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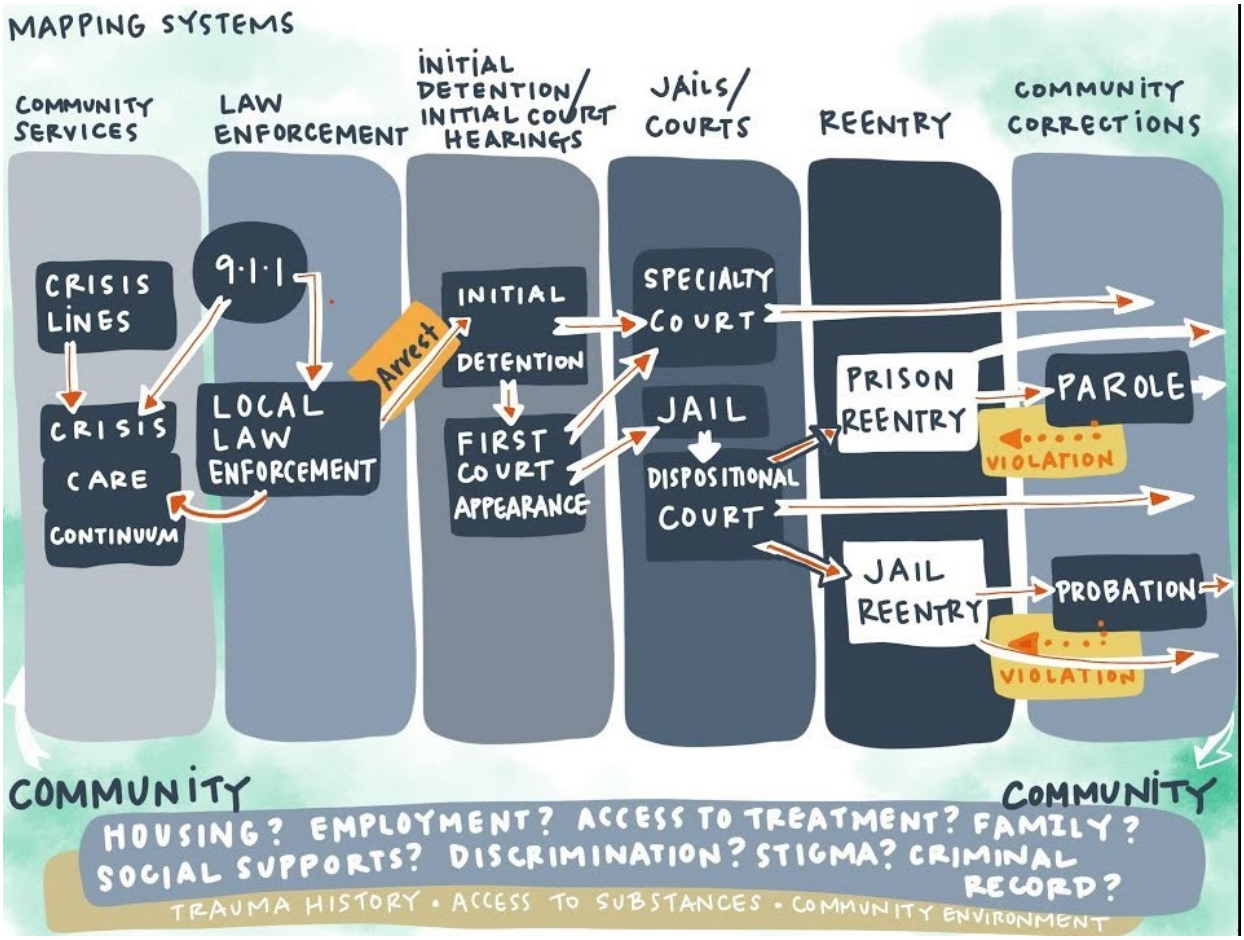

Dane County Mental Health Court Feasibility Study

November 2021

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This study was commissioned and funded by Dane County on behalf of the Dane County Department of Human Services.

Acknowledgements: Thank you to Todd Campbell, Carrie Simon, and Hannah Whaley whose incisive questions guided this work. The students of Public Health 786 were enormously helpful in collecting publications for the literature review. DHS data support was provided by Betsy Strahin and Jenna Ramaker.

To the many people who generously agreed to speak with us: thank you for the education, for your time, and for your always thoughtful and compassionate insights.

Suggested citation: Feder, E. and Vigna, A. (2021). UW-Madison Population Health Institute. *Dane County Mental Health Court Feasibility Study.*

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Mental Health Court Feasibility Study Executive Summary

This study was commissioned by Dane County to assess the feasibility of implementing a Mental Health Court (MHC) in Dane County. The scope included:

- A literature review of best practices
- A rough estimate of the degree of need for a MHC in Dane Co
- An assessment of community interest and readiness for a MHC in Dane County, including an analysis of how a MHC would align with existing criminal justice diversion programming in Dane Co.

Our recommendations based upon these findings:

A MHC would add value to existing jail diversion services by providing a needed opportunity for defendants to earn a clean record via treatment engagement. However, because of the intensity of resources required to run a MHC, and the increased likelihood of revocations associated with intensive supervision, **the court would only be appropriate for individuals who are at high-risk of recidivating because of unmanaged mental illness, AND who require intensive support services to sustain initial engagement with support services.**

A MHC should be implemented **ONLY IF** the County can achieve a true collaboration between the county criminal justice and behavioral health/substance use systems to meet the following conditions:

- Accept the risk of committing the court to serving those in the community who are genuinely high risk and high need, and
- Provide a sufficient quantity of culturally-matched services in a timely fashion,
- Recruit the appropriate champions to the team, and
- Increase the capacity of the DA to staff another treatment court by increasing staffing or otherwise reducing the backlog of criminal cases

Sub-recommendations:

Eligibility:

- Accept BOTH misdemeanants and felony cases; consider violence on a case-by-case basis
- Don't require a previous mental health diagnosis, accept a current assessment
- Use the same screeners and assessment tools across all courts to maximize appropriate placement

Treatment Court Team should include:

- Dedicated prescriber
- Culturally-matched Peer Support Specialists (engaged at early stages and compensated)
- Judge who understands serious mental illness, holds a compassionate and healing-centered approach to bench-side manner, and prefers community service sanctions over incarceration sanctions

Resources:

- Housing support; Housing First assistance for an inconsistently houseless population
- Transportation assistance
- Culturally-matched community support services for sustaining beyond graduation
- The capacity to monitor referrals, participation, sanctions, and disposition for bias in court processes

Introduction: Purpose of this Project

As part of an initiative toward de-carceration, the Dane County Department of Human Services commissioned UW Population Health Institute to conduct a study to assess the feasibility of implementing a Mental Health Court (MHC) in Dane County. The authors reviewed national best practices, analyzed intake data from contracted providers of behavioral health services in Dane County, and conducted 26 key informant interviews with local experts and stakeholders (see *Appendix 1, Organizations represented in interviews*, for a list of agencies, roles and sectors represented in the key informant data). This report is divided into three sections. In the first section we summarize the literature on the purpose of a MHC, the evidence of their effectiveness, their essential components, and the emerging data regarding best practices in operating effective MHCs. In the second section we narrow in on the evidence suggesting a need for a MHC and summarize key informants' perspectives on the feasibility of establishing a MHC in Dane County, including key equity considerations and potential barriers to keep in mind. The third and final section describes next steps in process of establishing and monitoring a MHC. Our recommendations are based on best practices but are also highly sensitive to the local context of Dane County.

I. Overview of Mental Health Courts

What is the purpose of a Mental Health Court?

Large numbers of people with mental health issues cycle through the criminal justice, behavioral health, and social support systems becoming ensnared by the lack of effective, integrated treatment and supervision. The costs are destructive, both to communities in terms of expenditures of limited resources and to individuals and their families. Jail diversion programs and preventative programs can curb the flow into the criminal justice system, but Mental Health Courts are an attempt to improve outcomes for individuals once they are involved in the system by providing a recovery-oriented judicial process. They are a hybrid institution requiring full collaboration between criminal justice professionals and behavioral healthcare providers to break the cycle of repeated involvement and improve individual and community outcomes.

From four in 1997 MHCs have grown to over 400 in the U.S. today. They emerged in direct response to the increase of defendants with mental health issues entering the criminal justice system. The rise in arrests of people with mental health concerns is the consequence of several policies. Large public scandals in the 1970s about the abuse taking place in in-patient institutions resulted in their closing. Then in the 1980s funding for public and community services were severely reduced and some important sources of low-income housing available to the very poor and newly "de-institutionalized", such as SROs, were closed. The result was a growing number of people with mental illnesses but insufficient housing or treatment.

Without these resources some rely upon illegal drugs to manage their symptoms leading many to violate laws and get routed into the criminal justice system to access care. Sometimes police arrest people with serious mental illnesses (PSMI) because few other options are readily available to handle their disruptive public behavior or to obtain for them much-needed treatment or housing. Other PSMI enter the criminal justice system because they have engaged in serious criminal

behavior that is often—but certainly not always—related to their untreated psychiatric and substance-use disorders.

However, the criminal justice (CJ) system was designed to punish and restrict individuals not to support mental stability and so invariably worsens the mental health of its entrants. This unfortunate situation has contributed significantly to the overrepresentation of people with severe mental disorders throughout the criminal justice system, especially those who are African American, Black, or Hispanic.

Some see Mental Health Courts as a crucial alternative to incarcerating the mentally ill. Others believe that communities are naïvely looking to MHCs to solve the much larger societal problems of lack of sufficient supportive housing and mental health services. Tackling these issues will require more extensive structural change.

Stigma and Criminalizing PSMI

Popular movies and television, along with sensationalistic media coverage of violent acts perpetrated by PSMI convey the notion that all such individuals are unpredictable and dangerous. Although untrue, the stigma that associates with mental illness with dangerousness directly prevents people from seeking support to stabilize their wellbeing.

Stigma has also influenced public policy decisions about access to treatment, housing, and other services that have brought people with severe mental disorders into closer contact with the criminal justice system.

These collective social forces, along with the declining availability of long-term psychiatric hospital care, have resulted in some people with severe mental disorders being jailed when they should have been hospitalized. This regrettable phenomenon has become known as the "criminalization" of people with mental disorders.

How do Mental Health Courts work?

Mental Health Courts operate primarily as post-booking diversion programs whereby eligible defendants voluntarily agree to judicial supervision of community-based mental health treatment, often in exchange for a reduced or dismissed charge upon successful completion. In general, potential clients are referred to the MHC staff by jail personnel, defense attorneys, and others who become familiar with the defendant. Mental Health Courts depart from the traditional punitive model used in most criminal proceedings. Instead, as a team and under the judge's guidance, prosecutors, defense attorneys, and mental health service providers connect eligible defendants with community-based mental health treatment and, in lieu of incarceration, assign them to community-based supervision. The judge, as well as the MHC team, is supportive, encourages behavioral changes, life skills development, and focuses on problem solving rather than on offenses and adjudication of guilt. Extended engagement in the program, involving regular scheduled meetings often for one year to eighteen months, provides the opportunity for positive personal relationships to form and for personal growth to occur. Those unable to fulfill the program requirements may be sanctioned, have their time extended or be returned to the traditional court system for adjudication.

Why invest in a Mental Health Court?

Mental Health Courts improve outcomes for individuals and their families.

Diversion from prison. In jail – and possibly prison – those with mental illness typically cannot be placed among the general population, yet solitary confinement is traumatizing and unethical. Nor does prison generally offer the necessary level of psychiatric and psychological treatment. In fact,

From the perspective of graduates, participation in the MHC resulted in:
Improved relationships with family
Sobriety
Mood stability
Increased patience
Ability to care about others
Greater understanding of mental illness.

defendants frequently cannot maintain their medications in jail if it is not on the jail formulary. Additionally, as Eyal Press reveals in a new book, *Dirty Work: Essential Jobs and the Hidden Toll of Inequality in America,* the mentally ill are frequently the victims of prison guards' intentional and sanctioned cruelty.

Treatment. Particularly for those who have refused treatment in the past, MHC is a lever to get people into treatment and stabilized. It provides structure, consistency, and accountability. The role of the judge in treatment adherence is considered crucial in both the literature and by those interviewed. Reasoning offered include: the regular and extended contact in court permits a personal relationship between the judge and defendant to develop; defendants have greater respect for a judge's authority than others; or a combination in which participants who grew up without a loving authority figure experience a transference to the judge.

"How willing (is the judge) to wrap around the people that they serve, and really use positive words, encouragement, 'You can do this'? Just seeing people who they are, that they're good, that they're worthy. So you got that, you got the positive, the judge is the biggest piece too. So sometimes there's a fill in judge that come in once in a while, and you can tell that they're not really harm reduction, they got that background and it's a crap show."

Increased quality of life. Extended case management and supervision permits individualized planning around a range of life issues including housing, employment, and benefits. It also may involve education in life skills such as financial management, job interviewing, and completing applications. It could also facilitate renewed connection to family and friends. Such assistance could result in an improved quality and engagement with life that can reinforce treatment stability and reduce recidivism.

Mental Health Courts Reduce Pressure on the Criminal Justice System

Better use of resources. Reduced recidivism eases pressure on law enforcement, jails, prosecutors, district attorneys, courts, and even hospitals. It could improve public safety. Measures of success in this arena include reduced arrests and jail days, reduced jail processing time, and overall reduced future contact with the criminal justice system.

Better experiences on both sides of the bench. A MHC would require specialized training for judges, prosecutors, public defenders and others in aspects of serious mental illness. Many interviewees expressed the hope that as turnover occurs the benefit of this knowledge would cascade beyond a particular branch throughout the system.

Are Mental Health Courts effective in improving outcomes?

A MHC can only be as effective as its resources, which tend to vary widely and are subject to changing fiscal priorities within local, state, and federal systems. Hence, conclusions about their success should be tempered by the understanding that availability of treatment varies geographically and temporally. [1]

Additionally, it should be recognized that MHCs are not a panacea. They should be considered but one component in a comprehensive strategy necessary to reverse the over-representation of people with mental illnesses in the criminal justice system. Their effectiveness is therefore also a function of strong and integrated programs along all stages of the intercept model.

To determine if MCH programs are worth the investment, researchers often look at graduation rates, improved mental health functioning, connections to treatment, and/or recidivism rates. Recidivism—which refers to a return to prison or jail, either with a new conviction or as the result of violating the terms of supervision—remains the most commonly used outcome measure for participant success. Graduation requirements vary by MHC program, but the criteria used by one study included spending a minimum time under court supervision (12-24 months), being alcohol and drug free for a certain period, being stabilized on medication, attending treatment or a support group, and having demonstrated the ability to function in the community.

Emerging data suggests that MHCs are modestly effective at reducing the number of adults with mental illness recidivating, or returning to the justice system, relative to traditional criminal court. This conclusion comes from a 2018 meta-analysis of 17 studies that assessed MCH outcomes using comparison groups composed of defendants with similar mental disorder but moving through a traditional criminal court environment.[2] They found that although MHC participation reduced the recidivism measures of severity of charge and jail time it did not significantly affect arrest or conviction.

However, the subset of studies that measured recidivism based on those completing MHC participation, rather than the entire entrance group (some of whom were either terminated or discharged) showed stronger effects on recidivism, including arrest and conviction.

Mental Health Court participation appears to be most effective at decreasing jail time. These findings suggest that MHCs may be most effective as a harm reduction intervention. It may not be realistic to expect complete desistance from criminal activity among MHC participants. Rather, **given the already high rates of reoffending in this population, MHC participation may be a means to mitigate the severity of future offending (that is, jail time associated with a new offense).**

The reductions in recidivism in terms of number of re-arrests continue to be seen over time. Longitudinal work suggests that while individualized plans containing the same package of services and supervision in a traditional criminal court also reduces recidivism over time, reductions were greatest among those that complete MHC, compared to those who exit MHC early or remain in traditional criminal court.[3]

Findings suggest that MHCs may be particularly effective for high-risk participants and that time spent in a MHC has positive effects on recidivism, regardless of graduation status.[4] These findings also provide evidence against the practice of many MHCs to accept only participants who are likely to graduate from the program.[5]

How different are Mental Health Courts throughout the nation?

The most recent comprehensive national survey of Mental Health Court design and practices is over ten years old. [6] Based on this data, there are some common patterns that seem to still be operative.

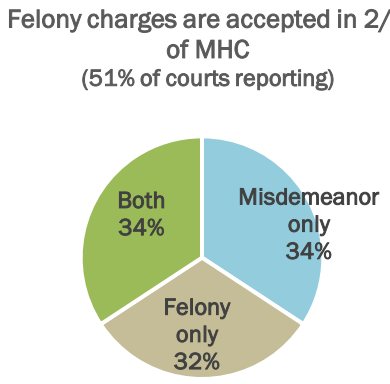
Within these themes, however, there is interesting – and creative -- variation in focus, practice, and organization among individual courts. Here we sketch general approaches and highlight a few specific strategies employed by individual courts.

Eligibility Standards: Who Do Mental Health Courts Serve?

Best practice eligibility requirements suggest that MHC participants should be "high risk-high need" individuals. This means they have a high risk of recidivism and very high mental health needs.

Types of Crimes: Most MHC accept individuals charged with a wide variety of crimes including misdemeanor and felony charges. Many accept both. A particular court focus may be less of a policy decision and more the result of a court's jurisdictional limits or of funding restrictions. It is also important to recognize that there is great variation in how the same criminal act may be charged in different jurisdictions. As MHCs became more available prosecutors may be using more discretion about which charges to file.

The tendency over time has been for courts to include more serious charges. This happened for two reasons. First, initially it was unclear how releasing those who are typically incarcerated would affect public safety. So MHCs began with nonviolent misdemeanor offenders to test the waters. As comfort with the model grew MHCs began to consider felony offenses on a case-by-case basis. Second, courts wanted to keep participants in treatment longer to improve outcomes. Accepting offenders with more serious charges could bring sentencing lengths into better alignment with increasing treatment times, avoiding violations of defendants' rights.



Surveying the SAMHSA GAINS Center's Adult Mental Health Treatment Court Locator (half of the courts reporting) shows courts evenly divided between those that accept only misdemeanor charges, only accept felony charges, and those that accept both. However, many of the courts accepting felonies specified that only low-level or reducible felony charges were eligible.[8]

Exclusions: While many courts may admit those charged with violent crimes if specific conditions are met and only a few courts have blanket exclusions for anyone with a history of violence, in most jurisdictions defendants accused of extremely violent crimes (these include murder, very serious sex offenses, violence where serious injuries resulted, and violence where a gun was used) are not eligible. Several courts in the GAINS sample had some blanket exclusions such as homicide, sex offenses, major controlled substance, weapons use, kidnapping charges. The GAINS locator shows 130 courts specifying only non-violent charges were eligible.

Exclusions		
Non-violent charges only	Weapons	Sex crimes
130	15	66

Finally, the role of victims has increased as those charged with violent offenses have been included. Some courts require a victim's consent for a defendant to participate in the MHC. Some require that victims be kept apprised of important court events (Wisconsin's Marsy's Law is such a requirement). The impact of victim involvement is unknown as courts do not keep such records.

Diagnoses: In accordance with best practice, almost all MHCs accept those primarily diagnosed with or exhibiting signs of Serious Mental Illness, described as either serious, chronic, or persistent. Such diagnoses are commonly defined as bipolar disorder, schizophrenia, schizoaffective disorder, psychosis, and major depressive disorder, or mood disorder. Some courts also include people with severe anxiety or PTSD.[9] Generally, courts want to accept people whose illness is treatable (often meaning that there is effective medication). Some courts also take those with lesser disorders.

A 2005 national survey of 90 mental health courts indicated that 16 percent of responding courts had some specifications as to what types of mental illnesses they accepted, but they did not report the nature of those specifications; 37 percent of responding courts accepted individuals with an Axis I disorder; 21 percent accepted individuals with a "serious and/or serious and persistent" mental illness; and 26 percent had no mental illness-specific admissions criteria.[10]

Other eligibility factors frequently mentioned in the literature include the strength of the perceived connection between mental illness and criminal behavior; treatment compliance while in jail (i.e., must take medication because that indicates "motivation"); past treatment compliance; and suitability for the court (i.e., "fits with the culture of the court").

Psychosis refers to a group of symptoms that vary in frequency, duration, and intensity within affected individuals. Examples include persecutory or paranoid delusions, where individuals believe they are being threatened or attacked, and command auditory hallucinations, where individuals hear voices directing them to do things that may include harming themselves or others. Mania likewise includes a range of symptoms that can vary over time. Common examples include significantly increased energy, irritability, impulsivity, and grandiosity, along with excessive involvement in high-risk activities such as reckless driving, unrestrained buying sprees, and sexual indiscretions.

If psychosis or mania emerge when the person is not in the care of a support team, the likelihood of erratic or defensive physical behavior increases. When severe, both psychosis and mania can manifest in complete loss of behavioral control that may necessitate the use of physical restraints or sedation, thus increasing the likelihood of arrest.

What happens to people who are deemed incompetent to stand trial or plead not guilty by reason of Insanity (NGRI)

Some defendants enter the CJ system because of their actions during times of psychosis. If these defendants are found to be incompetent to stand trial or consent to MHC proceedings and their evaluation concludes that they are likely to regain competency if treated, they are committed to in-patient treatment for competency restoration.

Competency restoration provides access to a sustained period of hospitalization, often with a lower threshold for ordering involuntary medication--a course of treatment that is otherwise relatively unavailable to non-forensic patients. Although the data is limited, there is some research on the role of competency to stand trial in MHCs. According to one study of defendants found incompetent to treated to competency, even with treatment to competency, 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. The authors of this study conclude that the ultimate diversion from the criminal justice system for incompetent misdemeanants may involve

involuntary hospitalization through a competency restoration commitment. For these individuals, inpatient competency restoration, coupled with intensive community-based services like assertive community treatment (ACT)- such as Community Treatment Alternatives in Wisconsin, may result in better community outcomes for defendants not able to participate in MHC, if they are initiated prior to discharge.[12]

Even if defendants meet the standard for legal competency to stand trial, their mental disorders may impair their abilities to make effective treatment decisions[13]. Given this, what expectations of competency should MHCs adopt? One approach to this difficult question is offered by King County, Washington, which permits defendants to enter treatment for a short period of time pre-plea to stabilize their condition and maximize their ability to make competent decisions about their legal and treatment options. In designing MHC programs, it is important to consider issues of competency, not only from a constitutional perspective, but to ensure that defendants who are too disturbed for MHC are also diverted from the criminal justice system. In Wisconsin patients too disturbed for a MHC would likely be committed to DHS and released into an institution via the Conditional Release program.

> "And somebody who has been found not competent, who's been then restored to competency. And then we're like, 'Well you know what? We're going to just put you on probation and with a hope and a prayer you get some treatment, that the DOC offers you some programming with no guidance that we're providing the DOC and no real control or accountability on our end. We're just hoping.' Right. Or sometimes, people will say, 'I don't want probation because I don't like probation.' They've had that experiences on probation. So then we say, 'Okay, fine, some jail.' That's the worst thing you can do for somebody who is dealing with mental health issues. Right. People so commonly, so often just further decompensate while sitting in the jail."

How do different Mental Health Courts motivate participants to comply with the treatment plan?

All MHCs strive to motivate via a balance of rewards and the threat of punishments, or sanctions. All participants are either promised dismissed charges or reduced probation sentences and threatened with some sort of sanction, either more jail time, or increased community service requirements. Interestingly, the King County Mental Health Court in Seattle, Washington tries to avoid using jail sanctions because offenders' mental condition often deteriorates in jail, making it harder for them to re-engage in treatment upon release.[14] The San Bernardino, California Mental Health Court also seeks to avoid the use of jail, but for a different reason. Interestingly, they found that offenders with mental illness were simply not motivated by the threat of jail. Many regarded a stay in jail as a welcome relief from the difficulties of life in treatment or in the community.[15] As a result, San Bernardino has aggressively employed community service sanctions instead.

To what degree do Mental Health Courts actually divert PSMI from the criminal justice system?

When a person is fully diverted from the system, they leave without serving time and without charges on their record impacting their ability to secure jobs or housing for any period of time. To truly divert persons with serious mental illness from the CJ system, courts need to engage people pre-adjudication.

Pre-plea or Post-adjudication: What is the difference?

- Pre-adjudication courts do not require a guilty plea or conviction before joining the program. Charges are held in abeyance until the program is successfully completed, then charges are usually dropped.
- Post-adjudication requires a guilty plea or a conviction before entering a MHC. However, some courts then allow participant's records to be expunged upon successful completion.

> In a 2003 national survey of 20 Mental Health Courts half required "guilty" or "no contest" pleas to participate. One-third allowed either dismissal or expungement upon completion. [16]

Mental Health Courts utilize both models, but newer, second-generation courts tend toward the post-adjudication model. This model has grown as courts accept more defendants charged with felony crimes. Others take a blended approach wherein participants can enter the court pre-plea if they have no prior offenses that involved serious acts of violence. And post-conviction participants who have some violence in their past could enter the MHC if they were seen as no longer posing a threat of danger to others as determined by the District Attorney and other MHC team members.

The **San Francisco, CA** Behavioral Health Court is a notable exception to the pattern. The court accepts those with felony charges but does not require a guilty plea. The reasons they offer is that a felony plea can negatively impact a person's ability to access housing and employment, nor do they want to force defendants to relinquish constitutional rights (such as the right to a jury trial) in exchange for access to mental health treatment.

What is the process for recruitment and retention of Mental Health Court participants?

All MHCs rely upon referrals from someone processing the offender, the DA or defense attorney, a family member, or the offender. Participation is voluntary and can be terminated by the client at any time. While, at least in some instances, the decision facing the client is jail or ''treatment,'' one study on defendant perceptions of MHCs reports that defendants do not perceive their court process as being as coercive as other types of criminal processing. [17]Premature termination from the program results in the client being faced with the same legal charges they had on entry to the program. For pre-plea clients, graduation from the program results in their charge being dropped, while post-conviction clients typically have a reduction in their terms of probation. The program can also terminate the client's participation, and primarily does so when clients commit new crimes that send them to prison and renders them ineligible for the program.

How is eligibility determined?

The literature on Mental Health Courts indicates that they should establish clear eligibility and priority criteria to select for those who are "high risk/high needs". What does it mean to be a high risk/high needs individual and how can courts ascertain that a defendant meets these criteria? Best practice suggests using formalized assessment procedures, without which program slots can easily end up filled with individuals in low-risk/low-need categories. Criminal justice and behavioral health professionals are often trying to meet the different goals of public safety and treatment needs and can easily speak past each other when trying to determine placement for individuals with mental health with or without co-occurring substance use disorders who find themselves involved with the criminal justice system. The Council of State Governments Justice Center created the Criminal

Justice/Mental Health Consensus Project to develop a systems-level framework that would bridge these seemingly competing needs to identify risks and needs.[19]

The framework has three consecutive steps: using validated tools defendants are first assessing for criminogenic risk and then for the seriousness of mental health needs and substance use disorders. People are then assigned to a group based on their score in each category. The goal is to match the intensity of treatment both to the level of risk of reoffending and to the level of need. Only those in the group with the highest risk for recidivism and with the highest mental health needs would be eligible for a MHC. This framework would also assist in determining whether someone with a co-occurring disorder should be placed in Drug Court or a Mental Health Court. A fuller discussion of this conceptual framework as well as the decision tree for assigning groups can be found in *Appendix 2, Assessing Eligibility*.

Operationalizing this framework requires separate tools to assess risk of recidivism and mental health as well as substance abuse needs. Since such a high proportion of those with mental health issues and criminal justice involvement have co-occurring substance use issues, it is advised to use a tool that is screens for co-occurrence and is validated for use in the criminal justice system. All of the SAMHSA recommended instruments in this category require administration by trained clinicians credentialed in assessing and diagnosing mental and substance use disorders and related psychosocial problems. SAMHSA's recommendations may also be found in *Appendix 2*.

Algorithms and Crime Prediction

Algorithms are commonly used to assess the statistical likelihood that a criminal defendant will commit another crime. These predictions are used in trial, parole, and sentencing decisions. The argument is that big data is more accurate and less biased than humans. However, a 2018 study of the COMPAS assessment tool found that a group of random volunteers recruited on the internet had "virtual equal predictive accuracy" as the algorithm. Does this matter? The Wisconsin Supreme Court thinks not. It ruled against a defendant who claimed the use of the algorithm violated his due process rights, saying that the sentence would have been the same had COMPAS not been used. Proponents of the algorithm argue that these findings actually validate the tool: asking people to focus on a clear set of determinants yields more accurate results than overloading a human with lot of subjective information. Several independent studies indicate that the predictive standard of the COMPAS reaches the accepted standard of .70. For the purpose of a MHC the use of the COMPAS is to also guide case management decisions.[18]

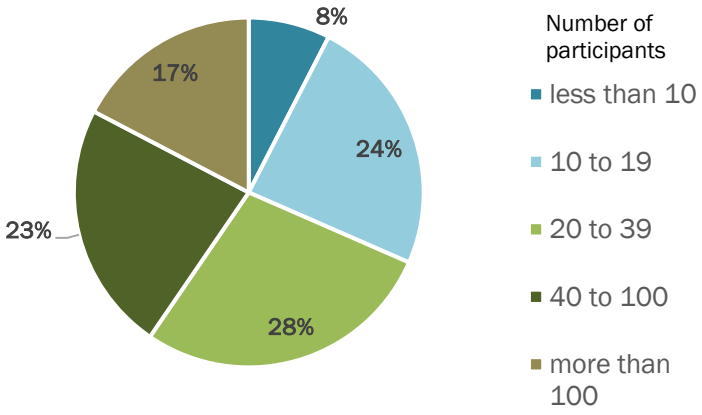
It is highly recommended that the same screening and assessment tools and procedures be used across all courts and diversion programs to assure people are placed in the most appropriate program.

How many people does a Mental Health Court typically serve each year?

Based on the 54% of courts that report this data in the SAMHSA GAINS Center Adult Mental Health Treatment Court Locator, it appears that courts are somewhat evenly distributed by size. About 40% of courts serve more than 40 participants each year, while 52% serve between 10 and 40 participants. Eight percent of courts see fewer than 10 participants a year.

What are the national best practices in the design of a Mental Health Court?

As measured by the number of participants served annually there is no "typical" size of court.



While there are some general patterns, there is also significant creative variation among Mental Health Courts. To promote peer-to-peer learning the Bureau of Justice Assistance has designated four MHCs as "Learning Sites". These courts provide a glimpse of the opportunities for diverse approaches courts can take. **Bonneville County, Idaho** prepares people nearing completion of the program to become peer support specialists or recovery coaches, both potential employment options. The **Ramsey County, Minnesota** MHC partners with a private law firm that provides pro bono legal services to their participating defendants. **Dougherty County, Georgia** Court supports people with developmental and other disabilities and its team includes caseworkers from a disability advocacy center. Court teams also include NAMI representatives, vocational rehabilitation specialists, or entitlement specialists. They may extend their resources by utilizing law students, or treatment interns. Local relationships and resources have clearly shaped the design and function of the courts. *Appendix 3, MHC Model Learning Sites*, provides a more detailed comparison of four Mental Health Court "Learning Sites".

How do the other Mental Health Courts in Wisconsin Operate?

Wisconsin has three MHCs. They are in Brown, Eau Claire, and Outagamie Counties. Started in the early 2010s they share many features with those considered "typical" courts. They accept participants charged with either felonies or misdemeanors, serve around 20 participants per year (although Eau Claire County's court is much smaller), and see people with severe mental illness. One interesting feature of the Eau Claire Circuit Courts is that they renamed all their treatment courts referring to them by Branch number to reduce any stigma attached to participating in a Drug or MHC. The case coordinators engage in constant networking to spread awareness of the courts and ensure referrals from the Jail and private defense attorneys. The court team reviews potential participants together to decide on placement in the appropriate court. More details on the Wisconsin courts can be found in *Appendix 4, Wisconsin Mental Health Courts Compared*.

What resources are necessary for a successful Mental Health Court?

Despite the fact that Mental Health Courts look different in different places there are nonetheless certain elements that have been identified as essential to their success. A table with the essential elements for success identified by the Bureau of Justice Assistance can be found in *Appendix 5, Ten Essential Elements of a MHC*, and there will be more discussion of them in the third section of the report focused on Next Steps. Here we highlight the essential resources courts need if they are to deliver on their promise to participants.

To serve high needs populations, MHCs must be highly resourced. Without these, people are being set up to fail. The highest priority services are:

Individual resources:
Dedicated medication management. Ideally the MHC would have its own psychiatrist and/or prescriber as part of the court team. Medication management needs to happen quickly and consistently and outsourcing this crucial feature can become a significant barrier to good practice.

Housing. A large portion of the people the MHC would serve are likely to be experiencing homelessness. Safe, stable, and supportive housing is the foundation of all treatment and recovery, and without it, success is highly unlikely. Additionally, a number of investigations have found that housing security is related to lowered recidivism rates among graduates of MHC, with the absence of housing security predicting a reduced number of days until first rearrests.[20,21]

Rehabilitative Services. Services such as **employment**, **substance abuse treatment**, **psychological counseling** that can provide evidence-based treatment such as CBT and addresses criminogenic needs, and **benefits counseling** were all considered essential. Additionally, **case management** that provides individualized life planning and connection to needed resources and social supports are also deemed critical. For defendants with co-occurring disorders, current recommended best practice is to have both mental health and substance use disorder treatment provided by a single clinician or by a coordinated clinical team.[22] The case manager should also be a stable part of the treatment team and not outsourced.

System resources
Judge. Probably the single most essential resource required for a MHC is an appropriate judge willing to commit to serving the court. Ideally this should be a person with some lived experience of mental health issues, whether personally or through family experience. The judge must be "the right" kind of person, meaning that they are skilled at working empathetically with the population; have a nuanced understanding of the relevant contexts; and can still provide authoritative oversight and hold participants accountable. When participants feel like they understand the court process, have a voice in the proceedings, and trust the neutrality of case decisions, it is due to elements of procedural justice. One of the few studies examining the role of the MHC judge in reducing recidivism found that judges who follow elements of procedural justice preside over courts with lower rates of recidivism. This includes treating participants with high levels of dignity and respect, holding participants and service providers accountable, and holding open negotiation processes to encourage decision-making transparency.[23]

Identifying potential participants for the Mental Health Court is also resource intensive. Pre-charge evaluation of mental health, not just criminal risk would be required. Ideally evaluations should be conducted by a person with **clinical experience**, not just a court administrator, located in the District Attorney's office. The **District Attorney's office** also requires enough prosecutorial staff to assess not just whether there are grounds to charge someone, but whether they should be charged and/or diverted to a different program or to a MHC. A best practice in this area is to move toward more universal screening for mental health concerns and risk of recidivism.[24] Evaluations also need to be administered fairly extensively to avoid bias in selecting candidates (see equity). For a more extensive discussion of the assessment process and evidence-based assessment recommendations see *Appendix 2, Assessing Eligibility*.

The Treatment Court Team. A dedicated Mental Health Court team includes the judge, the DA, a **Case Manager**, a **psychiatrist** for immediate assessments and services, as well as a **peer support specialist** for the defendant and extended family members. The court team needs to consist of individuals with some professional background in behavioral health treatment for proper selection of individuals who could most benefit and for the coordination of care and supervision required for their success. All of these members need to meet regularly, have open communication channels between meetings, and have **extensive and on-going training** in the operation of MHCs and in mental illness. It is critical that case-managers have strong relationships with community partners to support referrals and strongly suggested by both interviews and the extant literature that court staff and mental health staff are cross-trained on each other's procedures.[25] Quality case managers have been identified as particularly important for effective MHCs.[26]

> "[What the courts need is] somebody who has some representation. Somebody who has lived experience with mental health and certainly with the criminal justice system. Someone who can help navigate, and advocate. And somebody who is your person, so that when you come in, whether it's at booking or at the point when you might be referred or to even know about this program. And somebody who helps you... Even if you end up in this mental health court with all these people around you, that's still a set of professionals, and your connection and trust of them is going to be limited at least, initially. So, a peer support person is somebody who hopefully a defendant would feel is more of a peer"

What are the critical equity issues to consider?

Could a Mental Health Court worsen inequities?
Standardized, equitable, unbiased screening, referral and termination policies are all critical if a MHC is not to reinscribe existing inequities. Creating such policies, however, requires that everyone involved in the creation and implementation of these policies is cognizant of the history of racial and other inequities in society and in the criminal justice system. Policies need to be created and continually examined with an eye to how they operate on and impact people who are differently situated. Regular monitoring and evaluation for disparate results is crucial to assure that the community is being served equitably.

> "I am concerned about the fact that this could turn into a way to just overcharge or charge more people who are dealing with mental health issues with crimes. For example, [in] our drug diversion court, often they won't take violent crimes, but they also won't take people charged with, most misdemeanors. And so, it's almost like this weird incentive to charge somebody with a felony when you otherwise wouldn't because you're like, 'There's no other way to get this person treatment,' which is a very screwed up incentive system. "

Will a Mental Health Court bias the system toward more coercive treatment? It is crucial that follow-up care be provided to reduce recidivism and repeat hospital admissions. Yet, it also begs the question of how long Mental Health Courts should maintain jurisdiction over defendants' treatment. That is if, in fact, MHCs improve access to mental health services, should court jurisdiction be expanded substantially (or permanently) to persons with severe mental illnesses who are partially or fully unresponsive to voluntary treatment? Even if clinically sound, does this not subject defendants with mental illnesses to longer supervision than would be the case but for the mental illness? Given the scarce public mental health resources available in many communities, will MHC defendants be given priority over non-offenders? The outcome to these questions has the propensity to significantly change the

outpatient mental health paradigm in favor of coercive treatment as a matter of routine for many persons with severe mental illnesses.[27]

Requiring a history of MH diagnoses. Although many MH courts require a documented history of mental health issues for eligibility to the MHC, this was raised as a potential systematic barrier for members of historically marginalized communities. People may not have received a diagnosis for many reasons. They may have been excluded from health insurance coverage, lacked services, been unable to pay for services, or have been unwilling to seek services because of stigma in their community. Although few jail diversion studies provide information about individuals who are referred for diversion but who are ultimately not diverted, of the two that have looked at this, individuals referred for diversion were disproportionately older, female, and white compared with arrestees nationwide. One explanation for this finding is that referrals and program decisions are influenced by subjective factors related to public fear and general beliefs about who is "deserving" of diversion. A second explanation is that there is inherent disproportionate representation in the jail population related to which subpopulations experience mental illness; in other words, older people, whites, and women are more likely to be referred and diverted because they are more likely to be identified as having a serious mental illness upon entry into the criminal justice system, [28] whereas people of color are more likely to be seen as inherently more criminogenic in nature.

> "a lot of these services are viewed through white lenses and that's a skewed approach. Individuals are not being provided service, or in a way assessed by somebody who looks like them. So, there's already this built-in bias. So, I think it's really a deep, rooted problem that I think all of our systems really have and that's a big question because we have a scarcity of clinicians, who identify as a person of color. I just don't think our services in our communities are diverse enough to be able to really focus on that issue and make changes. I think we're trying, but it's going to be a long road."

Do eligibility and referral processes bias the court toward only serving populations deemed "redeemable" in the court of popular opinion: Court Usage Surveillance & Monitoring. Some research indicates that women and white people may be overrepresented in Mental Health Courts, compared with their proportion of the local criminal justice population, and that this "bias" seems to occur at the point of referral, rather than acceptance, into the program. Regular measurement of who is, and is not, being referred and served as well as analysis of this data must be a central part of performance measures of a MHC.

Does the court center white norms and expectations? Representation is key at all stages of the court. Mental health and substance abuse problems are spread equally across the population. Yet, the lack of diversity within the courts and among those implementing programs and providing clinical treatment creates an unhospitable and inequitable system for many. **Peer support specialists** could help with this issue. They could enter at an early stage such as at booking. Over time they could take on larger roles and become a regular part of the MHC team. People of color, as well as those with lived experience at the intersection of mental illness and criminal justice must be involved from the very beginning with the design of a court.

Are financial barriers preventing some folks from benefitting from a Mental Health Court? No one should be prevented from accessing a MHC because they are unable to pay bail to leave jail. Some

WI counties have buy-ins for treatment or diversion courts. The court must be available to all regardless of economic situation. Additionally, many PSMI engaged by the criminal justice system accrue a number of misdemeanors and subsequently fines. These fines can prevent the now stabilized person from qualifying for housing because they go to collections and are counted as debt against them.

> "Somebody said along the way, people that has violent histories do not qualify. And I think that that is [about] not having the belief that people can change.... If you could bring yourself to remember the time that you were the most angry in your life, and you might have done something different. A lot of the people that we get to work with were never taught that anger is a valid experience. And there's also a way to express it and a way to not express it. But it's valid, nonetheless...And there's some challenges because there's domestic violence and what they refer to as people who repeatedly do these types of things and don't seem to be capable of changing the narrative. But I would argue with that too, because we don't know because nobody ever gave them the chance. They were somehow labeled and cast off as somebody that only deserve to go to an institution, rather than look at that rehabilitation piece."

Eligibility criteria may systematically keep historically marginalized populations out. The process of efficiently identifying eligible defendants is a key area to consider equity. While there is precedent for setting universal eligibility criteria for entering a MHC, there are also concerns that such criteria may unintentionally deepen racial inequities in incarceration by structurally excluding certain groups from the opportunity to avoid incarceration and have one's charges dropped. Many courts only take defendants with certain diagnoses, a history of treatment, or with certain types of offences (e.g., only misdemeanor or only felony offences; no violent offenses).

Excluding convictions involving violence will disqualify more BIPOC (Black, Indigenous, People of Color) defendants who tend to be given more serious charges. In addition to the implicit biases widely noted in disproportionate police contact and use of force with civilians with darker skin tones, key informants noted that BIPOC individuals are given more serious charges. In many cases, this makes them ineligible for MHC participation. This issue could be avoided by using alternatives to Treatment and Diversion (TAD) funding from the federal government.

> "The other concern is the fines that come with these five or 10 disorderly conducts. I mean, it's just putting people into collections and then they can't get housing because they owe this money and so I would say if they go to mental health court they don't have fines. . . . If you could say, "Hey, work with this court and we'll drop your fines. You just have to work with these people for a year. Something like that. I could see mental health court in that array, in that situation"

Do the assessment tools have a bias toward screening BIPOC defendants out of the Mental Health Court?

Biases in Mental Health Screeners. The Brief Jail Mental Health Screen (BJMHS) is one of the few screeners that has been analyzed for racial bias. Analyses suggest that the BJMHS has a bias for screening Blacks and Latinos out of eligibility because of appreciably lower odds of endorsing items regarding prior mental health service utilization.[30] This finding illustrates how structural racism can inadvertently influence access to a MHC via screening processes.

Biases in the use of algorithmic risk assessment tools. Black defendants are frequently classified as higher risk than white defendants (see box) and these classification errors mean that Black defendants are more likely to have bail requirements and receive higher sentences than whites. Perhaps this is less of an equity issue when being considered for a MHC as it would mean Black defendants would have an increased eligibility for the program. Nonetheless, the disproportionate impact on Black defendants should be of concern. Algorithms can improve the efficiency -- and by removing individual bias, improve the equity -- of judicial decisions. But they also raise ethical issues and require that a human lens with an equity focus needs to be applied. One example of this is the suggestion that rather than eliminate the use of predictive algorithms we eliminate bail altogether in favor of electronic monitoring so that no one is unnecessarily jailed.[31]

Is COMPAS racially biased?

A 2016 ProPublica investigation charged that the frequently algorithm used to make bail and sentencing decisions was racially biased against Black defendants. This claim has been rebutted and the tool remains highly predictive of recidivism based on scores. Yet, concerns remain about the fairness of the scores. Within each risk category – "low" and "medium to high" -- recidivism rates among Black and white defendants is about the same. The overall recidivism rate, however, is higher for Blacks. That is because Black defendants are assigned to the higher risk category more than whites. Mathematically, that means that more Blacks who don't reoffend are classified as higher risk than whites. While the algorithm does not explicitly include the defendant's race Black defendants are more likely to have prior arrests and other flags used by the algorithm to predict reoffending. Re-arrest, the measure risk assessment algorithms are designed to predict, may also be a biased measure of public safety. If policing is heavier in Black neighborhoods, then Blacks are more likely to be (re)arrested than whites who commit the same offense. [29][31]

Is the stigma associated with mental illness and legacies of harm cause by institutions preventing some populations from choosing to engage with a MHC? Evidence has shown that MHCs were disproportionately serving white males in their mid-thirties and offenders of ethnic and racial minority groups declined participation or withdrew early. There were four main reasons identified for cited for this withdrawal. First was the stigma associated with mental illness. Second, the historical distrust of the court system. Third, the familiarity of the traditional court system. Last, the distrust of the behavioral health system.[32]

Are existing services in the community culturally-matched and geographically equitably distributed?

Access to services is a key issue related to existing gaps in behavioral services across the state of Wisconsin. If the court seeks to reduce the overrepresentation of BIPOC and other historically marginalized populations in the criminal justice system, then the services to support and stabilize them in the community need to be accessible. Additionally, because of legacies of trauma, many individuals from historically marginalized communities are more willing to engage with treatment provided by people who look like them or face similar barriers out in the world.

> ""[What the courts need is] Somebody who has some representation. Somebody who has lived experience with mental health and certainly with the criminal justice system. Someone who can help navigate, and advocate. And somebody who is your person, so that when you come in, whether it's at booking or at the point when you might be referred or to even know about this program. And somebody who helps you... Even if you end up in this mental health court with all these people around you, that's still a set of professionals, and your connection and trust of them is going to be limited at least, initially. So, a peer support person is somebody who hopefully a defendant would feel is more of a peer"

Performance metrics for Mental Health Courts

Success of a MHC is ultimately evaluated in light of the court's own goals. Although MHCs are an investment designed to reduce the burden untreated adults with mental illness place on the criminal justice system, zero recidivism is broadly understood as an unachievable goal.

Additionally, since unexamined biases can produce a court that actually deepens disparities by only qualifying adults generally seen as redeemable and easy to treat, its equally as important to judge a court's success by its equitable impact on the target population. This would involve monitoring for equivalence across groups for program completion **rates**, **quality and intensity of services**, and **administration of incentives and sanctions**, including **sentencing disparities**.

> "[BIPOC] folks are not getting referrals for these differed programs. They're just not. They're getting booked, they're getting sent to jail. So, when you talk about fairness of equitable services, it's clearly not happening, [When you look at the numbers for our CTA program] people of color are a really tiny amount [because]…men with dark skin or different color skin are always diverted to the criminal justice system versus the mental health system."

S.M.A.R.T.I.E. Performance goals for measuring the success of a program are Specific, Measurable, Achievable, Realistic, Time-bound, Inclusive and Equitable. The National Center for State Courts piloted performance measures in four Mental Health Courts in 2010. They settled on fourteen measures that cover participant accountability, case processing, collaboration, appropriate treatment, procedural fairness, and aftercare/post-exit transitions. These measures focus primarily on how well the court is operating. They have created an implementation and user guide as well as Excel based templates that can be downloaded for data collection and analysis. All documents can be found here. The Bureau of Justice Assistance also has a Guide to Collecting Mental Health Court Outcome Data[33] which has a more detailed list of outcome measures in four outcomes areas: Participants, Services, Criminal Justice Outcomes and Mental Health Outcomes. *Appendix 6, MHC Performance Metrics*, provides a table detailing these measures.

Wisconsin metrics. Wisconsin's MHCs vary considerably in the depth of metrics they track. Brown County counts the number of completions and terminations. Eau Claire and Outagamie Counties track individual data for three years post program, with Outagamie comparing data for individuals pertaining to employment, volunteering, homelessness, and alcohol use before, during, and after participation in the MHC. Both track recidivism for three years as well as additional system-level data. Outagamie tracks expenditures for UA testing and hospitalizations; Eau Claire calculates incarceration days saved. Eau Claire also surveys participants

> "Recidivism is going to happen, it's inevitable. But I think if the recidivism is framed as somebody who once committed a violent crime against a person, but then commits property crime or commits some form of theft. I think that's a really important nuanced point that has to be made because I think our community is safer when somebody is less likely to commit a violent crime that they once committed, and then, yeah, probably they stole $4,000 worth of merchandise from a Home Depot and that's not good and that's unacceptable, but I think we can all agree, we would much rather have that than that person biting the earlobe off their romantic partner."

for procedural fairness and recovery coach satisfaction. More details can be found in *Appendix 4: Wisconsin Mental Health Courts Compared*.

II. Looking Local: Considerations for Implementing a Mental Health Court in Dane County

This section summarizes findings from our secondary data analyses and key informant interviews.

> "either we can incarcerate people indefinitely who have proven to be potentially dangerous, which I think we all agree is a very, very bad choice, inhumane and probably unconstitutional under almost all but the most serious circumstances, or we could try to deal with root causes and a root cause is so often mental health"

Key Findings:

- Most respondents think a Mental Health Court could, under the right circumstances, be beneficial in Dane County.

- Data from Dane County Human Services (DHS) records suggests there is a sufficient population of individuals with severe and persistent mental health concerns and criminal justice engagement to justify establishing a Mental Health Court.

- Most respondents think there are some clear **benefits** to a Mental Health Court. But no one saw a MHC as a panacea. At best it is seen as playing a **limited role** at a late stage in a comprehensive CJ/MH system. A MHC was **acceptable to the degree that it reduced the number of people with mental illness in prison** and diverted them from the criminal justice system. But, **unacceptable to the degree that it would substitute for comprehensive services** and diversion approaches or attempt to solve social problems by bringing people with mental illness into the criminal justice system using extensive supervisory procedures. Other interventions were seen as equally or even more effective were other forms of pre-trial diversion, use of court-appointed mental health advocates and case managers, and mandatory treatment as part of probation or parole.

- Providing **access to comprehensive treatment and services is a higher priority** to most respondents than providing judicial oversight or leverage to engage in treatment. There was, therefore, more interest in better coordinating and expanding Dane County's comprehensive system of community-based services and supports for those with mental health conditions before implementing a Mental Health Court.

- Most respondents thought that the community's goal should be to divert people with mental illness from the criminal justice system at the earliest possible stage. Priorities were therefore to **focus on the community's early intercept initiatives** before implementing a Mental Health Court.

- A definitive set of **eligibility criteria** did not emerge from the interviews. Some thought those who would most benefit were repeat misdemeanor offenders and others thought the court would focus on those charged with more serious offenses. Still others thought . . . This suggests a court that accepts those charged with both types of crimes.

- Respondents recognized that a Mental Health Court would serve a very high needs population, who by definition will require **considerable resources.** There was complete agreement that developing a Mental Health Court without these necessary resources would be disastrous for participants.

- There are several structural issues regarding racial (and other) **equity** that would require attention.

- There are also significant **additional concerns –** both concrete and philosophical – that would need to be addressed for those interviewed to feel comfortable about implementation of a Mental Health Court.

Is there a need for a Mental Health Court in Dane County?

Both key informants and secondary data sources suggest there is a sizeable population that could benefit from the opportunity to enter a MHC. Since eligibility typically rests on a number of factors, including the degree to which the crime is attributed to mental health concerns, exact numbers are hard to estimate without reviewing each case. However, as is the true across the country, there is evidence that a significant proportion of adults engaged by the criminal justice system also have ongoing mental health concerns that may be playing a causative role in their drain on law enforcement and judicial resources.

> "There's a whole lot of people that have 20 open misdemeanor cases in Dane County courts right now who should be in mental health court or should be looking at a diversion that gets them treatment because all those crappy misdemeanors are going to do nothing but tie up the system and cost a whole lot of money and it's because they're ill, and impulsive."

According to data from the jail, 48% of inmates are taking medication for managing mental health concerns. Data published in the 2019 sequential intercept study suggest that like most CJ systems, Dane County is engaging a large number of defendants who may benefit from a mental health focused problem-solving court.[34]

Additionally, of the 8,747 intake assessments completed by jail staff over the 10 months between November 2016 and August 2017:

- 33% of individuals had previously used mental health medication
- 25% were currently on mental health medication at the time of intake
- 37% had received previous mental health treatment
- 46% had received a mental health diagnosis in the past
- 21% reported self-harm in their past

Estimates on the number of potentially eligible defendants in Dane County

Each year, approximately 262 adults with Axis I diagnoses receiving services from providers contracted by DHS also have criminal justice involvement. This is the intial pool of people who would be eligible for a MHC. The group would then be filtered by their actual criminal justice charges, data we did not have access to, to be considered for MHC participation.

According to data entered into service authorization forms and CCS intake forms by mental health providers contracted with DHS, of the 13,372 individuals who received mental health services in Dane County between 2017 and 2020, 1,656 also had criminal justice involvement (including probation, parole, and arrests).[35] New arrest rates ranged from 204 to 379 individuals a year and between 107 and 179 individuals receiving mental health services via providers contracting with DHS were imprisoned each year.

> Between 2017--2020
> among adults receiving mental health services each year:
> 204-379 were arrested and
> 107-179 were imprisoned

63% of adults (n=1045) receiving mental health treatment and having criminal justice system engagement between 2017 and 2020 had a diagnosis that is typically eligible for MHC. Of the 1,656 individuals who had CJ involvement while receiving mental health services by providers contracted with DHS between 2017 and 2020, 63% (n=1045) of these individuals had at least one axis 1 diagnoses (See Table 1 for a breakdown of specific diagnoses). Of this group, over half (56%, n=582) had a bipolar diagnosis that was severe, or bipolar with psychoses or mania.

The pool of defendants potentially eligible for MHC is disproportionately Black and houseless relative to the general population of Dane County. Of the 1045 individuals with CJ involvement and an eligible diagnosis, 12% were unhoused; 66% were Male; and 60% were White (34% Black). According to the U.S. census, only 5% of the Dane County population identifies as Black.

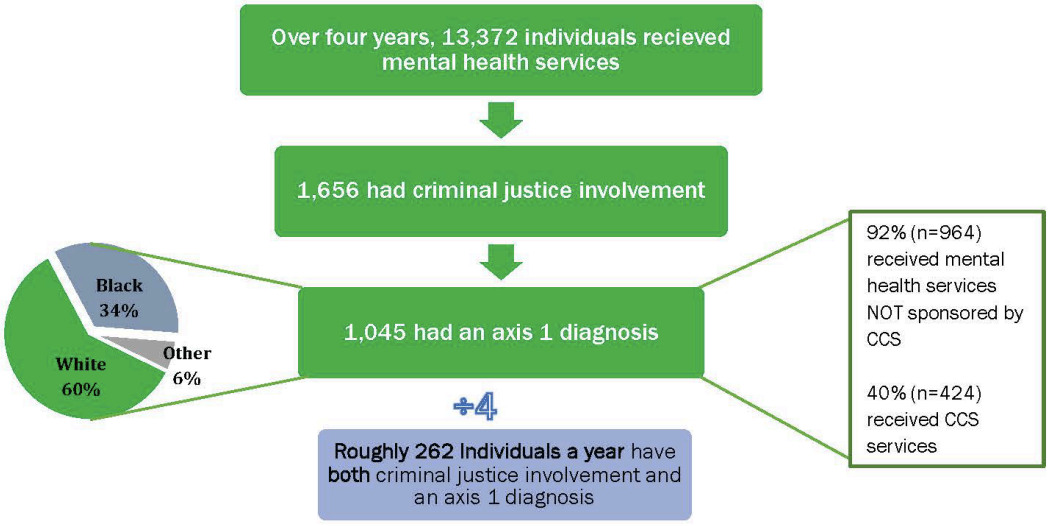


Table 1.
Over half of the individuals receiving state-sponsored mental health services between 2017-2020 (N=1045) had one or more eligible diagnoses

Diagnoses eligible for MHC	n	%
Bipolar [Severe; or with Psychoses, or mania]	582	56%
Schizoaffective Disorder	275	26%

PTSD	305	29%
Mood Disorder NOS or Psychotic Disorder	239	23%
Major Depressive Disorder [Severe &/or with Psychoses]	107	10%
Schizophrenia	68	.06%

Note. PTSD= Post Traumatic Stress Disorder. Dx= diagnoses. NOS= not otherwise specified. All but three had multiple points of contact with CCS and multiple diagnoses entered into their service authorization forms. Therefore, the diagnoses are not mutually exclusive, and the column total should not equal N=1045.

How would a Mental Health Court integrate with the other problem-solving courts in Dane county?

Key informants from the Dane County drug court noted that while a portion of their defendants also had mental health issues, they did not feel that a Mental Health Court would draw from the same pool that are matched to their court.

According to a dataset of 788 adult clients[36] who received services from AODA deferral programs between 2017-2020, 288 had at least one mental health service authorization via community coordinated services. Of the 288, n=87 had an eligible diagnosis (see Table 2 for details). Each year, this amounts to approximately 21 clients in AODA deferral services that may be eligible for entering into MHC instead. However, this pool would only be deemed eligible if it appears their underlying mental health needs were causing their substance use disorder and related to the crime for which they are being charged.

According to AODA deferral program data from 2017-2020

Each year, approximately **21 individuals** participating in AODA referral services **may be eligible for MHC**

Table 2. Number of Adults in AODA deferral services with an eligible diagnosis

At least 10% of individuals in AODA deferral services between 2017 & 2020 (N=288) had at least one eligible diagnosis

Diagnoses eligible for MHC	n	%
Bipolar [Severe; OR with Psychoses, OR manic]	30	10%
Major Depressive Disorder [Severe &/or with Psychoses]	28	10%
Mood Disorder NOS or Psychotic Disorder	20	7%
Schizophrenia	14	5%
Schizoaffective Disorder	5	.02%
PTSD [n=3 cases with just a PTSD Dx]	19	7%

Note. PTSD= Post Traumatic Stress Disorder. Dx= diagnosis. NOS= not otherwise specified. Diagnoses are NOT mutually exclusive. All but three had multiple points of contact with CCS and multiple diagnoses entered into their service authorization forms. Therefore, the column total will not equal 87.

How would a Mental Health Court integrate with other existing criminal diversion programs in Dane Co?

Community Treatment Alternatives. Dane County benefits from a number of Community Support Programs (CSP) designed to divert people with severe mental illness from the CJ system. Community Treatment Alternatives (CTA) is a CSP for people who have a serious mental illness and are incarcerated in the Dane County Jail **or** have been granted a Conditional Release *after* being found not guilty by reason of mental disease or defect (NGRI). Through NGRI and conditional release, people who are truly not guilty due to their mental illness are diverted from the criminal justice side of things and pushed more into the mental health side of things. If their release is revoked, they return to one of the in-patient institutions. While CTA serves the majority of conditional release individuals and the majority of clients on conditional release in Wisconsin have been charged with a felony crime, conditional release clients appear to be a fraction of the CTA caseload. According to CTA data, only 22% of their clients had felony charges, while 62% had CJ involvement for misdemeanor charges, while 9% were probation holds, and 7% were criminal traffic charges. This means the CTA program appears to skew away from serving clients with felony offenses, a niche a MHC could fill.

Much like a MHC, CTA was targets people who committed a crime related or because of their mental health issues and require intensive wraparound services. Like a MHC, engagement in the CTA program is voluntary, and all who choose to enter CTA are legally required to participate in treatment. CTA referrals come from many of the same sources as a MHC and more: the Public Defender's office, the District Attorney's office, the Dane County Conditional Release coordinator, probation and parole agents, parents, and occasionally the potential clients themselves.

> A graduate of CTA has a criminal conviction on their record forever, whereas a successful graduate of a MHC will eventually be free of a criminal justice record

> "There are some wonderful programs out there, like the PACT program here in Dane County that offer great wraparound services for people who really need that support. But it's grossly underfunded…Look, if you want to expand programming that makes it less likely or less necessary for there even to be a criminal or a court intervention, I'm all for that. But I think the argument against that is that it's just not happening and it's not going to happen."

Similarly, just as a MHC would, CTA historically provided assistance finding the appropriate mechanism to obtain the person's release from jail (e.g. – bail modification, sentence modification, differed prosecution, alternative to revocation of probation/parole, etc.). However, according to staff, it has been some time since the DA's office has had the capacity to coordinate with CTA staff to defer prosecution. Upon release clients are provided with comprehensive, ongoing services, following the principles developed by the Program of Assertive Community Treatment (PACT). CTA was the first jail diversion program in the country to employ the

principles of Assertive Community Treatment. Services provided by CTA also overlap considerably and at times exceed the depth of services typically provided by a MHC. These include: medication evaluation and monitoring, assistance in obtaining a source of income, locating housing, securing and maintaining competitive employment, counseling for alcohol and other drug abuse, and help with the activities of daily living (e.g., grocery shopping, cleaning apartments, transportation, etc.).

According to key informants from the organization running CTA, the key advantages of a MHC over CTA include (1) the ongoing ability of the court to provide sanctions; (2) the built-in mechanism to hold charges in abeyance and dismiss them upon successful program completion; and (3) the greater deference some clients may feel toward a judge, compared to the deference afforded a social worker. While CTA offers more wraparound and stabilization services than does a typical MHC, an important benefit of a MHC over CTA is the ability of the MHC to dismiss charges after successful completion. This means that a graduate of CTA has a criminal conviction on their record forever, whereas a successful graduate of a MHC may have the dismiss charge expunged from their record after two years.

> "if some's found incompetent and is treated to competency they could still go back and plead NGI to their crime. Most don't. Most end up proceeding down the criminal justice route, which is too bad. It may be appropriate in some cases, but I think in some cases it's too bad. Clearly, they were really ill at some point and weren't competent. So, I think we do lose those folks to the criminal justice system side of things. So, there are parts of the state that the same people that are doing treat to competency are also working in conditional release, but in our county it's separate."

According to providers of CSP's, this ability to dismiss charges is the only obvious benefit a MHC provides that CTA does not. As such, we recommend the MHC be reserved for defendants that are either disinclined to sustain treatment overtime without the pressure of an authority; (2) those who have the opportunity to get a clean record upon completion of the program; or (3) have a high likelihood of continuing to accrue misdemeanors without treatment and are not so severe as to qualify for ACT.

Opening Avenues to Reentry Success (OARS). Opening Avenues to Reentry Success (OARS) supports the prison to community transition of inmates living with a serious and persistent mental illness who are medium-to-high-risk of reoffending according to the Department of Corrections assessment. Inmates who have a minimum of six months of supervision upon release are eligible for OARS, provided their mental health needs and risk factors for criminal behavior meet the criteria for enrollment. Prison staff recommend inmates for the program.

	MHC	CTA	OARS
Serves High-risk, High-need PSMI	Y	Y	Y
Avoids trauma of (further) incarceration	Y	Y	N
Provides wraparound services and case management	Y	Y	Y
Provides sanctions or incentives to motivate engagement with the treatment plan	Y	N	N
Provides judicial oversight	Y- regularly	N	N
Provides intensive supervision with possibility of revocations	Y	Y - for those on conditional	Y

		release after a NGRI plea	
Funding Source	Federal funds + County levy	WI DHS, county levy, Medicaid billing. Some private insurance or Family Care MCO	State: DoC + DHS
Length of structured support	9-18 months or longer	CSP/ACT involvement ongoing; as long as needed	Up to 2yrs or sooner if connected to services and stabilized
Clears charges from client's record upon graduation	Y	N	N

An OARS social worker, OARS program specialist, case manager, and community corrections agent works with each enrollee three to six months prior to release to prepare them for life in the community. This team continues to support the participant throughout their time in the program to ensure the goals in their individualized service plan are achieved. Depending on their needs, participants may receive services for six months or up to two years in the community.

Unlike a MHC which graduates participants after adherence to the treatment plan for a scheduled period of time, participants graduate from the OARS program when they demonstrate the ability to maintain their mental health and basic needs without the assistance of their program team.

Additionally, while OARs serves returning citizens who have served their time, a MHC offers the opportunity to be diverted from incarceration and have one's charges dismissed.

Who should a Mental Health Court in Dane County serve?

High risk, high need individuals who need the intensive structure of judicial oversight and could benefit from having their charges dismissed.

All those interviewed agreed with the literature's best-practices recommendation that the court should be reserved for "high risk, high need" individuals. Although, this phrase did not evoke the same people for all, typically the ideal candidate was described as having a history of resisting to engage with or an inability to sustain treatment voluntarily and who is at high risk of recidivating or causing harm to someone because of their untreated mental illness. Additionally, the ideal candidate has some criminogenic tendencies that require judicial oversight but are mainly exacerbated by their unmanaged mental illness.

Since CTA gets PSMI out of jail and into intensive, wraparound treatment and case management, a MHC is only appropriate for those that need authoritative oversight and/or stand the chance of living without a record if they can get these particular charges dropped. For those that already have extensive criminal histories and are responsive to wraparound case management services, CTA is the recommended alternative. Alternately, for the person with many misdemeanor tickets and thus fines accrued but not much supervision required from a traditional court, the ability to waive fines may serve as an excellent motivator to engage this person in treatment when they don't yet qualify for CSP or CTA. As one key informant said, "[this could be good for] the guy who has mental illness but hasn't been diverted to a CSP Program or an ACT Program or whatever and has all these tickets. If you could say, "Hey, work with this court and we'll drop your fines. You just have to work with these people for a year. Something like that. I could see mental health court in that array, in that situation."

Ultimately, most agreed that while a MHC should have a clear target population it should retain some flexibility around eligibility in order to avoid deepening inequities. Notably, several shared the fear that if the court only serves those with felonies, it may have the impact of incentivizing the DA to charge some defendants with a felony in order to get them into treatment. Similarly, if the court is reserved for those who have benefitted from a history of mental health system contact, this may inadvertently screen out those that have been systematically excluded from such things because of their race or insurance status (see the section on Equity considerations for more detail).

Defining high-need: Determining the defendants degree of need typically involves a clinical assessment and review of the tenor their previous engagement with treatment. A classification of "high-needs" is given to a person in need of wrap-around case management support to help stabilize their mental illness. To be deemed appropriate for a MHC in Dane Co, their assessment should suggest that they will be more responsive to the authority of a judge than a social worker. While clinical diagnoses can indicate probability of being high-need, they are not absolute indicators of need and so should NOT serve as the definitive eligibility marker.

Clinical criteria generally considered high-need. The following DSM-V diagnoses typically encompass the range of **serious**, **persistent**, and **treatable** mental illnesses:

- bi-polar disorder,
- schizophrenia,
- schizoaffective disorder,
- major depressive disorder (if severe or with psychosis), and
- mood disorder not otherwise specified (NOS).

Primary diagnoses that they suggested should NOT automatically qualify for eligibility due to the difficulty to treat or to tie to criminogenic behaviors include:

- Personality disorders
- Anxiety
- Post-Traumatic Stress Disorder, although this might be considered on a case-by-case basis.

However, most respondents felt that early evaluation for substance use dependency and mental health needs during the arraignment process is an important step to equitably establishing eligibility for entry to a MHC. Importantly, this evaluation needs to be conducted by someone with a clinical background in behavioral health provision.

Defining high-risk: Criminal Justice Criteria. Two areas of risk were discussed: risk of recidivism and risk of danger to themselves or others.

> "Risk? That has to be defined because if it's risk of new criminal activity, yeah, they're likely high risk, but that means they're going to steal a bottle of vodka from a retail store, or they're going to be caught peeing in public or something."

- Unanimously, stakeholders agreed with the literature that a MHC should be reserved for those with a high risk of recidivism.
- **Violent offenses should not automatically disqualify someone from a MHC.** Many felt violence should not necessarily disqualify someone, particularly since Wisconsin has a mandatory arrest for domestic disputes, which includes adult children with severe mental illness aggressing against the parents they live with. Others were concerned about public safety if violent offenders were released back into the community for treatment. They might be willing to include first time violent offenders but thought that repeat violent offenders were too risky to stay in the community. Possibly this assessment could wait until after someone is medically stabilized. If medication is correct, concerns about violent behavior might become irrelevant.

Category of crimes typically seen in high-risk, high-needs populations. The types of offenders frequently discussed fell into a few general groups. Interestingly, however, there was no clear consensus about which group(s) were the correct candidates for Mental Health Court. In other words, there was general agreement about the groups creating challenges for the criminal justice system, just no clear agreement on how to handle them.

> "We talk a lot about the familiar faces, what you might call the nuisance situations. Those people need help too. I just don't think the criminal justice system needs to help them. I think there are other systems that can help them."

Familiar faces – low level. The limitation to using risk assessment to determine eligibility is that someone can have a high risk of repeating a relatively minor, or "nuisance" crime. Most people interviewed thought that such offenders could and should probably be handled outside of the criminal justice system. They were optimistic about the new Mobile Response Team and the forthcoming Triage Center for handling this population and would reserve the MHC for those who had committed more serious crimes. However, a substantial number of people assumed that this group of "familiar faces," especially if they experienced chronic homelessness would be the most likely population seen in a MHC.

High level offenses. To many interviewed, people with major psychiatric disorders who have committed serious, even violent offenses seemingly connected to their disorder are the obvious candidates for a Mental Health Court. Others argued that the D.A. is already quite good at recognizing these situations and stipulating to an NGI resolution of the case. A MHC is not needed or appropriate for these people.

Other candidates

Adult children with SMI living at home with parents. Such people often have psychosis and can be very disruptive but don't meet the standards for civil commitment. They were often mentioned as

the ideal MHC candidate. Others, however, thought they could be handled at an earlier intercept point by a Mobile Crisis Unit or later through a conditional release.

> "regardless of how many crimes they've been convicted of, if they are seen fit to be living in our community…we should be trying to get people programming, period. I don't care if this is your 30th alleged offense, there's probably a reason it's your 30th alleged offense and it has something to do with the fact that you've never gotten the services you need."

What are the biggest concerns and potential barriers regarding implementing a Mental Health Court in Dane County?

Stakeholder Concerns Regarding MHC Implementation

- Staffing levels at the DA's office and at the County Courts has both created a backlog of criminal cases and can impact the ability of these offices to provide the required individualized services moving forward.
- Wait lists for psychiatric treatment and in-patient treatment.
- Unstable or inconsistent medication management during jail time.
- Potential inadequacy of community support services, especially housing.
- Not enough BIPOC providers in both the mental health and criminal justice systems.
- Defendant stigma about receiving a mental health label and/or public availability of this status.
- Community reluctance to take a risk with genuinely high-need, high-risk defendants, and to accept reduced definitions and rates of success.

We have insufficient prosecutorial resources to identify candidates for diversion and staff another specialty court.

According to many interviewees, within the tight window of due process, the staffing to case ratio leaves only enough time to identify *if* there is enough evidence to charge someone not whether they *should* prosecute. According to key informants at the county contractor, in the past there was a regular line of communication between the DAs office and their intensive community services coordinator. However, since the number of prosecutorial staff has not increased to match the growth of the number of criminal cases, this regular collaboration has stopped. For individuals already engaged in treatment, incarceration will actually remove them from treatment and tracking them through MHC would most likely de-stabilize them just to get them back into the same treatment they were engaged in before they were charged. This inability to review each case carefully and determine best steps for community safety will ultimately result in some individuals decompensating in jail when they should have been diverted pre-charge and others not being offered the opportunity to

participate in a MHC and emerging from serving their sentences a greater danger to themselves or others than they were before being arrested.

The backlog in criminal case processing will reduce the efficacy of a Mental Health Court

Timeliness matters. Since the very purpose of a MHC is to reduce the time spent incarcerated, minimizing jail time and speeding the connection to support services. should be a critical concern. Jail can have negative effects on those with mental illness, particularly if defendants are not receiving treatment or medication during this time, which raises due process concerns. The length of pretrial detainment will at best destabilize their mental well-being and at worst, any decompensation could put their competency to stand trial in question. Additionally, according to analysis of all jail bookings over a year in Kentucky, as length of pretrial detention goes up, risk of recidivism sharply increases, especially for low-risk offenders.[37]

> "There used to be more flexibility in the DA's Office. There used to be people we could call and explain that we're already involved with this person, this is what's going on, and it would literally go away before charge. That has changed over the years. There's not the flexibility we used to have."

> "is it a higher priority to create another criminal branch, which could help relieve a backlog and speed up case processing times, get people through more quickly for a large number of people? Or to create a mental health court that would serve a relatively small number of people if you've got to choose? Or what the DA told us at the time we were looking at expanding the branches is, "We may not be able to staff your drug courts if you create another branch in the criminal because we just don't have the people. It might mean you can't have your drug treatment court."

Although COVID 19 pandemic has worsened the situation, according to stakeholders in the Dane County court system, the backlog in criminal court vastly predates the 2020 shutdown. The cause of this is perceived to be the dearth of staff in the DA's office.

> "my biggest concern in our system right now is the housing market, the housing situation. Like no one is going to be successful in a mental health court, and a triage center, and CARES. None of our folks are going to be successful if they have nowhere to live. "

The problem of backlogged cases plagues courts across the nation, but some courts have found ways to reduce the times between referral and enrollment in MHC. For example, in **Broward County, FL** cases are heard every day and so people can be admitted within hours of referral. The inability to post bond can also delay participation in MHC. The MHC in **Orange County, NC** has addressed this by releasing all people charged with minor crimes even if they could not post bail.

The contractor fulfilling psychotropics in the jail has a limited formulary that may destabilize defendants. We heard from several judges and defense attorneys that the limited formulary provided at the jail can play a key role in reducing the success of any criminal justice intervention. Instances of defendants pulled off their regular medications and put on new medications covered in the formulary were common. This class of medications are commonly associated with significant side effects. Appropriate medication management and adherence is a key predictor of success of a MHC and switching medications based on contractual restrictions rather than medical advice could compromise the success of a MHC in significant ways.

Waitlists for MH Treatment and in-patient placement can be months long. The average waitlist of in-patient services was just over two months at the time of writing this report. Combined with the backlog in the courts, interviewees expressed that the insufficient supply of in-patient resources contribute to a "churning" phenomenon. Essentially, it is a challenge to coordinate treatment with court appearance such that at times result in defendants cycling into and out of competency, delaying their capacity to stand before a judge when they finally get on the court docket.

Dane county may or may not have the critical services to support a MHC. Although the unavailability of affordable and safe housing for PSMI was unanimously identified as a key barrier among our interviews, opinions about the availability of other key services were mixed. While many judges and defense attorneys felt the wait to see a psychiatrist was a key weakness inhibiting the success of diversion programs such as treatment courts, administrators at the state level felt the system currently has the capacity to fast-track high-need individuals with psychiatrists immediately. This contradiction in response suggests one of three things. One possibility is that changes in service availability haven't saturated the criminal justice process because of the backlog. Another is that awareness of these services hasn't yet spread and so they are being underutilized. The third is that it is these recent changes remain insufficient for meeting the needs of the criminal justice system.

Dane Co may lack a sufficient stock of culturally-matched providers and services to meet the needs of the MHC clientele.
As one key informant stated, "When it comes to treatment providers is we need culturally competent treatment and support. And so, if we are seeing worse outcomes for people with certain backgrounds. . . it's probably much more reflective of a failure in providing culturally competent services. We as Dane County are overwhelmingly white community, but I mean, our people of color are vastly overrepresented in the criminal justice system in this county. Having culturally competent services is probably not going to be an easy task for us, but it's going to be critically important."

The stigma associated with mental health may prevent people from consenting to participate.
Interviewees staffing other treatment courts in Wisconsin highlighted that the name, "mental health court" can be a tough sell because of the stigma associated with mental illness. In response, other courts have shifted to just referring to the bench number or using the more neutral term, "treatment court."

III. Report Recommendations andNext Steps for Implementing a Mental Health Court in Dane County

Recommendations

A MHC would add value to existing jail diversion services by providing a needed opportunity for defendants to earn a clean record via treatment engagement. However, because of the intensity of resources required to run a MHC, and the increased likelihood of revocations associated with intensive supervision, **the court would only be appropriate for individuals who are at high-risk of recidivating because of unmanaged mental illness, AND who require intensive support services to sustain initial engagement with support services.**

A MHC should be implemented **ONLY IF** the County can achieve a true collaboration between the county criminal justice and behavioral health/substance use systems to meet the following conditions:

- Accept the risk of committing the court to serving those in the community who are genuinely high risk and high need, and
- Provide a sufficient quantity of culturally-matched services in a timely fashion, and
- Recruit the appropriate champions to the team
- Increase the capacity of the DA to staff another treatment court by increasing staffing or otherwise reducing the backlog of criminal cases

Sub-recommendations:

Eligibility:

- Accept BOTH misdemeanants and felony cases; consider violence on a case-by-case basis
- Don't require a previous mental health diagnosis, accept a current assessment
- Use the same screeners and assessment tools across all courts to maximize appropriate placement

Treatment Court Team should include:

- Dedicated prescriber
- Culturally-matched Peer Support Specialists (engaged at early stages and compensated)
- Judge who understands SMI, holds a compassionate and healing-centered approach to bench-side manner, and prefers community service sanctions over incarceration sanctions

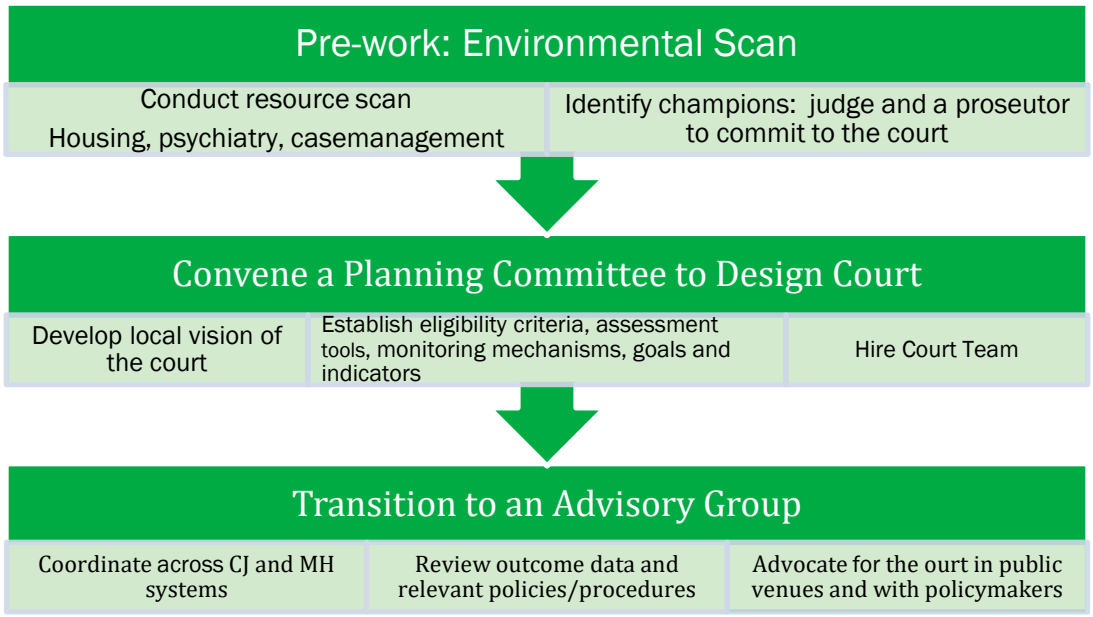
Resources:

- Housing support
- Transportation assistance
- Culturally-matched community support services for sustaining beyond graduation

The capacity to monitor referrals, participation, sanctions and disposition for disproportionate representation of historically-centered populations (i.e., White, English-speaking, heterosexual, able-bodied, housed.

What are the steps to implementing a Mental Health Court in Dane County?

We envision a three-step process. If the outcome of the first step is successful, then the subsequent steps will be taken.



Step 1: Environmental Scan of Resources for Pre-work

We heard repeatedly that a Mental Health Court should only be implemented if there were adequate resources. During this phase PHMDC would ascertain that there are adequate community-based service agencies to enable the court to link all participants to all necessary services in a timely fashion. Additionally, finding a judge –one who is passionate about the court's mission and trained in supporting PSMI– to lead the court probably the single most essential resource without which the court cannot move forward. The district attorney's office needs to feel sufficiently resourced to staff this court and the judges in the county need to endorse the redistribution of caseloads in order to staff a MHC. Identifying a prosecutor who is willing to be a part of the regular Court Team is also important. PHMDC may seek these champions themselves or delegate this important task to a community member with the connections to undertake this work. In this phase the county can also draw up budgets, identify necessary funding, and begin to draw up service agreements.

The necessary services in sufficient quantity and the champions may not be in place currently, in which case they can be developed. But it is very clear that until such resources are established the next steps toward implementing a MHC should not take place.

Step 2: Convene a Planning Committee

While the Mental Health Court literature offers much guidance on the design of a MHC some issues pose trade-offs that ultimately can only be resolved within the context of the community's values and risk tolerance. Stakeholder interviews indicated that there was not yet clear agreement about some features. Broad stakeholder input in planning is necessary to build consensus around the court's overall mission. A table adapted from the BJA report, *Ten Essential Elements of a Mental Health Court*[38] is included as *Appendix 5*.

At startup the Planning Committee is charged with designing the court. This involves both visioning and concrete tasks, including:

- Establishing eligibility criteria
- Selecting assessment tools
- Developing monitoring mechanisms and other court procedures, including a referral plan
- Formulating a local vision for a MHC in Dane County
- Articulating clear, specific, and realizable goals and indicators of success that reflect agreement on the Court's purposes and provide the foundation for measuring the Court's impact.

Cross-system collaboration is the foundation for a successful MHC and needs to be built in from the start. The planning committee should be a broad-based group of stakeholders representing the criminal justice, behavioral health, and substance abuse treatment systems, and relevant service agencies. Since the criminal justice system is such a central player, they should have a substantial representation that includes the judiciary, the prosecutor's office, and defense attorneys. Advocacy organizations and people with lived experience should also have a prominent place in this group. Because equity also needs to be baked into design the racial/ethnic composition of this group is critical. It could be helpful to have someone familiar with MHCs staff this committee.

Step 3: Transition to an Advisory Group

This can be the same group as the Planning Committee, a different group, or have some overlapping membership. But once the Mental Health Court is started this group will transition into the standing Advisory Group charged with monitoring the Court's adherence to its mission, including:

- Coordinating relevant activities across the Criminal Justice and Mental Health (and Substance Abuse) systems
- Regularly reviewing and suggesting revisions to policies and procedures when necessary
- Serving as the public face of the Court, advocating for its support and for necessary resources, and interfacing with policymakers and officials
- Facilitating opportunities for on-going training and education for the Court Team
- Providing general support to the Court Team who administer the Court's daily operations.

The Advisory Group monitors the court's performance data and suggests revisions to policies and practices. They should be especially attentive to monitoring data about the racial and ethnic composition of referrals, participation, and outcomes and investigate any disparities. Additionally, the MHC will exist within and alongside broader community efforts to improve responses to people involved in the CJ system who have mental illness. These processes need to be coordinated to optimize smooth transition between intercepts and assure clear and timely communications between all sectors. The Advisory Group can be responsible for convening representatives from these other programs to engage in on-going process improvement efforts to coordinate services across the intercepts.

Since advocacy for resources is a key role for this group it would be helpful for policymakers to serve on the committee. State legislators, county board of commissioners, sheriff's department, DOJ officials, would all be important to consider for membership. It would also be helpful to have someone familiar with data analysis and evaluation as staff to this committee.

Toolkits and Support

Should Dane County decide to move forward with implementing a Mental Health Court there are some excellent toolkits and technical supports available to assist with the process.

- **Bureau of Justice Assistance** (BJA) in the US Department of Justice provides on-site and off-site training and technical assistance on designing and implementing Mental Health Courts. https://bja.ojp.gov/program/mental-health-courts-program/training-technical-assistance. It's **Mental Health Courts Program** also funds grants to communities to implement innovative programs to improve how the needs of adult offenders with mental illnesses are addressed. https://bja.ojp.gov/program/mental-health-courts-program/overview
- **Council of State Governments Justice Center** (CSG)[39] has provided training and technical assistance for new Mental Health Courts since 2002. This includes consultation and free written materials, https://csgjusticecenter.org/projects/mental-health-courts as well as an excellent series of learning modules. https://csgjusticecenter.org/projects/mental-health-courts/learning/learning-modules/ . CSG also provides education for judges regarding mental illnesses and behavioral health needs as well as advances in criminology, and other relevant social sciences.
- **National Center for State Courts** (NCSC) maintains a substantial resource center. Key resources include a Mental Health Court database, performance measures, a free interdisciplinary curriculum, and state standards. https://www.ncsc.org/topics/alternative-dockets/problem-solving-courts/mental-health-courts/resource-guide

- **Center for Court Innovation** is a justice reform organization that pilots innovative programs and conducts original research to create a more fair, equitable, and humane justice system. They do not provide direct TTA, but they are a resource for case studies regarding current court models and practices. https://www.courtinnovation.org/search/site/mental%20health%20courts

- This article provides recommendations for how best to evaluate Mental Health Courts to inform best practice and policy. **Measuring the Effectiveness of Mental Health Courts Challenges and Recommendations**[40]

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Appendix 1 Key Informant Interviews

Interviews were conducted via Zoom with 26 individuals engaged in the justice sector, treatment providers, behavioral health system administrators, and advocates. The Table below indicates the sector and agencies represented in the interviews.

Sector	Office/Agency/roles
JUSTICE	Public Defenders
	Dane County District Attorney
	Private defense attorneys
	Department of Corrections
	Dane County Treatment Court Judges
	Dane County Treatment Court Peer Support Specialist
	Forensic Psychiatrist
	Dane County Board of Supervisors, Policy and Practice Division
	Madison Police Department- Mental Health Unit
	Brown County Treatment Court
	Outagamie County Treatment Court
	Eau Claire County Treatment Court
TREATMENT PROVIDERS	Journey Mental Health
	Community Treatment Alternatives CSP
	Community Treatment Alternatives (CTA)
	Comprehensive Community Services (CCS)
	Emergency Services
BEHAVIORAL HEALTH SYSTEM ADMINISTRATORS	Dane County Human Services
	Bureau of Community Forensic Services
	Adult Community Services Division
	NGRI conditional release program
	Conditional and supervised release program
	Outpatient competency evaluation and restoration program
ADVOCATES	Nehemiah
	NAMI, Dane County

APPENDIX 2: Assessing Eligibility

What does it mean to be a high needs/high risk individual?

Mental Health Courts are hybrids, operating at the intersection of the mental health system and the correctional system. This can create some implementation challenges, among the most important of which is the issue of eligibility and who to prioritize for services. Confusion or outright disagreement about this issue largely stems from the different roles and priorities of the two systems. The criminal justice system is primarily concerned about public safety; professionals here focus on the risk of an individual's committing another crime. The primary focus of the behavioral health system is on stabilizing people with disorders that cause impairment. Beyond consideration of overt threat of harm to self or others the risk of committing a future crime in not considered in most mental health assessments or as a factor in prioritizing treatment. Success here is improved functioning and often measured by reduced hospital and emergency room use. Despite significant overlap in the populations served, these different structural priorities can result in disagreement about who should receive what placements, including in a Mental Health Court.

What follows is a general discussion of some of the conceptual issues surrounding assessment, including a conceptual framework at the systems level for identifying risk and needs that bridges the seemingly competing priorities of the behavioral health and correctional systems. This is then followed by specific tools and instruments that can operationalize their concepts.

Why assess? Without clear eligibility and priority criteria program slots can easily end up filled with individuals in low-risk/low-need categories. Some defendants with high treatment needs may refuse treatment while others with low needs sign up for substance abuse or other treatment programs to reduce the time they need to serve. Motivation is often considered as a filter for participation, but this ignores the fact that the least motivated may be those who pose the greatest risk to public safety. Sometimes crime categories are used as a basis for program participation rather than the risk of reoffending. Not only does engaging people with low risk actually increase their likelihood of reoffending, but it also lowers the effectiveness of programs for higher-risk participants. [1] Perhaps most importantly, lower risk individuals take up scarce and valuable treatment and other cognitive skills program slots.

Assessing Criminogenic Risk and Needs

The "Risk-Need-Responsivity" (RNR) model is widely recognized as the approach corrections should be taking to identify and prioritize individuals for various interventions. The model categorizes individuals' risk of committing another crime, but it also identifies supervision and treatment needs, thus connecting behavioral health needs to criminogenic risk. The model operationalizes three key principles:

Risk Principle: Match the intensity of treatment to level of risk of reoffending.

[1] Andrews, Donald A., and Craig Dowden, "Risk Principle of Case Classification in Correctional Treatment: A Meta-Analytic Investigation," *International Journal of Offender Therapy and Comparative Criminology* 50, no. 1 (2006): 88–100.

Need Principle: Target criminogenic needs – the 8 central dynamic factors that are related to the likelihood of reoffending.[2]
Responsivity Principle: Address barriers to learning in the treatment intervention design. This includes addressing factors such as antisocial thinking and teaching problem-solving skills.[3] This principle also alerts us to the need for culturally sensitive tools, treatment, and personnel.

What is the connection between mental health, substance use, and criminogenic need?

Mental health status is not a criminogenic risk factor. By itself it is not a predictor of future criminality. But people with SMI in the criminal justice system have more of the central eight dynamic risk factors than those without SMI. Mental illness may also cause functional impairments that impact responsivity to treatment. It is the high prevalence of SUD among those with SMI, however, that boosts the risk scores for those with mental illness. [4] Substance use disorders are a major risk factor for criminal activity both by their direct relationship to crime but also indirectly because addiction significantly reduces responsiveness to interventions. Co-occurring disorders, therefore, synergistically contribute significantly to the risk of criminal justice involvement.

Research indicates that without concurrent attention to both mental health and substance abuse outcomes for individuals with co-occurring disorders are very poor. However, the degree of severity of each disorder differs among individuals, with substantial implications for appropriate treatment setting and level of care.

Studies suggest that the co-occurrence of mental health and substance use disorders is also common. In jails, of the approximately 17 percent with *serious* mental illness, an estimated 72 percent had a co-occurring substance use disorder.19 Approximately 59 percent of state prisoners with mental illnesses had a co-occurring drug or alcohol problem.[5]

Assessing Co-occurring disorders by severity

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors developed a model to address the needs of people with co-occurring disorders using severity as the guide to treatment requirements. These categories provide mental health and substance use providers with a common language and a path to guide priorities.

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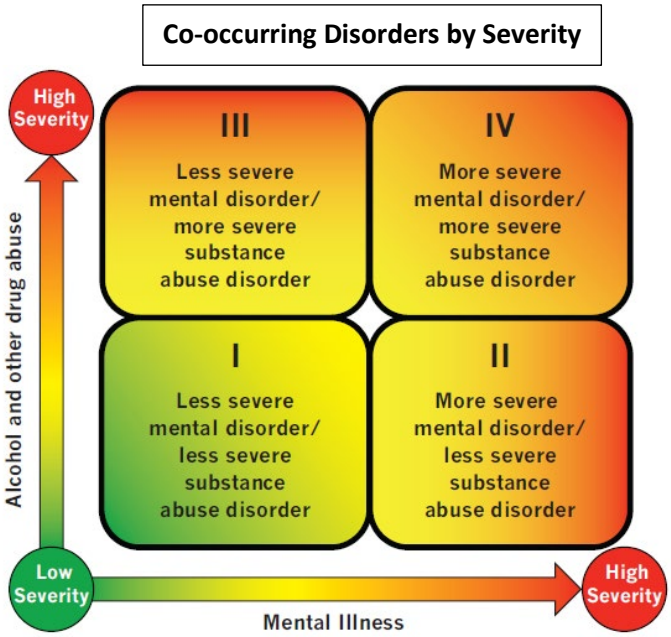
[2] Static risk factors are those that cannot be changed, such as age at first arrest. Dynamic risk factors are those that change over time and are thus amenable to intervention. These include employment or education, the quality of family and other relationships, involvement in satisfying community and leisure pursuits, and cognitive and behavioral patterns.

[3] While treatment planning must address non-criminogenic barriers to program participation (such as depression) and be trauma-informed (since the majority of people in the correctional system have trauma histories), the focus must always be on the criminogenic needs themselves.

[4] Kessler et al, "The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization," 17–31.

[5] Ditton, Paula, Mental Health and Treatment of Inmates and Probationers (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1999.



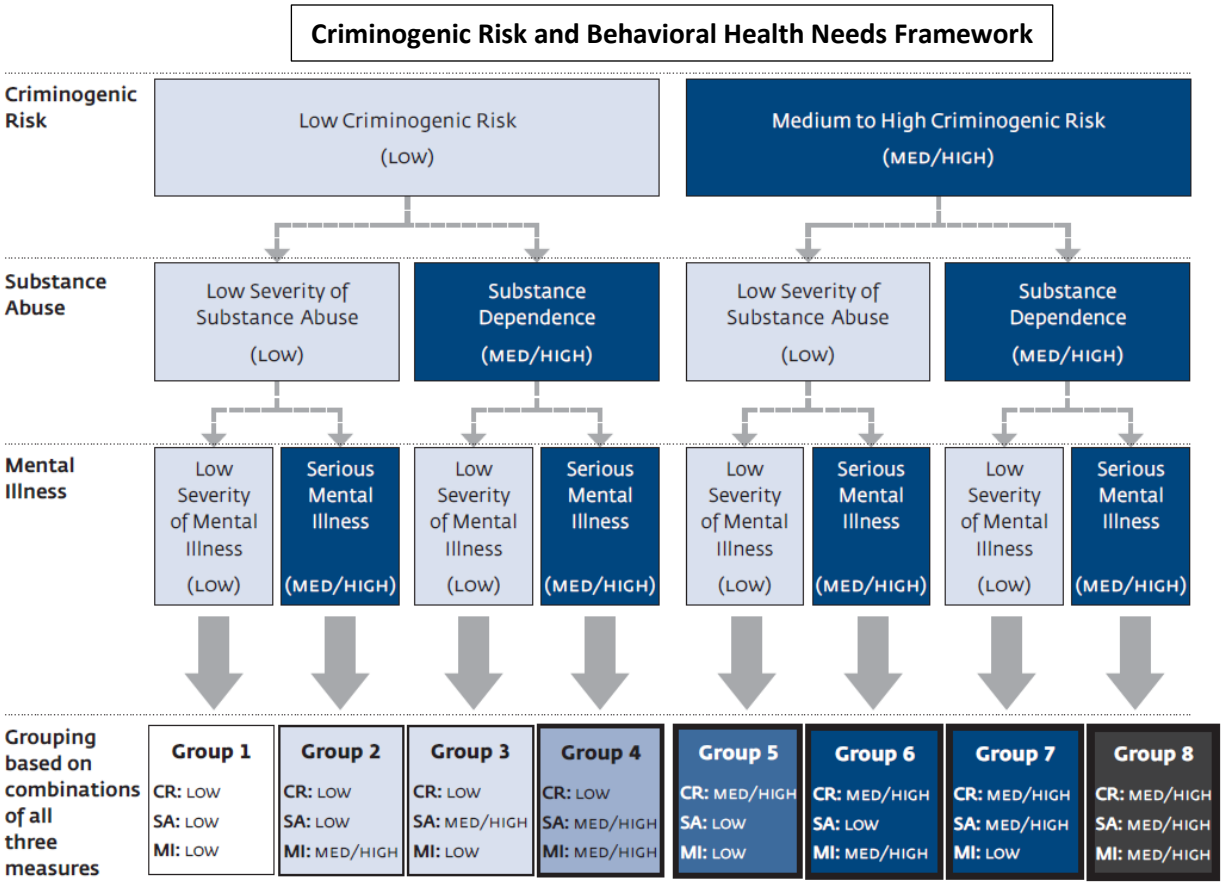
This model could offer a guide to determining whether someone with a co-occurring disorder should be placed in a Drug Court or in a Mental Health Court. A person with a category III assessment (high SUD but low mental health disorder would be a better candidate for Drug Court. A person with a category II or IV would be better served in a MHC, assuming that their substance issues are also addressed.

Overlapping objectives of corrections and behavioral health: recidivism, individual recovery, and improved public health

Recognizing the need to address distinct but overlapping goals, an interagency collaboration between the US Department of Justice's National Institute of Corrections (NIC), the Bureau of Justice Assistance (BJA), and US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) convened associations, stakeholders, and researchers to create a planning tool to guide service decisions. The product of this work is the Council of State Governments Justice Center's **Criminogenic Risk and Behavioral Health Needs Framework**,[6] which provides a coordinated approach to improve outcomes for those in the criminal justice system with mental illness, substance use disorders, or both.

The framework below assigns risk levels to individuals on each of the three dimensions resulting in eight possible risk/need groups. Using this categorization guides determination of services to administer or to divert from the systems altogether. The second sorting can be either for substance abuse or for mental health. It is second in the framework because SUD are more prevalent than mental health disorders and because SUD carries a high level of criminogenic risk. But, a MHC could easily prioritize the mental health assessment.

[6] A Shared Framework for Reducing Recidivism and Promoting Recovery. Fred Osher, MD; David A. D'Amora, MS; Martha Plotkin, JD; Nicole Jarrett, PhD; and Alexa Eggleston, JD | September 27, 2012 | The Council of State Governments Justice Center
https://csgjusticecenter.org/publications/behavioral-health-framework/



The usefulness of such a framework for determining eligibility for a Mental Health Court would be to conceptualize defendants who are in Groups 6 and 8 as potential participants because both have medium-high risk of recidivism and medium to high mental health needs. They may have a range of substance abuse needs. Group 7, however, would not be included because their mental health needs are low. They might, however, be suitable for participation in a Drug Court because they have medium to high substance abuse needs.

Operationalizing Risk: Selecting Assessment Tools

What tools tell you how to rate someone as low, medium, or high risk or needs? What are the major considerations in either selecting tools or in implementing assessments?

The most appropriate screening and assessment tools depends on the population being assessed. The following recommended instruments are based on SAMHSA review of research literature examining the efficacy of both assessment and diagnostic instruments for use with co-occurring disorders. [7]

[7] Substance Abuse and Mental Health Services Administration. *Screening and Assessment of Co-occurring Disorders in the Justice System.* HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Selection criteria included:

- Empirical evidence supporting reliability and validity
- Ability to assess multiple MH problems
- Relative cost
- Ease of administration and interpretation
- Use within justice settings
- Aligned to DSM-5 criteria

All the recommended assessment instruments require significant training in administration, scoring and interpretation and should only be administered by trained clinicians credentialed in assessing and diagnosing mental and substance use disorders and related psychosocial problems. This training becomes evident when considering some of the significant challenges in assessment. These include determining whether symptoms of mental disorders are caused by recent substance use or reflect underlying mental disorder as well as the effects of CODs on memory and cognitive function.

Additionally, those conducting assessments will need strategies to engage offenders in the assessment process and to understand offenders' responses within their life context(s). Administrators that represent offenders' communities is an important part of addressing these cultural considerations. Here we only review assessment instruments. Screenings -- a brief review of symptoms and behaviors to determine whether a full assessment is necessary -- should be conducted as early in the justice system process as possible. Screenings require only minimal training to administer.

Key issues related to screening and assessment of CODs in the justice system:

- Failure to comprehensively examine one or more of the disorders
- Inadequate staff training to identify and assess the disorders
- Bifurcated mental health and substance use service systems that feature separate screening and assessment processes
- Use of ineffective and non-standardized screening and assessment instruments
- Absence of management information systems to identify people with CODs as they move from one point to another in the justice system

**Screening and Assessment of Co-Occurring Disorders in the Justice System*

https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS

Figure 1: Recommended Assessment Instruments

Mental Disorders	Substance Use Disorders and Treatment Matching	Co-occurring Disorders	Trauma History and PTSD	Suicide Risk
Personality Assessment Inventory (PAI)	TCU Drug Screen V (TCUDS V)*, TCU Client Evaluation of Self and Treatment (TCU CEST)*, TCU Mental Trauma and PTSD Screen (TCU TRMA)*, and TCU Physical and Mental Health Status Screen (TCU HLTH)* (and/or) TCU Criminal Justice Comprehensive Intake (TCU CJ CI)*	Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV)* (or) Mini International Neuropsychiatric Interview (MINI) (or) Structured Clinical Interview for DSM (SCID)	Posttraumatic Symptom Scale (PSS-I)* (or) Posttraumatic Diagnostic Scale (PDS) (or) Clinician Assisted PTSD Scale for DSM-5 (CAPS-5)*	Suicide Risk Decision Tree (SRDT)*

*Instrument available at no cost

- Self-administered objective test; empirically derived and based on clinical research and personality theory
- Widely used in justice settings. Additional software available for assessment of risk and psychological need in justice settings
- Standardized for gender, race, and age
- Available in Spanish
- Provides information about symptom severity
- Subscales provide risk factors that predict recidivism and violence

Its primary downside is that it is lengthy to administer. It generally takes about 45 minutes to an hour but depending on the offender's presenting symptoms could take as long as 2.5 hours. It is also a commercial product, which must be purchased.

Key recommendations for effective use of instruments

- Use selected assessment instruments consistently.
- Ideally, the instruments selected should have been validated for use within the criminal justice setting.
- Develop unified screening and assessment procedures and instruments for use across all diversion programs to assure that people are placed in the most appropriate program.
- Utilize an integrated assessment approach: combine instruments to assess both mental health and substance use as no single instrument provides a comprehensive review of both.

Detailed review of the selected recommendations and the instruments that were not chosen can be found in the full report, *Screening and Assessment of Co-occurring Disorders in the Justice System.*

Appendix 3: Mental Health Court "Learning Sites"

To facilitate peer-to-peer assistance among jurisdictions that have established or are planning to establish MHCs, the Bureau of Justice Assistance (BJA), through its technical assistance provider, The Council of State Governments Justice Center, has designated four jurisdictions as MHC "learning sites." Located across the country, these MHC Learning Sites represent a diverse cross-section of perspectives and program examples. MHC Learning Sites host in-person visits to their courts and respond to telephone and email inquiries from the field. https://csgjusticecenter.org/projects/mental-health-courts/mental-health-court-learning-sites/

	Bonneville County, Idaho	Dougherty County, Georgia	New York City	Ramsey County, Minnesota
Established	2002	2002	2002-2013	2005
Approximate participants per year	45	50-75	630 across 4 boroughs Under Education & Assistance (EAC) Case Management – a not-for-profit service agency	40
Adjudication stage	Generally, in post-conviction stage	Majority enter court after violating terms of probation		Post
Notable Features	A rural program that has strong support from the state and uses an assertive community treatment (ACT) model for all participants	A rural jurisdiction that offers a competency restoration docket—a process that helps people with mental health issues stand trial	Employs Clinically Informed Judicial Supervision, which considers a person's assessed risk of reoffending and violence, as well as mental health and substance use or social service needs, to inform judges' responses. Uses this model not only in MHC but throughout the courts.	An urban, pre- and post-adjudication program that aims to offer treatment in the community rather than in a court or hospital setting
	Focuses exclusively on high-risk, high-needs people	Works closely with the state Department of Behavioral Health and Developmental Disabilities on competency and restoration	Emphasizes clinical understanding of behavior by including licensed clinical psychologists on the diversion program team, who serve as a consultative liaison with social service providers	Attorneys from Briggs & Morgan partner with court to provide pro bono legal services to participating defendants
	Offers mentoring services to prepare participants who are near completing the program to	Provides training to court professionals across the country and works with		

	become peer support specialists or recovery coaches—both potential employment options after graduation from the program	behavioral health partners to provide crisis intervention team (CIT) training to other jurisdictions		
Court Team	Judge Court coordinator Prosecutor, Public Defender Probation officers BH Tx providers Law enforcement officer Vocational rehabilitation assistant NAMI member Housing providers All receive regular cross disciplinary and specialized training in evidence-based practices used in the program.	Judge Court coordinator 2 probation officers Clinician 2 caseworkers (MH & SUD) 2 public defenders 2 district attorneys Caseworkers from county's Assertive Community Treatment (ACT) team and from Advocacy Resource Center (ARC), a group that advocates for people with disabilities	Judges and court staff work with EAC team: • Clinical directors -supervise evaluations and risk assessments • Program supervisors and senior case mangers • Client support • Crisis intervention • Peer specialists • Entitlement specialists • People with vocational evaluation expertise	3 judges; program coordinator 2 case managers 2 prosecutors (city and county) Public defender 3 pro bono defense lawyers 2 graduate clinical interns Law student certified to practice
Program eligibility	• Misdemeanor and felony • Med-high risk of reoffending • Severe and persistent mental illness and significant impairment in multiple life areas • Most have co-occurring SUDs	Nonviolent felonies Tracks: 1. mental illness; 2. co-occurring SUD; 3. primary SUD; 4. Reentry from prison or jail Only Track 4 accepts those charged with violent offenses	Misdemeanor and felony offenses Violent and nonviolent And have mental illness With or without co-occurring SUD Severity of mental illness can range from SMI to a mental health condition resulting in less severe impairment	• Nonviolent misdemeanor or felony with SMI. • Legally competent and with no history of violent offenses.
Exclusions	• Developmental disabilities • Applicants with sex offenses considered on case-by-case basis	Crimes against children Sex offenses Histories of violence Primary diagnoses of developmental disabilities or organic brain injuries		Those charged with offenses deemed violent by federal definition. Primary diagnosis of developmental disability or traumatic brain injury.
How does the program work?	Minimum of 1 year Average is 18 mos.	Minimum of 18 mos		Minimum of 1-3 years

	4 phases: Engagement and Orientation; Intensive Treatment; Transition and Community Engagement; Maintenance and Continued Care Hearings held weekly Pre-court staff and clinical staff also meet weekly	3 Phases • **Phase 1:** lasts approximately 6 months and includes Moral Reconation Therapy (MRT) groups, clinical and medical appointments, random drug screens, and attendance at 12-step meetings. • **Phase 2** lasts between 4 and 6 months and includes substance use disorder group therapy or peer support groups provided by the local community services board, clinical appointments, random drug screens, and 12-step meeting attendance. • **Phase 3** is a six-month period intended to transition participants into graduation from the program.	Utilizes a comprehensive approach to structured risk assessment; systematic review of mental health, substance use, and general health needs and social service challenges; and flexible but consistent use of rewards and sanctions. Case managers are trained in motivational interviewing and interactive journaling, and clinical directors provide case managers with support for dealing with clients whose behavior is challenging. EAC uses up-front assessment at intake and ongoing clinical evaluation to modify treatment as needed	4 phases: Engagement, Active Treatment, Stabilization, Program Completion Employs "psycho-education" a type of intervention that is intended to help people with mental illnesses move toward recovery.
Funding	• Idaho legislature funds court • MH Tx funded by Div. of BH in Dept of Health and Welfare; Medicaid • State and County funds probation and prosecutor and PD • Vocational rehab and peer support funded by the state	County provides in-kind contributions of physical space, sheriff staff and state probation officers Community Service Board provides Tx and counseling using state funds MHC judge is active in training and outreach with numerous state agencies Court staff meet with stakeholders and advocates such as NAMI to facilitate CIT training	EAC utilized federal and state grants for expansion and evaluation Collaborated with city, state, and federal agencies in research, evaluation, training EAC runs a training program for college students to increase program capacity and introduce people to the field	• MN Dept of Human Services • Volunteer graduate-level clinical case management interns and student certified attorneys and program interns increase court capacity. • District Court • County MH and Chemical Health Services • Grants: State Justice Dept • All expansions via federal grants
Contact	**Eric Olson** *District Mental Health Court Manager* 208-360-0262 ericolson@qwestoffice.net	**Patricia Griffin** *Program Coordinator* 229-878-3183 patricia.e.griffin@gmail.com	**Merrill Rotter, MD** *Program Coordinator* 914-288-5419 merrill.rotter@gmail.com	**Dustin Rockow** *Treatment Courts Supervisor* 651-266-8168 Dustin.Rockow@courts.state.mn.us

Appendix 4: Wisconsin Mental Health Courts Compared

Wisconsin Mental Health Courts			
	Brown County	Eau Claire County	Outagamie County
Year Founded	2015	2011	2012
Number Served Annually	18 Currently 83 since inception	2020: 4 graduates/3 terminations 30 graduates since 2009 (grad rate of 34%)	20-23 for past 3 years
Funding Source	County tax levy	CCS, CSP	County tax levy; TAD grant
Approx. budget	$95,000-110,000		
Risk Level	Moderate to High	High, Moderate to high, Moderate, Low to Moderate	High, Moderate to high
Charge		Felony or Misdemeanor	Felony or Habitual Misdemeanor
Eligibility Criteria	Mental Health diagnosis meeting DSM IV-R. Recurrent and persistent.	Diagnosis DSM-5 (but not sexual paraphilia alone or if primary) and possibly SUD diagnosis	Severe and persistent mental illness (i.e. bipolar disorder, schizophrenia, schizoaffective disorder, etc)
Exclusions	Current open criminal case must be non-violent. Prior or current sex offenses, stalking, arson, or kidnapping	Potentially violence	Level of violence strongly considered as admission factor. Those with prior violent crime or weapons charge considered at Court Team's discretion Lack of prior probation or treatment history
Assessment Tools	RANT (Risks and Needs Triage)	COMPAS, TCU Criminal Thinking, NIJ Mental Health, Women's Core COMPAS, URICA, TCU AODA, PCL-C Trauma	COMPAS

Admission	Post-conviction	Post-adjudication or conviction	Pre-plea, Post-plea/pre-adjudication or conviction, Post-adjudication or conviction
Probation or ES Status	At least 12 months	At least 13 months	At least 24 months
Alternative to Revocation Admission	Yes	Yes	Yes
Other	Must have insurance to pay for treatment	Renamed all treatment courts by number to reduce stigma	
Court employees	1 FTE Case Manager	9 member team	1 FTE Coordinator. 15 team members are all volunteers
Performance Metrics	Number of completions and terminations	Completion, in-program recidivism, terminations, 2 and 3 year recidivism, incarceration days saved – new charges and ATRs, sustained sobriety 90 days post graduation, positive drug screens, employment upon graduation, improved employment status, residency status, improved residency status, pro-social connections, criminogenic needs addressed, procedural fairness recovery coach satisfaction	Data tracked for 3 years prior to MHC, during, and 3 years after MHC Expenditures for UA testing, hospitalization, treatment. Recidivism for 3 years post MHC. Reasons that referrals were denied. Employment prior and during MHC; Volunteer prior and during MHC; Homeless prior and after MHC, alcohol monitoring
Website		https://www.co.eau-claire.wi.us/our-government/departments-and-facilities/depart	https://www.outagamie.org/government/departments-a-e/clerk-of-circuit-courts/treatment-courts

Appendix 5: Ten Essential Elements of a Mental Health Court

These elements are drawn from the experience of existing courts and are not research-based. Realizing each of these elements -- and thus operating a successful MHC -- require cross-system collaboration between Criminal Justice, Mental Health, Substance Abuse, and related systems.
site

Essential Elements of a Mental Health Court	
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.***
Adapted from: Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court. New York, 2007. Council of State Governments Justice Center	

Appendix 6: Performance Metrics

Participants

How many people did the court serve, and what are their characteristics?

- Number of individuals screened
- Number of individuals eligible (according to program criteria)
- Number of individuals accepted
- Relevant characteristics of the individuals who were eligible but not accepted (including demographics, charges, prior criminal history, diagnosis)
- Reasons not accepted (including legal or clinical reasons)
- Relevant characteristics of the eligible defendants who decline to participate
- Reasons for declining to participate (e.g., requirements too strict, supervision time too long)
- Relevant characteristics of those who were accepted into the court (e.g., demographics, charges, prior criminal history, diagnosis)
- Length of time between key decision points (e.g., screening to acceptance, acceptance to case termination)
- Reasons for termination (e.g., drop-out, completion, revocation)

Services

What services/what type of services did the court participants receive? How often did they receive them (e.g., once a week)? For how long did they receive them (e.g., six months)? These services might include:

- Assessment
- Case management
- Medication appointments
- Outpatient treatment
- Intensive outpatient treatment
- Psychosocial rehabilitation
- Housing
- Residential substance abuse treatment
- Integrated treatment for co-occurring disorders
- Supported employment, other vocational or employment training
- Education, GED preparation and testing
- Self-help groups
- Enrollment in Medicaid, Supplemental Security Income (SSI), and Social Security Disability Income (SSDI)
- Other locally important services

Criminal Justice Outcomes

What were the effects of these services on participants' criminal justice involvement?

- Number of arrests during program participation and subsequent to participation
- Type of charge (e.g., violent, property, drug, etc.)
- Number of admissions to jail or prison during program participation and subsequent to participation
- Reason for admission (e.g., new charge, technical violation)
- Number of days in jail or prison for new crimes
- Number of days in jail because of sanctions for nonadherence to court conditions

Mental Health Outcomes

What were the effects of the services on participants' mental health symptoms and overall functioning?

- Number of inpatient hospitalizations and length of stay
- Number of emergency room admissions and type of treatment received
- Changes in symptoms (using, for example, the Modified Colorado Symptom Index)[3]
- Number of days homeless
- Number of victimizations (e.g., domestic violence, assault, robbery)
- Level of satisfaction with services offered
- Changes in quality of life (using, for example, Lehman's Quality of Life Interview)[4]
- Number of days clean/sober, or number of positive urinalysis tests
- Number of days employed or in school during a specified period (e.g., 10 out of the last 30 days)
- Level of compliance with psychotropic medication plan

Bureau of Justice Guide to Collecting Mental Health Court Outcome Data