



Model Legal Processes to Support Clinical Intervention
for Persons with Serious Mental Illnesses
and
Pathways to Care: A Roadmap for Coordinating
Criminal Justice, Mental Health Care, and Civil Court Systems
to Meet the Needs of Individuals and Society

August 2022

Preface

Project History

The Equitas Project, Mental Health Colorado’s national initiative to disentangle mental health and criminal justice, has been generously supported by The David and Laura Merage Foundation. Our call to action is *Care, Not Cuffs!*—we are advocating for a health care response to people’s unmet health needs.

Mental Health Colorado is the state affiliate of Mental Health America. Since 1953, our mission has been to promote mental health, expand access to services, and transform systems of health care. To achieve healthier minds across the lifespan, we advocate for a strong start for all children; support for families; access to housing, health care, supports, and services; wellness in aging; reduced harm from drugs and alcohol; and the decriminalization of mental health.

A continuum of care, supports, and services throughout every stage of life enables human populations to thrive—and nowhere in this nation is such a continuum equitably available. The criminalization of people with unmet mental health and substance use care needs, and the impact of that criminalization on their families and communities, are costly to society and avoidable. Decriminalizing mental health and meeting people’s needs for mental health and substance use care, supports, and services are top priorities for our advocacy work. *Care, not cuffs!*

In partnership with Equitas National Advisors, the Hon. Steven Leifman, J.D. and Ronald Honberg, J.D., we formed the Model Legal Processes Work Group in 2019 for the purpose of writing model civil and criminal mental health law that could be distributed and promoted for broad adoption across the country. The work group aimed to produce legislative language that reflects cutting edge brain and behavior research, the civil liberties and patient’s rights advocacy of consumers and families, as well as health provider and public safety innovations and efficiencies. The work group of nationally recognized experts in mental health law, psychiatry, and advocacy aspired to create model law which would set the gold standard for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety.

From May 2019 through June 2022, The Equitas Project convened a series of work sessions to scope and fully execute the guidance documents presented here: *Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illness* and *Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society*.

Project Purpose

As advocates informed by individuals with lived experience of the tragic flaws in our health care and criminal justice systems, we are sharing this guidance document for the purpose of stimulating more enlightened and urgent conversation among partners and allies nationwide about our mental

health and substance use crisis and the imperative of increasing access to housing, health care, supports, and services. Failure to thrive, homelessness, overdose, incarceration, suicide, and other premature death--the too prevalent consequences of Americans' unmet health care needs--must not be tolerated by those of us who aspire to build a stronger, better nation.

Advocacy Considerations and Priorities

As consumer advocates, we appreciate and acknowledge that there are alternative pathways to well-being and understand that different approaches may be effective for some individuals. We also support cultural competence in providing equitable care, supports, and services for widely diverse individuals. We most urgently acknowledge that the present default pathway into jails and prisons, especially for underserved and vulnerable populations, yields terrible health outcomes and at great cost to individuals, families, and society. What we urgently need is an equitably accessible, reliably compassionate system of care, supports, and services that leaves no one's needs unmet.

Our purpose is to create surer, more equitable, more inclusive, pathways to care and well-being. To that desirable end, one of the most important stipulations in this guidance document is that:

Having placement options and a continuum of appropriate related services is a key part of achieving successful outcomes. All three branches of government must collaborate to create and maintain such a system, and that collaboration likely requires coordination and communication at the state and local levels. Permanent interdisciplinary oversight structures – committees, task forces, commissions - are helpful in ensuring that collaboration and mutual accountability.

The statutory language proposed in this document would create a more accessible legal pathway to involuntary care for the sake of an individual's health and well-being than is presently available in most states. Ensuring that "placement options and a continuum of appropriate related services" are available for the court's referral and, more importantly, that those services are available before someone gets to the point of needing crisis intervention and involuntary care must remain the focus for our collective advocacy.

Passing laws and changing practices within the justice system may be easier than creating an equitable continuity of housing, health care, supports, and services where there is little or none. In Colorado, Mental Health Colorado helped pass *SB19-222 Individuals at Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization* (see Appendix IV)—which was a triumph of bipartisan recognition that the state needs a safety net system to prevent vulnerable individuals with mental health and substance use need for care from becoming involved in the criminal justice system. But recognizing the need and passing the law is not like waving a magic wand. Implementation takes time and resources and collaborative commitment which must be continuously cultivated.

This guidance document wisely stipulates that involuntary commitment be contingent upon attempts made “to engage the person in receiving person-centered health care and a continuum of supports and services.” As consumer advocates we support and insist upon this. Again, mobilizing a system that is truly person-centered (inclusive, equitable, culturally competent) and that reliably makes such outreach and engagement attempts must be a focus for our collective advocacy.

This document also includes guidance for emergency intervention that our work group formulated at the very same time as Mental Health Colorado’s VP for Government Affairs, Lauren Snyder, was leading Colorado stakeholders in a year-long process which led to the passage of *HB22-1256 Modifications to Civil Involuntary Commitment statutes for persons with mental health disorders* (see Appendix V for summary and link). This law revises Colorado’s involuntary mental health treatment procedures for the first time since the 1970s and, among other things, establishes certain rights for persons being transported for evaluation and requires a discharging facility to establish continuity of care after discharge. We recommend that this new Colorado law be considered alongside the recommendations presented in this document.

Acknowledgements

We are very grateful to The David and Laura Merage Foundation for their generous support of this project and our other efforts to disentangle mental health and criminal justice. We are deeply grateful to the members of the work group for their expertise, their passionate commitment to addressing egregious failures in our systems of health and justice, and for their generosity with their time and attention to this project over these past three years. We are particularly grateful to Judge Leifman for his suggestion that The Equitas Project support this work, for his leadership of the group, for his understanding and insight regarding the intersection of mental health and criminal justice, and for his warm heart, his joy, and his sense of humor.

Throughout the duration of the process, The Equitas Project provided staff support for the work of the group, and we gratefully acknowledge the skillful attention of Project Managers Gwendolyn West and Adam Goss, and Model Legal Processes Group Reporter Richard Schwermer (for whose outstanding services and expertise we contracted with the National Center for State Courts). We are also grateful to Ken Sonnenfeld and his associates at Ballard Spahr, Brittany Wilson and Erin Blasberg, for their legal expertise and research support. We have edited what follows for consistency and for inclusive, non-discriminatory language and we own and acknowledge all errors or deviations from what the work group authored which may have resulted from that editing process. We wholly credit the work group for all the valuable substance of this guidance.

Finally, we thank you, Readers, for your empathy, your caution, your wisdom, your gratitude for diversity, your respect for liberty, and your humanity.

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Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses

Introduction

Most states' laws for the involuntary treatment of persons with mental illnesses in existence today were adopted in the 1970's. As part of an effort to deinstitutionalize the treatment of mental illness, this generation of statutes favored "dangerousness" standards and individual rights-oriented court processes for involuntary treatment over the need-for-treatment standards and informal procedures that existed before. As a result, in some states today, individuals with mental illnesses who do not clearly present an imminent risk of harm may not be able to benefit from pathways to well-being that may only be available through involuntary treatment. If there are no other pathways to treatment, these persons can be more likely to experience homelessness, poverty, serious health consequences, and involvement in the criminal justice system.

Modern mental health laws must be modified—and systems of health care, supports, and services enhanced—to improve access to timely, appropriate mental health care delivered in the least restrictive manner possible for those unwilling or unable to voluntarily accept that treatment. These laws also must appropriately take into account the person's right to self-determination. Statutory modifications should both ensure that persons with mental health and substance use care needs are able to access needed services voluntarily and provide for involuntary treatment not only for individuals who do meet traditional dangerousness criteria but also for those who are at significant risk of experiencing a crisis.

This guidance document is intended to provide policymakers with a template for revising all aspects of our current, often outdated and piecemeal, approach to mental health care. The proposed statutes and non-statutory guidance language lay out a more modern and cohesive model for effectively creating pathways to care for people with serious mental health and substance use care needs, consistent with today's scientific understanding of brain functioning.

Part I. Guidance for Court Ordered Mental Health Treatment

This first section is proposed statutory language. Italicized text below is commentary intended to provide context and reasoning for the statutory language.

Statutory Language

1. "Person requiring court ordered treatment" means an individual who, as a result of mental illness and based on recent actions, omissions, or behaviors:

(a) presents a substantial risk of harm to self or others in the near future, which includes:

- (i) suicidal behavior or inflicting significant self-injury; or**
- (ii) attempting, causing, or threatening to cause serious injury to others; or**

(b) has demonstrated an inability to:

**attend to basic physical needs such as medical care, food, clothing, or shelter; or
protect the self from harm or victimization by others; or
exercise sufficient behavioral control to avoid serious criminal justice involvement;
or**

**(c) lacks the capacity to recognize that they are experiencing symptoms of a serious
mental illness and therefore are unable to:**

**make a decision regarding treatment; or
understand or retain information relevant to the treatment decision; or
use, weigh or appreciate that information as part of the process of making the
treatment decision; or
communicate the decision; or
appreciate the risks or benefits of treatment; and
in the absence of treatment is likely to experience a relapse or deterioration of
condition that would meet the criteria in (a) or (b).**

**2. The court shall order treatment of a person requiring court ordered treatment in an
outpatient setting unless the court determines that outpatient treatment will not provide
reasonable assurances for the safety of the individual or others or will not meet the
person’s treatment needs.**

*Court-ordered psychiatric treatment is reserved for individuals with a mental illness for which
treatment is likely to be effective. Treatment must be provided in the least restrictive setting
consistent with the needs of the individual and the interests of the public.*

*Court-ordered treatment is a significant event. By definition, it marks a diminution of the
individual rights and freedoms of the person, so it is a legal step to be taken carefully. Taking
account of current scientific understanding and legal precedent, the criteria for court-ordered
treatment narrowly and objectively define the circumstances under which protecting a person’s
long-term well-being justifies overriding a person’s freedom.*

*This definition intentionally refers to “court ordered treatment” as opposed to the term
“commitment” as that term implies custodial treatment and confinement, whereas the type of
treatment ordered and its setting should be the least restrictive that will be safe and effective.
This least restrictive environment principle respects the rights of the individual, but it also is
consistent with best medical practice and with the goal of using scarce treatment resources
wisely.*

*Finally, the introductory provision of this definition requires a nexus between the person’s
mental illness and the need for court intervention. This does not, however, mean that it is
necessary to find that mental illness is the sole cause of the person’s dangerous behavior or
incapacity. For example, a large percentage of individuals experiencing mental illnesses have
co-occurring substance use and distinguishing between the two or trying to disentangle them is*

not required. However, the finding of a mental illness will likely require the presentation of clinical assessment evidence that establishes one or more suggested diagnoses based on the latest version of the Diagnostic and Statistical Manual.

The court order must be based on evidence sufficient to meet one or more of the criteria specified in subsections (a), (b), or (c). Consistent with current case law, the existence of one or more of these provisions needs to be proven by the petitioner by clear and convincing evidence. This higher civil standard is required given the potential loss of liberty by the individual (see Addington v. Texas).

Subsection (a) is similar to many existing “dangerousness” provisions, but the risk of harm must be substantial, not merely speculative, and the harm anticipated must be proximate in time. Admittedly there is some element of prediction involved in these determinations, but established past conduct is relevant. The number of times harm has resulted in the past, the severity of that harm, how long-ago harmful conduct occurred, what treatment interventions, supports, and services may have intervened and could ameliorate repeat conduct –may all be relevant in establishing the nature and imminence of future conduct. The testimony of experts can also be particularly helpful in this assessment.

Subsection (b) considers a type of harm different from the type of harm in subsection (a). This second type of harm requires a finding of an inability to provide for basic life needs. The implication is that it requires a showing of more than poor life choices, or choices different than ones someone else might make, but rather substantial deficits in the ability to even make those choices. Again, these substantial deficits must be “as a result of a mental illness.” People are entitled to make poor choices, but if they lack the ability to make better choices as the result of unmet mental health or substance use care needs, and those choices relate to basic life necessities, then court intervention may be justified.

The alternative finding that the person has substantial deficits in the ability to protect the self from harm also requires a distinction between making choices with which some would disagree and that could result in harm (drinking alcohol, under- or over-eating, or riding a skateboard without a helmet) and a fundamental inability to weigh risks and make a choice. As with subsection (a), a prediction of serious harm based on a clear history or recent behavior would be required to justify court-ordered treatment.

Subsection (c) applies to individuals who do not meet the requirements of subsections (a) or (b), but who likely will meet one of those thresholds without treatment. Because of the nature of this standard, it requires an additional finding that the person lacks the capacity to recognize their symptoms of mental illness. This condition is a prerequisite for using this additional criterion. For example, a person might lack capacity to make a rational decision about the need for treatment if that person is regarded as unable to understand the information relevant to the decision due to mental illness. Alternatively, a person might be able to use information for some purposes but, due to their mental illness, still not be able to appreciate the way the information pertains to their own situation.

(c)(vi) requires a finding that this condition contributes to a likelihood that the person will, in the future, meet the criteria described in (a) or (b). This finding would be based on evidence of past deterioration or relapse episodes. No specific timeline for that predicted deterioration is included because of the individualized nature of relapse.

While the criteria found in subsections (a) and (b) are relatively standard provisions in state statutes, this alternative criterion for court-ordered treatment is advanced in response to the frequent complaint that under most existing laws a person must actually harm themselves or someone else in order to justify judicial intervention, no matter how clear, serious, or imminent the harm may be. The criterion is also intended to better comport with modern medical understanding of the symptoms of untreated serious mental illness.

If the court-ordered treatment involves medication, the court may authorize medication over objection if the court finds that the criteria in the Medication Over Objection provision in Part III are met.

*Section 2 makes explicit the presumption for treatment in the least restrictive environment. It also directly reflects the requirement set forth in *Olmstead v. LC* that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions.¹ This presumption should apply not only at the initial determination of capacity, but at each treatment placement decision and review opportunity.*

Section 2 also obviates the need for a separate provision for Assisted Outpatient Treatment (AOT). Rather than having a distinct process for outpatient court-ordered treatment, the standard to invoke all non-emergency involuntary mental health treatment would be the same. Traditionally, after an order for treatment the court has no further role other than to review or terminate that order at some future time. However, a number of jurisdictions have added a more direct role for judicial oversight and encouragement of the person and their treatment. Adding a statutory provision directing that kind of oversight for appropriate persons is a worthwhile option for policymakers to consider. But we do not do so here.

The following section sets out guidelines for the procedure to be followed in determining whether an individual meets the criteria for inpatient or outpatient treatment.

Proposed procedural processes

1. Any adult over the age of 18 should be able to file a petition for court-ordered treatment of a person if the petitioner believes, in good faith, that the person has a mental illness and is in need of court ordered involuntary treatment consistent with the criteria of this statute.²

¹ *Olmstead* provides that the community setting is required if a three-part test is met: the person's treatment professionals determine that community supports are appropriate; the person does not object to living in the community; and the provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

² For emergency interventions, see the separate Emergency Intervention Guidance that follows

2. A clinical certificate from an independent qualified mental health professional should be sufficient to hold a person in a treatment facility pending a hearing. Anecdotal reports suggest that many patients who are held pending a hearing are discharged prior to the hearing, sign in voluntarily, agree to services in the community, or stipulate to the entry of an order.
3. The individual should have the right to attend the hearing in person (although the hearing could be conducted remotely as long as the person can participate). If medication over objection is involved, ideally the process set forth in Part III of this document is included in this initial hearing rather than in a separate subsequent hearing.
4. If the court finds that the individual meets the statutory criteria, it should have authority to order placement of the individual in an inpatient or outpatient treatment setting, or a combination of both, depending on their assessed clinical need.

Having placement options and a continuum of appropriate related services is a key part of achieving successful outcomes. All three branches of government must collaborate to create and maintain such a system, and that collaboration likely requires coordination and communication at the state and local levels. Permanent interdisciplinary oversight structures – committees, task forces, commissions - are helpful in ensuring that collaboration and mutual accountability.

Part II. Guidance Language for Emergency Psychiatric Intervention

In many cases, before the hearing described in Part I takes place, an emergency intervention is necessary.

This section is intended to provide guidance for an emergency intervention. Recommended standards and procedures cover the initial emergency assessment and subsequent assessments and processes short of a judicial determination of incapacity. The language may be adapted according to jurisdictional needs. The language contained in this section is not precise statutory language to be adopted verbatim. Italicized text serves as commentary for additional context and reasoning.

Often the need for an emergency assessment arises because of a call for assistance, usually to 911. The better practice is the emerging initiative of 988 or other trained dispatch personnel who can make a more competent determination about the necessity of a law enforcement response. Better outcomes often occur when communities use co-responders or mobile crisis teams of clinically trained responders.

The standard for Emergency Intervention is by necessity lower than that for longer term court orders for treatment. Less information is available on which to make longer term decisions, and the presumption should be that a person's self-determination is limited only to the extent

necessary to assess the person’s safety and prognosis. The initial detention for emergency assessment should be as brief as possible, and oriented to a treatment intervention as opposed to a criminal justice intervention, and a determination of the appropriateness of further detention.

1. Purpose

To provide a pathway to emergency psychiatric assessment and intervention that does not require an initial judicial process.

2. Definitions

a. “Best Interest” means it can be reasonably established by an independent party that emergency mental health evaluation and intervention will be beneficial or that the person would otherwise consent to it if not incapacitated.

b. “Emergency Medical Technicians (EMTs)” are state certified emergency responders trained to provide emergency medical care to people who are seriously ill or injured. The responsibilities of EMTs include the transport of individuals to hospital emergency departments or other facilities responsible for providing emergency or crisis care.

c. “Legally empowered persons” include (1) physicians, nurse practitioners, advanced practice nurses, and physician assistants; (2) health care providers with expertise in diagnosing and treating mental illness, including but not limited to psychiatrists, advanced practice nurses with psychiatric expertise, psychiatric nurse practitioners, licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors; (3) judges and other quasi-judicial officers such as a magistrate or magistrates; (4) law enforcement personnel and emergency medical personnel and (5) legal guardians of the individual subject to treatment under this provision.

d. “Mental illness” as utilized in this section includes any mental illness in the most recent Diagnostic and Statistical Manual (DSM) In addition, as utilized in this section, people with “mental illness” include people with substance-induced mental illness, co-occurring mental illness and substance use and/or substance use disorders, and/or cognitive disability, and/or other medical conditions or disabilities contributing to the symptoms or behaviors that are the reason that emergency psychiatric intervention may be needed.

e. “Qualified Mental Health Professionals” include psychiatrists, psychiatric nurse practitioners, advance practice nurses with psychiatric training, physicians and physician assistants with psychiatric training, psychologists, and others defined in state laws as qualified to conduct emergency psychiatric assessments.

f. “Paramedics” are advanced, state certified providers of emergency medical care, with more extensive training than EMTs in providing emergency assessments, transportation, and care.

g. “Telehealth” is the use of electronic information and telecommunications to support and promote long distance clinical health care, including mental health care.

3. Initial emergency psychiatric assessment

a. A legally empowered person may initiate the process of obtaining an emergency assessment of an individual if there is good cause to believe that, as a result of mental illness and based on the individual's recent actions, omission, or behaviors, the individual:

(1) poses a substantial risk of

- i. attempting suicide or inflicting serious self-injury;
- ii. causing or inflicting injury on others or engaging in threatening behavior or verbal threats that arouses fear of serious harm to self or others;
- iii. being unable to provide for immediate essential needs such as food, clothing, or shelter;
- iv. being unable to protect self from victimization by others; or
- v. being unable to exercise sufficient behavioral control to avoid criminal justice involvement, or

(2) is unable to recognize symptoms or appreciate the risks and benefits of treatment and, as a result, is unable or unwilling to adhere to treatment and attempts have been made to engage the person in receiving person-centered health care and a continuum of supports and services, placing them at substantial risk of a serious deterioration in their mental condition in the near future that would result in their meeting one or more of the criteria specified in (1).

“Good cause” may be based on an examination of the individual, observation of the individual’s behavior, and information provided by third parties, including family members, associates, or others who have observed the person’s behavior. Laws preventing the use of this third-party information in determining whether an emergency evaluation is appropriate should be examined to determine applicability, and exceptions to their applicability may need to be created.

b. To initiate the process of obtaining an emergency assessment, the legally empowered person may, if it is safe to do so, directly transport the person or may contact the authorized transport (described in section 4), and, if the latter, should provide to the transporting authority, in writing or orally, the reason for the finding.

c. Nothing in this section precludes a person, the person’s legal guardian, or other legally authorized representative from seeking a voluntary emergency psychiatric assessment.

4. Safe transportation

A person for whom transportation has been requested should be transported to a location designated for an emergency psychiatric assessment by EMTs, paramedics, mobile crisis personnel, or other trained peers or crisis responders. Law enforcement officers should provide transport only when no other means are available to protect the safety of the individual or those providing the transport. Unmarked vehicles should be used whenever possible. Handcuffs or physical restraints should be used only as a last resort and limited to those persons who have been identified as risks to self or others without the use of restraints.

EMTs and paramedics responsible for routinely transporting individuals for emergency psychiatric assessments should complete Crisis Intervention Team (CIT) training or another certified training program in crisis de-escalation and the safe transportation of persons experiencing mental health crises.

When transported by law enforcement, handcuffs and other physical restraints should be considered only in emergency situations to immediately secure an out-of-control individual safely. However, even if used to get an individual under immediate control, the individual should then be transported as a medical emergency utilizing soft medical restraints if necessary and not in handcuffs.

One or more facilities or agencies within each region or mental health catchment area should be responsible for providing a safe, secure, welcoming space for conducting involuntary emergency psychiatric assessments. Such assessment sites should be within reasonable driving distances commensurate with access to emergency medical care, and qualified mental health professionals should be available to conduct emergency psychiatric assessments, based on projected levels of need.

These sites should be staffed by qualified mental health professionals. Additionally, they must have the capacity to provide basic medical screening and have relationships with emergency medical facilities for those individuals who require emergency medical interventions.

Local jails must not be used as an alternative to an appropriate assessment site, solely to detain persons who meet the criteria for emergency psychiatric assessment. The intent of these provisions is to prevent arrest as a mechanism to access care because there is no access to emergency psychiatric assessment.

5. Emergency psychiatric assessment

a. Emergency psychiatric assessments must be conducted by a qualified mental health professional to determine whether the person meets the criteria in 3(a) for continued emergency assessment and intervention and, if so, whether the person needs continued treatment, the best type of facility or other setting in which to provide that treatment, consistent with the principle of using the least restrictive environment, and whether the individual will accept such treatment voluntarily.

This determination should consider not only the individual's appearance and behavior in the evaluation facility but also the individual's likely risks if discharged. The psychiatric assessment and determination of risk should also consider the contributions of co-occurring substance use, cognitive impairment, and medical issues that may exacerbate current or future risk. The evaluator should make every attempt to seek input from any care providers, family members, or others who have treated or observed the individual as part of the assessment, even absent the individual's explicit consent.

b. Emergency psychiatric assessments may be provided either on site or through telehealth. Whether provided on site or virtually, emergency psychiatric assessments must include timely access to evaluations by qualified mental health professionals.

c. Emergency psychiatric assessments shall be initiated within 4 hours of arrival at an assessment site and shall be completed within 24 hours of arrival. Exceptions to these time requirements may be made only when medically necessary, and the facility must document that additional time is required in order to provide for safe transfer or discharge.

Assessments should comport with clinical best practice standards for such assessments, in the same way we would expect for emergency medical assessments.

6. Treatment during the emergency psychiatric assessment

During the period of the emergency psychiatric assessment, access to consultation with an appropriate psychiatric care provider must be available, in person or via telehealth, and appropriate treatment provided.

The designated site should provide or arrange for provision of treatment interventions to address the individual's immediate health needs and take all steps necessary to determine an appropriate disposition, including 24-hour observation of the individual and contacts with family members or others with knowledge of the facts who can be helpful in providing information pertinent to determining the level of risk, and recommended next steps. If emergency involuntary psychiatric medications are necessary, they are administered consistent with relevant rules and regulations governing such administration.

If a person receiving emergency psychiatric assessment or the family or friends of this person presents a valid psychiatric advance directive (PAD), the facility and personnel responsible for conducting the assessment should honor the individual's preferences stated therein with respect to treatment and substitute decision makers, subject to limitations prescribed by state law.

7. Continuing Emergency Psychiatric Treatment

a. If, after completion of the emergency psychiatric assessment and any emergency interventions deemed medically necessary the individual continues to meet emergency treatment criteria of 3(a) and requires continued involuntary emergency mental health evaluation and intervention, the individual may be held for up to an additional five calendar days in an appropriate facility or site.

Persons subject to continuing emergency evaluations and intervention should continue to have access to a range of services, which may include medications (consistent with relevant state law), crisis intervention therapies, engagement with key caregivers and supporters, and provision of support by certified peer support specialists. As before, this facility or site should not be an emergency department of a hospital.

One value of a longer hold is that it may obviate further need for involuntary treatment because either the person signs in voluntarily or they improve to the point that they don't

require court ordered treatment. Five days is a balance between individual due process rights and effective opportunities for treatment.

State law should designate inpatient facilities that can provide continuing emergency evaluation and intervention. Such facilities:

- i. may be situated at the same location as the designated facility for emergency psychiatric assessment, such as a psychiatric inpatient unit located at the same hospital where there is a psychiatric emergency assessment or crisis center, at another facility qualified or licensed by state regulation to provide involuntary emergency mental health evaluation and intervention, or in a community-based residential program qualified or licensed by state regulation to provide involuntary mental health evaluation and crisis intervention services, such as a secure locked 24/7 crisis stabilization program.
- ii. must, if not situated near the initial evaluation center, be established within reasonable driving distances, commensurate with access to emergency medical hospitalization, and must have the capacity to admit individuals for continuing involuntary emergency mental health evaluation and intervention based on projected levels of the individual's need.
- iii. should provide safe, secure, welcoming space for providing involuntary emergency and/or acute mental health evaluation and intervention, and must include the capacity to integrate attention to individuals who have co-occurring substance use conditions and cognitive disabilities, as well as accommodate individuals with common medical conditions and physical disabilities.
- iv. should have capacity to provide the same services to individuals who are admitted voluntarily, or who choose to convert to voluntary status after admission.
- v. should collectively have sufficient capacity to serve individuals with or without any type of insurance coverage.

b. Under no circumstances shall it be permissible to exclude persons from these services solely on the basis of having co-occurring substance use disorders, intellectual/ developmental disabilities (I/DD), physical disabilities, or medical conditions that do not require inpatient medical care.

c. If emergency involuntary psychiatric medications are necessary, they are to be administered in compliance with relevant state laws governing such administration.

d. If a person subject to a continuing emergency behavioral health evaluation and intervention or the family or friends of this person presents a valid psychiatric advance directive (PAD), the facility and personnel responsible for providing the evaluation and intervention shall

honor the individual's preferences stated therein with respect to treatment and substitute decision makers, subject to limitations imposed by state law.

The use and contents of PADs vary greatly, as do laws recognizing their legal force. While they may contain provisions explicitly applicable to emergency evaluation settings, they are more commonly designed for non-emergency contexts. Nonetheless, information about de-escalation strategies and medication preferences may be particularly useful in an emergency assessment process as a matter of good clinical practice.

8. Disposition after the continuing emergency hold is completed

a. The period of involuntary mental health evaluation and intervention may continue up to, but no longer than 5 calendar days from the beginning of the assessment.

b. Upon completion of the evaluation and intervention, one of the following dispositions must occur, as determined by a qualified mental health professional, in consultation with the individual and the individual's caregivers and other mental health professionals who evaluated and treated the individual:

i. Discharge and referral for voluntary outpatient, home-based, or residential services in the community when the symptoms and behaviors that gave rise to the original emergency involuntary admission are no longer present and the individual's underlying condition has stabilized or improved to the degree that the individual is able to voluntarily, safely, and effectively receive continuing treatment at a less intensive level of care, and appropriate services are available to provide that continuing treatment at the lower level of care

ii. Continued hospitalization on a voluntary basis, as determined by the treatment team in consultation with the individual and the individual's caregivers, as available, when it is determined that the person still needs an inpatient level of care and has agreed to participate voluntarily. If a voluntary patient chooses to leave against medical advice, the staff of the facility shall evaluate the individual to determine whether he or she meets criteria for continued involuntary mental health evaluation and intervention and should document that evaluation.

iii. A petition for involuntary treatment for either inpatient or outpatient treatment when it is determined that the person meets the criteria for involuntary treatment (such as those set out in Part I of this document). The decision whether to seek involuntary treatment on an inpatient or outpatient basis shall be based on an assessment of the level of care and supervision required by the individual as well as the availability of resources to provide such care. If a petition for involuntary inpatient or outpatient mental health treatment for an individual is filed, the individual is entitled to a hearing as soon as practicable, but in no circumstance longer than 7 days, in order to determine whether the individual meets the criteria for civil commitment for involuntary mental health treatment. During this period, treatment under the conditions described in section 7 should

continue, and the individual should be regularly offered the opportunity to convert to voluntary status if clinically appropriate.

Discharge planning and a seamless transition to the community are essential to achieving long term success. While an individual's medical privacy rights must be respected, it is important to at least attempt to gather information, support, and agreement from family members or other caregivers and the individual regarding that transition and what supports will be needed in the community.

If a person agrees to voluntary status, particular attention should be paid to providing timely access to community care and enhanced transition services. Collaboration between all health care and supervision partners is also essential for successful transitions to voluntary community care.

Part III. Medication Over Objection

Principles for the Non-Emergency Administration of Psychiatric Medications Over Objection in Civil Matters

Introduction

After formal commitment or emergency intervention (as described in Parts I and II), mental health professionals may determine that treatment with medication is necessary. This part sets out guidelines governing when such medication may be administered over objection in non-emergency situations. The fundamental right of individuals to consent to medical treatment, including mental health treatment, is well established in American law. However, this right is not absolute. As established in cases interpreting both the Constitution and common law, in the civil setting, whether a person is inpatient or outpatient, it is acceptable to administer psychiatric medication over a person's objections on a **non-emergency** basis when three conditions are met: **First**, it must be determined that the individual lacks capacity to make treatment decisions in the individual's own behalf. **Second**, the recommended treatment must be determined to be medically appropriate. **Third**, the treatment must further governmental interests that are sufficiently important to justify overriding the person's treatment refusal.

Key concepts are clarified in the following:

Non-emergency: All states have legal provisions for administering psychiatric medication over objection in situations in which there is documentation of immediate risk of harm to self or others. This document does not address those circumstances, nor make any recommendations that are intended to change the existing legal capacity for emergency medication administration. This document is only intended to address those situations in which there is no immediate emergency, but there are compelling reasons to provide psychiatric medications over objection in an ongoing manner in order to prevent future harm, as described in the following.

Incapacity: Persons have a recognized right to make their own decisions about medication, so the administration of medication over one's objection is only permissible if that person has

already been determined to lack decisional capacity, after due process. Involuntarily medicating an individual requires a finding of decisional incapacity *plus* a determination about the appropriateness of the medication. For purposes of these recommended principles, in the context of incapacity due to a mental illness, the procedure and standard for a determination of capacity is the same as described in Part I relative to defining a “person requiring court ordered treatment.” Note that while this proposed incapacity language intentionally goes beyond traditional “danger to self and others” and “gravely disabled” standards for incapacity, cases that have allowed medication over objection have only been based on these existing standards for incapacity, along with added requirements for assessments of best medical interests and findings of important governmental interests. “Danger to self or others” has been held to be an “important governmental interest,” but whether the proposed broadened definition of incapacity in Part I, particularly (1)(c) will also be sufficient to constitute an important governmental interest has yet to be determined.

Best Medical Interests: Courts have held that decisions about the best medical interests of an individual are ideally made by medical professionals, based on prevailing clinical standards. This determination should take into consideration factors such as the availability of less intrusive alternatives to involuntary psychotropic medications, the balancing of benefits and side effects and other potential negative effects of recommended medications, and the existence of previously documented expressions of treatment preferences by the individual who is being considered for involuntary medication through, for example, psychiatric advance directives.

Furthering Governmental Interests: Courts have recognized the existence of important governmental interests with respect to involuntary psychiatric treatment under two broad constitutional authorities: the state’s right to act to protect its citizens from harm (“police powers”) and its authority to act on behalf of individuals who are unable to help or protect themselves (“*parens patriae*”). In the civil context, assuming other requirements are met, the involuntary administration of non-emergency psychiatric medication may be authorized when necessary to prevent future harms to self or others, even when an emergency is not involved.

Nexus with involuntary inpatient or assisted outpatient treatment (AOT):

The principles below assume that medication over objection will be considered only for persons who have been court ordered to inpatient or outpatient treatment. Persons who do not meet criteria in a proceeding that meets due process requirements should not be subjected to medication over their objection.

In addition, even when a person meets criteria, voluntary participation in treatment is always preferable. Clinicians should work proactively with individuals to find the most preferable treatment options. The involuntary administration of medications should be a last resort when the three conditions above are met, and the person is unable (by virtue of incapacity) to identify a preferable medically appropriate treatment option that will effectively prevent future harm.

Guardianships: When a person who refuses medication has a guardian of the person, relevant state law should be consulted to determine if the guardian may authorize medication. Whether or not that is the case, the principles set forth below should guide decisions regarding medication over objection for persons under guardianships.

Psychiatric Advance Directive (PAD): An emerging tool for achieving the balance between self-determination and the need for involuntary treatment is the Psychiatric Advance Directive (PAD). The PAD allows those with recurring episodes of disabling mental illness, while in a stable phase, to explicitly provide anticipatory legal directives for consent to particular treatment or preferences relative to specific treatment components. In some circumstances these PADs also explain past treatment histories, successful and unsuccessful, with particular medications, approaches, and strategies.

Principles Applicable to Involuntary Medication

1. Basis for Treatment: Administration of non-emergency involuntary psychiatric medication should only occur if there is clear and convincing evidence, in most instances based on the individual's history of prior treatment experiences and both successful and unsuccessful treatment responses, that:
 - a. Efforts to engage the person voluntarily in treatment have been tried but have not succeeded;
 - b. The medication is effective and medically appropriate (i.e., the benefits of the proposed treatment outweigh the risks, including the risks of the treatment and the risks of no treatment);
 - c. The medication is the least intrusive strategy for ameliorating the symptoms of mental illness that led to the person's court ordered treatment; and
 - d. The person lacks capacity to make an informed treatment decision. If the person has executed a psychiatric advance directive (PAD) or another legally valid document in which the person expresses his or her preferences regarding treatment, it should be consulted in determining the most desirable course of treatment.
2. Medication over Objection Treatment Hearing: The determination as to whether a person meets the criteria in section 1 should be made by a judge or by an administrative panel containing at least one medical professional who is not involved in the person's treatment.
 - a. The person who is the subject of the hearing is entitled to be present, represented by counsel, and afforded the opportunity to present evidence.
 - b. Whenever possible, the hearing should immediately follow the hearing on inpatient or outpatient court ordered treatment.
 - c. Involuntary treatment orders should be as specific as possible and should contain information including the medication(s) to be prescribed, how adherence to the medication(s) will be monitored, and the degree to which modifications to the medications can be made without returning to court.

The reference to administrative panels is a recognition that in some states these panels, when appropriately constituted, are permissible and effective. Ideally, this court hearing is combined with the initial determination of decisional incapacity, rather than holding a separate, subsequent hearing.

3. Continuation of Involuntary Treatment: Administration of psychiatric medications under this provision may be authorized for the duration of the inpatient or outpatient treatment order. Efforts should be undertaken throughout this period to engage the person in a voluntary treatment process. These efforts should include working with the person to improve the person's ability and capacity to make appropriate treatment decisions regarding mental illness, and to identify alternative treatment and medication options that may be preferable. The treatment team should document regular review of the order to administer medication(s) over objection to determine whether the specific medication(s) and dosages remain clinically appropriate and serve the best interests of the individual. Procedures should be in place by which medication over objection orders can be modified without a hearing, in consultation between clinicians and the individual, to ensure that the order is best meeting the person's needs.

4. Additional procedures for implementation of medication over objection under outpatient treatment: In states that require the court to monitor individuals subject to outpatient treatment orders including medication over objection, check-in with the court should be flexible, so as not to overburden either the individual or the judicial system. If a person who is not in a hospital setting does not adhere to the court order requiring medication over objection, and the treatment team determines that continued medication remains necessary, and the person's failure to adhere to medication has led to court ordered treatment in the past:

- a. In non-emergency situations, an ex-parte order may be obtained from the judge to have the person transported to a designated emergency facility to assess the need for involuntary medication(s) and to administer such medication(s).
- b. In emergency situations (as defined in Part II Section 3 of this guidance document), the treatment team may initiate the order to have the person transported to a designated emergency facility for administration of involuntary medication(s).
- c. States may facilitate this process further by granting the physician on the treatment team who is prescribing the medication the authority to initiate the order even on a non-emergency basis.

Part IV. Pathways to Care

While the focus of this guidance document is on civil pathways to care, most contacts that people with unmet mental health and substance use care needs have with the justice system are in the criminal context, and far too many people who do contact the criminal justice system have poor outcomes. Part IV of this guidance document describes opportunities for diverting people from the criminal justice system, and ways in which procedures in criminal justice can be retooled to produce better outcomes – both for public safety and for people needing mental health and substance use care.

**Pathways to Care:
A Roadmap for Coordinating Criminal Justice, Mental Health Care, and
Civil Court Systems to Meet the Needs of Individuals and Society**

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Introduction

Almost every year, the United States incarcerates more people per capita than any other nation,³ at an annual cost of over \$1 trillion in direct and indirect costs.⁴ Yet criminalization and incarceration reduce crime only marginally, and are linked to a range of harms to individual and community well-being.⁵ In particular, incarcerated persons have a harder time finding work and housing, are more likely to experience ruptured relationships, and are more likely to suffer from mental and physical health concerns.⁶ Recidivism rates reflect these negative effects, with over 80% of those exiting jails and prisons rearrested or reincarcerated within 9 years.⁷

Populations with the lowest incomes⁸ and with the greatest share of trauma are the most likely to be incarcerated.⁹ These high-risk populations also include a high prevalence of individuals with mental illnesses and/or substance use. By some estimates, over 70% of individuals in jail have at least one mental health or substance use care need, and up to one-third of those in jail have serious mental illnesses, much higher than the rate found in the general population.¹⁰

Among incarcerated populations, mental illnesses and substance use disorders are the norm, not the exception.

³ https://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=All

⁴ <https://joinnia.com/wp-content/uploads/2017/02/The-Economic-Burden-of-Incarceration-in-the-US-2016.pdf>

⁵ <https://www.americanactionforum.org/research/the-economic-costs-of-the-u-s-criminal-justice-system/>

⁶ <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration>

⁷ <https://www.bjs.gov/content/pub/pdf/18upr9yfup0514.pdf>

⁸ <https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/>

⁹ <https://www.prisonpolicy.org/blog/2020/12/02/witnessing-prison-violence/#:~:text=Even%20before%20entering%20a%20prison,of%20the%20general%20male%20population>

¹⁰ See: <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf>; pp. 1.

People with mental health and substance use care needs spend more time incarcerated than those without those needs for the same crime.¹¹ In many such cases, assessment and health care make more sense than criminalization and incarceration from both the government's and the individual's perspective; these individuals often have diminished responsibility for their violation of law, and access to quality inpatient or outpatient health care can better protect the public and help the individual than jail or prison, especially if little or no care is provided there. Many actors in the system—including judges, lawyers, law enforcement officers, and mental health evaluators—agree with this view but have no way of implementing it.

Housing these populations in jail costs far more taxpayer dollars than providing appropriate care, supports, and services for them in the community. Incarceration can also be much more harmful to people with mental illness than others.¹² Unfortunately, despite clear data on the high prevalence of mental health and/or substance use care needs in the criminal justice system, traditional criminal justice systems are designed and resourced as if mental health and substance use care needs were rare. For that reason, relatively few individuals with mental health and/or substance use care needs receive therapeutic interventions, usually through specialty court dockets with small numbers of participants, and the vast majority of individuals with mental health and/or substance use care needs are subjected to “traditional” criminal justice processes.

In our view, use of the traditional criminal justice system will often be inappropriate when a major contributor to the conduct is a serious mental health condition or substance use. Further, many individuals with relatively non-serious crimes, for which there may be little or no value ultimately in prosecution, are referred by the criminal court for “competency evaluation and potential restoration,” simply for want of any other perceived alternative for providing assessment and access to care. However, competency restoration is a costly process which may provide minimal health care and is primarily focused on returning the person to legal competence in preparation for prosecution, and therefore usually does little in the way of substantially addressing a defendant's long-term health care needs or criminogenic prognosis. Most states expend enormous resources on “competency restoration” processes, with little evidence of long-term effectiveness for either the individuals involved or for public safety. Further, if, after all the cost and effort invested in “competency restoration,” the person is ultimately returned for trial, they are often released with no continuity of care, or if incarcerated following trial, they may receive little assistance afterwards. Relative to the criminal justice system generally, according to SAMHSA, currently, “few specialized treatment programs exist in jails, prisons, or court and

¹¹ <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>

¹² Lea Johnston, Vulnerability and Justice Desert: A Theory of Sentencing and Mental Illness, 103 J. Crime & Criminal. 147, 158-183 (2013) (describing negative effects of prison on people with mental illness).

community corrections settings.”¹³ By contrast, research shows that public safety is enhanced, and recidivism is reduced when care interventions are matched to the needs of the individual.¹⁴

A range of initiatives has been designed to tackle small corners of this problem with specialized programs, but the broader criminal justice system continues to function inefficiently and ineffectively because it fails to routinely match best practice interventions to prevent recidivism to individual needs, for the majority of individuals who are experiencing MI and/or SUD. Taxpayers deserve to see their limited public funds targeted to create a systematic approach with better outcomes.

Our thesis in this “Roadmap” is that criminal justice systems that are appropriately designed and structured to promote wellness and recovery for the high-volume population with mental illness and substance use disorders would save money and produce better results. While transitioning from the current state to implementation of therapeutic interventions at scale may have relatively high initial costs, provision of effective intervention at the outset is a more sensible investment than repeated ineffective interventions. In fact, repeatedly cycling people with mental illnesses and substance use disorders through the traditional criminal justice system often makes things worse. It is harmful to them, fails to rehabilitate them, and often makes them more likely to return to jail. It is time our systems were redesigned to address more effectively the astonishing prevalence of people with mental health and substance use disorders within the system.

Our Proposal: The often-siloed relationships among the criminal justice system, the civil system, and the mental health treatment system - should be reimagined so that all work together as partners to use resources more efficiently, make the most effective services the norm, and thereby achieve the best outcomes for this population more routinely.

Our Goal. Our goal is to demonstrate how to reimagine and realign use of resources to ensure that they are precisely tailored to meet the therapeutic and other needs of the populations subject to the criminal justice system. Justice system dollars are ill-spent when the bulk of funding and resources are invested in traditional criminal justice processes which do not lead to good outcomes. Further, specialized therapeutic programs such as problem-solving courts, while they move in the right direction, are essentially costly system “workarounds”, often imposing restrictive eligibility requirements based on nature of offense, degree of disorder and other variables; thus, they affect only a small percentage of people in need and bring only marginal changes in community safety and overall recidivism rates.¹⁵

¹³ <https://www.equivant.com/on-the-rise-the-cost-of-mental-health-care/>

¹⁴ Jennifer L. Skeem & Sarah M. Manchak, Does Specialty Mental Health Probation “Fight Crime and Save Money”? A Cost-Benefit Analysis, Presentation at the American Psychology-Law Society (AP-LS) Annual Conference, San Juan, Puerto Rico (Mar. 14-17, 2012)).

¹⁵ See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, *J Am Acad Psychiatry Law* 49(4): 517-525, 2021 (DOI:10.29158/JAAPL.210076-21)

Taking therapeutic interventions to scale would allow courts to have routine processes in place, using existing resources more efficiently, to tailor interventions to the needs of the majority of individuals (those with MI and/or SUD), while at the same time focusing improved criminal justice interventions appropriately on those who pose significant risk to public safety, rather than unnecessarily providing low-risk and low-need individuals intensive services that they do not need, and that may make them worse. These reimagined criminal justice systems would be designed to recognize that everyone presents a combination of needs including varying therapeutic needs, housing and medical needs, and criminogenic risk-needs, and achieve better outcomes through more effectively matched interventions.

More specifically, a reimagined justice and community health system based on therapeutic interventions and risk need responsivity (RNR)¹⁶ principles would prioritize, at minimum: use of incentives, procedural fairness principles, linkages to community services, collaboration among systems, community integration, therapies targeting criminogenic risk and needs, and individualized treatments and programming tailored according to the results of individual assessments. Note: While preventative childhood and other “upstream” resiliency building interventions exist for a wide array of populations, this Roadmap for reform specifically focuses on adults with mental illnesses and/or substance use disorders.

A Purposeful Focus on People in the Criminal Justice System. Every effort should be made to address disparities in access to mental health care outside of the criminal justice system. A more robust continuum of community behavioral health responses, also tailored to individual needs, could prevent unnecessary justice involvement for many with unmet mental health needs. However, improving access to mental health care alone will do little to prevent justice involvement for a significant share of incarcerated individuals with mental illnesses, in particular those who also score high on criminogenic risk-needs assessments. Systems must also be equipped to respond with a tailored mix of criminal court supervision or connections to civil responses according to individual needs. These pathways to care can be aligned according to the Sequential Intercept Model (SIM), which is a model for visualizing the criminal justice system split into six “intercepts” or points of engagement with defendants: Community Services, Law Enforcement, Initial Detention and Court Hearings, Jail or Court Supervision, Reentry, and Community Corrections. The SIM map is described in greater detail in Appendix I. While the SIM facilitates the design of a range of pathways out of the criminal justice system and into treatment, this Roadmap provides a more detailed model for building those pathways.

Roadmap in Context. Inter-system collaboration among justice system actors, mental health providers and administrators, housing providers, and other community agencies is an integral part of this Roadmap. Thus, this Roadmap is intended to be both a standalone document and one part of a larger document titled *Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses*. The *Model Legal Processes* document describes a system of access to both emergency involuntary mental health care and to a range of civil court processes outside the criminal justice system, for example Assisted Outpatient Treatment, that

¹⁶ <https://www.prainc.com/risk-need-responsivity/>

facilitate legally authorized treatment interventions for acute and repeatedly unaddressed mental health needs that today often go unaddressed or are difficult to access because of antiquated legal hurdles and gaps in the system of care. The “pathways to care” mentioned above and described below will link back to other sections in the *Model Legal Processes* document in order to redirect individuals into health care and away from a tragically criminogenic justice system.¹⁷ At the same time, because all jurisdictions are unique, the language and resources included in this document are intended to be adapted to suit the needs of each jurisdiction.

Terminology. “Deflection,” “redirection,” and “diversion” are terms frequently used interchangeably when referring to alternative procedural approaches to public safety other than traditional pathways of arrest, charging and booking, detention and correction, and so on. Deflection and redirection both refer to early-stage interventions, although deflection can also occur ahead of any justice involvement. Diversion programs often originate from and are managed by prosecutors. Diversion can sometimes amount to holding a plea in abeyance, with post-plea variations sometimes referred to as “deferred prosecution” programs. Some of the procedures proposed below divert individuals from the criminal justice system, while others integrate a health approach into routine criminal justice processes. This Roadmap will describe an array of interventions similar to, but not identical with, “redirection,” “deflection,” and “diversion,” because rather than creating an array of specialized programs, this model is designed to reorient the entire criminal system, in alignment with parallel civil processes, to find the most appropriate intervention according to the needs of each person.

Responsibilities for Health Care. Communities should endeavor to build out a robust set of mental health and substance use services, effectively partner with the criminal justice system to create and support deflection and diversion pathways consistent with the SIM, and proactively deliver health care supports and services, including supportive housing, with a goal of preventing criminal justice involvement.

The outsized role of the criminal justice system—from police, to prosecutors, to prisons—in responding to population health, behavioral health, and other unmet needs better served by social and health systems is widely recognized. This project aims to promote recovery and reduce the populations with serious mental illnesses in jails, in prisons, and on the streets and urges greater “upstream” investment in health-focused crisis response alternatives. While the larger document includes a model emergency intervention process, vital resources and assistance should be made available even before that emergency intervention takes place, ideally obviating its need. This document endeavors to create alternative pathways for individuals needing mental health and substance use care. Following emergency intervention, well-designed court-ordered outpatient treatment, or Assisted Outpatient Treatment (AOT), has increasingly been proven to help stabilize and integrate individuals in need of care to avoid criminal justice involvement.

¹⁷ https://ecommons.luc.edu/cgi/viewcontent.cgi?article=1027&context=criminaljustice_facpubs

Who Should Use This Roadmap? This Roadmap is to be used by state and county-level policymakers and legislators, judges, leaders and stakeholders in mental health and substance use care, criminal justice system stakeholders, and advocates, to redesign their state and/or local criminal justice systems, step by step, to increasingly redirect justice-involved individuals with mental health and substance use care needs into the most appropriate pathway based on their criminogenic risks and needs and taking into account relevant responsivity and clinical considerations. Each of the following sections is labelled according to the stakeholder to which the section would be most applicable. Legislators and other policymakers should consider the entire document, as it represents a coordinated system of management promising long-term cost savings and improved public safety and health for the entire community.

Whom This Roadmap Will Most Affect. This Roadmap focuses on adults, particularly adults who have entered the criminal justice system but are not yet sentenced – that is, individuals with mental health and substance use care needs who are at any criminal justice intercept point from arrest up to incarceration. Note that similar considerations apply to juvenile justice systems, and in fact, many communities have already taken these approaches further to scale in juvenile justice. The following sections describe the role of this new Roadmap in context, then lays out the Roadmap itself, including descriptions of the pathways, a visual mapping tool, and a list of assessments. Finally, Appendix III applies hypothetical case studies to the Roadmap, describing types of individuals who might follow each pathway.

The Roadmap: Overview

The following sections are relevant to all stakeholders.

This Roadmap is based on current scientific knowledge regarding the prevalence and treatment of individuals with mental health and substance use care needs throughout the criminal justice system. Systems and care plans should be designed to ask and answer the following questions:

What are the person’s criminogenic risks and needs? To what degree did those needs contribute to the crime?

What are the individual’s mental health needs? How acute and severe are they? Did they contribute to the crime? To what degree?

Does the individual have a substance use disorder? How active and severe? Did it contribute to the crime? To what degree?

Are there I/DD, brain injury, or neurodiversity issues present? How severe? What was their contribution to the crime?

What traumas has the individual experienced? How severe? What contribution to the crime is there?

How should these experiences affect the delivery of care and related services?

Is there a significant state interest in prosecution?

In order to answer these questions, screenings must take place as described in the “Procedures” section immediately below. Screening tools and procedures allow systems to more quickly identify and respond to an individual’s needs by directing them to designated pathways suited to address the clinical, criminogenic, and other needs of the individual. The pathways are described after the Procedures section. Finally, a variety of screening tools are described starting on page 31 below.

The Roadmap: Procedures

The key to responding appropriately to individuals with mental health and substance use care needs is identifying those needs as soon as possible. Ideally, every person who comes in contact with the criminal justice system in a custodial context would initially receive a validated screen for mental health and substance use care needs, and for criminogenic risk. These screenings can be conducted in the field if a responding professional is trained to perform them, or upon booking in the jail.

However, even if an individual is not screened at one of these initial opportunities, any professional in the system thereafter should be empowered to initiate a screening process, and then an additional assessment if the screening instrument so indicates. Trauma screening tools, of which several are listed on page 31, have long been used to inform clinicians about individuals’ trauma histories in order to build responsive care plans. Care planning should also incorporate trauma responsiveness.

- Any peace officer, correctional officer, or other justice system/detention staff person should have the discretion and incentive to initiate a screening and assessment procedure at any appropriate point in the process.
- Once screening and assessment take place there need to be procedures designed to ensure that the results of the screening are communicated to the appropriate entities so that – when indicated – appropriate case redirection and care coordination can begin.
- Every individual screened and identified for therapeutic intervention through this process should be provided with appropriate case management services, including linkages to appropriate community care and support based on results of the screenings. These processes could be incorporated into existing functions, such as probation or pretrial services, and could be termed “community management services.”

Pathways and Eligibility Categories:

Individuals screened as described above should then be directed into the following pathways. Tools to aid decision making are listed starting on page 42 below. The pathways are described in the “Pathway Descriptions” section starting on the next page and the decision-making process to reach those pathways is visually represented in the Decision Tree on page 41 below. Note that these pathways begin at the point of arrest, but that deflection and diversion practices that keep individuals from even entering the criminal justice system are enormously important to achieving better outcomes for those individuals and for public safety.

The following pathways are described in terms of the justice system interventions designed to meet individual needs. While eligibility for each pathway is described below, descriptions of who might be suitable for the pathway is by no means exhaustive and may depend on jurisdictional preferences and resources. In general, however, low-risk, lower-need individuals should be subject to minimal oversight and supported by case management and access to quality care, while higher-risk individuals with more significant needs should be redirected to proportionate levels of supervision and care, including, when appropriate, either civil court interventions such as Assisted Outpatient Treatment (AOT), or criminal court supervision in various therapeutic interventions. Additionally, while a range of support should be offered depending on the scores generated to inform placement in a given pathway, the precise mix of care, supports, and services tailored to each individual will also not be exhaustively described below. Therapeutic interventions should be selected and offered according to the principles described above, in order to successfully integrate individuals into the community after any of the interventions listed below.

Finally, another goal of this reimagined system is to be able to limit the use of competency restoration. Competency restoration should not be used simply because there is no other pathway for the person to receive needed care. Similarly, traditional criminal justice interventions should be more narrowly targeted to the minority of defendants with significant risk and little to no mental health or substance use contribution to their criminal behavior. Competency restoration should only be considered when the state's interest in prosecution is significant.¹⁸ Although the role of competency restoration and traditional criminal justice responses are recognized in some of the following pathways, their use should be limited, as they are rarely the most effective response if the individual has significant mental health or substance use care needs.

Key Terms

Mental Illness: “Mental illness” as utilized in this section includes any mental illness in the most recent Diagnostic and Statistical Manual (DSM) In addition, as utilized in this section, people with “mental illness” include people with substance-induced mental illness, co-occurring mental illness and substance use and/or substance use disorders, and/or cognitive disability, and/or other medical conditions or disabilities contributing to the symptoms or behaviors that are the reason that emergency psychiatric intervention may be needed.

Mental Illness Contribution: This term poses the question, “Would the crime likely have been committed in the absence of the individual’s mental illness(es)?” The crux of this metric is to determine whether the individual’s criminal behavior is better addressed through mental health care rather than incarceration or other punitive restrictions. Research suggests that mental illness in general is not a risk factor for criminal conduct. There are clear data about criminogenic risk factors, i.e., conditions that cause crime, and mental illness is not a criminogenic risk factor. However, there are clearly individual situations where active and untreated mental illness directly contributes to particular crimes. Further, mental illness is more commonly a responsivity factor, that is, a condition that must be taken into account and treated before other interventions, criminal

¹⁸ See [Leading Reform: Competence to Stand Trial Systems](#)

justice related or otherwise, can be expected to succeed. Mental illness contribution may include co-occurring substance use and/or cognitive impairment, and courts and clinicians should determine an approach suitable to treat all co-occurring conditions, no matter the pathway. Greater mental illness contribution may correspond to greater care needs.

Needs: This term refers to criminogenic needs and other needs, such as responsivity needs and maintenance needs. Criminogenic needs are “[r]isk factors for criminal recidivism that are potentially changeable or treatable.”¹⁹ Responsivity needs are “[c]linical syndromes, impairments, or social service needs that usually do not cause crime but can interfere with rehabilitation.”²⁰ Finally, maintenance needs are “[c]linical syndromes, impairments, or social service needs that do not cause crime or interfere with rehabilitation efforts but can degrade rehabilitation gains.”²¹ Criminogenic risk and needs screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk needs responsivity principle. Over time, changing levels of risk (and needs) according to these assessments can help systems monitor client progress and inform supervision and care decisions.²²

Risk: Here, “risk” refers to criminogenic risk. Criminogenic risk means the likelihood of criminal recidivism, typically, the probability of being arrested for or convicted of any new crime or returned to custody for a technical violation.²³ Criminogenic risk screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk needs responsivity principle. Over time, changing levels of risk according to these screenings and assessments can help systems monitor client progress and inform supervision decisions.^{24 25}

Severity: This term refers to the severity of the crime. While this Roadmap moves away from “misdemeanor” and “felony” categories, a misdemeanor would almost always be a low-severity crime as would many less serious felonies, and a high severity crime would be a serious felony.

Substance Use Contribution: This phrase poses the question, “Would the crime likely have been committed in the absence of the individual’s substance use?” The crux of this metric is to determine whether the root cause of the individual’s criminal behavior is better addressed through substance use care rather than only through interventions targeting the criminal behavior.

¹⁹ <https://www.prainc.com/risk-need-responsivity/>

²⁰ Id.

²¹ Id.

²² <https://www.ndci.org/wp-content/uploads/Fact%20Sheet%20Risk%20Assessment.pdf>; see also: <https://ark.nadcp.org/>

²³ <https://www.prainc.com/risk-need-responsivity/>

²⁴ <https://www.ndci.org/wp-content/uploads/Fact%20Sheet%20Risk%20Assessment.pdf>

²⁵ See also: <https://ark.nadcp.org/>

Pathway Descriptions

As noted above, these pathways assume that an arrest has been made and therefore that the criminal justice process has started. While this suggested model begins at that point, the importance of deflection (law enforcement discretion exercised to not make an arrest, and to instead direct the person to crisis services or community care and support) and diversion (withholding or deferring the initiation of criminal charges) cannot be overstated.²⁶ Pathway header colors indicate recommended process based on severity of mental health and substance use contribution and criminogenic risk-needs for the individual. Header colors correspond with pathway colors represented in the decision tree. See illustration on p.13.

Pathway 1:

Minimize Court Intervention and Connect to Care

Individuals best suited for this pathway score as low risk, low need, and their risks of recidivism will be significantly reduced with mental health and/or substance use care. These individuals are likely to participate voluntarily in care, and a referral should be sufficient to redirect them to care. Although communities sometimes direct low-risk individuals to therapeutic dockets, low-risk individuals are poor candidates for criminal justice system supervision and are best supported with referrals to health care and minimal criminal justice oversight.²⁷ These individuals must have enough self-awareness to engage in care without oversight, or they are considered higher risk and/or need and are better suited to Pathway 2 or 3.

Eligibility:

High mental health and/or substance use contribution, low criminogenic risk and need, low severity crime, participation must be voluntary.

Pathway:

Complete transition to health care, supports, and services and no further criminal justice oversight.

May still require a future check-in with a judge to ensure ultimate compliance.

Charges dropped or held in abeyance, pending compliance and successful participation

²⁶ See Vera Institute, Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses and Council of State Governments Justice Center, Behavioral Health Diversion Interventions: Moving from Individual Programs to a Systems-Wide Strategy

²⁷ Learn more about this research from Policy Research Associates (PRA) at their website: <https://www.prainc.com/risk-need-responsitivity/>

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Low	Low	Low-Mod	Voluntary

Pathway 2: Connect to Civil System for Supervision and Treatment

Few criminal court systems regularly transition suitable candidates out of the criminal system to civil court proceedings. Doing so, as described in this pathway, would preserve resources and better meet the needs of individuals to receive tailored therapies and safely return to the community.

This pathway affords more judicial flexibility because it can be tailored according to the needs and risks of the individual. This pathway is not suitable for individuals found to be criminogenically high-risk or for those who have committed egregious crimes that would justify a significant state interest in prosecution. However, an individual with high health care needs would be suitable for the increased court oversight available in this pathway. When appropriate the individual should be transferred from the jail to an appropriate crisis stabilization or other care setting. Such individuals should not be retained in the criminal justice system (in contrast to cases described in Pathway 3). Instead, the criminal charges should be dismissed, and jurisdiction should be formally transferred to the civil court system, where care plan compliance can be monitored and enforced with non-criminal consequences. In some states, this approach may be implemented by applying customary civil criteria and procedures. In other states, however, it may be necessary to formulate modified criteria and procedures designed specifically for individuals formally diverted from the criminal justice system.²⁸

Individuals best suited for this pathway would respond best to tailored levels of oversight by the civil court system and assisted outpatient treatment plans where participants are otherwise likely to discontinue engagement with care. These individuals are low-moderate risk, moderate-high need, and likely would not have been justice-involved but for a mental health, substance use, or co-occurring mental health and substance use issue. Typically, higher levels of oversight may be considered appropriate if the individual has higher needs for care, supports, and services and/or if the crime produced a victim.

Eligibility: High mental illness and/or substance use contribution, low-moderate risk, moderate-high needs, low-moderate severity crime. Participation may be voluntary or involuntary (court ordered treatment though often participation is “chosen” only because of the more coercive nature of the alternative.

²⁸ See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, *J Am Acad Psychiatry Law* 49(4): 517-525, 2021 (DOI:10.29158/JAAPL.210076-21)

Pathway:

Immediately transfer to civil court with petition for AOT supervision, or other civil treatment hearings.

Civil Court should be engaged in ongoing oversight, with gradually diminishing involvement, and the option to increase court involvement or transfer to criminal court as a consequence of non-adherence.

Care plan to include therapeutic interventions responsive to criminogenic risk factors.

Charges dropped upon completion of the program.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Moderate	Moderate	Low-Mod	Voluntary or Involuntary

Pathway 3: Supervision and Care Managed by Criminal Courts; Step-Down to Civil

High-risk individuals respond best to intensive supervision in coordination with therapies tailored to their criminogenic needs. This pathway resembles a scaled-up behavioral health court docket in that this is a criminal court operating with treatment court principles.²⁹

Jurisdictions may be more confident in a criminal oversight mechanism with possible court-imposed ramifications for non-adherence, but this pathway should be reserved for those who are high-risk, moderate-high need, and whose risks of recidivism will be significantly reduced with mental health and/or substance use care. If an individual otherwise suitable for Pathway 2 but whose crime the state has a minimal political interest in prosecuting, Pathway 3 may also be most suitable. Please note that the traditional criminal justice interventions described in Pathways 5 and 6 are still available should the state’s interest in prosecution outweigh the potential benefits of this approach for the defendant.

Eligibility: High mental illness and/or substance use contribution, moderate-high risk, moderate-high needs, moderate severity crime. May also include high severity if jurisdiction deems appropriate. May be voluntary or involuntary participation.

²⁹ See e.g. Adult Drug Court Best Practice Standards, National Association of Drug Court Professionals, <https://www.nadcp.org/standards/>

Pathway:

Maintain criminal justice supervision in a courtroom engaging in treatment court principles such as a mental or behavioral health court, or a court with a dedicated mental health docket.

Step down civil court ordered treatment as needed to either inpatient or assisted outpatient (AOT).

Care plan to include therapeutic interventions responsive to criminogenic risk factors.

Charges frequently dismissed when the person has adhered to the court ordered conditions and has shown improvement.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	High	High	Low-Mod	Voluntary or Involuntary

<p>Pathway 4: “Traditional” Pathway with Ongoing Treatment</p>

This pathway is reserved for those whose mental illnesses or substance use had little to do with their crime. Regardless of whether the individual’s mental illnesses or substance use contributed to the crime, individuals should be offered appropriate health care, supports, and services to address their needs. Where an individual has a mental illness and assesses as low-risk, diversion should be prioritized. Incarceration of people with mental illnesses should be an absolute last resort and where it is done, appropriate health care must be made available to them. Additionally, incarcerating low-risk people often does more harm than good.

Eligibility: Mental illness or substance use with little or no contribution to the crime, low-moderate risk, low-moderate needs, low-moderate severity crime. Participation in diversion should be voluntary.

Pathway:

Coordinate referrals to care in the community. Therapies must include those targeted to criminogenic risk.

Include ongoing care and provide resources to meet identified needs, including any criminogenic risk factors or other unmet needs.

Because the mental illness did not significantly contribute to the crime, it would be inappropriate to resume prosecution for a failure to comply with or otherwise participate in recommended health care.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Low-Mod	Low-Mod	Low-Mod	Voluntary Diversion

Pathway 5: “Traditional” Criminal Justice Pathway with Ongoing Treatment

Where an individual’s mental illness or substance use has not contributed to the crime, communities should first identify whether the individual can be diverted from the criminal justice system, as people with mental illness are more susceptible to the harmful effects of punitive interventions and jail than are people without mental illness. The individual may proceed through the “traditional” criminal justice procedures, but any court, detention facility, or other community supervision department should regularly provide these individuals with necessary health care, including, if applicable, cognitive behavioral therapy or other therapies designed to specifically address criminogenic risk factors.

Eligibility: Mental illness or substance use with little or no contribution to the crime (may have a co-morbid cognitive disorder), moderate-high risk and need, low-moderate severity crime.

OR: No mental illness or substance use present. No impairment preventing the individual from understanding the charges brought against him or her. Significant state interest in prosecuting and/or egregious charges with no opportunity for diversion to care.

Pathway:

Consider other deferred prosecution or diversion program eligibility. Diversion should be voluntary. This is unrelated to the individual’s mental illness or substance use.

Proceed with traditional court processes but order ongoing therapeutic interventions if incarcerated, including interventions specifically addressing criminogenic risk and needs.

Supervised probation and/or court monitoring recommended according to risk.

Incorporate ongoing risk/needs-responsive supports during incarceration and upon release, as applicable and needed.

Generally, criminogenic risk-needs should still be addressed.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Mod-High	Mod-High	Low-Mod or Significant State Interest	Voluntary or Involuntary

Pathway 6:**Competency Restoration – Use Sparingly**

In instances where there is a significant state interest in prosecuting someone who is incompetent to stand trial, competency restoration³⁰ should be carefully considered. Competency restoration procedures often are not health care per se, frequently result in excessive jail stays while individuals wait for restoration services and impart little long term therapeutic benefit. Because of the minimal state interest in prosecuting misdemeanors and those assessed as low risk, competency restoration is rarely appropriate for those charged with a misdemeanor, and alternatives to criminal prosecution should be utilized.

Eligibility: Should be limited to those cases for which the state has a significant interest in prosecuting (particularly egregious crimes) and there is a significant ongoing impairment or inability to participate in court proceedings.

Pathway:

Proceed with competency evaluation, restoration, and trial, only as appropriate

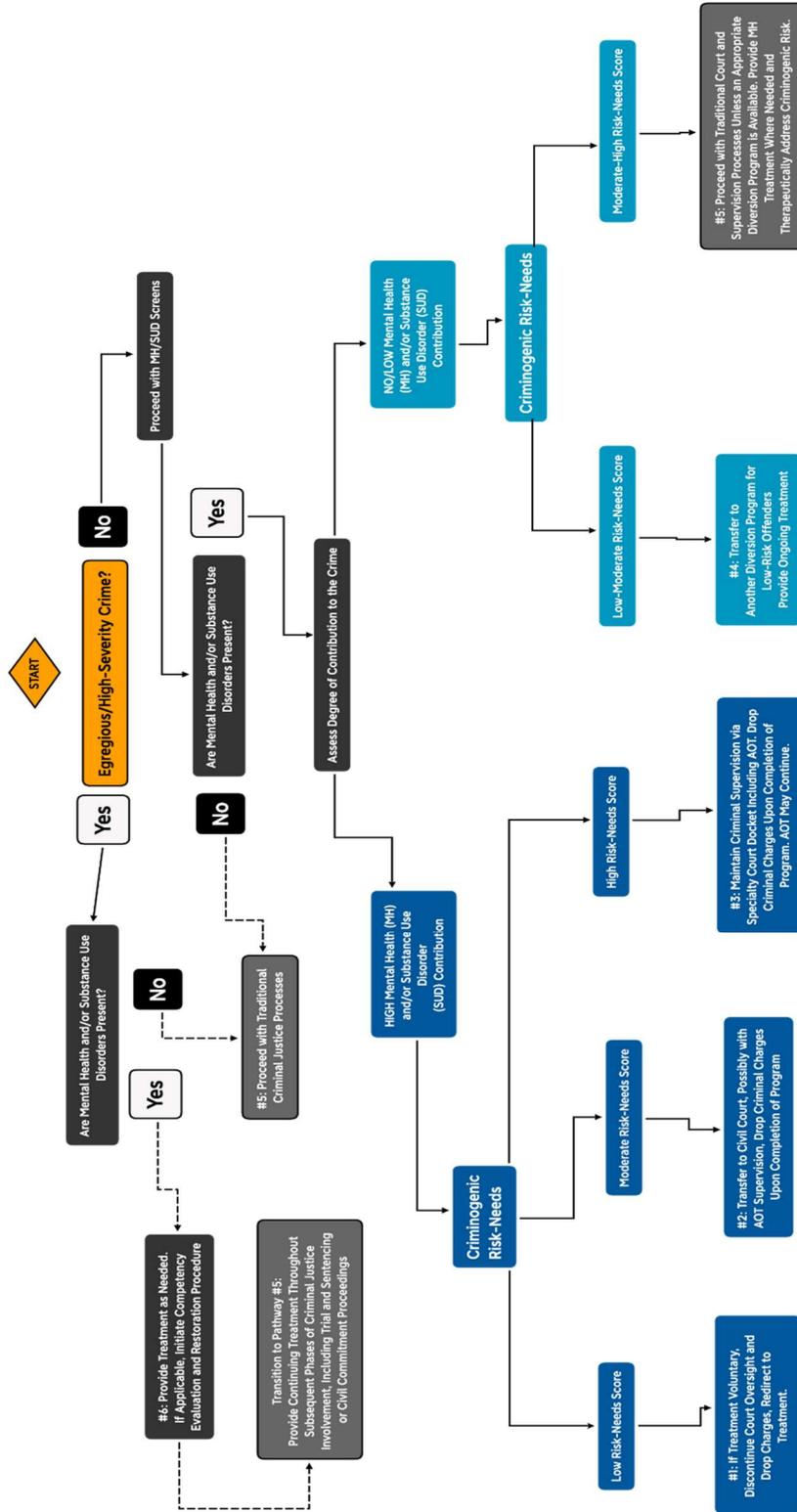
There still may be an opportunity for civil interventions, and those should be considered

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
MI/SUD Present	High	Any	High & Sig. State Interest	N/A

See the Decision Tree on the next page for a visual representation of this decision-making process.

³⁰ For further discussion of competency restoration system issues, see <https://www.ncsc.org/behavioralhealth/task-force-publications-2/criminal-justice3/competence-to-stand-trial>

Criminal Justice Redirection Framework Decision Tree



Screening Tools and Decision Making

This section is most relevant to mental health providers and administrators.

The following section includes model screening tools. Though these tools were identified by the partner jurisdictions that developed this guide, a given jurisdiction may find one or another tool more suitable to meet their unique needs.³¹

Screening and assessment results should be used to help make decisions about pathways into or away from court interventions at a number of points along the way. Screening results do not always align with intuitions. For example, the lowest-risk individuals, while politically safest to divert, are actually the least suitable for court supervision. Instead, communities should mandate court supervision only for moderate- to high-risk individuals. Ultimately, diversion decisions should be guided by these objective measures and each individual's needs, rather than allowing the criminal charge to be overly dispositive. Charges may be an indication of specific conduct at a specific moment in time, but the legal label for the crime often does not provide meaningful information about the defendant's suitability for a particular, tailored disposition. Instead, traits like those described below should inform the appropriateness of non-criminal options.

Mental Health Screening. Valid and reliable mental health screening instruments both out of custody and at jail intake can be used to help identify new health care needs (or initial health care needs) pending pre-trial release. Some screening and assessment information can also be provided directly to the court to facilitate more appropriate and tailored pre-trial orders, referral to an appropriate treatment court, and in-court responses to individuals.

Common mental health screens include:

Mental Health Screening Form-III (MHSF-III)

K6 and K10 Scales

The two most prevalent correctional or jail-specific mental health screens are:

Brief Jail Mental Health Screen

Correctional Mental Health Screen (CMHS)

Note that there is a version for men and a version for women.

³¹ For more on finding the right tool, see: Stepping Up Initiative, [Implementing Mental Health Screening and Assessment](#); Center for Court Innovation, [Digest of Evidence-based Assessment Tools](#); National Drug Court Institute, [Selecting and Using Risk and Need Assessments](#).

The relative attributes of these two screens are discussed extensively in a National Institute of Justice publication: [Mental Health Screens for Corrections](#).

Criminogenic Risk Screening. Criminogenic risk screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk need responsivity principle. Common risk and need screens and assessment instruments include:

[The Level of Service Inventory–Revised \(LSI-R\)](#)

[Ohio Risk Assessment System \(ORAS\)](#)

[Correctional Offender Management Profiling for Alternative Sanctions \(COMPAS\)](#)

[Risk and Needs Triage \(RANT\)](#)

Substance Use Disorder Screening. Substance use disorders (SUD) are associated with worse criminal justice outcomes and therefore require special and dynamic treatment strategies. Once in custody, validated and reliable screening tools should be used to identify substance use disorders to provide detention partners with an informed picture of treatment and custody needs. These tools typically include fewer than a dozen items, can be administered by non-clinicians, and are often freely available in the public domain. Many screening tools also now implicitly recognize the reality that mental health needs co-occur with substance use disorders.³²

Examples of brief SUD screens include:

[TCU \(Texas Christian University\) Drug Screen V](#)

[DAST \(Drug Abuse Screening Tool\)](#)

[SSI-SA \(Simple Screening Instrument for Substance Abuse\)](#)

Trauma Screening. Trauma is a frequent responsivity factor that should be identified as early in the process as possible in order to identify appropriate treatment interventions and to avoid re-traumatizing the person while they are in treatment or custody. Widely validated and used tools include:

[Trauma Screening Questionnaire \(TSQ\)](#)

[PTSD Checklist – Civilian Version \(PCL-C\)](#)

³² An excellent treatise on why and how to effectively use screening and assessment in a justice context is SAMHSA’s [Screening and Assessment of Co-Occurring Disorders in the Justice System](#).

Generally. An excellent treatise on why and how to effectively use screening and assessment in a justice context is SAMHSA’s Screening and Assessment of Co-Occurring Disorders in the Justice System. This resource can further help jurisdictions identify the best tools available, according to their needs.

Planning for a Re-Envisioned System

This section is relevant to all stakeholders.

To build the system described in this document, jurisdictions should have a change management plan including system and resource mapping³³, data gathering regarding the availability of services, capacity of those services, and unmet needs, as well as project management capacity to review progress, adjust, and expand service availability as needed. Ideally a jurisdiction would have sufficient demographic and prevalence data to allow the jurisdiction to project the number of individuals likely to fall into each of the pathways. These projections can then be used to identify resource gaps and other system needs.

Ensuring cooperation among all justice system partners requires careful system planning at the outset. Leveraging iterative project development processes and data collection and analysis can ensure that processes work according to plan, partners are heard, and the project vision is achieved. Agency funding and staffing are in short supply in many jurisdictions across the country. Jurisdictions interested in long-term acute-care savings and improved outcomes for the whole community should consider the changes described in this document as a justice reinvestment opportunity. And given the central role of courts, dedicated resources should be designated to serve as points of contact and leaders in collaboration and coordination efforts.³⁴ The following steps describe recommended early planning and development steps in order to promote the adoption of best practices.

Numerous models have been developed to help jurisdictions manage systems change. The following are just some of the many available options:

The Stepping Up Initiative is a model to promote collaboration among county leadership through convening and planning to reduce the population of individuals with mental illnesses in jails.

National Center for State Courts (NCSC) offers a guide called Leading Change: Improving the Court and Community’s Response to Mental Health and Co-Occurring

³³ For example, a Sequential Intercept Mapping

³⁴ See e.g. this National Judicial Task Force to Examine the State Courts’ Response to Mental Illness resource https://www.ncsc.org/data/assets/pdf_file/0011/70013/BH-Recommended-Leadership-Positions.pdf

Disorders and a resource hub with additional information and resources at the intersection of mental health and criminal justice.

GAP Roadmap to the Ideal Crisis System, including a guide for overseeing, funding, and building a changed system. These principles can be applied to the process of building an ideal crisis system and can be adapted for building a health-oriented justice system, as described here.

Policy Research Associates Sequential Intercept Model Map and Mapping Resources can help with data gathering, identifying gaps, and planning to meet service needs.

Council of State Governments Justice Center offers a range of tools for leadership self-assessment, funding, reporting, and local policy information.

The Alliance for Community and Justice Innovation provides training and change management consultation and other resources to leaders in the criminal justice system.

A. Purposeful System Planning and Assessment:

Oversight. Early in the process of developing a model system to redirect justice-involved individuals needing care for mental health and problematic substance use into civil mental health care, a collaborative cross-system oversight body should be convened to plan, develop, and eventually oversee the system. This oversight body might include the following: judicial system leaders, police and sheriff leadership, local prosecutors' offices, the public defender's office, local mental health providers, hospitals, public health and social services departments, housing authorities, and other community partners. System planners should consider implementing trainings both for the oversight body itself and their staff to ensure all collaborators possess similar levels of familiarity with the guiding principles and mechanisms of the system.³⁵

A Shared Vision. Long term goals should include building trust and collaboration, regularly assessing what resources currently exist and what gaps in those services need to be addressed; reduction or reallocation of spending on crisis-level criminal justice interventions; increased access and scope of health system responses; and enhanced public safety, including recidivism reduction. Data collection, data sharing, iterative problem-solving, and other regular communication strategies are also key.

Staff. Increased health care, supports, and services staff may well be needed over time, depending on the needs and resources of the community. These may include clinical

³⁵ For training resources, visit Crisis Intervention Team (CIT) International here: <https://www.citinternational.org/> and the National Center for State Courts behavioral health website here: <https://mhbb.azurewebsites.net/>

staff, social workers to perform daily assessments, peer support service providers, case management and transition planning, and others.

Many jurisdictions lack adequate clinical staffing, but wherever possible, staff assignments or memoranda of understanding should be used to establish a point person with the authority to make real care plan recommendations for justice-involved individuals, with the cooperation of the courts and other justice system stakeholders.

Several jurisdictions have had success through designating coordinators or case managers specific to the intersection of mental health and criminal justice. Some use this resource as a boundary spanner, i.e., someone who can negotiate various court systems and legal issues in order to combine or defer pending cases in other jurisdictions, clear warrants, and perhaps consolidate prosecutions. Others designate coordinators to expedite assessments, referrals to service, and ancillary resources; and still others use the resource specifically to coordinate competency to stand trial issues – evaluations, transportation, and instigation to and transition from restoration services.

Peer support specialists are critical components of a well-functioning system intending to engage with individuals experiencing mental illnesses, as they help build trust and improve communication between individuals in the program and those managing and coordinating it.

Transition Planning: Public Safety and Courts

This section is most applicable to public safety and judicial stakeholders.

After the above screenings are administered and results are gathered, a designated transition team such as a “community management services” team should be charged with transferring adults in custody into the most appropriate treatment setting. Preserving public safety is an integral goal of this process. Therefore, based on the treatment needs identified, the likelihood of compliance with court directives (based on the level of criminogenic risk), and the responsivity needs of the defendant (including mental illness and trauma history), the program team, including the prosecutors and other criminal justice professionals, should consider:

Dismissal of charges with referral to care

Pre-plea diversion or contingent dismissal, dependent on compliance with court ordered treatment and supervision conditions

Pre-plea diversion to a court-supervised civil option, such as Assisted Outpatient Treatment

Post-plea diversion or contingent dismissal, dependent on compliance with court ordered treatment and supervision conditions

Pre- or post-plea referral to an appropriate problem-solving court

Transition Planning: Health Care

This section is most appropriate for community mental health centers, Medicaid coordinating entities, state departments of mental and behavioral health, and similar entities.

A well-coordinated collaborative system will delegate responsibilities at the highest levels, with practical changes affecting every level of staff involved. The following sample procedures are just a few of many that may be delegated to mental health care agencies via memoranda of understanding or other arrangements.

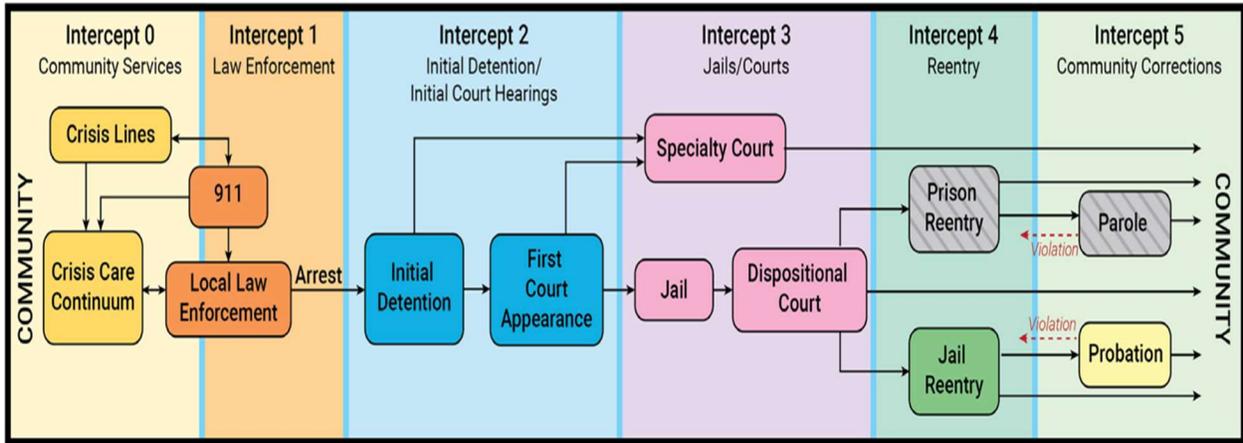
If approved for redirection to the civil system or supervised community integration:

1. All appropriate counselors and case workers will be assigned, will design the transition plan, and will obtain the individual's consent to treatment and to the release of records and other information. **See Appendix II below for the APIC transition planning model.**
2. Medical clearance is completed, and a supply of medication is provided.
3. A Peer Specialist will provide services upon release from jail including a "warm handoff" and ongoing support in the community.
4. Designated staff gather data to ensure compliance with the transition plan.

Appendices

Appendix I: The Sequential Intercept Model (SIM)

According to PRA, the creators of the SIM, “the Sequential Intercept Model was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.” It provides a linear representation of the justice system with which communities may strategically plan to deflect, redirect, and divert individuals with mental illnesses and substance use disorders.



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For more information on the Sequential Intercept Model, visit: <https://www.prainc.com/sim/>

Appendix II: APIC Model

The *APIC Model* is a best-practice approach for transition planning for people meeting the criteria for redirection out of the justice system, wherever appropriate. The individuals suitable for the APIC Model plan are those with mental health and co-occurring substance use conditions, whose risks and needs must be incorporated into their intervention planning in order to most effectively promote health and preserve public safety.

APIC is not the only transition planning model, however. See SAMHSA’s website (<https://www.samhsa.gov/sbirt>) for more.

The APIC Model provides a set of critical elements that are likely to improve outcomes for the target population. APIC is an acronym standing for: Assess, Plan, Identify, and Coordinate:

Assess the clinical and social needs and public safety risks of the individual. Gather information, catalog needs, consider cultural issues, engage individual in self-assessment, and ensure access to and means to pay for services.

Plan for the treatment and services required to address the individual’s needs. Address critical period following release from jail, as well as long-term needs, seek family input, address housing needs, arrange integrated treatment for people with co-occurring disorders, and ensure access to medications as needed.

Identify programs responsible for services. Specify appropriate referrals in the treatment plan, forward treatment summaries to the provider, and ensure the treatment plan reflects the individual’s level of disability, motivation for change, and availability of community resources.

Coordinate the transition plan to ensure implementation and to avoid gaps in care. Utilize case management services, make referral and placement decisions cooperatively, provide consumers with specific contact information for providers, and follow up with consumers who miss scheduled appointments.

Appendix III:

Case Examples: These illustrations provide scenarios to which the diversion approaches that are outlined in this document can be applied. Each case below corresponds to the eight pathways in the order in which they appear above. How do the resources and culture in your jurisdiction accommodate opportunities to redirect individuals with cases like these away from criminal justice involvement and toward health supports?

Pathway/Category 1:

Alex normally managed his bipolar disorder well, but when stress at work became overwhelming, Alex became inconsistent with his medication and experienced a manic episode. Police were called when Alex was acting out of control, and during the encounter, Alex pushed a police officer. After being taken to jail, Alex was screened for criminogenic risk-needs and the presence of mental health and substance use issues. Alex was found to have low criminogenic risks or supervisory needs and could voluntarily participate in treatment. Even if Alex’s charge would have been considered violent, Alex’s risk-needs assessment indicated that Alex was not a risk to recidivate, and given Alex’s low needs score and agreement to engage in community-based treatment, no further civil or criminal supervision is indicated.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Low	Low	Low-Mod	Voluntary

Pathway/Category 2:

Ben has a schizoaffective disorder. He had stable housing but had been previously convicted of low-level crimes. Ben was off his prescribed medication for the second time in a year. While in a psychotic state, Ben stole a cell phone from an electronics store. Ben was clearly psychotic at the time of the incident. The police were called, and because the high value of the phone made the offense a felony, he was arrested. A risk-needs assessment and a mental health and substance use evaluation were performed. Ben’s moderate risk and moderate needs, combined with a property crime indicated that he was appropriate for pre-trial release and civil interventions, not criminal sanctions. Charges were deferred as a clinician at the community mental health center initiated the filing of a petition for a court hearing to determine what, if any, court oversight would be needed based on Ben’s presentation. Meanwhile, Ben was connected with peer support and case navigation to ensure he would appear for his court date and access services in the community.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Moderate	Moderate	Low-Mod	Voluntary or Involuntary

Pathway/Category 3:

Connie, a young woman diagnosed with co-occurring substance use disorders, a bipolar disorder, and a with a history of very serious trauma had cycled in and out of jail and prison. Most recently, she was charged with aggravated assault (no weapons involved) while she was under the influence of stimulants. Whenever Connie was off her prescribed medications and using certain other substances, she lost control and became violent. To ensure that Connie would receive the appropriate level of support, a criminogenic assessment was conducted, confirming Connie’s high risk-needs scores, and the presence of her serious mental illness and a co-occurring substance use disorder. The county’s dedicated jail diversion program immediately began transition planning and referrals to treatment. Once stable, Connie needed to voluntarily agree to participate in the program in lieu of proceeding with criminal charges. The program included integrated MI/SUD treatment, a step-down court supervision process and drug screenings. Upon accepting the program, she was assigned a peer support specialist and a case manager who ensured that she stayed housed and stabilized while participating in the program. She also received treatment for her PTSD, and her treatment plan included strategies to account for her trauma. Upon successful completion of the program, charges were dropped, and Connie was connected to a community provider to continue treatment on an ongoing basis.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	High	High	Low-Mod	Voluntary or Involuntary

Pathway/Category 4:

Don was a man in his mid-fifties with schizoaffective disorder. Several days after being evicted from his apartment, with no other housing options he broke into an unoccupied house and was arrested and charged with felony breaking and entering. He had no prior convictions, and because Don’s screening indicated he had low to moderate criminogenic needs and because his illness did not directly cause him to commit his crime, he was not directed to a mental health docket or civil treatment but was instead ordered to a diversion program that provided cognitive behavioral therapy to address his criminal thinking, required periodic check-ins with probation staff, and provided housing support. Upon successful completion of the diversion program, the charges against Don were dismissed.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Low-Mod	Low-Mod	Low-Mod	Voluntary Diversion

Pathway/Category 5 – Traditional Criminal Justice Pathway:

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Mod-High	Mod-High	Low-Mod or Significant State Interest	Voluntary or Involuntary

Pathway/Category 6 – Competency Restoration:

Hank was in his late 30s. He was homeless and suffered from serious, untreated schizophrenia. He believed he heard God’s commands and assaulted and attempted to murder a young woman in broad daylight. Hank was taken into custody where the nature of his crime precluded him from undergoing any presumptive diversion procedures. The egregious nature of the crime necessitated pursuing prosecution and trial. The victim expressed an interest in Hank getting treatment as well. In custody, Hank received care from jail-based clinicians and was housed in a therapeutic environment in the jail while awaiting his first hearing. At the hearing, Hank’s appointed attorney raised competency concerns, and Hank was then evaluated, adjudicated incompetent to stand trial, and referred to in-patient competency restoration. Once stabilized, Hank was found to have regained competency, went to trial, and the jury found him not guilty by reason of insanity, and he was then committed to the forensic wing of the state hospital for close supervision and treatment. The court takes the mental illness into consideration after the defendant enters a plea of guilty to a reduced charge and gives him credit for time served and orders that he follow the terms of the court-ordered treatment.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
MI/SUD Present	High	Any	High & Sig. State Interest	N/A

Appendix IV:

Colorado SB19-222 (Link to full text: https://leg.colorado.gov/sites/default/files/2019a_222_signed.pdf)

Individuals At Risk of Institutionalization

Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation.

Bill Summary

Medicaid - 1115 demonstration waiver - criminal or juvenile justice system prevention - mental health institute admission criteria - community behavioral health safety net system - appropriation. The act requires the department of health care policy and

financing (state department) to develop measurable outcomes to monitor efforts to prevent Medicaid recipients from becoming involved in the criminal or juvenile justice system.

The act requires the state department to work collaboratively with managed care entities to create incentives for behavioral health providers to accept Medicaid recipients with severe behavioral health disorders. The act requires the state department to determine if seeking a 1115 demonstration waiver is the necessary response to ensure inpatient services are available to individuals with a serious mental illness. If the state department determines it is not appropriate, the state department shall submit a report to the general assembly with the state department's reasoning and an alternative plan and proposed timeline for the implementation of the alternative plan.

The act requires the state department to develop and implement admission criteria to the mental health institutes at Pueblo and Fort Logan.

The act creates a community behavioral health safety net system (safety net system) and requires the department of human services, in collaboration with the state department, to conduct the following activities:

- 1) Define what constitutes a high-intensity behavioral health treatment program (treatment program), determine what an adequate network of high-intensity behavioral health treatment services includes, and identify existing treatment programs;
- 2) Develop an implementation plan to increase the number of treatment programs in the state; Identify an advisory body to assist the department in creating a comprehensive proposal to strengthen and expand the safety net system;
- 3) Develop a comprehensive proposal to strengthen and expand the safety net system that provides behavioral health services for individuals with severe behavioral health disorders;
- 4) Implement the comprehensive proposal and the funding model no later than January 1, 2024; and Provide an annual report from January 1, 2022, until July 1, 2024, on the safety net system to the public through the annual SMART Act hearing.

Appendix V:

Colorado HB22-1256 (link to full text:
https://leg.colorado.gov/sites/default/files/2022a_1256_signed.pdf)

Modifications To Civil Involuntary Commitment

Concerning modifications to civil involuntary commitment statutes for persons with mental health disorders, and, in connection therewith, making an appropriation.

Bill Summary

Current law sets forth emergency procedures to transport a person for a screening and to detain a person for a 72-hour treatment and evaluation if the person appears to have a mental health disorder, and as a result of the mental health disorder, appears to be an imminent danger to

the person's self or others, or appears to be gravely disabled. Current law also sets forth procedures to certify a person for short-term or long-term care and treatment if the person has a mental health disorder, and as a result of the mental health disorder, is a danger to the person's self or others, or is gravely disabled. The bill modifies these procedures by:

- 1) Transferring duties of the executive director of the department of human services to the commissioner (commissioner) of the behavioral health administration (BHA);
- 2) Limiting who can take a person into protective custody and transport the person to an outpatient mental health facility, a facility designated by the commissioner of the BHA (designated facility), or an emergency medical services facility (EMS facility) if the person has probable cause to believe a person is experiencing a behavioral health crisis;
- 3) Requiring the facility where the person is transported to require an application, in writing, stating the circumstances and specific facts under which the person's condition was called to the attention of a certified peace officer or emergency medical services provider;
- 4) Requiring an intervening professional to screen the person immediately or within 8 hours after the person's arrival at the facility to determine if the person meets the criteria for an emergency mental health hold;
- 5) Establishing certain rights for a person being transported, which must be explained prior to transporting the person;

Effective July 1, 2023:

- 6) Subjecting a person who files a malicious or false petition for an evaluation of a respondent to criminal prosecution;
- 7) Authorizing a certified peace officer to transport a person to an emergency medical services facility (EMS facility) even if a warrant has been issued for the person's arrest, if the certified peace officer believes it is in the best interest of the person;
- 8) Authorizing an intervening professional or certified peace officer to initiate an emergency mental health hold at the time of screening the respondent;
- 9) Authorizing a secure transportation provider to take a respondent into custody and transport the person to an EMS facility or designated facility for an emergency mental health hold;
- 10) Expanding the list of professionals who may terminate the emergency mental health hold;
- 11) Requiring the evaluation to be completed using a standardized form approved by the commissioner;
- 12) Requiring an EMS facility to immediately notify the BHA if a person is evaluated and the evaluating professional determines that the person continues to meet the criteria for an emergency mental health hold and the *facility cannot locate appropriate placement*;
- 13) Requiring the BHA to support the EMS facility in locating an appropriate placement option. If an appropriate placement option cannot be located, the bill authorizes the EMS facility to place the person under a *subsequent* emergency mental health hold and requires the court to immediately appoint an attorney;
- 14) Authorizing a designated facility to place the person under a *subsequent* emergency mental health hold if the person has been recently transferred from an EMS facility to the designated facility and the designated facility is unable to complete the evaluation before the initial emergency mental health hold is set to expire;

15) Requiring the facility to provide the person with discharge *instructions* by facilitating a follow-up appointment within 7 calendar days after discharge, attempting to follow up with the person 48 hours after discharge, and encouraging the person to designate a family member, friend, or lay person to participate in the person's discharge planning.

Effective January 1, 2025:

- 16) Authorizing the BHA to delegate physical custody of the respondent to a designated facility;
- 17) Requiring an extended certification to be filed with the court at least 30 days prior to the expiration of the original certification;
- 18) Establishing requirements for a short-term or long-term certification on an outpatient basis;
- 19) Requiring the outpatient treatment provider, in collaboration with the BHA, to develop a treatment plan for the respondent and requiring the BHA to create a one-step grievance process for the respondent related to the respondent's treatment plan or provider.

The bill establishes a right to an attorney for a person certified for short-term or long-term care and treatment, regardless of income.

The bill establishes certain rights for a person transported or detained for an emergency mental health hold or certified on an outpatient basis. The bill modifies current rights for a person certified for short-term or long-term care and treatment on an inpatient basis.

Beginning January 1, 2025, the bill requires the BHA to annually submit a report to the general assembly on the outcomes and effectiveness of the involuntary commitment system, disaggregated by region, including any recommendations to improve the system and outcomes for persons involuntarily committed or certified.

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