The Sequential Intercept Model (SIM) with a Focus on Mental Health Courts

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About Policy Research Associates, Inc.

- A national leader in behavioral health technical assistance and research, Policy Research Associates, Inc. (PRA) is a Women-Owned Small Business that was founded in 1987.
- In partnership with our sister non-profit, Policy Research, Inc. (PRI), we offer four core services: policy, research, technical assistance, and training.
- Through our work, we enhance systems that assist individuals with behavioral health needs on their journey to recovery.
- Home to SAMHSA's GAINS Center

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What is the Sequential Intercept Model – the SIM?

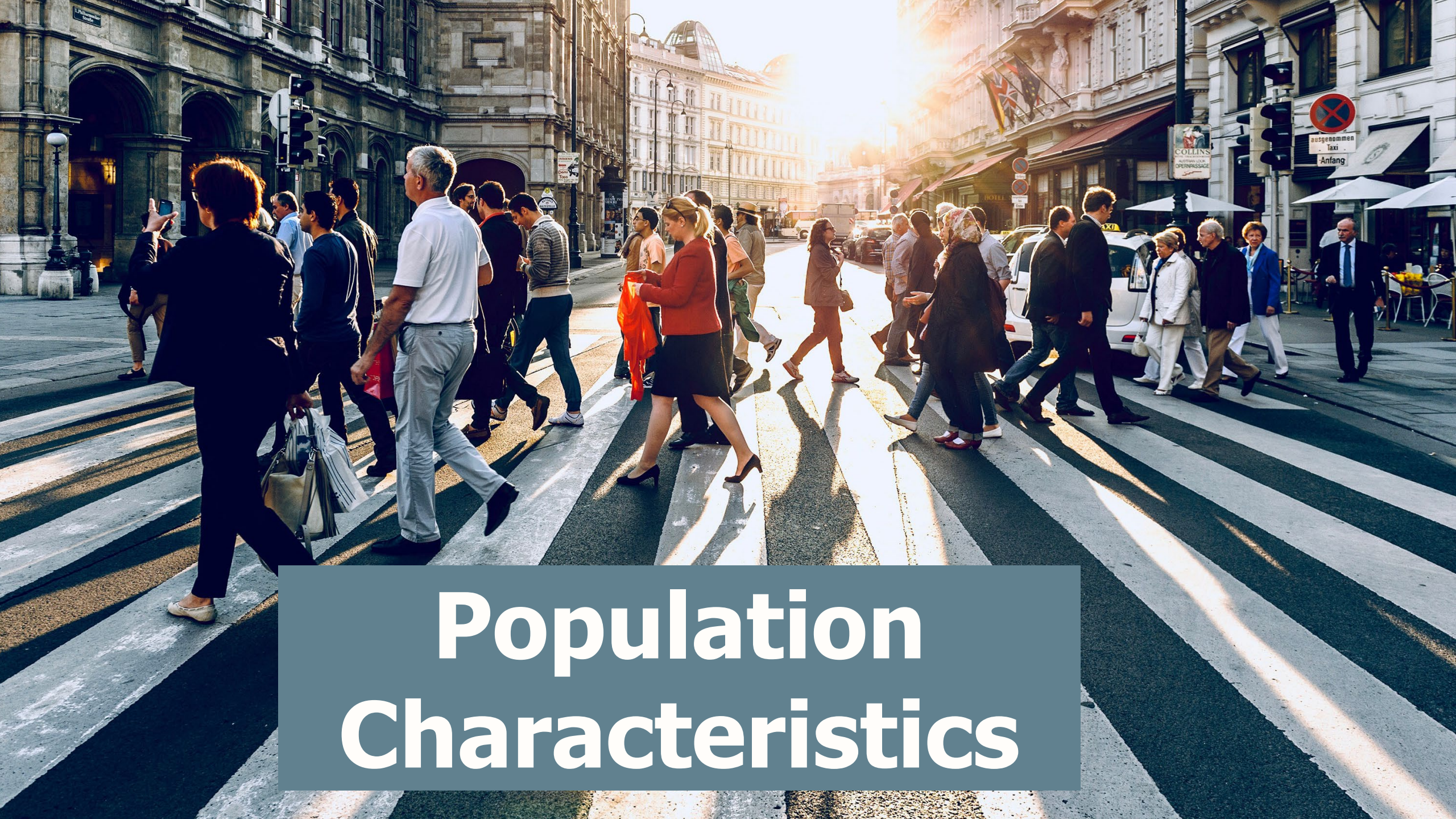
SIM Tasks

1. **Collaborate** Across Systems
2. **Map** the Local System
3. Agree on **Priorities**
4. Develop an **Action Plan**

- Men and women with…
  - Serious mental illness, trauma, and often
  - Co-occurring substance use disorders
  - Involved with the criminal justice system OR at risk of involvement

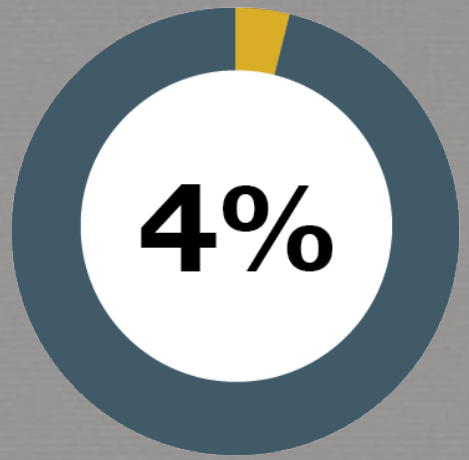
Goals

- Promote and support **recovery**
- Provide **safety**, quality of life for all
- Keep people out of jail, in **treatment**
- Provide **constitutionally adequate** treatment in jail
- Link to comprehensive, appropriate, and integrated **community-based services**

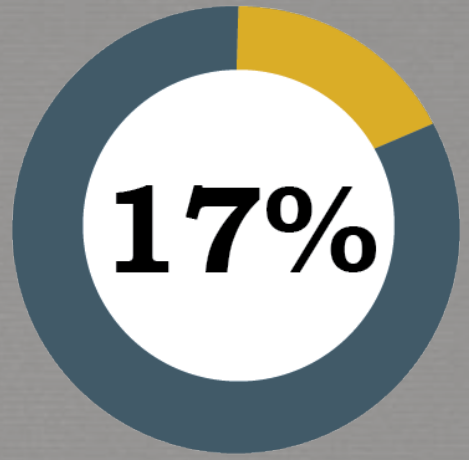


Population Characteristics

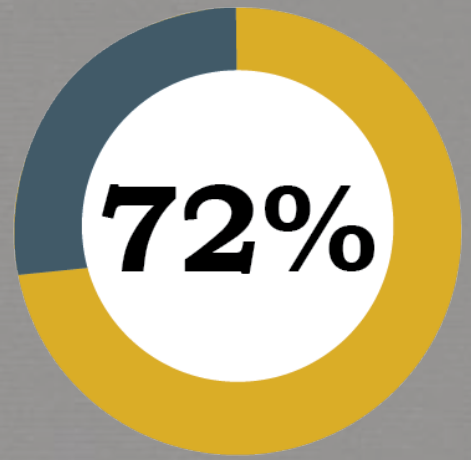
Jails and Mental Disorders



of the **general population** have SMI



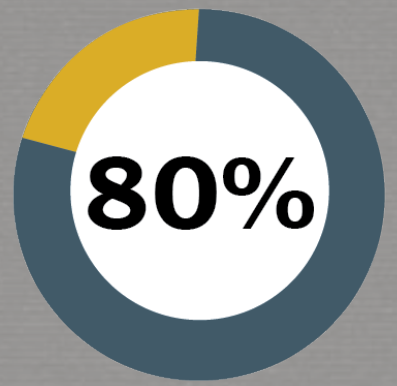
of **jail inmates** have SMI



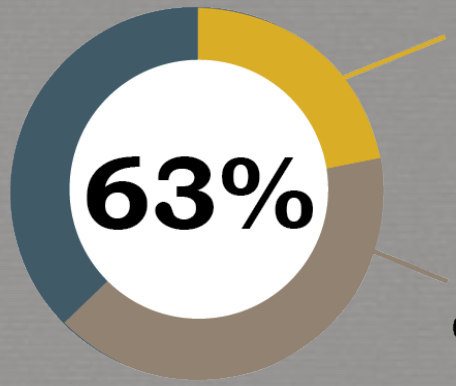
of those in jail with SMI have a **co-occurring disorder**

Sources: Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1990
Teplin, Abram, & McClelland, 1996; Abram, Teplin, & McClelland, 2003

Jails and Substance Use Disorders



of **arrestees** tested positive for a drug



of jail inmates have a **substance use disorder**

Only **1 in 5** inmates receive drug treatment while incarcerated

Sources: Arrestee Drug Abuse Monitoring, 2013; Bronson, Zimmer, & Berzofsky, 2017; Wilson, Draine, Hadley, Metraux, & Evans, 2011

Prevalence of Trauma

Trauma and the Justice System

Any Physical or Sexual Abuse
(N=2,122)

	Lifetime	Current
Female	95.5%	73.9%
Male	88.6%	86.1%
Total	92.2%	79.0%

Source: Policy Research Associates. (2011). *Targeted Capacity Expansion for Jail Diversion Programs: Final Evaluation Report.* Delmar, NY: PRA

Racial Disparities Exist Across Systems

- Racism is a serious threat to the public's health (CDC, 2021)
- Minority groups are less likely to receive mental health services (Agency for Healthcare Research and Quality, 2016)
- Disparities in treatment access and availability of culturally-competent treatment (Kugelmass, 2016)
- Higher arrest rates and disparities in referrals to diversion programs (Fielding-Miller, Davidson, & Raj, 2016)
- Higher prevalence of pretrial incarceration and higher bail amounts set (Sawyer, 2019)
- Lower rates of admission to drug courts; lower graduation from drug court (Nicosia, MacDonald, & Arkes, 2013; Gallagher, 2013)
- More likely to have probation revoked (Jannetta, Breaux, & Ho, 2014)


Improve integrated service delivery by promoting
collaboration

Challenges to Collaboration

Funding silos

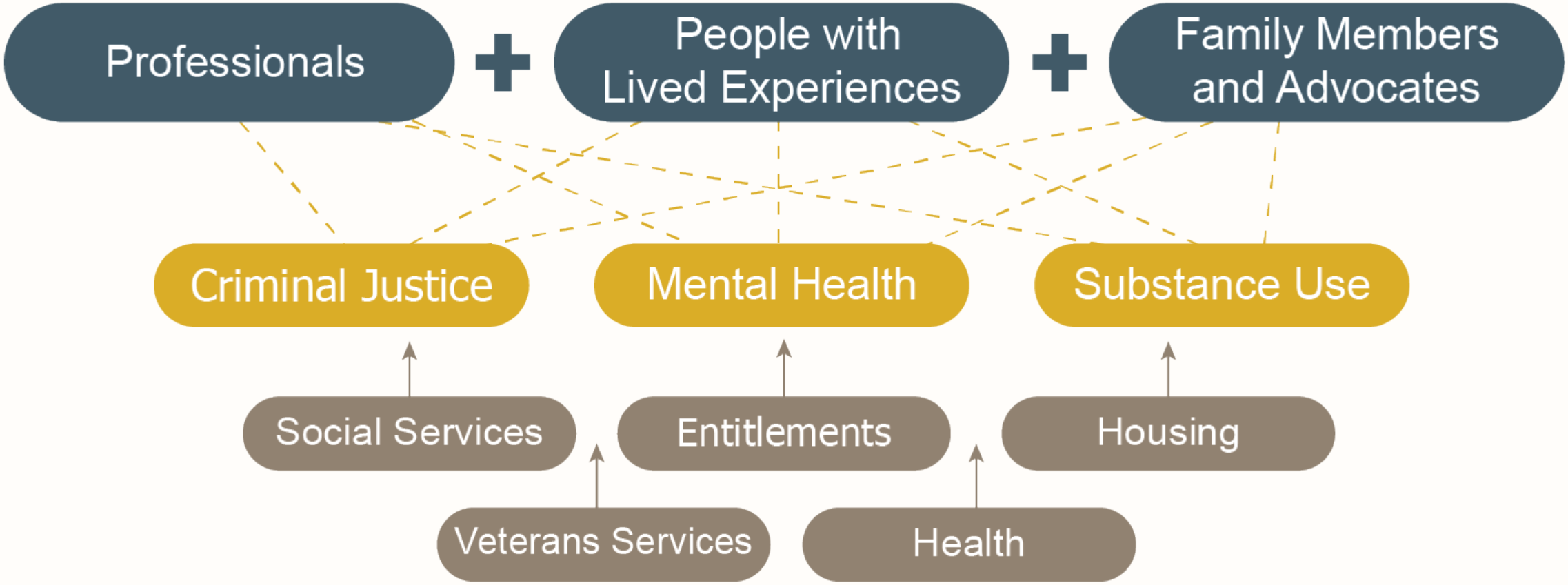
Limited resources create a competitive and/or protective environment

System cultures

Enhancing Collaboration

- Cross-training
- Interagency agreements
  - Coordinate services
  - Communicate
  - Share data/information
  - Build partnerships
- Success involves:
  - Task forces
  - People with lived experiences
  - Boundary spanners/ champions

TASK FORCE COLLABORATION



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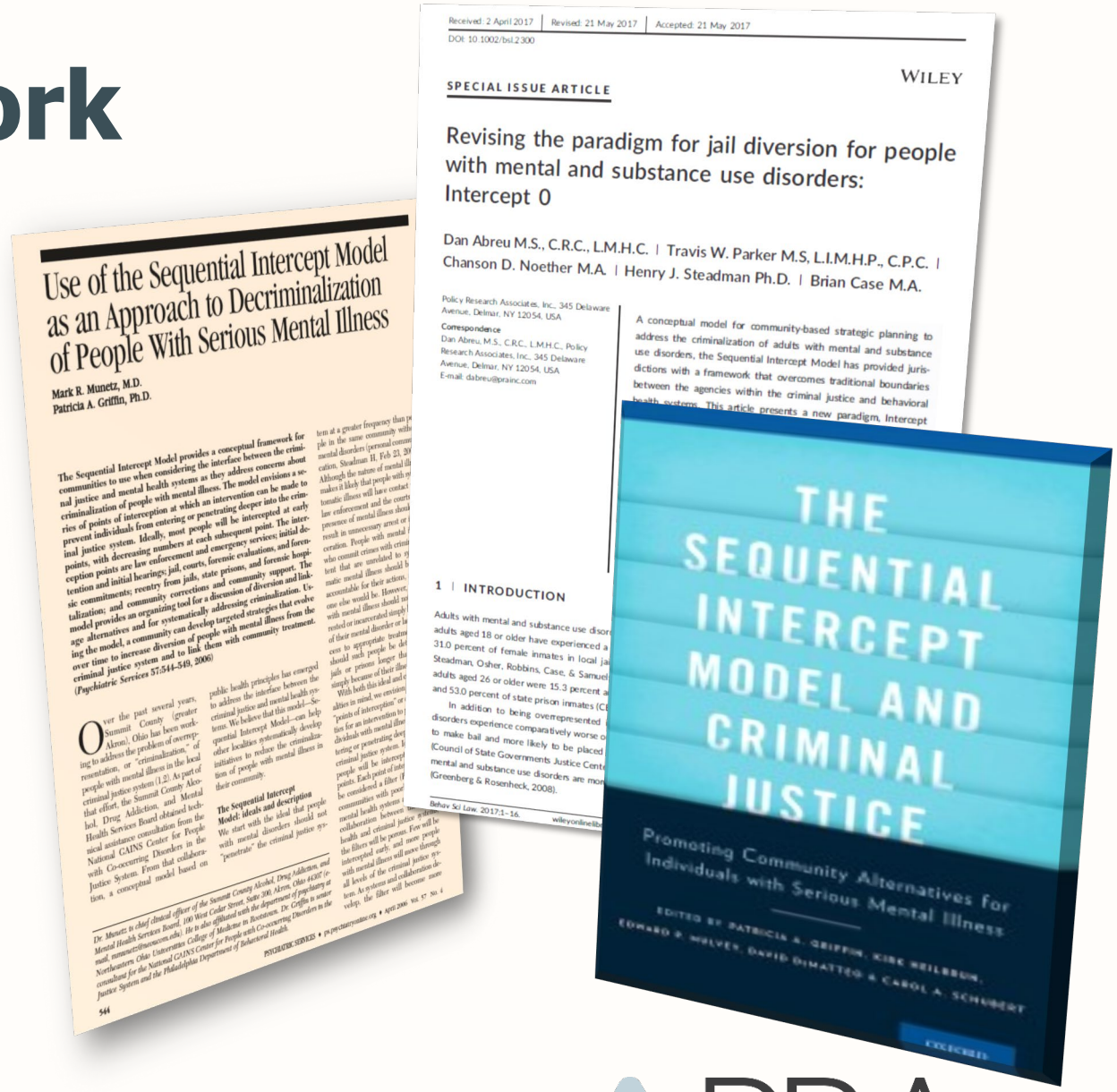
Conceptual Framework

- A conceptual framework for communities
- For considering interface between criminal justice and behavioral health systems
- An organizing tool



Munetz & Griffin 2006; Abreu, Parker, Noether, Steadman, & Case, 2017; Griffin, et al, eds. 2015

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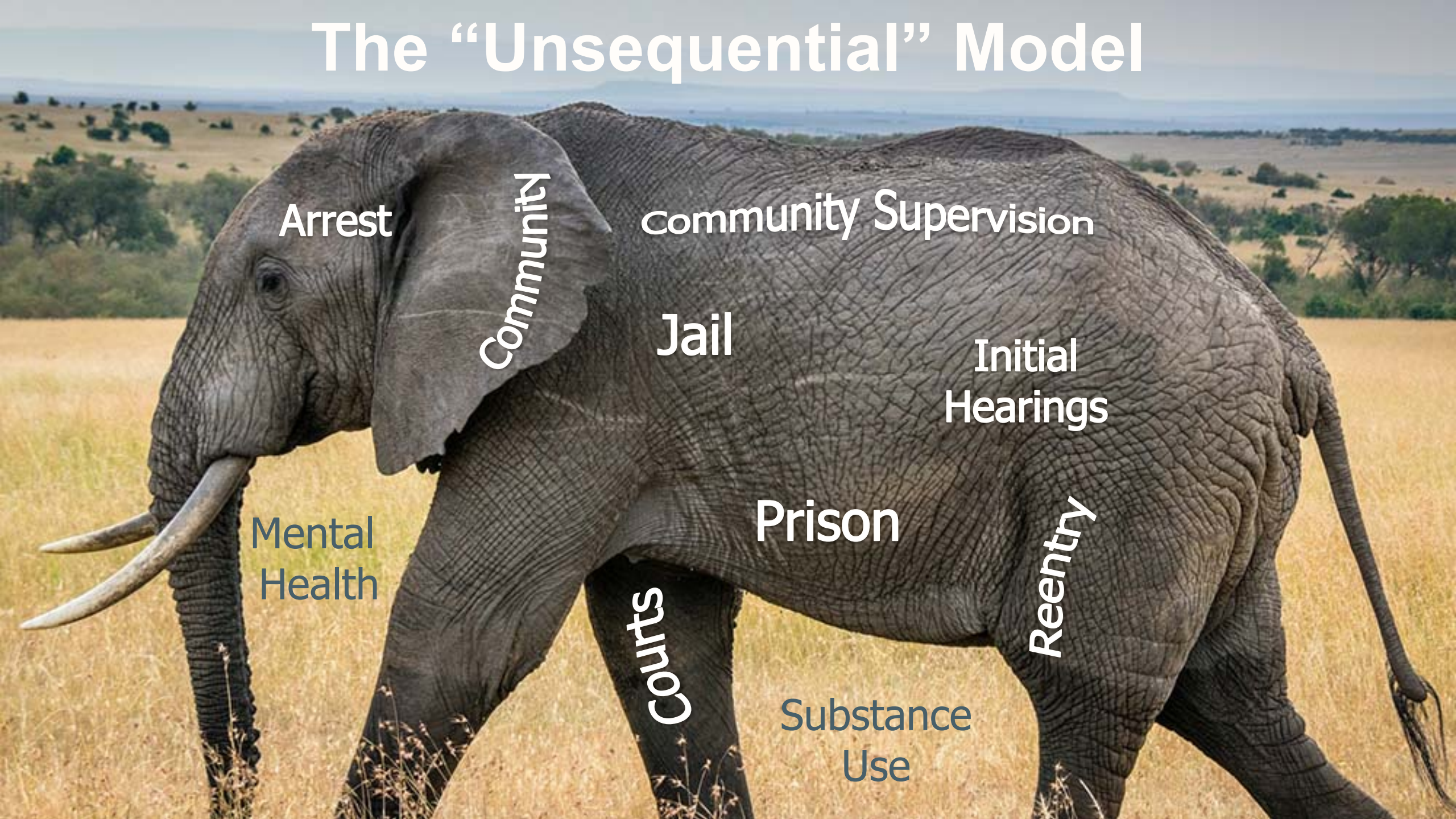
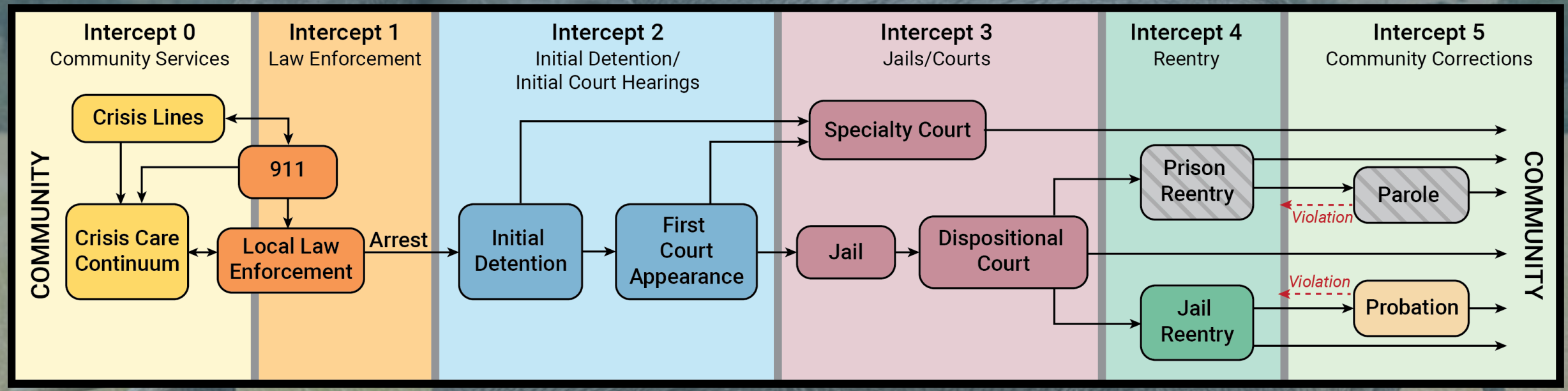
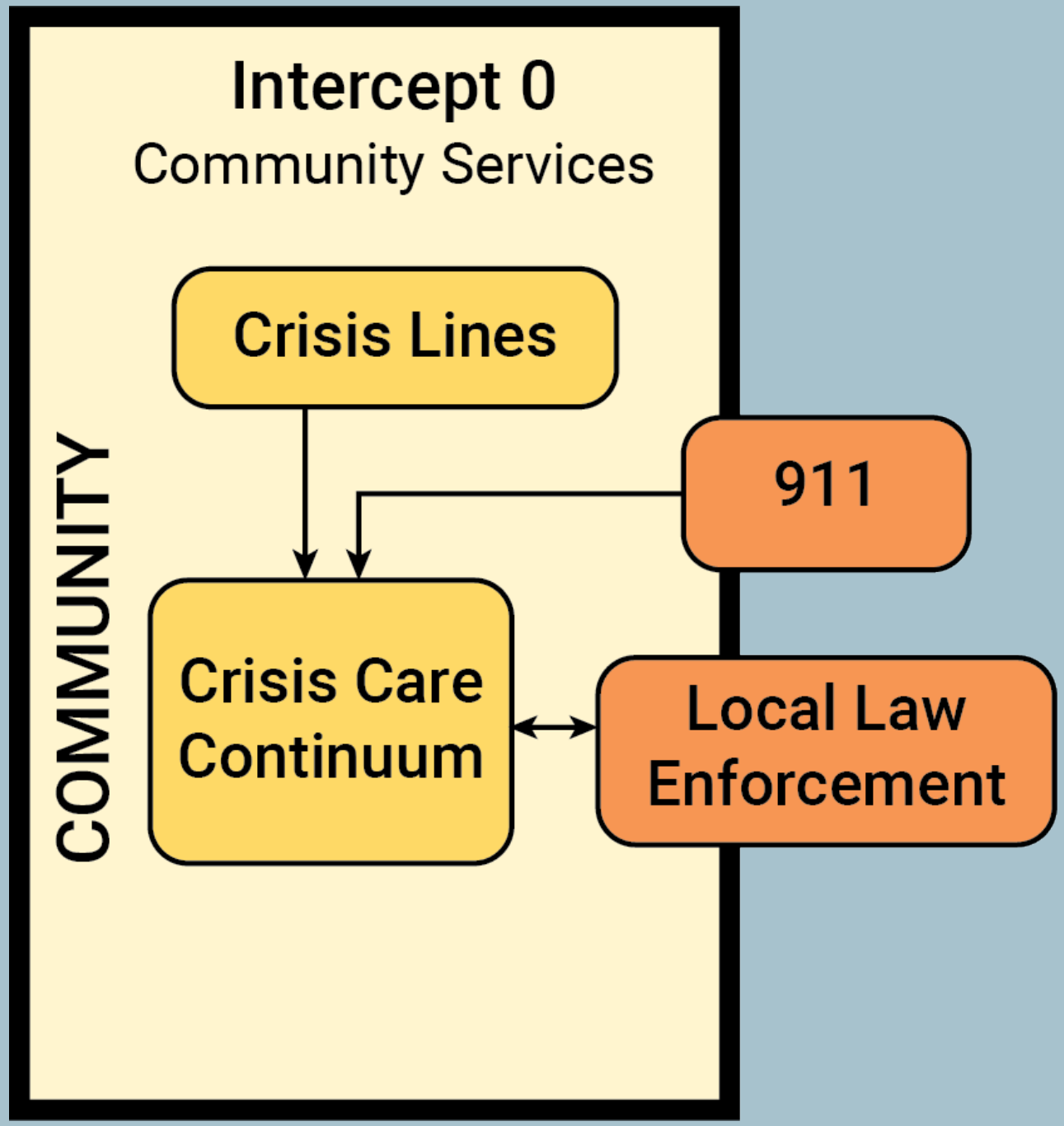
The "Unsequential" Model



Sequential Intercept Model

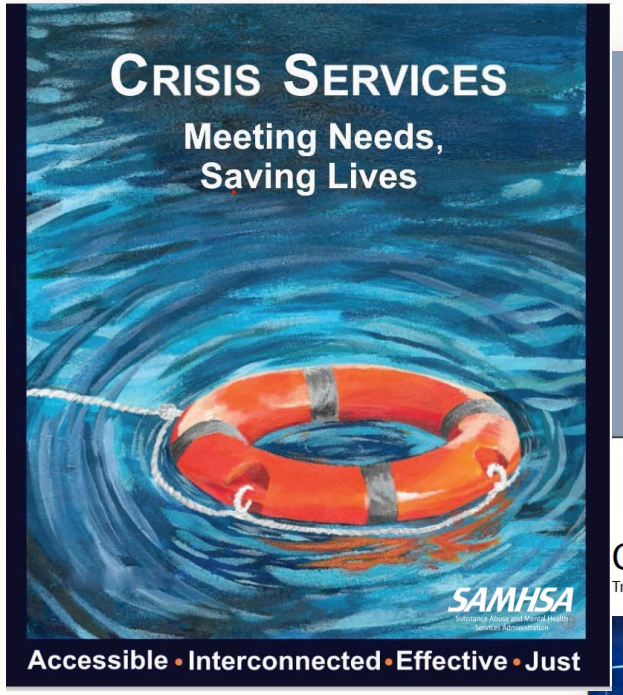


Intercept 0
Community
Services

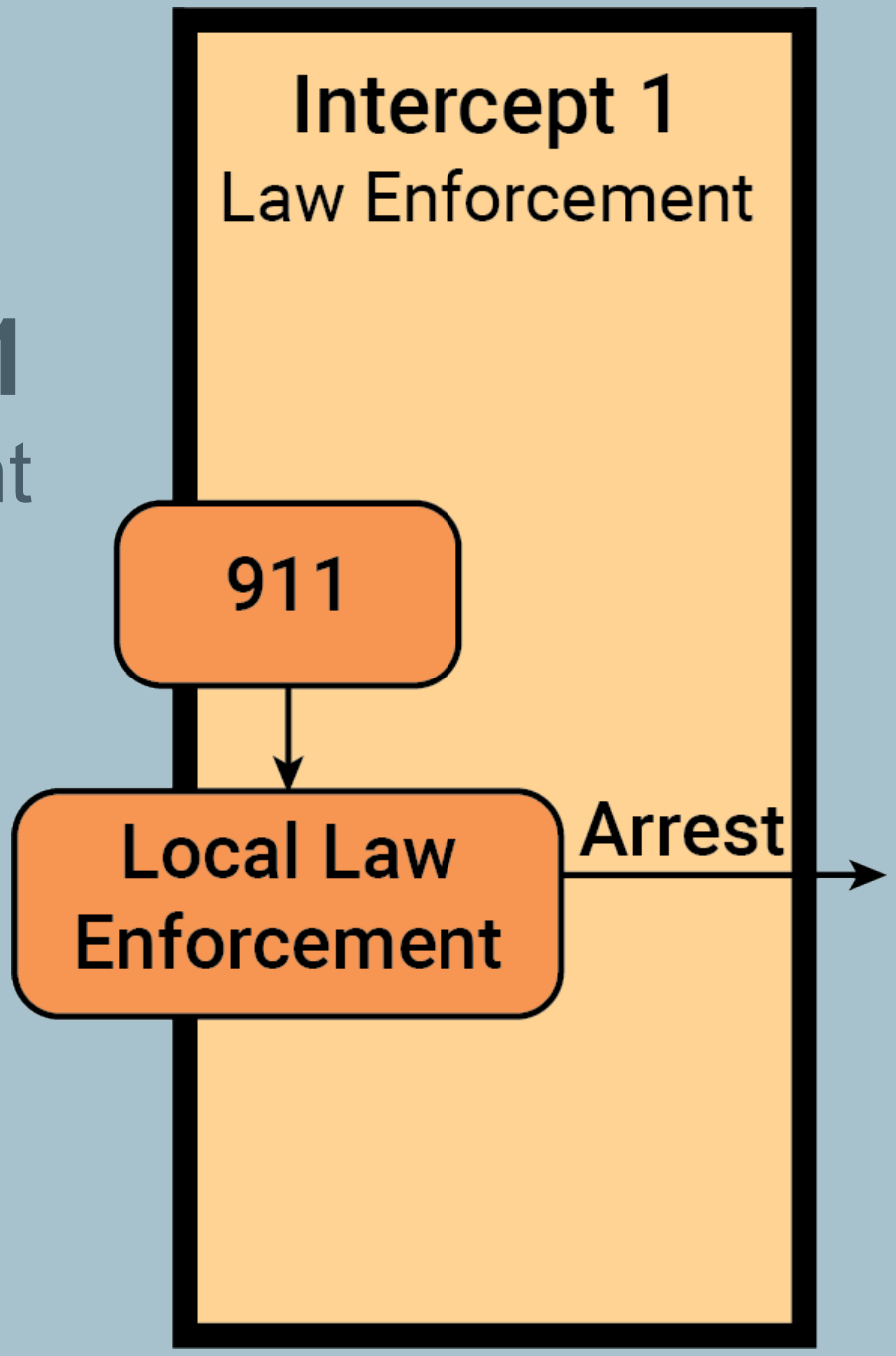


Crisis to Stabilization Care Continuum

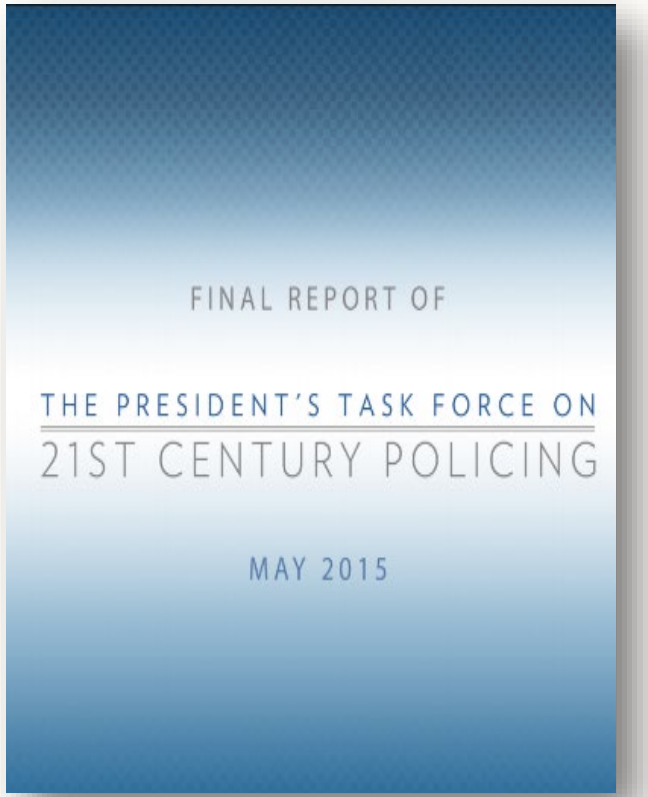
- Mobile Crisis Outreach/Police co-response
- 24/7 Walk-in/Urgent Care w/connectivity
- ER Diversion and Peer Support/Navigators
- Crisis Stabilization – 16 beds, 3-5 days
- Crisis Residential – 18 beds, 10-14 days
- Crisis Respite – Apartment-style 30 days
- Transition Residential – Apartment-style 90 days
- Peer Respite Residential
- Critical Time Intervention: up to 9 months



Intercept 1
Law Enforcement



LE Roles: Warrior vs. Guardian



- Focus on preventative policing: "Absence of crime is not the final goal of law enforcement. Rather, it is the promotion of and protection of public safety while respecting the dignity and rights of all."
- "Least harm" approach by all, not just specialized units

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9-1-1: Asking Specifically About BH?

- Does this call involve anyone with mental health issues?
  - If **No**, proceed with call-slip processing
- If **Yes**, the following questions are to be asked and the responses added to the call-slip:
  - Does the individual appear to pose a danger to him/herself or others?
  - Does the person possess or have access to weapons?
  - Are you aware of the person's MH or SA history?

9-8-8 Hotline Implementation

- July 2020: nationwide 3-digit number adopted for MH, substance use, and suicide crisis
- By July 2022: all carriers must direct 988 calls the National Suicide Prevention Lifeline
- Coordination, infrastructure, and funding are necessary

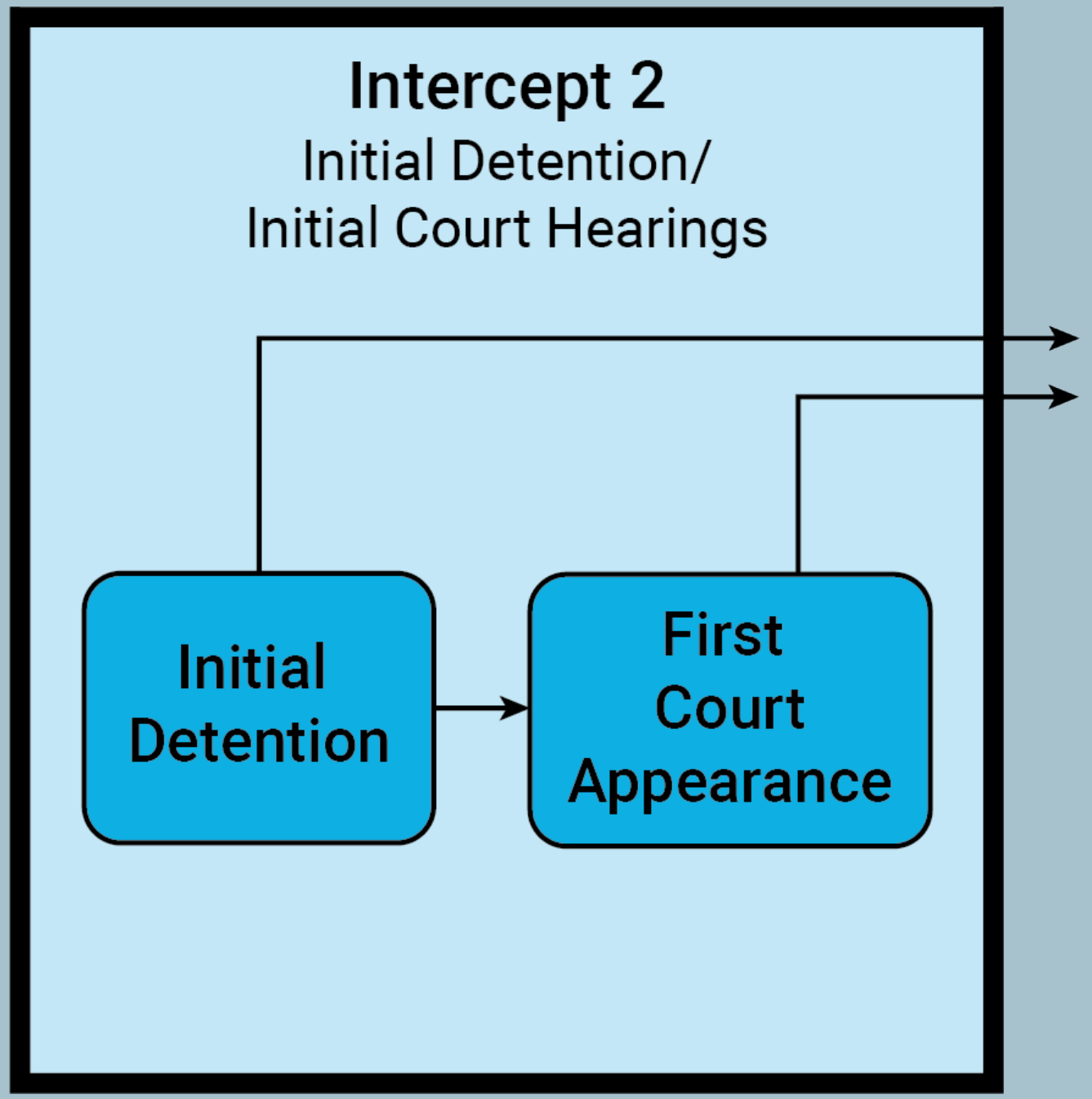
Law Enforcement/Emergency Services Models

- **Crisis Intervention Teams (CIT)**
  - Community partnership
  - 40-hour training
  - Accessible, responsive crisis care system
- **Off-site support**
  - Telephone support to on scene officers (Hawaii, Fort Worth)
  - Video conference support to on scene officers (Lincoln, NE, Springfield, MO)
- **Mobile mental health crisis teams (MCT)**
- **Specialized EMS Response**
  - Ambulance/Fire specialized MH training/co-response (Atlanta, Wake Co, NC, Denver)
- **Co-Responder Model**
  - Mental health professionals employed by, or working along side LE
    - LAPD MEU: CAMP, SMART; Triage Unit
    - Early Diversion: Boulder; Knoxville
    - Houston PD MH Division
    - Pima County MHIST
    - Spokane & Yakima Counties WA

Reimagining Response

- Atlanta 911 call analysis = 311 referral line for quality of life concerns
- Policing Alternatives & Diversion (PAD) Harm Reduction teams (similar analysis in MI, CT, MN, LA, OR, CA, WA, & AZ cities, CFAP, 2020)
- Eugene OR: CAHOOTS, pairs mental health clinician & paramedic
- San Francisco: Fire Dept. paramedic, psychologist/social worker, & peer specialist mobile teams for MH calls
- Tompkins Co, NY: unarmed, civilian-led Dept. of Community Solutions and Public Safety for non-violent call types
- Albuquerque: new Community Safety Department as 3rd dispatch option (social workers, peers, clinicians, etc.)

Intercept 2
Initial Detention/
Initial Court Hearings/
Pre-trial



Importance of Intercept 2 Diversion

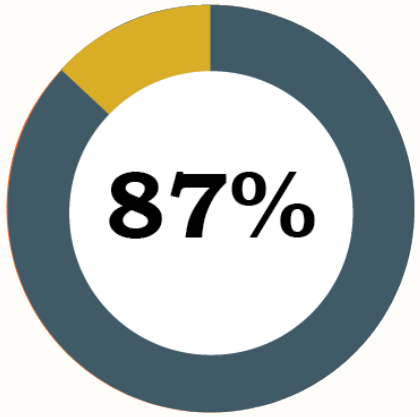
2013 study of pretrial detention in Kentucky (N=155,000)

- When held **2-3 days**, low-risk defendants **40% more likely** to commit crimes before trial
- When held **8-14 days**, low-risk defendants are **51% more likely** to commit crimes 2 years after case disposition

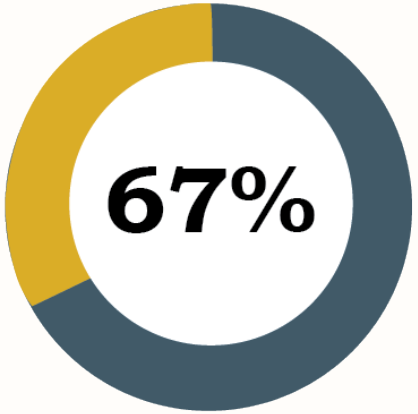
*Detention of **low** and **moderate-risk** defendants increases their rates of new crimes*

Source: Lowenkamp, Van Norstand, & Holsinger 2013

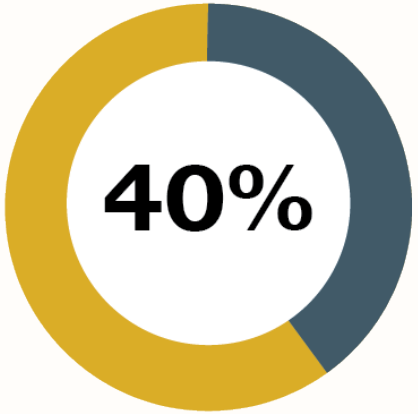
NACo Analysis of Jail Populations



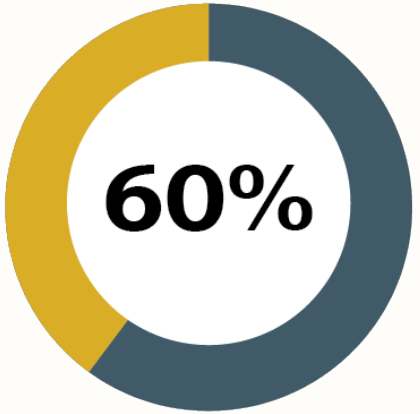
of jails are owned by **counties**



of confined jail population is **pretrial**



of jails use a **risk assessment**



of jail population **assessed "low risk"** among jails that use risk assessments

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Identification and Referral

Systems	Strategies
Law enforcement	Law enforcement observations
Pretrial services	Validated risk-based screening/ assessment
Booking officers	Inmate identification and classification
Jail medical staff	Medical/BH current & future needs
Prosecutors	Charging and initial diversion options
Public defenders	Identify potential options
Judges	Weighing risk and options

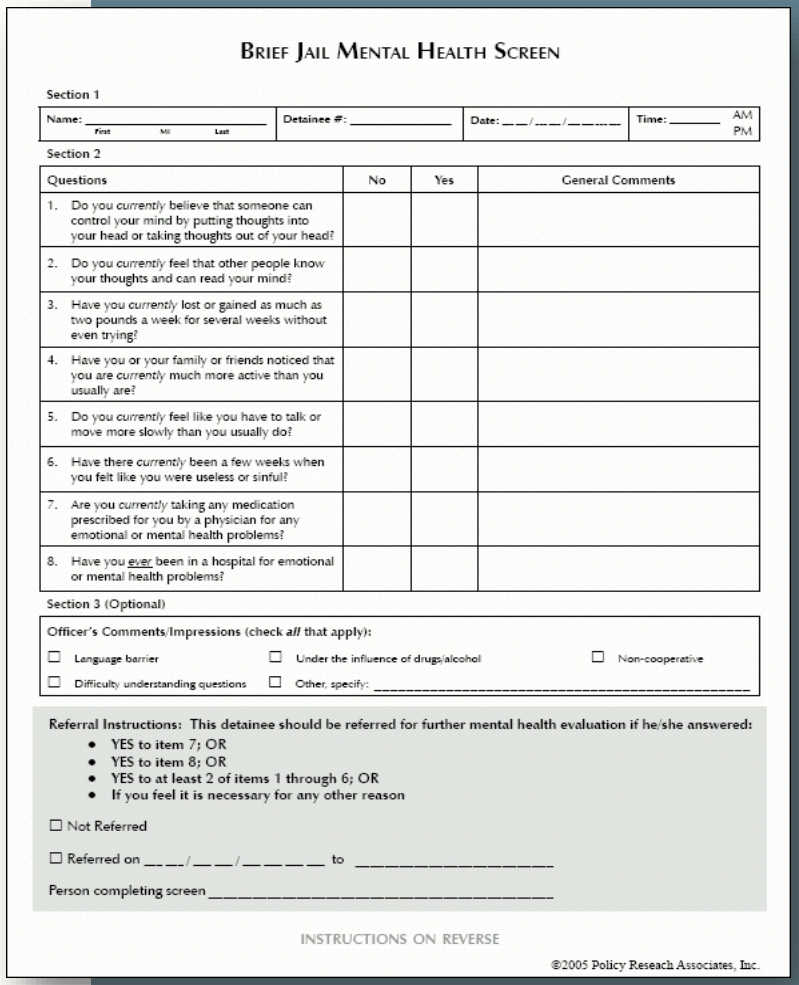
Goal:
Balancing public safety, personal rights, and appropriate use of jail

Sample Mental Health Screens

- Brief Jail Mental Health Screen (BJMHS)
  - Designed for correctional officers to administer at booking
- Correctional Mental Health Screen (CMHS)
  - Separate versions for male and female inmates
- Mental Health Screening Form III (MHSF-III)
  - Designed for people being admitted into substance use treatment

Brief Jail Mental Health Screen

- 3 minutes at booking by CO
- 8 yes/no questions
- General, not specific mental illness
- Referral rate: 11%
  - Men: 73%
  - Women: 61%



BRIEF JAIL MENTAL HEALTH SCREEN

Section 1

Name: (First / MI / Last)	Detainee #:	Date: __ __ / __ __ / __ __ __ __	Time: ____ AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you *ever* been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

☐ Not Referred

☐ Referred on __ __ / __ __ / __ __ __ __ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

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Sample Substance Use Screens

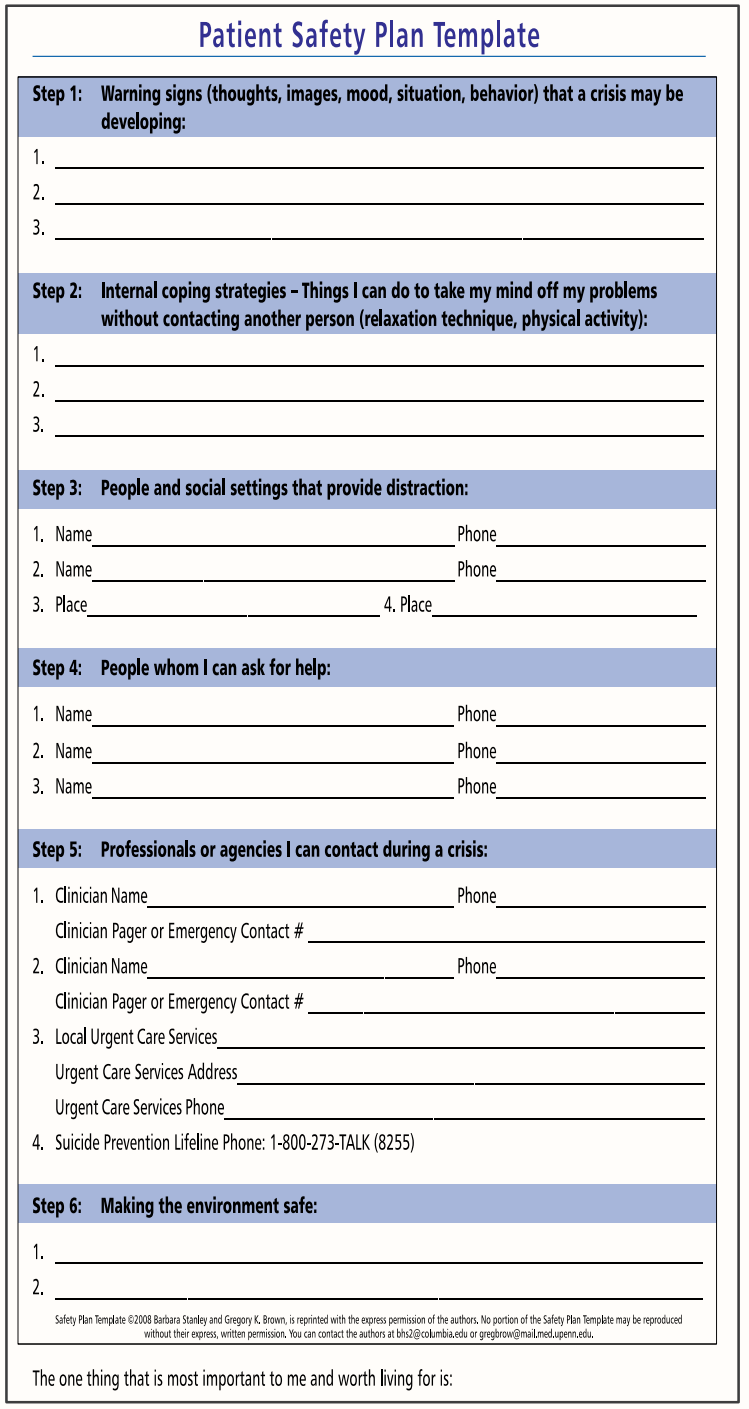
- Texas Christian University Drug Screen-V (TCUDS)
  - Past 12-month use based on DSM-V criteria; 17 items
  - Consider combining with the AUDIT for alcohol use

- Simple Screening Instrument for Substance Abuse (SSI-SA)
  - Past 6-month alcohol and drug use; 16 items
  - Considering combining with the AUDIT for alcohol use

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
  - Screens for lifetime use, current use, severity of use, and risk of IV use. Available from the World Health Organization and NIDA

Suicide Prevention Screening

- Safety Planning
  - Warning signs
  - Coping strategies
  - Identify social supports
  - Link to MH care
  - Minimize barriers to treatment
  - Remove access to means
- 1-hour brief intervention



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

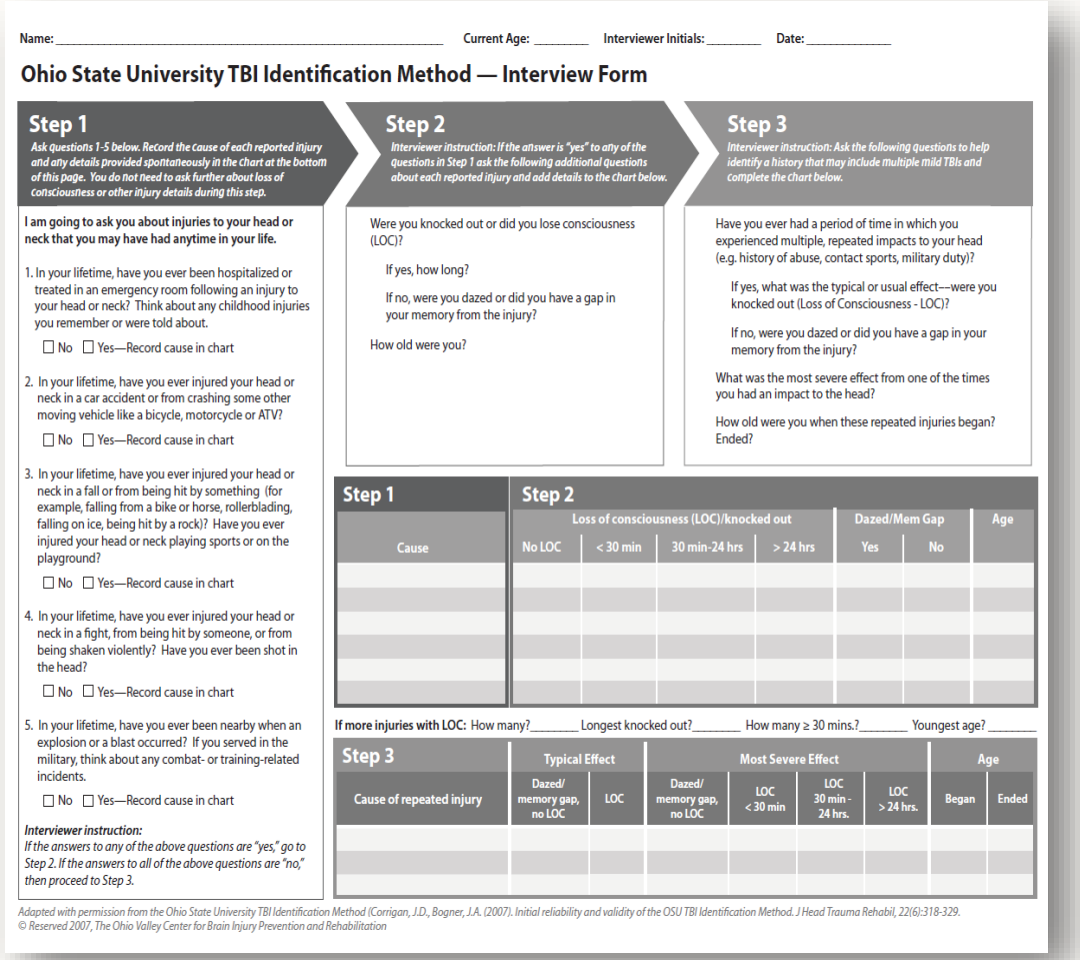
1. _____
2. _____

The one thing that is most important to me and worth living for is:

Traumatic Brain Injury (TBI) Screening

In your lifetime, have you ever…

1. Been hospitalized or treated in an emergency room following an injury to your head or neck?
2. Injured your head or neck in a car accident or from crashing some other moving vehicle, like a bicycle, motorcycle, or ATV?
3. Injured your fall or from being hit by something?
4. Injured your head or neck in a fight, from being hit by someone, or from being shaken violently?
5. Been nearby when an explosion or blast occurred?



Name: _____ Current Age: _____ Interviewer Initials: _____ Date: _____

Ohio State University TBI Identification Method — Interview Form

Step 1

Ask questions 1-5 below. Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.

I am going to ask you about injuries to your head or neck that you may have had anytime in your life.

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
   ☐ No ☐ Yes—Record cause in chart
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
   ☐ No ☐ Yes—Record cause in chart
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
   ☐ No ☐ Yes—Record cause in chart
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
   ☐ No ☐ Yes—Record cause in chart
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
   ☐ No ☐ Yes—Record cause in chart

Interviewer instruction:
If the answers to any of the above questions are "yes," go to Step 2. If the answers to all of the above questions are "no," then proceed to Step 3.

Step 2

Interviewer instruction: If the answer is "yes" to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart below.

Were you knocked out or did you lose consciousness (LOC)?

If yes, how long?

If no, were you dazed or did you have a gap in your memory from the injury?

How old were you?

Step 3

Interviewer instruction: Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

If yes, what was the typical or usual effect—were you knocked out (Loss of Consciousness - LOC)?

If no, were you dazed or did you have a gap in your memory from the injury?

What was the most severe effect from one of the times you had an impact to the head?

How old were you when these repeated injuries began? Ended?

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Adapted with permission from the Ohio State University TBI Identification Method (Corrigan, J.D., Bogner, J.A. (2007). Initial reliability and validity of the OSU TBI Identification Method. J Head Trauma Rehabil, 22(6):318-329.
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Identification and Referral of Veterans

Veterans Reentry Search Service (VRSS)

VA's web-based system to allow prison, jail, and court staff to quickly and accurately identify Veterans among their inmate populations

https://vrss.va.gov/

Veteran Justice Outreach (VJO) Program

Site Specific Info

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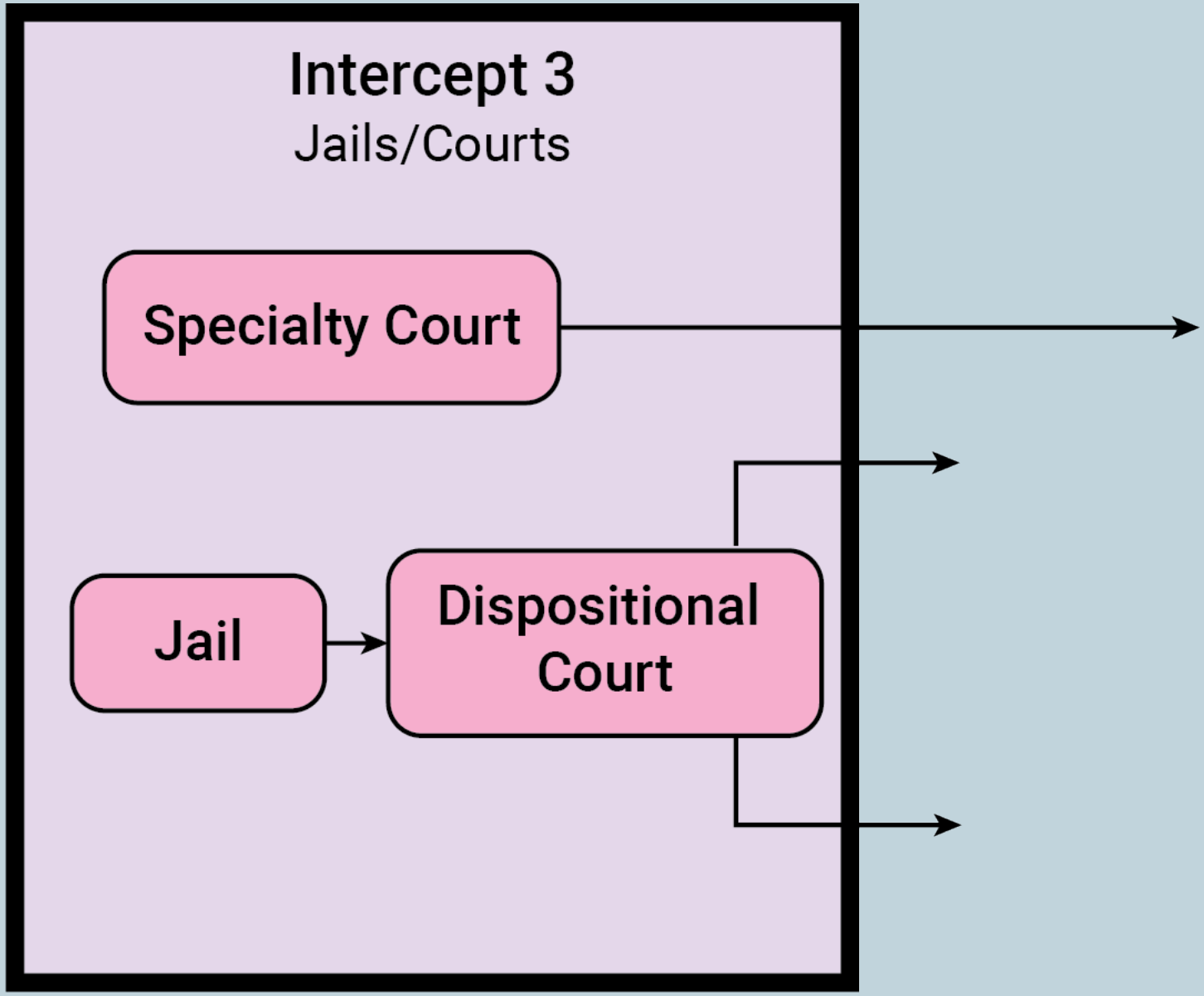
Intercept 3

Jails/Courts



Jails and Courts

- In-Jail Services
  - Assessment of in-custody needs
  - Access to medications, MH services, and SU services
  - Communication with community-based providers

- Specialty/Treatment Courts
  - Drug/DUI courts, mental health courts, veterans court, DV, Tribal Wellness courts, reentry courts, etc.

Using Criminal Charges as Treatment Leverage

- Pre-plea: diversion to services in lieu of further case processing
- Post-plea: deferred or modified sentence, often to treatment court
- Probation-based: conviction with treatment as term of probation

Adult Treatment Courts in U.S.

Adult Treatment Courts	
Drug Court	1,729
DWI/DUI Court	286
Drug/DUI Hybrid Court	312
COD Court	69
Family Drug Treatment Court	318
Veterans Treatment Court	473
Mental Health Court	533
Tribal Healing to Wellness Court	138
Re-entry Court	65

Juvenile Tx Cts	
Drug Court	309
COD	11
MH/Wellness	43
Other	26

Sources: ndcrc.org; samhsa.gov/gains-center

Minnesota Treatment Courts

Adult Drug Court	20
Drug/Driving While Intoxicated (DWI) Hybrid	17
Drug/DWI/Family Dependence Hybrid	1
Juvenile Drug Court	1
Family Dependency Treatment Court	3
DWI/DUI	14
Veterans Treatment Court	8
Mental Health Court	4

Source: Minnesota Judicial Branch - Treatment Courts (mncourts.gov)

Consequences Courts May Consider

- Continuity of care
- Housing
- Employment/ Ban the Box
- Child/elder care
- Temporary Assistance for Needy Families
- Food assistance
- Identification

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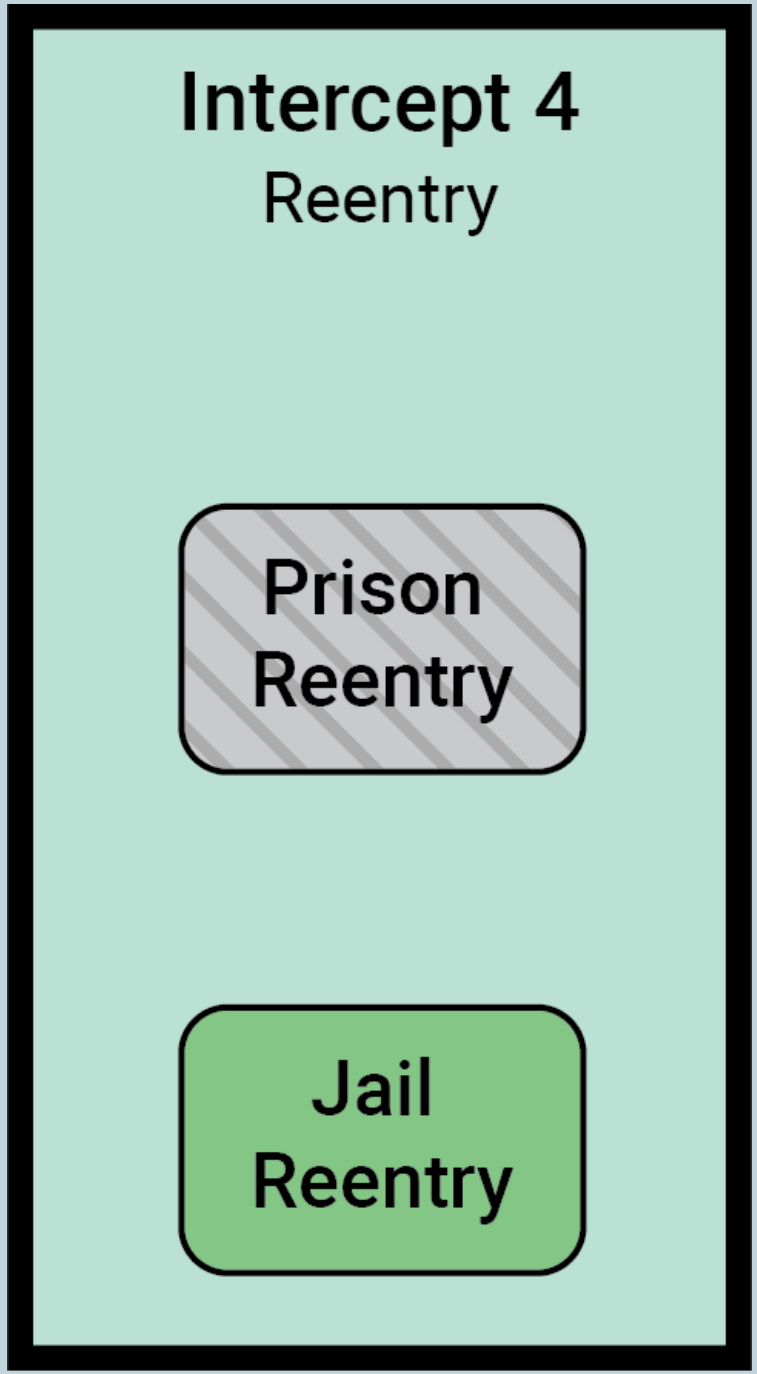
Behavioral Health Treatment Court Lessons

Lessons from 11 jurisdictions working to align the work of multiple treatment courts

- Judicial leadership is key
- Regular meetings and communication with partners
- EBPs take time to implement; communities need a continuum of treatment resources
- Paid peer staff can make a significant impact
- Services and supervision need to account for co-occurring disorders
- Flexibility and individual treatment plan are necessary

Advocates for Human Potential. (2014). *ATCC Final Report.* Sudbury, MA: AHP.

Intercept 4
Reentry



Reentry: A Matter of Life and Death?

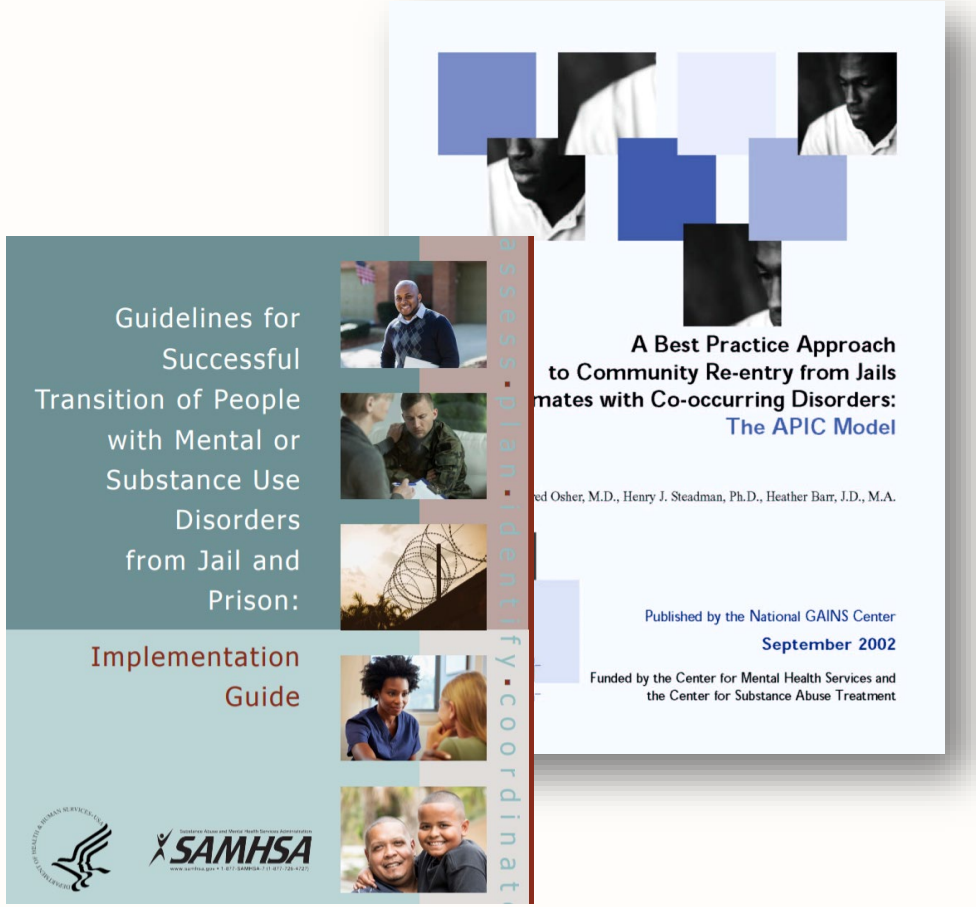
- Study of 30,000 prisoners released in Washington State (2007)
  - 443 died during follow-up period of 1.9 years
    - Death rate 3.5 times higher than general population
  - Primary causes of death
    - Drug overdose (71% of deaths)
    - Other: heart disease, homicide, and suicide
- Consider suicide risk both during and after release
- Post-release opioid-related overdose is the leading cause of death among people released from jails or prisons (2019)

New England Journal of Medicine, 2007; Addiction Science & Clinical Practice, 2019

Facility-to-Community Transition

Reentry Framework

- Reentry should begin at facility entry
- Integrate refer out AND reach in for providers
- Sort the facility population by risk and need. Focus on medium-high risk persons.
- Use a validated risk/need screening tool for criminogenic needs and "check list" for transitional needs
- Focus on addressing stability needs in the first: 24 hours, 1 week, 3 months and 9 months



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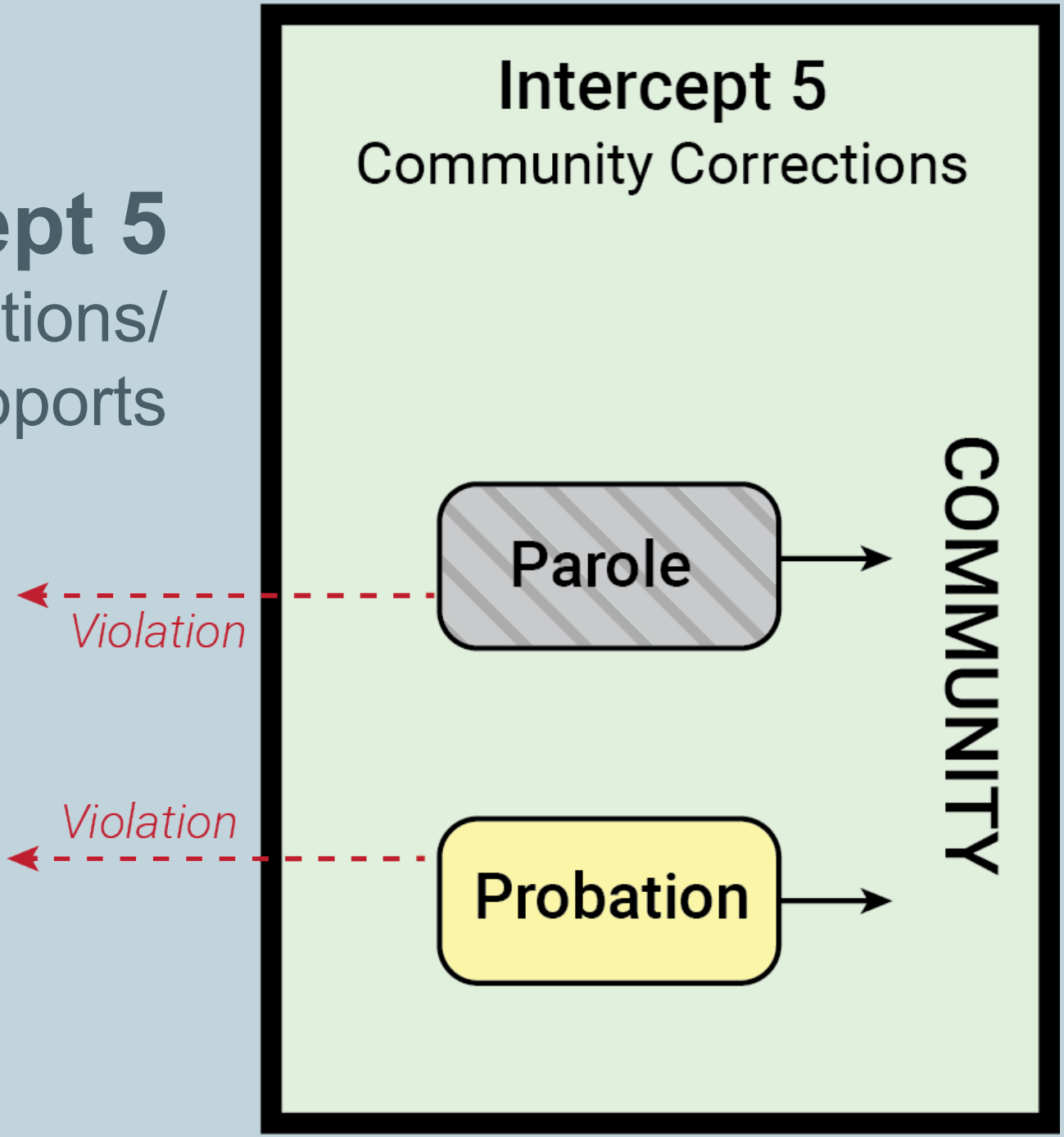
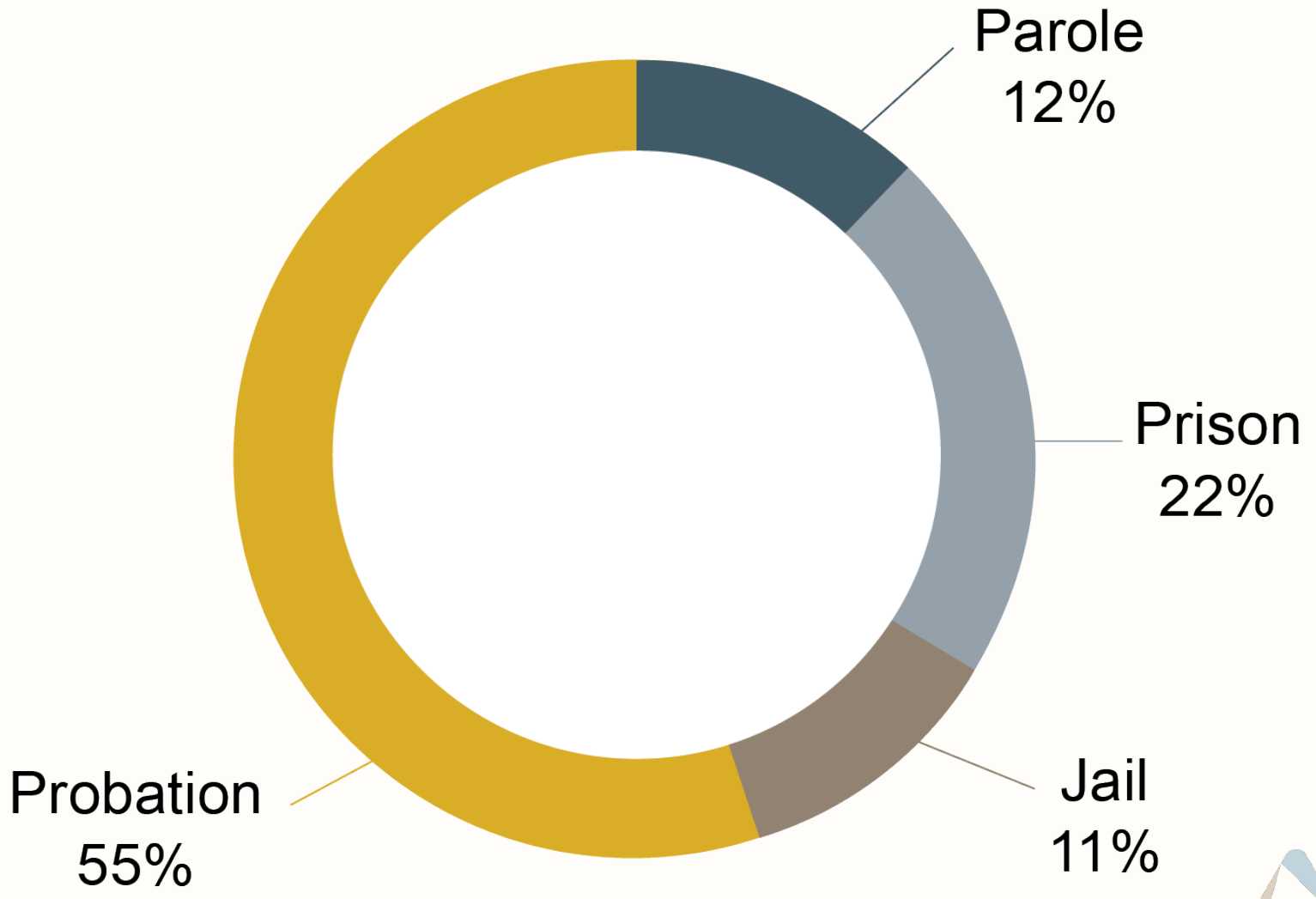
Intercept 5

Community Corrections/ Community Supports



6.9 Million Under Correctional Supervision



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Specialized Caseloads: Promising Practice

- Rely on an effective partnership between supervising probation officers and treatment providers
- Benefits
  - Improves linkage to services
  - Improves functioning
  - Reduces risk of violation- fewer arrests and jail days
  - Cost savings- reduced recidivism and ED/inpatient use
- Probation best practices: validated assessment tools, training for officers, including Motivational Interviewing and building cognitive skills, case planning, & a focus on criminogenic risks

CSG, 2021

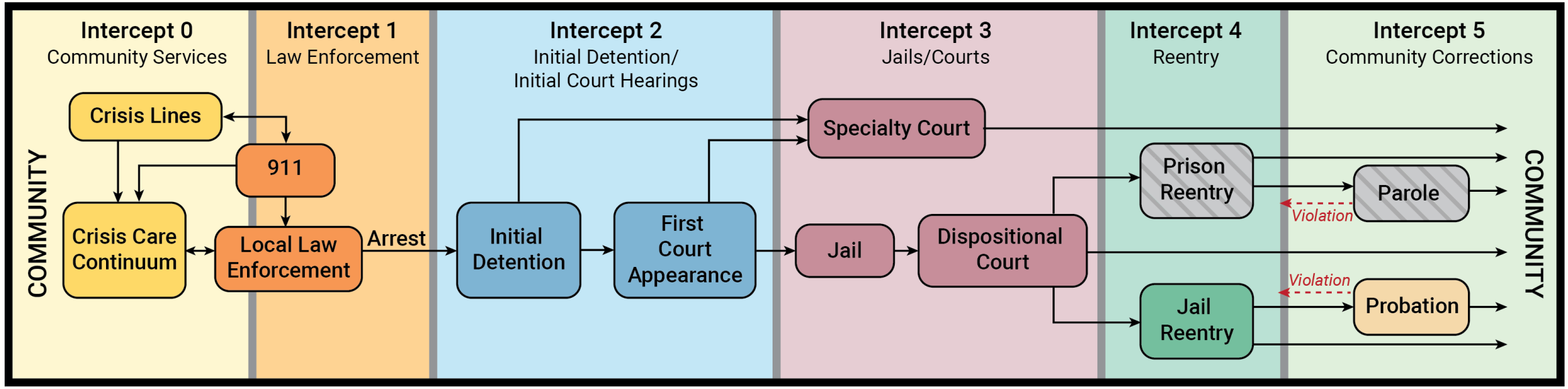
Cross-intercept Best Practices

- Risk-Need-Responsivity Model (RNR)
- Substance Use Services
- Peer Support
- Housing Continuum
- Addressing Racial Inequities and Disparities

Cross-Intercept Gaps

- Lack of a formal planning structure and coordination
- Information sharing and data integration
- Cross-training
- Evidence-based practices
- Trauma-informed approaches and trauma-specific treatment
- Cross-system screening for military service
- Integrated health services and healthcare reform
- Integration of peer services
- Housing, transportation, employment
- Data, Data, Data

Collaboration and Data Sharing



How can PHI go to law enforcement?

How can PHI go to the jail from treatment providers?

How can judges address information sharing?

How can PHI go to the jail from treatment providers?

How can providers share information with each other?

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Summary

- Using the SIM model to leverage the community brain trust
- Justice-involved behavioral health populations are
  - Heavy healthcare utilizers
  - At risk for earlier illness and death
  - At risk of deepening exposure to criminal justice
- Seamless transition across the system
- Strategic approach to protect public safety and improve public health

Let’s take a 10 minute break

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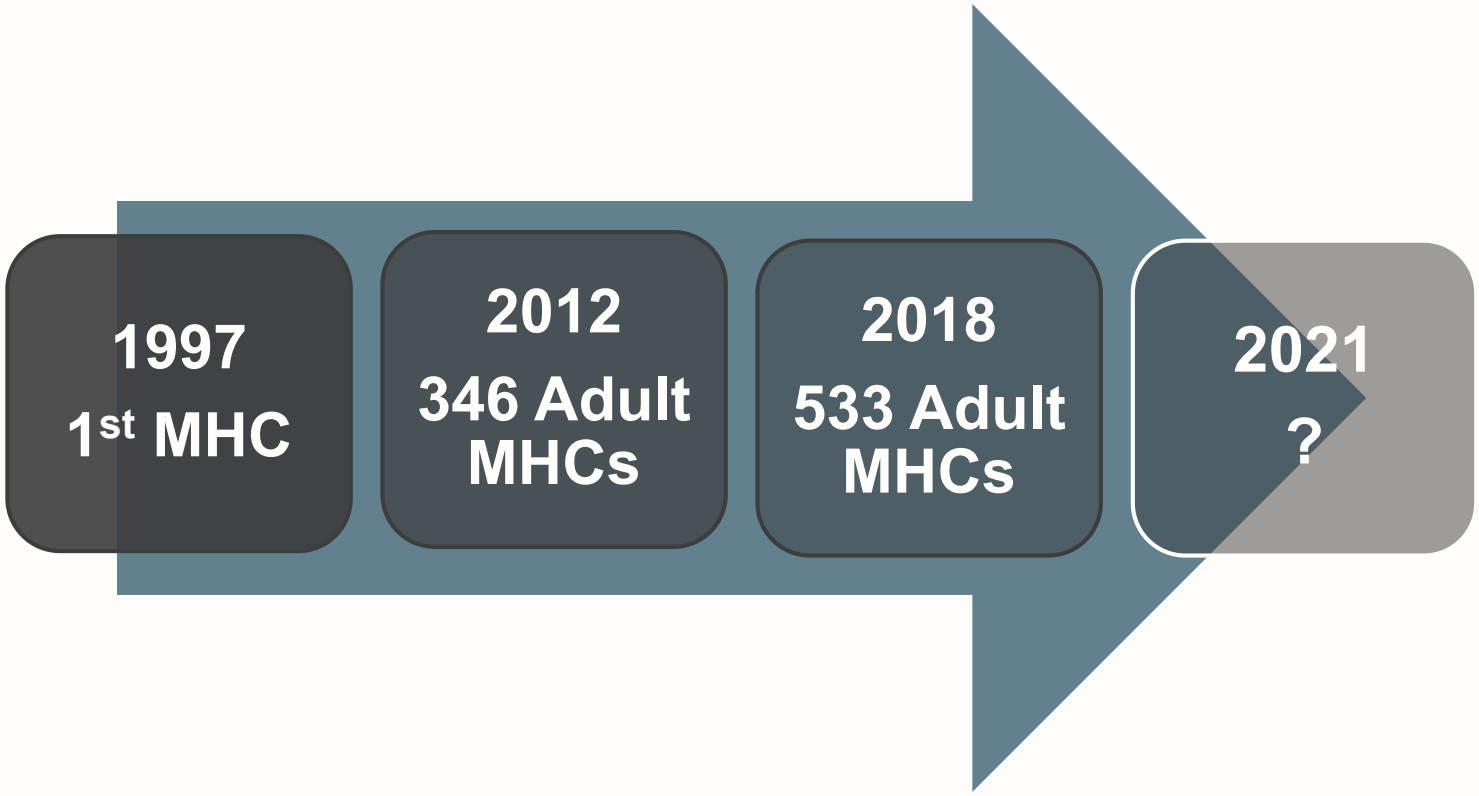
Mental Health Courts in the 21st Century: What the Research Demonstrates (and Doesn't)

Development of Mental Health Courts in the U.S.



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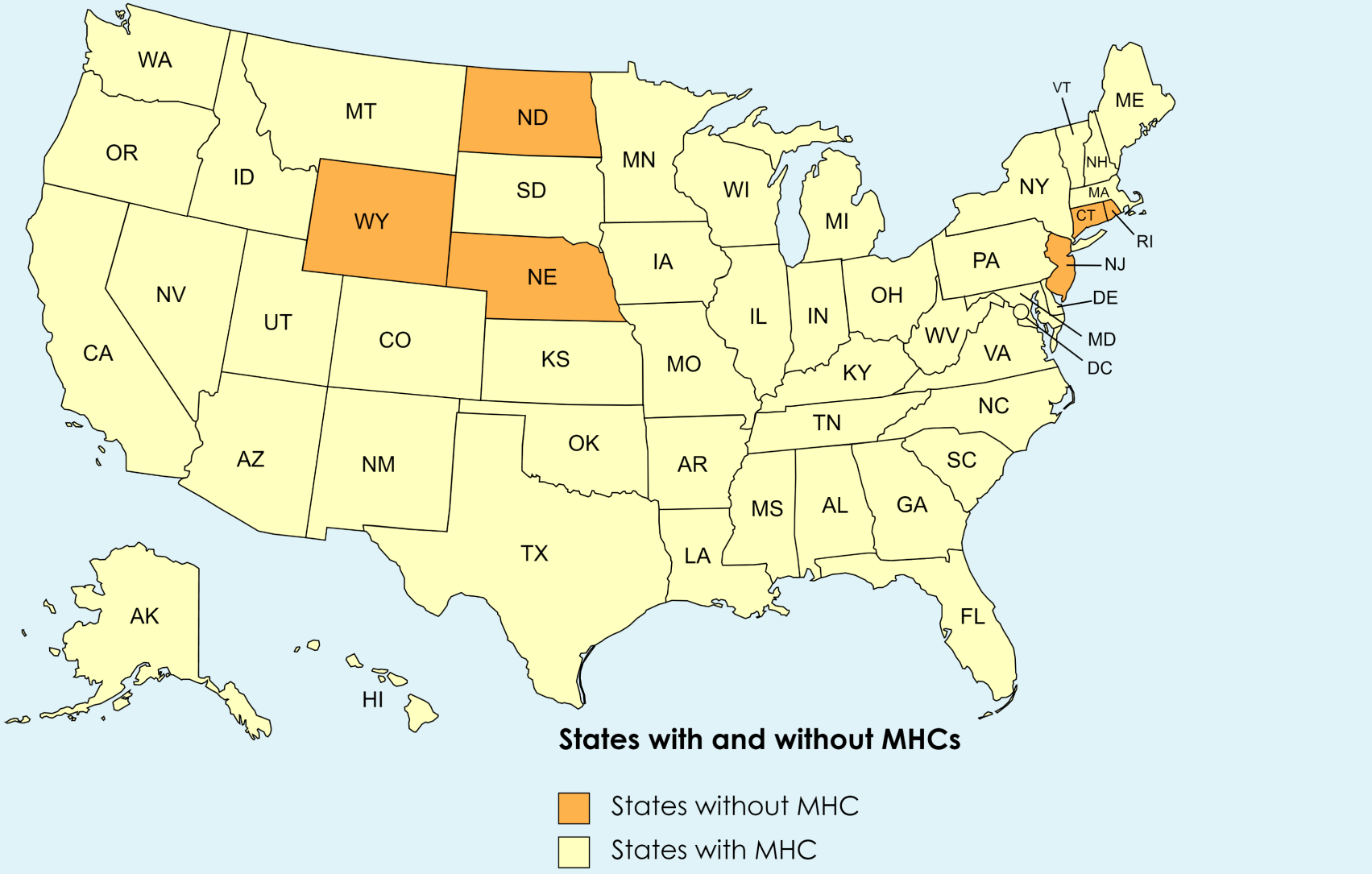
States with & without Adult MHCs



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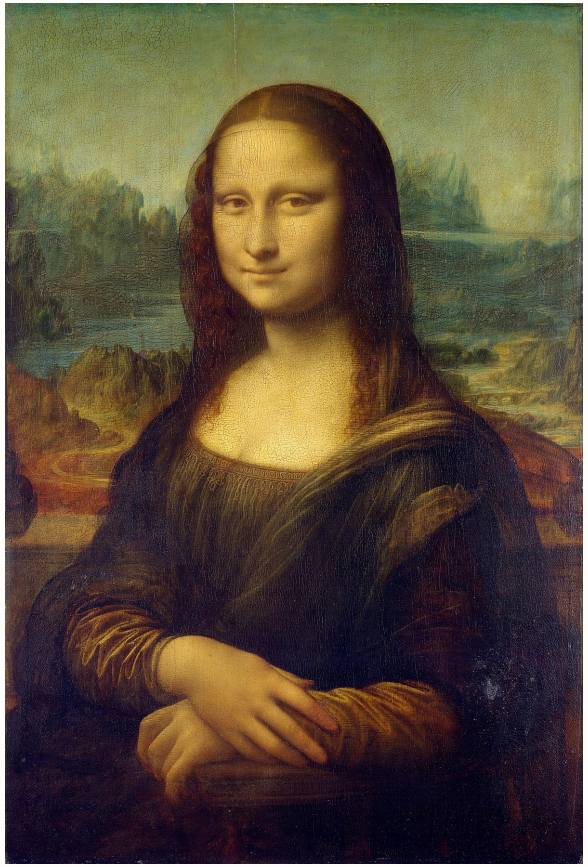
Prevalence of MHCs and DTCs

- While most states have MHCs, most counties (84%) do not
- Every state and large proportion of counties have at least one DTC, often multiple drug courts (e.g. DUI, Veteran, Re-entry)
- There are 3.5x as many DTCs as MHCs
  - Are DTCs prepared and willing to handle SMI and COD?
  - How do DTCs adjust to effectively enroll persons with SPMI?

How do drug courts and mental health courts differ?

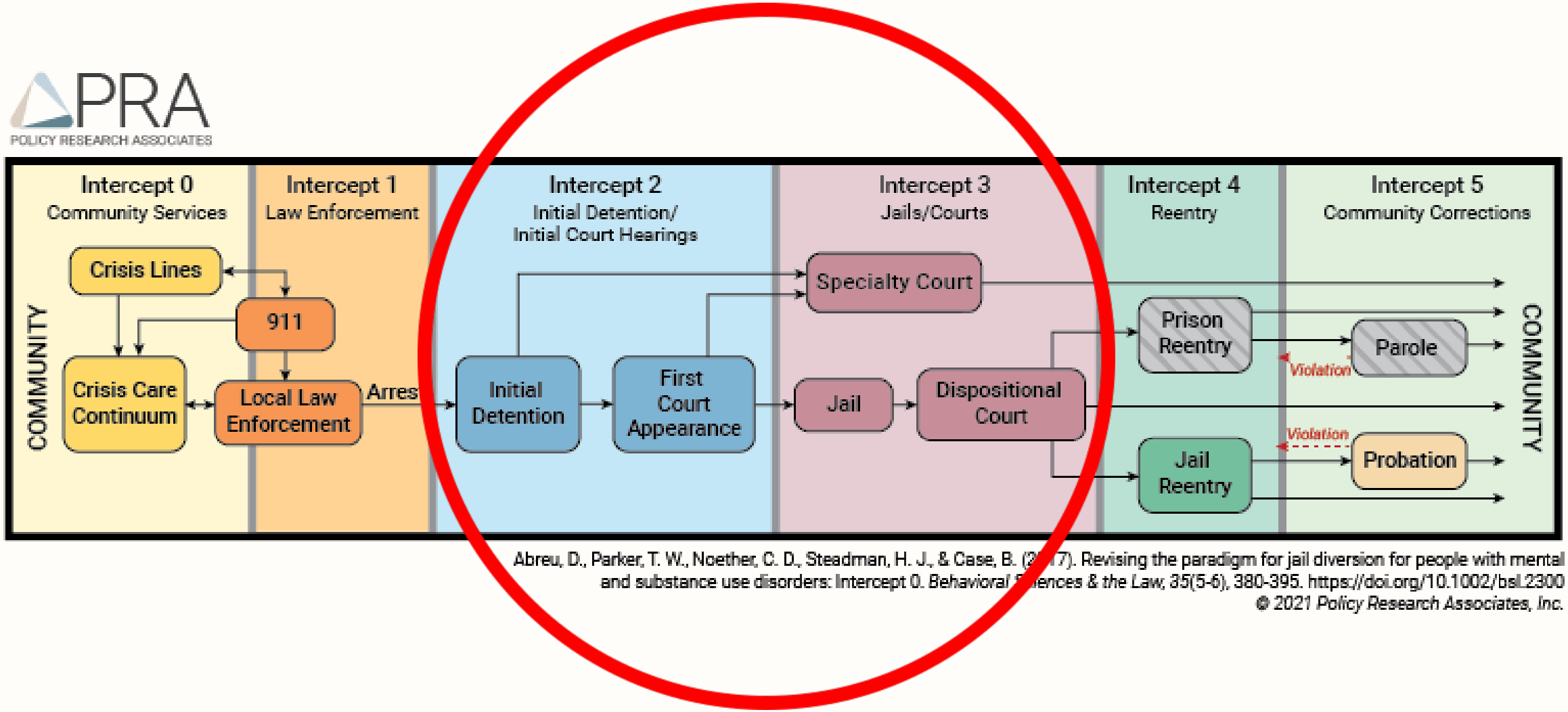


Mona Lisa by Leonardo da Vinci,1503

Autumn Rhythm #30 by Jackson Pollack, 1950

Thanks to The Honorable Christopher Stride, Lake County IL, for this inspiration

Sequential Intercept Model (SIM)



Abreu, 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*(5-6), 380-395. https://doi.org/10.1002/bsl.2300

National Guidelines or Standards

- Presently, there are no national guidelines, standards, or best practices for adult mental health courts
- 18 states have MHC standards
- 16 states have treatment court standards
- 13 states have MHCs but no MHC standards

10 Essential Elements of Adult MHCs

1. Planning & administration – broad range of stakeholders
2. Target population
3. Timely participant identification & linkage to services
4. Terms of participation
5. Informed choice/voluntariness
6. Treatment supports & services
7. Confidentiality
8. Interdisciplinary court team
9. Monitoring & adherence to court requirements
10. Sustainability

Characteristics of Most MHCs

- Post-booking
- Voluntary participation in program, guilty plea required
- Judicial supervision w/ regular appearances before court
- Community-based treatment, compliance required
- Completion is usually in exchange for "something" tangible such as reduced or dismissed charges

Early Research on MHCs

- Single site
- Completers/Graduates only
- No comparison group
- Short follow-up period
- Wide variation in point in time measures are taken
- Internal evaluations

2 Multi-site Studies with Comparison Groups

- MacArthur 4-site Mental Health Court Study
- NIJ 2-site Mental Health Court Study (same city)

Who is the Target Population of MHCs?

	1	2	3	4
	MHC (n=108)	MHC (n=136)	MHC (n=105)	MHC (n=99)
% Male	73	55	52	49
Average Age - Years	38	38	38	36
Diagnosis:	%	%	%	%
% Schizophrenia/Other Psych	57	32	36	38
% Bi-polar Disorder	9	24	35	48
% Depression	16	24	24	11
% Other	19	20	6	3
Target Crime:				
% Violent/Pot. Violent*	49	15	18	26
% Property	25	17	47	30
% Drug	22	60	8	14
% Minor	4	8	28	29

Are there differences between male & female MHC participants?

Females are more likely to:

- have been ($p<.001$), or currently ($p<.001$), be married
- have had a father who used drugs ($<.05$) or was arrested ($p<.05$)
- have witnessed parents throwing things at one another ($p<.001$)
- have been injured by a parent to require MD attention ($p<.001$)
- have been raped before age 20 ($p<.001$)
- be diagnosed with bi-polar disorder, men with schizophrenia ($p<.001$)
- be charged with a property or drug crime ($p<.01$)
- be older at age of first arrest ($p<.001$)
- have fewer lifetime arrests ($p<.05$)
- have considered ($p<.05$) or attempted ($p<.001$) to "hurt" oneself

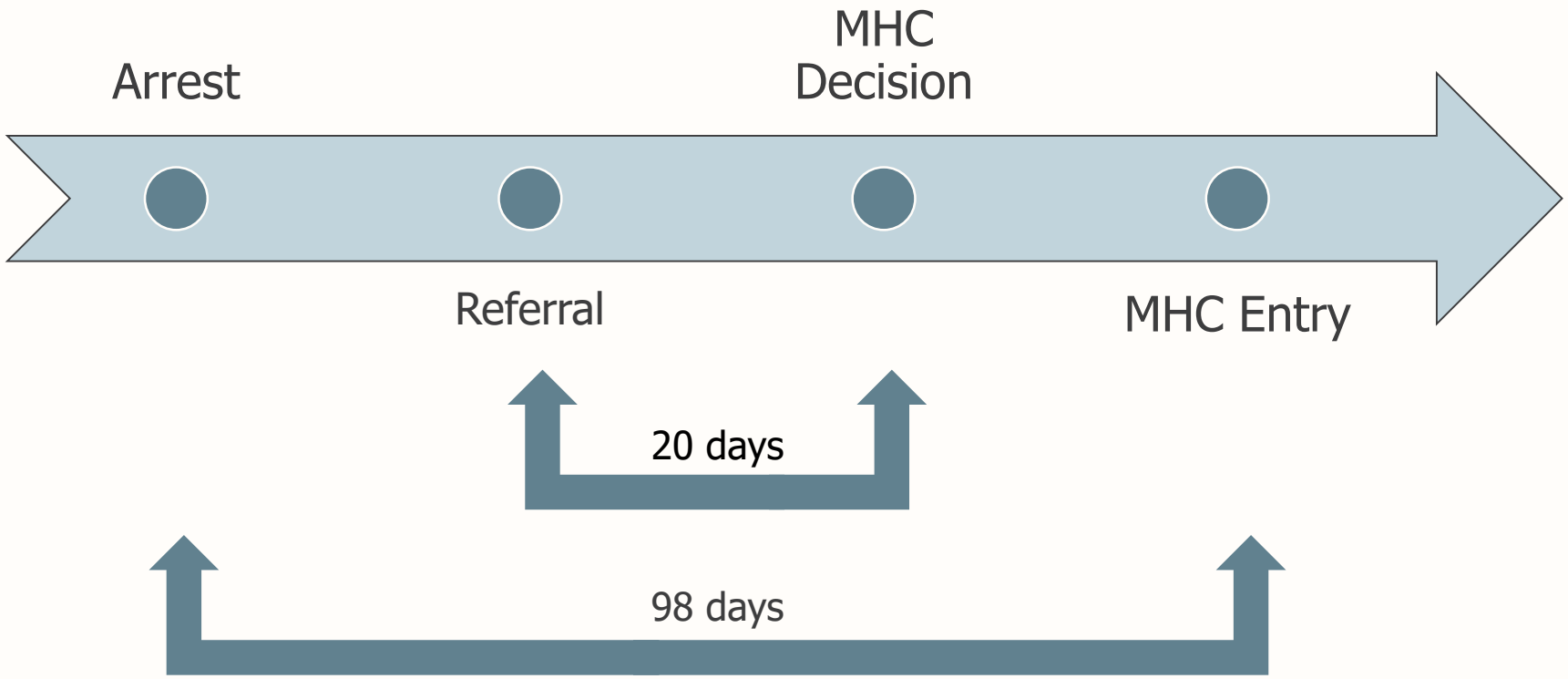
What are the similarities between male & female MHC participants?

- Most (62%) were unemployed prior to arrest/enrollment
- Most (74%) have a diagnosis of SUD, and most (75%) have been in a psychiatric hospital/wing
- Most (83%) have received mental health treatment prior to enrollment
- Most (39%) have never received SUD treatment prior to enrollment
- Most have been arrested for at least one property and one violent crime
- Half have been arrested for at least one drug crime
- Most report not having engaged in any violence in past 6 months (18% been in a fight)
- Of those who report having recently tried to hurt oneself (6 months prior to enrollment), almost half said they were trying to kill him/herself
- 27% of women and 32% of men were terminated from MHC
- No differences between men and women: compliance with orders, appointments, medications, whether they received a jail sanction, re-arrested after 18M of enrollment

MHC Participants with Co-occurring Disorder

- 60-75%+ of MHC participants have a COD, primary diagnosis does not matter
- Less likely to comply with judicial orders, appointments, & medications according to MHC officials.*
- More likely to have their MHC hearings while in custody
- More likely to be sanctioned by MHC, including returning to jail.
- More likely (81%) to be arrested post-enrollment than participants without COD (68%)
- Spend twice as much time in jail post MHC enrollment
- Higher social impairments/needs
- More likely to be terminated from MHC
- High utilizers of treatment and justice system (e.g. jail)
- High cost-drivers for MHCs

Do MHCs link participants to services in a "timely" manner?



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Do MHCs link participants to treatment to a greater extent than similar defendants?

- Most MHC and "treatment as usual" (TAU) individuals accessed treatment in the year before their target arrest (74%, 56%)
- After MHC enrollment, 84% of MHC participants received some type of treatment compared with 56% of the TAU
- Before MHC enrollment, participants accessed significantly more crisis and therapeutic treatment services than TAUs.
- After MHC enrollment, participants continued to access therapeutic services but accessed crisis services = TAU
- Following discharge from jail (MHC enrollment), participants accessed their first treatment contact in 7 days compared with 64 days for the TAU
- CONCLUSION: MHC participants are more likely than their TAU peers to access more therapeutic treatment post-enrollment and more quickly following discharge. MHC participants also show a decrease in crisis services.

What incentives are used in MHC?

- Only 9% of participants do not recall receiving an incentive.
- Of those who did:
  - *79% received a good report from the judge*
  - 69% received a good report from CM/PO
  - 51% received praise/clapping
  - 42% received fewer status hearings
  - 12% received a tangible "reward"

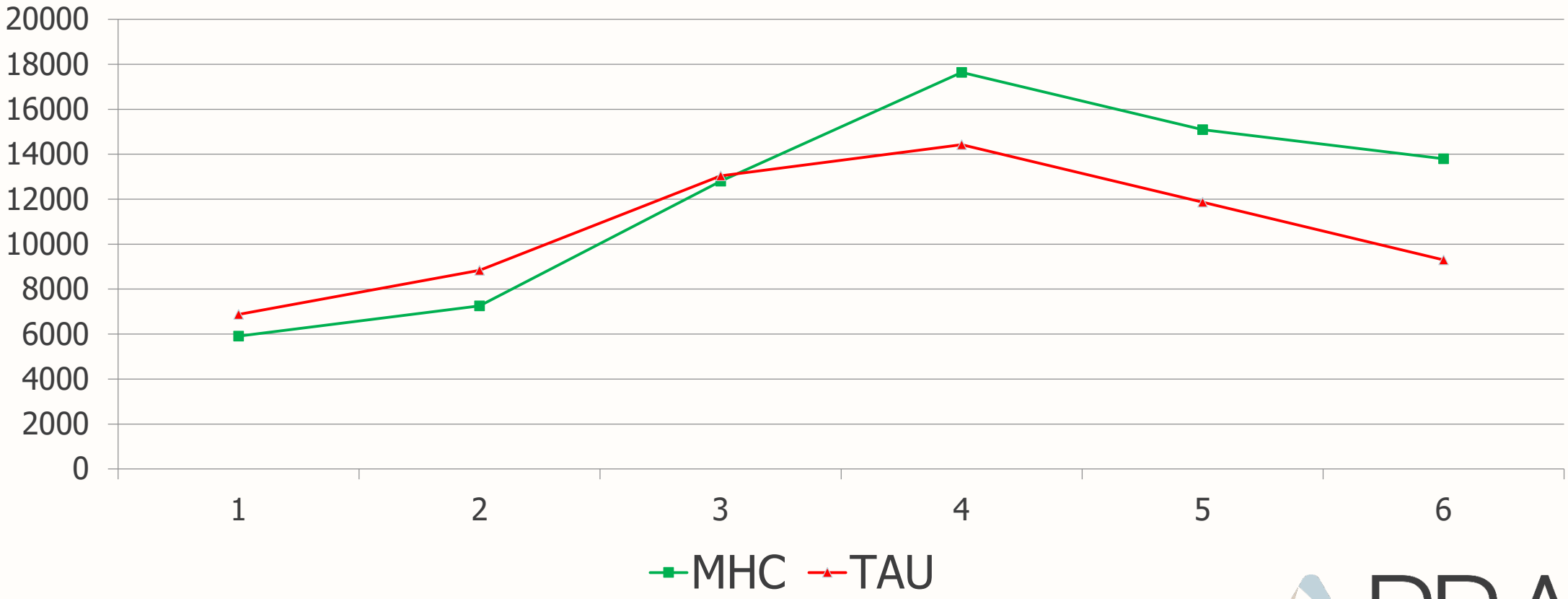
What sanctions are used in MHCs?

- Many MHC participants never receive a sanction (47%)
- Of those who did:
  - *28% receive a lecture from the judge*
  - 24% required to see clinician or supervision more often
  - 24% received jail sanction
  - 23% required to have more frequently status hearing
  - 13% lost privileges
- Program adherence and jail sanctions most often related to drug use, having a COD, and history of drug arrests.

Do mental health courts improve public safety?

- Individual studies show improvements in post-MHC criminal recidivism. Lower quality studies show "best" outcomes.
- Recent meta-analysis of "qualified" empirical studies show a *modest effect* on recidivism across *all* participants.
- Participants who graduate from MHC have stronger outcomes with regard to recidivism.
- MHC participation has greatest effect on reducing jail time after leaving MHC.
- Improved outcomes observed to be sustained over time.

Are MHCs Cost-Effective? Year-by-Year Total Cost



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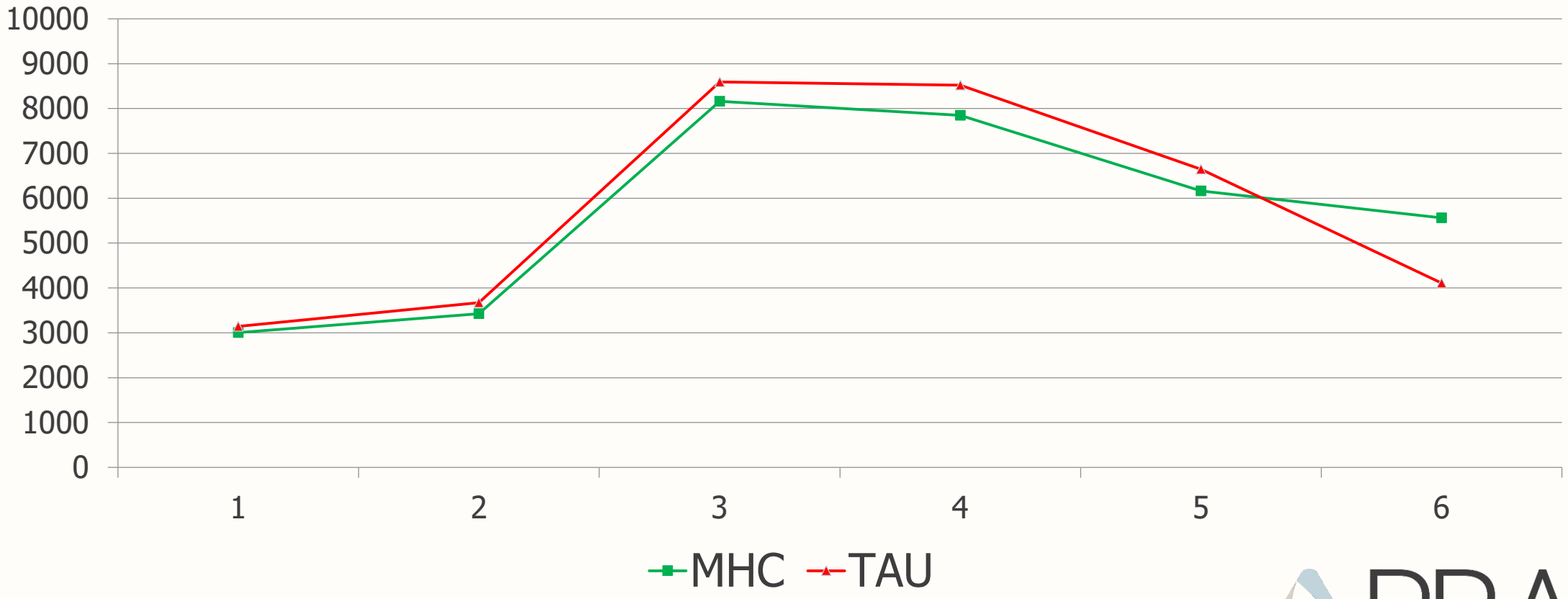
Are MHCs Cost-Effective?
Year-by-Year Criminal Justice Costs



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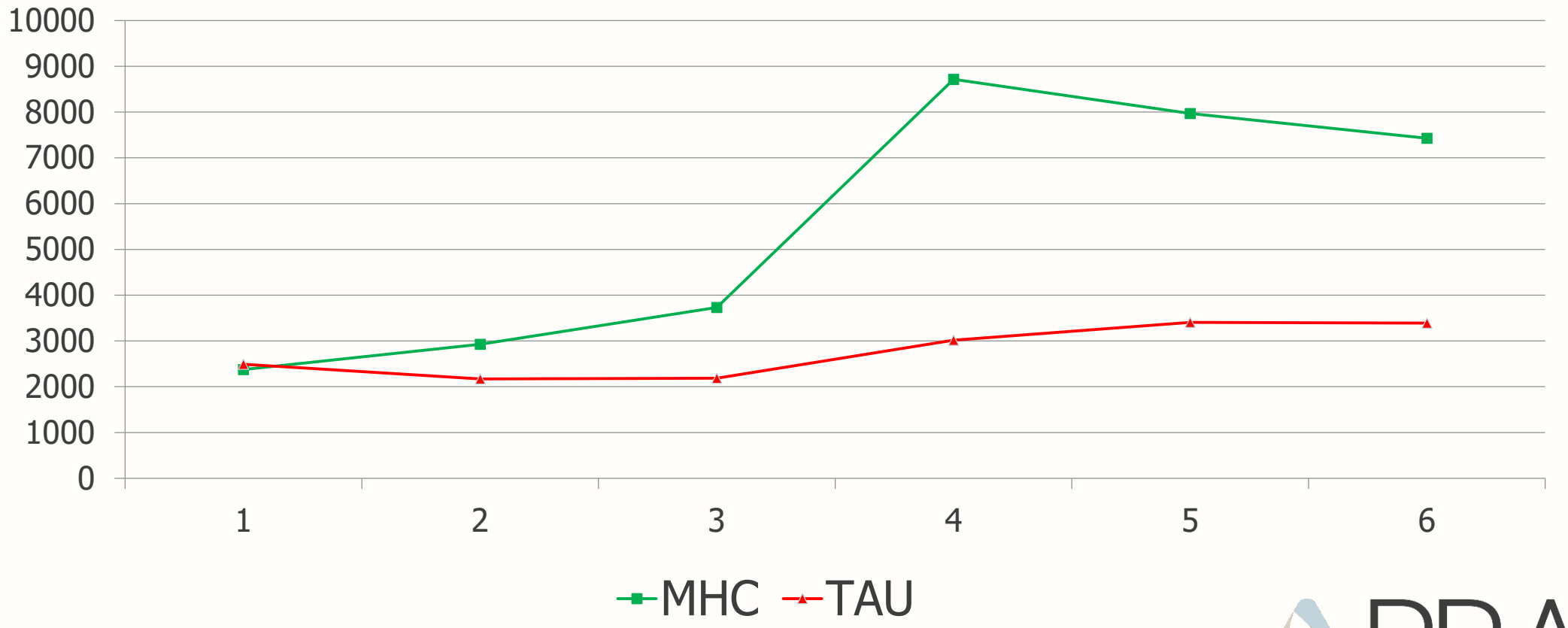
Are MHCs Cost-Effective?
Year-by-Year Treatment Costs



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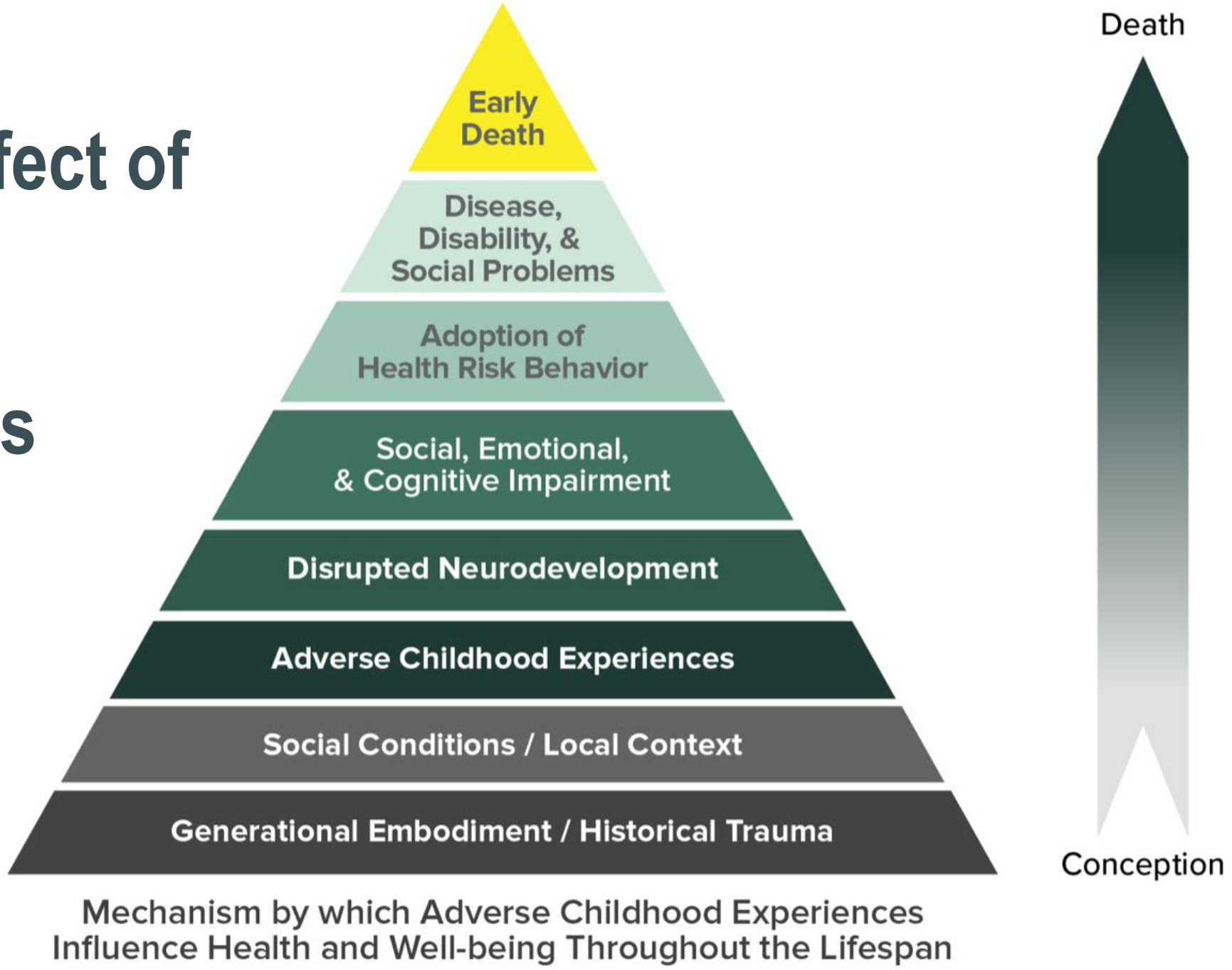
What don’t we know? (a lot)

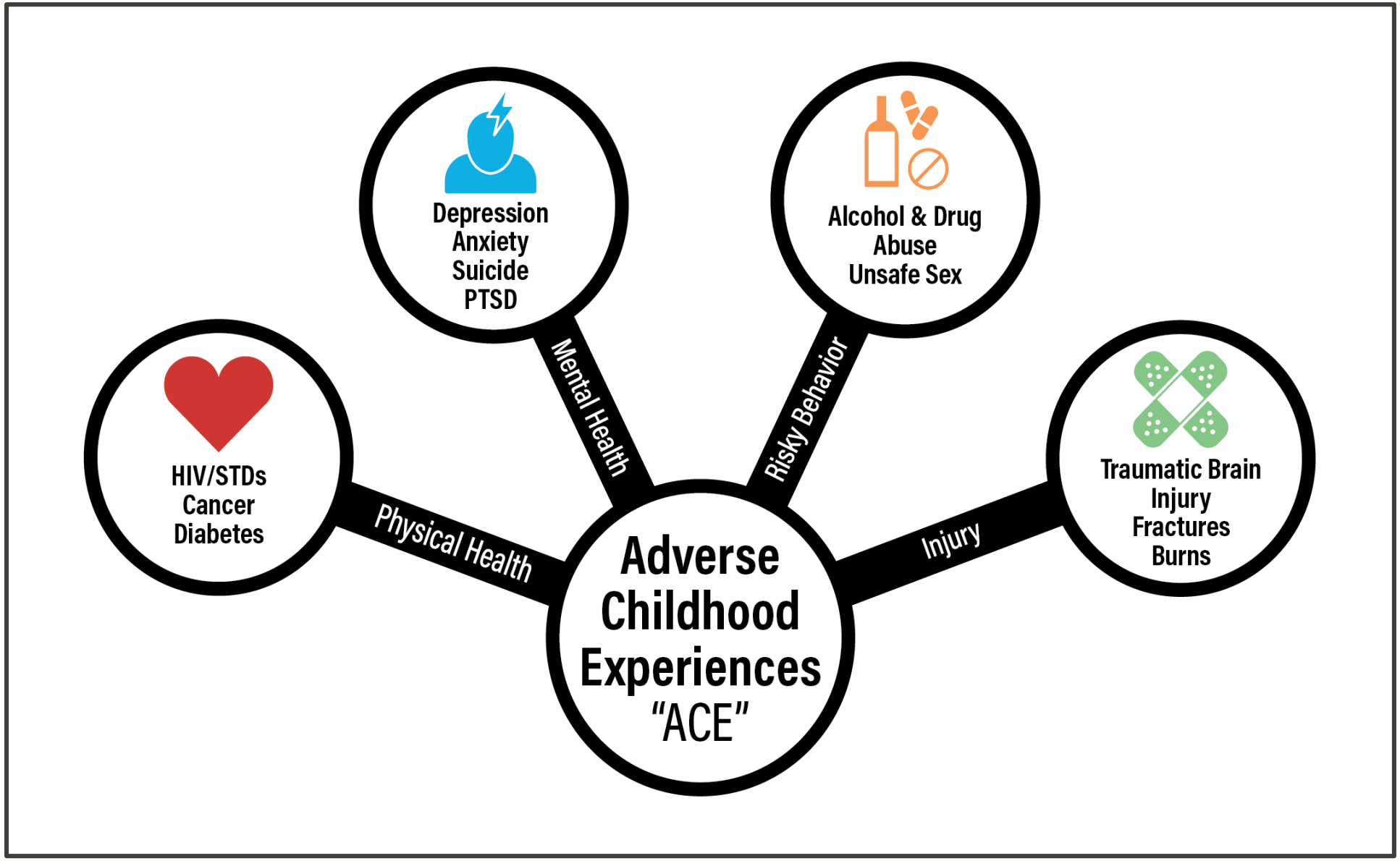
- What program strategies improve engagement?
  - ✓ More hearings? More treatment?
- Do MHCs improve cross-system outcomes?
  - ✓ Are service referrals and program engagement improved?
- How do factors known to be associated with elevated risk contribute to outcomes in MHC?
  - ✓ Housing, financial resources, criminal thinking
- What is “success” in MHC?
  - ✓ Harm reduction in a high-offending population? Improved quality of life?

Lifelong Effect of Adverse Childhood Experiences

Source: cdc.gov



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



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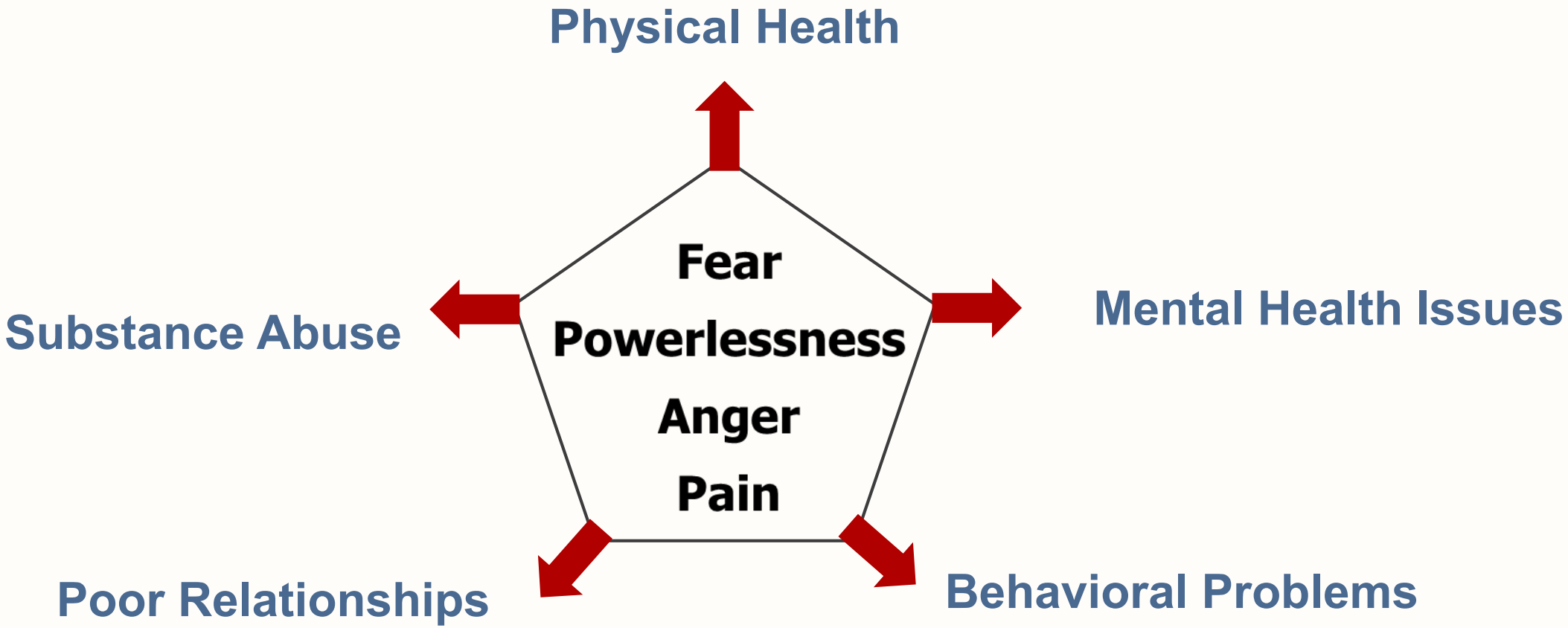
Expanding Definitions of Adversity

- ACES include 10 items
- Broadening the Focus – Additional items:
  - Low SES → lower physical health score
  - High peer victimization → higher distress symptoms
  - High peer social isolation → higher distress symptoms
  - High exposure to community violence → higher distress symptoms

Long-term Effects of Trauma



The “Toxic Triad”

- Exposure to Parental DV -> maltreatment, social & behavioral problems, depression, anxiety, lower social skills, violent & risky delinquency, adult abuse, negative health behaviors
- Parental Addiction -> maltreatment, lower academic achievement, substance abuse, aggression, criminal behavior, depression, psychopathology
- Parental Mental Illness -> maltreatment, mood disorders, internalizing & externalizing, depression, substance abuse

Fuller-Thompson, Sawyer, & Agbeyaka, 2019

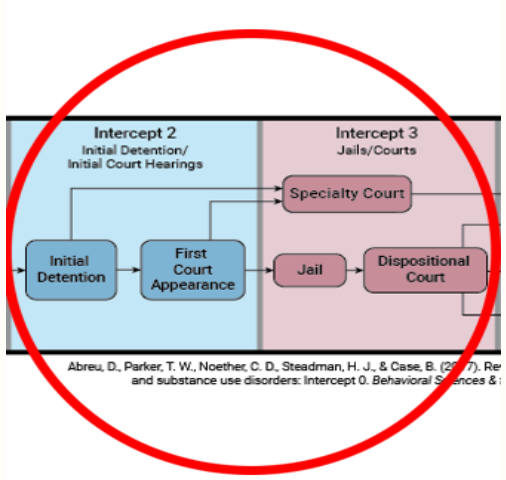
Toxic Triad in CJ Populations

	HH IPV -> Mother	HH Sub Use	HH MI/ Suicide
US Adult Population[1]	13%	27%	19%
Adult COD Court[2]	83%	45%	37%
Juvenile COD Court[3]	24%	43%	44%
Boys in State Detention[4]	81%	24%	8%
Girls in State Detention[4]	84%	30%	12%

1 Feletti et al., 1998
2 IL Tx Ct
3 Callahan et al., 2014
4 Fox et al., 2015

Trauma-informed Adaptations & Programs at Intercepts 2/3

- Screening & assessment for trauma/other issues -> placement
- Integration of peers & navigators at every step
- Diversion as the assumption, not the exception
- Awareness of impact of suspension of entitlements based on length of jail term
- Awareness of impact of costs of incarceration
- Continuity of care – medications and providers
- In-reach of community-based behavioral health professionals
- Specialized dockets
- Recovery courts
- Focus on wellness of staff
- Training for staff



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Courtroom Procedures

COURTROOM PROCEDURES	REACTIONS OF TRAUMA SURVIVOR	TRAUMA-INFORMED APPROACH
All defendants are transported from the jail to court in a van, in jail clothing, & shackled together. Everyone sits together in the courtroom to the judges' left, fully visible to anyone in court. When their name is called, the individual is unshackled and escorted by a bailiff to stand before the judge and meet their public defender.	"I don't want the judge to see me like this. I know her. I am not going to look her in the eye when she calls my name. I am such a bad person. My attorney doesn't even know my name. I am worthless. I should just go back to jail."	The judge calls the defendant by name and makes sure the defender does as well. She asks him how he has been doing since she last saw him and if he has anywhere to live. She asks if he needs help, pointing to the court social worker sitting in the jury box who will meet him in lockup and arrange a place for him to stay when he is discharged later that day.
"Are you back again? What did you do this time?"	"I am a failure."	The court social worker approaches him, introduces himself, and shakes his hand. He tells the defendant that he is there to help him and will meet him later at the lockup. He follows through and reports back to the court.

Courtroom Environment

PHYSICAL ENVIRONMENT	REACTION OF TRAUMA SURVIVOR	TRAUMA-INFORMED APPROACH?
A court officer jingles handcuffs while standing behind a defendant.	Anxiety; inability to pay attention to what the judge is saying; fear.	
Multiple signs tells defendants (and others) what not to do.	Feeling intimidated; lack of respect; untrustworthy; treated like a child	
The judge sits behind a bench, in a black robe, often elevated, defendant is at a table some distance away.	Fear of authority; inability to communicate clearly, especially if perpetrator/abuser in courtroom.	

Questions to Consider in Your Court

- Do defendants, families, victims, witnesses, and staff feel safe?
- Can people in my court hear what the judge and other key officials are saying? Do we speak clearly?
- Do court staff show respect toward people in court?
- Do we explain court procedures to people in the courtroom?
- What do we hope to gain by being a trauma-informed court?
- Is my courtroom set up in a trauma-informed way?
- How can we alter the courtroom set up to be more trauma-informed?
- How can we adapt our policies and procedures to be more trauma-informed?

Is Your Mental Health Court Working?

Do we need to collect data? (yes)

- What data are essential to your funding/sustainability?
- What are your goals for your MHC? Is that a commonly-agreed upon list across your community and stakeholders?
- For example, are you planning to save costs to community? To the justice system? To the treatment continuum of care?
- Chances are, you are collecting too much data and not all of the right data.

Basic data to collect on participants to know if your MHC "works":

- Referrals & enrollments:
  - Demographics
  - CJ History – self-report, official statistics
  - Local data bases
- Treatment History: self-report, MOUs with providers
- Dates: When referred, when assessed, when enrolled
- Progress in Program:
  - Phase/program progress – dates, reasons for change
  - Compliance with court orders, status hearings, tx, supervision
  - Sanctions & incentives – dates/types/reasons
  - Outcome – date/reason
- Mid-program & exit Interview with all participants

Basic Program Data

- What are your program goals – are you collecting data you need?
  - Recidivism? Improved Quality of life? Treatment adherence?
  - Linkages to EBPs in community?
  - Improvement in symptoms – mental illness, substance use, trauma?
  - Save money – data from key stakeholders required
  - Sustainability – meet funding entities' requirements

Basic Program Data

- Referral – who, why/not, time, standardized screening
- Enrollment – first point of contact, who is agreeing/ refusing to enroll, how much time
- Implementation – phase/program advancement, need tracks, partner cooperation, gaps in service delivery
- Sanction/Incentives – rational? Who? Resources?
- Meeting program goals
- Meeting needs of participants

Steps to Know if Your MHC is Working:

1. Identify program goals – stakeholders, team
2. Identify data you need to measure each goal
3. Identify the person/people responsible for data collection, analysis, reporting – DUAs and MOUs in hand
4. Set a reasonable time frame for implementation
5. Identify purpose of the data collection

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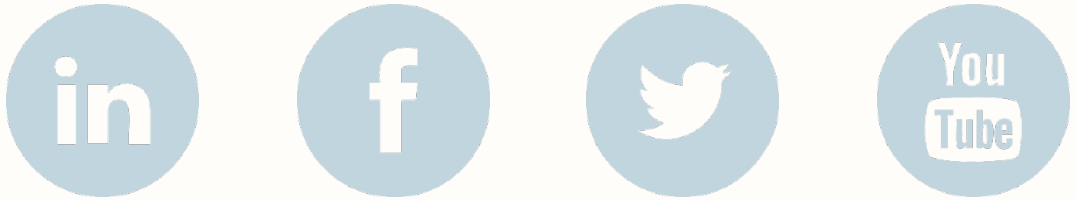
Creating positive social change through technical assistance, research, and training for people who are disadvantaged.



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