

Criticisms of Mental Health Courts

Several of the general experts who testified before the panel were skeptical about the effectiveness or utility of mental health courts at all, contending that in many instances they do more harm than good. While acknowledging that they had only limited knowledge of how the mental health court operates in the District, they pointed out problems that have been encountered and issues that have been raised about mental health courts across the country.

Prof. Boldt testified⁷¹ that while mental health courts may help some individuals, preliminary research suggests that participants in such programs may end up experiencing more, not less, criminal justice involvement, confinement, or supervision.⁷² He believes that using “a single hybrid institution” to perform both a punitive and therapeutic function “is fraught with risks” because the ends served by punishment are often “far removed from, and sometimes inconsistent with providing treatment and other services to offenders.”⁷³

In addition to the fact that many problem-solving courts do not have a formal system for when to impose sanctions, and often fail to document when they are imposed, Prof. Boldt argues that some participants who fail at treatment, which can often be the result of “poor treatment matching,” are subjected to “augmented punishment” imposed by a judge “whose capacity for formal fairness has been compromised by problem-solving informality.”⁷⁴ In light of these and other concerns, Prof. Boldt thinks that the “better approach” for policymakers would be to invest more resources “in programs designed to divert low-risk offenders out of the criminal system, and into therapeutic and other social services in the community,” rather than problem-solving courts.⁷⁵ He also believes that in order to address this problem, there must be “transitional housing, structured care, [and]

⁶⁸ “Mental Health Community Court Case Management Plan,” p. 5, <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf> (accessed September 2, 2020).

⁶⁹ Canada Testimony, *DC Briefing*, p. 22; *see also* Keary Testimony, *DC Briefing*, p. 187.

⁷⁰ Keary Testimony, *DC Briefing*, p. 188.

⁷¹ Boldt Testimony, *DC Briefing*, pp. 13-20.

⁷² *Ibid.*, 16.

⁷³ *Ibid.*, 16-17.

⁷⁴ *Ibid.*, 17, 19.

⁷⁵ *Ibid.*, 19.

assertive community treatment of people who are decompensating.”⁷⁶ Although he added that mental health courts could enjoy some success if they used risk-needs assessments to target “a limited group of very high-risk offenders.”⁷⁷

Prof. Johnston testified⁷⁸ that in her view, mental health courts, which are expensive and resource-intensive and tend to have high termination rates, should not focus on individuals charged with misdemeanor offenses.⁷⁹ She noted that “decades of science have shown that mental illness is not a direct significant contributor to crime,” but that individuals with mental illness have a higher concentration of other criminogenic risks and needs, such as substance abuse, homelessness, antisocial thinking and associates, poor family support, unemployment, and lack of education.⁸⁰ Moreover, she identified several potential problems with mental health court programs. Among them is “net widening,” that is an increase in the number of people with mental illnesses being treated in the criminal justice system because of the existence of mental health programs.⁸¹ This can happen in several ways. For example, individuals with mental illnesses facing minor criminal charges may be induced to participate in a mental health court program when, in all likelihood, they would have received no jail time or had their charges dismissed had they remained in the regular court system.⁸² These individuals may end up under court supervision for a significant period of time, and some may end up being prosecuted and incarcerated if they fail to complete the requirements of the program.⁸³ According to Prof. Johnston, “mental health court termination rates are typically very high,”⁸⁴ and “termination may result in punitive sentences.”⁸⁵ Further,

⁷⁶ Ibid., 54-55.

⁷⁷ Ibid., 65-66.

⁷⁸ Johnston Testimony, *DC Briefing*, pp. 26-37; *see also* Johnston, Statement, at 8-9.

⁷⁹ Johnston Testimony, *DC Briefing*, p. 27.

⁸⁰ Ibid., 63-64.

⁸¹ Ibid., 29.

⁸² Prof. Johnston cited a 2015 study that reviewed follow-up data on “six years of non-completers from a pre-adjudication mental health court.” The study found that after leaving a mental health court program, almost sixty-four percent of non-completers, those who failed to maintain the requirements to remain enrolled in the DCMHCC, had their charges dismissed because they didn’t merit prosecution in the first place. Johnston Testimony, *DC Briefing*, pp. 29-30.

⁸³ Ibid., p. 33.

⁸⁴ Prof. Johnston referenced a recent meta-analysis that looked at 24 studies published between 2004 and 2014 which found that nearly half of the participants in mental health courts failed to graduate. Ibid., 31. Similarly, Prof. Redlich cited three studies that found that 42 percent of the participants in the D.C. MHCC did not graduate. Alison Redlich, Professor of Criminology, Law & Society, *Prepared Written Statement, Read by Chairman into the record for DC Briefing*, transcript, pp 29-30 (hereafter Redlich Statement at *DC Briefing*).

⁸⁵ Prof. Johnston conducted a study where she compared the sentences imposed by mental health courts to those imposed by traditional courts across twelve categories of criminal offenses. She found that mental health court

because of the availability of treatment through mental health courts, some police officers may arrest individuals who commit minor offenses and who are in need of treatment who otherwise would not have been arrested.⁸⁶ Similarly, family members may report illusory crimes “committed” by loved ones suffering from a mental illness in order to get them treated,⁸⁷ and individuals may themselves decide to commit crimes in order to get treatment that they have been unable to obtain by themselves in their community.

In general, Prof. Johnson stated that she “would have serious reservations about investing funds in a mental health court, especially one that admits misdemeanants, as opposed to investing in community health services, or pre-adjudication diversion.”⁸⁸ She would limit mental health court participation to “high-risk, deeply involved individuals who otherwise would go to prison, who are charged with felonies.”⁸⁹

Prof. McMahon testified⁹⁰ that while the DC Mental Health Community Court (DCMHCC) is “much larger than many health courts in this country,” and “has done some excellent work in moving people into treatment options,” it “will make only a small dent in the problem, and in some ways could make it worse.”⁹¹ She believes that “focusing solely on mental health courts as the only solution to our mental health crisis” can encourage officials to arrest more people for minor charges, like Jamycheal Mitchell, and that it would be better “to divert most individuals in crisis from the criminal justice system altogether.”⁹² Prof. McMahon believes it also would be far better to invest more in community health treatment.⁹³

In that regard, several of the panelists referred to the Sequential Intercept Model (SIM), which outlines several off-ramps for individuals suffering from mental illness before they become justice-

sentencings exceeded traditional courts by more than a year, are more likely to send misdemeanants to prison rather than probation, and are more likely to grant consecutive, as opposed to concurrent, sentences to misdemeanants with multiple convictions. Johnston Testimony, *DC Briefing*, p. 31.

⁸⁶ McMahon Testimony, *DC Briefing*, p. 38.

⁸⁷ For example, Prof. Johnston recalled a time where a 42-year-old schizophrenic living with his parents was turned into the police by them, claiming their son struck the father. The parents’ hope was that if their son was involved with the criminal justice system, he could finally get the treatment he needed through a mental health court program. *Ibid.*, 74.

⁸⁸ *Ibid.*, 32.

⁸⁹ *Ibid.*, 62.

⁹⁰ McMahon Testimony, *DC Briefing*, pp. 33-37.

⁹¹ *Ibid.*, 34, 36.

⁹² *Ibid.*, 39.

⁹³ *Ibid.*, 93.

involved, as providing the means to the “gold standard” of care for persons in crisis.⁹⁴ This model is composed of six community intercepts that progressively work to re-integrate a person in crisis back into society by providing critical support early and maintaining that support, if necessary.⁹⁵ The design of the model is to provide assistance to an individual with mental illness at any stage of their involvement with the justice system.⁹⁶

In a written statement that was read into the record, Prof. Redlich testified that while studies indicate that graduates of the DCMHCC are less likely to recidivate, a significant percentage of participants do not graduate.⁹⁷ Moreover, her own research has led her to conclude that “significant minorities of mental health court participants would likely not have met the threshold for adjudicative competence, despite being presumed to have done so, and despite having pled guilty to enroll in the courts.”⁹⁸ She also believes that the DCMHCC case management plan contains too much legalese and is unlikely to be understood by most individuals who must decide whether to volunteer to participate in the program.⁹⁹

⁹⁴ Boldt Testimony, *DC Briefing*, pp. 85-87; see also Johnston Testimony, *DC Briefing*, pp. 82-83, Terrance D. Walton, Chief Operating Officer, National Association of Drug Court Professionals, Alexandria, VA, Testimony, *DC Briefing*, pp. 83-84.

⁹⁵ “The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental Illness and Substance Use Disorders.” *Policy Research Associates*. The six intercepts are:

- Intercept 0 – Community Services: Mobile Crisis Outreach Teams and Co-responders: behavioral health practitioners who can respond to a crisis or co-respond with law enforcement. Police-friendly crisis services: an alternative to jail for officers to drop off a person in crisis.
- Intercept 1 – Law Enforcement: police training in Crisis Intervention and de-escalation tactics.
- Intercept 2 – Initial Detention/Initial Court Hearings: mental health and substance abuse screening. “Data matching initiatives between the jail and community-based behavioral health providers.” Pretrial supervision and diversion services to diminish rates of incarceration.
- Intercept 3 – Jails/Courts: DC MHCC and other treatment courts provide a means for those with a serious mental illness and who are repeated criminal justice offenders to be diverted into alternative treatment programs.
- Intercept 4 – Reentry: case managers are enlisted to create a transition plan for persons post-release by tailoring to an individual’s needs. Providing access to medication and prescriptions after release to assist with continuing treatment.
- Intercept 5 – Community Corrections: specialized community supervisors, recovery support and benefits, housing, and competitive employment assistance. See Appendix 3.3.iv of this Report.

⁹⁶ Johnston Testimony, *DC Briefing*, p. 82.

⁹⁷ Redlich Statement at *DC Briefing*, p. 37-42.

⁹⁸ *Ibid.*, 40.

⁹⁹ *Ibid.*, 40-41. In her analysis, Prof. Redlich found that 69 percent of defendants claimed that they chose to enroll in the mental health court system, while 60 percent of defendants claimed that they had not been told that the choice to enroll was voluntary. Similarly, she found that the case management plan, which outlines the agreement between the defendant and the prosecution, “is quite dense and seems to be written by legal professionals well-versed in the law.”⁹⁹ Most offenders, on the other hand, read at a 6th grade level or lower, while the case management plan requires at least an 11th grade reading level to fully understand. Finally, she said, the case management plan does not

Prof. Canada noted that there appears to be a disparity in the outcomes of mental health court participation between higher-risk, felony defendants, and low-risk misdemeanants. Prof. Canada referred to a recent study conducted in Michigan that demonstrated that mental health court participants with felony charges had a decline in recidivism rates post-exit, but that there was a slight increase in recidivism rates post-exit for misdemeanant participants.¹⁰⁰ This study suggests that the DCMHCC program may not reduce recidivism among misdemeanants and that pre-arrest methods should be utilized instead. She also said that she hopes that many more people will be diverted by pre-arrest options than is occurring today, and that more attention should be devoted to providing stable housing, since “[m]any people who have mental illnesses and have criminal justice involvement are being pushed to some of the more problematic neighborhoods in our communities,” which, she said, “does not help their trajectory.”¹⁰¹

There were also some criticisms specifically about how the DCMHCC operates, mostly from individuals who believe the criteria for admission into the program are too stringent, and that it should be opened up to include individuals suffering from a severe mental illness who are charged with violent felonies.¹⁰² Mr. Rickard stated that the U.S. Attorney’s Office does meet periodically to discuss whether to revise the policy, and stressed that exceptions to the policy have been made for special circumstances and that individual prosecutors have some discretion when it comes to charging decisions.¹⁰³ Moreover, there have also been periodic “stakeholders’ meetings” where policy issues have been discussed, that were attended by representatives of the U.S. Attorney’s Office.¹⁰⁴

But those criticisms of mental health court programs were not universal. Prof. Canada also testified¹⁰⁵ that diversion programs, including mental health courts, are necessary, and that participation in such programs “does reduce recidivism in the months and years following mental health court, even with people with mental illness and co-occurring substance use, which is a high-risk population for recidivism.”¹⁰⁶ She added that “[m]ental health court participants are less likely to be homeless,” and that they “perceived improved stability, longer periods of sobriety, and

explain the possible downsides of enrolling in the mental health court system, calling into question the overall fairness of the process and voluntariness of the defendant’s initial enrollment choice and implicating other potential violations of the defendant’s civil rights. Redlich Statement at 2-3.

¹⁰⁰ Ibid., 105-06.

¹⁰¹ Ibid., 98.

¹⁰² Rose Testimony, *DC Briefing*, p.118; see also Baron Testimony, *DC Briefing*, p. 131.

¹⁰³ Rickard Testimony, *DC Briefing*, pp. 153-54, 158, 162.

¹⁰⁴ Keary Testimony, *DC Briefing*, pp. 242-43.

¹⁰⁵ Canada Testimony, *DC Briefing*, pp. 20-26.

¹⁰⁶ Ibid., 25.

improved relationships with their family and friends.¹⁰⁷ Procedural justice and making positive life changes may in part account for mental health court successes.”¹⁰⁸

From the perspective of program participants, Prof. Canada believes that “support from mental health court staff, the structure and accountability, access to treatment and services, and prompting motivation to change are key components to improved mental health and reduced criminal justice contact.”¹⁰⁹ As this report will highlight, the DCMHCC fares well in these areas, especially compared to mental health court programs in other parts of the country.

Analysis of D.C. Mental Health Court

Mr. Walton, who served for several years as the Director of Treatment for the Pretrial Services Agency for the District of Columbia (PSA), testified that even though there has been significant growth in the number of adult and juvenile mental health courts in the last decade, most counties in this country do not have one.¹¹⁰ While overall, “mental health courts have been found to have a modest effect on recidivism,” Mr. Walton noted that there have been “[o]ther positive outcomes for completers includ[ing] reduced jail days, better treatment services, access, and connections. That’s certainly been the case in DC.”¹¹¹

Mr. Walton stated that he has examined problem-solving courts around the country and that when it comes to mental health courts, he believes that “DC is different,” in that many of the concerns expressed by some of the other panelists have been and are being addressed by the DCMHCC.¹¹² For example, he stated that DC has “a very robust pre-trial services agency,” which conducts risk-needs assessments, has an on-staff behavioral health provider, and connects participants with treatment services.¹¹³ He added that participants receive minimal supervision by trained personnel in the Specialized Supervision Unit (SSU), and that judges in the DCMHCC run “the most nurturing, caring, court room I’ve ever been in. And I’ve been all over the country.”¹¹⁴

¹⁰⁷ Ibid, 26.

¹⁰⁸ Ibid, 25.

¹⁰⁹ Ibid., 25-26.

¹¹⁰ Walton Testimony, *DC Briefing*, pp. 42-49.

¹¹¹ Ibid., 48.

¹¹² Ibid., 71.

¹¹³ Ibid., 67-68.

¹¹⁴ Ibid., 70.

Mr. Walton suggested, though, that the DCMHCC establish standards in order “to minimize the differences that happen when judges change, and coordinators leave.”¹¹⁵ He added that it is also unclear whether mental health courts are *only* treating those with a serious mental illness *and* significant justice involvement.¹¹⁶ Instead, some defendants have serious mental illness, but lack the significant justice involvement, or the likelihood of such involvement.¹¹⁷ Mr. Walton provided

¹¹⁵ Ibid., 81.

¹¹⁶ Ibid., 46.

¹¹⁷ Ibid.

the Committee a copy of the standards created for mental health courts by the Council of State Governments,¹¹⁸ which he cited with approval.¹¹⁹

Since its creation in 2007, local officials and researchers have attempted to measure the efficacy of the DCMHCC. Although limited in scope because of the limited time frame and sample size, as well as the transient nature of most program participants, these studies provide useful insights

¹¹⁸ “Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court.”

Justice Center: Council of State Governments,

https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/MHC_Essential_Elements.pdf (accessed September 2, 2020). The Council lists 10 “essential elements” that it believes all mental health courts should possess in order to be beneficial. They are:

1. **Planning and Administration** – “A broad-based group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court.”
2. **Target Population** – “Eligibility criteria address public safety and consider a community’s treatment capacity, in addition to the availability of alternatives to pretrial detention for defendants with mental illnesses. Eligibility criteria also take into account the relationship between mental illness and a defendant’s offenses, while allowing the individual circumstances of each case to be considered.”
3. **Timely Participant Identification and Linkage to Services** – “Participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible.”
4. **Terms of Participation** – “Terms of participation are clear, promote public safety, facilitate the defendant’s engagement in treatment, are individualized to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for those individuals who successfully complete the program.”
5. **Informed Choice** – “Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant’s competency whenever they arise.”
6. **Treatment Supports and Services** – “Mental health courts connect participants to comprehensive and individualized treatment supports and services in the community. They strive to use—and increase the availability of— treatment and services that are evidence-based.”
7. **Confidentiality** – “Health and legal information should be shared in a way that protects potential participants’ confidentiality rights as mental health consumers and their constitutional rights as defendants. Information gathered as part of the participants’ court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.”
8. **Court Team** – “A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process.”
9. **Monitoring Adherence to Court Requirements** – “Criminal justice and mental health staff collaboratively monitor participants’ adherence to court conditions, offer individualized graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants’ recovery.”
10. **Sustainability** – “Data are collected and analyzed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalized, and support for the court in the community is cultivated and expanded.”

¹¹⁹ Walton Testimony, *DC Briefing*, p. 84.

and have generally concluded that the DCMHCC is effective in reducing recidivism among its participant populations.¹²⁰

According to Judge Keary, in a 2013 study, researchers found that DCMHCC participants were less-likely to be arrested one-year after completion than their similarly situated counterparts in non-mental health courts.¹²¹ Likewise, she stated, participants who both participated in and completed their assigned mental health court treatment were 51% less likely to be rearrested than their non-mental health court counterparts, and even those who did not complete their treatment were less likely to be rearrested than non-participants.¹²²

A 2015 study similarly concluded that participation in the DCMHCC dramatically decreases the likelihood of participants being rearrested one to two years post-completion.¹²³ The study found that among three different groups [(a) non-substance users with one or no arrests in the year prior, (b) illegal substance users, and (c) those with three or more arrests], a majority of those who successfully completed the DCMHCC program were less likely to reoffend.¹²⁴ Similarly, one year after exiting the DCMHCC program, the proportion of offenders arrested was much lower than the year before their DCMHCC entry.¹²⁵ Offenders with a severe mental illness were significantly less likely to reoffend one year after exit from the DCMHCC than similarly situated offenders in the traditional court system.¹²⁶ As in previous studies, those who successfully completed the DCMHCC program had the lowest levels of recidivism, with DCMHCC participants who did not successfully complete the program being the next lowest, and participants of the traditional court system being the highest.¹²⁷

¹²⁰ It should be noted that the studies possess other inherent limitations, which they acknowledge. First, the studies typically examined a population which is older, whiter, and with more women than the average jail population and average court participating population. Second, because mental health courts are voluntary and the USAO has discretion in determining the eligibility of participants, the population examined may be “cherry-picked” and may not adequately represent how mental health courts would function with a different subset of offenders. Finally, these studies did not disaggregate severe mental illness from other criminogenic factors (e.g., homelessness, educational attainment) and demographic factors (e.g., age, race, sex) in measuring recidivism rates for offenders. See Redlich Statement at Appendix 3.b of this Report; see also Virginia Aldigé Hiday, et al., *Effectiveness of a Short-Term Mental Health Court: Criminal Recidivism One Year Postexit*, 37 L. & HUM. BEHAV., 401, 409-10, (2013).

¹²¹ Keary Testimony, *DC Briefing*, pp. 191-92.

¹²² *Ibid.*, 203.

¹²³ Virginia Aldigé Hiday, et al., *Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit*, 67 PSYCHIATRIC SERVS., 378–83 (2016).

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

Several of the panelists stressed the need for long-term tracking of individuals who participate in the DCMHCC. The panelists and researchers stated that gathering additional information on the long-term impact on recidivism rates at the one-, two-, and five-year post-exit mark for participants in the DCMHCC would be extremely helpful in determining the efficacy of the program.¹²⁸ Judge Keary agreed and added that it would also be useful to see if participants are following through with the services they had been provided after completing the program.¹²⁹

Ms. Terry, who also agreed about the need for long-term tracking, stated that the DCMHCC program “is currently a research evaluation internally by the DC Court’s Office of Strategic Management,” and that her office has requested data from Department of Behavioral Health (DBH).¹³⁰ She further noted that “although there are no mental health court standards,” researchers were currently evaluating how the program measures up according to the 10 “essential elements” listed by the Council of State Governments, and previously cited approvingly by Mr. Walton.¹³¹

Ms. Terry noted several unique features of the DCMHCC, including the fact that the court operates four days a week and does not have a cap on the number of participants who can be accepted into the program.¹³² Additionally, the DCMHCC is the only mental health court in the country to have an urgent care clinic inside the court building.¹³³ The clinic is funded by Behavioral Health and is staffed with a clinical psychiatrist, case managers, substance abuse counselors, and peer professionals, all there to assist the clients of the DCMHCC.¹³⁴ Finally, the DCMHCC is not a “one-for-all program,” where participants would only be allowed to get the benefit of participating one time only; instead, the DCMHCC allows individuals with up to six cases, six pending charges, or those who have benefited from the program before to re-enter the program.¹³⁵

The has one of the highest caseloads in the country, having handled about 4,000 cases in the first decade of its existence.¹³⁶ This averages close to 400 cases per year, far outperforming other mental health courts in the country that handle a maximum of 250 cases per year.¹³⁷ Ms. Terry also reported that DBH has doubled the number of service providers and agencies, from 20 to 40,

¹²⁸ Terry Testimony, DC Briefing, pp. 258-260; *see also*, Johnston Statement, at 26-27; Redlich Statement, at 4-5.

¹²⁹ Keary Testimony, *DC Briefing*, pp. 245-46.

¹³⁰ Terry Testimony, *DC Briefing*, p. 259.

¹³¹ *Ibid.*, 245.

¹³² *Ibid.*, 197.

¹³³ *Ibid.*, 201.

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*, 198-99.

¹³⁶ McMahon Testimony, *DC Briefing*, p. 36.

¹³⁷ Redlich Statement at *DC Briefing*, at 42.

to assist those with mental health diagnoses over the past year.¹³⁸ This includes services for both individuals in the mental health court system and community participants.¹³⁹ Ms. Terry further stated they work with many of these service providers to “strongly encourage and recommend that they address the housing issues with our participants,”¹⁴⁰ something that many speakers, including Judge Keary,¹⁴¹ cited as an impediment to homeless participants achieving stability and to treatment success.

PSA is one of the main providers assisting in identifying risk factors and attempting to maximize the likelihood of defendants attending their next court appearance.¹⁴² It has an 88 percent success rate in released defendants appearing for court hearing and remaining arrest-free while in the community.¹⁴³ Similarly, DBH-funded Assertive Community Treatment (ACT) teams provide additional community outreach and referral services to individuals in need.¹⁴⁴ ACT teams are usually composed of psychiatrists, social workers, and nurses.¹⁴⁵ DBH also sponsors and operates a 24/7 access helpline for people in crisis to call to find out where and how to receive treatment and stabilization.¹⁴⁶

Judge Keary emphasized that “[m]ental health diversion courts ... don’t typically involve trial, verdicts of guilt or innocence. They’re more outcome oriented. They attempt to address the treatment needs and the social service problems which may have brought the individuals before the court.”¹⁴⁷

Judge Keary emphasized the importance of procedural justice to the DCMHCC’s success, stating that, “if the Judge is recognizing the person, giving them a voice and dignity, treating them with respect, that may be a novel experience, one that is game-changing for the individual involved. It can cause persons who may have felt in the past they have always been treated unfairly to feel that now there’s some basis to accept the obedience to the law and community standards.”¹⁴⁸

¹³⁸ Terry Testimony, *DC Briefing*, p. 199.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 214.

¹⁴¹ Keary Testimony, *DC Briefing*, pp. 212-13.

¹⁴² Wright Testimony, *DC Briefing*, pp. 203-04.

¹⁴³ *Ibid.*

¹⁴⁴ Keary Testimony, *DC Briefing*, p. 217.

¹⁴⁵ *Ibid.*

¹⁴⁶ Terry Testimony, *DC Briefing*, p. 222.

¹⁴⁷ Keary Testimony, *DC Briefing*, p. 184.

¹⁴⁸ *Ibid.*, 191.

A 2010 study examined the effect of procedural justice on the perceived experience of the participants in the program.¹⁴⁹ As Judge Keary outlined, the theory of procedural justice is that if a judge affirms the dignity of the defendant, helps the defendant feel more comfortable and respected in the courtroom, and actively encourages the defendant to become involved in the decision-making process, this will lead to the defendant taking more responsibility for his or her treatment and court-ordered requirements and will generally lead to better outcomes.¹⁵⁰ The study concluded that DCMHCC participants perceived their overall experience in court and with the judge as positive and reported experiencing high levels of procedural justice in their treatment.¹⁵¹

The program, Judge Keary emphasized, is entirely voluntary. No defendant is forced into the program against his or her will.¹⁵² When defendants are non-compliant with the imposed conditions, Judge Keary stated, “the Judge continues with collaborative input from all the parties to work with the defendant to bring him back into compliance, sometimes extending the agreement to more than the four-month period to allow the pursuit of a successful outcome.”¹⁵³ Ms. Terry added that the DCMHCC is “the court of many chances,” and that “the instability of a person’s mental health condition is not unusual and it may take some time to identify the most appropriate treatment option for that individual.”¹⁵⁴

Judge Keary stated that the program is not “sanctions-based,” and that judges in the DCMHCC communicate “directly with participants, coaching and encouraging them as they progress, holding them accountable if they’re not following the program.”¹⁵⁵ She also stressed that the decision-making process is more collaborative than most court processes in that judges consult regularly with others connected to each case, including the mental health community court coordinator, the licensed social worker, the PSA representative, defense counsel, and the prosecutor.¹⁵⁶ Ms. Terry testified that, “often times our courtroom is run like a case management office.”¹⁵⁷

¹⁴⁹ Heathcote W. Wales, et al., *Procedural Justice and the Mental Health Court Judge’s Role in Reducing Recidivism*, 33 INT’L J. L. & PSYCHIATRY, 265-71 (2010).

¹⁵⁰ Keary Testimony, *DC Briefing*, pp. 202.

¹⁵¹ Wales, *Procedural Justice*, *supra* note 149.

¹⁵² Judge Keary mentioned that in other systems with different bail practices, some defendants are detained unless and until they agree to participate in a mental health program. In D.C., only defendants who have not been detained and are otherwise eligible can be accepted into the program, which makes it more likely that their decision to participate is truly voluntary. *Ibid.*, 211-12.

¹⁵³ *Ibid.*, 189.

¹⁵⁴ Terry Testimony, *DC Briefing*, pp. 195-96.

¹⁵⁵ Keary Testimony, *DC Briefing*, pp. 189-90.

¹⁵⁶ *Ibid.*, 190.

¹⁵⁷ Terry Testimony, *DC Briefing*, p. 196.

Reiterating this point, Mr. Baron stated that, “[o]ne of the reasons mental health court is so successful ... is the way it treats clients.”¹⁵⁸ He added: “The judges are very solicitous of the clients’ wants and needs. The judges will very often take the time to talk to the client and ask the client things like, well, what do you think is working? Is there anything else that you think that we could provide you with that you’re not getting? I think that goes a long way in explaining why clients who enter mental health court, even if they ultimately don’t complete the program, I think they’re better off.”¹⁵⁹ Ms. Terry also stressed that the dedication of the judges on the DCMHCC is the key to the program’s success.¹⁶⁰

The Committee heard from Anthony Ellis and Tania Taylor, two members of the public who chose to offer comments. Both had previously participated in the DCMHCC, and Mr. Ellis also had previous experience with the mental health court system in New York City.¹⁶¹ Both were effusive in their praise of the DCMHCC. Mr. Ellis described his past experience and the progress he has made since graduating from the program. He stated, “I love the mental health court. ... [A] mental health court gives you a chance to prove yourself, and what a great thing to prove yourself to people that don’t know you but yet they trust you. ... I feel good being here because they helped me.”¹⁶² Ms. Taylor also described her past experience and the progress she has made, stating that the DCMHCC as “an amazing, wonderful thing.”¹⁶³ She added, “I’m very grateful for the mental health court, and it’s really changed my life.”¹⁶⁴

Service Providers’ Perspective

Dr. Freeman outlined some of the services provided by Community Connections, where he serves as a psychologist and chief clinical officer, and emphasized the Options program, one of several programs Community Connections developed in 2000 to address the needs of justice-involved individuals. Dr. Freeman testified that Options “was a pretrial diversion program for people who suffered from co-occurring behavioral health problems” and “was predicated on the hypothesis that an arrest could serve as a positive turning point in a person’s life.”¹⁶⁵ The program consisted of a bridge housing program for up to 10 participants and a “case management of wraparound services that emphasized coordination care with the criminal justice system” for those suffering

¹⁵⁸ Baron Testimony, *DC Briefing*, pp. 145.

¹⁵⁹ *Ibid.*, 137-38.

¹⁶⁰ Terry Testimony, *DC Briefing*, p. 194.

¹⁶¹ Anthony Ellis, Graduate of the D.C. Mental Health Community Court, Testimony, *DC Briefing*, pp. 337-51.

¹⁶² *Ibid.*, 339.

¹⁶³ Tania Taylor, Graduate of the D.C. Mental Health Community Court, Testimony, *DC Briefing*, p. 345.

¹⁶⁴ *Ibid.*, 347.

¹⁶⁵ David Freeman, Chief Clinical Officer of Community Connections, Inc., Washington, D.C., Testimony, *DC Briefing*, p. 256.

from “a major mental illness.”¹⁶⁶ He described the program as “wildly successful,” with 95 percent of participants obtaining “improved or stabilized housing,” a 60 percent reduction in six-month post-intervention arrest rates, reductions in substance use, and improved mental health functioning.¹⁶⁷ Once the DC Mental Health Community Court (DCMHCC) was created, Dr. Freeman stated that Options service providers would engage in “regular team meetings with judges sharing knowledge about how resources were accessed, how defendants could better get what they needed and how we could correct misinformation that came into the courtroom.”¹⁶⁸ Dr. Freeman lamented the fact that approximately five years ago, Department of Behavioral Health (DBH) decided to redistribute the funds that had gone to the Options program to other programs and providers throughout the city, which resulted in the closing of the program.¹⁶⁹

Ms. Respress outlined the services provided by Pathways to Housing DC, where she serves as the Executive Director. The organization’s mission “is to end homelessness and support recovery for adults living with serious mental illness, addiction, and other complex health challenges.”¹⁷⁰ Each year, her organization serves over 3,500 individuals who are homeless or at risk of becoming homeless.¹⁷¹ According to Respress, “Pathways currently operates the largest street outreach program in the [D]istrict.”¹⁷² As other witnesses emphasized, Ms. Respress expressed the belief that, “[a]lthough education, employment, and treatment for drug and mental health issues all play a role in successful reintegration, these factors have little hope in the absence of stable housing.”¹⁷³ She added: “When people have open charges or [are] on probation or parole, it’s even more challenging for people with mental illness staying on the street to meet their legal obligations, not surprisingly. The simple act of keeping track of notifications from the court can become impossible without a fixed address.”¹⁷⁴

¹⁶⁶ Ibid., 256-57.

¹⁶⁷ Ibid., 259.

¹⁶⁸ Ibid., 261.

¹⁶⁹ Ibid., 263. When asked why this was done, the Department of Behavioral Health responded: “Because of growing recognition that many individuals with serious and persistent mental illness have intermittent contact with the criminal justice system, DBH sought to enable all Core Service Agency (CSA) to better engage at all points along the “sequential intercept” model by making in-reach and discharge planning universal across the provider network, rather than a specialty service provided by [three] (3) CSAs. Unfortunately, local dollars to pay for jail in-reach contracted simultaneously.” See Letter of April 27, 2020 from Dr. Richard Bebout, Deputy Director, Adult Services, Department of Behavioral Health, District of Columbia. See Appendix 4.c of this Report.

¹⁷⁰ Christy Respress, Executive Director, Pathways to Housing DC, Washington, DC, Testimony, *DC Briefing*, p. 264.

¹⁷¹ Ibid., 265.

¹⁷² Ibid., 270.

¹⁷³ Ibid., 269.

¹⁷⁴ Ibid., 271-72.

The need for stable housing for offenders with a psychiatric disability upon release from incarceration was also emphasized by Mr. Gray, a former justice-involved individual himself who now works for Disability Rights DC as an advocate for those in jail or prison.¹⁷⁵ He also believes, as did Dr. Freeman¹⁷⁶ and other witnesses as previously mentioned, that the eligibility criteria for admission to the DCMHCC program should be “expanded to include people who have been charged with a wider range of offenses in order to best serve the community and the residents of the District.”¹⁷⁷

In his April 27, 2020 letter, Dr. Bebout provided additional information about DBH’s efforts to ensure the quality of care provided by service providers for individuals with mental illness who become involved in the criminal justice system.¹⁷⁸ He stated: "DBH uses Key Performance Indicators (KPI) to monitor strategic initiatives and goals. As it pertains to justice-involved consumers, DBH specifically looks to the following KPI:

1. Percent of inpatient consumers restored to competency; and
2. Consumers who are in need of linkage support at the DOC who are actually linked by DBH staff.

Grants require specific outcome measures and have unique reporting requirements. DBH recently overhauled its grant management process. To measure the effectiveness, each grantee must meet performance goals established by the scope of work on the grant agreement. DBH monitors grantee progress towards these goals by reviewing programmatic and financial reports and through site visits. If DBH identifies deficiencies in a grantee’s performance, DBH provides technical assistance when a deficiency can be remedied and suspends or terminates an award for serious performance deficiencies.”¹⁷⁹

¹⁷⁵ Andre Gray, Peer Navigator, D.C. Jail and Prison Advocacy Project, University Legal Services, Washington, D.C., Testimony, *DC Briefing*, p. 279.

¹⁷⁶ Freeman Testimony, *DC Briefing*, pp. 294-95.

¹⁷⁷ Gray Testimony, *DC Briefing*, p. 280.

¹⁷⁸ Richard Bebout, Deputy Director, Adult Services, Department of Behavioral Health, *Response to Request for Information*, Apr. 27, 2020.

¹⁷⁹ *Ibid.*, 2-3.

Recommendations

Overall, the DC Mental Health Community Court (DCMHCC) program has helped to reduce the recidivism rates of, and helped to provide treatment and other services for, individuals with severe mental illness who become involved in the criminal justice system in the District of Columbia. As stated at the outset, the Committee is aware that the Commission pursues its statutory mission by “studying alleged deprivations of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, or national origin, or in the administration of justice.”¹⁸⁰ So far as the Committee can discern, the DCMHCC does not discriminate against individuals who fit within any of these protected classes. To the contrary, in many ways, the DCMHCC seems to be at the top of the class in terms of mental health court programs that deal with individuals who suffer from a disability—specifically, a severe mental illness—who commit criminal offenses.

Clearly additional community-based care providers and housing would greatly assist those suffering from severe mental illness and might prevent many of them from becoming justice-involved in the first place. Similarly, additional police training and resources can assist in helping those suffering from a mental illness receive treatment in the community and in reducing recidivism rates among offenders with mental illness. Programs such as the Metropolitan Police Department’s (MPD) pre-arrest diversion (PAD) program should be encouraged and adequately funded.

With respect specifically to the DCMHCC program, the DC Advisory Committee has several recommendations for the U.S. Commission on Civil Rights to consider as ways to potentially improve the system or which warrant further study.

Recommendation 1:

Encourage the continued funding and operation of the DCMHCC and suggest that the DCMHCC or an interested academic institution create a long-term tracking system for participants in the DCMHCC, periodically measuring their status (e.g., following the 1st, 2nd, and 5th years) after completion of the program. Have the long-term tracking include both static factors (e.g., age, race, sex, etc.) and dynamic factors (e.g., residence status, substance use, etc.), if possible.

Recommendation 2:

Urge the U.S. Attorney’s Office to consult with prosecutors in other districts regarding their experiences with mental health courts and review the eligibility criteria annually to determine whether to expand the eligibility for participation in the DCMHCC program. Such a re-evaluation of the eligibility criteria for offenders suffering from severe mental illness, who could benefit from participation in the DCMHCC program, may be particularly appropriate now in light of the added risk of infection by the coronavirus pandemic to those who are incarcerated.

Recommendation 3:

¹⁸⁰ U.S. Commission on Civil Rights Mission, <https://www.usccr.gov/about/>.

Encourage, to the extent possible, community-based care programs to promote long-term goals of providing housing, education, counseling, and employment services to those with serious mental illness, including individuals who have recently been released from, or otherwise involved in, the criminal justice system.

Recommendation 4:

Urge the DCMHCC, in consultation with the Department of Behavioral Health (DBH), to devise standards, to the extent possible, for assessing the quality of care provided by service providers for DCMHCC participants and develop schedules for conducting such assessments.

Recommendation 5:

Urge the DCMHCC to examine the standards it uses, comparing them with the “essential” standards recommended for use by the Council of State Governments and specifically assessing, preferably in a written report, any discrepancies.

Appendices



**District of Columbia Advisory Committee to the U.S. Commission on
Civil Rights Public Briefing:**

Mental Health, Mental Health Courts and the Criminal Justice System

Thursday, November 7, 2019 | 9:00 am – 5:00 pm (ET)
U.S. Commission on Civil Rights
1331 National Place Building, 11th Floor
Washington, DC

AGENDA

- 9:00 am – 9:15 am** **Welcome and Introductions**
- 9:15 am – 10:45 am** **Panel 1. Mental Health Court Experts**
- Richard Boldt
 T. Carroll Brown Professor of Law
 University of Maryland Carey School of Law
 Baltimore, MD
- Kelli Canada
 Associate Professor and Associate Director
 of Research School of Social Work
 University of Missouri, Columbia, MO
- E. Lea Johnston, Professor of Law
 University of Florida Levin College of Law
 Gainesville, FL
- Susan McMahon, Professor of Law
 Georgetown University Law Center
 Washington, DC
- Allison Redlich, Professor of Criminology, Law
 & Society (*Unable to Attend*)
 George Mason University
 Fairfax, VA

Terrence D. Walton, Chief Operating Officer
National Association of Drug Court Professionals
Alexandria, VA

10:45 am – 12:15 pm

**Panel 2. DC Mental Health Court
Stakeholders**

Kelly O'Meara, Executive Director
Strategic Change Division
Metropolitan Police Department
Washington, DC

Stephen Rickard, Chief, General Crimes Section
Accompanied by: L'Shauntee Robertson, AUSA
Mental Health Court
D.C. U.S. Attorney's Office
Washington, DC

Laura L. Rose, Esq.
Mental Health Specialist for the Trial Division
Public Defender Service for DC
Washington, DC

Gregg Baron, Esq.
Defense Counsel
Washington, DC

12:15 pm – 1:00 pm

Lunch Break

1:00 pm – 2:30 pm

**Panel 3: DC Mental Health Court
Stakeholders**

Hon. Ann O'Regan Keary, Senior Judge
DC Superior Court
Washington, DC

Cleonia Terry, Coordinator, Mental Health
Community Court
DC Superior Court
Washington, DC

Jeffrey Wright
Treatment Program Manager
Pretrial Services for the District of Columbia
Washington, DC

2:30 pm – 4:00 pm

Panel 4: DC Mental Health Court Stakeholders

Tammy Seltzer, Director (*Unable to Attend*)
DC Jail and Prison Advocacy Project
University Legal Services
Washington, DC

David Freeman, Chief Clinical Officer
Community Connections, Inc.
Washington, DC

Christy Respress, Executive Director
Pathways to Housing DC
Washington, DC

Andre Gray, Peer Navigator
DC Jail and Prison Advocacy Project
University Legal Services
Washington, DC

4:00 pm – 5:00 pm

Public Open Comments Session

Mr. Anthony Ellis, Graduate
DC Mental Health and Community Court

Ms. Tania Taylor, Graduate
DC Mental Health and Community Court
Accompanied by Courtney Burns, Case Manager

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The U.S. Commission on Civil Rights, established by the Civil Rights Act of 1957, is an independent, bipartisan agency charged with advising the President and Congress on civil rights. It is the only federal department, agency or commission with a network of 51 statutorily-mandated federal advisory committees in each state and the District of Columbia – that study civil rights issues in their states and report the results of their reviews to the Commission. For more information about the Commission, and the DC Advisory Committee, please visit www.usccr.gov and follow us on [Twitter](#) and [Facebook](#).

PREPARED WRITTEN STATEMENT OF GREGG BARON, ESQ.

I have been practicing law as a criminal defense attorney in the Superior Court for the District of Columbia for nearly twenty-five years. During that time, I have observed an ever-increasing number of clients - both as a percentage of my own case load and in terms of absolute numbers - who suffer from at least one form of mental illness. This includes those who enter the criminal justice system for the first time as well as those who cycle through the system repeatedly. By necessity, therefore, how we as defense attorneys practice law has changed over the years to meet changing client needs and circumstances. Since many here at these proceedings may have only a vague or limited knowledge of the role defense attorneys play in representing clients with mental health issues in court, it is my hope to provide you with an appreciation for the kind of work we do and some of the challenges we face representing those individuals in court.

First, let me just express my belief that indigent defendants in the District of Columbia, including those who suffer from mental health issues, who are appointed an attorney by the courts, receive legal representation that is second to none. Assuming a defendant meets the financial qualifications, he or she is appointed either an attorney from the Public Defender Service or from a panel of attorneys selected by judges of the D.C. Superior Court to take cases under the Criminal Justice Act (CJA). The Public Defender Service, in addition to providing top notch legal representation, has resources devoted to assisting clients in obtaining services in many areas, including mental health services. Attorneys on the CJA Panel are subjected to a very thorough and painstaking vetting process by a committee of judges of the Superior Court and must re-apply to that panel every four years. Thus, in my opinion, individuals with mental health issues who are defendants in criminal cases in D.C. Superior Court have access to the highest quality legal representation whether they ultimately choose to avail themselves of the Court's Mental Health Community Court or pursue some other avenue in their case.

Second, I firmly believe, based on my own experience and input from other defense attorneys who practice in D.C. Superior Court, that the Mental Health Community Court has been very successful in responding to many of the problems and issues being discussed at these proceedings. It provides clients with an opportunity to gain access to services they might otherwise not get and provides them a vehicle to get through the court system with a favorable outcome in their cases. As a representative on the Court's Stakeholders Committee, I have had the opportunity to work with several judges who have presided over Mental Health Community Court, representatives from the U.S. Attorney's Office, Pretrial Services and other interested stakeholders. One of the things that makes this such a successful problem-solving program is the willingness and ability to be flexible and to change in response to new information and changing awareness.

The Initial Meeting

In the typical case, the first meeting between a lawyer and client takes place in a crowded cell block and across a screen or a set of bars. This first meeting is an opportunity for the lawyer to gather information about both the client and events leading up to that client's arrest. It is also a crucial opportunity for the lawyer to begin to form a relationship with the client and to establish trust.

Among the information the lawyer tries to get from the client during this first encounter is whether or not the client suffers from or has ever been diagnosed with any mental illness. Some clients are very forthcoming about their mental health and will be able to give the names and phone numbers of various case workers and core service agencies. Others are not as revealing. Some lack the kind of self-awareness necessary to have that discussion. Some do not trust the

lawyer that they are just meeting for the first time. Many, unfortunately, are still reluctant to address their own mental health issues because of the stigma that still attaches in their community to having a mental illness. This last reason is perhaps the most frustrating. While it may be beyond the scope of these hearings, I believe that still greater efforts need to be made in educating people in the community about these types of issues as a means of trying to reduce the number of individuals suffering from mental illness who get entangled in the criminal justice system.

The information the lawyer is able to obtain from the client regarding the client's mental health will be important both in seeking the client's release in the case and in assessing what options (including Mental Health Community Court) might be available to the client as the case progresses through the system.

The Initial Court Appearance

In the typical case, the client's first appearance before a judge is a brief one. The lawyer enters a plea of Not Guilty and asserts a number of Constitutional rights on behalf of the client. The Court will then hear from the parties regarding the client's release. Ultimately, the decision to release a defendant, and what, if any, conditions to put on that release is solely up to the judge. If appropriate, the lawyer may ask that the client be assessed by the Pretrial Services Agency for placement into Pretrial's Specialized Supervision Unit (SSU). SSU is a unit within the Pretrial Services Agency that monitors and assists defendants with certain mental health diagnoses. Not every defendant with a mental illness will qualify to be placed in SSU; however, SSU placement is a requirement to get into Mental Health Community Court.

The Status Hearing

The next stage in most criminal proceedings is the Status Hearing. At this stage, the parties advise the presiding judge of the posture of the case and what course the case will take (for example, whether a client will accept a plea offer or set the case for trial). A client with a mental illness may be eligible to participate in Mental Health Community Court. In order to participate, the client must be approved by both the United States Attorney's Office and by Pretrial Services. Each of those agencies have their own criteria for eligibility. In preparation for the Status Hearing, a defense lawyer will, in addition to investigating the case, gather and try to verify information pertaining to the client's mental health and any connection with a core service agency in the community. If the client is not connected, the lawyer can work with the client to get the client connected. The lawyer may also have discussions with the prosecutor or with a Pretrial Services representative to provide information that might aid in getting a client into Mental Health Community Court.

It should be kept in mind that it is ultimately the client's decision whether to participate in Mental Health Court or choose some other course. A defense lawyer will provide counsel, but crosses a line if he or she tells a client what choice to make in the case. Mental Health Community Court is a voluntary program, and a client may, for a variety of reasons, opt not to enter the program. Those clients who do not participate in Mental Health Community Court may still be eligible to receive mental health services through placement into SSU.

Mental Health Community Court

Assuming the client has a requisite mental health diagnosis and is connected and actively engaged in receiving mental health services, the client's case will be sent to Mental Health Community Court. Once in Mental Health Court, and upon submission of the requisite number of clean drug tests, the Government will offer the client an Agreement that will result in a favorable

outcome for the client. In misdemeanor cases the successful completion of the Agreement will result in the dismissal of the case. In felony cases, successful completion of the Agreement will result in the felony charge being reduced to a misdemeanor.

To some extent, the defense lawyer practicing in Mental Health Community Court faces tensions in his or her role that they do not face in other aspects of their practice in Superior Court. On one hand, Mental Health Community Court is far less concerned with a client's guilt or innocence than it is with getting clients the services they need. Everyone wants to see the client succeed in Mental Health Court. As such, there is the tendency to want the defense lawyer to act more like a "team player" to help bring that success about. On the other hand, the defense lawyer represents the client in the case *and only the client*. Thus, the defense lawyer must be ever vigilant in making sure the client is afforded due process at all times, even when it may appear to go against the grain with what is trying to be accomplished at any given time.

Defense lawyers who practice in Mental Health Community Court also often find themselves in the unfamiliar waters of practicing social work. As a general matter, we are used to advocating within the confines of an adversarial setting. By design, Mental Health Community Court is non-adversarial in nature. In representing clients in this setting we more often find ourselves talking with case managers, various mental health professionals and pretrial officers. Discussions focus on issues related to housing, drug treatment and other services the individual client might want or need. While these are conversations we still might have in other cases, they are the focus in Mental Health Court. The lawyer needs to be well versed and well informed with respect to what services the client is receiving, which services are working and which ones are not, and which ones the client still might need or benefit from.

On the whole, as I stated earlier, I believe that clients benefit greatly by participating in Mental Health Community Court. Those who complete the program benefit not only by getting a favorable outcome in their case, but they also graduate from the program in a more stable position than when they entered. Many remain connected to their core service agencies and continue to receive services. I will leave studies of recidivism rates to those more qualified than I; however, I will note anecdotally that I have seen far fewer successful Mental Health Court clients (I can count them on one hand) come back into the system than clients who have not had the benefit of Mental Health Court.

Areas for Improvement

While there continue to be resources available to assist clients who suffer from mental illness, some problems persist. It has been my observation that homelessness among this population is considerably higher than for clients who do not suffer mental illness. I have also noticed that once clients with a mental illness are able to achieve stable housing, they tend to fare better in other aspects of their lives. They are better able to find and maintain employment. They tend to make more of their appointments and keep current with their mental health regimens. Perhaps most importantly, since they no longer live on the street, they are less likely to be in many of the locations and situations that would put them at risk of being arrested. This is certainly more an issue of funding than anything else.

There are many core service agencies in the community, some better than others, but it has been my observation that the case workers at these agencies - the people who probably have the most interaction with these client - are managing large caseloads, which in turn leads to a high rate of turnover. This is a problem in that we are dealing with a population for whom consistency and continuity go a long way. My observation is that when clients are able to establish a longer lasting relationship with a case worker, it leads to greater trust, which, in turn,

leads to clients following through on getting services. Again, this is probably more of a funding issue.

As I mentioned earlier, general education in the community regarding mental illness would go a long way. As enlightened as we have become as a society, there are still large swaths of the population in which mental illness carries a stigma. It is often not just the client who does not want to talk about mental health, but often friends and family who deny the existence of a problem. "Oh, he's not crazy. He's just a little slow." Unfortunately, these attitudes still permeate all social and economic strata of society.

In closing, it has been my purpose to try to educate participants about the role that defense attorneys play in representing clients with mental health issues in criminal cases in the District of Columbia Superior Court and to provide some insight into some of the challenges we face. I have also attempted to share some observations regarding the Mental Health Community Court, its challenges and its successes.

Prepared Written Statement of Professor Richard Boldt

My name is Richard Boldt. I am a professor at the University of Maryland Carey School of Law. My research and teaching interests include criminal law, mental disability law, constitutional law, and torts. A good deal of my research focuses on the legal issues surrounding behavioral health and substance use disorders. I have written extensively on drug treatment courts and other problem-solving courts, including mental health courts.¹

I thank the Committee for holding this timely hearing on Mental Illness, Mental Health Courts, and the Criminal Justice System in the District of Columbia. The project proposal for this hearing notes: “The links between those suffering from mental illness, the problems of homelessness, and the criminal justice system have been clearly established, and all three are a problem in the District of Columbia.” The project proposal, and actors in this area generally, connect these problems with “[t]he national movement in the 1970s to deinstitutionalize individuals suffering from mental illness” and with the failure of relevant decision makers to meet the needs of this population “with a corresponding increase in the availability of other support services.”

There has indeed been a remarkable shift in the essential structure of the behavioral health treatment system in the United States over the past fifty years. The most dramatic element in this shifting landscape has been an extreme decline in the system’s reliance on large state hospitals for the long-term care of persons with severe chronic mental illnesses and other significant mental disabilities. This is the well-documented phenomenon of deinstitutionalization. In 1955, the daily patient census in state and county psychiatric hospitals was roughly 560,000 individuals. By 2003, that number had declined to less than 50,000 individuals. The shifting landscape has other features worth noting as well. The location of inpatient treatment provided to psychiatric patients has moved significantly to acute care settings in the private sector, which includes general and private psychiatric hospitals. The duration of inpatient episodes is now, on average, measured in days rather than weeks or months. And, because of a decline in private psychiatric hospital beds as well as beds in state facilities, the system now relies on an increased use of emergency departments as sites for delivering acute psychiatric care.

Associated with these shifts in the system for delivering behavioral health care has been a profound increase in the incidence of severely mentally ill persons who experience homelessness and/or criminal system involvement. While it is tempting to construct a straightforward causal account of this association and to search for policy interventions, including mental health courts, that are designed to address the causal “problem” so identified, both the problems and effective solutions likely require a more nuanced understanding of the dynamics at work here.

Deinstitutionalization, Homelessness, and the Criminal Justice System.

¹ This written statement draws from my published work on problem-solving courts and behavioral health. See Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 Wash. U. L.Q. 1205 (1998); Richard Boldt & Jana Singer, *Juristocracy in the Trenches: Problem-Solving Judges and Therapeutic Jurisprudence in Drug Treatment Courts and Unified Family Courts*, 65 Md. L. REV. 82 (2006); Richard C. Boldt, *The “Tomahawk” and the “Healing Balm”*: *Drug Treatment Courts in Theory and Practice*, 10 Md. L.J. Race, Religion, Gender & Class 45 (2010); Richard C. Boldt, *Problem-Solving Courts and Pragmatism*, 73 Md. L. REV. 1120 (2014); Richard C. Boldt, *Problem-Solving Courts*, in ACADEMY FOR JUSTICE, A REPORT ON SCHOLARSHIP AND CRIMINAL JUSTICE REFORM (Erik Luna ed., 2017). See also, Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 DREXEL L. REV. 1 (2018).

Thoughtful research has suggested that the legalization of the civil commitment process in the 1960s and 1970s had a relatively minor role to play in the shifting landscape for behavioral health care in the United States. Likely more important was the introduction and proliferation in the use of neuroleptic medications in the middle portion of the twentieth century and the further refinement of psychiatric pharmacotherapy, including the development of a second generation of antipsychotic drugs in the more recent past, which enabled a whole class of long-term patients to be discharged to community treatment. More important still were fundamental developments within the health-care finance system, which created strong incentives for states to shift the locus of treatment from state hospitals to other settings.²

Regardless of whether deinstitutionalization was driven primarily by economics, civil libertarian legal reforms, the availability of new medical technologies, or a combination of these factors, the benefits to many patients in avoiding lengthy involuntary psychiatric hospitalizations have been considerable. Research suggests that brief hospitalizations focused on stabilizing acutely ill psychiatric patients on medication and arranging aftercare in the community can be as effective in preventing self-harming behavior as long-term inpatient treatment. If patients are stabilized and released quickly, it is likely that the considerable human costs of long-term hospitalization, including the loss of privacy and autonomy, an increased risk of physical harm, the functional deterioration that often attends lengthy institutionalization, and isolation from family and community, can be minimized or avoided.

At the same time, the choice to limit the use of involuntary inpatient psychiatric treatment and to shorten the length of stay for those who are admitted may exact costs that approach or are even greater than those associated with the excess use of custodial care. A number of observers have argued that moving the locus of treatment from the state hospital to the community has contributed to an epidemic of the “homeless mentally ill,” and has pushed many persons with chronic mental illness into the criminal justice system, where their interests in being treated with dignity and receiving effective care are likely to be further undermined. Indeed, some writers have described as a “near-consensus” the view that deinstitutionalization has been a failure of well-intended but poorly thought-out public policy.

The two narratives underlying the notion that deinstitutionalization has been a failure—that it has contributed to an epidemic of homelessness and that it has forced thousands of severely mentally ill individuals into jails and prisons—have become the subject of energetic critiques by others who have studied these phenomena. With respect to the first, Samuel Bagenstos, Michael Perlin and others have argued that in the early years of deinstitutionalization the declining patient population of state and county mental hospitals was “more than offset” by a growing reliance on nursing homes and general hospitals, and that the increase of homelessness among those with chronic mental illness beginning in the 1980s and continuing to the present has been more a function of the deterioration of housing conditions, a failure of state and local governments to provide adequate supportive services, and declining support from the federal government and the states by way of Supplemental Security Income (SSI) and housing assistance.³

The second narrative at the heart of the claim that deinstitutionalization has been a policy failure is based on a thesis that some have labeled “trans-institutionalization.” Proponents of this view start with the

² Thus, in 1970, nearly 80% of the available inpatient psychiatric beds in the United States were in state and county hospitals. By 2002, not only had the total number of beds declined significantly, but only about a quarter were located in public psychiatric hospitals. Indeed, by the first decade of the twenty-first century, 60% of the costs of inpatient psychiatric treatment were borne by Medicaid or Medicare. The states had off-loaded a significant financial burden from their budgets onto federal health insurance programs by moving long-term psychiatric patients into nursing homes, group homes, and other community-based settings, and by encouraging the use of smaller psychiatric units in general hospitals and private psychiatric hospitals to deliver short-term acute care.

³ See Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 *CARDOZO L. REV.* 1, 10-12 (2012); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 *HOUS. L. REV.* 63 (1991).

assumption that state and country psychiatric hospitals and the institutions of the criminal justice system are functionally interdependent. The hypothesis that follows is that when states reduced the availability of psychiatric beds in state hospitals the displaced population of former patients with severe mental illness found themselves in the community with inadequate treatment and other human service and were drawn into jails and prisons, which became “de facto treatment facilities.” The narrative derived from this set of assumptions is causal in nature. The claim, in effect, is that deinstitutionalization, coupled with the failure of the community mental health system to provide adequate alternative care, caused a significant number of individuals with chronic mental disabilities to become enmeshed in a criminal system ill-suited to their needs.

Thoughtful critics of this trans-institutionalization account have described it as a “reductionist narrative” that “mistakenly draw[s] a causal connection between two merely correlated trends: the decline in the availability of state psychiatric hospital beds and the rise in prevalence of [serious mental illness] in jails and prisons.”⁴ The essential mistake they cite is the assumption that the group of persons formerly served as inpatients in state and county psychiatric hospitals share relevant characteristics with the universe of offenders with mental illness who end up in the criminal justice system. In addition, they argue, the relative proportion of criminal offenders with serious mental illnesses has not increased in response to the decline in state hospital populations; rather, the increase in mentally ill inmates appears to be tied to the increase overall in the incarceration rate. One measure of this claim is derived from data showing that the proportion of individuals with serious mental illness living in the community has remained relatively stable in recent decades at about 80%. To be sure, many more people with serious psychiatric disorders are now incarcerated, but it appears that this increase has more to do with broader shifts in the use and composition of jails and prisons than it does with a declining reliance within the behavioral health-care system on long-term inpatient treatment.

With these observations about the complex relationship between mental illness, homelessness, and criminal system involvement in mind, I now turn to a consideration of mental health courts as one response to these interrelated challenges. In the remainder of this statement, I offer a preliminary assessment of the promise and perils of the problem-solving approach that virtually all mental health courts follow, noting the particular challenges presented by efforts to intermix rehabilitative and punitive functions within existing criminal justice institutions. In addition, I briefly describe the so-called “risk-need-responsivity” model, which has been developed to help identify offenders who might benefit from rehabilitative interventions and to identify the particular interventions that are most likely to reduce re-offending in a given case.

Given the limitations in the research, the inherent risks of the problem-solving approach, and the importance of attending to the risk-need-responsivity criteria, I recommend that policymakers prioritize alternatives to criminal system-located mental health courts and other problem-solving courts for those who currently are brought into the system as a consequence of low-level drug offenses and other quality of life infractions. These better alternatives include diversion prior to arrest or pre-adjudication, and health and social service interventions in the community. Moreover, to the extent that the mental health court approach is employed, either to adjudicate criminal charges or to manage offenders after a plea, they should focus on higher risk offenders, particularly those with multiple risk factors. If they target this more challenging population, these courts should offer a menu of services that match the full range of needs participants present, not just their drug use disorders or mental illnesses, and should draw upon a diverse service provider network offering a range of modalities of treatment. Finally, I recommend that mental health courts adopt structural features designed to ameliorate or minimize the tendency of these rehabilitative intentions to devolve into punitive practices. These features include a preference for the pre-

4 Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 COMMUNITY MENTAL HEALTH J. 716, 720 (2011).

adjudication version of the problem-solving court model and an expectation that they adopt formal procedures governing the use of graduated sanctions and other responses to participant noncompliance with program requirements.

Mental Health Courts: The Complex Relationship Between Mental Illness and Offending.

Several important limitations characterize much of the research on problem-solving courts, including mental health courts. First, because it is difficult to create a research design in this area with randomly assigned study and control groups, many of the studies use comparisons between study subjects who have participated in problem-solving courts and others who have not but have similar characteristics (in terms of demographic and criminal justice factors). Some recent studies have used fairly sophisticated techniques for controlling for confounding variables, but the gold standard double-blind methodology is rare in this area. In addition, many of the studies focus on recidivism as the primary or only outcome measure (other measures include court appearances, convictions, or self-reported substance use or criminal behavior). The relatively few studies that have measured outcomes such as employment, housing status, or family attachment, have reported mixed success. Moreover, much of the research measures reoffending in the short-term.

Taken as a whole, and bearing in mind the limitations of the data, the evidence on mental health courts paints a complex picture. In general, it suggests that these courts may have a positive impact on criminal system re-involvement for some clients, but likely do not measurably improve most participants' mental health. In addition, preliminary research suggests that participants in mental health court risk experiencing more and not less criminal system confinement and/or criminal justice supervision.⁵

Advocates of mental health courts frequently assert two rather straightforward premises underlying their efforts to link therapeutic services to criminal case management. The first is that there is a direct causal relationship between mental illness and criminal conduct.⁶ The second is that the effective treatment of an offender's underlying mental illness is likely to prevent his or her future criminality (or at least reduce recidivism). As it happens, the association between mental illness and criminality is more complex than this account suggests, and, in most cases, is not directly causal. Researchers studying the question have concluded that the group of offenders whose mental disorders can be said to have directly caused their criminal conduct is actually quite small. A second category of offenders, which is much larger, is comprised of offenders whose criminal conduct is best understood as only indirectly the result of mental illness. In the case of these individuals, the effects of their mental disorders generally are mediated by factors either brought about by their underlying disability or at least associated with it. Consistent with this more nuanced understanding, the best evidence is that a number of the risk factors most associated with criminality (substance misuse, weak family ties, and so forth) are also associated with severe mental illness. Understood in this fashion, while mental illness *simpliciter* is not highly predictive of criminal recidivism, mental illness does play an important indirect role in fostering a set of circumstances that are positively associated with criminal system involvement. Not surprisingly, programs that target this broad spectrum of "criminogenic needs" produce greater "treatment effects" than do programs that are more narrowly focused on mental illness and medication management alone.

⁵ See E. Lea Johnston and Connor Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685 (2017) (reporting study findings that "anticipated mental health court sentences typically exceed — by years — the supervisory periods that offenders would otherwise receive in a county criminal court. Second, mental health court participants with multiple convictions were significantly more likely to receive consecutive, as opposed to concurrent, sentences than those sentenced by traditional courts. Third, the analysis suggests the mental health court usually does not divert individuals from jail or prison sentences — a primary justification for these courts — but instead merely extends state control over individuals with serious mental illnesses.").

⁶ See E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 552 (2012) ("At the core of mental health courts is a belief that, were it not for eligible offenders' mental illnesses, these individuals would not have engaged in the criminal behavior that prompted their arrest.").

Because mental illness does not hold a simple, causal relationship with criminality (the first premise often advocated by mental health court advocates), medication management and other treatment interventions targeting participants' mental illness, taken in isolation, are unlikely to produce robust and sustainable reductions in recidivism (the second premise). Instead, courts that formulate a broader and more comprehensive understanding of the problem, and thereby seek to address a fuller range of associated needs contributing to the dysfunction and distress of the offenders before them, are more likely to have a measurable impact on the daily functioning of these individuals. Moreover, if the definition of the problem is informed by an acknowledgement that the relationship between mental disorder and criminal system involvement is not directly causal in most cases, but instead is mediated by a range of associated characteristics, then the identification of appropriate goals is also likely to take on a broader, more comprehensive cast, to include not just (or even primarily) a reduction in criminal recidivism.

The Risk-Need-Responsivity Model.

The risk-need-responsivity (RNR) model was first developed in the early 1990s to help identify offenders who might benefit from rehabilitative interventions and to identify the particular interventions that would be most likely to reduce re-offending in a given case. The model is comprised of the principles of risk, need, and responsivity. The *risk* principle promotes the use of empirically validated assessment tools that measure both static risk factors such as age and criminal history and dynamic risk factors, including substance misuse, to ensure that intensive case management and intervention services are reserved for high risk offenders. The *need* principle states that to reduce recidivism, treatment should target a group or package of "criminogenic needs" rather than a single need thought to be a risk factor. Thus, instead of focusing solely on drug use treatment for persons with drug problems or medication management for offenders with mental illness, the need principle calls for the delivery of an integrated suite of services designed to meet all (or at least most) of the deficits that collectively contribute to their criminal involvement.⁷ The *responsivity* principle urges officials to adapt interventions to the specific needs of offenders. In general, treatments based on cognitive-social learning methods are thought to be the most effective at reducing criminal behavior, and intervention strategies tailored to match the offender's individual learning styles, motivations, and abilities (e.g., physical disabilities, mental health, level of intelligence) are encouraged. Research has demonstrated the value of adherence to the RNR model for the purposes of risk reduction in offender populations.

Mental health courts increasingly are being structured as post-adjudication programs (thus, typically, requiring a plea), or, occasionally, as probation-based programs. The requirements imposed on participants, therefore, frequently are structured either as conditions associated with a suspended sentence or conditions of probation. Consistent with the set of insights about risk, need, and the importance of matching interventions to the individual characteristics of individuals inherent in the RNR model, and given the high rates of re-offending among persons under supervision generally, the best evidence suggests that treatment court programs should be targeted to those most likely to need them and limited by the terms of participation so that these interventions do not themselves promote reoffending and inhibit the reintegration of offenders.

As applied to problem-solving courts, the evidence suggests that targeting the most intensive services and treatment to higher risk offenders yields better recidivism outcomes. This works in two directions. First, it turns out that providing intensive treatment and other interventions to lower risk offenders can increase their rates of recidivism. Especially for offenders with drug use disorders, while the efficacy of treatment ordinarily increases with duration, the results can diminish if treatment goes on too

7. See Mary Ann Campbell et al., *Multidimensional Evaluation of a Mental Health Court: Adherence to the Risk-Need-Responsivity Model*, 39 LAW & HUM. BEHAV. 489, 490–91 (2015); see also Michael Rempel, *Evidence-Based Strategies for Working with Offenders*, CENTER FOR COURT INNOVATION (Apr. 2014),

long. More generally, the research shows that requiring lower risk offenders to participate in intensive or multiple programs can disrupt their social functioning and actually introduce new risk factors.

On the other hand, for offenders with multiple risk factors, including severe mental illness, co-morbid drug or alcohol problems, and/or personality disorders, more intensive interventions may provide better recidivism outcomes. For these individuals, and indeed for most offenders brought into problem-solving courts, it appears that the most effective techniques include cognitive behavioral approaches and structured social learning, where new skills and behaviors are modeled and practiced. Programs that focus on fear, shaming, and other emotional appeals consistently have been found to be ineffective.

The Problems of Problem-Solving Courts.

While most problem-solving courts, including mental health courts, seek to integrate the punishment goals of the criminal legal system with the treatment goals of community-based human services programs, some critics have suggested that these objectives are not only fundamentally different, they may well be contradictory and irreconcilable in practice.

Additionally, the very design of these courts tends to reinforce the primacy of the criminal punishment components over the therapeutic/helping elements. Although the judge, attorneys, probation and parole officials and service providers often are described as functioning as a ‘treatment team,’ it is significant that the team is headed by the judge, who, by training, professional culture, and role definition, is bound to enforce legal norms. Thus, unlike treatment services provided voluntarily in the community, fundamental decisions made in problem-solving courts, including decisions about whether a violation of conditions should be met with a therapeutic response or a more punitive imposition of incarceration or expulsion from the program, are made authoritatively by an actor bound to a larger institutional system that takes as its goals deterrence, retribution and incapacitation.⁸

As the broad but ultimately unsuccessful effort to adopt rehabilitative penal approaches in the middle part of the twentieth century (and the more particularized failures of the juvenile court movement over most of the last century) suggests, joining punitive and therapeutic functions within a single hybrid institutional structure is fraught with risks.⁹ These risks derive from a number of sources, but especially from what the mid-century critics of the “rehabilitative ideal” referred to as the inherent tendency of these merged enterprises “in practical application to become debased and to serve other social ends far removed from and sometimes inconsistent with the reform of offenders.”¹⁰ The critics argued that the “natural progress of any program of coercion is one of escalation,”¹¹ and that a persistent “competition between rehabilitation and the punitive and deterrent purposes of penal justice . . . [in which the] rehabilitative ideal is ordinarily outmatched in the struggle”¹² helps to explain this inclination toward debasement.

A second problem with problem-solving courts, including mental health courts, is associated with treatment court failure. A 2013 meta-analysis of incarceration outcomes, using data from 19 studies in the US, concluded that drug treatment court participants overall do not spend less time incarcerated than similarly situated non-participants, primarily because of the relatively long sentences imposed on those

8. Richard C. Boldt, *A Circumspect Look at Problem-Solving Courts*, in *PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?*, *supra* note 1, at 13, 20–21.

9. See Richard C. Boldt, *Rehabilitative Punishment*, *supra* note 1, at 1218–45, 1269–78. See also FRANCIS A. ALLEN, *THE DECLINE OF THE REHABILITATIVE IDEAL* (1981); ELLEN RYERSON, *THE BEST-LAID PLANS: AMERICA’S JUVENILE COURT EXPERIMENT* (1978).

10. ALLEN, *supra* note 8, at 49.

11. AM. FRIENDS SERVICE COMM., *STRUGGLE FOR JUSTICE: A REPORT ON CRIME AND PUNISHMENT IN AMERICA* 25 (1971).

12. ALLEN, *supra* note 8, at 53–54.

who fail to graduate.¹³ Given that graduation rates vary widely from court to court (and in many courts are extremely low), this means that the reduced time in jail spent by those who succeed may be offset by the additional time triggered by treatment failures.

In addition, there are costs to system legitimacy incurred as a result of the diminished procedural safeguards and broad procedural informality that characterize the sentencing decisions of problem-solving court judges. The National Institute of Justice noted that many courts do not have a formal system under which sanctions are imposed, nor are records kept for when and why sanctions are enforced. This relaxed procedural stance may be relatively benign in those instances in which participants adhere to program requirements and thereby avoid further criminal punishment, but it produces a corrosive effect in the class of cases in which participants fail at treatment and are subjected to augmented punishment ordered by a decision-maker whose capacity for formal fairness has been compromised by problem-solving informality.

A third concern, inherent in the design of many of these courts, has to do with the use of criminal punishment as a response to treatment failure. As the Open Society Foundations observed in a recent report on this subject: “Punishment for a subjectively judged treatment ‘failure’ violates international standards of care of drug dependence and flies in the face of basic tenants of the right to health.”¹⁴ Some researchers have noted an increase in the total amount of time that many treatment court participants spend in jail even when they ultimately are successful in the program, because of the frequent use in some jurisdictions of brief periods of incarceration as a response to program infractions. Thus, participants may be punished with multiple stays in jail for offenses that would have resulted in far shorter periods of incarceration if they had never enrolled in the treatment court.¹⁵ Similarly, in the context of mental health courts, particularly as more of these courts move to a post-plea model, some research has shown that the use of incarceration as a sanction has increased, as well as a shift toward the use of criminal justice mechanisms of supervision as opposed to supervision by mental health officials.¹⁶

A final concern has to do with uneven access to appropriate treatment. “Insufficiently trained court staff often send participants to services irrespective of their specific needs. Some courts use a ‘shotgun’ approach in which they subject participants to several programs with incompatible philosophies.”¹⁷ Poor treatment matching not only violates the principles of the RNR model, it also leads to a high rate of program failure. Moreover, effective treatment for mental disabilities and substance use disorders often requires a group of coordinated interventions designed to meet the complex needs of participants. Too frequently, treatment courts fail to deliver the full range of other medical, legal, and social services necessary for success in the program.

Recommendations

In light of the instability of the treatment/punishment hybrid and the significant costs incurred when participants fail to complete a problem-solving court regime, policymakers should be thoughtful about the choice between devoting additional resources to problem-solving courts as opposed to investing

13. See Eric L. Sevigny et al., *Do Drug Courts Reduce The Use of Incarceration?: A Meta-Analysis*, 41 J. CRIM. JUST. 416 (2013).

14. JOANNE CSETE & DENISE TOMASINI-JOSHI, DRUG COURTS: EQUIVOCAL EVIDENCE ON A POPULAR INTERVENTION 7, <https://www.opensocietyfoundations.org/reports/drug-courts-equivocal-evidence-popular-intervention>.

15. See REGINALD FLUELLEN & JENNIFER TRONE, VERA INSTITUTE OF JUSTICE, DO DRUG COURTS SAVE JAIL AND PRISON BEDS? 6 (2000).

16. See Lisa Callahan, Henry J. Steadman, & Sheila Tillman, *A Multi-Site Study of the Use of Sanctions and Incentives in Mental Health Courts*, 37 LAW & HUM. BEHAV. 1, 1–9 (2013).

17. DRUG POLICY ALLIANCE, DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 12 (2011).

in programs designed to divert low-risk offenders out of the criminal system and into therapeutic and other social services in the community. As a rule, having a need for substance use or mental health treatment should never be a sufficient reason for an individual's entry into the criminal justice system, and the criminal system should never be the only or primary means of obtaining needed treatment.

These basic principles yield a number of conclusions. First, policymakers should prioritize alternatives to criminal system-located mental health courts and other problem-solving courts for those who currently are brought into the system as a consequence of low-level drug offenses and other quality of life infractions.¹⁸ These alternatives include “pre-arrest diversion, health and social service interventions, and legislative change to remove these infractions from penal codes.”¹⁹ Of course, a policy that seeks to direct low risk offenders into community-based treatment must have adequate resources available outside of the criminal justice system. Unfortunately, the public treatment system has not kept pace with the growth in criminal justice referrals. This is a misallocation of valuable resources and a rebalancing is urgently needed.

Second, problem-solving courts should focus on higher risk offenders, particularly those with multiple risk factors. This may require treatment courts to refrain from excluding persons with histories of violent offending, or at the least to rework eligibility criteria so that mere possession of a weapon at the time of arrest does not work an exclusion.

Third, if they have targeted this more challenging population, these courts should offer a menu of human services that match the full range of needs these participants present with, not just their mental illness and/or substance use disorder, and should draw upon a diverse service provider network offering a range of modalities of treatment, including methadone maintenance and/or buprenorphine treatment for some clients with severe opioid use disorders.

Fourth, mental health courts and other problem-solving courts should adopt structural features designed to ameliorate or minimize the tendency of rehabilitative intentions to devolve into punitive practices. Pre-plea or pre-adjudication models should be favored over post-adjudication approaches that require participants to enter a guilty plea before entering treatment. Defense counsel should be accorded sufficient independence from the court's “treatment team” to ensure that participants' essential trial rights are safeguarded.²⁰ The use of incarceration as a response to relapse should be minimized, and judges should follow written protocols for the imposition of graduated sanctions. Drug testing should never be used as a punishment. Finally, while drug treatment courts and other problem-solving courts should increase intensity based upon risk, overall the duration of these programs should be reduced. Many participants in drug treatment courts in particular spend too long going through the program and, as a result, completion rates are often too low. Problem-solving courts, in short, should be reserved for those most likely to benefit from them, and should be designed to maximize the likelihood that participants will succeed.

18. See Edward P. Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons* 21-25 (2017) available at: <http://www.journals.uchicago.edu/doi/abs/10.1086/688461> (recommending that jurisdictions “[d]ivert seriously mentally ill individuals charged with less serious crimes out of the criminal justice system at the earliest possible stages of official processing, preferably before or in lieu of jail entry.”).

19. CSETE & TOMASINI-JOSHI, *supra* note 13, at 5.

20. See Richard C. Boldt, *Rehabilitative Punishment*, *supra* note 1, at 1286–1300.

HOMELESS, MENTAL ILLNESS & THE CRIMINAL JUSTICE SYSTEM IN DC

Prepared Written Statement
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Thank you for the opportunity to present a written statement on the intersection of homelessness, mental illness, and the criminal justice system. Below I outline an overview of the problem, how mental health courts are used to address the problem, additional solutions that may be beneficial, and my professional recommendations.

Introduction

Homelessness, mental illness, and criminal justice involvement are highly intertwined. Studies estimate that over half of people who are homeless have multiple stays in jail¹ and when studies examine people with mental illness who are homeless, this number increases substantially.² Overall, the U.S. ranks highest in the world in the number of people who are in jail or prison.³ One out of every 100 adults in the U.S. is incarcerated, a nearly seven-fold increase since the 1970s.⁴ The local jail population increased 296% from 1980 to 2015.⁵ Jails have 19 times as many annual admissions as prisons do nationally at 11,700,000 a year.⁶ Jails serve about fifteen times more people each year in the U.S. compared to prisons yet operate on much smaller per inmate budgets.⁷ Spending time in jail can create strain on families, work, treatment, and social supports. Extended jail stays increase the risk of recidivism compared to less punitive sanctions such as probation.⁸ In fact, women are impacted by even short stays in jail, creating cumulative stressors related to family caregiving, employment, and financial responsibility.⁹

¹ Gonzales, J. R., Jetelina, K. K., Roberts, M., Reitzel, L. R., Kendzor, D., Walters, S., & Businelle, M. S. (2017). Criminal justice system involvement among homeless adults. *American Journal of Criminal Justice*, 43(2), 158-166.

² Fox, Mulvey, Katz, & Shafer (2013). Untangling the relationship between mental health and homelessness among a sample of arrestees. *Crime & Delinquency*, 65(5), 592-613.

³ Sawyer, W. & Wagner, P. (2019). Mass incarceration: The whole pie 2019. Retrieved from <https://www.prisonpolicy.org/reports/pie2019.html>.

⁴ Holder, E. (2009). Attorney General Eric Holder at the Vera Institute of Justice's third annual justice address. Retrieved from <http://www.justice.gov/ag/speeches/2009/ag-speech-090709.html>.

⁵ Minton, T. D., & Zeng, Z. (2016). *Jail inmates in 2015*. Washing DC: US Dep. Of Justice.

⁶ Subramanian, R., Delaney, R., Roberts, S., Fishman, N., & McGarry, P. (2015). *Incarceration's front door: The misuse of jails in America*. Vera Institute of Justice, New York, NY: Center on Sentencing and Corrections.

⁷ Henrichson, C., Rinaldi, J., & Delaney, R. (2015). *The price of jails: Measuring the taxpayer cost of local incarceration*. Vera Institute of Justice, Center on Sentencing and Corrections.

⁸ Cochran, J. C., Mears, D. P., & Bales, W. D. (2014). Does inmate behavior affect post-release offending? Investigating the misconduct-recidivism relationship among youth and adults. *Justice Quarterly*, 31(6), 1044-1073.

⁹ Van Olpen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, & Policy*, 4(10), 1-10.

Mental Illness and Jails. One of the greatest challenges for jails is the increasing number of people who are in need of mental health and substance use services. Among jail inmates, 11%-19% of males and 22%-42% of females have serious mental illness (i.e., bipolar, schizophrenia spectrum, major depression, delusional, and psychotic disorders).¹⁰ Estimates of serious mental illness in jails is higher than the prevalence in the community.¹¹ When the definition of mental illness is broadened to include any mental health disorder in the past year, 44% of jail inmates, on average, had a mental disorder; lifetime prevalence rates reached 68% for females and 41% for males.¹² Over half of jail inmates used substances at the time of their offense¹³ and 53% of jailed females met criteria for post-traumatic stress disorder in their lifetime.¹⁴ The overrepresentation of people with mental illnesses in jails impacts smaller rural communities as well as the largest jails systems in the U.S.¹⁵ Having such high proportions of people with mental illness in jails is problematic for the individual, family, jail staff, and community.

Incarceration Negatively Impacts People with Mental Illness. People with mental illness can have difficulty adjusting to incarceration, which can worsen symptoms.¹⁶ This may result from the stress of the environment; interrupted, poor, or no treatment; stigma; or a combination of factors.¹⁷ People with mental illness are at heightened risk of victimization,¹⁸ suicide,¹⁹ and being sent to segregation.²⁰ People with mental illness who are in contact with the criminal justice system are at risk of cycling in and out of the system with low-level felonies and probation revocation for technical violations.²¹ However, people with mental illness on probation are equally likely to be rearrested for a new crime but significantly more likely to violate the terms of probation.²² They also face higher risk of re-incarceration and homelessness following criminal justice contact compared to people without mental illness,²³ a risk that is magnified when there are co-occurring substance use problems.²⁴ Following incarceration, people with mental illness are at a high risk of homelessness. One study found

¹⁰ Steadman, J. H., Osher, C. F., Robbins, C. P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761-765.

¹¹ Teplin, A. L., Abram, M. K., & McClelland, M. G. (1996). Prevalence of psychiatric disorders among incarcerated women: I. Pretrial jail detainees. *JAMA Psychiatry, 53*(6), 505-512; Teplin, A. L. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the Epidemiologic Catchment Area Program. *American Journal of Public Health, 80*(6), 663-669.

¹² Bronson, J., & Berzofsky, M. (2015). *Indicators of mental health problems reported by prisoners and jail inmates, 2011-12*. Washington, DC: U.S. Department of Justice.

¹³ Ditton, P. (1999). Mental health and treatment of inmates and probationers. *Bureau of Justice Special Report, NCJ 174463*.

¹⁴ Lynch, S. M., Dehart, D. D., Belknap, J. E., Green, B. L., Dass-Brailsford, P., Johnson, K. A., & Whalley, E. (2014). A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. *Psychiatric Services, 65*(5), 670-4.

¹⁵ Raggio, A. L., Hoffmann, N. G., & Kopak, A. M. (2017). Results from a comprehensive assessment of behavioral health problems among rural jail inmates. *Journal of Offender Rehabilitation, 56*(3), 217-235.

¹⁶ Morgan, D. W., Edwards, A. C., & Faulkner L. R. (1993). The adaptation to prison by individuals with schizophrenia. *Bulletin of American Academy of Psychiatry & the Law, 21*(4), 427-433.

¹⁷ Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821; Human Rights Watch. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York, NY: Human Rights Watch; Fellner, J. (2006). A correction quandary: Mental illness and prison rules. *Harvard Civil Rights-Civil Liberties Law Review, 41*, 391-412.

¹⁸ Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law & Psychiatry, 31*, 385-393; Dumond, R. W. (2000). Inmate sexual assault: The plague that persists. *The Prison Journal, 80*(4), 407-414; Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services, 58*, 1087-1094.

¹⁹ Choi, N. G., DiNitto, D. M., & Marti, C. N. (2019). Suicide decedents in correctional settings: Mental health treatment for suicidal ideation, plans, and/or attempts. *Journal of Correctional Health Care, 25*(1), 70-83; Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*(1), 103-109.

²⁰ Fellner, J. (2006). A correction quandary: Mental illness and prison rules. *Harvard Civil Rights-Civil Liberties Law Review, 41*, 391-412.

²¹ Lamb, R., & Weinberger, E. L. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry, 33*, 529-34; Lurigio, A., Rollins, A., & Fallon, J. (2004). The effect of serious mental illness on offender reentry. *Federal Probation, 68*(2), 45-52; Skeem, L. J., & Loudon, E. J. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services, 57*(3), 333-342.

²² Skeem, L. J., Manchak, S., Peterson, K. J. (2010). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law & Human Behavior, 35*(2), 110-126.

²³ Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*(1), 103-109.

²⁴ Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15*(1), 84-99.

that substance use, in fact, mediated the relationship between mental illness and homelessness (i.e., substance use explained the relationship between these variables).²⁵

Jails and Prisons are Not Rehabilitation Facilities. There is a great need for people in jails to receive services, but only about one-third receive treatment.²⁶ Services are often minimal, with only medication administration and infrequent visits from medical professionals. Psychotropic medications²⁷ and access to mental health professionals are limited.²⁸ Mental health status is not clinically monitored throughout the jail stay in most facilities, so changes in status are often missed. People in need of services can go unnoticed, particularly when experiencing internalizing symptoms (e.g., suicidal ideation).²⁹ Correctional officers report they do not have adequate training regarding general mental illness knowledge, lack expertise in identifying symptoms, and under-refer people to services.³⁰ Correctional officers are trained to maintain safety by using command and control techniques, which do not work well with people in crisis. Rather than taking control, situations can escalate and increase risk of injury.³¹ U.S. jails are not equipped to manage the needs of people with mental illness yet people with mental illness can become stuck in jails while waiting for pre-trial services.³² Unmet mental health needs in jail impacts people during incarceration and back in the community.

Incarceration is Costly. Incarceration is expensive—to counties, families, and individuals. Counties are responsible for most of the costs of running the jail. Communities spent approximately \$22.2 billion on jails in 2011, four times more than 1983.³³ Many counties face overcrowding issues, requiring that they house some people out of the county or manage more people with less staff.³⁴ A survey conducted in 2018 estimates that 45% of Americans report incarceration among immediate family members with estimates increasing among Black families (63%).³⁵ Families may experience financial burden due to the cost of visitation,³⁶ psychological distress and poor quality of life,³⁷ and an impact on household assets.³⁸ The financial and emotional struggles persist beyond periods of incarceration and impact families even while people are under community supervision.³⁹ Financial

²⁵ Fox, Mulvey, Katz, & Shafer (2013). Untangling the relationship between mental health and homelessness among a sample of arrestees. *Crime & Delinquency*, 65(5), 592-613.

²⁶ Bernstein, R., & Seltzer, T. (2003). Criminalization of people with mental illnesses: The role of mental health courts in system reform. *University of the District of Columbia Law Review*, 7(1), 143-162.

²⁷ Appelbaum, K. L. (2009). Attention deficit hyperactivity disorder in prison: A treatment protocol. *Journal of American Academy of Psychiatry & the Law*, 37, 45-9.

²⁸ Dvoskin, J. A., & Spiers, E. M. (2004). On the role of correctional officers in prison mental health. *Psychiatric Quarterly*, 75(1), 41-59.

²⁹ Human Rights Watch. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York, NY: Human Rights Watch.

³⁰ CHPPR [Center for Health Policy, Planning, and Research] (2007). Crisis intervention team (CIT) training for correctional officers. Portland, ME: University of New England; Human Rights Watch. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York, NY: Human Rights Watch.

³¹ Adams, K. (1986). The disciplinary experiences of mentally disorder inmates. *Criminal Justice & Behavior*, 13(3), 297-316; CHPPR [Center for Health Policy, Planning, and Research] (2007). Crisis intervention team (CIT) training for correctional officers. Portland, ME: University of New England.

³² Fisher, H. W., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health Services Research*, 33(5), 533-557.

³³ Henrichson, C., Rinaldi, J., & Delaney, R. (2015). *The price of jails: Measuring the taxpayer cost of local incarceration*. Vera Institute of Justice, Center on Sentencing and Corrections.

³⁴ Boone County (2016). *Statistics and reports*. Retrieved from <https://www.boonecountymtmo.org/sheriff/statistics.aspx>.

³⁵ Enns, P. K., Yi, Y., Comfort, M., Goldman, A. W., Lee, H., Muller, C., Wakefield, S., Wang, A. E., & Wildeman, C. (2019). What percentage of Americans have ever had a family member incarcerated?: Evidence from the family history of incarceration survey (FamHIS). *Socius: Sociological Research for a Dynamic World*, 5, 1-45.

³⁶ Christian, J. (2005). Riding the bus: Barriers to prison visitation and family management strategies. *Journal of Contemporary Criminal Justice*, 21(1), 31-48.

³⁷ Wildeman, C., Goldman, A. W., & Lee, H. (2019). Health consequences of family member incarceration for adults in the household. *Public Health Reports*, 134(supplement 1), 15S-21S.

³⁸ Turney, K., & Schneider, D. (2016). Incarceration and household asset ownership. *Demography*, 53(6), 2075-2103. <https://doi.org/10.1007/s13524-016-0519-1>.

³⁹ Comfort, M. (2016). "A twenty-hour-a-day job": The impact of frequent low-level criminal justice involvement on family life. *The Annals of the American Academy*, 665, 63-79.

burden from fines and fees when people exit jail and prison compound existing poverty experienced by a large portion of people in custody.⁴⁰

Preventing Recidivism

The best way to reduce the negative impacts of incarceration for people with mental illness is to prevent or divert them from entering/reentering the system. The sequential intercept model⁴¹ points to five intercepts for intervention to divert, reduce further movement into the system, and prevent recidivism for people with mental illness. The five intercepts include law enforcement, initial detention and court hearing, jails and courts, re-entry from jail and prison, and community corrections. Early diversion efforts aimed to prevent people with mental illness from entering the criminal justice system, referred by some as intercept zero,⁴² begins with high quality and rapidly available behavioral health and substance use treatment as well as social services to collectively address mental illness, substance abuse, and criminogenic risks. SAMHSA (2019)⁴³ identified seven guiding principles for community-based practice for justice-involved people to prevent recidivism. These principles include: (1) cross-training behavioral health and criminal justice professionals; (2) collaboration; (3) use of evidence-based and promising practices; (4) criminogenic risks and needs integrated into treatment plans; (5) integrated physical and behavioral health care; (6) trauma-informed practice and policies; (7) case management involving treatment, support, and social services; and (8) strategies to recognize and address systemic and structural bias.

Intercept One. Several promising practices are available to divert people with mental illness when they have police contact. Two prominent models are crisis intervention teams (CIT) and co-responder models. **CIT** involves two core components – specialized, 40-hr training on responding to mental health crisis and partnerships between police and community mental health stakeholders (e.g., providers, consumers, families, emergency services).⁴⁴ Based on nearly two decades of research on CIT,⁴⁵ CIT's impact on arrest has a medium effect size in some jurisdictions but no effect in others; across studies, CIT reduces officer stigma and increases service connection. **Co-responder models** involve a police officer and behavioral health expert jointly responding to calls involving mental health crises.⁴⁶ The evidence base for co-responders models is still developing, with a recent systematic review finding no randomized trials, yet some evidence for reductions in arrest and hospitalizations using quasi-experimental designs.⁴⁷

Intercept Two/Three. Diversion from arrest is not always possible or appropriate. With the use of evidence-based screening tools, people with MI can be identified upon initial detention for in-

⁴⁰ Eisen, L. B. (2015). Charging inmate perpetuates mass incarceration. Retrieved from http://www.brennancenter.org/sites/default/files/publications/Charging_Inmates_Mass_Incarceration.pdf.

⁴¹ Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544-9.

⁴² Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Chase, B. Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law, 35*(5-6), 380-395.

⁴³ SAMHSA (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy, Planning, and Innovation.

⁴⁴ Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: A primer for mental health practitioners. *Best Practices in Mental Health, 8*(2), 71.

⁴⁵ Wood, J. D., & Watson, A. C. (2017). Improving police interventions during mental health-related encounters: Past, present and future. *Policing & Society, 27*, 289-299. doi:10.1080/10439463.2016.1219734.

⁴⁶ Morabito, M. S., Savage, J., Sneider, L., & Wallace, K. (2018) Police response to people with mental illnesses in a major U.S. city: The Boston experience with the co-responder model. *Victims & Offenders, 13*(8), 1093-1105, DOI: [10.1080/15564886.2018.1514340](https://doi.org/10.1080/15564886.2018.1514340).

⁴⁷ Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E., & Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry, 18*(256), 1-11.

house services or treatment court.⁴⁸ Treatment courts engage people in intensive, community-based services while diverting them from prison. Mental health courts (MHC) are an example of one type of treatment court for people with mental illness. MHC involves interdisciplinary collaboration from criminal justice and mental health providers. Participants are linked with treatment and services while reporting to the courts on a regular basis.⁴⁹ Complex interventions like MHCs are typically lumped together in research and treated as a single program or intervention.⁵⁰ When the component parts of those programs and interventions are the same, data can be synthesized; however, when component parts vary across programs, it complicates the ability to compare across programs and to summarize findings. Further, when a program may actually work differently for subpopulations, it is important to attend to those subpopulations in order to determine differential impacts. MHC research is challenged by the inability to randomize. However, quasi-experimental studies do find MHCs reduce recidivism for the people who select into the program, although this medium to small effect may differ based on key variations in MHC programming (e.g., pre- vs. post-adjudication). Reductions in recidivism were found even among one of the highest risk groups, people with mental illness and co-occurring substance use.⁵¹ MHC participation has also been associated with reductions in homelessness⁵² following court participation. The specific mechanisms or components of MHC that contribute to positive outcomes are still being explored. A burgeoning body of research suggests perceptions of procedural justice,⁵³ therapeutic jurisprudence,⁵⁴ and making positive life changes⁵⁵ may, in part, account for MHC successes. From MHC participant perspectives, support from the MHC staff, structure and accountability, access to treatment and services, and promoting motivation to change are key components to improved mental health and reduced criminal justice contact.⁵⁶

Intercept Four. People are the most vulnerable to recidivate during the year following release. People who use substances relapse more frequently during the first few months.⁵⁷ Women, in particular, experience distress following release due to disrupted family situations, child care, mental health, substance use, housing, and employment. Women reported they experienced stigma and social isolation upon return.⁵⁸ Needs at the time of re-entry may include simple tasks like contacting probation officers to more complex tasks like obtaining food and housing. Completing these tasks can be difficult for people who are in crisis or struggling with symptoms,⁵⁹ which can contribute to

⁴⁸ Gonzales, A. R., Schofield, R. B., & Hagy, D. W. (2007). Mental health screens for corrections. NCJ Publication number 216152. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>.

⁴⁹ Redlich, A. D., Steadman, H. J., Monahan, J., Petrila, J., & Griffin, P. A. (2005). The second generation of mental health courts. *Psychology, Public Policy, and Law*, 11(4), 527-538.

⁵⁰ Canada, K. E., Barrenger, S. L., & Ray, B. (2019). Bridging mental health and criminal justice systems: A systematic review of the impact of mental health courts on individuals and communities. *Psychology, Public Policy, & Law*, 25(2), 73-91.

⁵¹ Gallagher, A. E., Anestis, J. C., Gottfried, E. D., & Carbonell, J. L. (2018). The effectiveness of a mental health court in reducing recidivism in individuals with severe mental illness and comorbid substance use disorder. *Psychological Injury & Law*, 11(2), 184-197.

⁵² Gonzales, L. & McNeil, D. E. (2018). Can reduced homelessness help explain public safety benefits of mental health court? *Psychology, Public Policy, & Law*, 24(2), 271-278.

⁵³ Dollar, C. B., Ray, B., Hudson, M. K., & Hood, B. J. (2018). Examining changes in procedural justice and their influence on problem-solving court outcomes. *Behavioral Sciences & the Law*, 36(1), 32-45.

⁵⁴ Redlich, A. D. & Han, W. (2014). Examining the links between therapeutic jurisprudence and mental health court completion. *Law & Human Behavior*, 38(2), 109-118.

⁵⁵ Han, W. (2019). Life changes matter more than satisfaction or sanctions/incentives: An examination of mental health court experience factors associated with arrest. *International Journal of Forensic Mental Health*.

⁵⁶ Canada, K. E. & Gunn, A. J. (2013). What factors work in mental health court? A consumer perspective. *Journal of Offender Rehabilitation*, 52, 311-337.

⁵⁷ Belenko, S., Langley, S., Crimmins, S., & Chaple, M. (2004). HIV risk behaviors, knowledge, and prevention among offenders under community supervision: A hidden risk group. *AIDS Education & Prevention*, 16, 367-385.

⁵⁸ Van Olpen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, & Policy*, 4(10), 1-10.

⁵⁹ Angell, B., Matthews, E., Barrenger, S., Watson, A. C., & Draine, J. (2014). Engagement processes in model programs for community reentry from prison for people with serious mental illness. *International Journal of Law & Psychiatry*, 37(5), 490-500.

recidivism and technical violations.⁶⁰ Mental health and substance use interventions for people with mental illness are needed upon release from jail. SAMHSA (2019) identified assertive community treatment (ACT) and critical time intervention (CTI) as evidence-based practices for people with mental illness involved in the justice system. Case management services impact recidivism rates.⁶¹ When people do not have social support systems or treatment access outside of jail, reentry programs are particularly important in bridging or connecting people to services.

ACT involves a multidisciplinary team providing treatments to people in the community. Caseloads are small and teams are available for as long as services are needed. ACT participation, compared to traditional case management, is more effective in reducing homelessness and symptoms across randomized trials but not in reducing hospitalizations.⁶² A less studied adaptation of ACT, forensic assertive community treatment (FACT), is promising for justice-involved people with MI. FACT teams include providers, probation officers, and peer specialists. Collaboration between criminal justice and mental health systems and using trauma-informed care are key. FACT participants had fewer new crime convictions and less time in jail and hospitals compared to controls.⁶³ **CTI** is a time-limited, phased case management model involving linkage to services and supports through skill building, coaching, support, and advocacy. Across studies, CTI participants experience less homelessness, fewer hospitalizations, symptom reductions, and improved continuity of care.⁶⁴ Other evidence-based services following release include integrated mental and physical health services, supported employment, permanent supportive housing, and pharmacotherapy.⁶⁵

Intercept Five. Finally, one strategy used in community corrections to reduce recidivism is specialized mental health caseloads, which involves probation or parole officers having a smaller caseload with only people with serious mental illness. Officers have training on mental illness and de-escalation, help link people with needed services, and offer extra time to assist people in addressing barriers to successful supervision.⁶⁶ This population is at a higher risk of recidivism;⁶⁷ specialized probation can reduce this risk.⁶⁸

Recommendations

Each intercept has mounting evidence for, at minimum, promising practices. Given the risks that people with mental illness face once they enter jails and prisons, interventions like MHCs are essential to diverting people from incarceration and providing access to community-based treatment

⁶⁰ White, D. M., Saunders, J., Fisher, C., & Mellow, J. (2012). Exploring inmate reentry in a local jail setting: Implications for outreach, service use, and recidivism. *Crime & Delinquency*, 58(1), 124-146.

⁶¹ Miller, J. M., Miller, H. V., & Barnes, J. C. (2019). Treating co-occurring disorders in jails: Outcome findings from a Second Chance Act offender reentry program. *Crime & Delinquency*, 65(5), 583-605. <https://doi.org/10.1177/0011128718789860>.

⁶² Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry*, 164, 393-399.

⁶³ Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T.,...Caine, E. D. (2017). A randomized controlled trial of the Rochester forensic assertive community treatment model. *Psychiatric Services*, 68(1), 1016-1024.

⁶⁴ Herman, D. B., & Mandiberg, J. M. (2010). Critical time intervention: Model description and implications for the significance of timing in social work interventions. *Research on Social Work Practice*, 20(5), 502-508.

⁶⁵ SAMHSA (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy, Planning, and Innovation.

⁶⁶ Lurigio, A., Epperson, M., Canada, K. E., & Babchuk, L. (2012). Specialized probation programs for people with mental illnesses: A review of practice and research. *Journal of Crime and Justice*, 35(2), 317-326.

⁶⁷ Skeem, L. J., Manchak, S., Peterson, K. J. (2010). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law & Human Behavior*, 35(2), 110-126.

⁶⁸ Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry*, 74(9), 942-948. doi:10.1001/jamapsychiatry.2017.1384.

and services. Jails and prisons were not created to provide clinical services yet they are currently some of the U.S.'s largest providers of mental health treatments. People with mental illnesses are best served in community settings with an **integrated team of licensed clinicians and service providers who are resourced to serve all people in need of services**. Access to Master's or Doctoral-level mental health professionals in the community is an essential component of care. These professionals must be cross-trained to understand criminogenic risk factors and utilize evidence-based practices to address these risks at the same time mental illness and substance use are treated. Without adequate food, housing, and safety, reaching treatment goals is near impossible. For those people who cannot be diverted from jails and prison through interventions noted above, access to quality mental health treatment while in custody and bridging services at discharge are critical to successful community re-entry.

A barrier many communities face, especially those states that did not expand Medicaid, is a lack of access to quality services to treat mental illness and substance use. **Treatment and social services must be adequately resourced**. People with mental illness are waiting months before they can see an individual therapist and psychiatrist; given a high proportion of people with mental illness in the criminal justice system are impoverished, they also face financial barriers to accessing medications. **Access to services also includes investment in our future and current workforce**. This includes education for the future workforce of social workers, psychologists, advanced practicing nurses, and psychiatrists and ongoing professional development of the existing workforce. Some communities face a shortage of psychiatrists while others have no licensed mental health professionals. Access to services includes an investment in ensuring we have properly trained professionals to carry out services—both in the community and within institutions. MHCs who partner with private agencies to serve court participants may have more flexibility to meet the needs of a justice-involved population by staffing agencies with professionals who are trained to serve this population and have the skill set to deliver evidence-based treatments to them. One critical component of working with partner agencies is setting up processes and policies to share information, with a patient's consent, to the team and provide opportunity for the MHC team to assist in developing integrated treatment plans. At the same time, communities must also have adequate resources for safe housing, community engagement, and food and nutrition.

State and local funding play an important role in research and evaluation of MHCs. Strong national and state organizations exist for other treatment courts but the same structures has not been developed for MHCs. For example, in Missouri, the Office of State Courts Administrator collects data from all treatment courts except MHCs. This makes state-level data on MHCs difficult to access because it is housed at the county-level. **Providing support to promote and fund MHCs at the local and state level would allow for additional research and evaluation to be conducted on MHCs and provide counties with the resources to develop sustainable MHCs**.

Finally, given the emergent evidence on procedural justice as a mechanism for promoting positive outcomes among MHC participants, trainings to support judges in learning strategies (e.g.,

reflective listening) and implementing processes to promote transparency in decision-making can be utilized to enhance perceptions of procedural justice among MHC participants.⁶⁹

In closing, given the current evidence from research and my professional practice, with adequate community resources (e.g., effective physical, mental health, substance use treatment including medication; stable and safe housing; access to food; vocational training and placement) and successful diversion programs (e.g., CIT or co-responder models), fewer homeless people with mental health issues would end up in jails and prisons. MHCs provide a “carrot” or external motivation to keep people working towards their goals despite the side effects and symptoms of mental illness (e.g., extreme fatigue, confusion, lack of motivation). These symptoms create barriers for people that get in the way of treatment adherence and use of services but the MHC team provides that safety net to help people get back on track. Without the safety net, people may not have a support system in place when their symptoms get the best of them, which may result in emergency or crisis services, relapse of substance use, contact with police, probation violations, and suicide. Finding ways to provide a safety net for people in the community is critical to prevent criminal justice contact altogether. I want to thank the Committee for this opportunity to present these pressing issues.

⁶⁹ Canada, K. E. & Watson, A. C. (2013). “Cause everybody likes to be treated good:” Perceptions of procedural justice among mental health court participants. *American Behavioral Scientist*, 57(2), 209-230.



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Prepared Written Statement of David Freeman

for the

District of Columbia Advisory Committee to the US Commission on Civil Rights
 Public Briefing: Mental Health, Mental Health Courts and the Criminal Justice System

My name is David Freeman and I am a psychologist and the Chief Clinical Officer at Community Connections in Washington DC. Community Connections is a multifaceted behavioral health agency with a comprehensive array of services. We serve people of all ages and from all wards in the city. Almost all our clients have Medicaid.

When Community Connections opened in 1984, we focused primarily on mental health and housing. Over our history we have expanded our scope of practice, first with substance use and dual diagnosis services, then homeless outreach, employment supports, trauma recovery, age specific services, and in 2000, dedicated services for the justice involved population. We provide aggressive community outreach, clinical case management, therapy, psychiatric service, and housing supports with better than 50% of our services delivered in the field. We “Think Clinically and Act Practically” as we work toward helping people develop more productive and satisfying lives in the community.

Starting in 2000 we developed a series of programs for justice involved people with co-occurring disorders. Foremost among these was our Options Program. Options, a pre-trial diversion program that enrolled people who suffered from co-occurring behavioral health problems, was predicated on the hypothesis that an arrest could serve as a turning point in a person’s life if they were provided with the right, time sensitive supports. Seeded with funds from a Pre-trial Diversion court-based work group, Options was eventually funded by both the DC Department of Behavioral Health and SAMHSA, a federal agency that provided crucial support for behavioral health services and program evaluation.

We called the Options service package Forensic Intensive Case Management (FICM). FICM was a comprehensive, assertive case management package of wrap around services that emphasized coordination of care with the criminal justice system. FICM blended the leverage of justice involvement with Motivational Interviewing, a well-known evidence-based practice that highlights person centered care. With the support of SAMHSA funding we developed a Fidelity Tool for FICM and measured our adherence to the designed practice on a regular basis.

Our evaluation partner was Policy Research Associates in New York. Over a five-year Period, PRA gathered data through client and clinician interviews and court records. At intake, enrolled participants described this problem profile: 100% had a mental health disorder with 70% suffering from an affective disorder (depression or bipolar disorder) and 30% from schizophrenia; 95% had a lifetime history of physical and or sexual abuse and 50% reported traumatic

experience in the year prior to arrest; 80% had a co-occurring substance use problem; 75% had a history of residential substance abuse treatment and 60% had a history of psychiatric hospitalization. Reflecting the active institutional presence in the lives of participant, there was an average of six inpatient psychiatric or residential substance abuse experiences by the time people were 35 years old. 50% were street or shelter homeless in the six months prior to enrollment and housing instability was almost universal in the six months prior to enrollment: even people who stayed out of shelters and off the streets had an average of 5 unique residences in this six month period.

By almost all measures, the program was wildly successful. 95% of participants improved or stabilized housing. Arrests in six months prior vs six months post intervention were reduced by 60%. Mental health functioning improved, and substance use was reduced.

As we immersed ourselves in the lives and the criminal justice obligations of 250 Options participants, we learned a great deal about the intersection of the behavioral health and criminal justice systems. Each system has a culture of its own with distinct values, languages, funding mechanisms, and expertise. To be effective, the Community Connections staff had to develop what Hank Steadman from PRA calls “criminal justice savvy”. We needed to learn what information the court deemed relevant and how to deal with the fire and brimstone judges. We needed to respond to unrealistic – but rational - judicial expectations of our staff. We needed to learn how to get into the jails and how to find a probation officer. We needed to learn the language of the court, and the justice system. Before we learned all this, the outcome of routine meetings was often stressful and disturbing, probably on both sides.

Meanwhile, prior to Options, clients did not disclose their criminal justice involvement, perhaps because of shame or fear of stigmatization and discrimination. Before Options, clients would go missing for 3-6 weeks and we would have no idea where they went or how to find them when in fact they had been incarcerated. We would receive subpoenas that staff would try to dodge because they were too afraid to go to court. When we did go to court we would often sit in the back, unrecognized, and under-utilized.

The Options program changed all that, and the systems change was radically accelerated with the formation of the Mental Health Community Court.

Instead of 15 judges we could now get to know one. Instead of a fairly random experience in the courtroom, we had regular team meetings with judges, sharing knowledge about how resources were accessed, how defendants could better get what they needed, and how we could correct misinformation that came into the court room. There was still tension between the justice and behavioral health systems, but the tension was productive. MHCC judges acted as advocates for the best possible care, expecting follow up on agency’s clinical promises, tracking the process of application for resources available in other city departments, leveraging the courts authority to push clients into a more genuinely collaborative posture. At one point, Community Connections was the service provider for 50% of clients in the Mental Health Community Court and we had a cohort of staff who had developed the necessary “criminal justice savvy”.

So, there were positive client outcomes and positive program outcomes as well. Crucially, Options provided us with the essential funding needed to cover services that are not otherwise billable. In a fee for service environment, which is still the source of funding for most Medicaid recipients, much required work is not reimbursable. Transporting clients to court, an essential activity in many cases, is not financially supported, time spent in court while waiting for a case to be called is not billable, any kind of written court reports are completed pro bono,

meetings with judges and stakeholders is unfunded. Options gave us just enough money to cover these costs. By describing a successful program, I hope to have provided a model of how we can create positive outcomes at the interface of the criminal justice and the behavioral health system. About five years ago, the Department of Behavioral Health decided to re-distribute Options funding so that all agencies could use the resource. This was a good idea in theory, but the mechanism for accessing the money was never articulated and in practice the money dried up all together. Funding for Options was effectively discontinued. Behavioral health agencies operate on a thin margin and we have to limit ourselves too services that are funded: without dedicated funds, projects wither.

After Options dissolved, we developed several other successful, but smaller and more specifically targeted programs at the interface of Justice and Behavioral Health. For example, we have two Forensic ACT teams which have had special training in justice system procedures. We have a Re-Entry Team funded by the Office of Victim Services and Justice grants. We have contracts with CSOSA to provide substance abuse services and with Bureau of Prisons to provide therapy for halfway house residents. None of these projects, however, fund the non-billable time that Options supported.

I am Andre Gray, a returning citizen from the federal prison system. I am also a former client and now employee at Disability Rights DC's DC Jail and Prison Advocacy Project at University Legal Services (DRDC) where I work as a Peer Navigator.

We are in need of a major investment into services and supports for people with mental health disorders to prevent them from getting involved in the criminal justice system and to help those already involved in the system to successfully return to the community. So many of the people I have worked with as a peer navigator do not fit the eligibility for the District of Columbia's Mental Health Community Court (MHCC) because they have charges that disqualify them or are dealing with technical violations of parole, probation or supervised release.

Recently I worked with a client that was involved in an argument with the driver of a van that transports people to homeless shelters. The client experiences difficulty interacting with others as a result of his mental health symptoms. He asked a simple question about where the van usually stops and felt provoked by a driver who didn't want to answer, leading to a verbal altercation. The driver called the police and the client decided to stay to explain what had happened. The client ended up being arrested on the spot and charged with attempted threats. Even the bus driver was surprised about the arrest. She thought the call would scare him off or that the police would just give him a talking to. The new charge violated his supervised release and he is now serving a 12-month sentence. Because of his criminal history, he was not eligible for mental health court. It was clear to me that the client needs mental health treatment and supports and could have benefited from a treatment court approach.

I grew up in this city and was a special education student. I had no knowledge of the legal system. My only survival was based on the information I learned from the streets and the

people and things I received from it. That's how I ended up in prison. After spending almost 20 years incarcerated, I've gone through reentry myself, so I know what someone needs when they're coming back to DC and they need to take care of their mental health and trauma, as well as the basics-housing, income, insurance, healthcare, and reuniting with family. DRDC made contact with me by letter while I was still incarcerated. It took several letters for me to realize that maybe they were serious about working with me. They worked with me to put together a reentry plan, picked me up at the Greyhound station when I arrived, and helped me get settled in a work bed program at a shelter. DRDC made sure I was connected to mental and physical health providers and helped me take care of things like getting an ID, clothes, and working on more permanent housing. Eventually, I got my own apartment, where I still live and take care of my two young adult sons with disabilities.

Now, I work with people like me, who are in need of mental health services and are returning to the community from the jail and prison. Currently, I'm working with a woman who has an intellectual disability and several chronic medical issues. When I first met her, she had been released from jail on a parole violation. She had housing from a woman she met who seemed to want to help her. Soon after her release from jail she picked up a minor charge and became involved in the MHCC. While she was still involved with MHCC, the housing she had fell through when the person she was staying with realized she wasn't going to get a disability check right away. This is common. People with psychiatric disabilities are particularly vulnerable to exploitation: those who are also returning citizens are even more vulnerable. Landlords, employers and family members know they can take advantage because the person needs the job or needs that apartment in order to stay in compliance with supervision. All it would take is

a call to the police or their community supervision officer to get them sent back to the jail.

When she was thrown out of the apartment, this client ended up living in a box. She was assaulted at least once during this time.

Too many mental health providers are failing at helping their clients with housing and other reentry services they need. At the Jail and Prison Advocacy Project, we try to get the mental health providers to help with housing, which they are supposed to do, but when they don't, we step in. No one is holding the mental health providers accountable for assisting their clients with housing. Even if they were, there's still not enough safe and affordable housing to go around. Right now, too many people leave the jail and the Federal Bureau of Prisons homeless or with only temporary, unstable housing plans. Even the most vulnerable people, who have long histories of homelessness, cannot be awarded a voucher while they are in the jail and cannot go straight into most transitional housing programs. This means people with psychiatric disabilities are forced to leave the jail or prison and be homeless before they will even be considered for housing. That's a recipe for re-incarceration if ever there was one. This is a policy decision by that could and should be changed. The MHCC could also be doing more to make sure people have stable housing. Stable housing is key to people having stability to get treatment, find a job if they are able to work, and to staying off the streets where they can come into contact with police on a regular basis.

Mental health courts offer an opportunity for people with serious mental illness to engage in treatment, connect with a provider and get the support they need to change their trajectory. However, the eligibility criteria excludes individuals who could benefit the most. The

MHCC needs to be expanded to include people who have been charged with a wider range of offenses in order to best serve the community and the residents of the District.

The kinds of services and supports that make returning citizens with mental illness successful should be available to anyone regardless of whether they go through the MHCC or traditional court. Through my twice daily visits with the woman living in a box, I was able to build trust and convince this client to first try a residential program for people with mental illness and substance use disorders. While there, she experienced complications of one of her medical conditions and was terminated from the program-leaving her homeless again. This is also a common experience in DC for people with both mental health and physical health problems. I was able to convince her to take up housing in a shelter as we attempt to help manage to get her into better housing situation. Both her mental health and physical health are more stable now that she is living at the shelter. This comes from creating a relationship over time that allows the client to trust the help that I am offering. Trust is not easy for individuals who already have issues from childhood trauma or other life traumas. Most individuals-over 90%--who have been incarcerated have experienced significant trauma in their lifetime. This is 100% for people with serious mental illness who have been incarcerated. Taking the time to build a trusting relationship is critical to their success.

Based on my own experience and the experiences of the people I work with, I know what works-a trusting relationship with an advocate or case manager; treatment for mental and physical health; help navigating the bureaucracy to get important documents and other essential services, including help with transportation; help with job training, employment, or applying for disability benefits; and a stable housing situation. The MHCC should offer all of

these services, but these services should not be limited to the MHCC. If DC is to reduce homelessness among this population, these services and supports must be available to everyone, regardless of whether they go through the MHCC or a traditional court or the US Parole Commission. And policies regarding homeless people need to change to so that people with a long history of homelessness don't have to leave jail or prison homeless in order to receive any kind of housing support.

Thank you for your time.

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Prepared Written Statement on Mental Health Courts, Mental Illness, and the Criminal Justice System

My name is Lea Johnston. I am a Professor of Law at the University of Florida Levin College of Law. I specialize in the intersection of mental health and criminal law and procedure. The views I express in this testimony are my own and do not represent any official position of the University of Florida.

I wish to thank Chairman John Malcom and the other Members of the D.C. State Advisory Committee of the U.S. Commission on Civil Rights for the opportunity to discuss the relationship between mental illness and crime, the efficacy of mental health courts (MHC), the adequacy of due process safeguards for persons referred to MHCs, and possible ways to improve MHCs in general and in the District of Columbia in particular. While I am not able to fully discuss all of these matters in my testimony, I will touch on each of them and provide footnotes to published articles and books expanding on specific points.

I have spent the last eight years studying MHCs and the relationship of mental illness to criminal behavior.¹ My years of study lead me to believe that, if the Committee seeks to address the mental health needs of the D.C. community, investing in MHCs is not the answer. MHCs are resource-intensive, serve few people, tend to have high termination rates, may be net-widening (meaning they widen the net of social control over offenders who would not otherwise have been processed by the criminal justice system), and may exact more punitive sentences than the traditional justice system. They are also founded on the erroneous and scientifically unsound notion that mental illness is a significant, direct contributor to criminal activity. By generating anecdotes of successful intervention, these courts allow stakeholders to paper over two serious problems—unmet mental health needs in the community, and mental illness in the criminal justice system—and avoid deeper investment and structural change. Finally—particularly in areas like D.C. where “access to

¹ I have written three articles relevant to the Committee’s current business: E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519 (2012); E. Lea Johnston & Conor P. Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685 (2017); and E. Lea Johnston, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*, 71 FLA. L. REV. 515 (2019). I would be happy to make these articles available to the Committee upon request.

mental health care has been described as ‘almost impossible’²—they may incentivize arrests and the commission of criminal behavior to obtain scarce mental health resources.

Indeed, in my opinion, the premise of this hearing—that MHCs may supply a plausible means to address mental illness in the community or in the criminal justice system—is problematic. First, it ignores problems of scale. For instance, an estimated 20% of jail inmates have a serious mental illness.³ Thus, if 2,000 inmates are housed in jail facilities in the District of Columbia,⁴ approximately 400 of them have a serious mental illness. There are too few MHCs—a costly and resource-intensive innovation⁵—to help the vast majority of these individuals, much less the entire population with a serious mental illness in the District. I do not have annual enrollment figures for the D.C. Mental Health Community Court (MHCC), but, according to recent GAINS Center data, the average MHC enrolls around 30 people per year.⁶ Thus, MHCs can only provide treatment for a tiny segment of the target population.

Second, the premise that MHCs—a specialized criminal docket—may supply a possible means to address mental illness assumes that the most efficient way to address

² Memorandum from Ivy L. Davis to Mauro Morales 1 (Feb. 12, 2018) (on file with author) (quoting a 2016 American Psychological Association report).

³ E. FULLER TORREY ET AL., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 24, 26 (2014). Cf. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 764 (2009) (estimating that roughly 14.5% of male jail inmates and as many as 31.0% of female jail inmates suffer from one or more serious mental illnesses, such as schizophrenia, bipolar disorder, and major depressive disorder). These rates are two to three times higher than those of the general population. See Nahama Bromer et al., *Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study*, 22 BEHAV. SCI. & L. 519, 519 (2004).

⁴ Prison Policy Initiative, District of Columbia Profile, available at <https://www.prisonpolicy.org/profiles/DC.html>.

⁵ See Henry J. Steadman et al., *Criminal Justice and Behavioral Health Care Costs of Mental Health Court Participants: A Six-Year Study*, 65 PSYCHIATRIC SERVS. 1100 (2014) (finding, in a study of cost data for 296 MHC participants and 386 matched jail detainees for three years after a target arrest, that total annual costs for MHC participants averaged \$4,000 more for all three follow-up years due to high treatment costs that were not offset by criminal justice system savings). *But see* M. SUSAN RIDGELY ET AL., RAND CORP., JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MHC 19–20, 26 (2007), https://www.rand.org/pubs/technical_reports/TR439.html (finding, in an analysis of 66 MHC participants over two years, that the “average annual costs are \$9,584 lower” per participant than the costs predicted if the participants had stayed in the traditional criminal justice system); Sheryl Kubiak et al., *Cost Analysis of Long-term Outcomes of an Urban Mental Health Court*, 52 EVALUATION & PROGRAM PLAN. 96, 99, 100 tbl.1, 102 tbl.3 (2015) (finding, in a comparison of the average treatment and criminal justice costs incurred per person by felony MHC participants in the one-year period after exiting the MHC and by MHC-eligible non-participants in the one-year period after being screened for MHC, that 40 MHC completers incurred costs of \$16,964, that 65 MHC non-completers incurred costs of \$32,258, and that 45 MHC-eligible non-participants incurred costs of \$39,870 because of greater costs of treatment and recidivism).

⁶ See *Adult Mental Health Treatment Court Locator*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/gains-center/mental-health-treatment-court-locator/adults> (last visited Sep. 20, 2019).

mental illness is to expand the mental health resources offered by the criminal justice system because mental illness typically and predictably results in criminal behavior (or at least involvement). Decades of science demonstrates, however, that mental illness is not a direct, substantial driver of criminal activity and that addressing mental health alone will not reduce recidivism.⁷ Instead, offenders with mental illness—like those without mental disorder—commit crimes because of criminogenic risk factors such as substance abuse, antisocial cognition, employment problems, and lack of family support.⁸ To reduce the cycling of offenders with mental disorder through the criminal justice system, we must reduce their levels of criminogenic risk by, for example, providing substance abuse treatment, supported employment, supported housing, and cognitive skills training focused on judgment and criminal behaviors to address criminal thinking.

If the Committee’s aim is to reduce the “prevalence of untreated mental illness” in the District,⁹ I respectfully suggest that the Committee recommend against expanding MHCs but instead recommend investing in evidence-based mental health services, such as assertive community treatment, supported housing, mobile crisis services, supported employment, and peer support services.¹⁰ Services provided prior to criminal justice involvement could help stabilize individuals with mental illness and prevent encounters with law enforcement.

The remainder of my written comments are organized in the following manner. First, I address the challenges associated with MHCs. Second, I discuss two inaccurate assumptions upon which MHCs are premised: an individual’s crimes are likely derived from her mental illness, and, by treating that mental illness, the offender will be less likely to engage in criminal behavior in the future. I set forth the science on mental illness and criminal behavior, including the dynamic factors demonstrated to actually affect an individual’s likelihood to engage in crime, and the dominant correctional paradigm used to treat these factors. Third, I propose recommendations for restructuring MHCs, including the D.C. MHCC, to align with these principles. However, because of the challenges inherent in MHCs, I ultimately conclude that the Committee should recommend against

⁷ See *infra* notes 74–83.

⁸ See *infra* notes 84–88.

⁹ Davis, *supra* note 2, at 1.

¹⁰ See BAZELON CENTER, DIVERSION TO WHAT? EVIDENCE-BASED MENTAL HEALTH SERVICES THAT PREVENT NEEDLESS INCARCERATION (Sept. 2019), available at http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (discussing each of these evidence-based approaches); Gary R. Bond et al., *How Evidence-Based Practices Contribute to Community Integration*, 40 COMMUNITY MENTAL HEALTH J. 569, 576–80 (2004) (discussing evidence-based practices for helping those with serious mental illness); Roger H. Peters et al., *Evidence-Based Treatment and Supervision Practices for Co-Occurring Mental and Substance Use Disorders in the Criminal Justice System*, 43 AM. J. DRUG & ALCOHOL ABUSE 475, 476, 483 (2017) (discussing empirically based models such as “(1) Integrated Dual Disorders Treatment (IDDT), (2) the Risk-Need-Responsivity (RNR) model, and (3) Cognitive-Behavioral Therapy (CBT)” and evidence-based interventions such as “Illness Management and Recovery (IMR), Therapeutic Communities (TCs), and Assertive Community Treatment”).

investment in these courts but rather recommend that any investment be channeled into expanding community mental health options.

I. MHCs

MHCs have been touted as a possible means to break the cycling of repeat offenders with untreated serious mental illness in the criminal justice system.¹¹ Propelled by federal funding and the strong support of the Council of State Governments' Justice Center, MHCs have enjoyed exponential growth, expanding from the first court in 1997 to around 450 courts across the United States today.¹² Supporters maintain these courts deliver much-needed treatment to individuals suffering from mental illness, reduce recidivism,¹³ improve quality of life,¹⁴ and even help diminish mass incarceration.¹⁵

¹¹ Generally speaking, MHCs are specialized criminal courts with dockets restricted to individuals with mental illnesses in which defendants choose a non-adversarial, problem-solving approach involving court-supervised treatment instead of traditional court processing. See Johnston, *Theorizing Mental Health Courts*, *supra* note 1, at 520. MHCs are idiosyncratic and vary widely in their mental health and criminal eligibility criteria, plea requirements, treatments offered, intensity and length of supervision, use of jail as a potential sanction for condition noncompliance, and the impact of program completion on participants' criminal cases. *Id.*

¹² *Drug Treatment Court Programs in the United States*, NAT'L DRUG COURT RES. CTR., <https://ndcrc.org/database/> (scroll down to "Court Types" and select "Mental Health") (last visited Oct. 5, 2019) (reporting 449 MHCs); *Adult Mental Health Treatment Court Locator*, *supra* note 6 (listing over 470 adult MHCs and over 50 juvenile MHCs).

¹³ See Evan M. Lowder et al., *Effectiveness of Mental Health Courts in Reducing Recidivism: A Meta-Analysis*, 69 PSYCHIATRIC SERVS. 15, 17 (2018) (reviewing 17 studies published between 2004 and 2017 and concluding there was "a significant, negative, and small effect of MHC participation on recidivism ($d = -.20$, 95% confidence interval) [relative to traditional processing]" and that "there was significant heterogeneity in this effect . . . , suggesting the presence of a high degree of variability in effect size across studies"); *Id.* (observing that moderate- and high-quality studies, as well as peer-reviewed publications, showed less of an effect on recidivism than did low-quality studies and dissertations); see also Kelli Canada et al., *Bridging Mental Health and Criminal Justice Systems: A Systematic Review of the Impact of MHCs on Individuals and Communities*, 25 PSYCHOL., PUB. POL'Y & L. 73, 76 (2019) (analyzing 29 studies of MHCs (identified by their having a subset of "essential elements"), finding mixed results for recidivism, and concluding that "results are generally promising for graduates of MHCs but for people who do not complete MHC, recidivism remains high"); Laura N. Honegger, *Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature*, 39 LAW & HUM. BEHAV. 478, 482–85 (2015) (collecting and reviewing extant studies on MHCs' abilities to reduce recidivism rates); Donald M. Linhorst & P. Ann Dirks-Linhorst, *Development, Outcomes, and Future Challenges*, 54 JUDGES' J. 22 (Spring 2015) (same). While the weight of extant studies suggest that MHCs may reduce recidivism, "limitations and challenges of MHC research prevent these problem-solving courts from rising to the level of an evidence-based practice." Honegger, *supra*, at 484.

¹⁴ See Allison D. Redlich et al., *Is Diversion Swift? Comparing Mental Health Court and Traditional Criminal Justice Processing*, 39 CRIM. JUST. & BEHAV. 420, 430–31 (2012) ("The short-term benefits of getting out of jail must be juxtaposed with the potential for longer-term benefits of MHC participation (i.e., access to treatment, reductions in recidivism, improved quality of life).").

¹⁵ See Roger K. Warren, *A Tale of Two Surveys: Judicial and Public Perspectives on State Sentencing Reforms*, 21 FED. SENT'G REP. 276, 282 (2009) (observing that 82% of respondents in a 2006 survey by the National Center for State Courts said MHCs are "a better way to sentence offenders than through the regular court system"); Jessica M. Eaglin, *The Drug Court Paradigm*, 53 AM. CRIM. L. REV. 595, 606, 609–13 (2016)

Proponents also laud the courts as models for treating defendants with dignity, facilitating defendants' "voice," and embodying other important procedural justice principles.¹⁶

However, MHCs pose many challenges. In particular, some commentators have criticized the diminished role of defense counsel in MHCs¹⁷ and the courts' net-widening effects.¹⁸ Others have expressed concerns about the coercive nature of the courts,¹⁹ offenders' competence to consent to diversion,²⁰ and infringement on participants' privacy.²¹ Gender and racial disparities may exist in the referral of participants and in the rate of program completion that benefit older, white women.²² Others have pointed to the increased

(asserting that treatment courts "are generally considered a leading alternative to incarceration" and discussing the role of problem-solving courts in the Department of Justice's Justice Reinvestment Initiative).

¹⁶ See Michael L. Perlin, "*The Judge, He Cast His Robe Aside*": *Mental Health Courts, Dignity and Due Process*, 3 MENTAL HEALTH L. & POL'Y J. 1, 2, 8, 20–23, 27–28 (2013).

¹⁷ See Tamar M. Meekins, "*Specialized Justice*": *The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 1–55 (2006); Steven K. Erickson et al., *Variations in Mental Health Courts: Challenges, Opportunities, and a Call for Caution*, 42 COMMUNITY MENTAL HEALTH JOURNAL 335, 337, 340 (2006); Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 539, 558–59 (2005); Timothy Casey, *When Good Intentions Are Not Enough: Problem-Solving Courts and the Impending Crisis of Legitimacy*, 57 SMU L. REV. 1459, 1483 (2004); Stacey M. Faraci, *Slip Slidin' Away? Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QLR 811, 825, 838–40, 844–45 (2004).

¹⁸ See Bradley Ray et al., *What Happens to Mental Health Court Noncompleters?*, 33 BEHAV. SCI. & L. 801–814 (2015) (examining non-completers in a pre-adjudication MHC that "accepts mostly misdemeanor offenders, many of whom had only one prior arrest" and finding that, after leaving MHC, nearly 64% had their charges dismissed when their case was sent back to traditional court); Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illness*, 11 PSYCHOL. PUB. POL'Y & L. 570, 581–82 (2005); Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507, 518 (2005).

¹⁹ See Allison D. Redlich et al., *Enrollment in Mental Health Courts: Voluntariness, Knowingness, and Adjudicative Competence*, 34 LAW & HUM. BEHAV. 91, 101 (2010) (finding that, while 66 to 71% of MHC participants said it was their choice to enroll in the court, about 60% claimed not to have been informed the decision to enroll was voluntary or told of MHC requirements prior to enrolling); Allison D. Redlich, *Voluntary, But Knowing and Intelligent?*, 11 PSYCHOL. PUB. POL'Y & L. 605 (2005); Stefan & Winick, *supra* note 18, at 512; Seltzer, *supra* note 18, at 574–75; Casey, *supra* note 17, at 1498–99; Faraci, *supra* note 17, at 845–47; Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illness: The Role of Mental Health Courts in System Reform*, 7 U.D.C. L. REV. 143, 150–51 (2003).

²⁰ See Kathleen P. Stafford & Dustin B. Wygant, *The Role of Competency to Stand Trial in Mental Health Courts*, 23 BEHAV. SCI. & L. 245, 256–57 (2005) (finding that, of the 80 defendants referred by one MHC for competency evaluations, 77.5% were found incompetent to stand trial and concluding: "the results of this study suggest that a number of defendants with major mental illness and misdemeanor charges lack the capacity to waive the constitutional rights and make the informed decisions necessary to participate in MHC"); Redlich et al., *Enrollment in Mental Health Courts*, *supra* note 19, at 101 (finding in a study of two MHCs that "16–27% of Brooklyn and 9–13% of Washoe participants demonstrated clinically significant impairments in their understanding of legal terms and concepts, and their ability to reason pertinent to legal decision-making").

²¹ See Bernstein & Seltzer, *supra* note 19, at 159.

²² See Timothy Ho et al., *Racial and Gender Disparities in Treatment Courts: Do They Exist and Is There Anything We Can Do To Change Them?*, 1 J. ADVANCING JUST. 5, 23, 27 (2018) (finding, in an

discretionary power and partiality of specialty court judges²³ and the potential of these courts to divert resources from law-abiding individuals with mental illnesses.²⁴ It is also not clear whether these courts' modest reductions in recidivism only accrue to graduates of the courts (not to the many participants who do not graduate) or why they might reduce recidivism.²⁵

As a professor of criminal law, criminal procedure, and mental health law, I want to draw particular attention to the criminal justice effects of MHCs. First, the typical requirement—reflected in part in the D.C. MHCC—that defendants plead guilty prior to entry is problematic.²⁶ Hundreds of collateral consequences attend criminal convictions,²⁷ and convictions following these pleas will follow an individual throughout her life. Indeed, a search of the National Inventory of Collateral Consequences of Conviction reveals that a misdemeanor conviction in the District of Columbia generates 365 possible collateral consequences, including termination of certain employment, ineligibility for employment and training services, termination of housing choice voucher assistance, denial of public housing or revoked tenancy, termination of a Section 8 lease by a landlord, and ineligibility for transition planning/services if disabled.²⁸ A felony conviction in the District generates 618 potential collateral consequences, including ineligibility for Temporary Assistance for

analysis of 20,800 participants across 142 treatment courts, that black participants had significantly lower graduation rates than white participants after controlling for education, employment, prior arrests, drug(s) used, and age); KAREN A. SNEDKER, *THERAPEUTIC JUSTICE* 93, 187–88 (2018) (finding, in her study of two MHCs, that racial and ethnic minority groups were underrepresented and a sex- and race-disparity benefiting whites and women in the offer to dismiss charges); Bradley Ray & Cindy Brooks Dollar, *Examining Mental Health Court Completion: A Focal Concerns Perspective*, 54 *SOCIOLOGICAL QUARTERLY* 647 (2013) (detailing observational findings indicating that gender influences the court's contextualization of noncompliance); Henry J. Steadman et al., *From Referral to Disposition: Case Processing in Seven Mental Health Courts*, 23 *BEHAV. SCI. & L.* 215, 219, 222–23 (2005) (finding in a study of seven MHCs that white, older women were disproportionately referred to MHCs but not finding that sex and race influenced MHC acceptance decisions in general); P. Ann Dirks-Linhorst et al., *Factors Associated with Mental Health Court Nonparticipation and Negative Termination*, 30 *JUST. QUARTERLY* 681 (2011) (examining MHC termination using data from more than 600 defendants, over an eight-year period, and finding black males more likely than other clients to terminate from MHC treatment).

²³ See John A. Bozza, *Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-Solving Courts*, 17 *WIDENER L. J.* 97, 113–14 (2007); Wolff & Pogorzelski, *supra* note 17, at 556, 558–59; Casey, *supra* note 17, at 1491–93, 1497–1500; Faraci, *supra* note 17, at 838–43; Bernstein & Seltzer, *supra* note 19, at 156–57.

²⁴ See Arthur J. Lurigio & Jessica Snowden, *Putting Therapeutic Jurisprudence into Practice: The Growth, Operations, and Effectiveness of Mental Health Court*, 30 *JUST. SYS. J.* 196, 212 (2009); Erickson et al., *supra* note 17, at 341; Seltzer, *supra* note 18, at 581; Faraci, *supra* note 17, at 848.

²⁵ See *supra* note 13; Lowder et al., *Effectiveness of Mental Health Courts*, *supra* note 13, at 17 (“Few studies have examined components of MHCs associated with improved participant outcomes, which is likely attributable to the limited knowledge of how MHCs operate across sites.”); Canada et al., *supra* note 13, at 88 (“Research is needed . . . to parse out the underlying mechanisms that contribute to effectiveness.”).

²⁶ See Virginia Barber-Rioja et al., *Diversion Evaluations: A Specialized Forensic Examination*, 35 *BEHAV. SCI. & L.* 418, 425 (2017) (identifying “the requirement for defendants to enter a plea of guilty before enrolling in diversion” as a core feature found in most post-adjudication mental health diversion programs).

²⁷ See CSG JUSTICE CENTER, *NATIONAL INVENTORY OF COLLATERAL CONSEQUENCES OF CONVICTION*, available at <https://niccc.csjusticecenter.org/>.

²⁸ *Id.*

Needy Families benefits, ineligibility for old-age/survivors/disability insurance benefit payments, forfeiture of veterans' disability benefits, and ineligibility for inclusion as a household member for the purpose of calculating food stamp benefits.²⁹ Thus, conviction of a criminal offense not only saddles a MHC participant with the stigma of criminal judgment, but also, in real terms, hinders her ability to find employment and housing and move beyond poverty.

The D.C. MHCC is not immune from this criticism. From what I understand, the MHCC accepts individuals charged with U.S. misdemeanors and nonviolent felonies. Participants charged with misdemeanors may be offered a deferred prosecution agreement, whereby the individual is not required to plead guilty and, upon successful completion, will have her charges dismissed. If the individual does not complete the program, her case will be “returned to the calendar from which it originally was sent to MHCC, and [the charged individual] must then decide whether to enter a plea of guilty or to proceed to a trial.”³⁰ Alternatively, a misdemeanant may be offered a deferred sentencing agreement, whereby the individual must enter a guilty plea to her charge(s). If she satisfies all conditions of the agreement, her plea will be vacated and her case will be dismissed; if not, the conviction will remain, and the deferred sentence will be imposed. On the other hand, those charged with low-level felonies (and possibly some misdemeanants) must enter into an amended sentencing agreement which requires a guilty plea to the felony charge(s). If all conditions are satisfied, the individual's felony charge will be reduced to a lesser charge, and the individual will then be convicted of and sentenced for the lesser charge. In summary, D.C. MHCC participants who enter with amended sentencing agreements must plead guilty, and those who enter under deferred sentencing agreements or deferred prosecution agreements and do not satisfy conditions of the program will also receive criminal convictions. This system is certainly better than requiring guilty pleas for all participants, but, without information on the proportion of each procedural option utilized and the graduation rate from the MHCC, it is impossible to discern the ultimate effect of the D.C. MHCC in generating convictions.

Second, criminal court statistics suggest that some MHC participants may not have been prosecuted had they remained in the traditional criminal justice system, particularly in cases involving low-level misdemeanors and/or defendants with minimal criminal history. Dismissal rates generally are high in criminal courts.³¹ For example, CY 2016 statistics from the D.C. Criminal Division reflect that—of the 2,491 D.C. misdemeanors charged in

²⁹ *Id.*

³⁰ DISTRICT OF COLUMBIA SUPERIOR COURT MENTAL HEALTH COMMUNITY COURT (MHCC) CASE MANAGEMENT PLAN 4, available at <https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf>.

³¹ See BRIAN A. REAVES, U.S. DEP'T OF JUSTICE, FELONY DEFENDANTS IN LARGE URBAN COUNTIES, 2009: STATISTICAL TABLES 22 (2013), <https://www.bjs.gov/content/pub/pdf/fdluc09.pdf> (finding that almost a quarter of felony cases were dismissed in the nation's seventy-five largest counties in 2009); LARRY J. SIEGEL & JOHN L. WORRALL, ESSENTIALS OF CRIMINAL JUSTICE 15 (Cengage, 11th ed. 2017) (“In actual practice, many suspects are released before trial because of a procedural error, evidence problems, or other reasons that result in a case dismissal by the prosecutor.”).

D.C. criminal court³²—38% (939 cases) were not prosecuted, that is, they were resolved by *nolle prosequi* (727 cases), dismissed for want of prosecution (169 cases), or simply dismissed (43).³³ An additional 345 cases were resolved through *nolle diversion*. Overall, only 12% of filed misdemeanor cases (300 cases) resulted in convictions through guilty pleas (276 cases) or guilty verdicts from a jury (1 case) or bench trial (23 cases).³⁴

MHC eligibility criteria and processes may increase the likelihood that prosecutors would not have pursued some participants' charges had they declined involvement in the specialty court. Entry into a MHC occurs early in the criminal justice process, often before any discovery has been provided by the prosecution or any investigation has been conducted by defense counsel.³⁵ At this point, defense counsel will be ill-equipped to evaluate the strength of the likely evidence against her client and may be unable to identify a weak case. Additionally, some potential MHC participants are of questionable competence to stand trial,³⁶ so, if a case is not diverted, a prosecutor might choose to dismiss charges rather than seek an evaluation and then treatment for restoration of competency, especially in a jurisdiction with a resource-strapped forensic mental health system. Moreover, a prosecutor should consider suffering from a serious mental illness at the time of an offense as a mitigating factor, thus reducing the likelihood that justice will demand punishment through the criminal system.

However, if MHCs are considered a viable and necessary gateway to treatment, prosecutors will be more likely to pursue cases and criminal justice system actors may use the leverage of possible incarceration as a means to facilitate entry, even in cases with questionable evidentiary bases. In addition, as others have suggested and as previously mentioned, if community mental health resources are scarce, (a) law enforcement will tend to arrest more symptomatic individuals in an effort to link them with treatment, and (b) individuals may opt to engage in criminal behavior to obtain treatment.³⁷ In this way, MHCs may carry a net-widening effect, increasing the number of individuals with mental illness entangled in the criminal justice system.³⁸

³² See DISTRICT OF COLUMBIA COURTS' STATISTICAL SUMMARY 12 (2016), available at <https://www.dccourts.gov/sites/default/files/matters-docs/Statistical-Summary-CY2016-Final.pdf>. I chose not to use statistics for U.S. misdemeanors here, even though these are the misdemeanors eligible for inclusion in the D.C. MHCC, because a much higher percentage of these misdemeanors were resolved through *nolle diversion*, thus skewing the other dismissal figures. *Id.*

³³ Sixteen percent of felony cases (1,260 / 7,822) were resolved in this manner. *Id.*

³⁴ Seventeen bench trials resulted in acquittals or not guilty verdicts. *Id.*

³⁵ See DISTRICT OF COLUMBIA SUPERIOR COURT MENTAL HEALTH COMMUNITY COURT (MHCC) CASE MANAGEMENT PLAN, *supra* note 28, at 4.

³⁶ See *supra* note 20.

³⁷ See Bernstein & Seltzer, *supra* note 19, at 160.

³⁸ See *supra* note 18.

Little research has been conducted on the net-widening potential of MHCs, but one study, which examined the traditional court outcomes for MHC non-completers, supports the notion that some MHC participants' cases might have been dismissed had they not participated in the MHC. In a 2015 study, Bradley Ray and his colleagues examined follow-up data on six years of non-completers (n=157) from a pre-adjudication MHC that accepted mostly misdemeanor offenders (only 12% of participants had a felony charge).³⁹ "The average rate of completion for this MHC was 45.6%," a finding that is consistent with existing literature reporting MHC completion rates.⁴⁰ They found that, after leaving the MHC, nearly 64% of non-completers had their charges dismissed when their case was sent back to traditional court.⁴¹ A substantial minority (27%) of these non-completers had only one prior arrest, but the average number of lifetime arrests for this group was 6.15.⁴² While the cases of defendants charged with felonies were less likely to be dismissed than those with a misdemeanor, most of the felony defendants' charges were ultimately dismissed as well, probably because the felonies were of low severity.⁴³ This study is strongly suggestive of the net-widening potential of these courts—spurring or deepening individuals' involvement in the criminal justice system.

Third, participation in a MHC may be predicated on the imposition of a disproportionately long sentence. Very little research has investigated differences in sentencing practices between mental health and traditional criminal courts.⁴⁴ There are reasons to be concerned: examination of sentence severity in drug courts, the specialty courts on which MHCs are modeled,⁴⁵ suggests that treatment courts may be more likely to issue harsher sentences than traditional courts.⁴⁶

³⁹ Ray et al., *What Happens to Mental Health Court Noncompleters?*, *supra* note 18.

⁴⁰ *Id.* at 809 (listing studies).

⁴¹ *Id.* at 805.

⁴² *Id.* at 805–06.

⁴³ *Id.* at 809.

⁴⁴ See Bernstein & Seltzer, *supra* note 19, at 157 (surveying twenty MHCs in 2001 and finding that, in at least 40% of reporting courts, the duration of court supervision "significantly exceed[ed] the possible length of incarceration or probation for the offense"); see also Carol Fisler, *Building Trust and Managing Risk: A Look at a Felony Mental Health Court*, 11 PSYCHOL. PUB. POL'Y & L. 587, 592 (2005) (explaining Brooklyn's decision to restrict its MHC to felonies and chronic misdemeanor offenders facing one-year jail sentences and reporting defense attorneys' concerns that, because "more than 90% of misdemeanants in Brooklyn serve less than 60 days in jail," treatment mandates of at least one year and potential jail sentences of a year or longer for program failure "were disproportionately onerous for misdemeanor offenders facing such short jail sentences"); LAUREN ALMQUIST & ELIZABETH DODD, MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 3–4 (2009), available at https://www.bja.gov/Publications/CSG_MHC_Research.pdf (noting that "some participants remain under court supervision for much longer than if they had been adjudicated in a traditional court" and that "[i]t can be unclear whether participation is always in their best interest").

⁴⁵ See ALMQUIST & DODD, *supra* note 44, at 1.

⁴⁶ See Mae C. Quinn, *Whose Team Am I On Anyway? Musings of a Public Defender About Drug Treatment Court Practice*, 26 N.Y.U. REV. & SOC. CHANGE 37, 49, 62 & n.145 (2000) (revealing that participants typically must plead guilty to the most serious offense charged, consent to participation in a

My colleague, Conor Flynn, and I published the first article on the topic of MHCs and sentencing in 2017. Using a case study approach, the article compared how Pennsylvania's Erie County MHC and county criminal courts sentenced individuals who committed the same offenses and held the same average criminal history score.⁴⁷ MHC data consisted of interviews with key MHC participants, the court's sentencing data from 2010 to 2014, and information gleaned from court materials. Anticipated MHC sentences derived primarily from interview data; the accuracy of those sentences was checked against actual sentencing data for 28 of the 33 individuals sentenced to the MHC over this five-year period. The analysis then used countywide sentencing data from the same period, obtained from the Pennsylvania Commission on Sentencing, to compare the sentencing of MHC participants to the sentencing of individuals with the same average criminal history score convicted of the same offenses in county criminal courts. The article analyzed a total of twelve offenses spanning four offense grades, all of which were accepted by the MHC. Because 68% (19/28) of Erie County MHC participants sentenced between 2010 and 2014

twelve- to eighteen-month drug treatment program, and agree to a suspended sentence of incarceration of two to six years—a sentence “far greater than most first-time drug sale defendants could receive outside of the treatment court by plea-bargain”); Denise C. Gottfredson & M. Lyn Exum, *The Baltimore City Drug Treatment Court: One-Year Results from a Randomized Study*, 39 J. RES. CRIME & DELINQ. 337, 350 & tbl. 5 (2002) (finding that treatment court participants received average probationary sentences of 745 days while the control group received probationary terms of 613 days); Denise C. Gottfredson et al., *Long Term Effects of Participation in the Baltimore City Drug Treatment Court: Results from an Experimental Study*, 2 J. EXPERIMENTAL CRIMINOLOGY 67, 79 tbl. 1 (2006) (finding that treatment court participants were incarcerated an average of 158.9 days (often for noncompliance), while control group members were incarcerated an average of 156.9 days); Gottfredson & Exum, *Baltimore City Drug Treatment Court*, *supra*, at 350 & tbl. 5 (finding that treatment court participants received average suspended sentences of incarceration of 1,252 days while the control group received suspended sentences of 1,068 days). Other studies have also found evidence of more severe sentences for drug court participants, especially for those failing to graduate. *See, e.g.*, Eric L. Sevigny et al., *Do Drug Courts Reduce the Use of Incarceration?: A Meta-Analysis*, 41 J. CRIM. JUST. 416, 416 (2013) (finding that drug courts significantly reduced the incidence of incarceration on the precipitating offense but “did not significantly reduce the average amount of time offenders spent behind bars, suggesting that any benefits realized from a lower incarceration rate are offset by the long sentences imposed on participants when they fail the program”); SHELLI B. ROSSMAN ET AL., THE MULTI-SITE ADULT DRUG COURT EVALUATION 8, 80 (2011), *available at* <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf> (examining two-year outcomes from 23 adult drug courts and six comparison sites from eight states and finding that, “when isolating the sentence on the precipitating criminal case that led to drug court or comparison group membership[,] . . . there was not a significant difference in the probability of a custodial sentence (22 percent for both samples) or in its average length, and the raw data pointed to a slightly higher average length among those in the drug court (97.2 vs. 76.7 days)”); MICHAEL REMPEL ET AL., THE NEW YORK STATE ADULT DRUG COURT EVALUATION: POLICIES, PARTICIPANTS AND IMPACTS 269, 281 (2003), *available at* http://www.courtinnovation.org/sites/default/files/drug_court_eval.pdf (finding, in a study of six drug courts in New York State that, while drug court participants were significantly less likely than control group members to be sentenced to jail or prison on the initial case, drug court failures were “significantly more likely than comparison defendants to have received at least some incarceration time as part of their sentence in five of six courts . . . [and that] failures had, on average, longer total incarceration sentences than comparison defendants in all courts except [one]”). For commentary on this phenomenon, see Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783, 787–94 (2008); Alex Kreit, *The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?*, 2010 U. CHI. LEGAL F. 299, 322–23; Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1551–61 (2004).

⁴⁷ See Johnston & Flynn, *supra* note 1.

had a prior record score of 0, the analysis compared the anticipated MHC sentences to county sentencing data limited to that criminal history score.⁴⁸

The findings of the study were striking. First, comparing anticipated MHC sentences to those imposed by county criminal courts revealed that anticipated treatment court sentences—for all grades of offense—typically exceeded county court sentences by more than a year.⁴⁹ Even for first-degree misdemeanors, the anticipated MHC sentence exceeded the length of all traditional dispositions for each offense by at least 1.5 years.⁵⁰ Second, this comparison suggested that most misdemeanants sentenced to the MHC would have received probationary, not carceral, sentences in traditional court.⁵¹ This conclusion appears to be somewhat less applicable to felons sentenced by the MHC, especially serious felons.⁵² Third, mental court participants in this dataset with multiple convictions more often received consecutive, as opposed to concurrent, sentences than those sentenced by traditional courts.⁵³ Fourth, key MHC actors appeared not to comprehend likely sentencing disparities, or the high rate of participant failures,⁵⁴ which suggested that these realities might not be communicated to applicants.⁵⁵

One key limitation of this study was that the Erie County MHC data set was very small, consisting only of 28 participants. However, these data served merely to supplement and act as a partial check on the accuracy of treatment team members' beliefs, as expressed through their interviews, regarding anticipated sentence length. The sentencing data showed that treatment team members' projected sentences for misdemeanors and third-degree felonies roughly correlated with actual sentences imposed.⁵⁶ Treatment team members'

⁴⁸ *See id.* at 728–29 (discussing how the variance in actual PRS scores might have affected the significance of the article's findings).

⁴⁹ *See id.* at Part II.C.

⁵⁰ *See id.* at Fig. 4; App. A. The one exception—the average jail/probation split sentence imposed on 18% of individuals convicted of terroristic threats—was six months shorter than the anticipated MHC term. *See id.* at Fig. 4; App. A.

⁵¹ *See id.* at Fig. 4; App. A.

⁵² *See id.* at Part II.C.2. Importantly, this analysis neglected two of the most likely sources of harsh treatment incurred by MHC participants: the use of jail as a sanction for program noncompliance and the activation or imposition of incarcerative sentences upon MHC failure. Because of these omissions, this examination understated—perhaps substantially—the severity of sanctions actually experienced by MHC participants.

⁵³ *See id.* at Part II.B.

⁵⁴ *See infra* note 57.

⁵⁵ *See Johnston & Flynn, supra* note I, at Part I.

⁵⁶ Interview data suggest that the Erie County MHC sentences individuals convicted of first-degree misdemeanors to five-year terms of intensive supervision, the longest term Pennsylvania law permits for this grade of offense. Actual sentencing data from the MHC from 2010 to 2014 confirm that most individuals convicted of first-degree misdemeanors receive sentences of approximately five years. On average, individuals convicted of this grade of offense received terms of supervision equivalent to 85.63% of the authorized limit, or 51.4 months of supervision. Treatment team members expected that MHC entrants

projected sentences for more serious felonies were less closely aligned with actual sentences; this could reflect the small sample size of second- and first-degree felonies (6) in the study. Although the overall sample size was quite small, the 28 participants represent almost all (85%) of the defendants processed through the MHC during the 2010 to 2014 time period.

One final problematic criminal justice effect of MHCs is that success is often elusive, and termination may result in punitive sentences. Many MHCs have high failure rates.⁵⁷ One recent analysis of the 24 studies published between 2004 and 2014 with an expressly stated MHC graduation rate found that “the mean and median rate of successful program completion is 53.65 and 54.435 percent respectively.”⁵⁸ Thus, roughly half of all individuals who enter MHCs fail to graduate. Individuals who are terminated from MHC programs will not receive credit for time served and—as experience with drug courts suggests⁵⁹—may receive more severe punishments upon resentencing than if they had remained in the traditional justice system.

II. Inaccurate Assumptions Underlying MHCs

More fundamentally, MHCs rely on two inaccurate assumptions: mental illness drives criminal behavior and the provision of mental health treatment will reduce

pleading guilty to third-degree felonies would receive supervisory sentences at the maximum length of supervision, or seven years (84 months). The actual sentence for the four third-degree felonies studied was 72 months.

⁵⁷ See, e.g., Ray et al., *What Happens to Mental Health Court Noncompleters?*, *supra* note 18, at 804 (finding “[t]he average noncompletion rate across these six years [in the studied MHC] was 45.6% (ranging from 52.4% to 41.0%), which is only slightly higher than the 41% average from studies reporting rates of MHC noncompletion” and listing studies); Johnston & Flynn, *supra* note 1, at 705 (concluding, in a study of the Erie County MHC in Pennsylvania that, “[w]hile studies from 2005 and 2007 found graduation rates of 55.6% and 68.2%, respectively, recent graduation rates hover between 30.0% and 37.5%.”); Virginia Aldigé Hiday et al., *Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit*, 67 PSYCHIATRIC SERVS. 378, 380 (2016) (finding that, of 408 participants in a MHC, 170 did not complete the program).

⁵⁸ STEPHEN GUY VANGEEM, AN EVALUATION OF THE UTAH FIRST DISTRICT MENTAL HEALTH COURT: GAUGING THE EFFICACY OF DIVERTING OFFENDERS SUFFERING WITH SERIOUS MENTAL ILLNESS 51, 52 tbl.5 (Apr. 9, 2015) (unpublished Ph.D. dissertation, University of South Florida) (on file with the University of South Florida Scholar Commons), <https://scholarcommons.usf.edu/etd/5593>.

⁵⁹ See, e.g., Seigny et al., *supra* note 46, at 416 (performing a series of meta-analyses of various incarceration outcomes and finding that drug courts significantly reduced the incidence of incarceration on the precipitating offense but “did not significantly reduce the average amount of time offenders spent behind bars, suggesting that any benefits realized from a lower incarceration rate are offset by the long sentences imposed on participants when they fail the program”); ROSSMAN ET AL., *supra* note 46, at 8, 80 (examining two-year outcomes from 23 adult drug courts and 6 comparison sites from 8 states and concluding that “drug courts nearly eliminate custodial time among those who graduate, but those benefits are counterbalanced by the high sentences imposed on those who fail the program”); REMPEL ET AL., *supra* note 46, at 269, 281 (finding, in a study of six drug courts in New York State that, while drug court participants were significantly less likely than control group members to be sentenced to jail or prison on the initial case, drug court failures were “significantly more likely than comparison defendants to have received at least some incarceration time as part of their sentence in five of six courts . . . [and that] failures had, on average, longer total incarceration sentences than comparison defendants in all courts except [one]”).

recidivism.⁶⁰ These beliefs are an outgrowth of the popular criminalization theory, which posits that individuals with serious mental illness have become enmeshed in the criminal justice system because the mental health system has failed.⁶¹ According to this theory, the closure of psychiatric hospitals released a flood of individuals with mental illness into communities. Without adequate community treatment or broad civil commitment laws, these individuals then were arrested for behavior deriving from their illness. Social scientists have observed that the criminalization theory lacks a strong evidentiary basis.⁶² However, this theory continues to dominate public discourse and serves as the underlying rationale for all major justice programs directed at offenders with mental illness—including MHCs.⁶³

A fundamental assumption underlying the criminalization theory is that the criminal behavior of individuals with serious mental illness stems from, or is a manifestation of, their illness.⁶⁴ Criminalization proponents believe that individuals with serious mental illness who cannot access care in the community “are arrested for psychosis-induced violence, disturbed behavior on the street, or ‘survival-type’ crimes (for example, ‘dine and dash’ from a restaurant).”⁶⁵ This notion is intuitive, reflects the commonly held stigma that links mental disorders to dangerousness, and reifies assumed differences between “mentally disordered” and “normal” individuals. Importantly, it also suggests a solution to end the cycling of individuals with mental disorder through the criminal justice system:

⁶⁰ See, e.g., Chris Gautz, *Mental-Health Court Celebrates Its First Anniversary, Honors First Two Graduates*, JACKSON CITIZEN PATRIOT, SATURDAY ED., Nov. 14, 2009, at A1 (quoting the judge of the MHC in Jackson County, Michigan, as explaining that MHCs provide treatment to offenders with mental illness because “[t]hey’re just going to recidivate if you don’t address the underlying pathology”); Kathleen Brady Shea, *Mental Health Courts on Horizon: Local Counties Want to Steer Ill Defendants into Treatment Instead of Jail*, PHILA. INQUIRER, June 30, 2008, at B1 (quoting Delaware County Court Judge Frank T. Hazel as expressing that offenders with mental illness often reoffend because they don’t receive adequate treatment for their mental illnesses).

⁶¹ See William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL’Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 544, 546 (2006).

⁶² See, e.g., Fisher et al., *supra* note 61, at 547–48 (marshalling evidence in support of, and challenging, the criminalization theory and concluding that the body of evidence is “at best equivocal in its support of the ‘criminalization due to inadequate mental health services’ model); John Junginger et al., *Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses*, 57 PSYCHIATRIC SERVS. 879, 879 (2006) (“In fact, what little empirical research exists on this particular interpretation of the criminalization hypothesis has produced no consensus.”); Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 116 (2011) (“There is no evidence for the basic criminalization premise that decreased psychiatric services explain the disproportionate risk of incarceration for individuals with mental illness.”).

⁶³ Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction*, 38 LAW & HUM. BEHAV. 212, 212 (2014) (“Most policy recommendations for this population reflect an implicit assumption that mental illness is the direct cause of criminal justice involvement, and psychiatric treatment is the principal solution.”).

⁶⁴ See Jillian Peterson et al., *Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis*, 61 PSYCHIATRIC SERVS. 1217, 1217 (2010).

⁶⁵ *Id.*

address the underlying cause of criminal behavior by providing needed mental health treatment.

However, research across jail,⁶⁶ parole,⁶⁷ and psychiatric samples⁶⁸ demonstrates that only a small minority of crimes—perhaps around 5% to 12% percent—committed by individuals with serious mental illness are the direct result of delusions or hallucinations.⁶⁹ An additional subset may be motivated by anger, impulsivity, or confusion stemming from a serious mood disorder.⁷⁰ In a 2014 study of 143 offenders with mental illness, Jillian Peterson and her colleagues found that 82% of crimes were held to be completely (64.7%) or mostly (17.2%) independent of offenders’ psychiatric illnesses.⁷¹ This conclusion coheres with other research on the subject.⁷² In addition, recent research has found that those offenders who commit symptom-based crime also commit crimes unrelated to their mental illness.⁷³

⁶⁶ See Junginger et al., *supra* note 62, at 879 (finding, in interviews of 113 offenders with co-occurring mental and substance abuse disorders shortly after their arrest, that delusions or hallucinations occurred concurrently with the index offense in 4% (n=4) of offenses).

⁶⁷ See Peterson et al., *Analyzing Offense Patterns*, *supra* note 64 (finding, in a retrospective study of 111 parolees with a serious mental illness, that 7% of mentally disordered offenders’ criminal behavior was a direct result of psychosis (5%, n=6) or constituted survival crimes related to poverty (2%, n=2)).

⁶⁸ See JOHN MONAHAN ET AL., *RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL ILLNESS AND VIOLENCE* (2001) (finding, in a study of over 608 violent incidents involving psychiatric patients, that psychosis immediately preceded violent incidents in 11% (N=67) of violent and aggressive incidents detected).

⁶⁹ See Jennifer L. Skeem et al., *Applicability of the Risk-Need-Responsivity Model to Persons with Mental Illness Involved in the Criminal Justice System*, 66 *PSYCHIATRIC SERVS.* 916, 919 (2015) (collecting studies).

⁷⁰ See Junginger et al., *supra* note 62, at 879 (finding that 4% (n=4) of crimes were related to “any other symptom-based influence, such as confusion, depression, thought disorder, or irritability”); Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?*, 38 *LAW & HUM. BEHAV.* 439, 446 (2014).

⁷¹ Peterson et. al., *How Often and How Consistently*, *supra* note 70, at 444 fig.3. They found that 4% of crimes had a mostly or completely direct relationship to psychosis, 3% had a mostly or completely direct relationship to depression, and 10% had a mostly or completely direct relationship to bipolar disorder. *Id.* at 446.

⁷² See *supra* notes 66–68 (detailing studies).

⁷³ Peterson et. al., *How Often and How Consistently*, *supra* note 70, at 446 (“[T]here is no subgroup of offenders with mental illness who only engage in criminal behavior when their symptoms directly cause such behavior.”). In the 2014 study by Peterson and colleagues, the 18% of crimes coded as mostly or completely related to symptoms were dispersed among 38% of offenders with mental illness. *Id.* at 445. Of the 38% of offenders with at least one direct crime, 67% also committed at least one crime found mostly or completely independent of symptoms. *Id.* at 445, 446.

Indeed, decades of research have found that clinical factors such as diagnosis and treatment history are, at most, weak predictors of criminal behavior.⁷⁴ A large, 2014 meta-analysis of the relative predictive validity of general and clinical risk factors confirmed the insignificance of clinical factors for recidivism.⁷⁵ This meta-analysis of 126 studies representing 96 unique samples concluded that, “for offenders, having a mental disorder was no more predictive of recidivism than not having a mental disorder.”⁷⁶ For both general⁷⁷ and violent⁷⁸ recidivism, the clinical variables of psychosis, schizophrenia (which was analyzed separately due to recent attention in the literature), mood disorder, prior admissions, length of hospitalization, psychiatric treatment history, and personality disorder were all insignificant predictors.⁷⁹

Consistent with research showing that mental illness is not a dynamic risk factor for re-offending, evidence shows that the provision of mental health treatment alone is not an effective strategy for reducing recidivism.⁸⁰ Studies have found that providing intensive

⁷⁴ See, e.g., James Bonta et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123(2) PSYCHOL. BULL. 123, 125 (1998) (finding that the effect of clinical variables—such as diagnosis, intellectual dysfunction, and treatment history—on recidivism was largely insignificant and paled in comparison to dozens of other factors that applied both to offenders with and without mental illness, such as criminal history, juvenile delinquency, antisocial personality, family problems, and substance abuse); D.A. Andrews et al., *The Recent Past and Near Future of Risk and/or Need Assessment*, 52 CRIME & DELINQ. 7, 10 (2006) (identifying major mental disorder as a “minor” risk factor but positing that its predictive validity is mediated by the general risk factors of antisocial cognition and antisocial personality pattern, as well as substance abuse).

⁷⁵ James Bonta et al., *A Theoretically Informed Meta-analysis of the Risk for General and Violent Recidivism for Mentally Disordered Offenders*, AGGRESSION & VIOLENT BEHAV. 278, 278 (2014).

⁷⁶ *Id.* at 286 (defining recidivism as any evidence of reoffending, such as arrests or convictions, and including recommitment to a psychiatric facility due to a new general or violent criminal offense).

⁷⁷ *Id.* at 281 (defining general recidivism as any recidivism, including violent recidivism).

⁷⁸ *Id.* (stating that violent recidivism includes sexual offenses).

⁷⁹ *Id.* at 285. The only exceptions were antisocial personality and psychopathy, which were significant predictors of both general and violent reoffending. *Id.* This predictive relationship is not surprising. Antisocial personality and psychopathy are closely aligned with and include aspects of antisocial personality pattern (e.g., criminal history and antisocial personality features such as impulsivity, hostility, and lack of empathy), which is a strong risk factor for criminal activity in individuals with and without mental disorder.

⁸⁰ See Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 120 (explaining that “even if mental illness contributed to downward socioeconomic drift, it is unlikely that symptom improvement will reverse poverty or associated criminogenic factors that are more socioeconomic than medical” and that “factors that originally caused criminal behavior may differ from those that maintain it”); Robert D. Morgan et al., *Prevalence of Criminal Thinking Among State Prison Inmates with Serious Mental Illness*, 34 LAW & HUM. BEHAV. 324, 334 (2010) (“Intensive, targeted treatment and service delivery approaches have not proven to be sufficiently preventive, nor has psychiatric treatment by itself.”); William H. Fisher et al., *Community Mental Health Services and Criminal Justice Involvement Among Persons with Mental Illness*, in COMMUNITY-BASED INTERVENTIONS FOR CRIMINAL OFFENDERS WITH SEVERE MENTAL ILLNESS 25, 37 (William H. Fisher ed., 2003) (discussing a series of findings suggesting “that ‘generic’ community mental health services of the kind provided to persons with severe mental illness, while providing important treatment and support services, may not in and of themselves reduce the risk of criminal justice involvement or re-involvement for some individuals in this population”).

mental health services, and not addressing broader criminogenic needs, does not reduce rates of criminal behavior for individuals with mental illnesses.⁸¹ Even evidence-based mental health services—those proven to have a reliable effect on clinical outcomes—have not reduced recidivism in programs designed to decrease the involvement of individuals with mental illness in the criminal justice system.⁸² Such findings prompted Professor Skeem and her colleagues to report that “no evidence” supports the assumption that the control or reduction of mental illness symptoms will reduce recidivism.⁸³

Instead, the same risks and needs that motivate individuals without mental illness also drive those with mental disorders to commit crimes. Over the last twenty-five years, researchers have identified eight criminogenic risk and need factors—the “Central Eight”—that accurately and reliably predict the risk of criminal behavior.⁸⁴ The first four factors include a history of antisocial behavior, antisocial personality pattern, antisocial cognition, and antisocial attitudes.⁸⁵ These variables involve poor socialization, restless energy, risk-taking, impulsivity, egocentrism, poor problem-solving skills, hostility, and a disregard for responsibilities and others.⁸⁶ The remaining four risk/need factors include family and/or marital problems, low levels of social and/or work performance, low levels of involvement and satisfaction in anti-criminal leisure pursuits, and substance abuse.⁸⁷ A number of studies, including large-scale meta-analyses, have confirmed the importance of criminogenic risk

⁸¹ See, e.g., Jennifer L. Skeem & Jennifer Eno Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment*, 57 PSYCHIATRIC SERVS. 333, 339 (2006) (finding, in an evaluation of a probation program and jail diversion programs, that increased access to and use of mental health services did not lead to a significant decrease in recidivism); Robin E. Clark et al., *Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders*, 50 PSYCHIATRIC SERVS. 641, 644 (1999) (finding that participants in assertive community treatment and those in standard case management did not differ significantly in arrests); Phyllis Solomon et al., *Jail Recidivism and Receipt of Community Mental Health Services*, 45(8) HOSP. & COMMUNITY PSYCHIATRY 793, 795 (1994) (finding that a greater proportion of clients assigned to receive intensive case management services from an assertive community treatment team returned to jail compared with clients assigned to individual case managers or referred to a community mental health center).

⁸² Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 114.

⁸³ *Id.* According to these researchers, existing data show that “offenders who (for whatever reason) show symptom improvement during a program are no less likely to recidivate than those whose symptoms remain unchanged or worsen.” *Id.*

⁸⁴ See Bonta et al., *A Theoretically Informed Meta-analysis*, *supra* note 75, at 280, 282 (listing and discussing the predictive validity of each criminogenic risk/need factor); JAMES BONTA & D.A. ANDREWS, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 63–64 (6th ed. 2017) (describing each factor in detail).

⁸⁵ Andrews et al., *The Recent Past*, *supra* note 74, at 11. Early prediction studies found these four factors—known colloquially as the “Big Four”—to be more predictive of criminal behavior than the four remaining factors that comprise the “Central Eight” criminogenic risks/needs. Recent research, however, has found no clear demarcation in the predictive weight of the eight factors for mentally disordered offenders, general offenders, youthful offenders, minority offenders, racial minorities, and drug offenders. See BONTA & ANDREWS, *supra* note 84, at 63 (listing studies).

⁸⁶ See D.A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 356 (2d ed. 1998).

⁸⁷ Andrews et al., *The Recent Past*, *supra* note 74, at 11.

factors in predicting recidivism among disordered and non-disordered offenders alike.⁸⁸ As mentioned, clinical variables, such as diagnosis or treatment history, do not improve predictive accuracy.⁸⁹

While major mental illness may not be a causal factor in the criminal behavior of most offenders with mental illness, mental illness may play an indirect role in generating socio-demographic conditions linked with criminal activity.⁹⁰ Mental illness may contribute, for instance, to a loss of employment, movement into disadvantaged neighborhoods, gain of antisocial acquaintances, and loss of prosocial (anti-criminal) support—all criminogenic risk factors that heighten risk of criminality.⁹¹ Offenders with mental illness are also more prone to homelessness and substance abuse, two factors highly correlated with recidivism.⁹² Evidence suggests that individuals with mental illness may also enjoy fewer social supports than non-ill individuals.⁹³ Indeed, some research suggests that offenders with mental illness may enter the criminal justice system with a higher concentration of criminogenic risk factors, on average, than non-ill offenders.⁹⁴

⁸⁸ See, e.g., Bonta et al., *A Theoretically Informed Meta-analysis*, *supra* note 75, at 282; BONTA & ANDREWS, *supra* note 84; Bonta et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Metaanalysis*, *supra* note 74, at 135.

⁸⁹ See *supra* notes 74–79 and associated text; Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too*, *supra* note 63, at 220.

⁹⁰ See J. Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illnesses*, 53 *PSYCHIATRIC SERVS.* 565, 565 (2003) (arguing that “[p]overty moderates the relationship between serious mental illness” and criminal behavior).

⁹¹ See Fisher et al., *Community Mental Health Services*, *supra* note 80, at 38 (“[A] conceptual model . . . would see severe mental illness as generating a set of social and economic statuses which in turn place individuals with those illnesses at risk for criminal justice involvement. Indeed, they experience the same kind of risk encountered by others of similar socioeconomic status who do not have serious mental illness.”)

⁹² See RICHARD D. SCHNEIDER ET AL., *MENTAL HEALTH COURTS: DECRIMINALIZING THE MENTALLY ILL* 57 (2007); Jeffrey Draine, *Mental or Criminal?*, 356 *LANCET* s48, s48 (SPECIAL ISSUE) (2000); see also Fred C. Osher & Henry J. Steadman, *Adapting Evidence-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System*, 58 *PSYCHIATRIC SERVS.* 1472, 1473 (2007) (“In jails 30.3% of inmates with mental illnesses were homeless in the year before arrest, compared with 17.3% of other inmates. Not having a home upon release from jail or prison also increases the risk of rearrest.”).

⁹³ See Lynette Feder, *A Comparison of the Community Adjustment of Mentally Ill Offenders with Those from the General Prison Population*, 15 *LAW & HUM. BEHAV.* 477, 483 (1991) (“Regardless of whether the mentally ill offenders were released from the prison or from the hospital, they were significantly less likely to receive support from family or friends upon release into the community (56% vs. 80% for those in the general prison population.”)).

⁹⁴ See Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too*, *supra* note 63, at 218 (finding that offenders with mental illness had significantly higher scores for the general risk factors of antisocial pattern, family or marital problems, low educational or employment success, and procriminal attitude orientation than their non-disordered counterparts); L. Girard & J. Wormith, *The Predictive Validity of the Level of Service Inventory-Ontario Revision on General and Violent Recidivism Among Various Offender Groups*, 31 *CRIM. JUST. & BEHAV.* 150 (2004) (finding, in a sample of 600 probationers that those with mental health problems (n=169) had significantly more general risk factors than those without mental illness); Nancy Wolff et al., *Thinking Styles and Emotional States of Male and Female Prison Inmates by Mental Disorder Status*, 62 *PSYCHIATRIC SERVS.* 1485, 1490–91 (2011) (finding that inmates who reported a

Strong evidence demonstrates that all of the Central Eight criminogenic risk factors—with the exception of established criminal history—are dynamic or capable of change.⁹⁵ Studies show that the most effective programs for reducing recidivism are those that target these dynamic risks.⁹⁶ Evidence demonstrates that appropriate offender rehabilitation programs that address criminogenic variables can reduce recidivism by 30%.⁹⁷ In light of this evidence, James Bonta and D.A. Andrews issued this opinion in relation to programs directed at offenders with mental illness:

Our argument is that if [mental health] treatment services are offered with the intention of reducing recidivism, changes must be encouraged on criminogenic need factors. Offenders also have a right to the highest quality service for their other needs, but that is not the focus of correctional rehabilitation. Striving to change noncriminologic needs is unlikely to alter future recidivism significantly unless it indirectly impacts on a criminogenic need. We may make an offender feel better, which is important and valued, but this may not necessarily reduce recidivism.⁹⁸

Thus, strong empirical evidence demonstrates that reducing recidivism of offenders with mental illness necessitates prioritizing the treatment of criminogenic risk factors, not merely treating the non-criminogenic factor of serious mental illness.

Recently, social scientists have begun to investigate the relationship of criminogenic risk factors to MHC success and failure.⁹⁹ Investigation of features of MHC participation

mental disorder scored significantly higher on measures of aggression and hopelessness and showed antisocial attitudes similar to or greater than those who did not report a mental disorder).

⁹⁵ See BONTA & ANDREWS, *supra* note 84, at 63.

⁹⁶ See, e.g., Craig Dowden & D.A. Andrews, *Effective Correctional Treatment and Violent Reoffending: A Meta-Analysis*, 42 CANADIAN J. CRIMINOLOGY 449, 459 (2000); Craig Dowden & D.A. Andrews, *The Importance of Staff Practices in Delivering Effective Correctional Treatment: A Meta-analysis of Core Correctional Practices*, 48 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 203, 211–12 (2004) (concluding that, when the principles of risk, need, and responsivity are followed in a rehabilitation program, “then we see average recidivism differences between the treated and non-treated offenders of 17% when delivered in residential/custodial settings and 35% when delivered in community settings”); D.A. Andrews & James Bonta, *Rehabilitating Criminal Justice Policy and Practice*, 16 PSYCHOL. PUB. POL'Y & L. 39, 47–48 (2010) (summarizing the empirical base for the RNR model).

⁹⁷ See Craig Dowden et al., *The Effectiveness of Relapse Prevention with Offenders: A Meta-analysis*, 47 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 516, 522 (2003); A. Murray Ferguson et al., *Predicting Recidivism by Mentally Disordered Offenders Using the LSI-R:SV*, 36 CRIM. JUST. & BEHAV. 5, 8 (2009); Dowden & Andrews, *The Importance of Staff Practices*, *supra* note 96, at 212 (2004); Andrews & Bonta, *supra* note 96, at 47–48.

⁹⁸ D.A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 244 (2d ed. 1998); see also Eric Silver, *Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective*, 30 LAW & HUM. BEHAV. 685, 689 (2006) (“If mental disorder is only a small part of the problem, services aimed at its control can only be a small part of the solution.”).

⁹⁹ See, e.g., Natalie Bonfine et al., *Exploring the Relationship Between Criminogenic Risk Assessment and Mental Health Court Program Completion*, 45 INT'L J. L. & PSYCHIATRY 9, 14 (2016) (finding that, net

beyond graduation status that contribute to reduced recidivism has been limited,¹⁰⁰ but some research suggests that addressing offenders' criminogenic risks and needs may contribute to MHC success.¹⁰¹ In addition, a small but growing body of research indicates that criminogenic characteristics related to a history antisocial behavior—prior number of arrests, incarcerations, or jail days; first offending prior to age 18; and prior probation or parole violation—are all associated with an increased rate of rearrest for MHC participants.¹⁰² Studies diverge on the relationship of substance abuse to likelihood of rearrest.¹⁰³

One recent study suggests that addressing environmental supports such as homelessness may contribute to MHC success. A 2018 study by Lauren Gonzales and Dale McNeil investigated the relationship between MHC participation, homelessness, and perpetration of violence and found that homelessness functioned as “a significant mediator of the relationship between MHC participation and lower risk of violence, such that when added to the model, the impact of MHC participation upon violence became nonsignificant.¹⁰⁴ This makes sense because “[h]omelessness can . . . be conceptualized as either a combination or consequence of other criminogenic variables for individuals involved with the criminal justice system.”¹⁰⁵ The study authors suggested that considerations of

of prior criminal history, high criminogenic risk/need level was associated with failure to graduate in one MHC); *infra* notes 100–104.

¹⁰⁰ Lowder et al., *Effectiveness of Mental Health Courts*, *supra* note 13, at 19 (“[A]ddressing the criminogenic risks and needs (for example, financial resources, housing, and procriminal attitudes) of MHC participants may contribute to greater reductions in recidivism, although the extent to which these criminogenic risks and needs are addressed in MHC case management and supervision is unknown.”).

¹⁰¹ See Mary Ann Campbell et al., *Multidimensional Evaluation of a Mental Health Court: Adherence to the Risk-Need-Responsivity Model*, 39 LAW & HUM. BEHAV. 489, 491 (2015) (finding, in a study of 196 offenders referred to a MHC over an eight-year period, that graduates experienced “moderate reductions in general recidivism risk and criminogenic needs, whereas partial-completers and nonstarters had little to no changes in these areas”); Lauren Gonzales & Dale E. McNeil, *Can Reduced Homelessness Help Explain Public Safety Benefits of Mental Health Court?*, 24 PSYCHOL., PUB. POL’Y, & L. 271 (2018) (finding that the MHC in San Francisco indirectly decreased rates of violence by decreasing the rate of homelessness among MHC participants); see also Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 121 (opining that, when specialized programs for offenders with mental illness work, they do so by inadvertently addressing criminogenic needs by, for instance, focusing on criminal thinking, reducing unemployment and homelessness, or “target[ing] factors that get an offender in trouble”).

¹⁰² See, e.g., Laura N. Honegger & Kyle S. Honegger, *Criminogenic Factors Associated with Noncompliance and Rearrest of Mental Health Court Participants*, 46 CRIM. JUST. & BEHAV. 1276, 1277, 1290 (2019); Padraic J. Burns et al., *Effectiveness 2 Years Postexit of a Recently Established Mental Health Court*, 57 AM. BEHAV. SCIENTIST 189 (2013); Warren A. Reich et al., *Predictors of Mental Health Court Program Compliance and Rearrest in Brooklyn, New York*, 54 J. OFFENDER REHAB. 391 (2015); Henry J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days*, 68 ARCHIVES GEN. PSYCHIATRY 167 (2011).

¹⁰³ Compare Honegger & Honegger, *supra* note 102, at 1277, 1290 (“[W]hile substance-related diagnoses were associated with an increased rate of receiving a jail sanction or bench warrant, the present study found no strong evidence of a relationship between substance diagnosis and rearrest.”), with Reich et al., *supra* note 102.

¹⁰⁴ Gonzales & McNeil, *supra* note 101, at 274 (2018).

¹⁰⁵ *Id.* at 275.

homelessness be integrated into treatment plans for MHC participants to enhance beneficial outcomes.¹⁰⁶

III. Treatment of Offenders with Mental Illness

The weight of the evidence suggests that effective interventions for offenders with serious mental illness require adopting a treatment framework that spans beyond mental health to address the broader set of criminogenic needs proven to drive criminal behavior.¹⁰⁷ Recently, some social scientists and policy advocates have suggested that the Risk-Needs-Responsivity (RNR) model, a highly influential correctional model that targets criminogenic needs, may provide a useful guide for MHCs, as well as the treatment of offenders with mental illness generally.¹⁰⁸

A. Risk-Needs-Responsivity Model

The RNR model is the leading evidence-based offender assessment and treatment model in the world.¹⁰⁹ The treatment framework involves three core principles: risk, need, and responsivity. The risk principle holds that the intensity of treatment services should match the risk level of the offender.¹¹⁰ Effectuating this principle requires designing and properly using reliable and valid evidence-based risk assessment instruments and then appropriately matching the level of service to an offender's risk level.¹¹¹ On the latter point, offenders at the highest risk levels should receive the most intensive services in order to yield the greatest reductions in recidivism.¹¹² Low-level offenders, on the other hand, should receive minimal or no services.¹¹³ Indeed, some studies have found that the intensive treatment of low-risk offenders can make them more likely to recidivate, likely because of their association with higher risk offenders and increased surveillance.¹¹⁴

¹⁰⁶ *Id.* at 275.

¹⁰⁷ See Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 116.

¹⁰⁸ See, e.g., Carol Fisler, *When Research Challenges Policy and Practice Toward A New Understanding of Mental Health Courts*, 54 JUDGES J. 8, 11 (2015) (suggesting the RNR model for MHCs); Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 121; Honegger & Honegger, *supra* note 102, at 1291.

¹⁰⁹ BONTA & ANDREWS, *supra* note 84, at 186.

¹¹⁰ *Id.* at 187.

¹¹¹ JAMES BONTA & D.A. ANDREWS, RISK-NEED-RESPONSIVITY MODEL FOR OFFENDER ASSESSMENT AND REHABILITATION 9 (2007), <https://www.pbpp.pa.gov/Information/Documents/Research/EBP7.pdf>.

¹¹² BONTA & ANDREWS, *supra* note 84, at 190–91.

¹¹³ *Id.*

¹¹⁴ See BONTA & ANDREWS, RISK-NEED-RESPONSIVITY MODEL, *supra* note 111, at 10 (collecting studies).

The need principle dictates that, to reduce risk of recidivism, treatment must focus on addressing an offender's set of dynamic criminogenic needs as opposed to focusing on other needs that are more distally related to offending.¹¹⁵ According to Andrews and colleagues:

The most promising intermediate targets include changing antisocial attitudes, feelings, and peer associations; promoting familial affection in combination with enhanced parental monitoring and supervision; promoting identification with anticriminal role models; increasing self-control and self-management skills; replacing the skills of lying, stealing, and aggression with other, more prosocial skills; reducing chemical dependencies; and generally shifting the density of rewards and costs for criminal and noncriminal activities in familial, academic, vocational, and other behavioral settings."¹¹⁶

The responsivity principle, which consists of general and specific components, focuses on effective service delivery. General responsivity dictates that interventions should target the right variables and be capable of addressing those variables.¹¹⁷ General responsivity calls for the use of cognitive-behavioral and cognitive-social learning strategies to influence behavior.¹¹⁸ Appropriate strategies include modeling and skill development, rehearsal, role playing, reinforcement, resource provision, detailed verbal guidance and explanations, and "practicing new, low-risk alternative behaviors repeatedly in a variety of high-risk situations until one gets very good at it."¹¹⁹ Applications of these practices involve the utilization of certain core correctional skills, including effective use of authority (a "firm but fair" approach), prosocial modeling and positive reinforcement, problem-solving, brokerage of community resources, and high quality relationships between staff and offenders.¹²⁰

The principle of specific responsivity, on the other hand, holds that service providers should tailor intervention strategies to match the setting of service and an offender's relevant characteristics.¹²¹ Of the core RNR principles, specific responsivity is the least developed or

¹¹⁵ See BONTA & ANDREWS, *supra* note 84, at 191–92; see *supra* notes 84–88 and associated text (discussing the Central Eight criminogenic needs).

¹¹⁶ D.A. Andrews et al., *Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis*, 28 CRIMINOLOGY 369, 375 (1990).

¹¹⁷ See Francis T. Cullen, *Rehabilitation: Beyond Nothing Works*, 42 CRIME & JUST. 299, 343 (2013).

¹¹⁸ BONTA & ANDREWS, *supra* note 84, at 187.

¹¹⁹ *Id.* at 193.

¹²⁰ See Andrews et al., *Does Correctional Treatment Work?*, *supra* note 116, at 375–76; Donald Andrews et al., *The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practices*, 48 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 203, 204 (2004).

¹²¹ See BONTA & ANDREWS, *supra* note 84, at 187.

understood.¹²² In 1995, Bonta stated that specific responsivity “focuses on personal characteristics that regulate an individual’s ability and motivation to learn.”¹²³ To facilitate effective treatment, programs should build on an individual’s strengths and reduce barriers to participation.¹²⁴

Social scientists have conceptualized mental health features, such as anxiety or depression, as specific responsivity factors that may impede the treatment of criminogenic needs.¹²⁵ Mental illness is a destabilizer that increases life’s demands, affects decision-making, and generates stress.¹²⁶ As Andrews and Bonta pithily explained, “[o]ne cannot successfully deal with a substance addiction if the client is psychotic; one cannot deal with employment problems if the person is suicidal.”¹²⁷ Numerous meta-analyses establish that mental health factors (and the treatment of mental health factors) are largely unrelated to recidivism,¹²⁸ but scholars have hypothesized that an individual’s mental illness may need to be stabilized so that she will be willing and able to participate in criminogenic-focused interventions.¹²⁹ However, little empirical research has interrogated the import of various aspects of mental health or mental health treatment for effective correctional treatment.¹³⁰ As Sarah McCormick and her colleagues have observed, because “responsivity variables have received little empirical attention in the RNR literature . . . this classification of mental health variables contributes little clarification as to their role, either in terms of risk

¹²² See Sarah McCormick et al., *The Role of Mental Health and Specific Responsivity in Juvenile Justice Rehabilitation*, 41 LAW & HUM. BEHAV. 55, 56 (2017); Thomas H. Cohen & Jay Whetzel, *The Neglected “R”-Responsivity and the Federal Offender*, 78 FED. PROB. 11, 17 (2014).

¹²³ James Bonta, *Responsivity Principle and Offender Rehabilitation*, 7 F. ON CORRECTIONS RES. 34, 35 (1995).

¹²⁴ D.A. Andrews, *The Risk-Need-Responsivity (RNR) Model of Correctional Assessment and Treatment*, in USING SOCIAL SCIENCE TO REDUCE VIOLENT OFFENDING 127, 139 (Joel A. Dvoskin et al., eds., 2011).

¹²⁵ See, e.g., Bonta, *Responsivity Principle*, *supra* note 123, at 36 tbl.1; Faye S. Taxman, *Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity*, 78 FED. PROB. 32, 33, 35 (2014); BONTA & ANDREWS, RISK-NEED-RESPONSIVITY MODEL, *supra* note 111. Importantly, the RNR model does not opine on the responsivity effect of particular diagnostic categories of mental illnesses but rather speaks to “particular features” of mental health and functioning. See Sarah McCormick et al., *Mental Health and Justice System Involvement: A Conceptual Analysis of the Literature*, 21 PSYCHOL. PUB. POLICY & L. 213, 217–18 (2015); see e.g., BONTA & ANDREWS, *supra* note 84, at 353 tbl.15.4 (including “cognitive/interpersonal skill level,” “interpersonal anxiety,” and “antisocial personality pattern” factors, as well as “mental disorder,” under the specific responsivity principle).

¹²⁶ See Taxman, *supra* note 125, at 35–37. (discussing the importance of stabilizers and destabilizers to specific responsivity).

¹²⁷ D.A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 311 (5th ed. 2010).

¹²⁸ See *supra* notes 74–79.

¹²⁹ See, e.g., Bonta, *Responsivity Principle*, *supra* note 123, at 37 (“Anxiety, depression and perhaps even some severe forms of mental disorder are key responsivity factors. . . [B]efore targeting criminogenic needs such as antisocial attitudes, responsivity factors may need to be addressed to prepare the offender to learn prosocial behaviour.”).

¹³⁰ See Skeem et al., *Applicability of the Risk-Need-Responsivity Model*, *supra* note 69, at 920 (“We are aware of no empirical support for the responsivity principle among persons with mental illness.”).

assessment or rehabilitative programming”¹³¹ Thus, it is currently unclear whether the treatment of mental health features facilitates or enhances the treatment of criminogenic needs.¹³²

B. Current Implementation of RNR Model

Even though “there is as yet no direct support for the applicability of the three core RNR principles to treat this population,”¹³³ a groundswell is building to apply the RNR model to offenders with serious mental illness, including MHCs.¹³⁴ This chorus consists of federal agencies, policy advocates, and social scientists and has resulted in the development of new risk assessment instruments and adapted cognitive-behavioral interventions.¹³⁵

The federal government now endorses the RNR model for allocation of services to individuals with mental illness in correctional institutions and on parole or probation.¹³⁶ In 2012, the Council of State Governments Justice Center, in partnership with a number of federal agencies,¹³⁷ published a framework and white paper to coordinate the activities of correctional and behavioral health service providers for this population.¹³⁸ The paper notes that “recent studies” undermine the criminalization theory and “suggest[] that interventions to reduce recidivism among people with mental illness in the criminal justice system need to not only include traditional mental health treatment, but also incorporate new multifaceted strategies.”¹³⁹ The framework for resource allocation includes three dimensions: criminogenic risk, need for mental health treatment, and need for substance abuse treatment.¹⁴⁰ In accordance with RNR principles, the framework dictates that institutions and practitioners prioritize those offenders at higher risk of recidivism to receive scarce correctional programming, services, and treatment resources.¹⁴¹ Providers should only address offenders’ mental health needs to the extent necessary to allow for the successful

¹³¹ McCormick et al., *supra* note 125, at 218.

¹³² *Id.* at 220.

¹³³ Skeem et al., *Applicability of the Risk-Need-Responsivity Model*, *supra* note 69, at 916.

¹³⁴ See, e.g., Honegger & Honegger, *supra* note 102, at 1291.

¹³⁵ See Johnston, *Reconceptualizing Criminal Justice Reform*, *supra* note 1, at 546–47.

¹³⁶ See FRED OSHER ET AL., COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION: A SHARED FRAMEWORK FOR REDUCING RECIDIVISM AND PROMOTING RECOVERY 45 (2012), https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf.

¹³⁷ These agencies include the Department of Justice’s National Institute of Corrections and Bureau of Justice Assistance as well as the Department of Health and Human Service’s Substance Abuse and Mental Health Services Administration (SAMSA).

¹³⁸ See *id.*

¹³⁹ *Id.* at 5.

¹⁴⁰ See *id.* at 32, 33 fig. 5.

¹⁴¹ *Id.* at 24, 36.

treatment of criminogenic needs and to satisfy constitutional obligations.¹⁴² The federal government has promoted the operationalization of this framework through funding and guidance.¹⁴³

In response to this call to action and the decades of science preceding it, social scientists have begun to create or adapt evidence-based assessment tools and interventions for use with offenders with mental illness. Empirical studies support the use of general risk assessment tools—including the leading correctional tool, the Levels of Service/Case Management Inventory (LS/CMI)—to measure this group’s risk of recidivism.¹⁴⁴ On the treatment front, Robert Morgan and colleagues created the Changing Lives and Changing Outcomes program, an evidenced-based intervention for this population that addresses mental health and criminogenic needs.¹⁴⁵ When adapting general risk reduction interventions, scholars have emphasized that modifications may be necessary to address the treatment needs of offenders with serious mental illness, accommodate their particular cognitive and emotional impairments, and deliver the intervention in a community mental health setting.¹⁴⁶ To date, one popular, structured cognitive-behavioral intervention for criminogenic risk factors—the “Reasoning and Rehabilitation” (R&R) program—has been modified to accommodate the learning abilities of offenders with mental illness. Several controlled studies have shown that this modified version can improve coping skills and reduce antisocial attitudes, violent thoughts, disruptive behavior, and substance abuse among forensic patients.¹⁴⁷ Other programs—including Thinking for a Change, Options, Moral

¹⁴² See *id.* at 7*, 24, 35–36. The white paper stresses that low risk inmates with high clinical needs should not be prioritized for the receipt of scarce mental health services, programming, or other correctional resources such as monitoring and supervision on probation. Such inmates, if incarcerated, should have their needs addressed to the extent necessary to satisfy correctional institutions’ duties to provide health care under the Eighth Amendment. On probation or at reentry, “these low-risk/high-need individuals should be linked to effective treatments for which they are eligible and that can be paid for by existing behavioral health financing mechanisms, such as Medicaid and other local, state, and federal funding sources.” *Id.* at 35.

¹⁴³ See, e.g., POLICY RESEARCH ASSOCS., GUIDELINES FOR SUCCESSFUL TRANSITION OF PEOPLE WITH MENTAL OR SUBSTANCE USE DISORDERS FROM JAIL AND PRISON: IMPLEMENTATION GUIDE (2017), <https://store.samhsa.gov/system/files/sma16-4998.pdf>; ALEX M. BLANDFORD & FRED OSHER, GUIDELINES FOR THE SUCCESSFUL TRANSITION OF PEOPLE WITH BEHAVIORAL HEALTH DISORDERS FROM JAIL AND PRISON (2013), <https://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-Successful-Transition.pdf>.

¹⁴⁴ Skeem et al., *Applicability of the Risk-Need-Responsivity Model*, *supra* note 69, at 917–18.

¹⁴⁵ See Robert Morgan et al., *Treating Justice-involved Persons with Mental Illness: Preliminary Evaluation of a Comprehensive Treatment Program*, 41 CRIM. J. & BEHAV. 902 (2014). While a preliminary evaluation showed reductions in psychological symptoms and criminal thinking, the program’s effect on recidivism is unknown. See BONTA & ANDREWS, *supra* note 84, at 332.

¹⁴⁶ See Amy Blank Wilson et al., *Translating Interventions that Target Criminogenic Risk Factors for use in Community Based Mental Health Settings*, 53 COMMUNITY MENTAL HEALTH J. 893 (2017); Merrill Rotter & W. Amory Carr, *Targeting Criminal Recidivism in Mentally Ill Offenders: Structured Clinical Approaches*, 47 COMMUNITY MENTAL HEALTH J. 723, 724–25 (2011); Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 120–21; Morgan et al., *Prevalence of Criminal Thinking*, *supra* note 80, at 334.

¹⁴⁷ See BONTA & ANDREWS, *supra* note 84, at 332; Skeem et al., *Applicability of the Risk-Need-Responsivity Model*, *supra* note 69, at 919 (collecting studies).

Reconciliation Therapy, and Interactive Journaling—have also been applied to offenders with mental illness.¹⁴⁸ In addition, structural mental health interventions that “emphasize clinical features associated with criminality such as frustration intolerance, social skills deficits, and misperceptions of the environment” have been modified for justice-involved individuals.¹⁴⁹ These efforts are nascent, however, and it appears that very little treatment currently offered to offenders with mental illness coheres with the RNR model.¹⁵⁰

Consistent with the RNR framework, some social scientists and policy advocates contend that MHCs should be modified to better and more systematically address criminogenic needs and to allocate resources by risk level. Researchers have urged MHCs to increase attention paid to participants’ criminogenic needs,¹⁵¹ and several scholars have suggested limiting these courts to high-risk individuals at high clinical need¹⁵² or, alternatively, accepting all individuals with high clinical needs but adopting multiple supervision tracks to address different levels of criminogenic risk.¹⁵³ However, recent commentary on the state of correctional programs reflects that these programs largely remain focused on clinical—not criminogenic—needs.¹⁵⁴

¹⁴⁸ See MERRILL ROTTER & W. AMORY CARR, SAMHSA’S GAINS CTR. FOR BEHAV. HEALTH & JUST. TRANSFORMATION, REDUCING CRIMINAL RECIDIVISM FOR JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESS: RISK/NEEDS/RESPONSIVITY AND COGNITIVE-BEHAVIORAL INTERVENTIONS 3 (2013).

¹⁴⁹ *Id.* (discussing the use of Dialectical Behavioral Therapy and Schema Focused Therapy).

¹⁵⁰ See Marshall T. Bewley & Robert D. Morgan, *A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who Is Doing What?*, 35 LAW & HUM. BEHAV. 351, 360 (2011) (finding, in a survey of 230 mental health service providers in 165 state correctional facilities, that only 15.7% reported incorporating each of the three RNR principles into their work with offenders with mental illness); BONTA & ANDREWS, *supra* note 84, at 331 (“Clinical intervention with the MDO [mentally disordered offender] usually involve treating psychological complaints or the behaviors that are disruptive to the functioning of the institution.”).

¹⁵¹ See, e.g., Bonfine et al., *Exploring the Relationship*, *supra* note 99; Fisler, *When Research Challenges Policy*, *supra* note 108, at 11; Campbell et al., *supra* note 101.

¹⁵² See Skeem et al., *Correctional Policy for Offenders with Mental Illness*, *supra* note 62, at 122 (advancing a model that would reserve intensive supervision and psychiatric treatment for those with the greatest criminogenic risk and clinical need and merely provide “good enough” supervision and community treatment for low-risk, low-need individuals).

¹⁵³ See Bonfine et al., *supra* note 151, at 14 (suggesting this approach); Bradley Ray et al., *Mental Health Court Outcomes by Offense Type at Admission*, 42 ADMIN. POL’Y MENTAL HEALTH 323, 330 (2015) (suggesting that “MHCs might consider modifying the intensity of the supervision for low-risk offenders”).

¹⁵⁴ See Fisler, *When Research Challenges Policy*, *supra* note 108, at 11 (explaining that most communities cannot afford to offer evidence-based practices through MHCs and that “far too many provide only minimal medication and counseling”); Honegger & Honegger, *supra* note 102, at 1276 (“In general, MHCs hold that psychiatric symptoms influence the criminal behavior of individuals with mental illness”); Debra A. Pinals, *Jail Diversion, Specialty Court, and Reentry Services: Partnerships between Behavioral Health and Justice Systems*, in PRINCIPLES & PRACTICE OF FORENSIC PSYCHIATRY 237, 239 (Richard Rosner & Charles Scott, eds., 3d ed. 2017) (reviewing the evolution of jail diversion and reentry programs and stating that, while RNR is “an increasingly emphasized sorting approach to help determine who can benefit most from particular diversion strategies,” “[t]raditional clinical services have not embraced or incorporated these [RNR] principles yet”).

IV. Recommendations

Depending on the ultimate aim of the Committee and Commission, I have a number of recommendations to suggest. These are detailed below.

A. Improve D.C. MHCC

If the Committee's aim is to optimize the D.C. MHCC to reduce the cycling of offenders with mental illness through the criminal justice system, I suggest taking the following steps. First, to reduce the possibility of net-widening, alter eligibility criteria to exclude low-level misdemeanors and prioritize individuals charged with felonies.¹⁵⁵ The criminal justice realities of the MHC system, at least as they appear now, militate toward excluding those charged with low-level crimes who would most likely face time served or a term of probation (with much less intensive conditions) if convicted.¹⁵⁶ Individuals charged with felonies are less likely to have their cases dismissed and, if convicted, would face long prison sentences. For these offenders, a MHC would offer an opportunity to avoid likely incarceration and the known dangers and hardships that incarceration poses for individuals with serious mental illness. While traditionally MHCs have prioritized those charged with misdemeanors, it appears that courts are increasingly accepting individuals charged with felonies.¹⁵⁷ I do not know the extent to which the participants of the D.C. MHCC have been charged with felonies or misdemeanors, but I urge the Committee to consider prioritizing (if not limiting the court) to the former.

Second, I recommend aligning MHCC eligibility criteria and treatment aims with RNR principles. In particular, use a validated risk assessment instrument to measure potential participants' risk levels and identify targets for treatment. Limit eligibility to high-risk offenders and focus treatment on criminogenic needs. Address participants' individual responsivity factors, including mental illness and learning styles, to facilitate their engagement in criminogenic needs interventions. Also consider adding environmental supports such as housing and employment assistance to facilitate environmental security.

¹⁵⁵ See, e.g., Ray et al., *What Happens to Mental Health Court Noncompleters?*, *supra* note 18, at 810 ("If it is the case that charges will ultimately be dismissed, then perhaps MHCs should consider limiting eligibility to more serious offenders, who are not eligible for other diversion programs."); Canada et al., *supra* note 13, at 88 ("The findings from this study suggest that [accepting felonies] may be a positive trend, as MHC defendants with a felony are at no greater risk of recidivism, but also that felony MHCs experience the greatest success in outcomes."); Ray et al., *Mental Health Court Outcomes by Offense Type at Admission*, *supra* note 153, at 329 (finding that misdemeanor defendants—both graduates and noncompleters—had increases in jail days during and after MHC supervision and suggesting the MHC intervention may be too intensive for low-risk offenders and produce an iatrogenic effect; also finding that people entering with felony charges had fewer days in jail after MHC, whether they graduated or not, but were more at risk of not completing MHC).

¹⁵⁶ See Bernstein & Seltzer, *supra* note 19, at 147, 154.

¹⁵⁷ See JENNIFER CHADWICK ERWIN, EXPLORING INDIVIDUAL- AND COURT-LEVEL PREDICTORS OF MENTAL HEALTH COURT COMPLETION 71–72 (Dec. 2018) (unpublished Ph.D. dissertation, University of Tennessee) (on file with Trace: Tennessee Research and Creative Exchange), https://trace.tennessee.edu/utk_graddiss/5302 (finding from an electronic survey that, of MHCs that responded to the survey, 50% allow defendants with violent felonies to enroll).

Existing evidence suggests (although it does not yet establish) that MHCs focused on addressing criminogenic risks may yield the greatest reductions in recidivism.

Third, I recommend the collection of data to allow for the evaluation and improvement of the MHCC. Data is necessary to determine for whom the MHCC works and at what cost, so that the court can be tailored to maximize its effectiveness and efficiency. To that end, administrators should retain records on the characteristics (diagnosis, risk level, criminal charges, sex, race, ethnicity, age, and criminal history) of MHCC referrals, participants, and graduates. They should also retain records on eligibility requirements, procedures, and services offered. Data should be collected on graduates and those who do not complete the program, including whether each participant enters the specialty court under an amended sentencing agreement, deferred sentencing agreement, or deferred prosecution agreement; participation length; services utilized (referrals and engagement); number of days of incarceration during the program; completion status (and, if terminated, the reason for termination); disposition after termination (e.g., dismissal or the sentence given when returned to the D.C. criminal court); and 12-36 months of rearrest data after exiting the program. A MHC's "success" can be defined in multiple ways, so it is important to collect data on the extent to which the MHCC reduces recidivism, reduces overall incarceration, and improves the psychosocial functioning of participants, both graduates and those who do not complete the program.

B. Reduce Involvement of Individuals with Mental Illness in the Criminal Justice System

The D.C. Project Proposal suggests that the Committee's aim extends beyond the D.C. MHCC.¹⁵⁸ If the Committee's goal is to reduce the involvement of individuals with mental illness in the criminal justice system, I recommend that the Committee consider the Sequential Intercept Model (SIM).¹⁵⁹ SIM's ideal is that mental illness should not cause individuals with mental illness to be involved in the criminal justice system more than other individuals in the community.¹⁶⁰ SIM identifies five key points where individuals with mental illness can be intercepted from the normal criminal justice system.¹⁶¹ These "points of interception" are (1) law enforcement; (2) initial detention and initial hearings; (3) jails, courts, forensic evaluations, and forensic commitments; (4) reentry from jails, state prisons, and forensic hospitalization; and (5) community corrections and community support services.¹⁶²

¹⁵⁸ Davis, *supra* note 2.

¹⁵⁹ For a brief overview of this model, see *The Sequential Intercept Model*, POLICY RESEARCH ASSOCS. (June 2018), <https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf>.

¹⁶⁰ Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 544, 544 (2006).

¹⁶¹ Kirk Heilbrun et al., *The Movement Toward Community-Based Alternatives to Criminal Justice Involvement and Incarceration for People with Severe Mental Illness*, in *THE SEQUENTIAL INTERCEPT MODEL AND CRIMINAL JUSTICE* 1, 5–6 (Patricia A. Griffin et al. eds., 2015).

¹⁶² Munetz & Griffin, *supra* note 160, at 545.

Often, law enforcement officers are the first point of contact with the criminal justice system for individuals with mental illness.¹⁶³ Individuals with mental illness tend to interact with law enforcement more often than other individuals do.¹⁶⁴ Without specialized training, police officers “are more likely to arrest individuals with mental illness than to help them seek treatment.”¹⁶⁵ Pre-arrest diversion programs (such as deploying mental health professionals in mobile crisis teams, employing mental health workers to advise police officers in the field, and having specially trained officers respond to calls involving mentally ill individuals) can keep individuals with mental illness from entering the criminal justice system.¹⁶⁶

After an arrest, initial detention and initial hearings provide another point of intercept.¹⁶⁷ Post-arrest screenings for mental illness allow courts to divert individuals into treatment programs instead of incarcerating or prosecuting these individuals.¹⁶⁸ The third intercept involves jails and courts.¹⁶⁹ Because many inmates have mental illnesses, jails and prisons need to provide quality mental health care.¹⁷⁰ In the court system, this intercept may involve specialized dockets and diversion programs such as MHCs.¹⁷¹

At the fourth intercept—reentry from jails, prisons, and hospitals—these institutions should help individuals with mental illness transition into appropriate care in the community.¹⁷² Unfortunately, there is often “little continuity of care between corrections and community mental health systems.”¹⁷³ The criminal justice system can create continuity by planning for the transition and by facilitating contact between the mental health provider and the individual before or at release.¹⁷⁴ Specifically, I recommend that the Committee urge jails and prisons to connect departing individuals—through an actual

¹⁶³ *Id.* at 545–46.

¹⁶⁴ Heilbrun et al., *supra* note 161, at 7.

¹⁶⁵ *Id.*

¹⁶⁶ See Munetz & Griffin, *supra* note 160, at 545–46; see also JANEEN BUCK WILLISON ET AL., URBAN INST., USING THE SEQUENTIAL INTERCEPT MODEL TO GUIDE LOCAL REFORM 3 (2018), https://www.urban.org/sites/default/files/publication/99169/using_the_sim_to_guide_local_reform__1.pdf.

¹⁶⁷ Munetz & Griffin, *supra* note 160, at 546.

¹⁶⁸ *Id.*; see also WILLISON ET AL., *supra* note 166, at 3 (“Strategies include use of validated screening to detect mental health issues, substance use disorders, and co-occurring disorders; pretrial diversion for low-level offenses with treatment as a condition of probation; and, data-matching between systems to link people to services.”).

¹⁶⁹ Munetz & Griffin, *supra* note 160, at 547.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² See *id.*

¹⁷³ *Id.*

¹⁷⁴ See WILLISON ET AL., *supra* note 166, at 4.

appointment—to a community mental health provider upon release and provide them with a three-month supply of medication. Before inmates leave confinement, jails and prisons should actively facilitate inmates' enrollment in federal income support programs like the Supplemental Security Income program (SSI) and health care programs like Medicaid.

The fifth intercept involves those individuals on probation and parole.¹⁷⁵ Probation and parole officers should be sensitive to the needs of individuals with mental illness and should work closely with mental health care providers in the community.¹⁷⁶ Communities can create specialized caseloads for individuals with mental illness and can use graduated responses to address problematic behavior instead of technical violations with jail time.¹⁷⁷ SIM is a useful framework for recognizing how individuals with mental illness are involved in the criminal justice system and how communities can keep these individuals from entering or reentering that system.¹⁷⁸

C. Address Broader Problem of Unmet Mental Health Needs

Finally, if the Committee's aim is to address the broader problem of unmet mental health needs in D.C. community, I recommend that the Committee invest in evidence-based community mental health services. To be clear, I do not recommend further investment in the D.C. MHCC. MHCs suffer from many of the problems discussed earlier and, in addition, lead mental health authorities to prioritize the delivery of scarce resources to those charged with criminal activity. Instead, I recommend that the Committee work to expand community mental health services and supports. As Robert Bernstein and Tammy Seltzer of the Judge David L. Bazelon Center for Mental Health Law have observed:

Breaking the cycle of repeated contact with the criminal or juvenile justice systems must start with expanded and more focused community-based services and supports. As currently configured in many communities, public mental health services are substantially targeted at prioritized populations: people exiting state psychiatric institutions, people regarded as being at risk of admission to these facilities, people in crisis and people whose treatment is governed by court orders. Individuals not falling into a defined priority group may find very limited services available to them.¹⁷⁹

If community mental health services are plentiful and accessible, resources can reach individuals before they become involved in the criminal justice system. These services would include supportive housing and assertive community treatment, among others. For

¹⁷⁵ Munetz & Griffin, *supra* note 160, at 547.

¹⁷⁶ *See id.*

¹⁷⁷ WILLISON ET AL., *supra* note 166, at 4.

¹⁷⁸ *See* Munetz & Griffin, *supra* note 160, at 547–48.

¹⁷⁹ Bernstein & Seltzer, *supra* note 19, at 148.

further guidance on how to maximize investment in a community mental health system, I suggest consulting with experts on that topic.

I appreciate your request to share my views on these important topics and would be happy to answer any questions or provide any resources that would be helpful to the Committee moving forward.

Prepared Written Statement of Judge Ann O'Regan Keary

Introduction

In 2007 the Superior Court of the District of Columbia took a significant step in attempting to address the issue on which the Committee is focusing at today's public hearing -- mentally ill persons in our local Criminal Justice System. That year, we launched a pilot mental health diversion program for criminal defendants in our Court, to divert seriously and persistently mentally ill persons out of the criminal misdemeanor calendars and into a completely different court calendar -- one aimed not at determining guilt or innocence on the criminal charges, but instead at getting the individuals engaged in mental health treatment and substance abuse treatment, as well, if needed. Twelve years later, I am happy to report that our initial project has been institutionalized as a permanent part of our Criminal Division and has been a highly successful experiment. It has been beneficial to many hundreds of mentally ill criminal defendants who participated in, and graduated from, the program. And as our published recidivism research has shown, our whole community has benefitted from it, from a public safety perspective as well.

Faced with a seemingly ever-increasing number of seriously mentally ill individuals charged with low level, non-violent offenses, in 2006 – 2007 our court leadership undertook, in conjunction with the U.S. Attorney's Office, and the Pretrial Services Agency of the District of Columbia, to develop a non-traditional approach to handling these individuals' cases -- one that would hopefully avoid incarceration of these individuals at the D.C. Jail and/or their lengthy institutionalization at St. Elizabeths Hospital (for those defendants considered incompetent to stand trial). Modeled on other problem-solving courts around the country, such as Drug Courts, mental health diversion courts typically do not involve trials, or verdicts of guilt or innocence; they are instead more outcome-oriented, in that they attempt to address the treatment needs and social service problems which likely contributed to the criminal conduct that has brought the person before the criminal courts. Several hundred of such courts are now in existence around the country, embodying a "therapeutic justice model," instead of traditional criminal case processing, and these efforts have helped many seriously ill individuals get fully engaged in mental health treatment, and get stable in the community. Such stability often involves homeless individuals finally obtaining housing as well, and has had a positive impact on the community, as well as the individual participants.

How Our Mental Health Diversion Program Works

Any of our Criminal Division judges may certify a defendant's criminal misdemeanor case, or a non-violent felony case or cases, to our Mental Health Community Court, once the Pretrial Services Agency, our partner agency, which supervises defendants released pretrial to the community, has confirmed, via a mental health provider, that the individual is seriously and persistently mentally ill, and receiving and participating in mental health treatment services. Certification must also be approved, of course, by the assigned prosecutor's office -- our U.S. Attorney's Office and our Attorney General's Office -- before it can occur. The program is a voluntary one -- defendants are only referred if they request it, and agree to it.

Once transferred to the Mental Health Community Court calendar the defendant has an admission hearing, and thereafter begins having at least monthly hearings, to monitor the defendant's progress toward entering a diversion agreement. Diversion agreements can only be entered after an individual is actively engaged in mental health services, and drug-free. While in Mental Health Community Court participants are also supervised by specially trained case managers from the Specialized Supervision Unit of Pretrial Services Agency, with weekly contact. These Pretrial Services Agency supervision officers assist in assuring that participants get connected to mental health services, funded by the Department of Behavioral Health, and, where appropriate, substance abuse treatment, so that the court can obtain the necessary information about their ongoing treatment participation.

Once entered, diversion agreements are designed to last for a 4 month period. In entering the agreement, the defendant promises to maintain his or her treatment, stay drug-free and not be rearrested. After successful completion of the diversion agreement, which involves interim hearings to monitor progress, the defendant will have the charges dismissed (or in the case of a felony, reduced to a misdemeanor and be given probation) and the Court will honor the defendant's accomplishment at an individual graduation ceremony in the courtroom. If a defendant falls into non-compliance or is rearrested on new criminal charges, depending on the type of agreement the prosecutor may revoke the agreement, and the case may be sent back to the Criminal Calendar for the more traditional case processing, or the defendant may resolve their case and be sentenced by the presiding judge in the Mental Health Community Court. In many cases however, consistent with the goals of this problem-solving court, the judge continues, with collaborative input from all parties, to work with the defendant to bring him or her back into compliance -- sometimes extending the agreement beyond the four month period -- to allow the defendant to pursue and achieve a successful outcome.

Notably, hearings in Mental Health Community Court differ in major ways from other criminal courtrooms. In our court, the judge communicates directly with the participants, coaching and encouraging them as they progress, and also holding them accountable if they are not following program rules. Our program is generally not a sanction-based program -- defendants are not stepped back for punitive jail detention if they violate the conditions of their pretrial release. However if they are not following through on their commitment to the program for a significant period of time, they may face discharge from our program and a return to the regular calendar. Additionally, decision making in Mental Health Community Court, unlike the usual criminal court, is more of a collaborative process, with the judge consulting with our Mental Health Community Court Coordinator, Cleonia Terry, who is a Clinical Social Worker, and the Pretrial Services Agency representative assigned to our calendar, on decision making regarding each defendant's case.

Impact of Our Diversion Program on Public Safety

Our court has only been in existence for 12 years, and we are right now in the midst of a broad study of its operation. We have, however, already had two studies and articles focusing on the recidivism rates of our program's participants, which were published within the last few years and provided some very encouraging data. One article, published in 2013 by Georgetown Law Professor Heathcote Wales and Professor Virginia Hiday of North Carolina State, reported that the participants in our Mental Health Community Court were significantly less likely to be arrested in the year after discharge than other criminal defendants not in the

program. This study involved several hundred defendants participating in the first three years of the program. Their rearrest rate was only about 27% compared to 37% for similar defendants whose cases remained in the traditional courts. Further, the defendants who not only participated in, but actually successfully completed it and graduated from the program were 51% less likely to be rearrested. At nine months after successful graduation, less than 12% of the graduates had been rearrested, though more than 24% of defendants on regular misdemeanor calendars had been. Similarly, a longer-focused study (two years after exit) by these same researchers published in 2016 also found the rearrest numbers to be significantly lower for Mental Health Community Court participants than for similar defendants who had their cases resolved on the regular criminal calendars.

Observations About Our System

In light of the good news regarding lowered recidivism rates that we see from these studies, we and the other stakeholders are considering means for increasing the population of participants in our program. Our program has already recently expanded to include Traffic and D.C. misdemeanor cases prosecuted by the Office of the Attorney General, and also to handle post-disposition, probation cases of convicted misdemeanor and felony offenders who are under supervision of the Court Services and Offender Supervision Agency (CSOSA). However, we still have the capacity for a greater number of participants in both portions of our program. Given the improved outcomes in terms of rearrests for those defendants who participated, increasing utilization of our program for seriously mentally ill persons would appear to be highly advantageous.

In terms of clinical mental health resources available to our program, it should be noted that in 2008 the Department of Behavioral Health, in coordination with the Court, took the significant step of opening a free-standing mental health clinic, funded by the Department of Behavioral Health -- the Urgent Care Clinic -- in our main court building. (It was operated originally by the Psychiatric Institute of Washington, and more recently, by Pathways to Housing.) Efforts are underway currently to increase the capacity of that program to assist in more quickly serving defendants with needed psychiatric services, and linking them with Core Service Agencies in the community, which will better enable our Court to guarantee success with the participants.

Further, the Department of Behavioral Health's increase over the last few years in treatment services of the ACT team variety has been a major help for our participants. Defendants who are provided this most intensive type of community-based treatment -- the "Cadillac" program in our system -- with placement on an Assertive Community Treatment (ACT) team, often do the best in compliance. As a large proportion of our participants are homeless, ACT team services can be crucial, as they involve clinical staff doing outreach to the clients where they are located in the community, rather than awaiting the clients attending set appointments at the clinical offices, which may be challenging for our homeless participants.

Lastly, it goes without saying that housing is the overarching challenge for a large portion of our population, as the lack of adequate affordable housing is a major issue in our jurisdiction. For many, the lack of stable housing and related transportation issues pose major obstacles to keeping mental health appointments and court obligations. Our diversion program, with its desirable outcome of getting a defendant's criminal charges dismissed, is in an excellent position

to incentivize persons in need of mental health treatment to pursue it, even when they may have been resistant to treatment in the past. However, the reality of the lack of available stable housing often stymies defendants from successful completion of our program, despite their motivation and good intentions.

Prepared Written Statement Of Susan McMahon
Professor of Law, Legal Practice
Georgetown University Law Center

Thank you for holding this hearing addressing the important issue of mental health and criminal justice in Washington, D.C.

I have taught at the Georgetown University Law Center for the last eight years. My scholarship focuses on how the criminal justice system interacts with individuals living with mental health conditions. I am mainly concerned with one piece of this interaction: the time after arrest but before trial. This is a period when many individuals with a mental health condition, who have not been convicted of any crime, are held in jail.

These individuals are treated unfairly and suffer significant harm while imprisoned. They are detained at higher rates and for longer periods than other individuals accused of similar crimes and with similar criminal histories.¹ Lengthy pre-trial detentions are especially problematic for individuals with mental health conditions, who rarely receive effective psychiatric treatment while in correctional facilities and who suffer abuse and neglect at much higher rates than other detainees. A person with a mental health condition is likely to emerge from jail far worse off than he was when he entered.²

Mental health courts provide one possible solution for some aspects of this crisis. Yet, alone, they will make only a small dent in the problem. First, restrictions on eligibility— requiring defendants be competent to stand trial, for example— exclude many individuals with mental health conditions. Second, mental health courts still operate within a criminal justice framework and individuals must endure arrest, criminal proceedings, and possible detentions or guilty pleas as a part of that process. A more effective solution would be treatment of mental health conditions *before* arrest, thus avoiding the involvement of the criminal justice system altogether.

Mental health courts are therefore one of many levers policymakers can press to more humanely and successfully address the unique challenges presented by individuals with mental health conditions. But other pieces of the solution include investing in community treatment options, pre-arrest diversion programs, and competence restoration reform.

I. The Harms of Imprisonment

My work has focused in part on the impact of pre-trial detention on individuals living with mental health conditions. As of 2013, forty percent of incarcerated people at D.C.'s Central Detention Facility, which is mainly populated with individuals awaiting trial or those serving

¹ See Susan McMahon, *Reforming Competence Restoration Statutes: An Outpatient Model*, 107 Geo. L.J. 601, 610-12 (2019).

² See *id.* at 613-17.

sentences for misdemeanor crimes, suffered from some form of mental illness.³ On any given day, that amounts to somewhere around 800 detainees with a mental health condition.⁴

While I have not studied the situation in the District specifically, jail environments across the United States generally are harmful for prisoners with mental illness because these individuals (1) often deteriorate from a lack of treatment and exposure to a chaotic, violent environment; (2) are put in solitary confinement for rule infractions or psychiatric monitoring at higher rates than defendants without mental illness; and (3) suffer abuse and neglect at higher rates than defendants without mental illness. All this is in addition to the disruption caused by incarceration itself and its attendant separation from family, community, and mental health care.

A. Jail Environment and Services

While in jail, most defendants receive no mental health services whatsoever.⁵ Defendants with mental health conditions are known to quickly deteriorate while imprisoned without adequate treatment. One report on the conditions for detainees living with mental illness in Washington state jails found that individuals who had no access to mental health services “decompensated to the point of smearing themselves with feces, considering suicide, and experiencing hallucinations and extreme fear.”⁶

The environment itself often contributes to the deterioration of these defendants. As one scholar succinctly put it, “[p]risons are places of intense brutality, violence, and dehumanization.”⁷ Prisoners are tightly controlled and required to follow orders backed by force—forced to eat, sleep, and interact with others on terms dictated by jailers.⁸ Violence is a common occurrence.⁹ For an individual living with mental illness, this setting is “at best, counter-therapeutic and, at worst, dangerous to [a prisoner’s] mental and physical well-being.”¹⁰

B. Solitary Confinement

Yet the deterioration of a detainee’s mental state may be the least of his concerns. Some individuals with mental health conditions have it far worse. Unable to follow the strict rules of a jail environment, they are punished and placed in solitary confinement at much higher rates than the

³ Aaron C. Davis, *Report: Rash of Suicides at D.C. Jail Points to Deep Problems with Inmate’s Mental Health Care*, WASH. POST, Nov. 7, 2013.

⁴ DEP’T OF CORRECTIONS POPULATION STATISTICS, AVERAGE DAILY POPULATION FOR OCTOBER 2014 THROUGH SEPTEMBER 2019 (noting that the population of inmates in D.C. correctional facilities vacillated between 1,524 and 2,160 inmates during the relevant time period).

⁵ One study found that only one in six jail inmates with mental illness received treatment after admission. DORIS J. JAMES & LAUREN E. GLAZE, *U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1* (2006); see also RAM SUBRAMANIAN ET AL., *VERA INST. OF JUSTICE, INCARCERATION’S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA 12* (2015), <http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/01/incarcerations-front-door-report.pdf> (“83 percent of jail inmates with mental illness did not receive mental health care after admission.”).

⁶ DISABILITY RIGHTS WASH., *LOST AND FORGOTTEN: CONDITIONS OF CONFINEMENT WHILE WAITING FOR COMPETENCY EVALUATION AND RESTORATION 7* (2013).

⁷ Allegra M. McLeod, *Prison Abolition and Grounded Justice*, 62 *UCLA L. REV.* 1156, 1173 (2015).

⁸ *E.g.*, *id.* at 1173–74.

⁹ See *id.* at 1204 (explaining that there were approximately 216,000 sexual assaults in U.S. prisons in 2008).

¹⁰ Jamie Fellner, *A Conundrum for Corrections, a Tragedy for Prisoners: Prisons as Facilities for the Mentally Ill*, 22 *WASH. U. J.L. & POL’Y* 135, 139 (2006); see also SUBRAMANIAN ET AL., *supra* note 5, at 12 (“Characterized by constant noise, bright lights, an ever-changing population, and an atmosphere of threat and violence, most jails are unlikely to offer any respite for people with mental illness.”).

general population.¹¹ In Pennsylvania and South Carolina, for example, a prisoner with a mental health condition is twice as likely to be placed in solitary confinement as a prisoner without one¹²—and those prisoners are particularly susceptible to the well-known psychological harms of solitary confinement. Even for prisoners with no history of mental illness, the conditions of extended solitary confinement “may press the outer bounds of what most humans can psychologically tolerate.”¹³

For prisoners living with a mental health condition, placing them in isolation is akin to “putting an asthmatic in a place with little air to breathe.”¹⁴ As one doctor testified, isolating prisoners in small cells for twenty-three hours a day intensifies any preexisting mental illness:

Prisoners who are prone to depression and have had past depressive episodes will become very depressed in isolated confinement. People who are prone to suicide ideation and attempts will become more suicidal in that setting. People who are prone to disorders of mood, either bipolar . . . or depressive[,] will become that and will have a breakdown in that direction. And people who are psychotic in any way . . . those people will tend to start losing touch with reality because of the lack of feedback and the lack of social interaction and will have another breakdown, whichever breakdown they’re prone to.¹⁵

Predictably, tragedy occurs when individuals with mental illness are placed in isolation. Suicide rates are higher among prisoners in segregation units than those in the general population.¹⁶ One prisoner mutilated his own genitals while in solitary confinement.¹⁷ Another prisoner in isolation refused food and medication, ingested feces, and smeared feces on himself.¹⁸ Eleven days after his transfer to the segregation cell, he was found lying naked on the floor covered in vomit, urine, and feces. He was hypothermic by the time he reached the hospital and died after going into cardiac arrest.¹⁹

¹¹ See, e.g., SUBRAMANIAN ET AL., *supra* note 5, at 12 (noting that defendants with mental illness are more likely to be placed in solitary confinement “either as punishment for breaking rules or for their own protection since they are also more likely to be victimized”).

¹² HUMAN RIGHTS WATCH, CALLOUS AND CRUEL: USE OF FORCE AGAINST INMATES WITH MENTAL DISABILITIES IN U.S. JAILS AND PRISONS (2015), <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and> [<https://perma.cc/B36K-XM2W>] [hereinafter HRW, CALLOUS AND CRUEL].

¹³ Madrid v. Gomez, 889 F. Supp. 1146, 1267 (N.D. Cal. 1995) (finding solitary confinement constitutes cruel and unusual punishment for prisoners living with mental illness); see also Reginald Dwayne Betts, *Only Once I Thought About Suicide*, 125 YALE L.J.F. 222, 228 (2016) (describing his time in solitary confinement: “Each day, I lost a little bit of what made me want to be free. . . . One afternoon, in a fit of panic, I slammed my right fist against the wall. I fractured my pinky. I thought about suicide. I almost disappeared.”).

¹⁴ Madrid, 889 F. Supp. at 1265.

¹⁵ HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 152 (2003) (quoting testimony of Dr. Terry Kupers in Jones’El v. Berge, No. 00-C-0421-C (W.D. Wis. 2001)).

¹⁶ See Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 PSYCHIATRIC SERVS. 676, 678 (2008) (“We found that the conditions of deprivation in locked units and higher-security housing were a common stressor shared by many of the prisoners who committed suicide.”).

¹⁷ Jason M. Breslow, *What Does Solitary Confinement Do to Your Mind?*, FRONTLINE (Apr. 22, 2014), <https://www.pbs.org/wgbh/frontline/article/what-does-solitary-confinement-do-to-your-mind/> [<https://perma.cc/6PFQ-7PGK>].

¹⁸ HRW, CALLOUS AND CRUEL, *supra* note 12.

¹⁹ *Id.*

C. Abuse and Neglect

Detainees with mental health conditions are among the most vulnerable prison populations and are often targeted by others.²⁰ They are twice as likely to be injured in a fight with another prisoner.²¹ Eight percent of male prisoners with a mental illness reported being sexually assaulted, as compared to three percent of male prisoners without a mental health disorder.²² Twenty-three percent of female prisoners with a mental health condition have reported a sexual assault.²³

Individuals with mental health conditions are not just victims of other prisoners, but also of the guards charged with their protection. In South Carolina, prison guards used force against these prisoners at a rate 2.5 times higher than other prisoners.²⁴ In Colorado, prisoners living with mental illness accounted for three percent of the prison population but thirty-six percent of use-of-force incidents.²⁵ In New York, over the course of eleven months, corrections officers at Rikers Island beat 129 prisoners so badly that they suffered “serious injuries” beyond the capacity of the jail clinic to treat, such as ruptured eardrums, broken jaws, and head trauma.²⁶ Most of the prisoners at Rikers are pretrial detainees,²⁷ and seventy-seven percent of the beaten prisoners had a diagnosed mental illness.²⁸

Elsewhere, one prisoner diagnosed with mental illness died after guards sprayed him with scalding water.²⁹ Another tried to commit suicide; rather than taking the prisoner for medical care, guards handcuffed him and punched him with such force “that he suffered a perforated bowel and needed emergency surgery.”³⁰ A third died from asphyxiation after officers restrained him, then allegedly kicked, choked, and stomped on him.³¹

Detainees with mental illnesses who are not actively abused in prison may suffer from neglect, which can lead to equally tragic outcomes. To take just a few examples: Jamycheal Mitchell, a young man from Virginia arrested for stealing a Mountain Dew and a Snickers bar, died after languishing in his jail cell for months. Other prisoners alleged that prison guards had denied Mitchell food, cut off

²⁰ *See id.* (“Experts we consulted for this report said that force is used disproportionately against prisoners with mental illness.”).

²¹ Seena Fazel et al., *Mental Health of Prisoners: Prevalence, Adverse Outcomes, and Interventions*, 3 LANCET PSYCHIATRY 871, 875 (2016).

²² *Id.*

²³ *Id.*; Annette S. Crisanti & B. Christopher Frueh, *Risk of Trauma Exposure Among Persons with Mental Illness in Jails and Prisons: What Do We Really Know?*, 24 CURRENT OPINION PSYCHIATRY 431, 433 (2011). These numbers are likely significantly higher, as sexual assault is an underreported crime both inside and outside the correctional system. Only twenty-two percent of male and thirty-four percent of female inmates report their assaults. *See* Shannon K. Fowler et al., *Would They Officially Report an In-Prison Sexual Assault? An Examination of Inmate Perceptions*, 90 PRISON J. 220, 221 (2010).

²⁴ HRW, CALLOUS AND CRUEL, *supra* note 12.

²⁵ *Id.*

²⁶ Michael Winerip & Michael Schwartz, *Rikers: Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES (July 14, 2014), <https://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html> [<https://nyti.ms/W2jVRj>].

²⁷ Michael Schwartz, *What Is Rikers Island?*, N.Y. TIMES (Apr. 5, 2017), <https://www.nytimes.com/2017/04/05/nyregion/rikers-island-prison-new-york.html> [<https://nyti.ms/2oJAH6O>] (“Most of the inmates— about 85 percent— have not yet been convicted of a crime; they are pretrial detainees, either held on bail or remanded to custody.”).

²⁸ Winerip & Schwartz, *supra* note 26.

²⁹ Eyal Press, *Madness: In Florida Prisons, Mentally Ill Inmates Have Been Tortured, Driven to Suicide, and Killed by Guards*, NEW YORKER (May 2, 2016), <https://www.newyorker.com/magazine/2016/05/02/the-torturing-of-mentally-ill-prisoners> [<https://perma.cc/6287-Y5CN>].

³⁰ Winerip & Schwartz, *supra* note 26.

³¹ HRW, CALLOUS AND CRUEL, *supra* note 12.

water to his cell, and confiscated his bed sheets, mattress, and clothing after Mitchell smeared feces on the wall of his cell.³² By the time of his death, he had lost forty pounds.³³ In Florida, a man with schizophrenia gouged out his eyes while awaiting hospital admission and treatment.³⁴ On Rikers Island, a prisoner in a mental health unit died after being found in an overheated jail cell; an officer should have been making rounds to check on the prisoners but remained in her chair for most of her shift.³⁵

II. Alternatives to Imprisonment

Given the devastating impact of jail on individuals with mental health conditions, detention should be the option of last resort for this population. Yet this is not the case; over sixty percent of jail prisoners reported symptoms of a mental health condition within the previous twelve months.³⁶ The largest psychiatric facility in the country is a jail in Chicago.³⁷

A. Mental Health Courts

Mental health courts provide one innovative option for moving individuals out of jail and into a treatment-focused model. But, as currently constituted, they simply cannot handle the number of individuals with mental health conditions caught up in the criminal justice system. Alone, they help at the margins, but the problem requires marshaling other resources to effectively reduce the number of individuals living with mental illness in contact with the criminal justice system.

Moreover, a focus on mental health courts as the sole solution to this problem may exacerbate it because it eases the pressure for a wholesale rethinking of a criminal justice solution to a social welfare problem.

1. Restrictions on Eligibility

The mental health court in D.C. is a wild success in the annals of these programs. It has greater capacity than most mental health courts and a track record of reducing recidivism and connecting participants to community resources for continued treatment.³⁸ Yet the program's small capacity and limits on who is eligible to take advantage of the alternative necessarily caps the ability of this program to be a panacea.

In its ten years of existence, the mental health court has provided services to around 4,000 defendants, and it is one of the largest such programs in the country.³⁹ But that amounts to only around 400 defendants per year. D.C. courts had 12,676 new criminal cases filed in 2018,⁴⁰ a

³² Complaint at 5–7, *Adams v. Naphcare, Inc.*, 246 F. Supp. 3d 1128 (E.D. Va. 2017) (No. 2:16-cv-229), *aff'd in part, rev'd in part sub nom. Adams v. Ferguson*, 884 F.3d 219 (4th Cir. 2018).

³³ *Id.* at 6.

³⁴ Hal Wortzel et al., *Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systemic Illness*, 35 J. AM. ACAD. & PSYCHIATRY L. 357, 359 (2007).

³⁵ Michael Schwartz, *Correction Dept. Investigating Death of Inmate at Rikers Island*, N.Y. TIMES (Mar. 19, 2014), <https://www.nytimes.com/2014/03/20/nyregion/correction-dept-investigating-death-of-inmate-at-rikers.html> [<https://nyti.ms/115cl2j>].

³⁶ DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEPT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006).

³⁷ Matt Ford, *America's Largest Mental Hospital Is a Jail*, THE ATLANTIC (Jun. 8, 2015).

³⁸ One study showed that participants in the mental health court had lower rates of re-arrest two years after their participation, as compared to defendants who also had mental health conditions and received treatment, but were not in the mental health court program. Virginia Aldigé Hiday et al., *Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit*, 67 PSYCHIATRIC SERVS. IN ADVANCE 1, 4 (2015).

³⁹ Jeffrey Anderson, *D.C.'s Mental Health Community Court Celebrates Its 10th Anniversary*, WASH. CITY PAPER (Oct. 2, 2017).

⁴⁰ DISTRICT OF COLUMBIA COURTS, STATISTICAL SUMMARY 5 (2018).

significant portion of which involved defendants living with mental health conditions. The mental health court is thus fulfilling only a miniscule portion of the need for imprisonment alternatives.

A number of restrictions keep the majority of individuals with mental health conditions out of mental health court, some of which can be adjusted, others of which cannot.

First, the court, like all other mental health courts, requires the consent of the defendant to participate. While the courts require voluntary participation to be successful (and constitutional), this limit necessarily restricts the number of participants. Those who are unwilling to agree to mental health courts must make use of the usual criminal justice process.

Second, eligibility requirements significantly narrow the mental health court population. For example, to participate in the mental health court, a defendant must be competent to stand trial. Moreover, only defendants who are accused of either a misdemeanor or a small number of Class B felonies are eligible for transfer. Thus, defendants found incompetent or those accused of more serious crimes remain outside the mental health court's scope.

Third, the structure of the court requires the U.S. Attorney's Office to sign off on transferring the defendant from criminal court to mental health court. Even if all parties, including the judge, agree that mental health court is the best option in the circumstances, the case cannot be transferred without agreement of the prosecutor's office.

By all accounts, the U.S. Attorney's Office has been an effective partner in the D.C. mental health courts and the sheer number of cases referred, as compared to the tiny numbers in other jurisdictions, is a testament to their commitment to the project. But the unique status of D.C. means that this power is being handed to an office that may have significantly different priorities than other institutions more accountable to the citizens of the District. In the future, the USAO may have a more restrictive vision for the mental health court that is at odds with other stakeholders and winnows the number of defendants referred.

2. *Difficulties with the Criminal Justice Framework*

Mental health courts sit within the criminal justice system in the District of Columbia. To take advantage of the opportunities provided by the court, a defendant must be arrested, processed, and, possibly, held in jail. The courts are also inherently coercive because failure to abide by the terms of the mental health court results in defendants being returned to the criminal justice system.

Focusing solely on a criminal justice *solution* like mental health courts diverts resources and attention from criminal justice *alternatives*. This can have unintended consequences. If a mental health court is the best opportunity to ensure a person receives treatment, then a police officer may be more likely to arrest a person in crisis rather than release him or attempt to obtain treatment for him. But if robust community treatment and diversion programs were readily available, then those individuals may never come into contact with police and, if they did, police would have options other than arrest.

Moreover, having a system like the mental health court in place could encourage prosecutors to keep cases in the criminal justice system that might otherwise be dismissed. If a prosecutor has a weak case against a defendant with a mental health condition, then the office might be more inclined to transfer that defendant to mental health court rather than risk dismissal of the case.⁴¹

⁴¹ Nancy Wolff et al., *Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency*, 35 LAW & HUM. BEHAV. 402 (2011) (finding willingness among prosecutors to "bend" the charges to fit the case for mental health court; "if, for example, the district attorney had a weak case against the defendant, then mental illness played a central role in the violent criminal behavior.").

These consequences are often borne of the best of intentions: public servants hoping to obtain treatment for individuals in crisis. But such an approach fails to appreciate the harms that any involvement in the criminal justice system can cause. Arrest alone can be a traumatic experience for any individual and a guilty plea, which is sometimes required of defendants participating in mental health courts, can carry lifetime collateral consequences. And any stay in a jail can be detrimental to an individual with a mental health condition, as noted above. Thus, even if all the restrictions on mental health court eligibility disappeared, the courts would not be the ideal solution for any and all cases. A better approach is to divert most individuals with mental illness from the criminal justice system altogether.

B. Other Options

Because mental health courts will only ever serve a small portion of the relevant population and because they require arrest and coercion to function, the District must also investigate other methods for disrupting the stream of individuals with mental illness who cycle through the criminal courts. Three places where an investment would likely make a significant impact: (1) community treatment facilities, (2) pre-arrest diversion programs, and (3) competence restoration reform.

1. *Community Treatment Facilities*

A recent report from the Office of the District of Columbia Auditor on mental health services in D.C. found that community mental health agencies, which provide the majority of publicly funded services to individuals with mental health conditions, were in financial crisis. Some have cut back services; others have closed their doors entirely.⁴² A number of providers attributed their financial stress to D.C.'s inadequate rate structure for services not covered by Medicaid.⁴³

But even beyond this current crisis, community treatment facilities have simply never been funded at the level required to meet the need in the community. Deinstitutionalization moved many individuals with mental illness out of long-term care centers, with the promise of federal funding for networks of mental health centers where these individuals could receive treatment. That promise never materialized. Federal legislation allocated money to build outpatient clinics in the community, which allowed states to close public mental health hospitals, but many of the community care centers either were never built or served populations with less severe forms of mental illness.⁴⁴ The money states spent on housing, clothing, feeding, and treating individuals with mental illness in institutions never followed those individuals into the community.

In the years following deinstitutionalization, funding for mental health programs has been cut repeatedly across the country. One researcher called it a “disaster situation” in most states.⁴⁵

Simply realizing the promise of the community care model could divert many individuals from the criminal justice system altogether. With medication and treatment, individuals with even the most serious mental illnesses can lead healthy and productive lives. Early intervention when individuals first show signs of mental illness could prevent the spiral into homelessness and arrest.

2. *Pre-Arrest Diversion*

If an individual with mental health issues does come in contact with a police officer, a pre-arrest diversion program would be an alternate way of dealing with the dispute that would not result in jail.

⁴² OFFICE OF THE DISTRICT OF COLUMBIA AUDITOR, IMPROVING MENTAL HEALTH SERVICES AND OUTCOMES FOR ALL: THE D.C. DEPARTMENT OF BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM 68-71 (Feb. 26, 2018).

⁴³ *Id.* at 68-70.

⁴⁴ ALISA ROTH, INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS 90-91 (2018).

⁴⁵ Michelle R. Smith, *Kennedy's Vision for Mental Health Never Realized*, ASSOCIATED PRESS, Oct. 20, 2013.

Last year, the District embarked on a pilot program adopting such an approach, which has been successful in other communities.

One example of such a program is Crisis Intervention Training, or CIT, a model of training police officers to engage with individuals in crisis that emphasizes de-escalation rather than establishing control over the individual. The training involves many dimensions, including how officers can recognize the symptoms of mental illness and techniques for communication that will avoid the need for force.⁴⁶

Some police organizations rely solely on this training as a means of improving interactions with the community. Others go further and establish relationships with mental health institutions that can provide support services for the individual. In these more-intensive models, mental health providers have specialized facilities to assist with individuals in an acute state of crisis. In Memphis, police officers have access to a centralized psychiatric emergency drop-off with a no-refusal policy. Officers can therefore drop off the individual for intake and return to the street with thirty minutes.⁴⁷

One story from the CIT trenches illustrates how the model can work. A man with schizophrenia was walking around a grocery store, “shaking and harassing customers.”⁴⁸ He refused to leave the store after asked. Officers recognized the symptoms of mental illness and convinced the man to go to a community mental health facility, where he had recently missed an appointment. Upon speaking further with the man and a case manager at the facility, they realized the man had stopped taking his medication, and officers transported him home so he could take it. While there, he picked up a knife and threatened the officers, but police again talked him down and convinced him to accept transportation to an inpatient facility, where he received treatment for his schizophrenia.

Before training, there were several points in that interaction where an officer could have reacted with arrest, especially when the man threatened them with a knife. But, as the director of the program noted:

No arrest occurred. No ‘take down’ occurred. No booking or jail time and resources were used. No injuries to patient, police, or public occurred. Instead, the patient entered the appropriate level of treatment weeks before his past entries. And his earlier detection and referral is resulting in a much quicker response to the appropriate medications.⁴⁹

Adopting a similar model in D.C. could divert many of the minor cases involving individuals with mental illness out of the criminal justice system altogether.

3. *Competence Restoration Reform*

If the previous two interventions fail and the individual with a mental health condition is arrested, he stands a good chance of being found incompetent to stand trial. But often, defendants found incompetent are detained and spend far longer periods in jail than other prisoners, often

⁴⁶ See Henry J. Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, 51 PSYCHIATRIC SERV. 645 (2000) (finding that officers in Memphis who had received training in the Memphis CIT model were less likely to arrest persons with mental illnesses than officers who used a different specialized response in two other jurisdictions); Jennifer L.S. Teller et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCHIATRIC SERV. 232, 234-35 (2006).

⁴⁷ Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crisis: A Primer for Mental Health Practitioners*, BEST PRACTICES IN MENTAL HEALTH (Dec. 2012).

⁴⁸ S.R. Thorward, *Crisis Intervention Team (CIT) Sees Immediate Results*, 32 CAP. U. L. R. 1075, 1076 (2004).

⁴⁹ *Id.*

because they are waiting for access to inpatient competence restoration treatment. Reform of this system could lead to reduced cost and better outcomes for this population.

Not enough public psychiatric beds exist to accommodate the defendants referred for competence restoration each year. Public hospital facilities nationwide have only about 38,000 staffed beds, or 11.7 beds per 100,000 people, less than thirty percent of what they need.⁵⁰

The result of the inpatient bed shortage is lengthy wait times for competence restoration services. In 2012, California's waitlist was commonly 200 to 300 defendants long.⁵¹ In 2010, the average wait time was 68 days, or over two months, with some prisoners waiting as long as 162 days, or over five months.⁵² The statistics in other states are equally dire. A survey of forty states found that thirty-one had waitlists, with average wait times of one month for criminal defendants to get hospital beds.⁵³ Three states had average wait times of six months to one year.⁵⁴

Judges on the D.C. Superior Court recently criticized Department of Behavioral Services representatives for their failure to follow court orders to provide inpatient competence restoration services, which resulted in defendants languishing in jail as they waited for a bed to open up.⁵⁵ The backlog at St. Elizabeth's Hospital, the facility charged with inpatient competence restoration services in the District, was eventually cleared through transfers of patients and reshuffling of units, sudden changes that some clinicians argued was detrimental to patient care.⁵⁶

Outpatient competence restoration programs are a promising alternative and could ease this backlog. Many states, such as Hawaii, have had great success with their outpatient programs, achieving similar restoration rates to inpatient programs at a fraction of the cost. An outpatient program exists in D.C., but many judges in the District continue to refer defendants for inpatient treatment, even in circumstances where it may be unnecessary.⁵⁷ Making improvements to the program, such as hiring additional qualified personnel, incorporating housing assistance, or offering sessions at additional times, could help the program become a reliable part of the city's competence restoration offerings.

Investment in outpatient restoration is a vital part of any transformation of the city's treatment of individuals with mental illness. While a person found incompetent to stand trial is not eligible for mental health courts, a re-imagining of the competence restoration process as a mainly outpatient program could parallel in some ways the benefits of mental health court: an out-of-jail model that relies on the defendant receiving treatment under close supervision.

III. Conclusion

Mental health courts are doing exceptional work in D.C. and other jurisdictions. Investments in expanding their capacity would be welcome. But there will always be a significant portion of the population of individuals with mental illness who will not qualify for mental health court, and many

⁵⁰ DORIS A. FULLER ET AL., TREATMENT ADVOCACY CIR.: OFFICE OF RESEARCH & PUB. AFFAIRS, GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS 1 (2016).

⁵¹ MAC TAYLOR, LEGISLATIVE ANALYST'S OFFICE, AN ALTERNATIVE APPROACH: TREATING THE INCOMPETENT TO STAND TRIAL 9 (2012), <http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.pdf>.

⁵² *Id.* at 8-9.

⁵³ W. LAWRENCE FITCH, NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., FORENSIC MENTAL HEALTH SERVICES IN THE UNITED STATES: 2014, at 30 (2014).

⁵⁴ *Id.*

⁵⁵ *See* OFFICE OF THE DISTRICT OF COLUMBIA AUDITOR, IMPROVING MENTAL HEALTH SERVICES AND OUTCOMES FOR ALL: THE D.C. DEPARTMENT OF BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM 60-61 (Feb. 26, 2018).

⁵⁶ *See id.* at 58-65.

⁵⁷ *Id.*

individuals would be better served by an approach that never funneled them into the criminal justice system in the first place. Moreover, if arrest is the only option, a combination of a robust mental health court and an extensive outpatient competence restoration program would ensure that the majority of defendants with mental health conditions would not be needlessly detained in jail as they await resolution of their case.

Simply put, it will take more than mental health courts to solve this crisis. I ask this committee to both to invest in mental health courts, but also to look beyond them, to re-imagine what justice in the District of Columbia could look like for our population of individuals with mental health conditions.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
METROPOLITAN POLICE DEPARTMENT



Public Hearing on

*Mental Health, Mental Health Courts,
and the Criminal Justice System*

Testimony of
Ms. Kelly O'Meara
Executive Director, Strategic Change Division

Before the
District of Columbia Advisory Committee to the
U.S. Commission on Civil Rights Public Briefing

November 7, 2019
1331 Pennsylvania Avenue, NW, Suite 1150
Washington, DC 20425



Good morning, Chairman Malcolm, other Committee members, and guests. My name is Kelly O'Meara, and I am the Executive Director of the Strategic Change Division of the District of Columbia's Metropolitan Police Department (MPD). Thank you for the opportunity to discuss with the Committee an issue critical to overall public safety in the District: the intersection of mental health services and the criminal justice system.

As an initial matter, I would like to note that while the focus of the mental health court is, understandably, on individuals facing mental health issues who commit crimes, MPD and the government of the District of Columbia look at the issue more broadly. These individuals may also be at higher risk for victimization and for critical public health issues, which may also lead to police contact and intervention. So while my focus here will largely be on individuals committing crimes, this does not represent MPD's entire experience with and view of the population.

Year after year, MPD interacts with hundreds or even thousands of individuals facing chronic mental illness in the District. Many encounters between police and individuals facing persistent and severe mental health issues do not result in arrest; others result in arrest for low-level offenses, with a low probability of prosecution. For cases that are prosecuted, MPD may or may not have information about the outcome of the case or any treatment plan for the arrestee. All too often, people end up back on the street, seemingly no closer to services or meaningful engagement with society.

This cycle falls short on many levels. It falls short for individuals experiencing behavioral health challenges because they are not getting needed treatment. It falls short for police officers who cannot solve the issues for either the individual or the community. It falls short for members of the public, for whom legitimate public safety or quality-of-life complaints may not be addressed. And it falls short for the taxpayer with an expensive and inefficient approach. This hearing and conversation come at an ideal time as the District has been developing new approaches to better address mental health and substance abuse disorder issues. Experiences with the new programs provides lessons that may be valuable to the District's Mental Health Court.

In 2018, MPD, in partnership with the Department of Behavioral Health (DBH) and the Department of Human Services (DHS), launched the Pre-Arrest Diversion Program (PAD). The program embraces the understanding that there must be multiple entry points to treatment and represents an enhancement to the District's Sequential Intercept Model. The sequential intercept model is a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems. It is a five-stage model for approaching ways in which those with behavioral health or substance use disorder challenges can access necessary treatment. The District had a gap at Intercept 1, the law enforcement entry point, which the PAD program worked to fill.

The program develops more effective means of supporting individuals in our community by:

- Increasing connectivity to behavioral health services;
- Improving housing stability;
- Increasing access to other supportive services such as enrollment in economic benefit programs and education and employment supports;
- Reducing arrests of those with behavioral health needs and substance use disorders; and
- Addressing the underlying conditions that may contribute to criminal behavior.

The program is run by Licensed Clinical Social Workers and certified peer specialists who have lived experience similar to the target clients. It began in two areas of the city with the highest concentrations of arrests for the low-level offenses that were potentially correlated with unmet behavioral health or social service needs, such as disorderly conduct, drug possession, and minor survival theft, such as shoplifting. The Diversion Program developed multiple entry points for services in order to maximize engagement rather than limit participation due to administrative barriers. These range from arrest-based referrals, to officer requests for consultations, to conventional DBH outreach.

All participants must have indicators of chronic behavioral health or substance use disorder issues. Committing a low-level crime or experiencing homelessness does not—on its own—meet the eligibility criteria. Regardless of the point of entry, all participation is voluntary, with no penalty for declining to participate. To put it succinctly, the program is all carrot, no stick.

Upon entering the program, Diversion staff conduct an assessment of each participant and collaborate with them to create plan tailored to individual needs. Program staff provide ongoing outreach, referrals and resources to participants and assess them for vulnerability and service needs throughout the program.

The Diversion Program serves an especially vulnerable population, even in comparison to other law enforcement assisted diversion programs in urban areas.

- Nine out of 10 participants had been diagnosed with severe mental illness.
- Nine out of 10 also had unstable housing, defined as chronically homeless, homeless, or at risk of homelessness.
- Sixty percent of participants lacked vital documents.
- Almost half of the participants have been diagnosed with co-occurring disorders.

Two thirds of participants have been reconnected with treatment or linked to a higher level of care. Many participants had been disenrolled from community-based providers because of an inability to utilize office-based services or the provider's inability to locate or engage them in the community.

Participant response has been extremely positive. I would like to highlight a few testimonials about the program that illustrate some key principals in the approach.

Case One: J, in her own words

“In April 2018, my illness convinced me I should leave my [apartment], move to...an empty [building] and sleep on their steps. In July 2018 I was introduced to the PAD program...[At that time] I was only willing to accept assistance with obtaining new forms of identification.

“The staff of the PAD program consistently visited me...In November 2018, because of their diligence in building a relationship with me, I became willing to accept their help in improving the quality of my life.

“It is Feb. 2019 and I have embraced the goals the PAD program had for me. It has truly improved the quality of my daily living and brought hope and a sense of normalcy back into my life that I have not recognized since 2010.

“The PAD program is out in the community every day, looking for their clients, making sure they set eyes on us, engaging us and ensuring we are alright. Without [that], I would not be moving back into an [apartment], seeing [a doctor] and taking my meds, getting to my other medical [appointments] and planning on re-entering the workforce.”

A key principal of the diversion program is that we must meet the participants where they are, acknowledging their values and letting them help to define their plan. Being non-judgmental and solution focused and working on situations that the participant views as most important first can help participants to feel more comfortable. Seemingly small steps can build trust and lead to more significant progress. It is certainly critical that a court program prioritize equity and a level of consistency. In the mental health arena, flexibility in designing individual programs is also invaluable.

Case Two: P

P. was referred to the Diversion Program as a social contact. At that time, she had five active criminal charges, as well as a long history of criminal justice involvement and noncompliance with legal requirements and treatment. She was street homeless because she was banned from all shelters due to violent conflicts. She could not access her core service agency after being barred from the building. She was also facing incarceration due to non-compliance.

Since enrollment in the program, P. has been compliant with her treatment program, including medications and therapy. She is also in compliance with the court, and her case may be dismissed. She remained in a shelter for two months and is moving into a shared apartment. She has no new criminal charges, and wants to return to work. As she told the Diversion team, “I never knew I could do this good!”

As we saw with P, it is critical that the criminal justice system understand that treatment is a comprehensive process. It is not just scheduling an appointment with service providers, but also ensuring that a support team can address often unpredictable barriers to treatment, such as a barring notice. Although I am not directly involved in this program, as I share some observations from colleagues, I do so with both respect for the Court and the tremendous work it does on behalf of these individuals, and humility as an executive who knows I can always do better myself. I have heard from colleagues that some basic program operations could be improved. Issues include establishing clear channels of communication between service providers and the Court, streamlining the release of information from service providers to the Court, and ensuring the Court is fully aware of health insurance limitations and program availability.

While program implementation is not always a very interesting or engaging topic, from my perspective, a program is only as effective as its execution. Given that there is always room for improvement, it may be useful for the Court to establish a regular feedback mechanism to ensure that a wide range of stakeholders can share information and experiences about the program.

Case Three: *G, in the words on an MPD officer*

“G. took me aside away from his friends at a known drug spot. “Officer, I am desperate to get some help. Please, help me.” G. shared how he had completed six months of a difficult recovery program, and was not sure he could stay sober around the shelter. This was the same area where he used to buy, sell, and use drugs. After he completed his recovery, they dropped him off right back where his troubles started.

“As an officer, I didn’t see how I could assist him: no crime, no involuntary commitment called for, and no crisis for mobile crisis response. And yet, G. looked to me, to the uniform and badge I wear, and trusted me enough as an MPD member to put the next months of his life in my hands. My instincts told me that he might end up dealing or overdosing within days.

“I called the Diversion Program Line. Jackie said she would be right out to meet with him. The team was able to provide safe housing and vocational assistance. Now, G. is training as a chef. When he walks through the old neighborhood, everyone tells him how happy and healthy he looks, and they beg for his gourmet dinner samplers.”

For justice-involved individuals, successful diversion is not a static state. It is vital that support be accessible to participants even after completion, for additional support information or new referrals to treatment. It is also helpful if staff or peer supports can connect participants with community services and economic supports. While this may not be within the purview of the Court, it is perhaps an opportunity for the Court to partner with the District on ensuring that this population is served by wrap-around services. The District has a strong interest in ensuring that support is available to those who successfully complete these programs. This underscores the critical need for robust information sharing between the Court and the District to ensure this population’s needs are met and the broader community is reassured of the safety of their neighborhoods.

Overall, perhaps the most important issue that is highlighted by the experience of the PAD program and its participants is that this population faces multiple challenges, often with co-occurring problems. Given that, one of the most troubling barriers to success may be the Mental Health Court requirements that participants be drug-free. Rather than excluding those with substance use disorder issues, it may help to acknowledge that individuals with severe and persistent mental health issues may not be able to distinguish between diagnosed mental health issues and drug dependency. They may also choose to self-medicate to address the underlying issues. Individuals most in need of help may not be able to address one issue on its own, but rather may need to address both simultaneously in order to make progress. The Court should examine this baseline assumption to determine if this best meets the needs of the District and the program participants.

* * * *

I would like to close by highlighting the District's new program to help meet the needs of individuals facing mental health challenges while safeguarding the community at large. This summer, DBH launched the Community Response Team (CRT), a 24-7 multidisciplinary team that expands community-based direct service efforts—including homeless outreach, mobile crisis, and pre-arrest diversion. The CRT supports adults who are experiencing emotional, psychiatric or substance use vulnerabilities to promote service engagement and overall behavioral health and wellness.

These supports are provided through assessment, referral, short-term care management, and follow-up for individuals across the District. CRT also provides community education, individual and neighborhood outreach, behavioral health consultation, short-term support for critical incidents, in addition to co-response and intervention support for our partner agencies and community organizations.

Teams of behavioral health specialists, licensed clinicians and peers in recovery have an ongoing presence in communities to:

- Conduct on the spot assessment and referral to behavioral health care.
- Engage regularly individuals living with unmet needs to encourage treatment.
- Connect to support services including employment, education and economic benefit programs.
- Offer harm reduction options such as life-saving naloxone while promoting treatment.
- Support diversion from the criminal justice system for low-level behavioral health related offenses.

The Community Response Team offers 24-hour services to communities experiencing psychiatric emergencies, trauma, or show signs of mental health and substance use disorders.

* * * *

In closing, I would like to thank the Commission for convening this important conversation. The Metropolitan Police Department is working closely with partner agencies to support a criminal justice and public health system that provides some individuals with needed services as an alternative to criminal charges. Together, we can help to break the cycle of arrest, incarceration, release, and re-arrest.

**Prepared Written Statement of Allison D. Redlich, PhD; George Mason
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I preface this document with the qualifier that I conduct research on mental health courts, though never with the DC MHCC directly. Further, I am not an expert on DC's issues with mental illness, crime, or homelessness. In the February 12, 2018 memo we were given, 9 topic areas were identified for experts to assist the Commission (see pp. 2-3 of memo). I have selected 3 areas.

1. The effectiveness of the District's mental health courts in producing positive long-term outcomes for its participants, and possibilities for increasing this effectiveness;

I have not directly studied the DC Mental Health Community Court (MHCC) myself, though I have familiarized myself with a series of studies conducted by Drs. Virginia Hiday and Bradley Ray, and Mr. Heathcote Wales (published between 2010 and 2016). The bottom line message of these studies is that the DC MHCC is effective in reducing recidivism. More specifically, these researchers found that MHC clients who completed (graduated) from the MHC were significantly less likely to get re-arrested up to two years after court participation, in comparison to MHC clients who did not complete the court and to a group of offenders with mental illness being supervised by the same agency (see Hiday, Ray, Wales, 2016). Certainly, this is promising and the good work that the DC MHC is doing should not be discounted. Nonetheless, in answer to this question, I focus on aspects in need of improvement.

As detailed by Hiday, Ray, and Wales in their series of published studies, there are limitations that serve to temper the findings. There are two types of bias present. First is 'cherry picking,' which refers to the possibility that persons identified as likely to succeed in the court are more likely to be referred and then more likely to be accepted into the MHC. Clearly there are eligibility criteria to be accepted into the court, with one being to have the motivation to be in the court and attend treatment. In this sense, then, it is not surprising that MHC clients who want to engage in treatment and follow court orders are more successful than the comparison sample. Second is 'selection bias,' which refers to the fact that MHC clients have to opt into the court. It is voluntary and thus, otherwise eligible clients (like those in the comparison sample) who do not wish to enter the court and follow the varied rules can choose to opt out. Again, this creates a bias towards those in the court, and those who in the court who are compliant.

In addition, another way to interpret the results of these published studies is to focus on the 41.7% of MHC participants who were terminated. Of course, it would be unrealistic to expect a 100% success rate for MHCs. MHC service a notoriously tough-to-treat population. Nonetheless, is a 42% unsuccessful rate too high? Why do the clients who are terminated not succeed? Are there aspects of the court and/or community treatment centers that could be improved?

Recommendations. As someone who conducts research for a living, it is clear to me that more research needs to be done with the DC MHCC specifically, and with all MHCs generally. To help alleviate the two biases described above, an important next-step is to conduct a randomized controlled trial (RCT) with the DC MHCC. That is, to randomly assign eligible offenders with mental health problems into the DC MHCC or into treatment-as-usual (traditional criminal court). RCTs are the gold-standard, and it is difficult, if not impossible, to determine effectiveness without using this method. RCTs have been done with other types of specialty courts (like Drug Courts), though rarely with MHCs (I know

of one study). To remain true to the model of the DC MHCC, participants would still need to be deemed eligible and voluntarily opt into the court (thus bias would be attenuated but not fully eliminated). Those randomly assigned to traditional court would still benefit from treatment services and supervision.

A second recommendation for research is to conduct interviews with MHC clients and others (judge, treatment personnel, court personnel). Wales and his colleagues (2010) did conduct interviews with 80 MHC clients (44% of the then-population) about perceived procedural justice. These findings while most certainly adding to our understanding, are now about 10 years old, represent a portion of the clients, and focus on one specific topic. My understanding is that the DC MHCC is now 11 years old, and thus these data must have been collected at its origin. My recommendation would be to conduct a more comprehensive interview study of the clients and others, allowing a better understanding of why Hiday and her colleagues found that more than two-fifths of clients were unsuccessful. An updated study would also allow for a determination of whether more or fewer clients succeed now that the court is more established and in existence for more than a decade.

2. *The adequacy of due process safeguards for persons referred to mental health court, and for those persons awaiting pre-trial mental health treatment to restore competency;*

In theory, MHC clients are legally required to make knowing, intelligent, and voluntary decisions to enter the court, but do they? (see Redlich, 2005). MHC clients should hold specific knowledge about the court's rules and procedures, as well as general legal knowledge. Given that competence is a threshold issue in that persons are presumed competent to stand trial unless the question is raised, in theory, MHC participants processed post-adjudication should meet these requirements (i.e., the requirements set in *Dusky v. US*, 1960). Moreover, mental illness is the primary reason to question competence (Pinals, 2005). In a court in which many clients have (serious) mental health problems, it stands to reason that some will not be considered competent to proceed.

To address these issues, my colleagues and I (Redlich et al., 2010a) surveyed 200 newly enrolled clients at two courts about their understanding and appreciation of MHC procedures and regulations and the voluntary nature of the courts and assessed adjudicative competence. We found that although most clients (69%), claimed that they chose to enroll in the court, at the same time, most (60%) claimed not to have been told that it was voluntary to enroll. In both courts, the majority claimed not to have been told about MHC requirements prior to entering, did not appreciate that they could stop participating, or have the ability to cite disadvantages to being in the court (e.g., having to comply with judicial and treatment orders, possible stigma associated with the MHC). As to adjudicative competence, at one court, approximately 17% of newly enrolled clients demonstrated either mild or significant impairments in adjudicative competence, and at the other court, about 39% showed similar impairments. Given that, in theory, all MHC clients are presumed competent (and in these two courts, had pled guilty), these rates of individuals with deficient knowledge are of concern.

Further, relevant due process concerns, such as making knowing and voluntary decisions in MHCs, can influence successful outcomes. My colleague and I (Redlich & Han, 2014) conducted a follow-up study examining whether knowledge and voluntariness at the outset of MHC participation influenced later success within the court. We found that among MHC clients from four separate courts, increased levels of initial perceived voluntariness and procedural justice, and MHC knowledge at enrollment led to decreased rates of new arrests, prison, MHC bench warrants, and increased court

compliance, which in turn, led to a higher likelihood of MHC graduation. This set of results speak directly to why clients succeed or not succeed (e.g., the 42% who had been terminated noted above).

Regarding the DC MHCC specifically, I reviewed the 9-page “District of Columbia Superior Court Mental Health Community Court (MHCC) Case Management Plan.” It is certainly beneficial to have such a written document, and I appreciated that some of the headings were in the form of questions. I did, however, note several concerns.

First, this document is quite dense and seems to be written by legal professionals well-versed with the law. At times it was not clear who the document was written for: the possible MHC client or the referring party, like a defense attorney. I believe the intent is for the former. As such, my opinion is that document would be largely not be understandable to the typical MHC client. I do not have data on the educational and socio-economic background of the DC MHCC clients. However, I suspect that, like most offenders, they are under-educated and impoverished. Most offenders read at a 6th-grade reading level or lower (Haigler et al., 1994). I submitted the Case Management Plan to a reading-grade level analysis. The results indicated an 11 to 12th grade reading level to understand and material that was “fairly difficult to read.”

Second, it is unclear when MHC clients have the opportunity for increased understanding. On p. 5, under the heading “Admission Orientation,” it explains that the “Coordinator will help you help you understand the requirements of the program and, if you do not, explain them further. The Coordinator will also address any questions you or your lawyer may have about the MHCC.....”. However, these explanations appear to come *after* the offender is expected to decide to enroll in the court. While it is important that the client has a complete understanding at the outset of participation, it is also important to understand to inform the decision to enroll. As explained above, such understanding is predictive of future success in the court.

Third, although the Case Management Plan delineates the benefits of enrolling in the MHCC, it does not explicate the downsides. As mentioned, in the Redlich et al. (2010a) study, across two MHCs and 200 MHC clients, almost all (91%) could cite advantages, but more than half could not cite a single disadvantage. Similarly, in the Wales et al. (2010) study, the most prevalent response to the question, What have you liked least, so far, about the MHC? was Nothing or it’s equivalent (see p. 269). In my opinion and supported by my research, it is important to be able to identify the disadvantages of participating in a specialty court so that one can be a knowing decision and be better prepared to address them going forward.

Fourth is the issue of competence. The Case Management Plan does indicate that eligible participants must be considered competent to proceed. And the Hiday et al. articles cite that all participants were competent. The mechanisms of how competence is established, however, are not clear. The DC MHCC may indeed have mechanisms in place which I was not privy to. In my experience, however, competence is presumed and only investigated if a question of competence is raised. As noted, in the Redlich et al. (2010a) study, 17-39% of participants may have been incompetent to proceed but nonetheless all had pled guilty and were allowed into the MHC. Further, across the US, an estimated 60,000 competence assessment take place annually; given prevalence statistics of persons with serious mental illness in the criminal justice system, this estimate represents about 5% of all such persons (Redlich, 2016). Thus, if not already in place, I would encourage the DC MHCC to not presume competence at the outset.

Recommendations: Research findings highlight the need for the courts to ensure that the persons entering the courts, ones often times who are marginalized and undereducated, are making voluntary and knowing decisions, and feeling respected when doing so. MHC enrollment decisions made in this manner are not only legally required but can help play a role in decreasing the revolving door phenomenon of persons with mental health problems that the courts were originally designed to combat.

3. *The efficacy of mental health court models employed by other jurisdictions, and whether any successful facets of those models should be utilized in the District;*

By most accounts, MHCs are successful in reducing recidivism and number of days/stays in jail (see, e.g., Lowder, Rade, & Desmarais, 2018; Steadman et al., 2011), either when compared to rates before MHC participation (pre-post designs) or when compared to traditional court samples (quasi-experimental designs). Similar to what was found in the series of studies on the DC MHCC, a consistent factor predicting reduced rearrests is the length of time the participant was in the MHC, or whether they received the full ‘dose’ of MHC and graduated. In one study of four MHCs, Compliance with the court’s orders was the only factor to significantly influence graduation vs. termination status; factors such as age, gender, race, diagnosis, and seriousness of arrest did not affect whether one was successful or not (Redlich et al., 2010b; see also, Hiday, Ray, & Wales, 2014). Generally, demographic and clinical factors inconsistently relate to success; that is, in some studies, for example, demographic factors (like gender and race) influence termination, whereas in other studies, they do not.

So far as I can tell, there are several unique aspects to the DC MHCC. First, it has an unusually large number of clients. The number of participants included in the series of Hiday et al. studies was 408 and these authors describe the court as having “high caseloads” (Hiday et al., 2013). Anderson (2017) reports that over 10 years, the court has provided services to close to 4,000 people. In contrast, a study of the then-population of adult MHCs found that the median number of participants per court was 36 and the mode was 30, though the number ranged from 3 to 852 participants (Redlich et al., 2006). Number of active participants was correlated to frequency of court hearings (more participants, less frequent hearings); proportion of felony defendants; and number of different forms of community supervision.

Second, and perhaps related to the large size, the DC MHCC has a shorter supervision period than most MHCs. The DC MHCC period of participation is 4 to 6 months; in contrast, other MHCs often supervise clients for 1 year or longer. For example, across four MHCs and 434 participants, length of time in the court varied from 29 days to 3.2 years (Redlich et al., 2010b). On average, those terminated were in the court 9.8 months, those still in the court had been in for 1.8 years, and those who graduated were in for 1.2 years. Thus, the DC MHCC’s period of 4-6 months is shorter than other courts, even among those who terminated.

Third, according to Anderson (2017), the DC MHCC is the only one in the nation to have a full service mental health clinic. I think this means on or near the premises of the courthouse. Such ready access to mental health treatment and close contact with treatment providers are important, and are likely to promote success.

In other ways, to my knowledge, the DC MHCC is similar to MHCs around the nation. According to Hiday and her colleagues, the DC MHCC follows the “10 Essential Elements of Mental Health Courts” (Thompson et al., 2008; see provided article, Redlich, 2013). It now includes both

misdemeanor and felony cases, which in my opinion, is appropriate and again in line with many other courts (e.g., in 2006, 59% of MHCS accepted felons). And like other MHCs around the nation, the DC MHCC does not have a 100% success (or graduation) rate. As noted, while it is not realistic to expect 100%, all courts have room for improvement. I do not know the current graduation rate of the DC MHCC; the Hiday et al. studies place it at 58%. The four-site study (Redlich et al., 2010b) found rates of 53% to 83%.

Recommendations. Again my recommendation is to conduct more empirical research with the DC MHCC, particularly now that it is more advanced. It is difficult to know, without empirical study, whether the unique aspects of the DC MHCC improve, reduce, or have no effect on its success rates. It will be important to conduct a randomized trial, if possible, and to interview different samples (clients, as well as court and treatment personnel, and a comparison sample). Another possibility to re-examine the same sample studied by Hiday, Ray, and Wales to determine the effectiveness of court participation some 10 years later. Have any participants been ‘re-diverted’? That is, participated in the DC MHCC more than once?

Thank you for this opportunity.

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Prepared Written Statement of Christy Respress

Mental Health, Homelessness, and the Mental Health Court

Good afternoon and thank you for the opportunity to speak at this important briefing. My name is Christy Respress and I am the Executive Director of Pathways to Housing DC. For the past 21 years I have dedicated my life to the work of ending homelessness. I've spent the last 15 years working at Pathways to Housing DC where our mission is to end homelessness and support recovery for adults living with serious mental illness, addictions, and other complex health challenges. Pathways has ended homelessness for over 1,000 people in our own Housing First program and hundreds of others with our partner agencies. Each year we serve over 3,500 people experiencing/at risk for homelessness in our Housing First programs, our street outreach program, and our Urgent Behavioral Health Clinic in the DC Superior Court.

Pathways opened our doors in 2004 at the request of the DC Department of Mental Health. Our goal was to bring the Housing First model to the District where it was so desperately needed. While a number of agencies were offering high quality mental health and housing services (like my fellow panelist here today), many people with the most complicated health challenges were unable to access those housing programs because of rules requiring them to be engaged in psychiatric treatment and to be clean and sober as a prerequisite. As you can imagine, these barriers kept people trapped in never-ending cycles of incarceration, hospitalization, and homelessness.

The good news is that we have the solution- it's housing- FIRST. Simply put, that means providing people immediate access to permanent housing with no barriers and then providing the wraparound support services they need to recover their lives. But before we get into solutions, I do want to share some additional context on the need for urgency in addressing the issues before us today.

People being treated by the public mental health system in our country are dying an average of 25 years sooner than most Americans. They are dying from treatable medical conditions related to smoking, obesity, substance use, and inadequate access to medical care.¹

We also know that according to National Health Care for the Homeless, people experiencing homelessness are three to six times more likely to become ill than people in housing. Additionally, the average life expectancy in the homeless population is estimated between 42 and 52 years, compared to 78 years in the general population. The reasons for these horrendous outcomes are many and include lack of access to preventative healthcare and the difficulties in

¹ *National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council:*
<http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>

managing chronic health conditions without regular housing.²As one of our tenants told us after moving into his apartment after 30 years of homelessness, “I can finally take my medicine now that I have a medicine cabinet to put it in!”.

Research also shows that persons experiencing homelessness, especially people with behavioral health challenges, are often some of the highest utilizers of costly public services such as ERs, ambulance, crisis programs, and jails.

As a nation, we know that homelessness is inextricably linked with the criminal legal system. According to the National Alliance to End Homelessness, almost 50,000 people a year go directly from incarceration into homeless shelters. People experiencing homelessness are more likely to report having a criminal record than the general public³. In addition, research shows that people who have experienced homelessness are overrepresented among those incarcerated in prisons or jails.

The District is no different. Each year, communities around the country conduct an annual “Point in Time” count with the goal of completing a brief questionnaire on every person experiencing homelessness in the City. That includes people staying in shelters and on the streets. Data from that count this year showed that roughly 6,904 people were experiencing homelessness on a single night in the District. 1,781 of these were people experiencing chronic homelessness, which means they have been homeless for at least a year and have a disability.

The good news is that there has been an overall **5.5% decrease** in the number of people experiencing homelessness in the District since 2018. This is mostly driven by the successes in our family systems. Unfortunately, the number of single adults experiencing homelessness actually rose by 2.8%. If DC were a state, we would have the highest rate of homelessness in the country, with 99 of every 10,000 residents counted as homeless. We’ve made some incredible strides in our community but ending homelessness remains one of the most important issues facing the District, and there is still much work to be done.

The survey completed at the Point in Time count is very brief and it tells us only basic information about a person’s homelessness. That’s why this year, the DC Interagency Council on Homelessness worked with homeless outreach and shelter programs around the City to conduct a much more thorough survey from a sample of 1,052 people experiencing homelessness.

One of the takeaways most relevant to today’s conversation is that 57% of respondents currently experiencing homelessness reported having been previously incarcerated, and a majority of those people (55%) entered homelessness after incarceration. In fact, 13% said that incarceration was the main reason for their first experience of homelessness, and for people with multiple experiences of homelessness, more than 1 out of 10 said that incarceration was the reason for their current situation. Although education, employment, and treatment for drug and mental health issues all play a role in successful reintegration, these factors have little hope in the

² O’Connell, J.J. “Premature Mortality in Homeless Populations: A Review of the Literature.” 19 pages. Nashville: National Health Care for the Homeless Council, Inc., 2005

³ Metraux, S., & Culhane, D. P. (2006). Recent Incarceration History Among a Sheltered Homeless Population. Retrieved from http://repository.upenn.edu/spp_papers/61

absence of stable housing. Few people leaving incarceration have the two months rent needed to move directly into an apartment of their own even if they did have a job lined up.

When the City dug deeper, they found that those who reported a history of incarceration also showed a higher rate of having a mental health condition compared to those who reported not having any mental health conditions. Unfortunately, I am not surprised by this data.

Pathways currently operates the largest street outreach program in the District. Last year our outreach teams worked with over 1,600 unique individuals. In our experience as many as 50% of the people we work with are living with mental illness, and many of them are living with serious mental illnesses such as schizophrenia, bipolar disorder, and major depression. Almost 100% of the people we work with on the street have experiences of trauma either prior to, or as a result of, experiencing homelessness. While many people are connected “on paper” to one of the many high-quality mental health service providers or “CSAs” certified by the DC Department of Behavioral Health, they often aren’t receiving the care they need as a direct result of their homelessness. For example, they may not have the bus fare to make it to their psychiatrist appointment, their phone got stolen and they don’t know how to reach their treatment provider, or they must wait in line to get into the shelter and miss an appointment with their therapist. Additionally, mental health agencies cannot bill Medicaid for looking for people, so they often lose connection with people who are unstably housed and difficult to locate. Our outreach teams report that approximately 40% of their time is spent reconnecting people with their mental health or case management providers.

When people have open charges or are on probation/parole, it is even more challenging for people with mental illness staying on the street to meet their legal obligations. The simple act of keeping track of notifications from the court can become impossible without a fixed address. Many of the people we work with are interacting with the legal system as a direct result of their homelessness or their homelessness and behavioral health challenges combined, like loitering, indecent exposure, possession, drinking in public, urinating in public, or sleeping in public.

The good news is, we have the solutions. The solution is providing people with immediate housing and the right level of services to help them remain in housing, regain their dignity, and reclaim their health. We call this model Housing First. It is the only evidenced based practice proven to end chronic homelessness and it is now the best practice in this City, around the United States, and around the world. Providing Housing First is not only the *right* thing to do, it is the *cost-effective* thing to do. Studies have repeatedly proven that giving people housing in addition to the supportive behavioral health services they need results in decreased arrests, detentions, police contacts, and court appearances.⁴

⁴Latimer, E., & Ly, A. (2015). Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature. *Can J Psychiatry*; 60(11): 475-487.

We know that our behavioral health, criminal justice, and homeless services systems must prioritize coordination and collaboration to achieve better outcomes for our residents. It's possible if we make it a priority.

I'll end before questions with a quick story of one of our very first tenants at Pathways. When I met Joe, he was sleeping in the alley next to the MLK library. He had undiagnosed and untreated bipolar disorder, he was in and out of jail for assault and drug related charges, he was using crack cocaine daily, and he had lost all connections to his family. When we met Joe and offered him an apartment in our Housing First program, he didn't believe or trust us. It all seemed too good to be true. He got the keys, moved back to the street, and quickly got rearrested for violating his probation. But we didn't go away. Over the course of the next few years, Joe cycled in and out of jail and even served 18 months in federal prison on drug related charges. The one thing that didn't change for him was the support of his Assertive Community Treatment team and the offer of stable housing from Pathways. Gradually, Joe accepted treatment for his mental illness, trauma, and addiction. He reconnected with his family, he became a DBH certified peer specialist, and he now works in outreach using his personal journey to connect others to housing and healthcare. Joe credits Housing First for the reason he was able to turn his life around. He likes to say, "If I can do it, everyone can!".

THE
PUBLIC
DEFENDER
SERVICE
for the District of Columbia



PREPARED WRITTEN STATEMENT OF LAURA L. ROSE
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THE PUBLIC DEFENDER SERVICE FOR THE DISTRICT OF COLUMBIA

HOMELESSNESS, MENTAL ILLNESS & THE CRIMINAL JUSTICE SYSTEM IN DC

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Thank you for the opportunity to address the impacts of mental illness and homelessness on criminal justice system involved individuals. I am Laura Rose, the Mental Health Specialist for the Trial Division of the Public Defender Service for the District of Columbia. In that role, I serve as the point person at PDS for mental health issues within a pretrial posture, most commonly competency to stand trial, the insanity defense, mitigation, and alternatives to incarceration, including mental health court. PDS appreciates the Committee's interest in these issues, which are so critical for our clients. The Trial Division of PDS represents a substantial percentage of the individuals facing serious charges in the District who also suffer from mental illness. The PDS Mental Health Division (MHD) represents individuals who have a mental illness and have been court ordered to receive treatment, either in an inpatient or outpatient setting. Many PDS clients in each division reside at or are detained/committed to at St. Elizabeths Hospital and many who reside in the community receive services through the D.C. Department of Behavioral Health (DBH). I have worked at PDS for 28 years; in the Trial Division for 20 years and in MHD for 6 years. I have been in my current position for the last 9 years.

During that time, it has become increasingly evident that diverting from the criminal system to the mental health system those clients whose criminal justice involvement stems from their disability is a critical component of justice and, ultimately, public safety. In situations where criminal involvement is the result of an individual's disability, quality health care treatment and resources are the solution, not incarceration. In such cases, treatment is the best mitigator of risk and thus most effectively protects public safety. Not only does incarceration not provide the treatment necessary to prevent recidivism, the conditions of incarceration are often intolerable and cruel, exacerbating mental illness and further increasing the risk of recidivism. For example, absent basic treatment, inmates with mental illness are often deemed behavioral challenges and placed in solitary confinement for long periods, which for this population can be as clinically distressing and destabilizing as physical torture¹. Simply put, traditional models of crime and punishment, when applied to mentally disabled defendants, cannot and do not obtain the desired results of rehabilitation and public safety.

¹ Jeffrey L. Metzner and Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, *Journal of the American Academy of Psychiatry and the Law*, 38 (1) 104-108 (Mar. 2010).

From this practitioner's perspective, I would like the Committee to focus on the following ways in which the D.C. criminal justice system and local agencies fail this vulnerable population: the extremely limited scope of our mental health court; treatment deficits for cognitively impaired persons; and the need for the implementation of best practices standards, training, and supervision of the Department of Behavioral Health (DBH) in its care, treatment, and forensic evaluation of justice involved consumers.

The consequences of a D.C. prison sentence for individuals with a mental disability are particularly dangerous at the present time. All persons sentenced to more than one year must serve their sentences at a facility within the Federal Bureau of Prisons. The majority of individuals suffering from a severe and persistent mental illness within the BOP will not be identified as requiring regular psychiatric care, nor will they receive such care.² Rather, they are at heightened risk of placement in solitary confinement, decompensation, and victimization. Over the past decade, I have regularly watched clients who were psychiatrically stable (and committed to taking medication) at the D.C. Jail and Saint Elizabeths Hospital totally decompensate upon having their medication abruptly discontinued during the process of being transported to the BOP; they are then placed in BOP facilities without access to psychiatric or psychological services, and denied antipsychotic medication. These devastating consequences of not diverting the mentally ill from such treatment hostile incarceration further heighten the need for a robust and inclusive mental health court in the District of Columbia.

At present, the District's mental health court is one of the narrowest in the country. Participation is currently limited based on a defendant's diagnosis and criminal charges: only those with a "serious and persistent" mental illness are allowed to participate, and the eligible charges are limited to most misdemeanors and very few minor felonies. Some defendants in misdemeanor mental health court may complete the program without entering a guilty plea, though others must initially enter a guilty plea to a misdemeanor charge. Both misdemeanor groups get their cases dismissed if they successfully complete the program. If they fail to complete the program, their cases are either set for trial or they are sentenced on the misdemeanor charge. Defendants in felony mental health court must initially enter a guilty plea

² A 2017 Report by the Inspector General addressing these issues is attached as Exhibit A. NOTE from USCCR staff: The IG report is too large to append; *see*,

<https://www.oversight.gov/sites/default/files/oig-reports/e1705.pdf>.

An article by the Marshall Project challenging BOP's assertion that only 2% of its inmates suffer from severe and persistent mental illness and thus receive regular mental health treatment is attached as Exhibit B. NOTE from

to a felony charge. If they successfully complete the program, their charge is reduced to a misdemeanor and they are sentenced on the reduced charge; if they do not, they are sentenced on the felony charge. Eligibility for both programs is determined at the sole discretion of the prosecution after the filing of charges. This process is the only formal mental health alternative to prosecution currently available in the District. I would advocate for an expansion of all aspects of our current model. A robust and inclusive system would require expanding: the type of recognized mental disabilities; the type of eligible offenses; the flexibility of the process to individualize the potential outcomes; and the points within the process at which diversion from the criminal system to appropriate treatment services can occur.

Since our mental health court is currently available only to individuals diagnosed with a serious and persistent mental illness, the program is not available to individuals diagnosed solely with cognitive disorders, including but not limited to, intellectual and developmental disabilities and other cognitive impairments such as traumatic brain injury and age-related neurological disorders such as dementia. Omission of these vulnerable individuals both risks unnecessary and dangerous imprisonment and misses the opportunity to provide them with necessary services.

With regard to eligible offenses, we would recommend that all offenses be eligible and that other stakeholders have a voice in determining individual eligibility. The District has fewer eligible offenses than most mental health courts. For example, Dallas, Texas has a more expansive list of eligible offenses. While every eligibility decision will ultimately rest with the Office of the United States Attorney, blanket exclusion of particular charges unnecessarily limits participation. At a minimum, all misdemeanor charges should be potentially eligible, as well as participation. At a minimum, all misdemeanor charges should be potentially eligible, as well as serious felonies. Currently, domestic violence misdemeanor charges are ineligible, as are all felonies except for property related offenses, unarmed drug offenses, escape, bail reform act violations, and threats. Such blanket limitations do not enhance public safety, as treatment based alternatives are more likely to provide effective long-term rehabilitation and lessen the likelihood of recidivism than periods of incarceration without meaningful psychiatric treatment.

I would also recommend a more flexible and individualized approach to utilizing potential mental health court alternatives. An individualized approach to the components, length

USCCR staff: The article is too large to append; see,

<https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons>

of participation, and outcomes of our mental health court would permit a more fulsome balancing of a defendant's circumstances with public safety and other law enforcement concerns. Participation in mental health court keeps the defendant squarely within the criminal system, with that system supervising his or her voluntary mental health treatment. Particularly in serious cases, outcomes would be improved by using mental health court to functionally transfer a client from the criminal system to the mental health system. In some cases, creating a process that would allow the parties to substitute civil commitment proceedings for criminal prosecution could provide an option that would better address both the interests of the government and the defendant. For example, compelled mental health treatment is a more effective prevention mechanism than prison or probation for a defendant whose offense is caused by his mental illness and who has never received consistent inpatient or outpatient mental health treatment. In that situation, a civil commitment petition, rather than a criminal prosecution, could provide the defendant with multiple services and treatment from the mental health system while also more effectively mitigating the chances of recidivism.

Finally, our mental health court should be expanded by adopting the sequential intercept model facilitating diversion from the criminal system at all possible points within the criminal justice system. We currently have no meaningful pre-arrest diversion program,³ despite full stakeholder support for pre-arrest diversion of misdemeanor charges arising from behavioral health issues. Additional points for diversion should include the time the USAO makes charging decisions and during the grand jury process. Policies should be developed about how to proceed – through facilitating voluntary treatment, by initiating civil commitment proceedings, or by proceeding with the criminal case – and those policies should be implemented pre-arrest, pre-charging decision, and throughout the remainder of the proceedings if appropriate. Utilization of even a conservative version of this program would greatly reduce costs and result in more effective mental health treatment.

In addition to expanding the District's mental health court, I would ask the Commission to consider addressing two ongoing concerns: the unavailability of treatment in the District's public health system for some neurological disorders and the need to ensure that the quality of DBH treatment and forensic evaluation meets professional standards. Unlike many jurisdictions, the District has a well-resourced and expansive Department of Behavioral Health and a

freestanding Department on Disability Services; however, there is no agency or public treatment provider dedicated to the treatment of non-developmental cognitive disorders. As a result, many individuals suffering from traumatic brain injury or cognitive disorders arising after the age of eighteen are without appropriate treatment. Second, we would be remiss if we did not ask the Commission to consider two recent events regarding the quality of DBH services. Deadly legionella bacteria was recently discovered in the Saint Elizabeth's Hospital water supply and the Hospital was without water for a month. The administration's response to this dangerous situation was inadequate. It is critical that DBH implement a meaningful monitoring system to prevent future harm to this vulnerable population. Finally, in 2018 the Office of the D.C. Auditor (ODCA) conducted a comprehensive review of mental health services provided by DBH to justice-involved individuals. The ODCA raised substantial concerns about the standard of services provided by DBH to its justice-involved consumers and addressed the need for pre-arrest diversion, alternatives to incarceration, and other issues of interest to this Committee.⁴

I appreciate the Committee's interest in these important issues that impact so many PDS clients. Thank you for holding this hearing and allowing us the opportunity to address these issues. We welcome participation in further discussions with the many concerned stakeholders in the District of Columbia.

³ The Mayor's Office initiated a very small pilot program, but it has not resulted in any ongoing diversion program or policies.

⁴ The Mayor's Office initiated a very small pilot program, but it has not resulted in any ongoing diversion program or policies.

Prepared Written Statement of Cleonia Terry

Mental Illness, Homelessness and the Criminal Justice System

Like many major cities across the country, the District of Columbia is challenged with determining how to adequately address homelessness and mental illness for criminal justice involved individuals. It is well-known that individuals with mental illness are significantly over-represented in the criminal justice system and more likely to be arrested than their non-mentally ill peers for similar offenses (Bronson & Berzofsky, 2017). Researchers have found that 7 to 16 percent of individuals in jails have a serious mental illness, with rates four times higher for males and eight times higher for females than in the general population (Cox., Morschauer, Banks, & Stone, 2001). James and Glaze (2006) found that a staggering 64% of inmates reported a recent "mental health problem." In addition, there is a chronic lack of housing for persons with severe and persistent mental illness and co-occurring mental health and substance abuse disorders involved in the criminal justice system. A January 2019 Point in Time (PIT) census of homeless persons in the District of Columbia, conducted by the Community Partnership for Prevention of Homelessness (TCP), found that 6,521 persons were experiencing homelessness. Of these individuals 608 persons were unsheltered, 4,679 were in emergency shelters, and 1,234 persons were in transitional housing. One in five homeless adults surveyed had histories of substance abuse or mental illness; nine percent reported having both conditions.

The DC Mental Health Community Court

The DC Courts Mental Health Diversion Court (MHDC) started in 2007 as a one-year pilot program in response to the growing number of seriously mentally ill defendants cycling through the court system. MHDC was a collaborative effort between DC Superior Court, the DC Pretrial Service Agency (PSA), the United States Attorney's Office (USAO), the Criminal Justice Act Bar, the Public Defender Service (PDS), and the DC Department of Behavioral Health (DBH). The court included a specialized court calendar and program for misdemeanor defendants with a serious mental illness or co-occurring mental health and substance use disorders. The DC Mental Health Diversion Court was designed to reduce recidivism by connecting eligible mentally ill offenders with mental health and substance abuse treatment, thus addressing the underlying causes of their crimes. The program expanded in 2010, allowing access to non-violent felony offenders (e.g. drug distribution, possession with intent to distribute, escape, receiving stolen property, unauthorized use of a vehicle, threats to do bodily harm, destruction of property, and first degree theft). In 2011 the program was

renamed the Mental Health Community Court Program (DC DC MHCC) to reflect the community-based approach. In 2017 the DC MHCC expanded the program a third time to include criminal offenders with serious and persistent mental illness convicted of and serving the probationary part of his or her sentence. The DC MHCC Post-Disposition Probation program accepts certification by DC Superior Court sentencing judges at the request of defense counsel, the USAO, the Office of the Attorney General (OAG), or Court Services and Offender Supervision Agency (CSOSA) for eligible offenders. Since the inception of the DC MHCC program in October 2007, over 4,000 people with misdemeanor charges have been certified to the program and more than half have successfully graduated and have had their criminal charges either dropped or dismissed. Many of the other mental health courts do not serve as many individuals as the DC Mental Health Court. The DC MHCC have dedicated judges who provide leadership over the program and direction for program policy and procedures.

Housing

DC MHCC participants are not required to have stable housing to participate in the program, such as in other mental health courts. The DC MHCC program accepts referrals on behalf all defendants that meet the legal and clinical eligibility prerequisites for the program, regardless of their housing situation. According to the Superior Court of the District of Columbia Mental Health Community Court Program Manual of Policies and Procedures eligibility criteria is determined by the United States Attorney's Office for DC (USAO) and the DC Pretrial Services Agency (PSA). The USAO determines if a person is legally eligible for DC MHCC based on a review of the defendant's criminal history, pending charges and public safety concerns. PSA determines diagnostic eligibility by verifying that the defendant meets the clinical criteria of having a serious and consistent mental illness. Although, the DC MHCC does not look at an individual's housing status for eligibility into the program, homelessness is a problem for many of the participants. DC MHCC refers participants in need of housing resources to outside stakeholders for assistance including, the Urgent Care Client, mental health case managers and DC Housing Authority.

Collaboration and Resources

Additionally, the DC MHCC utilizes a team approach and works closely with representatives from the United States Attorney's Office for DC, Pretrial Services Agency for DC, DC

Department of Behavioral Health, Office of Attorney General for DC, Court Services and Offender Supervision Agency for DC, defense counsel and community mental health service providers to assist defendants participating in the program with needed resources. According to the National Center for State Courts, the primary characteristic of problem solving, and community courts is a closer collaboration with the service providers and a multidisciplinary, problem solving approach to address the underlying needs of individuals appearing in court. If left unaddressed, these underlying needs often lead to a “revolving door” where individuals cycle in and out of the criminal justice system due to lack of treatment. One important factor that distinguishes the DC MHCC from other mental health courts across the country is that it does not directly provide or procure treatment for participants. Rather, services are provided by a group of core agencies contracted and managed by the DC Department of Behavioral Health. So while the DC MHCC orders treatment, it does not have input into the selection or management of treatment services available for participants. The Urgent Care Clinic (UCC) located inside the DC Superior Court Moultrie Courthouse Building on the first floor is one valuable resource for individuals in the DC criminal justice system in need of immediate mental health and/or substance abuse treatment. The UCC is a collaborative effort between Pathways to Housing DC, Department of Behavioral Health and DC Superior Court. The clinic provides immediate access to mental health assessments and treatment, substance abuse screening and referrals, assessment for housing needs and establishes linkages to long-term providers for continuity of treatment once individuals are no longer criminally justice involved.

Consent

Furthermore, participants referred to the DC MHCC program must be legally competent to participant in the program. It is the policy of the DC MHCC to ensure that the rights of defendants are protected, and that each participant of the program is making an informed and voluntary decision to participate in the program. If at the time of admissions the person is not competent the person will not be admitted into the program and the case will be transferred back to the original calendar judge. During the Admissions Hearing in DC MHCC, the judge formally welcomes each defendant to the program, explains how the program works, and provides defendants with a participant brochure. In addition, the Mental Health Community Court Coordinator is available to meet with defendants at any point during the admissions process to ensure that defendants understand the requirements of the program and, if not, will explain them in further detail. Consequently, if a defendant decompensates while participating in the DC MHCC program, and is unable to willfully participate due to competency concerns, in most cases the defendant will remain in DC MHCC, and may be ordered by the

court to participate in treatment for restoration of competence on an inpatient or outpatient basis in the least restrictive setting. The court may order inpatient treatment if the defendant is unlikely to comply with an order for outpatient treatment. Outpatient restoration treatment services are provided by the DC Department of Behavioral Health.

Access to Mental Health and Legal Services

Individuals in need of mental services, whether involved in the DC MHCC or not may access mental health treatment in the District of Columbia by contacting the DC Department of Behavioral Health Access Help Line at 1-888-793-4357. According to the DC.gov website, the Access Help Line is a 24-hour, seven-day-a-week telephone line that is staffed by behavioral health professional that is available to assist with referring callers to immediate mental health help or ongoing care. Additionally, the access helpline can respond to emergency psychiatric and emotional crisis involving individuals unable or unwilling to receive behavioral health services by activating a mobile crisis team, which is also available 24-hours and seven-days-a-week. Lastly, according to the DC Superior Court Mental Health Community Court Program Case Management Plan, defendants charged with a criminal offense have a right to an attorney. If a defendant cannot afford an attorney, qualified individuals may have attorney appointed by the court under guidelines established by the Court's Criminal Justice Act plan.

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Prepared Written Statement of Terrance

Good Morning,

I am Terrence Walton, the National Association of Drug Court Professional's chief operating officer. NADCP is a 5013c nonprofit that provides training and technical assistance to treatment courts of all varieties—including mental health courts. We also develop national standards and other resources for treatment courts and educate federal legislators and the public about treatment courts and other aspects of justice reform.

My work at NADCP has allowed me to spend time with hundreds of treatment court teams nationwide and has given me an insider's view of how treatment courts, including mental health courts operate; as well as insight into some of their persistent challenges. Additionally, while this is not the focus of my remarks this morning, I served as Director of Treatment for the Pretrial Services Agency for the District of Columbia for many years, including when DC's Mental Health Community Court (MHCC) was established. One of the PSA units that I led provided direct court representation, clinical case management, supervision and other services to the MHC.

I am pleased to address this distinguished committee and the public, as a part of this briefing on mental health, mental health treatment courts, and the justice system.

Background

Mental health courts were developed to address growing concerns among judges that people with serious mental illness in the US were becoming familiar faces in the criminal justice system, receiving limited treatment, and further clinically and behaviorally decompensating.

Mental Health Courts are Growing (despite little federal funding compared with drug courts.)

In 2012, the Substance Abuse and Mental Health Services Administration's GAINS Center reported that there were 346 adult mental health courts and 51 juvenile mental health courts. Today the GAINS Center reports that there are 533 adult mental health courts, an increase of over 50% in just six years. There was also a slight increase in juvenile mental health courts by the end of 2018.

Mental Health Courts Target Justice-Involved Individuals with Serious Mental Illness

The target population for adult mental health courts is persons with serious mental illness who also have significant justice involvement based partly on severity of an offense or frequency of arrests. Significant justice involvement in this context is sometimes referenced as high risk.

While the majority of mental health courts target those with serious mental illness, it is less clear whether most MHCs serve only those with significant justice involvement. In my

observation, most do not. Instead they may include many individuals with serious mental illness, but who lack significant justice system involvement or likelihood of such involvement based on valid assessment of risk. This not a best practice. For such individuals, diversion from the justice system, including pre-booking diversion is likely to be the more effective (including cost effective) and less risky approach.

What are Mental Health Courts?

It's difficult to define specifically how MH court operate because there is wide variability across programs. This is likely because presently there are no national mental health court standards or guidelines.

Where are Mental Health Courts?

Despite the uptick in the number of adult MHCs, 84% of US counties do not have one. Nationwide, people involved in the justice system who have SMI or COD are being diverted away from the justice system and into services; or being treated in regular drug courts or co-occurring disorder courts; or being supervised and connected to mental health services by supervision officers; or their mental health issues are not being addressed at all.

Are Adult Mental Health Courts Effective?

Overall, MHCs have been found to have a modest positive effect on recidivism compared to business as usual. Other positive outcomes include reduced jail days, and better treatment services, access, and connection.

My more comprehensive written statement includes a few recommendations for you to consider. I am also happy to discuss some of them during our question and answer exchange that begins shortly.

There is still much work to be done to further define how MHCs should operate to achieve significant outcomes for the participants, their families and our communities; however, there is no question that MHC is an essential tool for effectively servicing persons with serious mental illness who are also at higher risk for significant justice system involvement. From my observation, that is certainly the case here in the District of Columbia, as well as everywhere else across the country.

Thank you

MENTAL HEALTH DIVERSION FOR CRIMINAL DEFENDANTS

One Judge's Experience

By Judge Ann O'Regan Keary

Several recent studies have reported the significant percentage of seriously mentally ill persons incarcerated in our nation's prisons and jails.¹ As courts across the country face an increasing presence of mentally ill individuals charged with criminal offenses, many of them misdemeanors or nonviolent offenses, and our institutions face the challenge of meeting the needs of these individuals, the role of judicial officers is evolving in significant ways through alternative courts developed to address this population.

No longer can judges limit their judicial functions to performing the traditional, classical judicial duties of presiding over criminal trials and fact-finding proceedings to address and process criminal cases brought before them. Increasingly, they must become involved with the aptly named "problem-solving" courts and address, in a more outcome-oriented fashion, the problems of mentally ill criminal offenders. The good news is that there are, at this point in time, many well-established models for such judicial functioning with well-documented positive outcomes. For some of us, there may be even better news regarding how satisfying the performance of this nontraditional function can be, as a new direction in one's judicial career.

Background

The formation of our own mental health diversion program in the District of Columbia stemmed from our court's earlier experience in a somewhat similar problem-solving court—the East of the River Community Court, which was begun in 2003. In this court, which handled defendants arrested in the two police districts on the eastern side of D.C., we offered

diversion, i.e., a predisposition dismissal of the criminal cases, to those misdemeanor defendants who performed 32 hours of community service and stayed arrest-free for a four-month period. While highly successful, it quickly became clear that such a "restorative justice" model was not really suitable for many of the defendants who came before our court, who suffered from mental illness and were too severely impaired to successfully meet community service obligations. Instead, we began, with the concurrence of the U.S. Attorney's Office and our federally funded Pretrial Services Agency, to target merely linking these individuals with mental health providers and requiring their engagement in treatment as a basis for dismissal of their case. The results were satisfying to all our stakeholders, and we soon decided this model should serve as the basis of a fully developed mental health diversion program open to all misdemeanor defendants citywide.

By 2007, we brought to the table all the necessary components to construct our diversion court—the prosecutor's office—U.S. Attorney's Office for the District of Columbia, which has jurisdiction over local as well as federal criminal cases in the District of Columbia; the District of Columbia's Department of Mental Health (recently renamed Department of Behavioral Health); and the Pretrial Services Agency (PSA), which supervises defendants on pretrial release in our criminal cases. With the approval of our chief judge, we launched a one-year pilot project at the end of 2007, utilizing as our first presiding judge a magistrate judge with an extensive background in mental health issues because she also served in our family court handling involuntary civil commitment cases.



In that first year, I made the prediction that we would have no more than about 50 cases referred, but, to my surprise, the number of defendants certified to our calendar greatly exceeded that expectation. Our mental health diversion court was embraced enthusiastically by the defense bar—an important contributor to its success—as it afforded defendants an opportunity for improved access to mental health services and, usually, a resulting improvement in their health and life adjustment. Perhaps more significant from the defense perspective, success in mental health diversion guaranteed a dismissal of the case after only a few months of court supervision. A few months after the program had launched, I sat in one day on the diversion court to observe how things were proceeding. After watching several hearings, I approached a veteran

often substance abuse treatment, the plea would be reduced to a misdemeanor charge, and the participant would receive a probationary sentence. While this outcome was not quite as desirable as the outright dismissal in the misdemeanor cases, it was still an attractive alternative to a potentially lengthy prison sentence if convicted of a felony charge.

Midway through the first year of our mental health court program, our undertaking was greatly aided by the District of Columbia's Department of Mental Health's establishment of a free-standing, fully staffed mental health clinic in our court building. The clinic, staffed with a psychiatrist and social workers/case managers, was available for "urgent care" treatment of any participants referred from our mental health diversion court (as well as from other criminal judges' calendars). While many courts across the nation (including our own) had on-site forensic mental health evaluation services to perform competency-to-stand-trial screenings and assessments, this clinic provided actual treatment staff, who could engage defendants at the courthouse—the very setting where they were required to appear for court hearings. This was a particular asset to our many homeless individuals in facilitating their getting into treatment, and was also an excellent example of how court leadership on an issue can encourage other stakeholders to pursue creative and progressive improvements in their own service delivery.

The Judicial Role in Mental Health Community Court: The Three C's

The operation of our mental health diversion court by definition involves holding status hearings and diversion review or supervision hearings, rather than the trials and other evidentiary proceedings of the traditional criminal court. In the typical criminal trial courtroom, the witness box is occupied by witnesses called to give testimony for the fact-finder—the judge or jury—to determine guilt or innocence. In contrast, our mental health courtroom's witness box serves as the on-site office for the court's PSA representative, who sits by

the judge, providing her with up-to-the-minute information from the defendants' case managers about each individual's engagement, and progress, in treatment and collaborating on how to assist the participant in getting necessary treatment.

The judge's role, as explained to the individual at her admission hearing, is not to determine whether a defendant is guilty or innocent, or what sentence should be imposed upon conviction. Instead, the judge's role involves reviewing defendants' progress at each hearing, acting as a coach, encouraging the defendants, and applauding their efforts, as well as addressing their failures when necessary, and holding them accountable for both.² The judge is required, daily, to supervise the entry and implementation of diversion agreements, which defendants earn by virtue of demonstrating engagement in services and stability in treatment in the community. Further, once placed on an agreement, each defendant's status and progress are reviewed by the judge, usually on a monthly basis. It was not unusual to have a hearing begin with a defendant's apologetic admission that he or she had "slipped up" (and relapsed into drug use) since the last hearing, which would lead to a frank discussion of the need for drug treatment, or improved mental health engagement. The judge oversees the progress of each defendant in the diversion program until completion of the diversion agreement, which is recognized in a formal, individualized, graduation ceremony.

At each graduation, the judge descends from the bench to congratulate the participant and reward the successful defendant



Judge Ann O'Regan Keary is an associate judge of the District of Columbia Superior Court and one of the founders of the

Court's Mental Health Community Court, over which she presided from 2012 through 2014.

defense counsel whose client had just had his hearing to ask his opinion of the program. He was quick to respond, "Oh, this is the best thing that the court has done in years!" I knew then we were onto something very promising. But little did I know that by late 2014 we would have had more than 1,150 successful graduates of the program.

At the end of a successful first year, the program continued on as a regular court calendar within our court's 26-judge Criminal Division, serving an ever-expanding group of defendants certified from our six regular misdemeanor calendars. Within three years of its inception, all agreed to expand and include nonviolent felony cases as well, though for felony cases it was agreed that a plea of guilty would be required and then, after a four-month period of supervision and continuing mental health and

with a certificate and tokens of recognition, to the applause and ovation of others in the courtroom. The graduation day was a thrill for defendants and for the judge as well because it was often a time for defendants to express their own views on what the program had meant to them. One participant, an older female who had completed a residential drug treatment program and obtained comprehensive mental health services commented, in response to my question about how she felt about what she had accomplished said, "I never thought I could feel this good!" In another case, a man who had been homeless and living in a small tent he had set up behind a commercial strip of stores, despite the winter weather, appeared at his graduation with his well-dressed brother; although his family had previously severed ties with him due to his untreated psychotic symptoms, the defendant's brother was now willing to help him obtain housing, as the defendant was finally receiving the mental health treatment he needed to function as a valued family member again. Whatever the individual participant's circumstances, most defendants were extremely grateful for the opportunity for services, as well as for the excellent outcome of dismissal (or reduction of charges, in the case of a felony).

Clearly, the very nature of the types of court proceedings in such an alternative program imposes a different role on the judge. Perhaps more important than the difference in the nature of the hearings themselves is the difference in the nature of the interaction between the participant and the judge that occurs in such a court setting. In our mental health court, it is the judge who is directly communicating with the mentally ill participants, inquiring about their engagement in services and whether they are satisfied with assistance they are receiving from their provider of service. In collaboration with the PSA representative, the judge often is required to strategize how to help some of the more impaired participants, or those who are treatment-resistant, to succeed. While in other criminal courts the judge traditionally speaks almost exclusively to the attorneys, here each court hearing

involves direct communication by the judge with the individual participant—something that the individual defendants, and some attorneys unfamiliar with the calendar, often found surprising.

One day, as I inquired of a defendant how he felt about a residential substance abuse treatment program he had just completed, I was surprised to see the defense attorney reach out and grab his client's arm and whisper to him that he should keep quiet and let the counsel handle the court's inquiry. I quickly corrected the counsel, explaining that here, in our court, the defendants and I would be talking directly about their progress and their compliance, or lack thereof, with the treatment goals in the diversion program. This coaching, cajoling, and congratulating—our "three C's"—became the judicial approach that defense counsel, and participants, came to expect in our court, and that set a decidedly different tone from the judicial/participant interaction in the typical criminal courtroom.

In addition to the direct collaboration from the PSA case manager in the courtroom, the judge in our mental health court is aided by a clinical staff member employed by the court itself to facilitate the operation and functioning of the court. This coordinator, with her clinical expertise and familiarity with services in our public system, serves as both clinical advisor to the court and as liaison to the District's public mental health delivery system. Our Mental Health Community Court (MHCC) coordinator greatly enhanced the court's capacity to solve problems, for instance, in identifying appropriate levels of service and helping remove barriers to the delivery of services for our most challenged participants. She was a major help to the individual, who may have received sub-optimal follow-through from a public provider and needed assistance in dealing with the bureaucracy that often envelops the delivery of health care in both our public and private systems of care. But perhaps even more importantly, the MHCC coordinator played a critical role in assisting the judge in handling hearings, given her professional background

and direct experience with dealing with, and recognizing, psychiatric symptomatology. She also had the responsibility, after each participant's admission hearing, of meeting with the participant, echoing the judge's welcome, answering questions, and reviewing the program requirements, to better ensure successful compliance with the necessary prerequisites to qualify for entry into the four-month diversion agreements that would lead to dismissal of the criminal charges.

A fairly common scene in our court involved a bench conference with both counsel, the PSA representative, and our clinical social worker, all collaborating on how to assist the individual participant who had not yet successfully engaged with mental health treatment. At the end of our bench conference, the judge would ultimately discuss with the participant what our new suggested plan would be and what all of us expected him or her to do to follow through and get the needed services. This coaching often involved demanding more extensive services from the treatment provider, including attendance with their client at the court hearing. Thus, in a sense, the court can hold not just the participant him- or herself accountable for failing to follow through with services, but also the service provider, if their failures or gaps in services were hampering a participant's success in our court diversion program.

Improved Outcomes: For the Participant and for the Public
When we began our program, we knew it was the right thing to do, not just for the huge number of marginally functional defendants on our criminal calendars, but also for the welfare of our community itself. Indeed, many studies had already shown that "problem-solving" courts had a positive impact on public safety in terms of reduced recidivism.³ In our own court's experience, we were able to see the same positive impact on public safety from an examination of rearrest data. Indeed, in a post-exit study comparing several hundred misdemeanor participants in our court between 2007 and 2009, with a control group of comparable criminal defendants

in the traditional criminal calendars, researchers found that participants in the mental health court were “significantly less likely to be arrested in the follow-up year” than others not in mental health court.⁴ Specifically, they found that our participants had a 27.5 percent rearrest rate, compared to a 37.3 percent rearrest rate for other defendants. Further, the study concluded that participants who successfully completed our program and graduated were 51 percent less likely than their comparison group members to be rearrested.⁵ The fact that those defendants, who not only participated in MHCC but also actually graduated, had such a reduced recidivism rate was striking. At nine months post-exit, less than 12 percent of MHCC graduates had been rearrested, compared to 24.2 percent of those in the control group who never participated in mental health court. While this first rearrest study is just one evaluation report, and there are other longer-term studies still to be performed, the recidivism statistics are quite promising, particularly as almost three-fifths of those admitted were able to graduate.⁶

Moreover, in another, less concrete measure of positive impacts on the community and public safety, procedural justice theorists have noted that when participants in mental health courts feel they are given voice and validation by voluntarily participating in such an alternative diversion program, their level of satisfaction with the procedural justice afforded them will increase the likelihood of future compliance with the law and with societal norms.⁷ Certainly this prospect itself supports and reflects a positive target benefit to our community.⁸

Message to Judges

While many judges may be reluctant to preside over a mental health court assignment, my own view is that many who may be reticent could be excellent judges in such a setting and would find it enormously satisfying. In my own career, I took great satisfaction from the intellectual challenge and important legal issues dealt with during my assignment to the homicide and violent crime calendars, and some of the

esoteric legal issues dealt with in our civil calendars; however, my experience as a mental health judge was quite special and most unique. In this calendar, there is a concrete opportunity to pursue alternatives to incarceration for seriously mentally ill individuals, while providing services and supervision that preserve public safety. While my own prior professional experience included working as counsel to our public mental health delivery system, and was certainly helpful in terms of providing me some background familiarity with mental health issues and our city’s services, it was not only that background that prepared me for the assignment, or made this a fulfilling and rewarding one. Instead, it was the joy of helping some of our most vulnerable citizens obtain the services necessary to improve their lives and, at the same time, public safety. Witnessing individuals reclaim their lives, over a period of several hearings, by beginning mental health treatment to ameliorate their psychosis and, often also, by obtaining necessary substance abuse treatment and reaching sobriety, was nothing short of inspiring.

Further, working collaboratively with the mental health professionals and case managers involved in the cases enables the judge to overcome the frequently frustrating bureaucratic problems that sometimes intrude on our handling of cases. This collaborative functioning also dramatically reduces the isolation judges may feel in the performance of their judicial functions. Most appealing of all, however, is the daily pleasure of taking on each case with the dual goal of immediately helping and encouraging the individual participants to achieve their short-term goals of improving their lives and usually those of their family, while at the same time achieving a long-term better outcome for public safety. For a public servant, it doesn’t get much better than that! ■

Endnotes

1. In jail settings alone, serious mental illness has been documented in 31 percent of women and 14.5 percent of all men, with the rate of serious mental illness being estimated between two and six times higher among incarcerated persons than in the general population, according to a Vera

Institute Research Summary published in February 2013. See also Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 *PSYCHIATRIC SERVS.* 761 (2009).

2. While our particular court does not utilize sanctions (such as short jail stays), if a defendant fails, on a continuing basis, to become engaged in mental health services or fails to stay free of illegal drugs, he or she may be sent back to the traditional criminal calendar to have his or her case set for trial.

3. See Marlee E. Moore & Virginia Aldigé Hiday, *Mental Health Court Outcomes: A Comparison of Rearrest and Rearrest Severity Between Mental Health Court and Traditional Court Participants*, 30 *L. & HUM. BEHAV.* 659 (2006); Dale E. McNeil & René L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 *AM. J. PSYCHIATRY* 1395 (2007).

4. Virginia Aldigé Hiday, Heathcote W. Wales & Bradley Ray, *Effectiveness of a Short-Term Mental Health Court: Criminal Recidivism One Year Postexit*, 37 *L. & HUM. BEHAV.* 401, 404 (2013).

5. *Id.* at 404–06.

6. In a recent article about our mental health court, it was noted that 58.3 percent of those who joined the program in its first two years of operation graduated. Virginia Aldigé Hiday, Bradley Ray & Heathcote W. Wales, *Predictors of Mental Health Court Graduation*, 20 *PSYCHOL., PUB. POLY & L.* 191, 193 (2014). Further, in our own internal court review of the program’s statistics, we have found that well over 70 percent of those participants who actually are able to enter a diversion agreement succeed in graduating.

7. Tom R. Tyler, *Legitimacy and Criminal Justice: The Benefits of Self-Regulation*, 7 *OHIO STATE J. CRIM. L.* 307 (2009); TOM T. TYLER, *WHY PEOPLE OBEY THE LAW* (2006).

8. “Persons insecure about their status, or from stigmatized groups are especially likely to respond positively to polite and respectful treatment. In settings comparable to those of Mental Health Courts, perceptions of procedural justice have been associated with reductions in recidivism for participants in drug courts, and with positive effects on judicial and police interactions with persons with serious mental illness.” Heathcote W. Wales, Virginia Aldigé Hiday & Bradley Ray, *Procedural Justice and the Mental Health Court Judge’s Role in Reducing Recidivism*, 33 *INT’L J. L. & PSYCHIATRY* 265, 266 (2010).

**Allison D. Redlich, PhD; George Mason University
Comprehensive Statement for the Record**

I preface this document with the qualifier that I conduct research on mental health courts, though never with the DC MHCC directly. Further, I am not an expert on DC's issues with mental illness, crime, or homelessness. In the February 12, 2018 memo we were given, 9 topic areas were identified for experts to assist the Commission (see pp. 2-3 of memo). I have selected 3 areas.

1. The effectiveness of the District's mental health courts in producing positive long-term outcomes for its participants, and possibilities for increasing this effectiveness;

I have not directly studied the DC Mental Health Community Court (MHCC) myself, though I have familiarized myself with a series of studies conducted by Drs. Virginia Hiday and Bradley Ray, and Mr. Heathcote Wales (published between 2010 and 2016). The bottom-line message of these studies is that the DC MHCC is effective in reducing recidivism. More specifically, these researchers found that MHC clients who completed (graduated) from the MHC were significantly less likely to get re-arrested up to two years after court participation, in comparison to MHC clients who did not complete the court and to a group of offenders with mental illness being supervised by the same agency (see Hiday, Ray, Wales, 2016). Certainly, this is promising and the good work that the DC MHC is doing should not be discounted. Nonetheless, in answer to this question, I focus on aspects in need of improvement.

As detailed by Hiday, Ray, and Wales in their series of published studies, there are limitations that serve to temper the findings. There are two types of bias present. First is 'cherry picking,' which refers to the possibility that persons identified as likely to succeed in the court are more likely to be referred and then more likely to be accepted into the MHC. Clearly there are eligibility criteria to be accepted into the court, with one being to have the motivation to be in the court and attend treatment. In this sense, then, it is not surprising that MHC clients who want to engage in treatment and follow court orders are more successful than the comparison sample. Second is 'selection bias,' which refers to the fact that MHC clients have to opt into the court. It is voluntary and thus, otherwise eligible clients (like those in the comparison sample) who do not wish to enter the court and follow the varied rules can choose to opt out. Again, this creates a bias towards those in the court, and those who in the court who are compliant.

In addition, another way to interpret the results of these published studies is to focus on the 41.7% of MHC participants who were terminated. Of course, it would be unrealistic to expect a 100% success rate for MHCs. MHC service a notoriously tough-to-treat population. Nonetheless, is a 42% unsuccessful rate too high? Why do the clients who are terminated not succeed? Are there aspects of the court and/or community treatment centers that could be improved?

Recommendations. As someone who conducts research for a living, it is clear to me that more research needs to be done with the DC MHCC specifically, and with all MHCs generally. To help alleviate the two biases described above, an important next-step is to conduct a randomized controlled trial (RCT) with the DC MHCC. That is, to randomly assign eligible offenders with mental health problems into the DC MHCC or into treatment-as-usual (traditional criminal court). RCTs are the gold-standard, and it is difficult, if not impossible, to determine effectiveness without using this method. RCTs have been done with other types of specialty courts (like Drug Courts), though rarely with MHCs (I know

of one study). To remain true to the model of the DC MHCC, participants would still need to be deemed eligible and voluntarily opt into the court (thus bias would be attenuated but not fully eliminated). Those randomly assigned to traditional court would still benefit from treatment services and supervision.

A second recommendation for research is to conduct interviews with MHC clients and others (judge, treatment personnel, court personnel). Wales and his colleagues (2010) did conduct interviews with 80 MHC clients (44% of the then-population) about perceived procedural justice. These findings while most certainly adding to our understanding, are now about 10 years old, represent a portion of the clients, and focus on one specific topic. My understanding is that the DC MHCC is now 11 years old, and thus these data must have been collected at its origin. My recommendation would be to conduct a more comprehensive interview study of the clients and others, allowing a better understanding of why Hiday and her colleagues found that more than two-fifths of clients were unsuccessful. An updated study would also allow for a determination of whether more or fewer clients succeed now that the court is more established and in existence for more than a decade.

2. *The adequacy of due process safeguards for persons referred to mental health court, and for those persons awaiting pre-trial mental health treatment to restore competency;*

In theory, MHC clients are legally required to make knowing, intelligent, and voluntary decisions to enter the court, but do they? (see Redlich, 2005). MHC clients should hold specific knowledge about the court's rules and procedures, as well as general legal knowledge. Given that competence is a threshold issue in that persons are presumed competent to stand trial unless the question is raised, in theory, MHC participants processed post-adjudication should meet these requirements (i.e., the requirements set in *Dusky v. US*, 1960). Moreover, mental illness is the primary reason to question competence (Pinals, 2005). In a court in which many clients have (serious) mental health problems, it stands to reason that some will not be considered competent to proceed.

To address these issues, my colleagues and I (Redlich et al., 2010a) surveyed 200 newly enrolled clients at two courts about their understanding and appreciation of MHC procedures and regulations and the voluntary nature of the courts and assessed adjudicative competence. We found that although most clients (69%), claimed that they chose to enroll in the court, at the same time, most (60%) claimed not to have been told that it was voluntary to enroll. In both courts, the majority claimed not to have been told about MHC requirements prior to entering, did not appreciate that they could stop participating, or have the ability to cite disadvantages to being in the court (e.g., having to comply with judicial and treatment orders, possible stigma associated with the MHC). As to adjudicative competence, at one court, approximately 17% of newly enrolled clients demonstrated either mild or significant impairments in adjudicative competence, and at the other court, about 39% showed similar impairments. Given that, in theory, all MHC clients are presumed competent (and in these two courts, had pled guilty), these rates of individuals with deficient knowledge are of concern.

Further, relevant due process concerns, such as making knowing and voluntary decisions in MHCs, can influence successful outcomes. My colleague and I (Redlich & Han, 2014) conducted a follow-up study examining whether knowledge and voluntariness at the outset of MHC participation influenced later success within the court. We found that among MHC clients from four separate courts, increased levels of initial perceived voluntariness and procedural justice, and MHC knowledge at enrollment led to decreased rates of new arrests, prison, MHC bench warrants, and increased court

compliance, which in turn, led to a higher likelihood of MHC graduation. This set of results speak directly to why clients succeed or not succeed (e.g., the 42% who had been terminated noted above).

Regarding the DC MHCC specifically, I reviewed the 9-page “District of Columbia Superior Court Mental Health Community Court (MHCC) Case Management Plan.” It is certainly beneficial to have such a written document, and I appreciated that some of the headings were in the form of questions. I did, however, note several concerns.

First, this document is quite dense and seems to be written by legal professionals well-versed with the law. At times it was not clear who the document was written for: the possible MHC client or the referring party, like a defense attorney. I believe the intent is for the former. As such, my opinion is that document would be largely not be understandable to the typical MHC client. I do not have data on the educational and socio-economic background of the DC MHCC clients. However, I suspect that, like most offenders, they are under-educated and impoverished. Most offenders read at a 6th-grade reading level or lower (Haigler et al., 1994). I submitted the Case Management Plan to a reading-grade level analysis. The results indicated an 11 to 12th grade reading level to understand and material that was “fairly difficult to read.”

Second, it is unclear when MHC clients have the opportunity for increased understanding. On p. 5, under the heading “Admission Orientation,” it explains that the “Coordinator will help you help you understand the requirements of the program and, if you do not, explain them further. The Coordinator will also address any questions you or your lawyer may have about the MHCC.....”. However, these explanations appear to come *after* the offender is expected to decide to enroll in the court. While it is important that the client has a complete understanding at the outset of participation, it is also important to understand to inform the decision to enroll. As explained above, such understanding is predictive of future success in the court.

Third, although the Case Management Plan delineates the benefits of enrolling in the MHCC, it does not explicate the downsides. As mentioned, in the Redlich et al. (2010a) study, across two MHCs and 200 MHC clients, almost all (91%) could cite advantages, but more than half could not cite a single disadvantage. Similarly, in the Wales et al. (2010) study, the most prevalent response to the question, What have you liked least, so far, about the MHC? was Nothing or its equivalent (see p. 269). In my opinion and supported by my research, it is important to be able to identify the disadvantages of participating in a specialty court so that one can be a knowing decision and be better prepared to address them going forward.

Fourth is the issue of competence. The Case Management Plan does indicate that eligible participants must be considered competent to proceed. And the Hiday et al. articles cite that all participants were competent. The mechanisms of how competence is established, however, are not clear. The DC MHCC may indeed have mechanisms in place which I was not privy to. In my experience, however, competence is presumed and only investigated if a question of competence is raised. As noted, in the Redlich et al. (2010a) study, 17-39% of participants may have been incompetent to proceed but nonetheless all had pled guilty and were allowed into the MHC. Further, across the US, an estimated 60,000 competence assessment take place annually; given prevalence statistics of persons with serious mental illness in the criminal justice system, this estimate represents about 5% of all such persons (Redlich, 2016). Thus, if not already in place, I would encourage the DC MHCC to not presume competence at the outset.

Recommendations: Research findings highlight the need for the courts to ensure that the persons entering the courts, ones often times who are marginalized and undereducated, are making voluntary and knowing decisions, and feeling respected when doing so. MHC enrollment decisions made in this manner are not only legally required but can help play a role in decreasing the revolving door phenomenon of persons with mental health problems that the courts were originally designed to combat.

3. *The efficacy of mental health court models employed by other jurisdictions, and whether any successful facets of those models should be utilized in the District;*

By most accounts, MHCs are successful in reducing recidivism and number of days/stays in jail (see, e.g., Lowder, Rade, & Desmarais, 2018; Steadman et al., 2011), either when compared to rates before MHC participation (pre-post designs) or when compared to traditional court samples (quasi-experimental designs). Similar to what was found in the series of studies on the DC MHCC, a consistent factor predicting reduced rearrests is the length of time the participant was in the MHC, or whether they received the full ‘dose’ of MHC and graduated. In one study of four MHCs, Compliance with the court’s orders was the only factor to significantly influence graduation vs. termination status; factors such as age, gender, race, diagnosis, and seriousness of arrest did not affect whether one was successful or not (Redlich et al., 2010b; see also, Hiday, Ray, & Wales, 2014). Generally, demographic and clinical factors inconsistently relate to success; that is, in some studies, for example, demographic factors (like gender and race) influence termination, whereas in other studies, they do not.

So far as I can tell, there are several unique aspects to the DC MHCC. First, it has an unusually large number of clients. The number of participants included in the series of Hiday et al. studies was 408 and these authors describe the court as having “high caseloads” (Hiday et al., 2013). Anderson (2017) reports that over 10 years, the court has provided services to close to 4,000 people. In contrast, a study of the then-population of adult MHCs found that the median number of participants per court was 36 and the mode was 30, though the number ranged from 3 to 852 participants (Redlich et al., 2006). Number of active participants was correlated to frequency of court hearings (more participants, less frequent hearings); proportion of felony defendants; and number of different forms of community supervision.

Second, and perhaps related to the large size, the DC MHCC has a shorter supervision period than most MHCs. The DC MHCC period of participation is 4 to 6 months; in contrast, other MHCs often supervise clients for 1 year or longer. For example, across four MHCs and 434 participants, length of time in the court varied from 29 days to 3.2 years (Redlich et al., 2010b). On average, those terminated were in the court 9.8 months, those still in the court had been in for 1.8 years, and those who graduated were in for 1.2 years. Thus, the DC MHCC’s period of 4-6 months is shorter than other courts, even among those who terminated.

Third, according to Anderson (2017), the DC MHCC is the only one in the nation to have a full-service mental health clinic. I think this means on or near the premises of the courthouse. Such ready access to mental health treatment and close contact with treatment providers are important, and are likely to promote success.

In other ways, to my knowledge, the DC MHCC is similar to MHCs around the nation. According to Hiday and her colleagues, the DC MHCC follows the “10 Essential Elements of Mental Health Courts” (Thompson et al., 2008; see provided article, Redlich, 2013). It now includes both

misdeemeanor and felony cases, which in my opinion, is appropriate and again in line with many other courts (e.g., in 2006, 59% of MHCS accepted felons). And like other MHCs around the nation, the DC MHCC does not have a 100% success (or graduation) rate. As noted, while it is not realistic to expect 100%, all courts have room for improvement. I do not know the current graduation rate of the DC MHCC; the Hiday et al. studies place it at 58%. The four-site study (Redlich et al., 2010b) found rates of 53% to 83%.

Recommendations. Again my recommendation is to conduct more empirical research with the DC MHCC, particularly now that it is more advanced. It is difficult to know, without empirical study, whether the unique aspects of the DC MHCC improve, reduce, or have no effect on its success rates. It will be important to conduct a randomized trial, if possible, and to interview different samples (clients, as well as court and treatment personnel, and a comparison sample). Another possibility to re-examine the same sample studied by Hiday, Ray, and Wales to determine the effectiveness of court participation some 10 years later. Have any participants been ‘re-diverted’? That is, participated in the DC MHCC more than once?

Thank you for this opportunity.

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Good Morning,

I am Terrence Walton, the National Association of Drug Court Professionals' chief operating officer. NADCP is a 5013c nonprofit that provides training and technical assistance to treatment courts of all varieties—including mental health courts. We also develop national standards and other resources for treatment courts and educate federal legislators and the public about treatment courts and other aspects of justice reform.

My work at NADCP has allowed me to spend time with hundreds of treatment court teams nationwide and has given me an insider's view of how treatment courts, including mental health courts operate; as well as insight into some of their persistent challenges. Additionally, while this is not the focus of my remarks this morning, I served as Director of Treatment for the Pretrial Services Agency for the District of Columbia for many years, including when DC's Mental Health Community Court (MHCC) was established. One of the PSA units that I led provided direct court representation, clinical case management, supervision and other services to the MHC.

I am pleased to address this distinguished committee and the public, as a part of this briefing on mental health, mental health treatment courts, and the justice system.

Background

Mental health courts were developed to address growing concerns among judges that people with serious mental illness in the US were becoming familiar faces in the criminal justice system, receiving limited treatment, and further clinically and behaviorally decompensating.

Mental Health Courts are Growing (despite little federal funding compared with drug courts.)

In 2012, the Substance Abuse and Mental Health Services Administration's GAINS Center identified all MHCs in the U.S. – there were 346 adult mental health courts and 51 juvenile mental health courts. In 2018, the GAINS Center updated the mental health court data base and identified 533 adult mental health courts, an increase of over 50% in just six years. There were 56 juvenile mental health courts by the end of 2018. The Mental Health Treatment Court Locators are on the SAMHSA GAINS webpage and is searchable to the public (<https://www.samhsa.gov/gains-center/mental-health-treatment-court-locators>).

Mental Health Courts Target Justice-Involved Individuals with Serious Mental Illness

The target population for adult mental health courts is persons with serious mental illness who have significant justice involvement in terms of severity of an offense or frequency of arrests. Significant justice involvement in this context are sometimes referenced as high risk. For example, in the MacArthur Mental Health Court Study conducted by Policy Research Associates (where the GAINS Center is located), 69% of MHC participants in four large MHCs had a primary diagnosis of either schizophrenia or bi-polar disorder; another 19% were diagnosed with depression. In an evaluation of two New York City MHCs, 63% of the participants had a primary diagnosis of a psychotic or mood disorder. For both studies, a large portion of the remaining third of MHC participants had a primary diagnosis of substance use with a secondary diagnosis of an SMI. An SMI is often the most important eligibility criterion for MHC enrollment.

While the majority of mental health courts target those with serious mental illness, it is less clear whether most MHCs serve only those with significant justice involvement. In my observation, most do not. Instead they may include many individuals with serious mental illness, but who lack significant justice system involvement or likelihood of such involvement based on valid assessment of risk. This not a best practice. For such individuals, diversion from the justice system, including pre-booking diversion is likely to be the more effective, including cost effective; and less risky approach.

What are Mental Health Courts?

It's difficult to define specifically how MH court operate because there is wide variability across programs. This likely because presently there are no national mental health court standards or guidelines. States have been left to develop their own program guidelines or standards, leading to a wide variation in what is considered a mental health court. There are 18 states that have developed mental health court standards and hold their states' courts to varying degrees to those standards, while 16 states have overall treatment court standards for therapeutic courts. There are 13 state with mental health courts and no standards at all.

Where are Mental Health Courts?

There are six states with no adult MHCs. Despite the uptick in the number of adult MHCs, most US counties do not have one (84%), and those that do tend to be in counties with large populations. There are 3.5 times as many adult drug treatment courts. Consequently, most MHCs co-exist in counties with a drug treatment court. One concern in areas with a drug court and no mental health court is to what extent is the drug court suitable to facilitate evidence-based treatment from screening to discharge planning for individuals with SMI or COD? If there is no mental health court in a jurisdiction with a drug court, their drug court is a de facto co-occurring disorder court. Some drug courts service this population well. Others are less able to do so. Nationwide, people involved in the justice system who have SMI or COD are being diverted earlier; being treated in regular drug courts or co-occurring disorder courts; being supervised and connected to mental health services by supervision officers; or their mental health issues are not being addressed at all.

Are Adult Mental Health Courts Effective?

There are approximately 17-20 studies on MHCs that meet the threshold for inclusion in a meta-analysis. The two major dimensions of adult MHS effectiveness are criminal justice and treatment outcomes. Most studies focus on criminal justice outcomes only. However, one recent study did measure treatment outcomes.

Criminal Justice Outcomes

- Arrests: A recent meta-analysis of 17 studies concludes that participation in an MHC has a modest effect on recidivism compared with criminal processing/treatment as usual.
 - The effect of MHC participation on arrests is most pronounced after program exit versus after program enrollment.
- Jail Days: MHC participation has a significant impact on reducing jail days after program exit.

Treatment Outcomes

- *Time and access to treatment:* MHC participants increase their treatment access following MHC enrollment compared with their pre-enrollment access and are more quickly connected to treatment than their TAU comparison group. In both the MacArthur and New York City studies, 80-83% of MHC participants accessed community treatment following enrollment.
- *Type of treatment:* In the period before MHC enrollment, participants accessed significantly more crisis episodes (crisis services and emergency room visits) than the TAU comparison sample; after enrollment, their use declined to be similar to the TAU group. Prior to enrollment, the MHC and TAU samples had similar intensive treatment episodes (inpatient days at short-term psychiatric facilities, 24-hour residential care, and detox services), but following enrollment the MHC sample had more episodes. In terms of therapeutic treatment episodes (community-based treatment and support services such as individual and group therapy, medication management, and case management), the MHC group had more pre-enrollment episodes than the TAU group, but that difference was even greater after enrollment.
- Overall, MHC participants who are still in MHC or graduated have more intensive and therapeutic episodes than participants who are terminated from MHC.

While there are over 75 published studies on mental health courts, many do not meet the criteria for “high” or “moderate” quality research. However, there exists a body of research on mental health courts that meet standard goalposts for high quality research such as comparison groups, multi-sites, sufficient sample size, and consistent outcome measures. There are additional robust studies which focus on specific topics integral to mental health courts such as whether or not there is a reduction in violence, how sanctions are used, and whether or not they are perceived as voluntary, all important concepts related to developing treatment court standards.

My more comprehensive written statement includes a few recommendations for you to consider. I am also happy to discuss some of them during our question and answer exchange that begins shortly.

There is still much work to be done to further define how MHCs should operate to achieve significant outcomes for the participants, their families and our communities; however, there is no question that MHC is an essential tool for effectively servicing persons with serious mental illness who are also at higher risk for significant justice system involvement. From my observation, that is certainly the case here in the District of Columbia, as well as everywhere else across the country.

What is needed? (Recommendations)

- Apply the GAIN Center/Policy Research Associates *Sequential Intercept Model* to identify how people with mental illness are handled currently in Washington, DC from the time they encounter law enforcement until there is no longer justice system involvement and beyond.

- Consider interventions at each intercept point identified above—including robust pre-arrest diversion for lower risk persons with serious mental illness.
- Conduct an independent process and outcome evaluation of the DC Superior Court Mental Health Community Court (MHCC) to both inform and impact program operations; and to assist in developing standards for MHCC.
- Develop binding evidence-based standards for the operation of the MHCC codified through administrative order.
- Experts in the DC MHCC should seek to influence national thought regarding MHC by analyzing current operations, modifying practices as necessary, developing MHC standards; and publicizing these actions and results in national forums.

Effectiveness of Mental Health Courts in Reducing Recidivism: A Meta-Analysis

Evan M. Lowder, Ph.D., Candalyn B. Rade, Ph.D., Sarah L. Desmarais, Ph.D.

Objective: Mental health courts (MHCs) were developed to address the overrepresentation of adults with mental illnesses in the U.S. criminal justice system through diversion into community-based treatment. Research on MHCs has proliferated in recent years, and there is a need to synthesize contemporary literature on MHC effectiveness. The authors conducted a meta-analytic investigation of the effect on criminal recidivism of adult MHC participation compared with traditional criminal processing.

Methods: Systematic search of three databases yielded 17 studies (N=16,129) published between 2004 and 2015. Study characteristics and potential moderators (that is, publication type, recidivism outcome, and length and timing of follow-up) were independently extracted by two of four raters for each study. Two raters coded each study for quality and extracted between-group effect sizes for measures of recidivism (that is, arrest, charge, conviction, and jail time; k=25). Results were synthesized by using random-effects

meta-analysis. Heterogeneity and publication bias were also assessed.

Results: Results showed a small effect of MHC participation on recidivism ($d = -.20$) relative to traditional criminal processing. MHCs were most effective with respect to jail time and charge outcomes compared with arrest and conviction, in studies measuring recidivism after MHC exit rather than at entry, and in lower-quality studies compared with moderate- and high-quality studies. Results showed significant heterogeneity in effect sizes across studies ($I^2 = 73.33$) but little evidence of publication bias.

Conclusions: Overall, a small effect of MHC participation on recidivism was noted, compared with traditional criminal processing. Findings suggest the need for research to identify additional sources of variability in the effectiveness of MHCs.

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Mental health courts (MHCs) were developed in the late 1990s to address growing numbers of adults with mental illnesses in the U.S. criminal justice system (1,2). These courts operate primarily as postbooking diversion programs whereby defendants voluntarily agree to judicial supervision of community-based mental health treatment, often in exchange for a reduced or dismissed index charge upon successful completion. MHCs may help reduce high rates of reoffending in this population (3). Although MHCs vary in their design (4), case processing (for example, proportion of referred cases accepted and time from referral to acceptance) (5), and selection of participants (6), they share several defining features. These include a separate docket (list of cases heard in court), judicial supervision of treatment plans, regular appearances of participants before the judge, and terms of participation for successful completion (for example, demonstrated treatment adherence) (7). Over the past 20 years, MHCs have spread rapidly, and there are now nearly 350 MHCs in the United States (8).

A key question is whether MHCs are effective in reducing reoffending among justice-involved adults with mental illnesses. Past studies have shown effects of MHC participation

on arrests (9–12), charges (13), and jail days (14,15). Other studies have failed to find effects of MHC participation on recidivism (16–18). A prior meta-analytic investigation examined 15 quasi-experimental and single-group studies published through July 2009, finding a positive effect, moderate in size, on recidivism (Hedges' $g = .55$) (19). However, this study also revealed evidence of publication bias (that is, published papers presented significant findings in favor of the MHC) and a high degree of heterogeneity across effect sizes. Together, findings to date suggest considerable variability in the effectiveness of MHCs.

Beyond variations in the structure and operation of MHCs, methodologies used to evaluate them may explain mixed findings. Some studies have examined recidivism after participants' enrollment in the MHC (12,15,16,18), whereas others have measured recidivism after MHC exit (13,14,17,20–22). In addition, length of follow-up has varied across studies, with few studies measuring recidivism longer than 12 months (13,15,16,18). Furthermore, the methodological quality of designs with nonequivalent comparison groups has varied significantly on key indicators, such as composition of the comparison group, use of matching strategies, and reporting

of confidence intervals. For these reasons, investigation of study-level characteristics may elucidate between-study variability and explain inconsistent findings regarding MHC effectiveness.

Since 2009, there has been considerable growth in the research literature on MHCs, including two multisite investigations (15,18) and several investigations employing comparison groups to examine the effectiveness of MHC participation compared with treatment as usual (11,14,15,17,18,22). As a result, there is a need to reexamine the contemporary literature on the effect of MHCs on recidivism. We conducted a meta-analytic investigation of the effectiveness of MHCs in reducing reoffending among adults with mental illnesses. Our aims were to establish the effect of MHC participation on criminal recidivism compared with treatment as usual and then to identify moderators of these effects, such as study quality and length and timing of follow-up.

METHODS

We followed the PRISMA guidelines (23,24) for reporting of inclusion criteria, assessment of publication bias, and synthesis of results.

Literature Search

Three primary inclusion criteria guided our literature search: first, the intervention was identified as an MHC for adults (as opposed to youths); second, recidivism was included as a dependent variable, operationalized as any continuous or dichotomous measure of arrest, criminal charge, conviction, or time in jail for a specified follow-up period; and third, the study included a comparison group. We conducted a systematic literature review in PsycINFO, Google Scholar, and National Criminal Justice Reference Service Abstracts using the key word "mental health court." The initial search identified 2,769 records. [A flowchart illustrating the search process is presented in an online supplement to this article.] An additional ten records were identified through reference review. Abstracts were screened by two members of the study team (EL and DB) to determine whether the study identified the intervention as an MHC, represented an empirical investigation, reported on an MHC participant-level outcome, and was published between January 1, 1995, and December 31, 2015. These criteria produced 75 unique records for full-text evaluation by two members of the study team (DB and BN) against primary inclusion criteria. Among eligible studies, we excluded one record for which information to compute a between-groups effect size could not be obtained (25) and 11 records of duplicate samples. As a quality control measure for our initial search, we replicated our original search criteria in PubMed (80 records) and LexisNexis (77 records). We also replicated our PsycINFO search using identical search constraints and several additional search terms: "diversion program*" (327 records), "problem-solving court*" (64 records), and "alternative to incarceration" (50 records). Review of these records yielded no new records meeting inclusion

criteria. Records for which effect sizes could be extracted by sample (that is, a specific MHC and jurisdiction) were treated as separate studies. A total of 16 records representing 17 unique studies were included in the meta-analysis (11–18,20–22,26–30).

Data Extraction

Two of four trained coders (EL, DB, ES, and KD) independently extracted the following data for each study: year of publication, composition of comparison group, MHC location (city, county, and state), dates of data collection, publication type (dissertation, publication, or report), recidivism outcome (arrest, charge, conviction, or jail), length of follow-up (12 months or >12 months), timing of follow-up (after MHC exit, after MHC enrollment, or after MHC referral), and sample characteristics overall and by group (percentage male, mean age, and percentage white). Excellent levels of agreement were achieved across categories (90.0% agreement). Discrepancies were resolved through discussion with the first author.

Because of the high risk of bias and a shortage of instruments of suitable quality for use in nonrandomized and retrospective investigations (31), we assessed study quality by using two measures: the SIGN Methodology Checklist 3 for Cohort Studies (32) and the Quality Assessment Tool (QAT) for Quantitative Studies (33). These were adapted to capture relevant methodological indicators and to generate quality ratings of low, moderate, or high. Each study was coded and scored independently on both measures by two authors (EL and CR). SIGN and QAT ratings showed strong evidence for convergent validity ($r=.75$, $p=.001$), corresponding to a large effect size (34). Interrater reliability was excellent for the SIGN framework ($\kappa=.80$; 87.5% agreement) and fair for the QAT framework ($\kappa=.39$; 62.5% agreement) (35). Average ratings across both frameworks produced an excellent level of interrater reliability (intraclass correlation coefficient=.91) (36).

Between-groups effects on recidivism ($k=25$) were extracted and coded with a consensus approach by two authors (EL and CR). Effect size direction was standardized such that negative effects represented lower recidivism for MHC participants relative to comparison group participants. Consistent with our operationalization of recidivism, effect sizes were first extracted for continuous measures (that is, arrests, charges, convictions, and jail days). If it was not possible to code continuous outcomes, effect sizes from dichotomized measures of recidivism were coded (that is, any arrest, charge, conviction, or jail time). All effect sizes were coded consistent with quality ratings and an intent-to-treat approach (37). For most effect sizes ($k=19$), sufficient information was provided to calculate a standardized mean difference (d). For studies that did not report a within-subjects correlation, we used an estimated correlation of $r=.50$, which we deemed conservative on the basis of published estimates in the literature (25). For all other effect sizes ($k=6$), odds ratios were coded and d estimated in

Comprehensive Meta-Analysis (CMA) software, version 3 (38). For studies reporting rate ratios ($N=2$, $k=4$), we recorded odds ratios for dichotomous outcomes to allow inclusion of all effect sizes. When separate effect sizes were presented for MHC completers and noncompleters ($N=2$ studies), effect sizes were coded separately ($k=3$) and aggregated.

Data Analysis

Analyses were conducted by using a random-effects model (39) because of known variability in the design and operation of MHCs (4–6). The random-effects model accounts for variability in the intervention- and study-level characteristics as well as sampling (40). Standardized mean difference (d) effect sizes were calculated for each study, weighted by inverse variance, and aggregated to produce weighted mean effect sizes. When multiple effect sizes were extracted for a single study, effect sizes were averaged across studies to minimize bias from correlated outcomes (41). Heterogeneity was assessed with Cochran's Q statistic, indicating the presence of heterogeneity, and with I^2 , approximating the amount of heterogeneity (42,43). I^2 values of 25%, 50%, and 75% represented low, moderate, and high heterogeneity (44). We tested four study-level moderators: study quality, recidivism outcome, length of follow-up, and timing of follow-up.

To assess publication bias, we examined publication type as a potential moderator. We then examined a funnel plot of standard errors from random effects (45), which provides a graphical representation of publication bias based on asymmetry across the vertical axis (46). Because the funnel plot interpretation is subjective (47), we conducted the "trim and fill" method, which quantifies and adjusts for funnel plot asymmetry and provides a corrected effect size (48), and computed a fail-safe N , which estimates the number of additional studies with a nonsignificant intervention effect needed to nullify the effect size (that is, to raise the p value above .05) (49). All analyses were conducted in CMA software, version 3 (38).

RESULTS

Study and Sample Characteristics

A total of 17 studies of 16,129 participants were published between 2004 and 2015. Study characteristics are presented in Table 1. Most studies were from peer-reviewed publications ($N=11$, 65%) rather than dissertations (26) and reports (both $N=3$, 18%). Most studies were rated as high quality ($N=8$, 47%), with fewer of moderate ($N=5$, 29%) and low ($N=4$, 23%) quality. Arrest was the most frequently investigated recidivism outcome ($N=12$, 70%), followed by jail ($N=6$, 35%), conviction ($N=5$, 29%), and charge ($N=2$, 12%). Recidivism was more frequently measured over a 12-month period ($N=11$, 65%) than over a period longer than 12 months ($N=6$, 35%). Follow-up periods typically began after MHC enrollment ($N=9$, 53%) or after MHC exit ($N=7$, 41%).

Sample characteristics are presented in Table 2. For one multisite investigation, sample-level effect sizes could not be computed and, consequently, aggregated descriptive statistics are provided (15). Across samples, participants were on average in their mid-30s and most were male. However, racial composition varied widely across studies.

Effect Sizes

Pooled effect sizes are presented in Table 3. Results showed a significant, negative, and small effect of MHC participation on recidivism ($d=-.20$, 95% confidence interval [CI]= $-.29$ to $-.10$, $p<.001$). In addition, there was significant heterogeneity in this effect ($Q=60.00$, $p<.001$, $I^2=73.33$), suggesting the presence of a high degree of variability in effect size across studies (44). Because high-quality nonrandomized investigations may produce effect sizes similar to those of randomized controlled trials (RCTs) (50), we included the single RCT investigation in our overall effect size. Exclusion of the RCT study did not change the direction, magnitude, or significance of results ($d=-.22$, CI= $-.31$ to $-.13$, $p<.001$).

Moderator analyses showed that low-quality studies produced significant effects of MHC participation on recidivism ($d=-.35$, CI= $-.57$ to $-.13$, $p=.002$). Moderate- and high-quality studies produced only trending effects (p values $\geq.054$). A follow-up length of 12 months produced effects ($d=-.19$, CI= $-.33$ to $-.06$, $p=.004$) similar to those of longer follow-up periods ($d=-.19$, CI= $-.34$ to $-.03$, $p=.016$). However, studies that measured recidivism after MHC exit ($d=-.26$, CI= $-.37$ to $-.15$, $p<.001$) versus after enrollment ($p=.058$) showed stronger effects on recidivism. For recidivism outcome, we found significant effects of MHC participation on charge ($d=-.36$, CI= $-.52$ to $-.20$, $p<.001$) and jail time ($d=-.36$, CI= $-.54$ to $-.19$, $p<.001$) but not on arrest or conviction (p values $\geq.161$).

Follow-up analysis by both recidivism outcome and timing of follow-up showed a significant effect of MHC participation on arrest when measured after MHC exit ($d=-.18$, CI= $-.29$ to $-.07$, $p=.002$) but not after enrollment ($p=.667$). Furthermore, the effect of MHC participation on jail time was stronger when measured after exit ($d=-.42$, CI= $-.68$ to $-.16$, $p=.002$) versus after enrollment ($d=-.38$, CI= $-.74$ to $-.03$, $p=.035$).

For publication bias, moderator analyses by publication type showed that dissertations ($d=-.33$, CI= $-.56$ to $-.10$, $p=.006$) yielded stronger effects than peer-reviewed publications ($d=-.18$, CI= $-.32$ to $-.05$, $p=.008$) and reports ($d=-.12$, CI= $-.22$ to $-.03$, $p=.013$). Visual inspection of the funnel plot showed little asymmetry and no studies in the lower quadrant of the plot, providing limited evidence of publication bias. This was confirmed by Duval and Tweedie's (48) trim-and-fill method, which resulted in identical observed and adjusted estimates. Similarly, results of the fail-safe N showed that an additional 264 studies would be needed to nullify the significant effect of MHC participation on recidivism found in this analysis (49). Taken together, findings showed little evidence of publication bias.

TABLE 1. Characteristics of 17 studies included in a meta-analytic investigation of the effect on criminal recidivism of mental health court (MHC) participation

Study	Year	Comparison group	Location	Data collection	Publication type	Study quality	Length of follow-up (months)	Timing of follow-up	Moderators		
									Arrest	Jail Charge	Recidivism outcome Conviction
Anestis and Carbonell (28)	2014	In traditional court, with mental illness	Florida	2008–2010	Peer-reviewed publication	Moderate	12	After enrollment	✓		✓
Ragwell (26)	2013	In traditional court, denied participation	Riverside County, California	2006–2012	Dissertation	Low	12	After enrollment	✓		✓
Christy et al (27)	2005	In traditional court, with mental illness	Broward County, Florida	1999–2001	Peer-reviewed publication	Moderate	12	After enrollment	✓		✓
Cosden et al (16)	2005	Referred to MHC and randomly assigned to control group	California	Pre–2005	Peer-reviewed publication	High	>12	After enrollment	✓	✓	✓
Dirks-Linhorst and Linhorst (17)	2010	Referred and opted out of MHC	St. Louis County, Missouri	2001–2008	Peer-reviewed publication	Low	12	After exit	✓		✓
Ferguson et al (20)	2008	In traditional court, not referred to MHC	Anchorage Municipality, Alaska	2003–2007	Report	Moderate	12	After exit	✓		✓
Fraling (21)	2010	Referred and opted out of MHC	Washoe County, Nevada	2006–2009	Peer-reviewed publication	Moderate	12	After exit	✓		✓
Hiday et al (11)	2013	MHC-eligible, receiving comparable services	Washington, D.C.	2007–2009	Peer-reviewed publication	High	12	After exit	✓		✓
Kubiak et al (22)	2015	MHC-eligible, not enrolled	Wayne County, Michigan	2009–2013	Peer-reviewed publication	Low	12	After exit	✓		✓
Lowder et al (14)	2016	In traditional court, with mental illness	Ramsey County, Minnesota	2005–2008	Peer-reviewed publication	High	12	After exit	✓		✓
McNeil and Binder (13)	2007	In jail, with mental illness	San Francisco County, California	2003–2005	Peer-reviewed publication	High	>12	After exit	✓		✓
Moore and Hiday (12)	2006	In traditional court, with mental illness, MHC eligible	County in North Carolina	1998–2002	Peer-reviewed publication	High	12	After enrollment	✓		✓
Morin (29)	2004	In diversion services	Hennepin County, Minnesota	2002–2004	Dissertation	Moderate	12	After referral			✓
Roman (30)	2011	In traditional court, with mental illness, ineligible for MHC or opted out	Sacramento County, California	2007–2010	Dissertation	Low	>12	After enrollment			✓
Rossman et al (18)	2012	In jail, with mental illness	Bronx County, New York	2002–2006	Report	High	>12	After enrollment	✓		✓
Rossman et al (18)	2012	In jail, with mental illness	Kings County, New York	2002–2006	Report	High	>12	After enrollment	✓		✓
Steadman et al (15)	2011	MHC-eligible, not referred or never rejected	Hennepin County, Minnesota; San Francisco County and Santa Clara County, California; Marion County, Indiana	2005–2008	Peer-reviewed publication	High	>12	After enrollment	✓		✓

TABLE 2. Characteristics of samples in 17 studies included in a meta-analytic investigation of the effect on criminal recidivism of mental health court (MHC) participation^a

Study	Year	k	N ^b	MHC group					Comparison group				
				N	Male (%)	Age		White (%)	N	Male (%)	Age		White (%)
						M	SD				M	SD	
Anestis and Carbonell (28)	2014	1	396	198	69	36.42	12.47	48	198	74	35.45	11.21	50
Bagwell (26)	2013	1	901	610	34	36.2	10.4	33	291	24	nr		31
Christy et al. (27)	2005	1	217	116	66	36.4	10.4	68	101	60	37.66	9.63	58
Cosden et al. (16)	2005	3	235	137	49	nr		71	98	52	nr		71
Dirks-Linhorst and Linhorst (17)	2010	1	577	488	nr	nr		nr	89	nr	nr		nr
Ferguson et al. (20)	2008	1	436	218	64	nr		52	218	nr	nr		nr
Frailing (21)	2010	1	551	313	54	nr		84	238	59	nr		83
Hiday and Wales (11)	2013	1	1,095	408	50	41.4	11.0	90	687	63	40.7	11.6	93
Kubiak et al. (22)	2015	2	150	105	69	nr		48	45	84	37.2	12.3	47
Lowder et al. (14)	2016	3	97	57	46	34.5	9.6	35	40	53	36.05	9.55	38
McNeil and Binder (13)	2007	1	8,237	170	74	37.3	11.0	32	8,067	78	37.9	11.0	41
Moore and Hiday (12)	2006	1	265	82	68	35.65	nr	61	183	73	30.08	nr	45
Morin (29)	2004	1	102	51	80	39.8	13.7	53	51	nr	29.04	9.12	22
Roman (30)	2011	1	89	43	65	36.93	11.25	54	46	83	38.4	12.0	26
Rossman et al. (18)	2012	2	1,128	564	62	36.79	nr	7	564	61	36.93	nr	7
Rossman et al. (18)	2012	2	606	303	76	34.8	nr	38	303	78	35.4	nr	41
Steadman et al. (15) ^c	2011	2	1,047	447	58	37.5	nr	57	600	63	36.6	nr	59

^a nr, statistic not reported or could not be calculated for group

^b Refers to total study sample size. Actual sample size for individual effect sizes (k) may vary

^c Effect sizes could not be coded for site-level data.

DISCUSSION

MHCs have grown more prevalent across the United States in the past decade (8). Although they are generally accepted as one strategy to reduce the overrepresentation of adults with mental illness in the criminal justice system, they are not without controversy (51–55). For instance, MHCs have been criticized as potentially obstructing defendants' due process rights (51,55,56). They also have been called a stopgap for pervasive, structural problems, such as stigma related to mental illness or inadequate community mental health resources (52,54). As a result of these critiques, questions remain regarding their effectiveness. We conducted a meta-analytic investigation of studies examining the effectiveness of MHC participation on recidivism relative to treatment as usual. We also examined the extent to which study-level factors attenuated effectiveness.

Overall, our findings indicate that MHC participation had a modest effect on recidivism relative to traditional criminal processing ($d = -.20$). Because we employed a strict intent-to-treat approach, this finding likely represents a conservative estimate (57). Specifically, previous research has demonstrated that graduation from an MHC, as opposed to participation more generally, is associated with better outcomes (14,58). However, in practice, not every participant who enrolls in an MHC will graduate. Rather than speaking to the effectiveness of successful participation in an MHC, our findings inform the overall effectiveness of MHCs as a judicial strategy to reduce the number of adults with mental illnesses who are returning to the criminal justice system.

Our findings suggest a need for research examining strategies (for example, more frequent status hearings and

intensive case management) to encourage participant engagement in MHCs. Indeed, there has been limited investigation of features of MHC participation beyond graduation status that may contribute to reduced recidivism (59–61). Furthermore, addressing the criminogenic risks and needs (for example, financial resources, housing, and pro-criminal attitudes) of MHC participants may contribute to greater reductions in recidivism (62), although the extent to which these criminogenic risks and needs are addressed in MHC case management and supervision is unknown.

Individual studies have produced significant effects of MHC participation on conviction and arrest outcomes. However, results from moderator analyses showed small effects of MHC participation on either outcome, especially when measured after MHC enrollment. Rather, MHC participation appeared to be most effective at decreasing jail time after exit from the MHC. These findings suggest that MHCs may be most effective as a harm reduction intervention. Specifically, given the already high rates of reoffending in this population (3), it may not be realistic to expect complete desistance from criminal activity among MHC participants. Rather, MHC participation may be a means to mitigate the severity of future offending (that is, jail time associated with a new offense).

Length of follow-up did not moderate the effect of MHC participation, suggesting sustained reductions in recidivism over time. To date, only one study has examined long-term recidivism outcomes, finding that 53.9% of participants were rearrested in a five-year period (58). However, that study did not include a comparison group of offenders undergoing traditional criminal justice processing. We also found stronger effects when recidivism was measured after exit

TABLE 3. Effect sizes for the effectiveness of mental health courts on recidivism in a meta-analysis of data from 17 studies

Effect size	k ^a	Total N ^b	d	SE	95% CI ^c	Z	Q _(k-1) ^d	I ^{2e}
Overall	17	16,036	-.20	.05	-.29 to -.10	-3.96***	60.00***	73.33
By recidivism								
Arrest	12	7,025	-.10	.07	-.23 to .04	-1.40	66.17***	83.38
Charge	2	8,334	-.36	.08	-.52 to -.20	-4.48***	.61	<.01
Conviction	5	2,127	-.11	.10	-.32 to .09	-1.10	13.83**	71.08
Jail	6	2,089	-.36	.09	-.54 to -.19	-4.03***	16.18**	69.09
By study quality								
Low	4	1,717	-.35	.11	-.57 to -.13	-3.14**	9.06*	66.90
Moderate	5	1,637	-.20	.10	-.40 to .01	-1.90†	15.84**	74.74
High	8	12,682	-.13	.07	-.26 to .002	-1.92†	27.26***	74.32
By length of follow-up								
12 months	11	4,722	-.19	.07	-.33 to -.06	-2.91**	37.54***	73.35
>12 months	6	11,314	-.19	.08	-.34 to -.03	-2.41*	21.57**	76.82
By timing of follow-up								
After enrollment	9	4,856	-.15	.08	-.30 to .005	-1.90†	45.72***	82.50
After exit	7	11,078	-.26	.06	-.37 to -.15	-4.66***	11.44†	47.57
By publication type								
Peer-reviewed publication	11	12,774	-.18	.07	-.32 to -.05	-2.65**	44.85***	77.70
Report	3	2,170	-.12	.05	-.22 to -.03	-2.49*	2.28	12.41
Dissertation	3	1,092	-.33	.12	-.56 to -.10	-2.77**	3.52	43.18

^a Number of effect sizes

^b Pooled sample size for mean effect sizes. When specific sample sizes for analyses were not reported in the original study, the study sample size was used.

^c For mean effect size

^d Chi-square homogeneity test

^e Degree of heterogeneity

p* < .05, *p* < .01, ****p* < .001, †*p* < .10

from the MHC versus after enrollment, which may reflect the intensive community monitoring of MHC participants and the widespread practice of using jail as a sanction for noncompliance (4,63).

Our findings raise a broader question regarding the types of improvements MHC participants should be expected to make during—and after—MHC participation. Future MHC research should adapt practices from an implementation science framework to examine the extent to which MHCs achieve key service outcomes—such as service referrals and engagement—and the extent to which these outcomes contribute to participant outcomes, such as improved psychosocial functioning and decreased recidivism (64). These investigations are critical to understanding how MHCs operate, what contributes to their effectiveness, and the extent to which short-term gains in treatment and service utilization result in long-term improvements in community functioning.

Finally, although we found limited evidence of publication bias, we observed a moderating effect of study quality, with lower-quality studies yielding higher effect sizes. Of note, few RCTs have been conducted in MHCs (16). Although some concerns have been raised regarding the use of RCTs to evaluate MHCs for reasons of procedural fairness (27), RCTs have been used successfully to evaluate other diversion strategies, including drug courts (65). Our findings highlight the need for increased rigor in evaluations of

MHCs, including improved measurement of recidivism and use of appropriate analytic strategies (66). For example, the dichotomization of recidivism measures (for example, any arrest: yes, no) has the potential to restrict response range and to bias results (67). When count variables are used (for example, number of arrests), their distributional properties must be assessed prior to analysis. Although a growing number of studies have employed Poisson-class regression (for example, negative binomial, Poisson, and zero-inflated models) to model count data, effect sizes are not consistently reported.

Our findings should be considered along with several limitations. First, our literature search focused on published studies and reports conducted by external researchers. We did not include data resulting from

internal evaluations, which may have excluded potential data sources. Nevertheless, our findings showed little evidence of publication bias. In addition, when means and standard deviations were used to calculate standardized mean differences, rarely could we determine whether distributions of recidivism variables met normality assumptions. When studies reported proper effect sizes for Poisson-class models (that is, incidence rate ratios), these could not be included in the meta-analysis because of our use of the standardized mean difference. Instead, we coded odds ratios from comparisons of dichotomous outcomes, reducing effect sizes for two studies (12,14). Finally, we could not investigate participant-level sources of effect size variability because of inconsistent reporting across studies, and although we investigated study-level moderators, we were unable to use meta-regression strategies to quantify these effects. These are important directions for future research.

CONCLUSIONS

Our findings support the effectiveness of MHCs in reducing recidivism but also highlight important directions for future research. In particular, although more methodologically rigorous research on the effectiveness of MHCs is needed, there is perhaps a greater need for research into the mechanisms through which MHCs contribute (or not) to reductions in

recidivism. Few studies have examined components of MHCs associated with improved participant outcomes, which is likely attributable to the limited knowledge of how MHCs operate across sites. However, examining variability in the design and operation of U.S. MHCs is critical to informing recommendations to improve their effectiveness.

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MHCPM

Mental Health Court Performance Measures

INTRODUCTION & OVERVIEW

www.ncsc.org/mhcpm



National Center for State Courts

PARTICIPANT ACCOUNTABILITY

1 *In-Program Reoffending* — The incidence of in-program reoffending (i.e., whether an arrest occurred, yes or no). In-program reoffending is defined as an arrest that results in the offender being formally charged (excluding traffic citations other than DUI) and which occurs between admission and exit. While the date of arrest must fall between the entry date and exit date, the charge date may come after the participant has exited the program. This measure serves as an important measure of offender compliance and the level of supervision received, hence, an indicator for public safety.

2 *Attendance at Scheduled Judicial Status Hearings* — The percent of scheduled judicial status hearings attended by the participant. The performance measure reflects the level of judicial supervision for each participant.

3 *Attendance at Scheduled Therapeutic Sessions* — The percent of scheduled therapeutic sessions (defined as services to address mental health and/or substance abuse problems) attended. Therapeutic treatment is an essential element of MHCs.

SOCIAL FUNCTIONING

4 *Living Arrangement* — Tracks the progress of MHC participants toward securing a stable living arrangement. Specifically, the percent of participants who are homeless or not at exit, by living status at entry. Adequate housing is a prerequisite for treatment effectiveness.

CASE PROCESSING

5 *Retention* — The percent of participants admitted to the MHC during the same time frame, who exit the program by one of the following means: Successful completion, administrative closure, voluntary withdrawal while in compliance, discharge, transfer, and failure/termination. Retention is important in MHCs because it is critical that participants receive treatment and supervision of long enough duration to affect change.

6 *Time from Arrest to Referral* — The average length of time between a participant's arrest and referral to MHC. While the referral process is not entirely under the court's control, it is an important component in obtaining relevant and timely information. This is especially true when offenders who are mentally ill are incarcerated and are at risk for decompensation.

7 *Time from Referral to Admission* — The average length of time between the referral to MHC and when the participant was accepted into the program. The span of time between referral and admission is an important part of controlling the length of time it takes to get a participant into treatment. This measure will help the court identify inefficiencies in the screening and qualification process.

8 *Total Time in Program* — The average length of time between a participant's admission into the MHC and permanent exit. If this time span is very short, participants may not be receiving enough treatment and care to affect long term improvement. If it is very long, courts may be devoting too great a share of their resources to difficult cases, denying opportunities to other potential participants.

COLLABORATION

9 *Team Collaboration* — The percentage of time that information relevant for discussion at the pre-docket meeting is available to the team. This provides a gauge to the court of the level of collaboration across the entire MHC team and allows for the identification of gaps in information sharing. With this measure, courts can investigate a lack of resources or lack of commitment by individuals/agencies. This is NOT a measure of attendance at pre-docket meetings.

10 *Agency Collaboration* — The percentage of time that a MHC representative was notified within 24 and 48 hours that a participant in the program was arrested. This measure assesses the timeliness of the basic communication flow between corrections (jail) and the MHC program so that services and medication are maintained during time spent in detention. Effective inter-agency collaboration will improve the effectiveness of the MHC and its operations.

INDIVIDUALIZED AND APPROPRIATE TREATMENT

11 *Need-Based Treatment and Supervision* — The goal of this measure is to align participants' diagnosis and criminogenic risk with the appropriate treatment and service dosage. The measure provides courts with an indicator of whether the resources available for supervision and treatment are allocated based on need. Operationally, it measures the percentage of participants who receive the highest (and alternatively lowest) level of services and supervision and whether those are the same participants who are designated as having highest (and lowest) needs. Achieving this will provide the necessary balance for effective use of tax payer money, ensuring public safety, and improving the welfare of the participant using need-based, individualized, and appropriate treatment.

PROCEDURAL FAIRNESS

12 *Participant-Level Satisfaction* — Perceived fairness of the program by the participant as expressed in a short 5-question survey. Research indicates that the perception of fairness is often more important than the actual outcome of the case (see e.g., procedural justice) making this measure important in gauging the perception of the participant.

AFTERCARE/POST-EXIT TRANSITION

13 *Participant Preparation for Transition* — Percent of correct responses by the participant identifying sources of assistance (e.g., for medication or mental health symptoms) to be used after exiting the program. This measure provides the MHC with an assessment of whether participants are prepared for their transition by ensuring that needed treatment and services will remain available and accessible after their court supervision concludes.

14 *Post-Program Recidivism* — Percentage of participants who reoffended within two years after exiting the MHC. This performance measure is an important measure of the lasting outcomes of the court's program as well as public safety. It captures longer-term outcomes, as compared to Measure 1 "In-Program Reoffending," and is thus reflective of the effectiveness of the program.

PERFORMANCE MEASURES FOR MENTAL HEALTH COURTS ARE USED...

- as a Management Tool,
- to Monitor Program Performance,
- to Demonstrate Accountability to Funding Agencies, Court Leaders, External Partners, and the Public.

Performance measurement is considered an essential activity in many government and non-profit agencies because it provides tools for managers to exercise and maintain control over their organizations, as well as provides a mechanism for governing bodies and funding agencies to hold organizations accountable for producing the intended results. As a relative newcomer among problem-solving courts, Mental Health Court (MHCs) are still seen as experimental models for courts in some jurisdictions.

MHCs are designed for offenders with mental illnesses who enter the criminal justice system. The programs are diverse, including specialized criminal dockets or pre-trial diversion programs, which operate to align the offender with mental health

A select advisory group of MHC experts and project staff from the National Center for State Courts (NCSC) worked together to produce a set of performance measures designed specifically for MHCs. These measures were then tested for feasibility, ease of implementation, and usefulness by four courts located in Orange Co., CA; Monroe Co., NY; York Co., PA; and Washington DC.

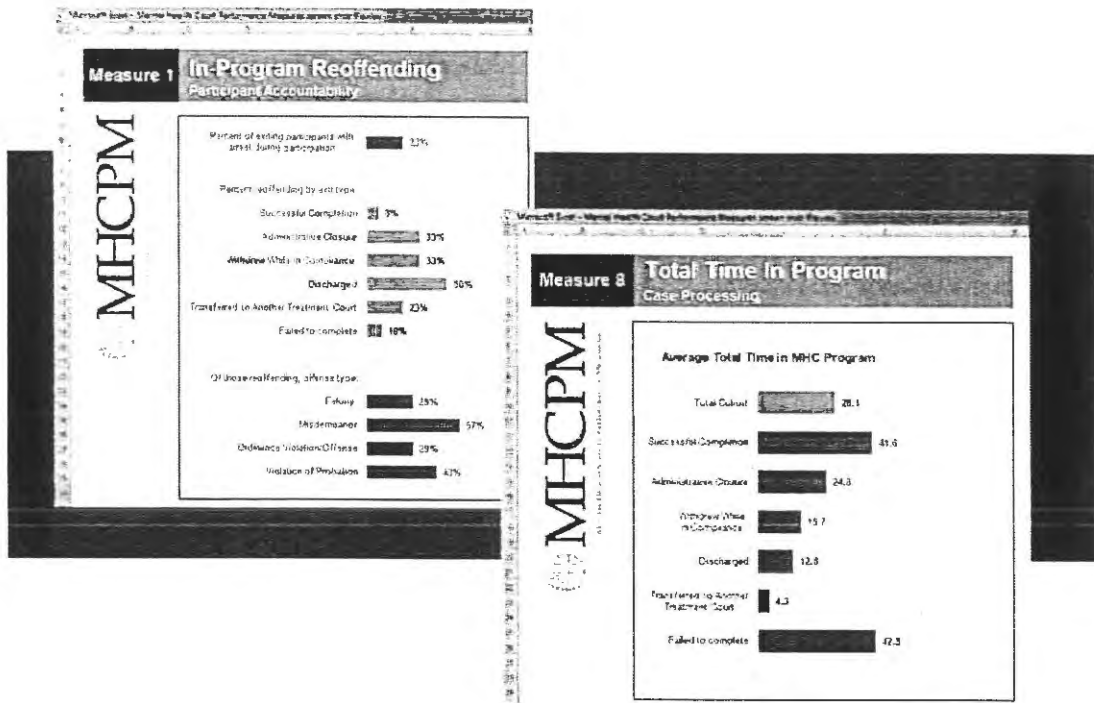
services and judicial supervision as an alternative to traditional jail time. While there are nearly 300 MHCs nationwide at the present time, there is a paucity of data to evaluate the success of MHCs. Moreover, there is a lack of consensus on what key elements ought to be used to measure the performance of MHCs. The extent to which MHCs offer an effective problem-solving alternative to the criminal justice system is currently unanswerable without adequate performance measures designed for MHCs.

14 CORE PERFORMANCE MEASURES

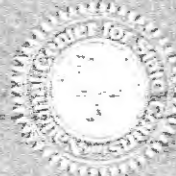
The performance measures are designed to be implemented as a complete and comprehensive set, providing balance across seven key measurement domains. These measures are both important management tools to gauge performance of the MHC program and relatively simple measures to implement. The performance measures are organized by domain.

MHCPM DATA ANALYSIS TEMPLATES

The project provides free, Excel-based templates that allow mental health court officials to enter data and produce easy to interpret data-based graphics. These graphics show the results for each measure on a summary level for the court, and can be viewed on screen or printed as hand-outs.



This project is the culmination of the NCSC's expertise on problem-solving courts paired with its expertise in designing performance measurement for state courts. For access to the complete Mental Health Court Performance Measures User's Guide, with data analysis templates (XLS) enabling the user to download spreadsheets, calculate the measures, and produce graphical output, go to: www.ncsc.org/mhcpm



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Behavioral Health Diversion Interventions:

Moving from Individual Programs
to a Systems-Wide Strategy

October 2019





INTRODUCTION

People who have mental illnesses and substance use disorders are overrepresented in the criminal justice system. Indeed, the prevalence of people in jails who have serious mental illnesses is often three to six times higher than that of the general public.¹ And for people who have serious mental illnesses and co-occurring mental health and substance use disorders, up to 50 percent have had criminal justice contact.² Often, these individuals cycle through local criminal justice systems, which are frequently not equipped to provide the costly treatment and support services needed by people who have behavioral health needs. This population's frequent contacts with the criminal justice system cause a strain on local resources and typically result in their increased chances of recidivism and behavior that can negatively impact the public's safety. These repeated contacts also often cause strain on a person's wellbeing and disrupt housing, jobs, and family stability as well as negatively impacting their physical and mental health.

To address these challenges, a growing number of communities are implementing behavioral health diversion programs as alternatives to conventional criminal justice case processing and incarceration, namely, by connecting people to the appropriate community-based treatment and support services outside of the criminal justice system.³ However, implementation of these alternatives has largely been kept to individual, or one-off, recognizable programs that are often insufficient in meeting the needs of the community and reducing the over-representation of people who have behavioral health needs in the criminal justice system. To achieve the greatest impact and reduce the overall number of people who have behavioral health needs in the criminal justice system, communities must have a range of diversion programs and practices embedded within a comprehensive, coordinated strategy which offers behavioral health diversion interventions at every point in the criminal justice system⁴ and fully leverages the community's resources.

While diversion may not be appropriate or possible for every person in the criminal justice system who has a behavioral health need, a strategic, systems-wide approach (which includes input from mental illness and substance use disorder treatment system leaders) will better define which interventions are best for a community and reduce the likelihood it is using inefficient programs and practices. This publication is intended to provide these local leaders with a systems-level conceptual framework for developing a continuum of behavioral health diversion interventions that span the community's criminal justice system—starting from first contact with law enforcement through incarceration.

DEVELOPING A CROSS-SYSTEMS BEHAVIORAL HEALTH DIVERSION STRATEGY

While the opportunities for behavioral health diversion look different in communities across the country, leaders are seeking opportunities to build bridges across systems to create community-wide strategies that have the greatest impact. In some places, the leadership comes from the courts, and in others, law enforcement or the jails are leading efforts. But from wherever they "sit," these leaders are learning that the overarching elements needed to create a holistic and effective diversion response strategy include the following key components:

1. Developing and engaging collaborative partnerships
2. Understanding the community's behavioral health needs
3. Identifying existing services and supports and gaps
4. Defining key measures and collecting data
5. Leveraging funding to prioritize interventions
6. Measuring and sustaining progress

¹ H. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (2009): 761–765.

² J. F. McGuire and R. A. Rosenheck, "Criminal history as a prognostic indicator in the treatment of homeless people with severe mental illness," *Psychiatric Services* 55, vol. 1 (2004): 55, 42–48.

³ Hailey Fader-Towe and Fred C. Osher, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements* (New York: The Council of State Governments Justice Center, 2015), 7. <http://www.csgjusticecenter.org/publications/essential-elements-improving-responses-to-people-with-mental-illnesses-at-the-pretrial-stage-essential-elements/>.

⁴ Many communities use the Sequential Intercept Model (SIM), which is a conceptual model to guide community and systemwide responses to people with mental and substance use disorders in the criminal justice system. SIM focuses on six discrete points of potential intervention (also known as intercepts) in the criminal justice system at which a person who has behavioral health needs might be screened, assessed, and connected to treatment. These six points are (0) community services, (1) law enforcement, (2) initial detention/initial court hearings, (3) jails/courts, (4) reentry, and (5) community corrections. See Policy Research Associates, *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders* (New York: Policy Research Associates, 2018). http://www.praassoc.com/wp-content/uploads/2018/06/PRA_SIM_vlater_Paper_2018.pdf.

BEHAVIORAL HEALTH DIVERSION TERMINOLOGY

While diversion, particularly behavioral health diversion, is becoming more common in the U.S. as an alternative to incarceration, there are not consistent, universally accepted terms and definitions that clarify who can be diverted, to what systems or services, and who can divert someone at various points in the criminal justice system. This lack of a shared language has led to wide variance among state "diversion" statutes⁵ and local practices and often creates inconsistencies in criteria and the ways programs operate by jurisdiction. For the purposes of this publication, **behavioral health diversion** refers to adult jail diversion, whereby a person who has a behavioral health need may still have involvement with the criminal justice system (such as the courts) but spends little to no time in a jail facility and is instead connected to community-based treatment and support services either with or without court involvement or correctional supervision.⁶

OTHER COMMON BEHAVIORAL HEALTH DIVERSION DEFINITIONS INCLUDE:

Behavioral health diversion intervention: These programs and practices reduce or eliminate jail time for people who have behavioral health needs by connecting them to community-based treatment and support services. This term includes recognizable diversion programs such as mobile crisis teams and Law Enforcement Assisted Diversion (LEAD), as well as local practices that lead to a diversion-related outcome.

Pre-arrest diversion: Refers to diversion whereby a person who has initial contact with the criminal justice system (typically with law enforcement or first responders) is not arrested, but is instead connected to a behavioral health community provider or potentially given a civil citation.

Pre-booking diversion: Most commonly defined as programs and practices that can occur at any point in the criminal justice system before a person is booked into a facility and relies heavily on effective interactions between police and community mental health and substance use disorder treatment providers.⁷

Post-booking diversion: Most commonly refers to programs that are used to identify and divert people who have behavioral health needs after they have been booked into jail.⁸ Post-booking diversion interventions are typically led by either the courts or jails.

Pretrial diversion: Pretrial diversion is a type of post-booking diversion. It is commonly defined as programs and practices that occur at any level or stage of justice supervision between law enforcement contact and a plea or other disposition of the criminal case. As a result, pretrial diversion may involve multiple agencies, including jail, pretrial release, prosecutors, defense counsel, and even probation departments that operate in a pretrial capacity.⁹

This publication delineates diversion opportunities as "pre-booking" or "post-booking" because different actors become involved once someone enters a correctional facility. Distinguishing the behavioral health diversion options into just these two categories also allows a clear line to be drawn when talking about the agencies within the system leading the implementation of a diversion intervention (see Figure 1). However, diversion opportunities are also often delineated by their place in the flow of the criminal case (e.g., pre-charge, pre-arraignment, pre-plea). While not a focus of this publication, consensus on which of these process points provide a ramp for diversion is critical.

⁵ "Pretrial Diversion," National Conference of State Legislatures, accessed September 11, 2019, <http://www.ncsl.org/resources-and-conferences/justice-system/diversion.aspx>.

⁶ This definition is adapted from the definition given in Judges' Criminal Justice/Mental Health Leadership Initiative, *Judges' Guide to Mental Health Diversion: A Reference for Justice System Practitioners* (Delmar, NY: Policy Research Associates, CMHS National GAINS Center, 2010). While some interventions can occur post-conviction (through reduced jail time or supervision for treatment compliance), this definition of diversion does not consider those interventions as diversion, but instead as reentry practices. Traditional reentry practices are an important piece of the criminal justice process; however, they are not considered diversion interventions.

⁷ CMHS National GAINS Center, *Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center* (Delmar, NY: Policy Research Associates, CMHS National GAINS Center, 2007).

⁸ *Ibid.*

⁹ The Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC), *No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives* (Chicago: The Center for Health and Justice at TASC, 2013).

UNDERSTANDING THE COMMUNITY'S BEHAVIORAL HEALTH NEEDS

To develop a systems-wide strategy for a continuum of behavioral health diversion interventions, local leaders must identify the people who have behavioral health needs in the criminal justice system, how they flow through the criminal justice system, and the gaps in community-based treatment and support services for this population. Identifying these needs and gaps can be accomplished by conducting comprehensive process analyses and inventorying any existing services and supports for people who have behavioral health needs. Local leaders should also consider engaging stakeholders in both the criminal justice and behavioral health systems, as well as people who have lived experiences, in discussions and efforts such as collecting baseline data on programs and practices geared to people who have behavioral health needs in the criminal justice system.¹⁹

Additional data collected from law enforcement, pretrial services, courts, jail facilities, health providers, and housing continuums of care can be used to analyze the number of people who have mental illnesses, substance use disorders, and co-occurring illnesses and how this population moves through the system. This type of data analysis can reveal potential areas where one or more diversion interventions are needed as part of an overarching strategy. For example, an analysis of data may reveal that too many people with low level offenses but who have significant behavioral health needs are being booked into the jail. In this instance, local leaders may consider implementing a pre-booking diversion intervention that connects this population to community-based mental health and substance use disorder services as part of their systems-wide strategy.

Often, leaders realize the need for a more comprehensive strategy when they determine that individual programs are not efficiently meeting the needs of their community. When this occurs, it is critical to have data and information from both criminal justice and behavioral health systems so these leaders can begin to rethink coordination across the multiple systems. In fact, while a comprehensive systems-wide diversion strategy would ideally begin before any programs or practices are implemented, communities that have already implemented individual diversion programs (such as a co-responder model or a mental health court) without a formal diversion strategy in place still have plenty of opportunities to build upon these programs to develop their strategy. In these instances, local leaders should conduct a gap analysis to examine the existing diversion intervention(s), assess what needs are not being met by these interventions based on data and information collected, and determine where any additional diversion interventions can be implemented.

When leaders have a clear understanding of the community's needs and gaps in treatment and services, they are better positioned to develop a systems-wide diversion strategy that includes diversion interventions at multiple points in the criminal justice system. This process can help a jurisdiction ensure resources are aligned correctly to maximize intended goals, both through sustaining successful interventions and filling gaps.

OPPORTUNITIES FOR BEHAVIORAL HEALTH DIVERSION

Like many systems, a local community's criminal justice system is a set of connected parts consisting of different agencies. Each of these agencies (i.e., law enforcement, courts, pretrial services, and jails) has opportunities to implement behavioral health diversion interventions at their respective points in the criminal justice system. Too often, however, these interventions operate as stand-alone programs in isolation of one another, and are not implemented in coordination with the interventions that can occur in other parts of the system. As a result, many communities find that these individual interventions—while effective for the people they reach—do not produce the desired results of reducing the overall number of people who have behavioral health needs in their criminal justice system.

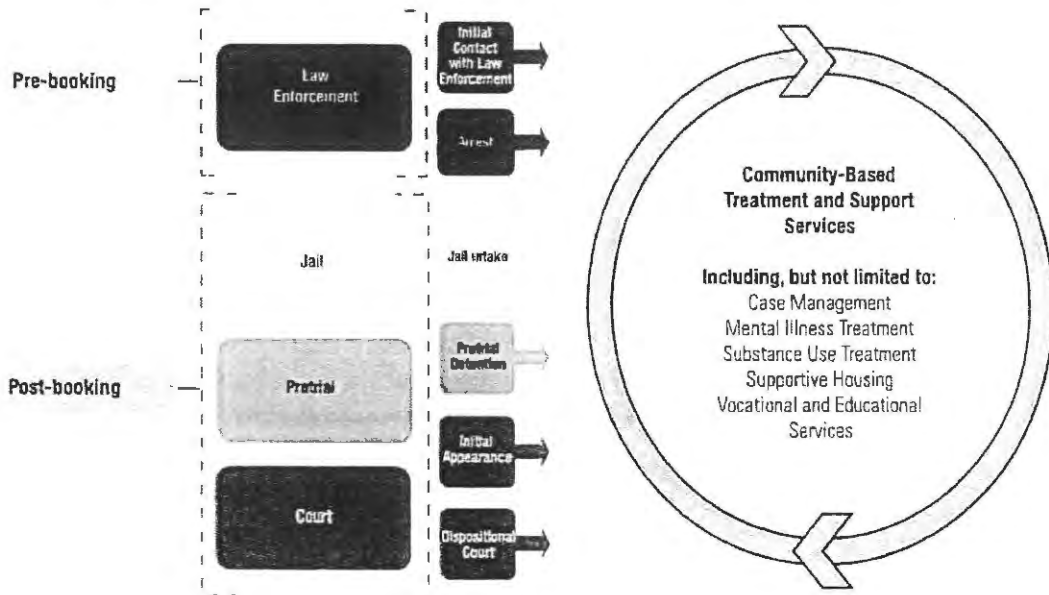
When this occurs, leaders should conduct an analysis of the behavioral health and criminal justice systems to help identify which agencies have the resources and best opportunities to implement coordinated behavioral health diversion interventions and engage new stakeholders from the different agencies to think through the communities' goals for behavioral health

¹⁹ Esco Hansberg et al., *Reducing the Number of People with Mental Illnesses in Jails* (New York: The Council of State Governments Justice Center, 2017), <https://www.csgjusticecenter.org/files/2017/05/17-01-Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jails.pdf>, and "The Steering Committee's Work," <https://www.csgjusticecenter.org/files/2017/05/17-01-Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jails.pdf>.

diversion. This analysis, in combination with information gathered about the people who have behavioral health needs in their criminal justice system and the gaps in community-based treatment and support services, can reveal which behavioral health diversion opportunities a community should prioritize and invest funding in.

Figure 1 shows the potential behavioral health diversion interventions within a community's criminal justice system that can be used to connect people to community-based treatment and support services, organized around the specific agencies that would best lead the implementation of a diversion intervention. These opportunities range from interventions that operate prior to arrest and booking by law enforcement to those that provide alternatives to incarceration at adjudication or sentencing. Categorized by which opportunities fall under the pre-booking and post-booking diversion classifications, the larger boxes indicate which agencies can lead implementation of the behavioral health diversion interventions, while the smaller boxes to the right describe key points in the criminal justice process where a behavioral health diversion intervention could be implemented based off the agency with the best opportunity to do so. Once implemented, these interventions should all have a similar end result: the person connected to community-based treatment and support services.¹¹

FIGURE 1. BEHAVIORAL HEALTH DIVERSION OPPORTUNITIES WITHIN A LOCAL CRIMINAL JUSTICE SYSTEM LEADING TO COMMUNITY-BASED TREATMENT AND SUPPORT SERVICES



This agency-specific framework helps local leaders determine which agencies will best lead their agreed upon behavioral health diversion interventions and how those agencies can collaborate to develop the systems-wide strategy, reducing the silos that often occur when interventions are implemented without community-wide coordination. By using this framework, agencies can have a better understanding of what behavioral health diversion interventions are possible. Communities can also determine what types of interventions best address their needs and where they should focus their interventions to create diversion opportunities across the criminal justice system. A systems mapping exercise, such as Sequential Intercept Mapping (derived from SIM), can be used to identify the agencies responsible for each process point and subsequent identification of a diversion intervention. Once local leaders have an understanding of the needs of their identified population, the diversion interventions already implemented, and the capacity of community-based services organizations, they can begin to explore behavioral health diversion interventions that would provide the level of treatment and supervision needed by this population.

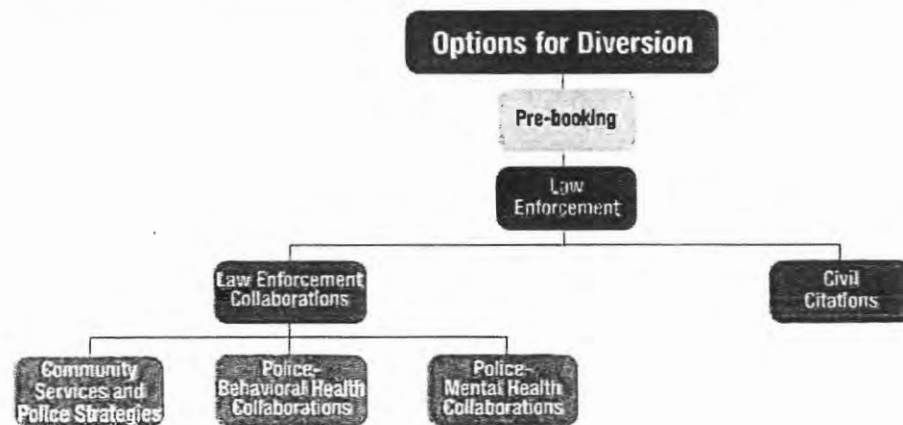
¹¹ Figure 1 highlights the agencies typically associated with each key process point in the criminal justice system of a given jurisdiction, but it is important to note that the agency responsible for each process point varies across jurisdictions. It also indicates examples of community-based treatment and support services that people should be connected to once they are diverted from the criminal justice system. Many communities have begun using Collaborative Comprehensive Case Plans to facilitate these efforts as part of a systems-wide strategy. See, "Collaborative Comprehensive Case Plans: Addressing Criminogenic Risk and Behavioral Health Needs," The Council of State Governments Justice Center, accessed September 13, 2019, <https://csgjusticecenter.org/wp-content/uploads/2019/09/CCCP-2019-09-13.pdf>.

Pre-booking Diversion Interventions

Although there are key points in the criminal justice process to divert people after they have been booked into jail, diverting people at the pre-booking stage typically results in limited or no jail time or justice involvement for an individual. Therefore, communities should consider investing in behavioral health diversion interventions at the pre-booking point in the criminal justice system if their data analysis reveals the needs of their identified population are best addressed through programs and practices that intervene early in the criminal justice process. If it is determined that a significant proportion of the population with behavioral health needs is arrested or convicted for low level offenses, for example, a pre-booking diversion intervention would allow people to be connected to community-based treatment and support services rather than booked into a jail facility. Pre-booking diversion interventions can reduce burdens on the booking and jail staff by diverting people prior to being booked into a jail, reducing the number of people who have behavioral health needs from entering a jail facility. These interventions can also reduce individual barriers to recovery. For people who have mental illnesses, jail time often means a disruption to community-based treatment, as well as any community supports, such as benefits enrollment, housing, and employment.¹²

Figure 2 illustrates the types of opportunities for pre-booking diversion interventions law enforcement agencies can implement. These interventions are often focused on law enforcement collaborations with community providers in the behavioral health system that have more knowledge and resources to treat people who have behavioral health needs.¹³

FIGURE 2. LAW ENFORCEMENT OPTIONS FOR IMPLEMENTING PRE-BOOKING DIVERSION INTERVENTIONS¹⁴



Post-booking Diversion Interventions

After an individual has been booked into jail, there are still numerous opportunities for diversion through the efforts of the jail, pretrial services, or the courts. Communities should consider investing in post-booking diversion interventions, if it is determined that existing treatment and service gaps are best addressed by the courts, jail facilities, or pretrial services. For example, a jurisdiction may determine that the people who have behavioral health needs in their community have longer lengths of stay in a jail facility or their criminal charges are largely predicated on their behavioral health need. Examples of post-booking diversion interventions can include a reduction in charges or case dismissal pending completion of a behavioral health diversion program. While these interventions will not reduce the number of jail bookings, they can significantly impact an individual's length of stay, as well as help avert the consequences of a criminal conviction.

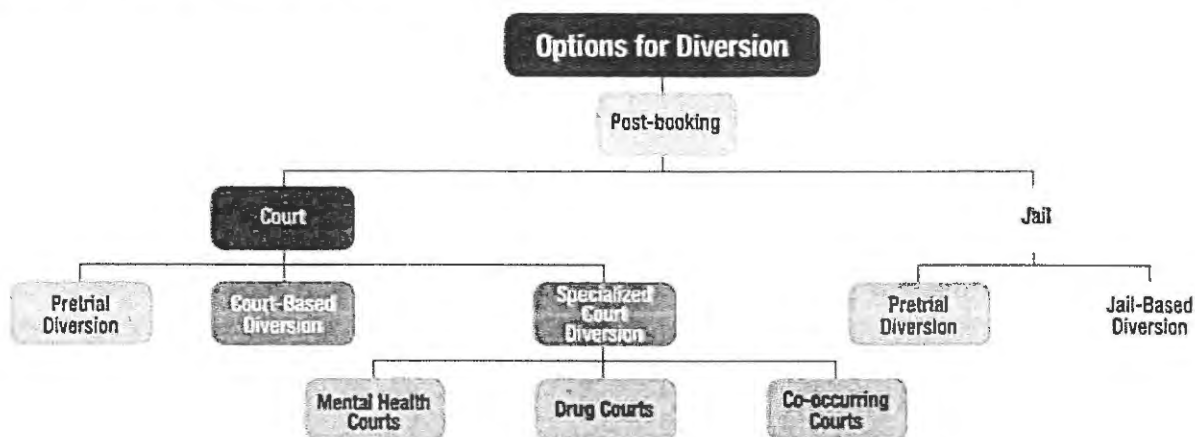
¹² Hallie Fader-Towe and Fred Osner, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*, 9, <https://www.ncjrs.gov/pdffiles1/nij/grants/251407.pdf>, responses to people with mental illnesses at the pretrial stage-essential elements.

¹³ The Council of State Governments Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* (New York: The Council of State Governments Justice Center, 2019), <https://www.csgjusticecenter.org/wp-content/uploads/2019/04/Police-Mental-Health-Collaboration-Framework.pdf>

¹⁴ Figure 2 uses categorizations to describe various collaborative efforts led or joined by law enforcement agencies across the country. "Community Services and Police Strategies" includes diversion interventions where a person is diverted to crisis services; "police-behavioral health collaborations" refers to diversion interventions where connecting people with substance use disorders or concerns to treatment is the primary focus; and "police-mental health collaborations" refers to diversion interventions where connecting people with mental health needs to treatment is the primary focus.

For these interventions, prosecutors, defense counsel, pretrial services staff, jail staff, judges or others working in the courts may help to identify people who meet eligibility criteria for diversion. Figure 3 illustrates some common post-booking diversion options based on the criminal justice agencies and partners that can best implement those programs and practices.

FIGURE 3. COURT AND JAIL OPTIONS FOR IMPLEMENTING POST-BOOKING DIVERSION INTERVENTIONS¹⁵



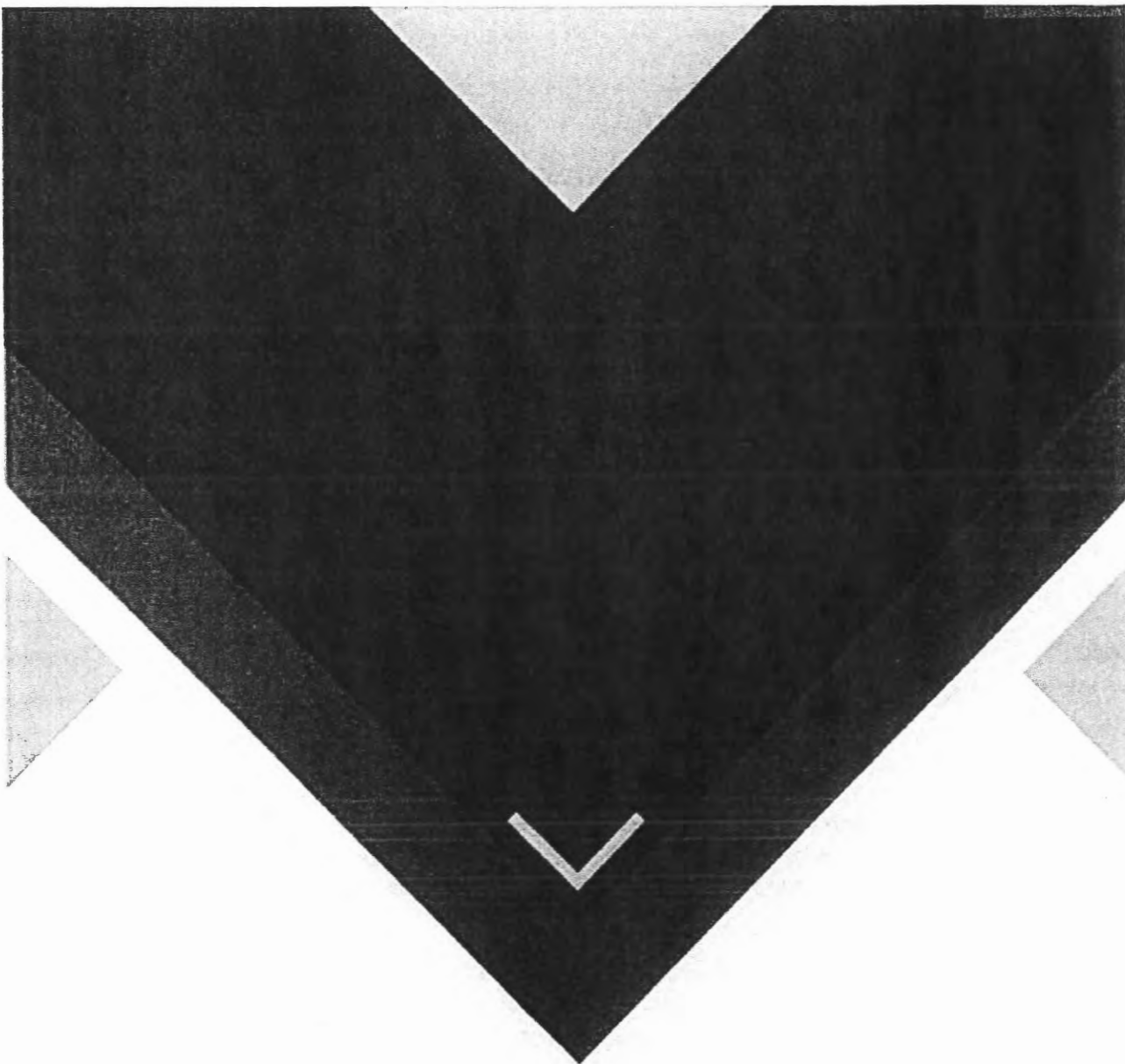
DEVELOPING A SYSTEMS-WIDE STRATEGY

Local leaders can begin developing a systems-wide strategy by engaging criminal justice and community partners in efforts to identify their behavioral health needs and gaps in services and determining the pre- and post-booking interventions that work best for them. They should use this information to inform the development of a systems-wide behavioral health diversion strategy based on what behavioral health needs they want to prioritize and which agencies are best positioned to lead and collaborate on implementing the behavioral health diversion interventions. To develop that strategy, leaders must also determine where they should focus their behavioral health diversion interventions within the various points in the criminal justice system.

The use of data, system mapping, and analysis of flow of people through a local criminal justice system can help to identify points in the criminal justice system where one or more behavioral health diversion interventions should be implemented. In addition to identifying areas to implement new programs and practices, local leaders should also examine and assess the performance of any existing efforts within the criminal justice and behavioral health systems. Combining both these efforts will help leaders develop a systems-wide strategy that includes multiple points in the criminal justice system where agencies have the ability to identify people who have behavioral health needs as well as divert them to the community-based providers that can provide the needed treatment and support services.

A thoughtful systems-wide behavioral health diversion strategy that builds a continuum of behavioral health diversion interventions into the criminal justice system will maximize the number of interventions available, ensure that the interventions offered meet the needs of the community, and more effectively reroute the appropriate people from conventional case processing and incarceration into the community-based treatment and support services that better serve their needs.

¹⁵ Although pretrial diversion is included as an intervention that can be led by either the courts or the local jail, it is often a stand-alone agency run by community supervision or a branch within the courts. The inclusion of pretrial diversion on both sides of Figure 3 reflects the variety of pretrial services administrative locations in communities. Additionally, under "specialized court diversion," it is worth noting that these programs are all pre-plea and may have a variety of program names depending on the jurisdiction. While drug courts, mental health courts, and co-occurring courts are among the most common types of specialized court diversion, jurisdictions are constantly innovating in this area, and there may be other specialized court diversions available that would be appropriate (e.g., homelessness court, opioid court, etc.).



Justice Center

THE COUNCIL OF STATE GOVERNMENTS

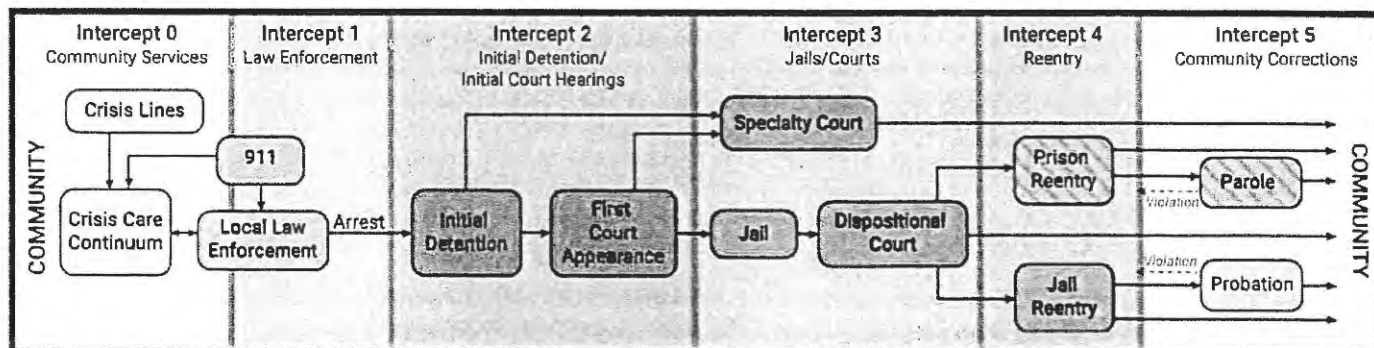
This project was supported by Grant No. 2016-MU-BX-K003, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

THE SEQUENTIAL INTERCEPT MODEL

Advancing Community-Based Solutions for Justice-Involved People
with Mental and Substance Use Disorders



The Sequential Intercept Model



Key Issues at Each Intercept

Intercept 0

Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.

Emergency Department diversion. Emergency department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.

Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.

Intercept 1

Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.

Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.

Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.

Intercept 2

Screening for mental and substance use disorders. Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.

Data matching initiatives between the jail and community-based behavioral health providers.

Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.

Intercept 3

Treatment courts for high-risk/high-need individuals. Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and veterans treatment courts.

Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment.

Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.

Intercept 4

Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.

Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days medication at release and have prescriptions in hand upon release.

Warm hand-offs from corrections to providers increases engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.

Intercept 5

Specialized community supervision caseloads of people with mental disorders.

Medication-assisted treatment for substance use disorders. Medication-assisted treatment approaches can reduce relapse episodes and overdoses among individuals returning from detention.

Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to behavioral health services. Removing criminal justice-specific barriers to access is critical.

Implementing Intercept 0

Crisis Response

Crisis response models provide short-term help to individuals who are experiencing behavioral health crisis and can divert individuals from the criminal justice system. Crisis response models include:

- Certified Community Behavioral Health Clinics
- Crisis Care Teams
- Crisis Response Centers
- Mobile Crisis Teams

Police Strategies

Proactive police response with disadvantaged and vulnerable populations are a unique method of diverting individuals from the criminal justice system. Proactive police response models include:

- Crisis Intervention Teams
- Homeless Outreach Teams
- Serial Inebriate Programs
- Systemwide Mental Assessment Response Team

Sequential Intercept Model as a Strategic Planning Tool

The **Sequential Intercept Model** is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others. Employed as a strategic planning tool, communities can use the **Sequential Intercept Model** to:

1. Develop a comprehensive picture of how people with mental and substance use disorders flow through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections
2. Identify gaps, resources, and opportunities at each intercept for adults with mental and substance use disorders
3. Develop priorities for action designed to improve system and service level responses for adults with mental and substance use disorders

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History and Impact of the Sequential Intercept Model

The Sequential Intercept Model (SIM) was developed over several years in the early 2000s by Mark Munez, MD and Patricia A. Griffin, PhD, along with Henry J. Steadman, PhD, of Policy Research Associates, Inc. The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.

After years of refinement and testing, several versions of the model emerged. The "linear" depiction of the model found in this publication was first conceptualized by Dr. Steadman of PRA in 2004¹ through his leadership of a National Institute of Mental Health-funded Small Business Innovative Research (SBIR) grant awarded to PRA. The linear SIM model was first published by PRA in 2005² through its contract to operate the GAINS Center on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA). The "filter" and "revolving door" versions of the model were formally introduced in a 2006 article in the peer-reviewed journal *Psychiatric Services* authored by Drs. Munez and Griffin³. A full history of the development of the SIM can be found in the book *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*⁴.

With funding from the National Institute of Mental Health, PRA developed the linear version of the SIM as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system by people with mental and substance use disorders. Through this grant, PRA, working with Dr. Griffin and others, produced an interactive, facilitated workshop based on the linear version of the SIM to assist cities and counties in determining how people with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community.

During the mapping process, the community stakeholders are introduced to evidence-based practices and emerging best practices from around the country. The culmination of the mapping process is the creation of a local strategic plan based on the gaps, resources, and priorities identified by community stakeholders.

Since its development, the use of the SIM as a strategic planning tool has grown tremendously. In the 21st Century Cures Act, the 114th Congress of the United States of America identified the SIM, specifically the mapping workshop as a means for promoting community-based strategies to reduce the justice system involvement of people with mental disorders. SAMHSA has supported community-based strategies to improve public health and public safety outcomes for justice-involved people with mental and substance use disorders through SIM Mapping Workshop national solicitations and by providing SIM workshops as technical assistance to its criminal justice and behavioral health grant programs. In addition, the Bureau of Justice Assistance has supported the SIM Mapping Workshop by including it as a priority for the Justice and Mental Health Collaboration Program grants.

With the advent of Intercept 0, the SIM continues to increase in utility as a strategic planning tool for communities who want to address the justice involvement of people with mental and substance use disorders.

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2. National GAINS Center. (2005). Developing a comprehensive state plan for mental health and criminal justice collaboration. Delmar, NY: Author.
3. Munez, M.R., & Griffin, P.A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57, 544-549. DOI: 10.1176/ps.2006.57.4.544
4. Griffin, P.A., Helbrun, K., Mulvey, E.P., DeMatteo, D., & Schubert, C.A. (Eds.). (2015). *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness*. New York: Oxford University Press. DOI: 10.1093/med-psych/9780199826759.001.0001
5. 21st Century Cures Act, Pub. L. 114-255, Title XIV, Subtitle B, Section 14021, codified as amended at 41 U.S.C. 3797aa, Title I, Section 2391
6. Aoreu, D., Parker, T.W., Noether, C.D., Steadman, H.J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders. *Intercept 0: Behavioral Sciences & the Law*, 35, 380-395. DOI: 10.1002/bsl.2300



PRETRIAL SERVICES AGENCY *for the* DISTRICT of COLUMBIA

Statement of Victor V. Davis, Chief of Staff, on behalf of Leslie C. Cooper, Director,
Pretrial Services Agency for the District of Columbia
Before the
District of Columbia Advisory Committee

**BRIEFING ON MENTAL HEALTH, HOMELESSNESS AND THE MENTAL HEALTH
COMMUNITY COURT IN THE DISTRICT OF COLUMBIA**

Thursday, November 7, 2019

Good afternoon, Chairman Malcolm and members of the Committee. It is my privilege to appear before you today to share the experience of the Pretrial Services Agency for the District of Columbia, or "PSA", in working with criminal justice involved individuals with mental health needs.

First let me share PSA's role in the DC justice system. PSA assists judicial officers in both the Superior Court of the District of Columbia and the United States District Court for the District of Columbia by conducting a risk assessment for every arrested person who will be presented in court and formulating release or detention recommendations based upon the arrestee's demographic information, criminal history, and substance use and/or mental health information. For defendants who are placed on conditional release pending trial, PSA provides supervision and treatment services that reasonably assure that they return to court and do not engage in criminal activity pending their trial and/or sentencing. In Washington, DC, over 90% of defendants are released pretrial without a financial bond. The vast majority of defendants who are not released pending trial are detained under one or more provisions of DC's preventive detention statute and no one is detained as a result of a financial bond that he/she cannot meet.

As reported in our FY 2020 budget, PSA has responsibility for over 17,000 defendants each year, and an average of 4,232 individuals on any given day. PSA's current caseloads include individuals being supervised on a full range of charges, from misdemeanor property offenses to felony murder. On average, defendants remain under supervision for 100 days.

PSA administers evidence-based and data informed risk assessment and supervision practices to identify factors related to pretrial misconduct and maximize the likelihood of arrest-free behavior and court appearance during the pretrial period. PSA's case management strategies are designed to increase the likelihood that supervised defendants make all scheduled court appearances and remain arrest-free during the pretrial period. All of PSA's release conditions are court-ordered and are designed to target and mitigate each defendant's assessed risk. Our supervision approaches include routine contact with a Pretrial Services Officer, notification of upcoming court dates, electronic monitoring, drug testing, and substance use disorder and/or mental health assessments and appropriate treatment, as indicated. Our substance use disorder treatment services, which are provided as a supplement to our supervision services, include intensive outpatient and residential treatment, primarily funded through PSA's appropriation.

The efficacy of PSA's supervision strategies for defendants is demonstrated by the results that we see. For our supervised population, over the past five years, about 88% of released defendants have made all scheduled court appearances and remained arrest free while in the community pending trial. Of those rearrested, only about 1% were arrested for a violent crime while in the community. In addition, about 88% of released defendants remained on pretrial release while their cases were pending without a revocation of release due to non-compliance.

The prevalence of mental health issues among PSA defendants is based on self-reported mental health status during the diagnostic interview, by mental health assessments completed by District's Department of Behavioral Health (DBH), or by PSA's Social Services and Assessment Center (SSAC).

Since FY 2015, an average of 15% of defendants have self-reported a mental health condition. Comparatively, although defendants with mental health illnesses account for only 15% of PSA's total population, 62% are assessed to pose high or very high risk of rearrest or failure to appear in court, compared with 31% of defendants with no mental illnesses.

Defendants with mental illness pose a disproportionate risk among our supervised population; presenting extraordinary challenge and requiring significantly more resources. According to Pretrial Services Officers, defendants with mental health conditions, especially those with severe mental illnesses, are more likely than the average defendant to miss their court date, refuse treatment, or get "stepped back" during the pretrial period. Defendants with mental health conditions also require significantly more effort to maintain contact; additional time and energy is needed to maintain outreach, such as collaboration with Assertive Community Treatment (ACT) teams to keep in contact with defendants suffering from severe mental illnesses.

PSA provides specialized supervision to defendants with severe mental health disorders through the Specialized Supervision Unit (SSU). The SSU relies almost exclusively on DBH to provide services for these individuals. In FY 2019, about 4% of PSA defendants who were assessed with severe mental illness were enrolled in the SSU and all SSU defendants were connected to DBH or a similar entity in order to address their mental health needs. Defendants who are not DC residents are connected to similar mental health organizations in Maryland and Virginia. In addition to connecting defendants to community services, PSA also utilizes a contractor to provide a limited number of services to eligible defendants. Since FY 2016, PSA has added an additional SSU staffing team to serve this population.

Since 2007, PSA has supported the Mental Health Community Court (MHCC), which is a partnership among the DC Superior Court, United States Attorney's Office for the District of Columbia, Office of the Attorney General for the District of Columbia, local defense bar and PSA to provide an alternative to traditional case processing for defendants with mental health issues. The MHCC addresses some of the issues related to the increased numbers of mentally ill persons within the justice system and offers deferred prosecution and amended sentencing agreements to eligible defendants. We assess and recommend eligible defendants for participation, provide close supervision and connection to mental health and substance use disorder treatment, and report compliance to the Court.

We appreciate the work of the Committee in examining this important issue and the opportunity to share PSA's experience in working with these individuals to support public safety within the District of Columbia.

Questions for Department of Behavioral Health

Mental Health, Mental Health Courts, and Criminal Justice

1. Do you have data available on the long-term tracking of the number of individuals who use/have used DBH services and have been previously enrolled in a mental health court program?
2. Dr. David Freedman, the Chief Clinical Officer at Community Connections in D.C., describes the redistribution of funds once provided by DBH to the *Options* program to “all of the providers in the city”, which resulted in the discontinuation of the *Options* program. Even though this decision was made five years ago, do you have any insight into why this redistribution of funds occurred and has the issue been re-visited since then?
3. Does DBH have any recommendations or future plans to address issues such as pre-arrest and post-release homelessness among persons with a mental health diagnosis?
4. What proactive measures does DBH take to help individuals with mental health diagnoses before they enter the criminal justice system? Is there any data on the effectiveness of these programs?
5. What procedures or methods do you use to review the effectiveness of your service programs or grants that target individuals with mental illness and who may be criminally involved?
6. How does DBH conduct first-responder situations? For example: If I report someone who I believe to be needing psychological help, how would DBH go about responding to the situation?
7. If additional resources (monetary or personnel) were available to DBH what would be your priorities in deploying them?



April 27, 2020

VIA ELECTRONIC MAIL

Ms. Ivy L. Davis
 Director, Eastern Regional Office-U.S. Commission on Civil Rights
 1331 Pennsylvania Avenue, N.W.
 Suite 1550
 Washington, DC 20425

RE: Response to Request for Information

Dear Ms. Davis:

Per your request for information dated March 6, 2020, the Department of Behavioral Health (DBH) is providing this initial response. Thank you for your patience during the COVID-19 emergency. DBH requests clarification as to the time frame for which you are seeking information in question number 1. DBH anticipates providing a supplemental response to the one (1) outstanding questions by no later than May 15, 2020.

Question 2: Dr. David Freedman, the Chief Clinical Officer at Community Connections in D.C., describes the redistribution of funds once provided by DBH to the *Options* program to “all of the providers in the city,” which resulted in the discontinuation of the *Options* program. Even though this decision was made five years ago, do you have any insight into why this redistribution of funds occurred and has the issue been re-visited since then?

Response: Because of growing recognition that many individuals with serious and persistent mental illness have intermittent contact with the criminal justice system, DBH sought to enable all Core Service Agency (CSA) to better engage at all points along the “sequential intercept” model by making in-reach and discharge planning universal across the provider network, rather than a specialty service provided by (3) CSAs. Unfortunately, local dollars to pay for jail in-reach contracted simultaneously.

Question 3: Does DBH have any recommendations or future plans to address issues such as pre-arrest and post-release homelessness among persons with a mental health diagnosis?

Response: In 2019, DBH created a new, consolidated Community Response Team (CRT) that consisted of DBH's homeless outreach team, a pilot pre-arrest diversion (PAD program) and the mobile crisis team.

DBH is cognizant that mental illness is a risk factor for homelessness and criminal justice involvement. Consequently, DBH prioritizes funding housing development for consumers (capital), supportive services in Permanent Supportive Housing, and roughly \$10,000,000.00 annually in rental assistance. DBH is working to align its housing investments with Homeward DC 2.0, the Mayor's strategic plan to end chronic homelessness in the District. DBH is also coordinating with the District of Columbia Interagency Council Agency on Homelessness and government and non-government partners to leverage appropriate housing resources for DBH consumers.

Further, DBH houses three (3) staff in the READY Center, an inter-agency resource center anchored at the Department of Corrections (DOC) and located outside of the D.C. Jail. At the READY Center, DBH staff contact all jail residents on the short-term release list during the thirty (30) days prior to their release to assess their behavioral health needs and to link individuals to CSAs and Substance Use Disorder (SUD) treatment resources upon release. DBH staff also review the daily intake list provided by DOC to advise Unity Health Care, the DOC Comprehensive Health Services Contractor, about which individuals were previously connected to a DBH provider to ensure continuity of care.

Question 4: What proactive measures does DBH take to help individuals with mental health diagnoses before they enter the criminal justice system? Is there any data on the effectiveness of these programs?

Response: The PAD function is integrated into the CRT. As such, the CRT staff co-respond with police to identify and divert individuals engaged in petty criminal offenses into needed behavioral health care. Additionally, DBH contracts with Pathways to Housing DC to provide urgent psychiatric care at the D.C. Superior Court.

DBH also provides training and education to its provider network on evidence based practices for individuals with behavioral health issues and criminal justice involvement to address risk factors known as criminogenic needs, including thought patterns that can be modified through highly targeted cognitive behavioral therapy strategies. Data are not yet available.

Question 5: What procedures or methods do you use to review the effectiveness of your service programs or grants that target individuals with mental illness and who may be criminally involved?

Response: DBH uses Key Performance Indicators (KPI) to monitor strategic initiatives and goals. As it pertains to justice-involved consumers, DBH specifically looks to the following KPI:

1. Percent of inpatient consumers restored to competency; and
2. Consumers who are in need of linkage support at the DOC who are actually linked by DBH staff.

Grants require specific outcome measures and have unique reporting requirements. DBH recently overhauled its grant management process. To measure the effectiveness, each grantee must meet performance goals established by the scope of work on the grant agreement. DBH monitors grantee progress towards these goals by reviewing programmatic and financial reports and through site visits. If

DBH identifies deficiencies in a grantee's performance, DBH provides technical assistance when a deficiency can be remedied, and suspends or terminates an award for serious performance deficiencies.

Question 6: How does DBH conduct first-responder situations? For example: If I report someone who I believe to be needing psychological help, how would DBH go about responding to the situation?

Response: DBH's CRT responds to emergency calls for psychiatric evaluation or support twenty-four (24) hours a day, seven (7) days a week both with and without co-responders from the Metropolitan Police Department (MPD). DBH also operates a call center known as the Access Help Line (1-888-7WE-HELP) that is open twenty-four (24) hours per day, seven (7) days per week to provide crisis counseling and linkage to the provider network. Finally, DBH trains MPD officers in Crisis Intervention Training, the national best practice model, so that officers may become certified Crisis Intervention Officers (CIO) and can be deployed to 911 calls where there is a suspected psychiatric component. CIO officers respond across precincts, are trained to recognize signs and symptoms of mental illness and to use specialized communication and de-escalation strategies.

Question 7: If additional resources (monetary or personnel) were available to DBH what would be your priorities in deploying them?

Response: DBH's priorities include:

1. Providing consumers additional housing resources;
2. Better care coordination to assure continuous access to high quality behavioral health services in the community, including support for medication adherence to reduce relapse and recidivism,
3. Universal CIO training for all MPD officers;
4. Expanded diversion efforts across all points along the sequential intercept;
5. A Mobile Psychiatric van for each ward; and
6. Scheduled transportation at the shelters to certain CSAs.

Please let me know if you have any questions. I can be reached at richard.bebout1@dc.gov.

Regards,

Richard R. Bebout

Richard Bebout, Ph.D.
Deputy Director, Adult Services

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GLOSSARY of ACRONYMS, ENTITIES and TERMS

Acronym, Entity, Terms	Url - Description
ACT: Assertive Community Treatment	https://dbh.dc.gov/sites/default/files/dc/sites/dmbh/publication/attachments/TL130.pdf
AUSA: Assistant U.S. Attorney	https://www.justice.gov/usao-dc
BOP: Bureau of Prisons, Bureau	https://www.bop.gov/
CIT: Crisis Intervention Team	https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs
CSAs: Core Service Agencies	https://dbh.dc.gov/page/list-community-based-service-providers
CSOSA: Court Services and Offender Supervision Agency	https://www.csosa.gov/
CTF: Correctional Treatment Facility	https://doc.dc.gov/page/correctional-facilities
DBH: DC Department of Behavioral Health	https://dbh.dc.gov/
DESC: Downtown Emergency Service Center, Seattle, WA	https://www.desc.org/
DHS: DC Department of Health Services	https://dhs.dc.gov/
FICM: Forensic Intensive Case Management	https://eac-network.org/forensic-intensive-case-management/
Georgetown University: Prisons and Justice Initiative Programs	https://prisonsandjustice.georgetown.edu/about/#
LICSW: Licensed Clinical Social Worker	https://www.humanservices.edu.org/licensed-clinical-social-worker-licsw.html
MHCC: DC Mental Health Community Court, Mental Health Court, Court	https://www.dccourts.gov/sites/default/files/matters-docs/MentalHealthCommunityCourtCaseManagementPlan.pdf
NACo: National Association for Counties	https://www.naco.org/
PAD: Pre-Arrest Diversion - program teams at DBH	https://saferstronger.dc.gov/sites/default/files/u23/DC%20Pre-Arrest%20Diversion%20Pilot%20Overview%20FINAL.PDF
Pivot Program, Prisons and Justice Initiative Programs of Georgetown University	https://pivot.georgetown.edu/program/
Prisons Scholars Program at the DC Jail, Prisons and Justice Initiative Programs of Georgetown University	https://prisonsandjustice.georgetown.edu/programs/scholarsprogram/#
PSA: Pretrial Services Agency, Pretrial	https://www.psa.gov/
PSO: Pretrial Services Agency Officer	https://www.psa.gov/?q=opportunities/prospective_employees Supervision officer employed by PSA to monitor participants in the DC Mental Health Community Court
PDSDC, PDS: Public Defender Services of DC	https://www.pdsdc.org/
PRCC: Psychosocial Rehabilitation and Recovery Center	https://www.veteranshealthlibrary.va.gov/MentalHealth/Recovery/142_41682_VA
SSU: Specialized Supervision Unit of the Pretrial Services Agency.	https://www.psa.gov/?q=programs/defendant_supervision Clients are required to be screened by SSU before being placed in the DC Mental Health Community Court
The ARC of DC	https://arcdc.net/
UCC: Urgent Care Clinic	https://www.dccourts.gov/press-releases/mental-health-urgent-care-clinic-opens-courtthouse Located in DC Superior Court and run by Pathways to Housing DC, through a contract with DC Department of Behavioral Health
VI-SPADAT: Vulnerability Index-Service Prioritization Decision Assistance Tool	VI-SPADAT:https://cchealth.org/h3/coe/pdf/2014-0521-packet-2.pdf Survey administered to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of becoming homeless persons.

**District of Columbia Advisory Committee to the
U.S. Commission on Civil Rights**



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