SAMHSA's GAINS CENTER

Mental Health Courts

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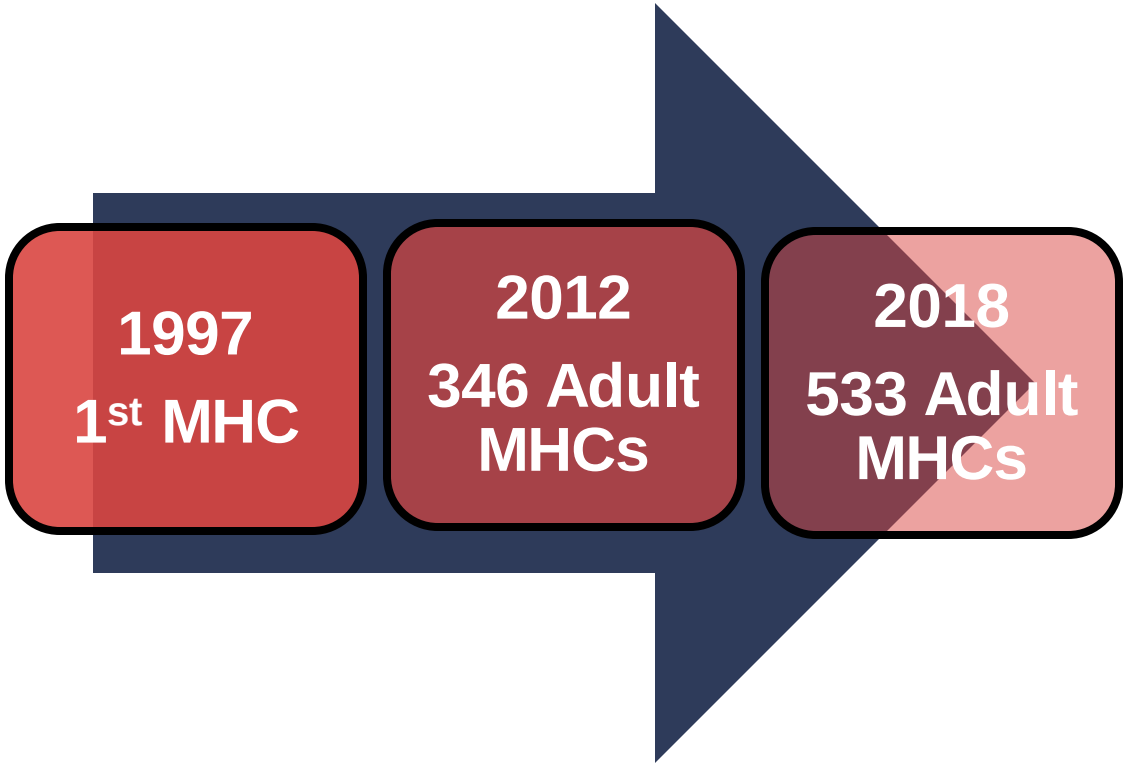
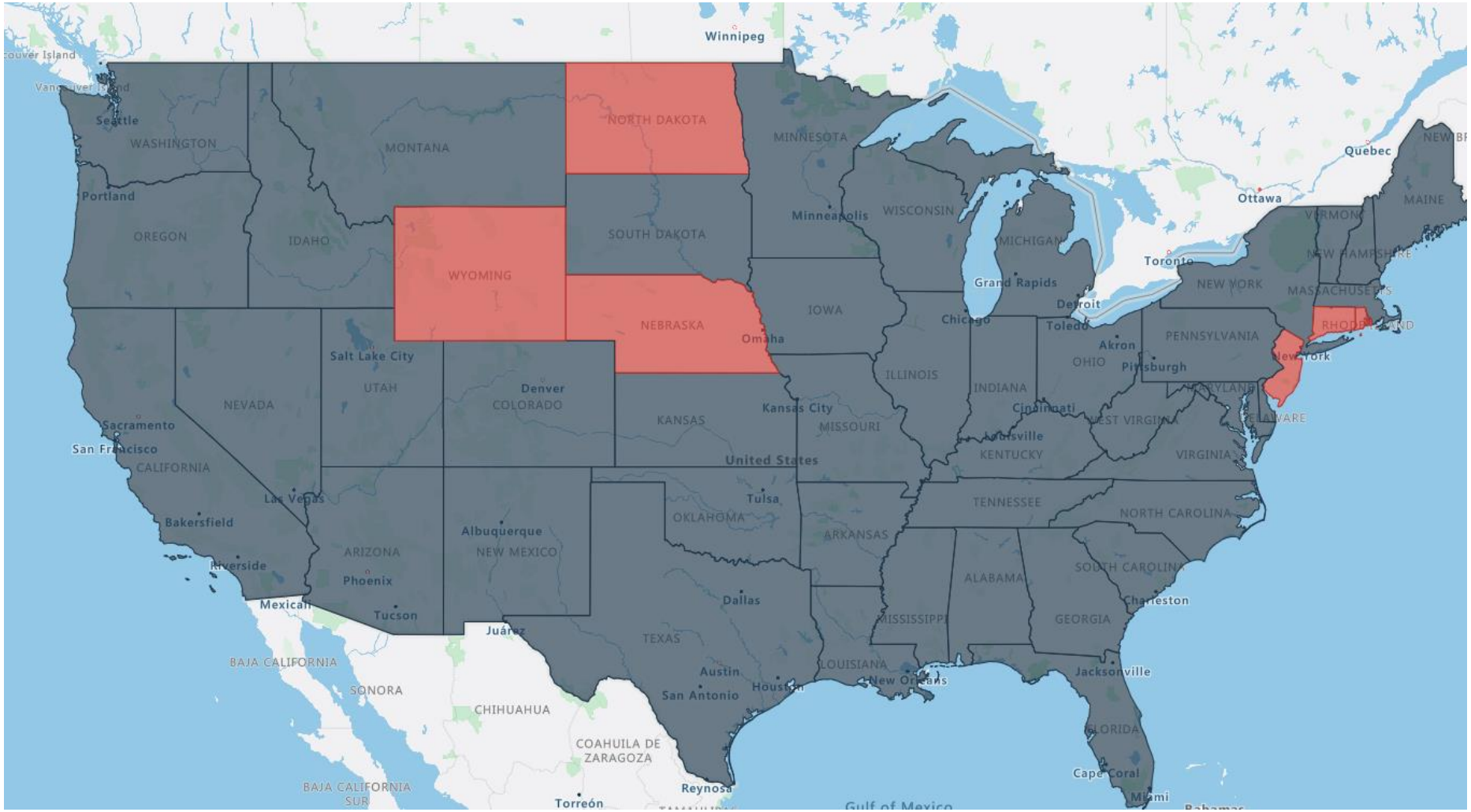
Development of Mental Health Courts in the U.S.



States with & without Adult MHCs



Prevalence of MHCs v DTCs

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

National Guidelines or Standards

- Presently (11/19) there are no national guidelines, standards, or best practices for adult mental health courts
- 18 states have MHC standards
- 16 states have treatment court standards
- 13 states have MHCs but no MHC standards

10 Essential Elements of Adult MHCs

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

Who is the Target Population of MHCs?

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

Are there difference between male & female MHC participants?

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

What are the similarities between male & female MHC participants?

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

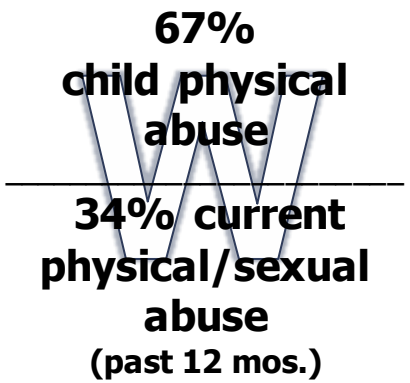
Adverse Childhood Experiences (ACE) Comparison Across Samples

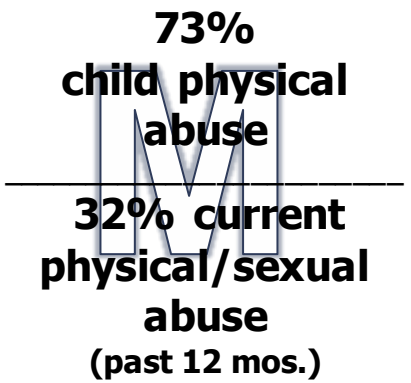
	US Adults[1] N=17,000+	ATC[2] N=90	JMHC[3] N=54	CA – CHC[4] N=701	FL – Boys[5] N=50,000+	FL – Girls[6] N=17.000+
Physical Abuse	11%	70%	27%	6%	31%	39%
Emotional Abuse	28%	93%	*	5%	26%	41%
Sexual Abuse	21%	31%	22%	4%	7%	31%
Emotional Neglect	15%	94%	56%	12%	31%	39%
Physical Neglect	10%	29%	2%	*	12%	18%
Mother/Other HH Treated Violently	13%	83%	24%	11%	81%	84%
HH Substance Abuse	27%	45%	43%	25%	24%	30%
HH Mental Illness/Suicide	19%	37%	44%	11%	8%	12%
Parents Sep/Div, 1/0 Parents	23%	68%	68%	62%	78%	84%
HH Member Incarcerated	5%	30%	35%	12%	65%	68%

[1] Feletti et al., 1998
[2] IL Tx Ct
[3] Callahan et al., 2014
[4,5] Fox et al., 2015

Trauma Reported by Adult MHC Participants

Abuse (self report)	% Women	% Men
Sexual abuse or rape (prior to age 20)	70	25
Parents hit or threw things at one another	46	27
Parents beat them with belt whip or strap	61	68
Parents hit them with something hard	43	36
Parents beat or really hurt them with their hands	42	36
Parents injured them enough to need medical attention	22	8

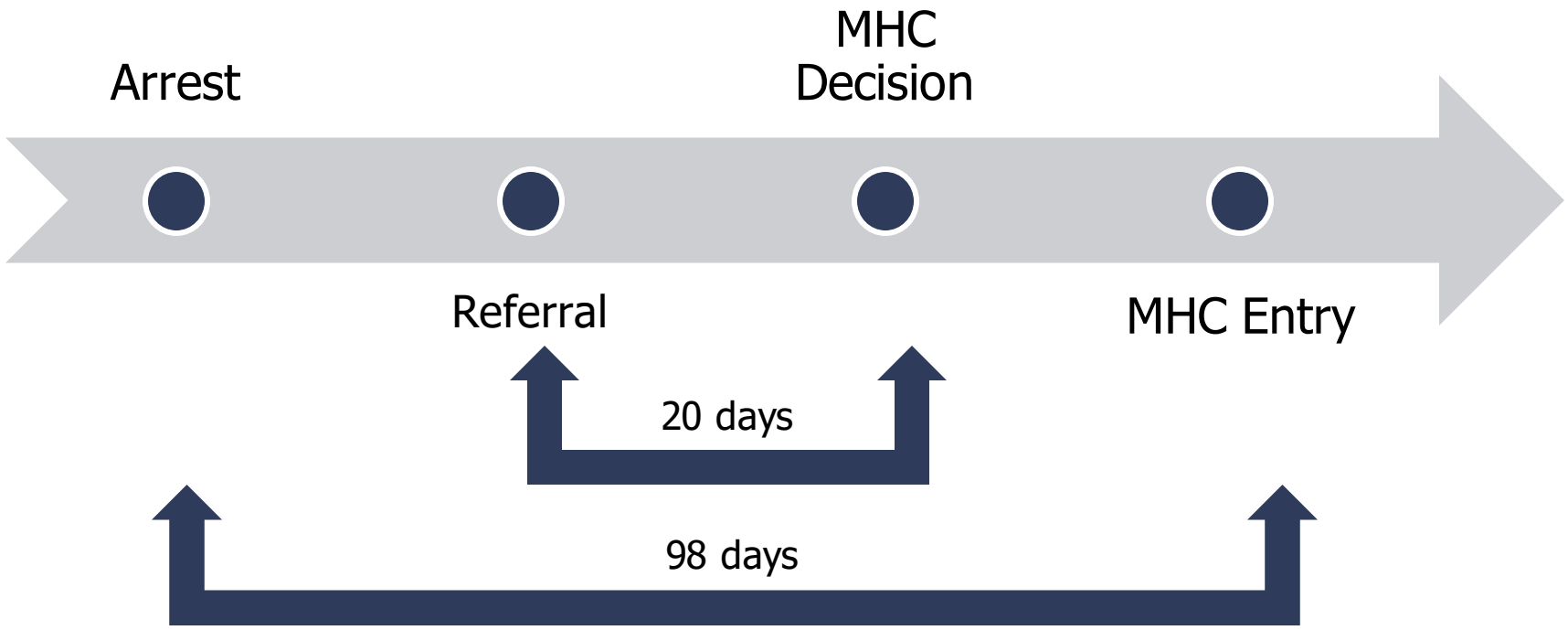




MHC Participants with Co-occurring Disorder

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

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



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

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

What incentives are used in MHC?

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

What sanctions are used in MHCs?

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

Do mental health courts improve public safety?

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

What don’t we know? (a lot)

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

Do we need to collect data? (yes)

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

What data do you need?

Participant/Referral Data

- Who is referred to/enrolled in your program – demographics, tx, cj – dates
- What is their progress in program – phases, compliance, sanctions/incentives, outcomes – dates

You will need releases, court orders, MOUs, and DUAs before you can collect all of these data – stakeholders are critical.

Are we meeting program goals?
Are we meeting community goals?
Are we meeting participant needs?

Program Data

- Connected to the goals of the program
- REFERRALS: Who is referring defendants to program? Single POA? Why not referring? How much time between referral & next steps? Are you using standardized screening?
- ENROLLMENT: What is first point of contact (who, what, where)? Who is agreeing or not to enroll? Is there a measure of voluntariness? Competence? How much time does it take?
- IMPLEMENTION: Are phases working? Do we need tracks? Gaps in services?
- INCENTIVES/SANCTIONS: Do we have a rational schedule/grid? Who is receiving them?

Thank You

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