MHSOAC Services Committee
Interim Stakeholder Report to Administrative Office of the Courts

"Facilitating Better Outcomes for Persons with Co-occurring Disorders in the Courts"

The Mental Health Services Oversight and Accountability Commission (MHSOAC) established the MHSA Services Committee to work on behalf of the Commission in making recommendations regarding implementation of MHSA programs and services. Activities of this committee include making recommendations to improve co-occurring disorders competency. In March 2009 the Administrative Office of the Courts, represented by Judge Wendy Lindley, approached the California Department of Mental Health, Department of Alcohol and Drug Programs and the Mental Health Services Oversight and Accountability Commission Services Committee to provide input to the courts to facilitate better outcomes for persons with co-occurring mental illness and substance abuse who are involved in the criminal justice system.

The following report summarizes stakeholder comments compiled during MHSA Services sub-committee discussions on the impact of co-occurring disorders in the criminal justice system. The issues and recommendations identified by this stakeholder group do not represent formal recommendations of the MHSOAC. These recommendations are intended to improve life outcomes for those persons with co-occurring mental illness and substance abuse involved in the criminal justice system, and promotes cost effectiveness for public mental health and alcohol and drug agencies, law enforcement and the courts.

BACKGROUND

Co-occurring mental illness and substance abuse disorder is pervasive. It is generally understood that 50% or more of persons with one of these conditions also has the other. The proportion of co-occurrence may even be higher among adolescents. Depression and alcohol are the most commonly cited co-occurring disorders in older adults. Co-occurring mental illness and substance abuse is the norm, not the exception. The prevalence of co-occurring mental illness and substance abuse are particularly high among un-served and underserved racial/ethnic and cultural groups, homeless persons and veterans. Persons experiencing trauma are also particularly vulnerable to co-occurring disorders (COD). Research indicates that early substance abuse and trauma are co-factors in the development of mental illness.

People with co-occurring disorders (COD) are disproportionately represented in the criminal justice system largely as a consequence of lack of access to mental health and substance abuse services. This lack of access results from multiple circumstances including: 1) an insufficient number of integrated treatment programs available through public mental health and alcohol and drug agencies for persons with co-occurring disorders; 2) a lack of available pre-booking and post-booking options for law enforcement that would divert someone from jail; 3) a lack of pre-trial opportunities for assessment of a

person's medical and mental health issues necessary to fully inform the judge and other officers of the court; 4) a lack of community supervision techniques employed by Probation Officers; and 5) a lack of information available to judges about specific treatment opportunities that may be available for the persons with co-occurring disorders appearing before them in court and any other issues relevant to the client.

Among primary care providers, mental health providers, alcohol and drug providers, law enforcement and court systems, there is also a general lack of systemic competency in dealing with persons with co-occurring mental illness and substance abuse. This results in poor life outcomes for persons with co-occurring disorders, poor community outcomes, and increased costs for public agencies and private business. A commonly stated goal for all entities involved is improved life outcomes for the persons with COD and significant cost savings/avoidance for communities including local service and law enforcement agencies.

KEY ISSUES

Issue 1: Shortage of Appropriate Treatment Programs

1. Numerous studies demonstrate that *integrated* mental health and substance abuse treatment is essential for the successful treatment of persons with co-occurring illness. Unfortunately, the general lack of available COD treatment programs and insufficient numbers of clinicians trained in providing COD treatment limits access to integrated treatment in both outpatient and inpatient mental health settings.

2. Most publically funded programs are not integrated and provide only mental health or substance abuse treatment. MHSA Full Service Partnership (FSP) programs are among the only significant publicly funded programs intended to and able to deliver integrated mental health and substance abuse services and supports. Most private insurance coverage and other funding mechanisms for treating mental illness or substance abuse are similarly separated. Recently limited funding was approved for integrated mental health and substance abuse treatment under California's Substance Abuse and Crime Prevention Act (Proposition 36). Early Prevention Screening Diagnosis and Treatment funds for youth provide one funding source for integrated mental health and substance abuse services and supports, unfortunately this entitlement is not widely understood by either the MH or AOD fields.

3. In California, the Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) sponsored the Co-occurring Joint Action Council (COJAC) to improve integration of COD services provided by state and county DMH and ADP. Working with DMH and ADP support, COJAC developed a COD State Action Plan. This plan endorses the development of a COD screening tool and templates for universal charts; explores alternative funding, program licensure and certification; and provides guidelines for training.

4. Several California counties have taken significant steps to become co-occurring competent counties including seven counties that followed the Comprehensively Continuous Integrated System of Care (CCISC) model of Minkoff and Cline, and six counties have adopted SAMHSA's Integrated Dual Diagnosis Treatment model.

Issue 2: Lack of Standard Pre-Booking and Post-Booking Options for Jail Diversion

1. Law enforcement officers, including staff working in jails, lack education and training in crisis intervention and the use of "sequential intercepts" which may inform officers' booking decisions. When officers encounter persons with COD committing minor crimes, such as unpaid fines or reporting requirements, or facinge multiple warrants, they may not consider alternatives to arrest. Crisis Intervention Training, such as the trainings offered by the California Institute for Mental Health, or training to reduce Stigma may reduce the need for arrest for individuals with mental illness or substance abuse.

2. Court staff including city attorneys, public defenders, and district attorneys also lack education and training about the effects of co-occurring mental illness and substance abuse. This frequently results in persons going to jail when the prosecutor could have chosen to drop the criminal charges pre-plea or recommend treatment alternatives rather than jail.

3. Lack of standardized pre-booking or post-booking diversion options limits opportunity to address mental illness and substance abuse. Law enforcement officials and judges frequently report that individuals are incarcerated simply due to the lack of available treatment and support options for persons with mental illness and substance abuse disorder. In general, while behavioral health diversion programs require considerable interagency collaboration, they have consistently demonstrated improved quality of care and are cost effective. Example programs include those in Bexar County, Texas; Allegheny County, New Hampshire and the Serial Inebriate Programs in San Diego and San Francisco Counties.

Issue 3: Lack of Screening for COD by Law Enforcement and Courts

1. Many individuals with suspected COD pass through the court system undetected. Pre-booking, post-booking or pre-trial screening for mental illness or substance abuse by law enforcement or court officers is neither routine nor standardized.

2. Individuals referred to treatment by the courts under the Substance Abuse and Crime Prevention Act (Proposition 36) are not routinely screened for COD.

3. Screening for COD conducted by law enforcement, probation and/or the courts will increase referrals to local mental health and alcohol and drug programs for more comprehensive COD assessment, treatment and support.

Issue 4: Judges and Courts need Relevant COD Information for Decision Making

1. Judges receive insufficient psychosocial or collateral information and are concerned about the outcomes of their judicial decisions for persons with suspected or identified co-occurring mental illness and substance abuse. Judges also lack sufficient information about the availability of appropriate and accessible treatment for individuals with COD. Without this information they cannot consider treatment alternatives to jail.

2. While specialty courts generally have established processes to inform court officers about a person's condition, often with mental health workers or other advocates working to inform the courts in the best interest of client, the quantity of mental health courts, drug courts or homeless courts is *insufficient* to accommodate the large number of persons with co-occurring mental illness and substance abuse in the criminal justice system.

3. Judges in regular courtrooms may employ 'therapeutic justice techniques' when dealing with persons with COD, however, they frequently lack established communication and liaison with public mental health and/or alcohol and drug programs needed to keep fully informed. Without treatment liaison, judges lack general information about services and client-specific needs.

4. Judges and court officers receive little or no training about co-occurring disorders or the impact of mental illness and substance abuse on behavior. Judges also lack specific training on post traumatic stress disorder and the impact of trauma on behavior. When incarceration is the outcome of a court appearance for an individual with co-occurring mental illness and substance abuse, the mental illness may be exacerbated. Similarly, failure to detect substance abuse may increase the risk for relapse and reincarceration.

Issue 5: Need to Enhance Community Supervision to Facilitate Treatment Participation

1. Probation violations and arrest for minor infractions are the most common reasons why individuals with mental illness or substance abuse and individuals with COD return to custody.

2. To maximize the effectiveness of community supervision by probation and parole officers working with COD populations, officers must strive to achieve a “seamless” working relationship with treatment providers. That relationship should be characterized by full information sharing (i.e. prior criminal history, pre-sentence report, etc), joint case planning, and on-going regular communication.

3. Mentally Ill Offender Crime Reduction (MIOCR) programs produced significant positive results in facilitating client involvement in treatment and reducing recidivism. This was due in great part to many Counties transforming the role of the Probation Officer providing community supervision to that of a supportive and motivating member of a multidisciplinary team, in addition to performing the mandated supervision duties.

4. Research supports training “hybrid” community supervision officers for probation and parole to improve treatment outcomes and reduce recidivism. Community supervision officers differ from both “law enforcement” and “treatment” oriented officers in that they address social or behavioral issues, such as mental illness, substance abuse, homelessness, poverty, and poor social networks. They utilize joint problem solving techniques, show overt respect for clients and require accountability from clients without threats. Techniques such as motivational interviewing are the hallmark of this approach along with reduced caseloads. Success is directly related to the amount of time spent focusing on supportive interventions.

Issue 6: Other Factors Judges Should Consider in Making Decisions

1. Persons with serious mental illness who have Medi-Cal eligibility lose that eligibility if they are incarcerated for 30 days or longer. When persons are incarcerated for longer than one year they must re-establish their Medi-Cal eligibility when they leave custody. Re-establishing eligibility frequently takes several months or a year preventing someone from receiving necessary treatment during that time.

2. In instances when an individual is diverted to treatment rather than sentenced to jail or prison and then successfully completes that treatment, their criminal record frequently still follows them creating barriers to employment, housing, etc. Even when the record is purged and ‘record clearance’ is ordered, records are still maintained at the state level which could jeopardize someone’s ability to gain employment or secure housing.

RECOMMENDATIONS

Recommendation 1. Re: Shortage of Treatment Programs

1. The AOC should work with DMH, ADP, CMHDA, CADPAAC and COJAC to promote the coordination of local mental health and alcohol and drug programs toward the goal of providing integrated treatment and the expansion of COD competency.

2. Local mental health and alcohol and drug agencies should work collaboratively with the courts to develop processes and pathways to provide appropriate assessment, referral and treatment services for individuals screened positive for COD.

3. As recommended by COJAC, treatment programs treating court-referred clients should use the Dual Diagnosis Competency Assessment Tool (DDCAT) self assessment tool to determine COD competency. Two versions of this tool are available, one for MH and one for AOD programs. Mental health and alcohol and drug treatment staff in these programs should receive training in screening, assessment and treatment for persons with COD, as well as, training in how to liaison with the courts.

4. The AOC should consider endorsing treatment program standards, such as the DDCAT, which would assure that individuals referred to treatment by the courts receive appropriate care.

5. The AOC should document the cost effectiveness of treatment as an alternative to incarceration and recommend that the legislature fund programs for COD offenders that would likely be sentenced to prison. The drug court programs funded through CDCR provide a model that could be replicated for mental health courts and persons with COD.

Recommendation 2. Re: Lack of Standard Pre-Booking and Post-Booking Options for Jail Diversion

1. Training should be provided for law enforcement officers in crisis intervention and the benefit of utilizing “sequential intercepts” when encountering individuals who may have COD. Training should include measures that promote stigma reduction, and education about the impact of trauma on mental health and substance abuse.

2. The AOC should support training and education for city attorneys, public defenders and district attorneys about the impact of co-occurring mental illness and substance abuse and the effects of trauma on that condition.

3. County agencies should be encouraged to initiate local discussion to develop pre-booking and post-booking options to facilitate diversion of individuals with COD from jail to treatment. This requires ongoing, established communication among local programs delivering COD services and local law enforcement and should result in a comprehensive, updated list of resources and contacts that law enforcement might consider prior to arresting an individual.

4. Determine feasibility of law enforcement officers utilizing the COJAC Screening Tool in the field to determine whether a person may have co-occurring mental illness and substance abuse disorder.

5. Review options to integrate healthcare and booking record information systems in order to coordinate sharing of relevant mental health or alcohol and drug information with law enforcement for the purpose of reducing unnecessary or inappropriate incarceration. Efforts to share information must include active protective measures to prevent misuse of medical or mental health information and be compliant with HIPAA and 42 CFR Part 2 confidentiality requirements.

Recommendation 3. Re: Lack of Opportunity for Screening for COD by the Courts

1. The AOC should support the training of law enforcement and court staff on the impact and prevalence of COD in the courts. Training should be provided on the value of screening for mental illness, substance abuse and trauma.

2. The AOC should implement the COJAC Screening tool in courts and develop pathways for additional assessment and referral with local mental health and alcohol and drug treatment agencies.

3. Support law enforcement and the courts receiving relevant psychosocial information, prognosis, recommendations and treatment alternatives for individuals with suspected or self-identified mental illness or substance abuse by standardizing communication between public mental health and/or alcohol and drug agencies and law enforcement and the courts.

Recommendation 4. Re: Making Relevant Information Available for Judges and Courts

1. The AOC should support training for judges and court officers about the effect of having co-occurring mental illness and substance abuse and the relationship between trauma and COD. The training provided should be developed in collaboration with persons who have experienced trauma.

2. Develop standard procedures that would result in information about a person's COD condition being available to court officers and judges. Enhance the scope of Pre-trial and Probation reports and recommendations to the Courts to ensure that comprehensive psycho-social summaries are included. This would fully inform the Courts by providing important contextual and historical information for sentencing or diversion decisions.

3. Develop professional or peer consultants to the court to facilitate liaison between the courts and mental health and alcohol and drug treatment systems. These consultants could provide screening, assessment, consultation to judges, serve as peer navigators for clients, assist with Medi-Cal eligibility and facilitate client linkage to services. The AOC should work with CMHDA, CADPAAC and local agencies to determine whether this service deserves local MHSA funding priority.

Recommendation 5. Re: Need to Enhance Community Supervision to Facilitate Treatment Participation

1. Training should be provided for Probation Officers that supports improved community supervision by utilizing joint problem solving techniques, showing overt respect for the client and requiring accountability from the client without threats. Training techniques such as motivational interviewing should be promoted as well as reduced caseloads for these officers.

2. Community supervision officers working with COD populations should be specifically well trained in mental illness and substance abuse, pharmacology, mental health and substance abuse treatment, and motivational interviewing. They must also be trained in how to work as part of an interdisciplinary team. That training would include learning the role and mission of each of the members of the team, overcoming obstacles to information sharing, and learning to use the leverage of probation/parole authority in a team concept.

3. The "Balanced Approach" to community supervision should be utilized in working with COD populations. In the "Balanced Approach", community supervision officers expand their traditional "enforcement" role to include an equally important social casework role. In the balanced approach the community supervision officer continues to monitor the conduct of the offender to ensure the individual complies with the orders of the court and terms of probation, but at the same time the officer employs the case management elements of assessment, referral, linkage, monitoring, and advocacy in an effort to facilitate behavior change. In the case of the COD offender that focus might be behavior "stabilization", more than behavior "change".

Acknowledgements

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Submitted 5/6/09