

## New Models of Collaboration Between Criminal Justice and Mental Health Systems

In 2007, 2.3 million persons were in prisons and jails in the United States compared with fewer than 400,000 only 35 years ago. This “trend” has been attributed to urbanization, political and social concerns about growing crime severity, and epidemics of drug abuse. In response, state legislatures abandoned the principles of individualized justice and therapeutic punishment that were hallmarks of American jurisprudence in the first half of the 20th century (1). In its place, a new punitive criminal justice policy emerged. Most states passed sentencing laws that fixed lengthy minimum incarceration terms for specific offenses and offenders.

This policy shift has had greater consequences for some subgroups of offenders. In particular, the large numbers of adults and juveniles with mental disorders entering the justice system have placed considerable strain on the ability of judges and corrections officials to apply these categorical decisions without forgoing individualized responses to these compromised individuals. As a result, there are now hundreds of thousands of individuals with mental illness under criminal and juvenile justice supervision throughout the United States (2). Out of necessity, criminal and juvenile justice agencies have turned to would-be partners and collaborators in mental health and drug treatment to find new solutions. Consequently, new models have sprung up as local solutions, striking responsive chords with communities who face similar problems, and they have diffused rapidly throughout the country, although without solid evidence about their effectiveness.

### New Models of Collaboration

Co-occurring substance use and mental disorders associated with deviant behavior and harsh sanctions for drug-related offenses are principal factors driving criminal involvement among persons with mental illness. However, the inattention of the mental health community to risk assessments and the over-reliance of the criminal justice system on such measures have created disconnects in care. In the last two decades, these two systems have formed new relationships where accommodation and antagonism have given way to joint efforts to find shared solutions. These newer arrangements integrate roles, rules, and relationships between the two systems in ways that appear to allow the needs of mentally ill persons to be addressed without undermining public safety goals. Three collaborative models (crisis intervention teams, mental health courts, and mental health probation and parole personnel) have received the most attention from practitioners and policy makers in both adult and juvenile systems.

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### *Crisis Intervention Teams*

Crisis intervention teams are police-based interventions situated at the front end of the justice system (3). The original model was developed in Memphis in 1988 (4). Sworn officers receive 40 hours of training about mental illness, de-escalation management, and how to divert persons suspected of having a serious mental illness by bringing them to a special mental health assessment facility rather than taking them to jail. One-fifth

of the officers in each adopting law enforcement agency are trained. More than 300 municipal or county departments across the country have followed this approach.

The current evidence in support of crisis intervention teams is mainly descriptive (5). The following questions pertaining to outcomes-oriented research would help to develop an evidence base for the effectiveness of crisis intervention teams:

**Training and community context.** Are there selection biases associated with the voluntary nature of enrollment such that officers' pre-existing attitudes and beliefs rather than crisis intervention team training account for their behavior as crisis intervention team officers? Are crisis intervention team effects confounded with the availability and adequacy of local mental health services, differences in emergency commitment statutes, and other community characteristics?

**Disposition outcomes.** How many individuals who are diverted into mental health services are stabilized and engaged in treatment? How do their experiences compare with individuals with mental illness who are arrested and jailed?

**Costs and benefits.** Who benefits and who pays for crisis intervention teams? Are there efficiencies for law enforcement? What is the impact on the mental health system? What is the impact on public safety?

### ***Mental Health Courts***

The blending of legal coercion and intensive treatment is the core of the mental health court model (6). The court typically adopts a therapeutic jurisprudence orientation in which both mental health workers and probation officers participate in the proceedings and offenders are placed on probation on condition of participation in treatment and making regular court appearances to report on their progress.

Since the first mental health court appeared in Broward County, Fla., in 1997, there are now well over 250 courts. Consensus guidelines on essential elements for a mental health court have been issued by the Council of State Governments Justice Center (7), but practices are quite variable across jurisdictions. Factors such as the growing need to respond to people with mental illness entering the justice system, the legal leverage these courts offer, and enhanced access to treatments have been identified as justification for their proliferation. At the same time, some advocates view mental health courts as a misguided attempt to address the problems of people with mental illnesses who become involved with the justice system (8).

These concerns have raised a number of significant questions about the role and effectiveness of mental health courts:

**Case referral and selection.** Do these courts result in more individuals being referred for court-mandated treatment than would be expected in comparable jurisdictions without a mental health court? Are only those individuals who are most likely to succeed selected?

**Access to treatment.** Does participation in a mental health court actually result in greater access to appropriate treatment? Can adherence to treatment be effectively "forced" on participants? To what extent do criminal offenders jump the line to get community-based treatment before others?

**Effectiveness.** Are criminal justice (public safety) and behavioral health outcomes (treatment engagement, symptom reduction, enhanced functioning) improved as a result of participation in mental health courts compared with usual criminal justice processing?

### ***Mental Health Probation and Parole***

Mental health probation and mental health parole are two other blended collaboration approaches combining community supervision via the courts (probation) or a state releasing authority (parole) with mental health treatment (9). Often, mental health probation is included as a component of other interventions, such as mental health courts and forensic assertive community treatment teams (10). The California Depart-

ment of Corrections (11) employs mental health clinicians within its parole division to operate community-based outpatient clinics for offenders with mental illness.

A recent review commissioned by the Council of State Governments Justice Center (12) found only a handful of studies on probation. Recidivism rates for offenders with mental illness are nearly twice as great as those for the general prison population (13). Some studies indicate that criminal justice involvements via revocations and technical violations are actually greater when probation or parole officers participate in mental health treatment teams (14), but arrests for new offenses may be lower. However, there are a number of questions that still need to be addressed:

**Compliance and treatment engagement.** Are offenders with mental illness more compliant with their probation/parole when supervised by officers with mentally ill only caseloads? Are they more engaged in treatment services? Do these compliance and engagement rates vary by probation or parole status, seriousness of offense, or seriousness of mental illness?

**Community adjustment and recidivism.** Does joint community supervision and mental health treatment promote public safety through reduced offending, enhanced functioning, and lowered recidivism rates? Are the rates of technical violations, revocations, and rearrests for new crimes greater for joint programs compared with usual arrangements?

## Advancing Research on Collaborations

Current efforts at both the federal and state levels provide ample occasions for policy research to address research questions about criminal justice mental health collaborations.

For the most part, however, these initiatives do not have a formal research component. Growing a firm evidence base will require well-designed multisite and multistate longitudinal studies. Without knowing whether the actual performance of these collaborative arrangements is consistent with the enthusiasm of their proponents, it is difficult to say whether they should continue to be expanded across the country or curtailed and abandoned.

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