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MENTAL HEALTH AND ITS IMPACT ON THE JUSTICE SYSTEM

SUBMISSION

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"COGNITIVE AND DEVELOPMENTAL DISABILITIES IN THE COURTROOM"

THE SUPREME COURT *of* OHIO

JUDICIAL & COURT SERVICES ■ TECHNICAL ASSISTANCE *and* RESOURCES *for* OHIO COURTS

SPECIALIZED DOCKETS SECTION

A Handbook *for* Developing a Mental Health Court Docket

Mental Health Court Docket
A Handbook *for* Ohio Judges

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CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Canadian Mental Health Association, ONTARIO

Mental Health Diversion and Court Support

Diversion and Court Support Services in Ontario
For a complete listing of diversion and court support services, see **Mental Health Service Information Ontario**.

Diversion is a process where alternatives to criminal sanctions are made available to people with mental illness who have come into contact with the law for minor offenses. The objective is to secure appropriate mental health services without invoking the usual criminal justice control of trial and/or incarceration. Treating the mental disorder, it is hoped, reduces the likelihood of further offending and the focus is on helping individuals to access community support and treatment.

In general, mental health diversion programs take one of three forms: (a) police pre-arrest, or pre-booking diversion; (b) court diversion and; (c) mental health courts (MHCs). Arrest diversion allows the police to use their discretion in laying charges. Court diversion programs, on the other hand, are post-booking, pre-arraignment programs that involve staying charges for eligible offenses if the person agrees to treatment. In addition to the mentally ill defendant and her or his family, MHCs involve a dedicated judge, crown, defence, and court support worker (CSW). Characteristics of MHCs include: (a) all identified mentally ill defendants are handled in a single court/docket, (b) the use of a collaborative team which includes a clinical specialist who recommends and makes linkages to treatment, (c) assurance of availability of appropriate clinical placement prior to the judge making a ruling, and (d) specialised court monitoring with possible sanctions for noncompliance (Steadman, Davidson & Brown, 2001).

Source: Dr. Kathleen Hartford et al., 'Evidence-Based Practices in Diversion Programs for Persons with Serious Mental Illness Who Are in Conflict with the Law' (September 2004)

Diversion Resources

Best Practices in Four Cities in Southwestern Ontario: The Interface between People with Mental Illness and the Criminal Justice System (May 2003)
Written by Dr. Kathleen Hartford of the Lawson Health Research Institute in London, the best practices document is based on a comprehensive survey of police services, crown attorneys, judges, defense attorneys, Canadian Mental Health Association branches, and probation services in Chatham, London, Sarnia and Windsor. The document includes detailed descriptions of protocols and practices, background information, and key informant contact information covering such issues as the need for a mental health court in Southwestern Ontario, court diversion, police response to mentally ill persons, charge diversion, fitness assessments, forensic assessment, probation and police training.

Cops, Courts and Compassion: Seeking Justice for the Mentally Ill (Winter 2005)
A special edition of CMHA Ontario's *Network* magazine focusing on strategies for mental health diversion from the criminal justice system.

Evidence-Based Practices in Diversion Programs for Persons with Serious Mental Illness Who Are in Conflict with the Law: Literature Review and Synthesis (September 2004)
A fundamental principle arising from *Making It Happen* (1999), the Ontario Ministry of Health and Long-Term Care's (MOHLTC) plan for mental health reform, is that effective diversion for persons with serious mental illness who are in contact with the law is an integral elemental of the mental health system. As part of their program of research to identify evidence-based practices in mental health diversion, the ministry funded a review and synthesis of all relevant published and unpublished literature.

Mental Health Court Support Services Policies and Procedures
Produced by the Mental Health Court Support Consortium, a formal network of organizations which provide mental health court support services to the five courthouses within the City of Toronto, this manual describes both common policies and individual procedures.

A Program Framework for Mental Health Diversion/Court Support Services (February 2006)
This document from the Ontario Ministry of Health and Long-Term Care sets out the target populations for diversion/court support services and provides details of service functions for each service type.

Mental Illness and the Courts:

Some Reflections on Judges as Innovators

John P. Petrila and Allison D. Redlich

Issues raised by the influx of defendants with serious mental illnesses are some of the most important that criminal judges confront. Because of the volume of defendants with mental illnesses, the impact goes beyond that of the individual case and extends to jails, police and sheriff departments, the treatment system, and ultimately to the role of the judge. This article suggests some of the ways in which communities have attempted to respond to these issues, and highlights the fact that judges have become significant leaders as well as innovators in such efforts. Not every judge will decide to adopt one or more of these roles, but regardless, it is likely that the issues that mental illness creates for the criminal justice system will exist far into the future.

PART 1. MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

On January 18, 2006, the Conference of Chief Justices adopted a resolution endorsing the use of problem-solving courts to address the impact of mental illness upon the criminal justice system.[1] This resolution formally acknowledged the emergence of therapeutic courts as part of the jurisprudential mainstream. As important, it highlighted the changing role of the judiciary in response to the many issues caused by the prevalence and volume of serious mental illnesses among defendants in courts across the country.[2] In fact, as this article suggests, state judges have been responsible for some of the most innovative solutions to these issues, a trend likely to continue for the foreseeable future. Some judges have embraced this new role, others have not, but—regardless of perspective—it is difficult for any criminal judge today to simply ignore the issue of mental illness.

There were approximately 14 million arrests in the United States in 2005.[3] The most conservative estimate is that approximately 900,000 of these arrestees were acutely mentally ill at the time of the arrest.[4] When substance abuse and other mental illness diagnoses are considered, the prevalence of mental disorder among arrestees is over 70%.[5] In addition, it is estimated that between 16% and 24% of people who are in jails and prisons have a major diagnosable mental illness such as depression, schizophrenia, or other psychotic or bipolar disorders.[6] Again, if all mental disorders—including substance-abuse disorders—are included, the prevalence of mental disorder in incarcerated populations is over 70%.

Until three decades ago, the majority of people with severe mental illnesses were confined for at least part of the time in state psychiatric hospitals. However, since then there has been a major diminution of the role of state hospitals, while the number of people with mental illnesses in jails and prisons has increased significantly. For example, in 2000, people with severe mental illnesses were more than five times likely to be confined to a jail than to a state psychiatric hospital (the rate of hospitalization in state psychiatric hospitals was 22 people per 100,000, but the rate of confinement in jail was 113 people with severe mental illnesses per 100,000.[7]) This is not to suggest that the answer to the problem of mental disorder in the criminal justice system is to recreate the state psychiatric hospital system. Rather, as we suggest below, the lack of effective community treatment in many jurisdictions is a more pressing issue than the absence of state hospital beds. In addition, changes in sentencing policy, particularly regarding substance-abuse offenses, has contributed to the influx of people with mental disorders. However, regardless of *why* it has hap-

Footnotes

1. Conference of Chief Justices, Policy Statements and Resolutions, Resolution 11, *In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative*, January 18, 2006, available at http://ccj.ncsc.dni.us/CriminalAdultResolutions/resol11Judicial CriminalJusticeMentalHealthInitiative.html.
2. Therapeutic courts are a comparatively recent development; the first drug court emerged in 1989 in Dade County, Florida, and the first mental-health courts of this era began in 1997 in Broward County, Florida and Marion County, Indiana. Today there are more than 1,000 such courts in the United States and their "fit" within the traditional justice system has been the subject of frequent discussion, including in this journal. For an example, *see* Daniel J. Becker & Maura D. Corrigan, *Moving Problem-Solving Courts Into the Mainstream: A Report Card from the CCJ-COSCA Problem-Solving Courts Committee*, COURT REVIEW, Spring 2002, at 1. *See also* Aubrey Fox and Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, COURT REVIEW, Fall 2002, at 4. Therapeutic courts have been developed in a number of other countries as well. John Petrila, *An Introduction to Special Jurisdiction Courts*. 26 INT'L J. LAW AND PSYCH. 3 (2003).
3. Table 29, U.S. Dept. of Justice, Fed. Bureau of Investigation, *Crime in the United States* (2005), available at http://www.fbi.gov/ucr/05cius/data/table_29.html.
4. NAT'L GAINS CTR., THE PREVALENCE OF CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS IN JAILS (rev. ed. 2004), available at http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf.
5. *Id.*
6. RICHARD LAMB AND LINDA E. WEINBERGER, *THE SHIFT OF PSYCHIATRIC INPATIENT CARE FROM HOSPITALS TO JAILS AND PRISONS*, 33 J. AMER. ACAD. PSYCH. & LAW 529 (2005). For the underlying data behind Lamb and Weinberger's estimates, *see* NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS ix-x, 57-80 (2002), available at http://www.ncchc.org/pubs/pubs_stbr.html.
7. *Id.*

pened, it is clear that there are many more individuals with major mental illnesses in the criminal justice system today than was the case 20 or 30 years ago.

The increase poses serious problems for the individual and for the justice system. People with mental illnesses are jailed on average two to three times longer than individuals without a mental illness arrested for a similar crime. A stay in jail may exacerbate the person's illness, and an arrest record may further complicate the person's efforts to live successfully in the community. In addition, jails incur significant costs associated with the oversight of individuals with mental illnesses (particularly regarding the threat of suicide) and for medication and other health-care services.

Mental-illness issues also present complications for a judge. Many criminal courts have overburdened dockets, which allow little time for an individual case. Yet dispositional questions involving a defendant with an acute mental illness are often not readily resolved. Ordering a competency examination may be easy; deciding whether and how to gain access to treatment that the individual needs may be considerably more difficult.[8] In addition, judges often encounter the same defendant with mental illness repeatedly; the individual is arrested usually for a comparatively minor offense, is released often for time served but with no access to treatment, and is then rearrested for the same type of offense. This cycle with "repeat defendants" creates frustration for judges unable to gain access to treatment that might have some impact on the defendant's behavior.

As the impact of mental illness on the criminal justice system has grown, judges increasingly have become leaders in seeking innovative solutions. This has often been by default; few judges take the bench with a primary goal of designing solutions to systemic issues that often appear to flow from failures in the mental-health and human-services systems. Yet in many communities, judges may be the only officials with the necessary formal and symbolic authority to create change.

This article describes a number of innovations that have been developed by individual judges and others within the criminal justice system in response to mental-illness issues. We first briefly describe the realities of today's mental-health system, which provides the context in which many criminal courts now sit. We then briefly discuss a number of discrete initiatives (pre-arrest diversion programs; post-arrest diversion programs, including therapeutic courts; post-disposition oversight, including specialty probation for defendants with mental illness) that various communities have tried. We conclude with some comments on the role of the judge in identifying and resolving these issues. We do not suggest that these initiatives are a good fit for every community. In fact, it is quite clear that local circumstances are the first thing that must be considered in determining which solutions to attempt. Nor will every judge wish to adopt a proactive role in seeking solutions. But addressing the needs of defendants with serious mental illnesses will be a problem that confronts virtually every criminal court judge, and so it may be useful, particularly for judges new to these issues, to have information regarding the strategies communities have used in response.

[M]any defendants with serious mental illness are arrested on relatively minor charges, and therefore formal competency adjudications . . . may have little appeal . . . .

Contextual issues. Mental illness has always been an issue in the criminal justice system, primarily because of its potential impact on mental state. Competency to stand trial assessments were (and continue to be) a staple of criminal proceedings, and the insanity defense and related pleas—such as guilty but mentally ill—have continuing relevance in a modest number of cases. In addition, courts have long made mental-health treatment a condition of disposition in resolving some criminal cases.

However, these traditional tools have little relevance to the vast majority of the people arrested each year who are acutely ill at the time of arrest. This is for at least two reasons. First, many defendants with serious mental illness are arrested on relatively minor charges, and therefore formal competency adjudications and pleas of insanity may have little appeal as a practical matter, though legally they might be preferred. Second, even if these mechanisms were employed in every one of the 900,000 cases in which the defendant is acutely ill at the time of arrest, it would only further exacerbate the problem of overburdened court dockets, because these issues do not lend themselves to quick disposition. As a result, many of the innovations discussed below are designed either to reduce the number of acutely ill defendants who enter the criminal justice system or to shorten the time spent there.

There have also been major changes in the last few decades in the treatment of people with serious mental illnesses.[9] Three are relevant here. First, the location and duration of much treatment has changed. State psychiatric hospitals used to provide most long-term care for serious mental illnesses. Most psychiatric hospital care today is provided in community outpatient settings because of a number of factors, including horrific conditions that developed in many state hospitals, as well as changing philosophies of—and advancements in—treatment. Community outpatient care is designed largely to control and reduce symptoms. Inpatient care is generally

8. It may be difficult even to gain access to treatment services for competency restoration. In Florida, judges held the Secretary of the state agency responsible for providing such services in contempt because of long waiting lists for beds in the hospitals charged with providing competency restoration. Abby Goodnough, *Officials Clash Over Mentally Ill in Florida Jails*, N.Y. TIMES, Nov. 15, 2006.

9. It should be noted that the influx of people with drug-abuse disorders that eventually resulted in the development of drug courts was caused in large part by changes in criminal laws, which brought more defendants into the criminal justice system for offenses related to substance abuse and resulted in lengthier sentences as well. *See* Petrila, *supra* note 2.

Formal diversion programs for persons with mental illness are growing in popularity and number.

short-term, and occurs most often in psychiatric units of community hospitals. There is little long-term, inpatient care for psychiatric illnesses available in the United States today.

Second, and relatedly, most people with serious mental illnesses spend the vast majority of their time in the community. At this juncture, it is beyond dispute that most people with serious mental illnesses can be treated successfully in the community and live productive lives, even if they suffer relapses during treatment.[10] However, the network of treatment services, social supports, and housing necessary to provide such treatment is rarely available in sufficient supply and in many communities is woefully lacking. As a result, many people with serious mental illnesses receive little or inadequate treatment. As a result, the symptoms of serious mental illness may be exacerbated. Mental illness does *not* necessarily lead to arrest, but conduct that may lead to arrest, such as loitering, public urination, or petty theft, may become more likely in the absence of treatment and social stability for at least some individuals with serious mental illnesses.

Third, the primary locus of responsibility for dealing with these failed treatment systems has shifted in many places from state government to local communities. The federal government funds many mental-health services through the Medicare and Medicaid programs but plays virtually no role in designing treatment systems. State governments traditionally assumed a leadership role for designing mental health services through the state mental health agency. However, many states have reduced funding for mental-health as a percentage of human services funding, and the authority of many state mental-health commissioners has been reduced as states grapple with rising costs in their Medicaid programs.

While there may not be a direct correlation between these changes and the impact of mental illnesses on local courts, they are contextual factors that have shifted the venue for innovative responses to local communities. Over time, a number of strategies have emerged in various communities that appear to hold some promise. We discuss the most common strategies below.

PART 2. STRATEGIES

As indicated above, the volume of persons with mental illness coming into contact with the justice system is so immense that the majority of communities have developed their own informal and formal strategies to combat associated issues. We focus here on formalized strategies that occur at different points along the criminal justice continuum, including 1) pre-arrest diversion programs; 2) post-arrest diversion programs, including mental-health courts; and 3) specialty probation. Below we provide brief descriptions and operational definitions of these three subtypes. For more detailed information, we refer interested readers to the National GAINS Center and its Technical Assistance and Policy Analysis Center for Jail Diversion[11] and the Council of State Governments' Criminal Justice Mental Health website.[12] These on-line resources offer many free publications, including guides on how to implement different diversion programs as well as an overview of the mental health service system for criminal justice professionals.[13]

Formal diversion programs for persons with mental illness are growing in popularity and number. While it is accurate to state that these diversion programs have resulted from local initiatives, the federal government also has demonstrated support. Specifically, the President's New Freedom Commission on Mental Health[14] recommended "widely adopting adult criminal justice and juvenile justice diversion....strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness." Further, over the past five years, federal government agencies, such as the Bureau of Justice Assistance and the Substance Abuse and Mental Health Administration, have contributed millions of dollars in grant funds toward the creation of local diversion programs.[15]

Pre-arrest diversion. As the name implies, pre-arrest—or pre-booking—diversion programs focus on diverting persons to treatment as an alternative to arrest. Such programs depend on law enforcement given that police and sheriff's deputies make the vast majority of decisions whether or not to arrest an individual engaged in criminal behavior. It is becoming increasingly popular because this type of diversion when suc-

10. Relapse is common for the most serious mental illnesses, for example, schizophrenia. As one group of commentators recently noted, "the course of early-phase schizophrenia is characterized by initial improvement in symptoms followed by repeated relapse and a low rate of sustained recovery." However, the same authors note that early intervention with effective medications can result in good control of symptoms and that even those who may not respond to treatment of an initial episode of treatment may attain recovery over time, given adequate treatment. Delbert G. Robinson et al., *Pharmacological Treatments for First-Episode Schizophrenia*, 31 SCHIZOPHRENIA BULL. 705 (2005). Not all mental illnesses are as devastating as schizophrenia, but because they often manifest themselves episodically, it is difficult to assume that an individual with a serious mental illness will necessarily be wholly compliant with court orders, particularly in the absence of adequate treatment and supervision.

11. *See* http://gainscenter.samhsa.gov/html/default.asp.

12. *See* http://www.consensusproject.org/.

13. JACKIE MASSARO, OVERVIEW OF THE MENTAL HEALTH SYSTEM FOR CRIMINAL JUSTICE PROFESSIONALS (2005), available at http://209.132.230.103/pdfs/jail_diversion/MassaroII.pdf.

14. PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HELATH CARE IN AMERICA 43-44 (2003) (hereinafter ACHIEVING THE PROMISE], available at http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

15. *See, e.g., America's Law Enforcement and Mental Health Project*, 42 U.S.C. §§ 3711, 3796ii-3796ii-7, 3793, Pub. L. 106-515 (2000). It is also worth noting that these grants have often been comparatively small, and while they have been important in seeding local projects, the funds allocated by the federal government for diversion are rarely adequate to enable the programs to sustain themselves.

Three core factors have been identified as essential to the success of a pre-arrest diversion program.

cessful can have an impact on court dockets and the use of jail beds.

There are three basic types of pre-arrest diversion: 1) police-based specialized police response, 2) police-based specialized mental-health response, and 3) mental-health-based specialized mental-health response.[16] In the first model, police officers are specially trained in crisis intervention and act as liaisons to the mental-health system. In the second model, mental-health professionals collaborate with police to provide on-site or telephone consultation on responding to individual cases. In the third model, which is the most common, mental-health professionals provide on-site help to the police in situations involving persons with mental illness.[17]

One of the most successful and most duplicated models for pre-arrest diversion is the Crisis Intervention Team (CIT) model, originally developed in Memphis, Tennessee. Today, many major and smaller U.S. cities have adopted CIT programs of their own. The CIT program in Memphis has been described in the following manner: A cadre of selected patrol officers (10 to 20 percent of those assigned to patrol) receive extra training (40 hours initially) and then serve as generalists/specialists; they perform the full range of regular patrol duties, but respond immediately (from anywhere in the city) whenever crisis situations occur involving people with mental illness. In those situations, these officers assume on-scene command as soon as they arrive. They are trained to handle the crisis situations as well as to facilitate the delivery of treatment and other services. In particular, they become knowledgeable about voluntary and involuntary commitment, plus they become well known to professionals in the mental-health community, facilitating the delivery of treatment and other services to the people in crisis.[18]

Three core factors have been identified as essential to the success of a pre-arrest diversion program. The first is training. The Memphis CIT model prides itself on its 40-hour (plus) intensive training for officers selected for the program. The curriculum includes information on mental illness, crisis skills, and a heavy concentration on interactive activities, such as role play. Refresher trainings are utilized as well. The second core element is the creation of partnerships between community mental-health providers and law-enforcement officials. Pre-arrest diversion programs require that police have access to treatment services reliably, predictably, and at all hours. If an officer finds it more difficult to gain access to assessment and treatment than to arrest the individual, diversion programs will founder. Therefore, in developing this option, communities often use a single point of entry to services, assure that no one referred for services will be refused at least an assessment, and provide streamlined intakes for police officers.[19] The third core element is re-conceptualizing the traditional police-officer role for the specialized-diversion officers. That is, under the CIT model, officers volunteer or are specially selected rather than randomly assigned, and the agency promotes collegiality and a sense of shared responsibility among the officers. It is also important that relevant statutes and policies encourage and support rather than create impediments to diversion. For example, crisis facilities must be enabled legally to accept and detain persons who may or may not have criminal charges pending.

Early research suggests that pre-arrest diversion programs can be successful in creating access to treatment without creating additional community risk. For example, in comparison to persons not diverted, persons diverted were more likely to be in counseling and to be taking prescribed medications. Re-arrest rates were not higher than those for non-diverted populations, despite the fact that individuals diverted before arrest were typically in the community for longer periods of time (and therefore potentially at risk for behavior leading to another arrest) than non-diverted individuals.[20] Currently, a major evaluation is underway of 32 pre and post-booking diversion programs, which may provide more definitive answers to whether pre-diversion programs are successful, for whom, and why.

Post-arrest diversion. After a person is arrested, formal diversion can occur at any point during the criminal process. We first discuss post-arrest, or post-booking diversion programs generally, and address mental-health courts (MHCs) separately.

16. For discussions of the various methods for organizing pre-arrest diversion, *see* Martha Williams-Dean et al., *Emerging Partnerships between Mental Health and Law Enforcement*, 50 PSYCH. SERVICES 99 (1999); Henry Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, 51 PSYCH. SERVICES 645 (2000).
17. MELISSA REULAND, A GUIDE TO IMPLEMENTING POLICE-BASED DIVERSION PROGRAMS FOR PEOPLE WITH MENTAL ILLNESS (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/PEREpdf.
18. This description is taken from an article at the website of the Center for Problem-Oriented Policing: Gary Cordner, *People with Mental Illness* 4 (2006), available at http://popcenter.org/problems/mental_illness. The article provides a good description not only of the CIT model but also of a number of other approaches adopted by police departments across the United States in addressing issues involving people with mental illnesses. The growing popularity of CIT as a strategy is reflected in attendance at the 2nd National CIT Conference held in fall 2006 in Orlando. It was attended by more than 800 individuals from 40 states, Canada, and Australia. Many of the attendees were police officers, and there were a number of judges in attendance and presenting as well.
19. Henry Steadman et al., *A Specialized Crisis Response as a Core Element of Police-Based Diversion Programs*, 52 PSYCH. SERVICES 219 (2001).
20. See Michelle Naples & Henry Steadman, *Can Persons with Co-Occurring Disorders and Violent Charges Be Successfully Diverted?*, 2 INT'L J. FORENSIC MENTAL HEALTH 137 (2003); THE NATIONAL GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM, WHAT CAN WE SAY ABOUT THE EFFECTIVENESS OF JAIL DIVERSION PROGRAMS FOR PERSONS WITH CO-OCCURRING DISABILITIES? (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/WhatCanWeSay.pdf.

Post-booking diversion. Post-booking diversion programs, like pre-arrest diversion programs, seek to engage eligible persons in community treatment with the hope that treatment will reduce the risk of behavior leading to future arrests. An obvious difference between the two approaches is that pre-arrest diversion attempts to keep the person from entering the criminal justice system at all, while post-arrest programs are not used until the person has already been arrested.

Post-booking diversion programs may seek to divert the individual to treatment at any point during the criminal process, and therefore, depending on the program, referrals may come from a variety of parties to the criminal justice system, including jail officials, law enforcement, magistrates, judges, and attorneys. One commentator suggests that there are two particularly important points at which defendants may be diverted post-arrest. The first is at the person's first court appearance, which in many jurisdictions will occur within a day or two after arrest. At this point, an arraigning judge might order the person released to community treatment as an alternative to continuing custody. A second point at which diversion might occur is when the prosecutor decides whether to proceed with charges. If the prosecutor is aware that the person has been accepted into a diversion program, he or she may be more willing to hold charges in abeyance pending successful completion of the program. Six critical elements of these diversion strategies have been identified: 1) involvement of all key parties (e.g., judges, prosecutors, defense attorneys, mental-health providers, etc.), 2) strong judicial leadership, 3) quick access to services to assess the defendant's mental health, 4) availability of mental-health-treatment resources, 5) assistance to the defendant in complying with imposed treatment conditions, and 6) patience among professionals from differing and sometimes conflicting systems. Of importance, both options—pretrial release and deferred prosecution—can occur in a matter of days after arrest.[21]

Post-diversion arrest also can take place much later. For example, a person may come before another judge who suspects the person may have a mental illness and be eligible for diversion. Similarly, a person's attorney, after some interaction, may conclude that the best option for his or her client is the diversion program. Diversion may even occur after sentencing, such that the sentence of jail or prison time is put on hold pending successful completion of treatment. Each of these options is available even if there is no formal effort at diversion; however, many communities have begun to attempt to formalize the processes by which defendants may be diverted into treatment as the criminal process proceeds.

A successful example of a post-booking diversion program attempting to address the needs of individuals charged with felonies is New York City's Nathaniel Project. The Nathaniel Project is "exclusively for people with psychiatric disabilities who have been indicted on a felony offense and are facing a lengthy sentence in New York State prison.... the program will consider any defendant regardless of offense, including violent offenses."[22] The Nathaniel Project began in 2000 and appears to be very effective in gaining access to treatment while reducing re-arrest: new arrests among their clients have dramatically decreased, 100% of their clients are engaged in treatment, and after one year, 79% had permanent housing. While many communities will choose not to focus diversion efforts on those charged with felonies, the Nathaniel Project provides evidence that diversion to treatment in lieu of incarceration can be effective in some circumstances even for a difficult population of offenders with mental illness.

New York City's Nathaniel Project . . . began in 2000 and appears to be very effective in gaining access to treatment while reducing re-arrest . . . .

Mental-health courts. Mental-health courts are one of the fastest growing vehicles for addressing the needs of mentally ill defendants. The first two mental-health courts appeared in 1997 in Marion County, Indiana and Broward County, Florida. However, today, there are estimated to be more than 150 U.S. mental-health courts with the number continuing to grow rapidly. A survey completed in January 2005 determined that MHCs were in operation in 34 states with many of the states operating multiple MHCs in different counties and jurisdictions.[23] Like other diversion programs, these therapeutic courts attempt to provide defendants with access to treatment and oversight with the goal of reducing the likelihood of future cycling through the criminal justice system.

Although MHCs vary in their procedures, operations, and eligibility requirements, there are several defining characteristics. First, MHCs are criminal courts, usually with one judge carrying a dedicated docket.[24] Second, MHCs typically have mental-health and criminal justice eligibility criteria in that they will only allow in persons with certain diagnoses and/or certain criminal charges. Earlier, or first-generation, mental-health courts usually limited their docket to misdemeanants,

21. For a general discussion of this type of diversion, *see* JOHN CLARK, NON-SPECIALTY FIRST APPEARANCE COURT MODELS FOR DIVERTING PERSONS WITH MENTAL ILLNESS: ALTERNATIVES TO MENTAL HEALTH COURTS (2004), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/pre_trial_nocover.pdf.

22. For a description of the Nathaniel Project, *see* THE NATIONAL GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM, THE NATHANIEL PROJECT: AN ALTERNATIVE TO INCARCERATION PROGRAM FOR PEOPLE WITH SERIOUS MENTAL ILLNESS WHO HAVE COMMITTED FELONY OFFENSES (rev. ed. 2005), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/nathaniel_project.pdf.

23. Allison D. Redlich et al., *Patterns of Pracice in Mental Health Courts: A National Survey*, 30 LAW & HUMAN BEHAV. 347 (2006).

24. It is worth noting that most mental-health courts have been created from existing resources; few jurisdictions have obtained additional judicial or attorney resources for these courts. In addition, caseloads in most jurisdictions are comparatively small (a mental-health court with a docket of more than 100 cases would be a relatively large mental-health court), and so the judge who presides over the court typically does so in addition to his or her usual responsibilities.

but a number of more recent courts use a mixed (misdemeanor-felony) caseload or only felony cases.[25] Third, MHCs not only require the defendant to receive treatment but also arrange for supervision and oversight of treatment compliance. Oversight takes several forms; for example, the judge will hold periodic status hearings on most cases, and ongoing supervision is provided by the probation officers, case managers, and/or MHC personnel. Fourth, the courts use a mix of incentives and sanctions in an effort to gain compliance. Incentives might include praise in the courtroom from the judge or gift cards marking progress with treatment, while punishment can range from reprimands from the judge to incarceration. Fifth, the courts generally adopt the philosophy of "therapeutic jurisprudence," which is an approach to law that places the therapeutic or non-therapeutic impact of legal rules and processes at the core of judging and practice.[26] Finally, participation in all mental-health courts is voluntary, and it is generally estimated that approximately 5% of defendants offered participation in a mental-health court decline.[27]

While MHCs continue to proliferate, they are not without controversy. Some of the controversies concern the use of jail as a sanction, whether the courts are truly voluntary, and whether MHCs are appropriate venues for persons charged with low-level crimes. Another issue is whether or not the courts "work." That is, do mental-health courts cause people to engage in treatment and ultimately reduce or eliminate future criminal justice involvement? Preliminary research suggests that the courts can be effective, especially when demographic, criminal, and diagnostic factors are considered, but the studies done to date have been of single courts, and so it is difficult to generalize from their findings.[28]

To encourage standardization of MHC operations and requirements, the Council of State Governments (CSG) has proposed 10 "essential elements" of mental-health-court design and implementation.[29] Although we list them here, readers are referred to the original document for more specific information on each element. The elements that must be tended to in the CSG's judgment are 1) Planning and Administration, 2) Identification of the Target Population, 3) Timely Participant Identification and Linkage to Services, 4) Terms of Participation, 5) Informed Choice, 6) Treatment Supports and Services, 7) Confidentiality, 8) Identi-fication of the Mental Health Court Team, 9) Monitoring Adherence to Court Requirements, and 10) Sustainability. In addition, CSG has identified five MHCs as "learning sites." The learning sites have been designated to provide support, including observation opportunities, to other courts looking to set up or expand upon an existing mental health court." The five courts were chosen primarily because of their fidelity to the Essential Elements. Judges and others who are considering establishing a MHC in their community might first obtain the *Essential Elements of a Mental Health Court* guide, and perhaps contact one or more of the MHCs identified as learning sites.[30]

[T]he Council of State Governments has proposed 10 "essential elements" of mental health court design and implementation.

Specialty probation. A more recent development for addressing the needs of defendants with mental illness is specialty probation. Because probationers with mental-health issues often have distinct issues that might affect their ability to comply with the usual conditions of probation, they may require more intensive supervision. While specialty probation is not a diversion program, a growing emphasis on it as a tool makes it worth mentioning here.

As discussed by Skeem, Emke-Francis, and Eno Louden,[31] specialty probation differs from traditional probation in several ways. In comparison to traditional probation officers, specialty probation officers 1) have exclusive caseloads of persons with mental illness, 2) have reduced caseloads (e.g., 30 open cases), and 3) receive mental-health training. Additionally, specialty probation officers tend to forge close working relationships with other professionals in the community relevant to the probationers' well-being. For example, specialty probation officers report having close relationships with treatment providers and

25. Allison Redlich et al., *The Second Generation of Mental Health Courts*, 11 PSYCH., PUB. POL'Y & LAW 527 (2005).
26. David Wexler and Bruce Winick, two law professors, are primarily responsible for the emergence of "therapeutic jurisprudence" as an approach to law. They have written extensively regarding the topic, as well as the manner in which therapeutic jurisprudence might be applied to various legal issues. One of their books is devoted specifically to therapeutic jurisprudence and the role of a judge. BRUCE WINICK & DAVID WEXLER, JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS (2003).
27. Allison Redlich, *Voluntary, But Knowing and Intelligent? Comprehension in Mental Health Courts*, 11 PSYCH., PUB. POL'Y & LAW 605 (2005).
28. For results from two single court studies, *see* Annette Christy et al., *Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court*, 23 BEHAV. SCI. & LAW 227 (2005); Merith Cosden, Jeffrey Ellens, Jeffrey Schnell & Yasmeen Yamini-Diouf, *Efficacy of a Mental Health Treatment Court with Assertive Community Treatment*, 23 BEHAV. SCI. & LAW 199 (2005), available at http://czresearch.com/dropbox/Cosden_BehavSciLaw_2005v23p199.pdf.
29. COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2008), available at http://consensusproject.org/mhcp/essential.elements.pdf.
30. *Id.* Additional resources may be viewed at http://consensusproject.org. The five learning sites are the Akron (Ohio) Municipal Mental Health Court, the Bonneville (Idaho) County Mental Health Court, the Bronx (New York) County Mental Health Court, the Dougherty (Georgia) Superior Court, and the Washoe County (New York) Mental Health Court. *See* http://consensusproject.org/mhcp/.
31. Jennifer Skeem et al., *Probation, Mental Health, and Mandated Treatment*, 33 CRIM. JUSTICE & BEHAV. 158 (2006).

[A] judge who wishes to play an active role in addressing mental illness issues may find that leadership is not forthcoming from the treatment community.

case managers. Finally, specialty officers report utilizing problem-solving strategies as their first strategy to deal with probationers' noncompliance (e.g., generating alternative strategies, and modifying treatment plans jointly with the probationer) rather than initially seeking punishment for violation of probation conditions. Currently, a comprehensive research study is underway comparing outcomes (e.g., re-arrests, treatment utilization) of probationers under traditional and specialty models.

PART 3. JUDICIAL ROLES

All judges with a criminal docket must address issues created by the presence of growing numbers of defendants with serious mental illnesses. However, individual judges will have different views about the appropriateness of assuming an active role in addressing these issues.

A recent article in this journal by Roger Hanson asserted, "...there are few judges who would claim that judging today is just like it was 30 years ago, or like they think it was 30 years ago."[32] Hanson observed that the emergence of problem-solving courts and problem-solving judges was having a significant impact on the discussion regarding judicial role. He characterized the discussion in the following manner:

"Frequently the discussion is framed in terms of whether the judiciary should be expected to behave in one of two polar-opposite ways. Should they be primarily almost aloof finders of fact, impartial and nearly devoid of intimate contact with and knowledge of litigants and their circumstances? Or should they be one of many possible partners to a diagnostic, therapeutically oriented response process to ameliorate underlying and messy problems of litigants?"[33]

Therefore, the manner in which a particular judge defines his or her role is a threshold question that will significantly influence whether the judge then plays the additional roles described briefly below. It should be noted that there is considerable evidence that many judges are interested in assuming a more active role in assuring access to community services for defendants with mental illnesses or substance-abuse problems and for those who have been victims of domestic violence.[34]

The judge as community convener and leader. Problem-solving or therapeutic courts by definition create a different relationship between the court and the surrounding community. Community treatment providers may lack experience in dealing with the needs of individuals who come into treatment through the criminal justice system, may be reluctant to assume responsibility for such clients because of liability concerns, and may be wary of working too closely with the criminal courts.[35] In addition, the lack of adequate housing is a systemic issue that affects the ability of nearly all people with serious mental illnesses to live successfully in the community and will become an issue for judges who seek to achieve successful treatment outcomes for defendants, particularly in therapeutic courts.[36]

For these reasons and for the reasons noted in Part 1 of this article, a judge who wishes to play an active role in addressing mental-illness issues may find that leadership is not forthcoming from the treatment community. As a result, a judge may find that assuming a leadership role is critical in bringing together community stakeholders. There has been considerable commentary in the last decade regarding why and how courts might reach out to communities, so the topic is not new.[37] The need for such a leadership role also is assumed as a sine qua non for

32. Roger Hanson, *The Changing Role of a Judge and Its Implications*, COURT REVIEW, Winter 2002, at 10.
33. *Id.*
34. *See, e.g.*, Aubrey Fox, *And the Survey Says . . . : State Court Judges and Problem-Solving Courts*, *in* CTR. FOR COURT INNOVATION, A PROBLEM-SOLVING REVOLUTION, MAKING CHANGE HAPPEN IN STATE COURTS (2004); Fox's chapter is available at http://www.courtinnovation.org/_uploads/documents/andthesurveysays.pdf. Fox reports the majority of judges responding to a survey of approximately 500 judges believed that the courts should be active in attempting to create access to services; he also reported widespread interest in problem-solving courts among the respondents. In a number of judicial systems, creating access to treatment for some types of defendants has become an article of faith; for example, the Massachusetts Supreme Judicial Court has asserted "Court involvement creates a crisis in a person's life, and courts are uniquely situated to take advantage of the crisis by directing the person toward treatment. A timely response to the individual's crisis is most likely to lead to success in treatment." Supreme Judicial Court Standards on Substance Abuse, Standard 5, Commentary. This and the other standards set by the Massachusetts Supreme Judicial Court can be found at http://www.mass.gov/courts/formsandguidelines/substancev.html
35. DEREK DENCKLA & GREG BERMAN, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS (2001), available at http://www.courtinnovation.org/_uploads/documents/rethinkingtherevolvingdoor.pdf.
36. Finding housing for people with mental illnesses is a long-standing problem in part because of stigma associated with mental illness and in part for economic reasons. In the last two decades, there has been significant experimentation with different models of housing, particularly regarding the linkage between housing and treatment. See, e.g., Sam Tsemberis, Ph.D. & Ronda F. Eisenberg, M.A., *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 PSYCH. SERVICES 487 (2000); Pamela Clark Robbins et al., *The Use of Housing as Leverage to Increase Adherence to Psychiatric Treatment in the Community*, 33 ADMIN. & POL'Y MENTAL HELATH & MENTAL HEALTH SERVICES RES. 226 (2006).
37. For example, David Rottman et al. have suggested that six benefits accrue from judicial outreach to communities: 1) an opportunity to influence public opinion and increase accessibility and fairness, 2) the opportunity to permit judges to respond to public criticism thereby strengthening judicial independence, 3) the opportunity to create better case dispositions, 4) the opportunity to create new programs required by defendants and victims in court proceedings, 5) an opportunity to strengthen communities by combining the force of judicial sanctions with the power of

[T]hese are parties that are typically not used to working together, and the building of enough trust to have non-defensive conversations ordinarily takes time.

judges overseeing therapeutic courts.[38] However, a judge may wish to convene community leaders *before* a therapeutic court or other specific initiatives are developed. A judge may be the one community official with sufficient prestige and authority to create a venue for discussion that other community leaders feel obligated to attend. Indeed, the Conference of Chief Justices, in the resolution noted at the beginning of this article, stated, "while leadership can come from different facets of the criminal justice and mental health systems, judges are particularly well positioned to lead reform efforts because of their unique ability to convene stakeholders."[39]

In considering strategies for addressing mental-illness issues, a judge might consider convening a number of parties, including the state's attorney, the public defender, the major local treatment providers, the local hospital that operates the major emergency services (since many people with mental illnesses may be hospitalized in the emergency room during an acute phase of illness), the sheriff and other local law-enforcement representatives, and social-welfare administrators. Each of these parties (and this list may not be exhaustive) will have some responsibility for—and feel the impact of—the issues associated with serious mental illness. Each will be necessary to creating any solutions to these issues.

If such a meeting occurs, little can be done in a single session. In most communities, these are parties that are typically not used to working together, and the building of enough trust to have non-defensive conversations occur ordinarily takes time. But over time, at least three things may happen. First, some measure of trust will develop. Second, once it does, problem identification may occur at both the individual-case level and at a systemic level. In many communities, a number of individuals will be known to all parts of the system; discussion of those individuals may assist in identifying gaps in services at a more general level.[40] Finally, such meetings, over time, will enable community leaders to discuss a variety of strategies, rather than a single strategy. Not every strategy fits every community, and efforts by one part of the criminal justice or treatment systems to impose a solution on all parts of those systems may have little chance of success. However, a group of community leaders that has developed trust may have the opportunity to sift through a variety of strategies, considering them against the backdrop of the group's collective knowledge of local resources, capacities, and political realities.[41]

The judge as program designer. Few communities have adequate treatment capacity for individuals with mental illnesses, and judges may conclude that treatment services for defendants in the criminal justice system are particularly lacking. This may be true, especially for the very high percentage of defendants with co-occurring mental illness and substance-

community networks to create better access to treatment and other resources, and 6) an opportunity to better accommodate concerns regarding diversity. David B. Rottman, Pamela Casey & Hillery Efkeman, *Court and Community Collaboration: Ends and Means* (1998), available at http://www.courtinfo.ca.gov/programs/community/endsmeans.htm. For another of many examples, the work of the California Court and Community Collaboration Project provides a number of documents on community collaboration largely initiated by the courts. *See* http://www.courtinfo.ca.gov/programs/community/

38. In other countries where therapeutic courts have been created, the judge as community leader is also considered essential. For example, a commentary reporting on such courts in Australia, Canada, and the United States observed "Judges in community courts are expected to have a high profile in the local community and to maintain good contacts with the community leaders. This is outside the normal judicial role." JOYCE PLOTNIKOFF & RICHARD WOOLFSON, REVIEW OF THE EFFECTIVENESS OF SPECIALIST COURTS IN OTHER JURISDICTIONS (2005), available at http://www.dca.gov.uk/research/2005/3_2005.pdf.
39. Conference of Chief Justices, *supra* note 1.
40. The identification of needs within a particular system has become quite sophisticated in recent years. One example, called Sequential Intercept Mapping Training, enables community representatives to create a map of how individuals with mental illnesses move across the criminal justice (and treatment) systems. In turn, this permits better planning for the allocation of assessment and treatment resources, as well as the identification of gaps in services. Information about this training may be obtained at http://gainscenter.samhsa.gov/html/tta/trainings.asp.
41. There are many examples of judicial leadership in convening community stakeholders on these issues. One occurred in Miami, Dade County, Florida, where the county was paying 16 million dollars per year to house and treat people with mental illnesses in the jail. Under the leadership of Judge Steve Leifman, a summit of key stakeholders was convened; this in turn led to the creation of Miami-Dade's 11th Judicial Circuit Criminal Mental Health Project under Judge Leifman's leadership. The group, which continues to meet, has been instrumental in efforts to create systemic responses to these issues. For a description, *see* http://www.naco.org/CountyNewsTemplate.cfm?template=/ContentManagement/ContentDisplay.cfm&ContentID=8091. In Broward County, Florida, Judge Mark Speiser created a multiagency Criminal Justice Mental Health Task Force in 1994. The Task Force continues to meet and has spawned a number of initiatives, including two mental-health courts (the first a misdemeanor court, the second a felony court) and specialty probation. In Ohio, Supreme Court Justice Evelyn Stratton has been a forceful advocate for the creation of mental-health courts, and, at least in part as a result, Ohio has more mental-health courts than any state in the United States. More recently, the Florida Supreme Court, under Judge Leifman's leadership, published a comprehensive report suggesting reforms in both the mental-health and criminal justice systems to provide better care for people with mental illnesses at risk of entering the criminal justice system. The report can be found at http://mhlp.fmhi.usf.edu/web/mhlp/documents/Supreme-Court-Report-2007.pdf.

abuse diagnoses. Treatment is often lacking for people with co-occurring disorders in the general population, and so the lack of adequate treatment capacity will be an issue confronting therapeutically oriented judges as well.[42]

Given these difficulties, judges may find themselves a part of an effort to create or design treatment and other services for defendants. Certainly there is precedent for this; judges presiding over drug courts are often intimately involved in overseeing treatment, and drug courts may operate services directly as well as contract with other treatment providers.[43] While a discussion of appropriate treatment services for defendants with mental illnesses is beyond the scope of this article, a judge in this position might consider the following:

First, creation of the capacity to assess serious mental-health issues rapidly and effectively is important, clinically and programmatically. From a clinical perspective, early assessment increases the chances for effective treatment to be provided. From a programmatic perspective, early assessment is important in determining whether an individual is suited for a particular intervention, for example, whether the individual meets criteria governing admission to a mental-health court. Therefore, the availability of good assessment services is critical, whether a community focuses on pre-arrest diversion, therapeutic courts, or post-sentencing alternatives such as specialty probation.[44]

Second, the development of treatment services does not occur in a scientific vacuum. In recent years, there has been a move toward the use of "evidence-based practices" for treating mental illnesses. Such practices are based on research and have been described as "specific interventions and treatment models that have been shown to improve client functioning and the course of severe mental illness."[45] According to the President's New Freedom Commission on Mental Health, a number of treatments can be characterized as evidence-based practices, including specific medications for specific conditions, cognitive and interpersonal therapies for depression, preventive interventions for children at risk for serious emotional disturbances, multisystemic therapy, parent-child interaction therapy, medication algorithms, family psycho-education, assertive community treatment, and collaborative treatment in primary care.[46] It should be noted that these treatments have not been proved effective in treating every type of mental illness, and therefore should not be adopted without first considering the clinical profile of individuals that are the focus of an intervention. However, they can provide a common frame of reference for discussions between representatives of the criminal justice and mental-health treatment systems.

Frequently the discussion is framed in terms of whether the judiciary should be expected to behave in one of two polar-opposite ways.

Third, the use of "boundary spanners" seems essential to cross-system collaboration. Henry Steadman describes boundary spanners as positions that link two or more systems whose goals and expectations are at least partially conflicting.[47] Specifically, an individual in a boundary-spanning position manages the day-to-day interactions between the criminal justice and mental-health systems. Whether the person works for the criminal justice system or the mental-health system is less important than whether the person has authority to make decisions regarding interactions between the systems.[48]

The judge as advocate. Judges may not act as lobbyists for ethical and legal reasons. However, judges increasingly play a role as advocates for services to people with mental illnesses. This role as advocate is a natural out-growth for a judge who becomes a community leader on these issues or who presides over a therapeutic court such as a mental-health court.

42. The President's New Freedom Commission on Mental Health found that individuals with co-occurring mental-illness and substance-abuse disorders are "treated for only one of the two disorders—if they are treated at all." According to the Commission, only 19% of individuals with serious co-occurring disorders received treatment for both disorders, while 29% received treatment for neither. The Commission observed that such individuals often use the most expensive forms of care, including hospital emergency rooms and inpatient facilities, and that the lack of treatment increased their risk for suicide attempts, violent behavior, legal problems, serious medical problems, and homelessness. *See* ACHIEVING THE PROMISE, *supra* note 14.
43. For a good overall discussion of drug courts, including recidivism and treatment issues, *see* U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES (2005), available at http://www.gao.gov/new.items/d05219.pdf.
44. Rapid assessment has long been a benchmark of drug-court programs, and it is also considered critical in the treatment of mental illnesses more generally. *See, e.g.*, NAT'L ASS'N OF DRUG CT. PROFESSIONALS, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997 ed., reprinted 2004), available at http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf. *See also* ACHIEVING THE PROMISE, *supra* note 14.
45. COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 251 (2002), available at http://consensusproject.org/downloads/Entire_report.pdf. Policy Statement No. 35 of the consensus project report urges the use of evidence-based practices in mental-health treatment. *Id.* at 250-56.
46. ACHIEVING THE PROMISE, *supra* note 14, Goal 5. The development of evidence-based practices is in an embryonic stage, and there is not complete consensus on which treatments should be classified as evidence-based practices. In addition, most jurisdictions rely on a treatment system in which some or all such practices are absent. This does not mean that treatment in such jurisdictions is necessarily suspect in all cases; however, in developing services to fill gaps in treatment, it seems useful to focus on evidence-based practices as an anchor for discussion.
47. Henry J. Steadman, *Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems*, 16 LAW & HUMAN BEHAV. 75 (1992).
48. Steadman notes that there is no best way to create a boundary-spanner position and that deciding where to place a boundary-spanner position "depends upon local politics, history, economics, and personalities." *Id.* at 84 n.23.

An example of such advocacy, as part of a broader coalition of stakeholders, is provided by the Florida Partners in Crisis. This coalition was begun in central Florida in 1999 under the leadership of Judge Belvin Perry in response to mental-health and substance-use issues affecting the mental-health system. Members include judges, law-enforcement officials, behavioral-health providers, correctional officials, and family members. Partners in Crisis has a number of goals, including increasing public awareness of mental-health and substance-use service needs throughout Florida.[49]

The emergence of organizations like Partners in Crisis is an important development politically. For years, mental-health providers, in particular, were suspicious of the legal system and the courts for a variety of reasons including malpractice concerns, and treatment providers also associated client involvement in the legal process with long, uncompensated hours spent waiting to testify. However, given declining financial support for mental-health services in many states, and given the reality that law-enforcement officials typically have more clout politically than mental-health providers, a coalition such as Partners in Crisis has the potential to focus legislative and executive branch attention on service needs in a way that treatment providers, acting alone, often cannot.

The judge as a member of the treatment team. Finally, therapeutic courts, in particular, require the judge to play a role that may conflict with the more traditional role of the judge. One commentator in this journal has written, "Specialized courts...are manifestations of a change in the role of the judge from 'dispassionate, disinterested magistrate' to that of a 'sensitive, emphatic counselor."[50] Justice Kaye, Chief of the New York Court of Appeals, has observed that therapeutic courts require a change in the role of lawyers as well, writing that in therapeutic courts, "the lawyers also have new roles. The prosecution and defense are not sparring champions, they are members of a team with a common goal: Getting the defendant off drugs. When this goal is attained, everyone wins. Defendants win dismissal of their charges...the public wins safer streets and reduced recidivism."[51]

Others have criticized these roles on a number of grounds including a claim that they may lead to the derogation of important legal rights enjoyed by the defendant. As noted earlier, this conflict over judicial role is not new. Boldt, for example, has argued that the creation of a "therapeutic relationship" between judge and defendant may compromise the role of defense counsel, among other things.[52]

Indeed, these arguments over the appropriate role of judges and lawyers have been at the heart of many of the debates regarding such roles in the context of civil commitment.[53] As with other role issues discussed in this article, judges will make individual decisions regarding the roles they wish to play, but the potential role conflict is worth noting.

Judges are providing critical leadership in communities across the United States in responding to the crisis of mental illness in the criminal justice system. In doing so, judges have adopted new and sometimes unfamiliar roles. While not all judges are comfortable with these new roles, it seems clear that in many instances, reform is simply impossible without judicial leadership.

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49. For a description of Partners in Crisis and its membership and activities, *see* http://www.flpic.org.
50. David Rottman, *Does Effective Therapeutic Jurisprudence Require Specialized Courts (And Do Specialized Courts Imply Specialist Judges)?*, COURT REVIEW, Spring 2000, at 22. Rottman provides an excellent summary of the arguments for and against specialization. He concludes that "the long-term future of the new specialized courts depends upon their successful incorporation into larger trial court systems...the investment of so many resources in special courts must ultimately be justified in terms of their role as agents of change beyond a few courtrooms." *Id.* at 26.
51. Judith Kaye, *Lawyering for a New Age*, 67 FORDHAM L. REV. 1 (1998).
52. Richard C. Boldt, *Rehabilitative Punishment and the Drug Court Treatment Movement*, 76 WASHINGTON UNIV. L.Q. 1206 (1998).
53. The most used legal textbook on mental-disability law notes "numerous studies have documented that attorneys rarely spend more than a few minutes preparing for the [civil commitment] hearing, seldom call witnesses, and usually fail to engage in vigorous cross-examination of the experts." RALPH REISNER, CHRISTOPHER SLOBOGIN & ARTI RAI, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 800 (4th ed. 2003).

Criminalization of Mental Illness

The Issue

The long-term trend of deinstitutionalizing people with mental illness – that is, releasing people from psychiatric hospitals to reside and be treated in the community – has been heralded by many as a step forward in the social acceptance and respectful treatment of people with mental illness. With the advent of new, more effective medications and better understanding of the range and types of community supports people with mental illness require, many people with mental illness live successfully in the community.

For a minority of people, usually those with multiple complex needs, deinstitutionalization combined with a lack of comprehensive community support systems has resulted in another type of 'institutionalization,' within prisons and jails rather than hospitals.

This is only one of the factors leading to an increase in what is generally known as the 'criminalization of mental illness,' i.e., where a criminal, legal response overtakes a medical response to behaviour related to mental illness. This is a distressing trend, with a number of contributing factors.

Ways Mental Illness is Criminalized

Research consistently shows us that a person with mental illness is more likely to be arrested for a minor criminal offence than a non-ill person. The majority of these arrests are for crimes – such as causing a disturbance, mischief, minor theft, failure to appear in court – directly or indirectly related to the mental illness. The majority of these arrests are also initiated by a report from a member of the public, rather than the police.

The range of mentally disordered offenders (i.e. persons with mental illness convicted of an offence) currently in jails and prisons is somewhere between 15 to 40%; highly disproportionate to the occurrence of mental illness in the population at large.

A number of factors contributing to the disproportionate incarceration of persons with mental illness have been identified in research literature:

- **Lack of sufficient community support** including housing, income, and mental health services. Persons with mental illness have a harder time finding employment and housing, and maintaining consistent contact with friends, relatives and treatment providers. It is estimated that 30%–35% of Canada's homeless population have a mental illness. Many become isolated, homeless, hungry, and poor due to the symptoms of their illness.
- **High rate of substance abuse.** Over 50% of people with mental illness have a co-occurring substance use disorder. Co-occurring disorders (mental illness and substance use disorder) are more difficult to treat than either mental illness or substance abuse alone, and there are insufficient treatment programs for the growing demand.
- **The 'Forensic' label.** Treatment is sometimes refused to persons who have committed a criminal offence or have been previously incarcerated. Hospital staff may refuse admission because it is considered a criminal matter, or the person may be considered too dangerous or disruptive for treatment by community resources – even if the offence for which the person was arrested or convicted does not involve violence.

- **Problems with treatment.** Some persons with mental illness try numerous treatments without success. Others refuse treatment because they cannot accept that they have an illness, they dislike medication side-effects, or due to symptoms of the illness itself. Lack of sufficient housing, income, and support also interfere with the ability to maintain treatment.
- **Lack of specialized cross-training for both criminal justice and mental health professionals.** Both systems need to provide information and training to staff on understanding mental health and law enforcement issues, respectively, in order to create successful collaboration.
- **Lack of timely access to mental health assessment and treatment.** Easy access is necessary for early intervention and prevention of deterioration, and also to provide law enforcement, courts, corrections, and communities the ability to access appropriate treatment for individuals in a timely way.

Research also indicates that incarceration is more problematic for a person with mental illness. People with mental illness also are more likely to be victimized by others and may exhibit disruptive behaviour as a symptom of their illness. Disciplinary measures including segregation or solitary confinement can be highly traumatic and cause breakdown or psychosis for a person with mental illness.

For a number of reasons, persons with mental illness are more likely to be arrested, detained, incarcerated, and more likely to be disciplined, rather than treated, while incarcerated. Once arrested and convicted, persons with mental illness are more likely to be arrested and detained again, repeating the cycle.

What Needs to Change

Most people would agree that a person with mental illness should be treated rather than punished. Police must be better trained to recognize symptoms of mental illness and have the capacity to immediately refer to mental health services instead of the criminal justice system. The courts must become more educated on the issues and solutions for persons with mental illness, and the corrections service must develop screening and appropriate treatment and care for offenders with mental illness and ensure appropriate post-release support. Most importantly, people with mental illness must have adequate and appropriate support in the community in terms of housing, income, job skill development and, above all, timely access to assessment and treatment through the mental health system.

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BC DIVISION

THE ROLE OF COLORADO COURTS IN ADDRESSING MENTAL ILLNESS ISSUES | 2008

FROM DSM-IV to C.R.S. § 27-10: UNDERSTANDING MENTAL ILLNESS **FRIDAY, MAY 16, 2008** **1:30 – 3:30 P.M.**	Introduction & Overview **Judge C. Jean Stewart** Keynote Speaker **Justice Alex Martinez** Panelists: **Justice Alex Martinez** **Dr. Richard Martinez** **Dr. Carolyn Tank** **Dr. Carl Clark** **From DSM IV to C.R. S. §27-10.** The purpose of this session is to provide the class with a very broad and basic understanding of clinical disorders that might give rise to a decision to certify a patient for involuntary treatment. Assist with an understanding of how certifying professionals reach the ultimate conclusion to certify; how the criteria of §27-10 are tested and applied; when disorders of thought or mood or behavior may be present but insufficient (*i.e.*, inadequate to meet Axis I diagnostic criteria or C.R.S. §27-10 standards) to substantiate a certification; how the certification and treatment processes proceed in the clinical setting, including observations about violence, child to geriatric issues, and related issues. Making the Axis I diagnosis and differentiating other diagnoses. Chronic vs. acute mental illness Addressing adults, children, the aging population with mental illness Identifying potential for violence How, where and when the mentally ill enter the court system C.R.S. §27-10 criteria The decision to certify Managing the certified patient inpatient/outpatient issues
CLE: (2) general credits	**Note**: There will be future separate classes on the certification process itself, on medications, on addictions, and on the criminal proceedings (incapacity to proceed and insanity defense). Hence this initial presentation allows the panel to focus on the disease process itself only as it leads to certification for involuntary treatment pursuant to state law.

CIVIL COMMITMENTS **FRIDAY, JUNE 6, 2008** **1:30 – 3:30 P.M.** **CLE accreditation** **(2) General** **(1) Ethics**	Panelists: **Judge Stewart** **City Attorney Michael Stafford** **Respondent Attorney Stuart Kutz, Ph.D.** **Doctor Bruce Leonard** **Respondent's perspective/MH advocate Heather Turner, JD** **Certification Review Process** C.R.S. §27-10-101, et. seq. Mental health certifications in Colorado are initiated by medical personnel, not by the court system. During the second session we will focus on the limited involvement of state courts after a mental health certification has been filed with the court. We will review: (1) the standards community treatment facilities must meet and maintain in order to be designated as approved §27-10 facilities; (2) procedures and forms approved by the Colorado Supreme Court for use in connection with certification, transfers, termination and related actions; (3) standards for appointment of Respondent's counsel; (4) conduct of court proceedings for review of certifications, including the standard of proof and each element that the People must prove to sustain the certification. In addition, we will provide an overview of the process for maintaining certification and provide some insight into various treatment models—inpatient and outpatient. Ethics: Discussion of changes in Rule 1.14 and whether attorneys feel free to fully advocate, an attorney's role as "counselor" (whether the advice is taken or not). Panelists will also discuss issues of following the client's directives to contest as compared to the attorney's control over the presentation of evidence (which can lead to disputes with clients, who may want to put on some evidence that is not justifiable or reasonable). Also, situations where the client refuses to communicate, or work with, counsel, and the attorney's role under those circumstances.

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MEDICATIONS **FRIDAY, JUNE 27, 2008** **1:30 – 3:30 P.M.** **CLE credits** **(2) general**	Update on psychiatric medications People v. Medina: case discussion and medications hearing checklist ECT Panelists: **Judge Stewart** **City Attorney (Ret.) Morris Evans** **Respondent Attorney Frank Slaninger** **Respondent Attorney Ken Ogawa** **Doctor Karen Fukutaki** Pursuant to the Colorado Code of Regulations, 2 CCR 502.1 (2007) **Care and Treatment of the Mentally Ill**, a physician may use emergency medications under limited conditions, including imminent danger to self or others; provided that **emergency medications** cannot continue for more than 72 hours without petition to the court for **involuntary medications,** including typical and atypical psychotropic medications, new medication trends, and use of electro-convulsive therapy. The purpose of this session is to discuss psychiatric medications, the legal procedures for utilizing emergency medications and seeking involuntary medications orders from the court. The panelists will discuss *People v. Medina*, 705 P.2d 961 (Colo. 1985) and the standards applicable in the institutions and in the courts for use of emergency and involuntary medications. Morris Evans, retired Denver City Attorney, who argued the Medina case in the Colorado Supreme Court will join the panel. Ethical issues will be examined by the panelists who deal with these matters regularly.

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ADDICTIONS **FRIDAY, JULY 11, 2008** **1:30 – 3:30 P.M.** **CLE accreditation (2) general credits**	ADDICTIONS Panelists: **ADAD Yolanda Gray, MA, LAC** **Judge C. Jean Stewart** **Arapahoe County Attorney Ginny Horton** **Respondent Attorney Stuart Kutz, Ph.D.** **Dr. Douglas Ikelheimer** **Involuntary Commitment of Alcoholics** C.R.S. §25-1-311 **Involuntary Commitment of Drug Abusers** C.R.S. §25-1-1107 In Colorado a person may be committed by the Court to the custody of the Division of Alcohol and Drug Abuse – such petitions are initiated by spouses, family members, caseworkers, health care providers, not by the court system. During the fourth session we will focus on: 1) the biology of addictions; 2) procedures and forms approved by the Colorado Supreme Court for use in connection with involuntary commitments, evaluations, placements, termination and related actions; 3) the process from filing a petition to Court approval, with discussion of why so few of these cases proceed to hearing, and why the participation of the Respondent is a critical component to successful treatment; 4) contrast of role of counsel in the certification process versus that of the involuntary commitment process (alcohol and drug respondents are not presumptively deemed incompetent, so Court must only appoint counsel upon Respondent's request); 5) role of attorney as client's advocate, oversight of the placement; 6) Discussion of various treatment models – inpatient and outpatient.

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CRIMINAL ISSUES **FRIDAY, JULY 25, 2008** **1:30 – 3:30 P.M.** **(2) CLE credits**	Insanity Defense & Capacity to Proceed to Trial Panelists: **Justice Alex Martinez** **Dr. Richard Martinez** **Iris Eytan, Esq.** **Chief Deputy District Attorney Lamar Sims** **Mental Incompetency to Proceed** **C.R.S. § 16-8-110, *et seq.*** What happens when it appears a defendant cannot understand the nature and course of criminal proceedings; or participate or assist in defense, or cooperate with defense counsel? Session five covers the scientific standards applied for assessing competency to proceed to trial, legal issues and procedures in Colorado. This course will cover practical matters: how does a district court judge in Colorado order a defendant to CMHI-Pueblo for a forensic evaluation, overview of the evaluation process, when (and how) the defendant returned to court, determination of restoration to competency, termination of proceedings. **Insanity Defense** **C.R.S. § 16-1-101, *et seq.*** Pleading insanity as a defense in Colorado: what is the law in Colorado, how is it the insanity defense asserted in the state, standards and criteria for application of this defense, Colorado's stance in context of other states. Discussion of the science of the insanity defense, and the contrast between the criminal nature of the insanity procedure versus the civil commitment process. **PLUS:** Discussion of two recent case announcements: 1) United States Supreme Court opinion in *Indiana v. Edwards* (right to proceed without counsel), the implications of the Edward opinion for Colorado cases; 2) Colorado Court of Appeals ruling on respondent's waiver of right to counsel. *The People in the Interest of Gunda Ofengand*, 07CA0845 (Colo. App. 2008); 3) And House Bill 08-1392

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TRENDS/ DEVELOPMENTS/ OTHER ISSUES

FRIDAY, AUGUST 1, 2008

1:30 – 4:30 P.M.

Please note: this session will be a *three-hour* course

CLE accreditation
(4) general
(1.2) ethics

1:30—1:45PM
Introduction
Discussion of Developmental Disabilities & Deprivation of Legal Rights
Presented by Hon. C. Jean Stewart
Presiding Judge, Denver Probate Court

1:45 –2:30PM
Dual diagnoses, alternative and complementary treatments
Presented by Libby Stuyt, MD
Medical Director, Circle Program, CMHI- Pueblo

2:30—3:30PM
Special Groups
2:30—3:00PM – Veterans Issues
Presented by David Iverson, MD
Director of Outpatient Mental Health for the Denver VA Hospital and the Eastern Colorado Health Care System
3:00—3:30PM – Pediatric and Geriatric Patients
Presented by Bruce Leonard, MD
Director, CMHI-Ft. Logan
Robert Hernandez, MD
Director of Pediatric Programming, CMHI-Ft. Logan

3:30—4:00PM
A Dialogue on Mental Health Courts
Presented by:
City Attorney (Ret.) Morris Evans
Respondent Attorney Stuart Kutz, Ph.D.
Regina Huerter, Executive Dir., Crime Prevention and Control Commission
Shari Lewinski, LPC, CAC III, "Court to Community" Court Coordinator

4:00—4:30PM Questions & Answers, Group Discussion

This is the sixth and final session in the Probate Court's educational series. During this session, our panelists will discuss trends and developments in the treatment of mental illness in Colorado. We will address alternate therapies and dual diagnoses, and will focus on special groups of persons: the developmentally disabled, veterans, children and the aging. Our panelists will lead discussion of mental health specialized courts. The course will conclude with an extended question and answer session and open discussion.

Care and Treatment of the Developmentally Disabled
C.R.S. §27-10.5-101, *et. seq.*

Imposition of Legal Disability – Removal of Legal Right
C.R.S. §27-10.5-110

Colorado law prohibits the deprivation of liberty of persons with developmental disabilities, except when such deprivation is for the purpose of providing services and supports which constitute the least restrictive available alternative adequate to meet the person's needs, and to ensure these services and supports afford due process protections. We will review the process that follows when an interested person petitions the court to impose a disability on, or remove a legal right from, a person with a developmental disability.

Trends and Developments in the Treatment of Mental Illness

CMHI-Pueblo is home to the Circle Program which serves dually-diagnosed substance abuse patients from the entire state of Colorado. This program provides treatment for patients identified with the most severe chemical dependencies and psychiatric disorders. The program requires that each patient remain tobacco-free while in treatment and provides an integrated treatment approach that actively addresses the individual's psychiatric disorders, chemical dependence, and criminal conduct through medications, individual and group psychotherapy, and other state-of-the-art treatments such as acupuncture, biofeedback, thought field therapy and brain synchronization therapy.

Special Groups
Veterans

Dr. Iverson will discuss the state of the current Veterans Administration system and will focus on Post-Traumatic Stress Disorder and its relevance to C.R.S. § 27-10.

Children and the Aging

Doctors Leonard and Hernandez will discuss the care and treatment of mentally ill children and elders; the growing trend of mental illness in pediatric patients; the complications associated with administering medications to children, whether the funding provision of Colorado's Child Mental Health Act have had a noticeable impact on the availability of care and treatment to children (C.R.S. §27-10.3-106).

	We will also cover the challenges of treating the geriatric person with mental illness: complications arising from the combination of mental illness and dementia, and the administration of medications to the elderly. In light of the trend of the aging population, we will ask where Colorado intends to house its geriatric mentally ill. **Mental Health Courts** Our panelists will discuss the nationwide trend of specialty mental health courts, the development of such courts in Colorado, and the positive aspects and limitations of such courts. We will have an introduction to Denver County's "Court to Community" program, which aims to address the needs of persons identified as having a mental illness who have been charged with municipal violations. Ethics: *Can we find an ethics credit in this course?* *Discussion of changes in Rule 1.14 and whether attorneys feel free to fully advocate, an attorney's role as "counselor" (whether the advice is taken or not). Panelists will also discuss issues of following the client's directives to contest as compared to the attorney's control over the presentation of evidence (which can lead to disputes with clients, who may want to put on some evidence that is not justifiable or reasonable). Also, situations where the client refuses to communicate, or work with, counsel, and the attorney's role under those circumstances.*

Solutions for the Mentally Ill in the Criminal Justice System

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio

November, 2001

Finding effective strategies for working with mentally ill persons in the criminal justice system is important to me, both personally and professionally.

As a family member of a person who once suffered from depression, I am aware of the stigma of mental illness. It is not a popular subject, but it is one that I am passionate about. As a former trial judge, I saw first hand the effects of mental illness on the legal system. I am extremely concerned about keeping people with mental illness out of jail and diverted into appropriate mental health treatment.

It is the right thing to do as well as a concept whose time has come. The numbers say it all.

- In 1955, there were 558,239 severely mentally ill patients in our nation's public psychiatric hospitals. In 1994, there were 71,619. Based on population growth, at the same per capita utilization as in 1955, estimates are that there would have been 885,010 patients in state hospitals in 1994. E. Fuller Torrey, M.D. in Out of the Shadows: Confronting America's Mental Illness Crisis, John Wiley & Sons, New York, 1997, page 8 -9

- Where have these severely mentally ill patients gone? Our jail population of people with mental illness has swelled to 285,000. According to a U.S. Department of Justice July 1999 Report, 16% of state prison inmates and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital.

- According to that same study, half of mentally ill inmates reported 3 or more prior sentences. Among the mentally ill, 52% of State prisoners, and 54% of jail inmates reported 3 or more prior sentences to probation or incarceration.

- In fact, according to March 2000 statistics from the Ohio Department of Rehabilitation and Correction, there were 6393 mentally ill inmates, 3051 of who were classified as severely mentally disabled.

- Many of the severely mentally ill who have been released into the community through de-institutionalization, are now part of the 600,000 people in America who are homeless. Of these, it is believed that at least a third are mentally ill. U.S. Department of Health and Human Services, 1992.

A revolving door problem has developed in this country. Jails and prisons have become the de facto mental health system of our day. We must reverse this trend. Over the past few years, innovative diversion programs and other

pioneering efforts across the nation have been successful in attacking this crisis. We must persevere to be able to provide community treatment for this population who were previously "warehoused," but who now are slipping through the cracks of our safety nets.

If not for altruistic reasons, this charge is crucial in terms of the cost savings to the taxpayer. Mentally ill inmates require far more jail and prison resources due to treatment and crisis intervention. But this revolving door has other costs, too. Taxpayer dollars are paying for police officers to repeatedly arrest, transport and process mentally ill defendants, jail costs associated with treatment and crisis intervention, salaries of judges and court staff, prosecutors and defense attorneys, and many more hidden costs. The question becomes would we rather spend these dollars to keep mentally ill citizens homeless, revolving in and out of our criminal justice system, or would we rather spend these dollars to help them to become stable productive citizens?

To address this problem, we have formed the Ohio Supreme Court Advisory Committee on the Mentally Ill in the Courts, made up of representatives from the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Rehabilitation and Correction, the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Office of Criminal Justice Services, Judges, law enforcement, mediation experts, housing and treatment providers, consumer advocacy groups, and other officials from across the state.

The Advisory Committee is working to establish local task forces in each county to bring similar local representatives together to collaborate and work on the issues of the mentally ill in the criminal justice system. We encourage each county to start a mental health specialty docket to deal with the issues, but have also found that the collaboration that results when all these groups get together goes far beyond the courtroom.

The Advisory Committee provides guidance, resources, materials and information to the local task forces. We provide role models of other successful mental health court dockets, encourage Crisis Intervention Training (CIT) for the police officers who deal with the mentally ill, and pass on grant and other funding opportunities to the task forces.

In the 1800's, the greatest challenge to the mental health and criminal justice systems was to get the mentally ill out of jails and prisons and into appropriate treatment. Still today, we face the same problem. But by joining forces and working together, we can make a difference.

Evelyn Lundberg Stratton is a Justice of the Ohio Supreme Court. To participate in the mental health initiative spearheaded by Justice Stratton, please call Melissa Knopp, Program Manager for Specialty Dockets at (614) 387-9427.

Mental Illness & Suicide in the Media

A Mindframe Resource for the Courts

c) Commonwealth of Australia

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The opinions expressed in this document are those of the authors and are not necessarily those of the Commonwealth.

Content developed by the Hunter Institute of Mental Health in consultation with an Advisory Group of experts, for the Mental Health and Suicide Prevention Programs Branch, of the Australian Government Department of Health and Ageing.

Designed by Advocart Pty Ltd

Publications approval number: P3-3362

The project website at **www.mindframe-media.info** contains the most up to date information and advice on how to obtain additional copies of the resource.

Foreword

In Australia, one in five people will directly experience a mental illness in their lifetime and recent data suggests about 1800 people take their own life each year. The media has an important role to play in influencing community attitudes towards and perceptions of both mental illness and suicide.

The courts are an important news source for most media organisations. Information is accessible, timely, and viewed as having high human or dramatic interest. Often, court stories involve themes of fear, horror or shock, and much information can be deeply personal and intimate. Through court and inquest proceedings journalists are privy to details about a person's mental health status, specific details about a suicide death, and claims made by witnesses, victims and experts called to give testimony.

Australian research[1] has indicated that the most problematic type of news coverage of mental illness and suicide results from information collected at courts and coroners courts, or from the police. While magistrates, coroners and other court officials may not talk directly to the media or seek out media coverage on a regular basis, their general dealings with journalists may have an impact on the way a story is developed.

Mental Illness & Suicide in the Media: A Mindframe Resource for Courts has been produced as part of the Australian Government's *Mindframe* National Media Initiative. This Initiative aims to encourage responsible, accurate and sensitive coverage of suicide and mental illness through a range of complimentary projects working with the media in Australia.

This resource provides practical advice and information for judges, magistrates, coroners, media liaison officers and other court staff to support their work with the media. This may be through indirect means, such as statements and remarks made in court, or directly through comments or information provided to the media.

As representatives of peak media bodies, suicide prevention and mental health organisations and the Australian Government, we commend this resource to you.

National Media and Mental Health Group, April 2008

About this resource

This resource contains practical information for courts to support their direct and indirect interactions with the media. It contains suggestions for providing or managing information about mental illness or suicide that are consistent with best practice guidelines for reporting.

'I don't want to be told what to say and do, but I do want to be informed about what I say and do'.

This resource has been developed as part of the *Mindframe for Police and Courts* Project. It was developed by the Hunter Institute of Mental Health in consultation with an Advisory Group of experts, with funding from the Australian Government Department of Health and Ageing as part of the *Mindframe* National Media Initiative.

The development of this resource has been informed by consultations with a variety of stakeholders across Australia, including:

- Media liaison officers in departments of justice;
- Individual judges, magistrates and coroners;
- Administrators of courts;
- Media professionals;
- Mental health and suicide prevention experts;
- Members of the National Media and Mental Health Group.

This resource is also available in electronic form at **www.mindframe-media.info**

Contents

Acknowledgements

This resource was developed by the Hunter Institute of Mental Health, in partnership with an Advisory Group of experts, for the Mental Health and Suicide Prevention Programs Branch of the Australian Government Department of Health and Ageing.

People involved in the **development** of this resource include:

Jaelea Skehan, Martin O'Connor, Michael Romeo, Amy Visser & Trevor Hazell (Hunter Institute of Mental Health); Jane Johnston (Griffith University); Terry Anderson (South Australia Courts); Elizabeth Gaynor (Victoria County Court); John Arms (NSW Coroner's Courts); Sue Hunt, Annabel Dobson & Kirrily Cornwell (Department of Health and Ageing).

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Part 1: For Judicial Officers

Consider the potential impact of the story and whether to make official media comment.

- Consider if you are able to provide comment or advice to media professionals. Do you need advice or support from your media liaison unit?
- Think about whether the story is likely to have benefits for the community. That is, does it provide an opportunity to increase community understanding, highlight groups at risk or promote help-seeking behaviour in some way? If this is the case, consider in what ways you may be able to have input.
- If the story is generally about suicide or suicide prevention, you may want to refer the journalist to the 'expert comment' section of the *Mindframe* website.

Avoid specific description of the method and location of suicide and consider how to manage this information in the courtroom.

- Where possible, avoid or minimise any detailed discussion of method or location of suicide. Reporting that includes detailed description or images of method and/or location of a suicide has been linked in some cases to further suicides using the same method or location.
- Consider whether summary remarks and official statements need to include detailed descriptions of the method and/or location of suicide. Use alternatives that do not provide specific details. For example:

Say...		Rather than...
the person took a 'cocktail of medications that should not be available over the counter'.	→	*outlining the specific medications that were taken and where they were sourced.*
the person 'fell to their death from a spot close to the CBD that should have been fenced'.	→	*they 'jumped from a known suicide spot, the Skyline building on Smith Street, which still only has a 3 ft safety fence'.*
the person 'took their own life in a hospital room' because appropriate mechanisms to ensure safety were not in place.	→	*'she used her bed sheet to hang herself from the ceiling fan' because the hospital failed to remove hanging points.*

- Consider how to manage details of the method or location that are raised as part of the proceedings. Is there an opportunity to remind journalists about their codes of practice that discourage any detailed description of method or location of a suicide death?
- When making recommendations about duty of care that may involve suicide methods, or highlighting the need for preventative measures at 'suicide spots', consider whether providing details may do more harm than good. For example, media stories highlighting the need for further fencing at a particular location may in fact increase rates of suicide from that location.
- Be mindful that for many Aboriginal and Torres Strait Islander communities there are cultural protocols around naming and showing pictures or video of a person who has passed away. Consider how to manage this information in the courtroom.

Check your language does not glamorise suicide or present it as normal or an option for dealing with problems.

- Have you considered the impact of verbal and written language you use about suicide? The language used in media reports can contribute to suicide being presented as glamorous, normal or as an option for dealing with problems.
- Consider how you might manage inappropriate language raised in the courtroom. Always use appropriate language when talking about suicide from the bench. For example:

Use...		Rather than...
'non fatal' or 'attempt on his/her life'	→	*'unsuccessful suicide'*
'took their own life' or 'died by suicide'	→	*'successful suicide' or 'committed suicide'*
statements such as 'increasing rates' or 'cluster of deaths'	→	*'suicide epidemic' which is sensationalist and inaccurate*

- Avoid simplistic explanations that suggest suicide might be the result of a single factor or event. This may be difficult when discussing a specific case, but ensure comments do not generalise one case to all cases.

Part 2: For Other Officers of the Court

Consider the potential impact of the story and whether to make official media comment.

- Find out what the journalist needs. Is the issue about an inquest or case or more generally about suicide or suicide prevention? Consider if you are the most appropriate person to be commenting on the issue under question.
- Avoid engaging in repetitive, prominent or excessive reporting of suicide, which may normalise suicide. This has been linked to increased rates of actual suicide. This does not, however, mean that all suicide reports should be avoided.
- Think about whether the story is likely to have benefits for the community. That is, does it provide an opportunity to increase community understanding, highlight groups at risk or promote help-seeking behaviour in some way? If this is the case, consider in what ways you may be able to have input.
- While you always have the option of saying 'no' you may want to consider the impact of not participating in a story. That is, the story may still be run without expert comment and advice.
- If the story is generally about suicide or suicide prevention, you may want to refer the journalist to the 'expert comment' section of the *Mindframe* website at **www.mindframe-media.info**
- You may want to designate at least one person who can discuss 'ways of reporting suicide' with media professionals who approach your jurisdiction and ensure they are aware of the *Mindframe* resources for media professionals. This may be a public affairs unit or an identified media liaison representative.

When deciding whether to participate in a story you may want to consider what type of media is making the approach and whether you are best placed to provide them with information. Do they require general information or information related to a specific case before the courts or coroner?

Avoid specific description of the method and location of suicide and instruct media to be cautious with this information.

- Details regarding the method and location of a suicide may be an important part of a coronial inquest, and included in documents and statements relating to the proceedings. Take any opportunity to remind journalists about their codes of practice that discourage any detailed description of method or location of a suicide death.
- Consider alternative suggestions for ways to talk about the method and location that do not provide specific details (see page 19 for some examples).
- For suicide deaths involving an Aboriginal or Torres Strait Islander person, be mindful of releasing their name or details to the media. Where the information is made public, request that media professionals respect appropriate cultural protocols.

Consider how to include information that will improve community understanding.

- Placing stories about suicide in the context of risk factors can assist in breaking down myths about suicide, and promote a better understanding of it as a wider community issue. This may be done directly through your work with the media, or in partnership with mental health and suicide prevention experts.
- Avoid simplistic explanations that suggest suicide might be the result of a single factor or event. This may be difficult when discussing a specific case, but ensure comments do not generalise one case to all cases.
- Provide suicide prevention information such as risk factors and warning signs and encourage its inclusion in the story (see pages 41-43).
- Provide information in simple terms and without jargon.

Consider the impact of a media story on people bereaved by suicide.

If the media wish to interview those who have been bereaved by suicide, be aware that these people may be quite vulnerable. People bereaved by suicide may be at risk of experiencing mental health problems and possibly taking their own lives. They may be particularly vulnerable in the first year following the death and on anniversaries after that time. Sometimes, the media may seek to access the bereaved at court or inquest locations. In these cases, they may need particular support from grief counselling services to deal with the distress of these interviews.

Include information that promotes help-seeking behaviour.

- Vulnerable people may be distressed by reports of suicide and in some cases may be prompted to harm themselves. As such, it is important that helpline numbers are included with all reports about suicide.
- Where possible provide media professionals with helpline numbers and information and suggest that the information is included in the report. Some numbers and services are provided on page 53. Alternatively refer the journalist to the *Mindframe* website.
- Preparing a list of contacts that you or your jurisdiction could use in stories will assist when deciding which details to give to media professionals. This may be particularly useful when information is required within a short deadline.

For most reports, a helpline such as Lifeline on **13 11 14** will be appropriate. It is important, however, to provide support information relevant to the audience for each story.

- Aboriginal and Torres Strait Islander people may prefer to see a health worker at their local Aboriginal Medical Service. See the VIBE website at **www.vibe.com.au**
- For Australians from culturally and linguistically diverse backgrounds it would be useful to include contact details for the relevant state transcultural mental health services as well as the national Telephone Interpreter Service (13 14 50). Information is available from Multicultural Mental Health Australia on 02 9840 3333 or **www.mmha.org.au**
- For young Australians it would be more useful to provide the Kids Helpline on 1800 55 1800, or websites such as **www.reachout.com.au**

Refer journalists to *Mindframe*.

- Are journalists covering the inquest or conducting an interview aware of the *Mindframe* guidelines for reporting suicide available from www.mindframe-media.info?
- Is there an opportunity to recommend they access the site for appropriate helpline numbers they can add and contact details for mental health and suicide prevention organisations that may be able to assist with the story?
- It is recommended that the *Mindframe* website be added to the bottom of all correspondence with media professionals that may involve suicide.

Mindframe Considerations for Media Professionals

Reporting Suicide and Mental Illness: A Mindframe resource for media professionals makes a number of suggestions for editors and journalists to consider when reporting suicide. These are based on research evidence into the impact of media portrayal of suicide, are consistent with industry codes of practice and are summarised below.

- Consider whether the story needs to be run and how many stories relating to suicide there have been in the last month, so as to avoid a succession of stories or a high volume.
- Refrain from using language that may glamorise or sensationalise suicide.
  - Avoid using the word suicide in a headline or lead, using phrases such as 'took their own life' as an alternative.
  - Refrain from using terms such as 'unsuccessful suicide', 'successful suicide' or 'committed suicide'.
  - Avoid sensational statements like 'suicide epidemic'. Statements such as 'increasing rates' or a 'cluster of suicides' are more accurate.
- Avoid detailed descriptions or visuals of the method and location of a suicide, and make comment on the wastefulness of the act.
- Take extra care when reporting celebrity suicide. This coverage has the potential to glamorise and normalise suicide and may prompt copycat behaviour.
- To reduce prominence, locate stories about suicide in the inside pages of a paper and further down the order of reports in TV or radio news.
- Follow media codes of practice around privacy, grief and trauma when reporting personal tragedy.
- Seek advice from recommended health experts and place the story in context by providing information about underlying causes and risk factors.
- Include helpline numbers and information about options for those seeking help.

A complete outline of 'issues to consider' for media professionals can be accessed from the *Mindframe* website at **www.mindframe-media.info**

About Mental Illness

This section includes some facts and statistics about mental illness as well as short descriptions of the more common illnesses. Comprehensive facts and statistics are available from the *Mindframe* website at www.mindframe-media.info

Clinical Definitions

Mental health is a positive term referring to a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community[50].

A **mental illness** (or **mental disorder**) is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. There are different types of mental illnesses and each of these will occur with a different degree of severity.

A **mental health problem** also interferes with a person's cognitive, emotional or social abilities, but may not meet the criteria of an illness. Mental health problems often occur as a result of life stressors, and are usually less severe and of shorter duration than mental disorders, although they may develop into mental disorders.

Legal Definitions

Mental illness – The legal definition of mental illness is more restricted. Mental Health Acts across Australia consider that a person's clinical diagnosis of mental illness can result in involuntary treatment if, owing to their illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary, for their own protection from serious harm, or for the protection of others from serious harm.

Mentally disordered – A person may be mentally disordered, even in the absence of a diagnosed mental illness, if their behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary for their own, or others' protection.

Specific Mental Illnesses

Depression

Mood disorders are those where a person's mood is distorted or inappropriate to their circumstances. The most commonly experienced mood disorder is depression. Clinical depression is more than just temporary unhappiness or feeling down. It is an illness that may be felt as a sadness that does not go away and/or an ongoing loss of pleasure and enjoyment in most activities.

Major depression will be experienced by one in five adults at some point in their lives and accounts for more days lost to illness than almost any other disorder, physical or mental[51]. Up to two fifths of Australia's young people experience depressed moods in any six-month period.

Some of the symptoms that often occur with major depression include: sleep disturbance, loss of energy and concentration, feelings of worthlessness, hopelessness and guilt, inability to cope with decisions, weight loss or gain, and thoughts of death.

Sometimes depression develops after a major event, such as a loss of a loved one or a separation. Depression may also occur after repeated stress or ongoing abuse. However, it can also occur without apparent cause and in people who have coped well with life previously. Sometimes depression will lift after only a few weeks. In other cases, the depression will continue for months or years, perhaps requiring hospitalisation, and affecting the person's life and relationships.

There are a number of treatments for depression, including professional counselling, psychotherapy and antidepressant medication. The vast majority of people experiencing a major depression will recover fully, sometimes without treatment. However, effective treatment can greatly assist people to recover much faster and can lessen the pain and the cost that may be associated with the illness.

Bipolar disorder

Bipolar disorder, previously known as manic depression, is characterised by recurrent episodes of extreme mood variation from major depression to very elevated mood (mania). The extent of mood range varies between people. Some experience both mania and depressed

mood, others only the 'highs' without depression. Episodes of both depression and mania can range from mild to severe. A person may also experience symptoms of psychosis (see page 29).

The symptoms of mania include: feeling very high and happy, increased energy and reduced need for sleep, rapid speech and thought, reduced inhibitions, grandiose plans and beliefs, and a lack of insight that these behaviours or beliefs are unusual.

These symptoms can be damaging to people's lives and relationships. People with bipolar disorder can have to contend with large debt, broken relationships and damaged reputations as a result of out-of-character behaviour during a manic episode.

Bipolar disorder is likely to be caused by several factors, including biochemistry, genetic inheritance, stress and sometimes seasonal effects[52]. Between episodes of low or high mood, people experience normal mood variation and are able to live full and productive lives. For some people, extreme mood swings occur regularly. For others, the highs or lows may be occasional with years of stable moods between.

Treatment for bipolar illness includes medication, psychological therapies and lifestyle changes.

Anxiety Disorders

Anxiety is a persistent sense of stress, fear or worry in the absence of a rational reason for these feelings. A person is said to be experiencing an anxiety disorder when they have an intense and paralysing sense of fear or a more sustained pattern of worrying, to the extent that it interferes with their everyday life. Some people experience physical sensations of fear, such as shortness of breath, a tight chest, racing heart or even dizziness. Approximately 20% of people will develop an anxiety disorder at some point in their lives[53]. This can occur at almost any age.

Many factors influence the development of an anxiety disorder, including genetic makeup, life experiences, developmental stage, family history, and factors such as stress and physical health. In some cases anxiety may be the result of a highly traumatic experience, such as torture or abuse. Many people with anxiety disorders also experience depression.

There are several different types of anxiety disorders. These share common symptoms, although the contexts in which the symptoms are experienced vary. The more common forms of anxiety disorders include: generalised anxiety disorder, panic disorder, phobic disorders, post-traumatic stress disorder and obsessive-compulsive disorder.

Anxiety symptoms can be treated using Cognitive Behavioural Therapy (CBT) or other psychological therapies. CBT works by focussing on changing the way a person thinks in order to modify how they respond to anxiety-provoking situations. Medication, such as anti-depressants, can also be useful for people experiencing severe anxiety.

Psychotic Disorders

Several mental illnesses are grouped under the term Psychotic disorders, which are characterised by some form of psychosis. Psychosis involves a loss of contact with, or distortion of, reality, which may include hallucinations or delusions, disorganisation of thought and lack of insight. These symptoms may cause difficulties in social situations and inability to cope with day-to-day living requirements.

Examples of psychotic disorders include: Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, Brief psychotic disorder, Delusional disorder, Shared psychotic disorder, Substance induced psychosis, and Psychosis due to a general medical condition.

The most common psychotic disorder is **Schizophrenia**. It is a serious mental illness which affects almost one person in 100[54]. The term covers several related disorders, all with overlapping symptoms. Each individual can have a unique combination of signs and symptoms and, therefore, a unique experience of the disorder.

The first onset of schizophrenia is typically in adolescence or early adulthood for males and a little later in females[55]. The onset may be rapid, developing over several weeks, or it may be slow, over months or years. Some people experience only one or more brief episodes and recover fully. Others may have to deal with the illness throughout their lives.

The symptoms of schizophrenia are grouped into two categories[56]. The term *positive symptoms* refers to an excess or distortion of everyday thought processes or perception (the process of acquiring, interpreting, selecting, and organising information gathered from the five senses). *Negative symptoms* refers to the onset of a loss or absence of everyday abilities.

Mental health clinicians use the umbrella term *psychosis* to describe the mental state of a person experiencing acute symptoms of schizophrenia. A *psychotic episode* is a term that describes a period of time whereby the positive or psychotic symptoms are highly active.

The positive symptoms of a psychotic episode include:

- **Thought disorder** – Thought disorder is a term that describes a persistent underlying disturbance of conscious thought and is classified largely by its effects on speech and writing[57]. Affected persons may: speak incessantly, invent words, use speech that reflects ideas switching from one train of thought to another or respond to questions with 'longwinded', unfocused or irrelevant answers.

- **Delusions** – A delusion is a fixed, false personal belief held with absolute conviction despite all evidence to the contrary. The belief is often pathological in nature, is outside the person's normal cultural practices and dominates their thoughts and behaviours[58]. Delusions are categorised according to their content. For example, delusions of persecution where there is a belief that another person or force is in some way interfering with the individual's life.

- **Hallucinations** – Hallucinations are false perceptions in the absence of a real external stimulus, affecting any of the five senses. The most common are auditory hallucinations which take the form of voices[59]. This occurs in 60–70% of people diagnosed with schizophrenia. Voices usually occur in the third person and provide a running commentary, arguing with the person or repeating the person's thoughts. Visual hallucinations occur in about 10% of people with schizophrenia, but are more indicative of an organic disorder.

Psychosis usually occurs in three stages:

1. *The Prodromal Phase.* A period of early symptoms and signs of schizophrenia that precede an acute fully developed psychotic episode. During this period (varying from weeks to years) a person experiences changes in their thoughts, feelings, behaviours and perception.

2. *The Acute Phase.* A period when positive symptoms of schizophrenia emerge. Most people come to the attention of mental health services and begin treatment at this stage.

3. *The Recovery Phase.* A period (6-8 months following acute treatment) when positive symptoms of the acute phase begin to dissipate, and negative symptoms become more prominent.

No cure is known for schizophrenia, but great advances have been made in early management and long term control of the illness. Early detection of the initial symptoms (early psychosis) and their management with medication, psychotherapy, social support and family programs can help to return the person to optimal functioning.

Personality Disorders

Personality Disorders are diagnostic categories used to describe specific types of personality problems. Clinicians use this term to describe patterns of thinking and behaviour that are extreme, inflexible and maladaptive[60]. Personality disorders may cause major disruption to a person's life and are usually associated with significant distress to the self or others. A person with a personality disorder has longstanding and persistent difficulties resulting from the way they feel about and view themselves, others and the world in general[61]. They often experience themselves as unworthy or different, experience others as uncaring or even hostile and may view the world as a dangerous place devoid of any real meaning or sense of purpose[62].

As a result of these ways of viewing themselves and the world, relationships – whether intimate or in work or social settings – are often fraught with difficulty. These difficulties are often so great that education, work and day-to-day living are disrupted to the point that significant social disadvantage may occur.

People with personality disorders experience an inner fragility and lack the resilience to cope with many of life's difficulties. Not only can stressful or adverse life events have a devastating impact on their wellbeing, but so too can the responses of others towards them.

Responses or actions of others which seem to confirm their sense of unworthiness or their expectation that others will treat them badly, for example, may lead to emotional responses of depression, anxiety, or even rage. These painful emotional experiences frequently lead to self-harm or suicide attempts. Substance abuse, compulsive behaviour or idiosyncratic preoccupations are other ways that people with personality disorders attempt to deal with their internal distress.

Treatment of personality disorders has generally been viewed as more difficult compared to other disorders. There is now, however, strong evidence for the benefit of certain types of therapies[63]. These are generally long-term and involve the development of a relationship with a therapist in which difficulties and their origins can be explored and understood, or in which new strategies, coping skills and alternative behaviours can be learnt.

Mental Illness in Australia

In 1997 the Australian Bureau of Statistics (ABS) conducted the *National Survey of Mental Health and Wellbeing*[64]. Findings of the adult survey are summarised below.

- Almost one in five Australians (17.7%) had experienced a mental illness at some time during the 12 months before the survey.
- Men and women experienced similar rates of mental illness. The incidence of mental illness was higher for men and women living alone than those living with other people. Similarly, rates of mental illness were higher among people who were separated or divorced (24% for men and 27% for women).
- Women were more likely than men to experience anxiety disorders (12% compared with 7.1%) and mood disorders (7.4% compared with 4.2%). Men were more than twice as likely as women to have substance abuse disorders (11% compared with 4.5%).
- People unemployed or not in the paid workforce had the highest rates of mental illness, a prevalence rate of 26.9% for unemployed men and 26% for unemployed women, compared with prevalence rates of 15.1% for men and 14.7% for women in full-time paid employment.
- Anxiety disorders were most common, and affected one in ten adults, followed by mood disorders 5.8% (of which depression is 5.1%), and substance use disorders – 7.7% (of which 6.5% is alcohol related).
- Women were more likely than men to use services for mental health problems.

Mental Illness and the Law

Research has found that, due to a range of reasons, people living with a mental illness may have particular barriers preventing them from participating in the legal system[65]. These barriers can be problematic for people appearing as witnesses or victims of a crime, as well as for those who may be accused.

The research indicated that people experiencing a mental illness often face difficulties in their day-to-day life. They are more likely to receive a low income, leading to problems with housing and homelessness. Additionally, the symptoms of some types of mental illnesses may manifest

as unusual behaviour, which may bring people displaying such symptoms to the attention of police. In extreme cases, such behaviour might result in charges such as offensive language and conduct, resisting arrest and assaulting police. This type of behaviour may be especially common in those with a coexisting substance abuse problem.

The particular barriers faced by people living with a mental illness are many and varied. Some of the key issues highlighted by research include:

People with a mental illness may find the legal process particularly stressful, especially courtroom situations. They may already experience significant stress in their lives, arising from family, financial and housing problems and may find the extra stress involved in the legal process overwhelming.

Some mental illnesses are characterised by cognitive impairment, including memory loss and problems with planning and concentrating. This can lead to problems with keeping appointments and understanding legal proceedings and documents.

People with a mental illness are often viewed as less credible by those in the legal sector. They may also be viewed as less credible by police when making statements relating to being the victims of crime, which may be taken less seriously as a result.

Disability caused by mental illness

Mental illness can be more disabling for some people than many chronic physical illnesses. 'Disability' refers to the degree to which an illness interferes with a person's ability to work, take care of themselves or carry on relationships. International research[66] looked at the amount of disability caused by a number of physical and mental health problems. From that research, some illustrative examples can be made:

- The disability caused by moderate depression is similar to the disability from relapsing multiple sclerosis, severe asthma, chronic hepatitis B or deafness;
- The disability from severe post-traumatic stress disorder is comparable to the disability from paraplegia;
- The disability from severe schizophrenia is comparable to the disability from quadriplegia.

In the Australian context, mental illnesses rank as the third biggest health concern after heart disease and cancer.

Common Myths about Mental Illness

Myth: People who are mentally ill are violent.

Research indicates that people receiving treatment for a mental illness are no more violent or dangerous than the general population[67].

People living with a mental illness are more likely to be victims of violence, especially self-harm. It has been calculated that the lifetime risk of someone with an illness such as schizophrenia seriously harming or killing another person is just .005%, while the risk of that person killing themselves is nearly 10%[68].

There appears to be a weak statistical association between mental illness and violence in certain subgroups, for example – people not receiving treatment who have a history of violence, and those who abuse drugs or alcohol.

The correlation between episodes of violence in people experiencing mental illness is comparatively weaker than violent behaviour in the context of alcohol abuse and violent behaviour in young males between the ages of 15 and 25[69].

Myth: Mental illness is a life sentence.

Depending on the age of onset and the severity of the mental illness, generally speaking, most people will experience complete recovery, especially if they receive help early. Some people may require ongoing treatment to manage their illness.

Some people have only one episode of mental illness and recover fully. For others, episodes of mental illness occur occasionally with years of wellness between episodes. For a minority of those with a more severe illness, periods of acute illness will occur regularly and, without medication and effective management, leave little room for recovery.

Though some people experience significant disability as a result of a mental illness, many go on to live full and productive lives while receiving ongoing treatment.

Myth: Mental illnesses are all the same.

There are many types of mental illnesses and many kinds of symptoms or effects.

Though a particular mental illness will tend to show a certain range of symptoms, not everyone will experience the same symptoms – for example many people with schizophrenia may hear voices, while others may not.

Simply knowing a person has a mental illness will not tell you how well or ill they are, what symptoms they are experiencing, or whether they may recover or manage the illness effectively.

Mental illnesses are not purely 'psychological' and can have many physical features. While a mental illness may affect a person's thinking and emotions, it can also have strong physical effects such as insomnia, speech impediment, weight gain or loss, increase or loss of energy, chest pain and nausea.

Myth: Some cultural groups are more likely than others to experience mental illness.

Anyone can develop a mental illness and no one is immune to mental health problems.

People born in Australia have slightly higher rates of mental illness than those born outside Australia in either English-speaking or non English-speaking countries.

Many people from culturally and linguistically diverse and refugee backgrounds have experienced torture, trauma and enormous loss before coming to Australia. These experiences can cause significant psychological distress and vulnerability to mental illness.

Cultural background affects how people experience mental illness and how they understand and interpret the symptoms of mental illness.

Centre for Addiction and Mental Health

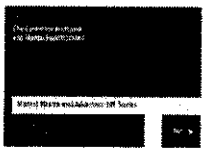
Interview

Information about mental health

CAMH has created materials to help clients and their families, professionals and the general public learn more about addiction and mental health issues. Our publications include helpful tips, answers to frequently-asked questions, best practices and emerging knowledge on different topics to help increase understanding, reduce stigma and promote informed decision-making.

For more information, check the online CAMH publications catalogue or call the CAMH McLaughlin Information Centre.

Online Self-directed Tutorials



The Mental Health and Addiction 101 series consists of a variety of quick, easy to use online tutorials for anyone who wants to learn more about mental health and addiction topics. This series includes tutorials such as: Introduction to Addiction, Anxiety Disorders, Bipolar Disorders, Depression, Older Adults, Posttraumatic Stress Disorders, Schizophrenia, Stages of Change, Stigma and more.

Anxiety Disorders

Anxiety Disorders : An Information Guide
This guide is for people with anxiety disorders, their families, partners, friends and anyone else who might be interested. The many aspects of anxiety disorders discussed in this book will answer some common questions, and help readers discuss anxiety disorders with treatment providers.

Bipolar Disorder

Bipolar Disorder: An Information Guide
A guide for people with bipolar disorder, their families and anyone who wants to understand the basics of this illness, its treatment and management.

- Bipolar Disorder fact sheet (web page) / PDF
- When a parent has bipolar disorder: What kids want to know (web page) / PDF

Borderline Personality Disorder

Borderline personality disorder: An information guide for families
This booklet is designed for people who have someone in their lives who has borderline personality disorder (BPD). The first three sections include information about the symptoms and causes and treatment of BPD. Section four talks about how to support someone who has BPD and the last section discusses self care for family and friends.

Concurrent Disorders

Concurrent disorders (CD for short) generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder. For more information, please consult the Information about Concurrent Disorders section of www.camh.net.

Depression

Postpartum Depression: A Guide for Front-Line Health and Social Service Providers
Chapter One: Clinical Overview
Chapter One describes the affective states that are common following childbirth, focusing on postpartum depression (PPD); other disorders described include the baby blues and pinks, postpartum anxiety and psychosis. The chapter will differentiate between the disorders, and highlight problems and symptoms that may require intervention.

Depressive Illness: An Information Guide
This guide is written for people living with depression, their families and anyone interested in gaining a basic understanding about this illness, its treatment and management.

- Depression fact sheet (web page) / PDF
- Depression Photo-novella (PDF only; 1.66 MB)
- When a parent is depressed: What kids want to know (web page) / PDF

Dual Diagnosis

In Ontario, "dual diagnosis" refers to people who have both an intellectual disability and mental health needs. For information about Dual Diagnosis, please refer to the Dual Diagnosis Program section of the website.

Getting help

Challenges & Choices: Finding mental health services in Ontario (web pages) / PDF (Booklet)
This guide provides information about mental health services available in Ontario to help you choose what's best for you. It also offers a brief description of some of the most common types of mental health problems. And it gives tips that will help you find the services you need.

Looking for mental health services in Ontario (web page) / PDF (Brochure)

- Resources for clients, families & friends

Couple Therapy: An Information Guide
At one time or another, every couple has difficulties with their relationship. Problems in a relationship have many causes. Some problems originate outside the relationship, such as job loss, illness or conflict in the family. Others stem from personality factors within the partners. Still other difficulties may be related to natural stages in the growth of the relationship.

Mood Disorders

Mood Disorders: Help for partners and families (web page) / PDF

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder: An Information Guide
This guide is for people with OCD, their families, partners, friends and anyone else who might be interested. The many aspects of OCD discussed in this book will answer some common questions, and help readers discuss obsessive compulsive disorder with treatment providers.

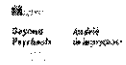
Obsessive Compulsive Disorder fact sheet (web page) / PDF
- Obsessive-compulsive disorder: Help for partners and families (web page) / PDF

Posttraumatic Stress Disorder

- Information on Posttraumatic Stress Disorder (PTSD) for refugees and new immigrants (web page) / PDF
- Post-traumatic Stress Disorder Photonovella (PDF only; 1.30 MB)
- Coping with Traumatic Events: Global Disasters Create Difficult and Uncertain Times

Psychosis

Promoting Recovery from First Episode Psychosis: A Guide for Families
Family members can play a significant role in helping to identify early signs of psychosis, in seeking prompt and appropriate treatment for their relative, and in promoting the recovery process. *Promoting Recovery from First Episode Psychosis* is based on research, practice guidelines and the authors' own experience working with clients and their families in the First Episode Division at CAMH.



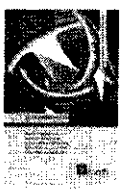
Beyond Psychosis: Exceeding Expectations from First Episode to Recovery
Five young people talk about their experiences with psychosis and recovery on this DVD resource.

First Episode Psychosis: An Information Guide
The purpose of this information guide is to provide information about a first episode of psychosis, its treatment and recovery. It has been written for people experiencing a first episode of psychosis and their family members, to help them gain a better understanding of this illness. Increased awareness of the signs, symptoms and treatment may improve the outcome for people with a first episode of psychosis.

Women & Psychosis: A Guide for Women and Their Families
Psychotic illness affects women and men in different ways. In women, schizophrenia—the most common form of psychotic illness — usually starts later in life and progresses at a different pace. This means that treatment for women needs to be specific to women. This guide speaks to the specific issues women and their families face during recovery from psychosis.

- Psychosis fact sheet (web page) / PDF
- When a parent has psychosis: What kids want to know (web page) / PDF

Schizophrenia



Schizophrenia: An Information Guide
This guide is written for people with schizophrenia, their families and partners, and those who want a basic understanding of this illness. It is not a substitute for treatment from a physician, but it can be used as a basis for questions and discussion about schizophrenia.

Schizophrenia fact sheet (web page) / PDF
- Schizophrenia: Help for partners and families (web page) / PDF

Stigma

Moving beyond stigma: Information for families of people with co-occurring mental health and substance use problems

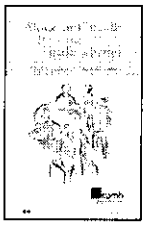
Stigma: Understanding the impact of prejudice and discrimination on people with mental health and substance use problems

Trauma

Women, Abuse and Trauma Therapy
This guide is for women who are in therapy, or who are looking for a therapist, to help them deal with the long-term effects of prolonged or repeated experiences of abuse and violence. It is also for family members and friends who want to understand and support a woman who is going through trauma therapy. Therapists may also find it useful as a resource to give to clients or to use themselves.

- Common questions about trauma
- Women: What do these signs have in common? Recognizing the effects of abuse-related trauma (web page) / PDF

Information for newcomers to Canada



Alone in Canada: 21 Ways to Make it Better
A self-help guide designed to help single new immigrants and refugees adjust to living in a new society as quickly and easily as possible. It provides suggestions on how to deal with 21 of the most common issues encountered by newcomers including how to overcome culture shock and isolation, cope with stress and discrimination, learn English, establish and manage new relationships and enjoy new experiences.

Information on Posttraumatic Stress Disorder (PTSD) for refugees and new immigrants (web page) / PDF

Parenting, Children & Teenagers

- Raising Resilient Children and Youth / PDF
- Aggressive behaviour in children and youth: When is it something to be concerned about?
- Tips for Parents On Building Healthy Relationships with their Teenagers
- When a parent dies by suicide: What kids want to know (web page) / PDF
- When a parent drinks too much: What kids want to know (web page) / PDF
- When a parent has bipolar disorder: What kids want to know (web page) / PDF
- When a parent has psychosis: What kids want to know (web page) / PDF
- When a parent is depressed: What kids want to know (web page) / PDF

Older Adults

- What older adults, their families and friends need to know about... Anxiety (web page) / PDF
- What older adults, their families and friends need to know about... Dementia (web page) / PDF
- What older adults, their families and friends need to know about... Depression (web page) / PDF

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Centre for Addiction and Mental Health

The Forensic Mental Health System in Ontario: An Information Guide

This guide will help you learn about the forensic mental health system in Ontario. If you, or someone you know, has a mental illness and has come into contact with the law, you should read this guide.

What is the forensic mental health system?
The mental health system is the network of people and services that care for people with mental illness. The criminal justice system includes the courts, the institutions and the professionals that deal with people accused or convicted of crimes. If you have a mental illness and you come into contact with the law, you could become involved with the forensic mental health system. More...

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- Appealing an ORB decision

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- Dual diagnosis
- Other organizations and services

Acknowledgment

The Centre for Addiction and Mental Health (CAMH) wishes to acknowledge the patients, families and professionals who helped to create this resource. Their expertise in the forensic mental health system has helped to make this an informative resource. Their commitment to providing clear, accessible information to those who need it deserves our thanks. Any shortcomings in this resource are solely the responsibility of CAMH.

Ministry of JUSTICE

Court experience of adults with mental health conditions, learning disabilities and limited mental capacity

Report 2: Before court

Rosie McLeod, Cassie Philpin, Anna Sweeting, Lucy Joyce and Roger Evans
BMRB and Liverpool John Moores University

Ministry of Justice Research Series 9/10
July 2010

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Report 2 of 6

This information is also available on the Ministry of Justice website:
www.justice.gov.uk/publications/research.htm

Analytical Services exists to improve policy making, decision taking and practice by the Ministry of Justice. It does this by providing robust, timely and relevant data and advice drawn from research and analysis undertaken by the department's analysts and by the wider research community.

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The authors

BMRB is the longest established research agency in Britain, having been founded in 1933. Throughout that time the company has built up a reputation for methodological excellence and innovation, and enjoys a reputation for producing strategic work of the highest quality and integrity. BMRB regularly carries out important studies to inform policy-making for major organisations in the public and private sectors.

Roger Evans is Director of the School of Law and Professor of Socio-Legal Studies at Liverpool John Moores University and a Non-Executive Director of a Mental Health NHS Foundation Trust. The team also worked in collaboration with Neil Hickman, a practitioner working in community health. The team holds a combination of policy knowledge, research expertise and practical experience of working with the specified vulnerable groups and of researching within the court setting. In the past, the team has collaborated on projects such as Victims' Advocates and a research project into vulnerable and intimidated witnesses for the Ministry of Justice.

This is the second in a series of six reports on a research project exploring the court experience of adults with mental health conditions, learning disabilities and limited mental capacity. The research relates to victims and witnesses in criminal cases, and to participants in civil and family cases.

Report 1 outlines the key findings from the research.

Opportunities for identification of court users with these vulnerabilities, and the extent of subsequent support, varied across the courts. A number of relevant policies and processes have been introduced in recent years. However, these tended not to be designed **specifically** for court users with mental health conditions, learning disabilities and limited mental capacity. Furthermore, policies related to particular stages of the court case or to particular agencies, rather than the whole 'journey' of an individual victim, witness or case participant through the justice system. The report therefore recommends a clear support pathway for vulnerable court users, supported by improved systems of accountability and the establishment of small multi-disciplinary teams. Better processes for early identification of conditions, and guidelines to increase awareness of how disclosures can be made, are also recommended. A single point of contact for vulnerable court users throughout a case is proposed, along with increased dissemination of tailored information, improved access to legal representation, additional and improved training for professionals, and improvements to implementation of special measures.

Report 2 outlines the experiences of court users with these vulnerabilities from their first involvement with the justice system until their attendance at court.

Across the courts, conditions were more likely to be identified when a support worker was present with the court user. In criminal cases, experiences varied greatly depending upon police awareness of the court user's support needs. In civil proceedings, a lack of contact with the courts could impede identification, and court users depended on legal representatives or existing support networks to identify needs and provide support. Identification was most likely in family proceedings where assessments and close contact with professionals were common. Court users were unlikely to disclose their condition unprompted. Protocols for support in criminal courts meant that court users were more content with the level of information and support offered than was the case in civil and family proceedings, where no protocols or designation of responsibility for support existed.

Report 3 considers the process of attending court, including arriving at court, waiting to go into the court room, being in the court room and giving evidence.

Generally, court users made their way to the court room alone and were daunted by the formal environment; this stress was significantly reduced by prior familiarisation with the court

process, the presence of a support worker, and the support of the Witness Service in criminal courts. Court users who felt they needed support were willing to disclose their condition, but were not always aware of whether disclosure was appropriate or who was responsible for informing the court. In turn, staff often assumed that identification would already have occurred and did not feel that they had the expertise to carry out this function. Where the judiciary were aware of need, the adjustments which they made were helpful to court users and increased their sense of inclusion in proceedings. In criminal cases, special measures were helpful in supporting court users to give evidence. More specialist support was only required by those who felt unable to manage their conditions.

Report 4 outlines the 'after-court' process, including receiving verdicts in court, leaving the court and making the journey home, awaiting outcomes and receiving news at home, and moving on from the experience.

Hearing a verdict in court and receiving news of the case outcome at home were times of particular stress and low mood for court users. They needed clear explanations to understand their case outcome, and emotional support to come to terms with it. Co-ordination between agencies to ensure that the court user was adequately supported at this point required careful management, but there are few protocols for support provision following court appearances. Many of the court users who were interviewed for this research did not feel any further support was necessary following case closure. However, where it was required, communication and cross-referrals between service providers were important to ensure the court user was not left unsupported.

Report 5 provides an overview of the policies, services and practices in place across the court system to support the needs of adults with mental health conditions, learning disabilities and limited mental capacity.

Two key policy processes within the criminal justice system are relevant. The first aims to better enable vulnerable or intimidated witnesses to give best evidence in court, (including the use of special measures). The second aims to improve the criminal justice system more widely to better meet the needs of victims and witnesses. Special measures has had a significant positive impact on court experience, and early evaluations of intermediary schemes are promising. A range of protocols are used by the police and the CPS to facilitate the identification and support of this group of court users. In the civil justice system, service delivery in this area has been guided by two policy aims: to improve, simplify and speed up the litigation system (assisted by the Civil Procedure Rules), and to strengthen the law in relation to Anti-Social Behaviour Orders, including the extension of special measures to anti-social behaviour cases. In the family courts, policy to harmonise the Family Procedure Rules with the Civil Procedure Rules, and guidelines to support the use of McKenzie Friends for litigants in person, are in place. The overarching policy outputs relevant to the study

are the amended Mental Health Act (2007), the Mental Capacity Act (2005), the Disability Discrimination Act (2005), and the Department of Health's 'No Secrets' (2000) guidance on protection of vulnerable adults.

Report 6 outlines the background to the research and presents the project's research aims and methodology.

Overall, this research aimed to examine how the court system supports the complex and specific needs of adults with mental health conditions, learning disabilities and limited mental capacity. It explored the direct experiences of victims and witnesses in criminal cases, and case participants in civil and family courts. The project had two phases: a developmental scoping study, and a programme of interviews with practitioners, court users and carers. The methodology was entirely qualitative. Recruitment was conducted in house through contact with a range of networks and support organisations. All study participants voluntarily self-disclosed their conditions, and definitions of conditions followed participants' own usage. A process of informed consent tailored to individual need was used for all interviews.

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Policy briefing

This research provided an in-depth exploration of the court experience of adults with mental health conditions, learning disabilities and limited mental capacity. Report 2 focuses on the experiences of court users leading up to appearance at court.

There was no formal point for identification of vulnerabilities. Sometimes identification was achieved through explicit strategies, such as asking a direct question in a police interview, but elsewhere it was dependent on incidental factors or ongoing contact with professionals. The creation of opportunities for identification of conditions should be increased using professional contact and the use of direct questions in formal correspondence, with responsibilities clearly communicated to professionals involved.

Protocols exist for support in criminal courts, provided by the police and the Witness Care Unit. These facilitated the provision of updates, pre-trial visits and special measures applications. Where this support was accessed it was praised by court users. Few protocols are in place for equivalent support in civil or family courts, where specialist support of the type offered in criminal proceedings was not generally available. Their introduction and promotion to these courts is recommended.

Information-sharing between agencies, to advise of vulnerabilities and support needs where identified, is crucial. Resources should be made available for police training in awareness and identification of conditions, and protocols for information-sharing should be developed for courts of all types. It is also important that special measures are utilised and explained appropriately in criminal cases.

Court users tended to depend on existing support networks, or on solicitors, to provide practical and emotional support during their case. Access to legal representation in civil and family proceedings was pivotal in its impact on court users' experiences. However, these court users' vulnerabilities constituted a barrier to access, because they tended to require higher input from solicitors for the same fixed fee. To access representation and support, improved access to information, legal representation and advocacy should be promoted through the courts, and links should be forged with local voluntary sector support provision.

Summary

Overall, this research examined the court experience of adults with mental health conditions, learning disabilities and limited mental capacity. The research formed part of the 'Court Experience of Vulnerable People' Research Programme, which provides evidence to facilitate improvement in Ministry of Justice (MoJ) services. Report 2 outlines the experiences of court users leading up to their attendance at court.

Context

There is limited research literature specifically concerned with the experiences of court users with mental health conditions, learning disabilities and limited mental capacity. However, previous research suggested this group were more likely to be a victim or party in a case, and to experience greater difficulties accessing justice. In addition, research has highlighted issues around the identification of these conditions/vulnerabilities among court users. Despite the development of a series of legislative and policy initiatives to meet the needs of this group more effectively, our findings suggest that further work is needed in this area.

Approach

The research comprised two phases: a scoping study (Phase 1) and a main stage of research (Phase 2). Phase 1 mapped the range of policies and structures in place within and outside different court settings to support people with mental health conditions, learning disabilities and mental capacity issues. It involved three stages: desk research, interviews with 27 key stakeholders, and consultation with the 25 Area Directors for Her Majesty's Courts Service (HMCS). Phase 2 built on Phase 1, and developed a more localised and in-depth understanding of the experiences of these vulnerable court users. It focused on London and the North East and involved: court observations; 143 interviews with practitioners; 61 interviews with court users with mental health conditions, learning disabilities or limited mental capacity; 23 interviews with carers; and journey mapping with the court users. The findings have been organised into six reports.

Findings and recommendations

Experiences of the court process

In criminal cases, the experience of reporting offences was influenced by the actions and behaviours of police, and the availability of and access to specialist support. Where police were aware of the victim or witness's condition, the inevitable stress of making a statement was lessened by support, including special measures. Receiving information about the court process prior to going to court (for example, the 'Going to Court' DVD produced by HMCS) was considered helpful in preparing for a court appearance. Pre-trial visits in criminal cases improved court users' experiences.

Court users in civil cases depended on legal representatives to provide information on their case. Legal representatives were required to adapt communication to the court user's needs. In order to attend meetings, court users often relied on existing support networks. For litigants in person, the lack of legal advice prior to court appearance caused high levels of stress and anxiety, partly due to the lack of information and support with preparation.

Family cases tended to last for a relatively long time. This provided more opportunities for professionals to interact with court users and explain court processes. Visits to court, equivalent to a pre-trial visit in criminal cases, were not offered by civil and family courts.

Identification of conditions

In criminal cases, opportunities for the identification of conditions arose during initial interviews with the police and in Witness Care Unit telephone assessments. This clarity of responsibility assisted identification, although a lack of training or inadequate implementation of protocols could hamper this. There was no equivalent process in place in civil or family cases. We recommend training for police to improve identification, and guidelines for professionals in civil and family cases to create opportunities and produce clear roles and responsibilities for identification.

In civil proceedings, a lack of contact with the courts generally impeded identification. Court users depended on legal representatives or existing support networks to identify needs and provide support. More contact points with civil court staff, and the inclusion of specific questions to encourage disclosure in correspondence sent to court users, are recommended.

Identification was most likely in family proceedings where close contact and assessments were common. However, these assessments tended to focus on one aspect of individual need and court users could be reluctant to communicate vulnerabilities due to concerns about the impact on their case.

Disclosure

Across case types, court users were unlikely to disclose their condition unprompted. Shyness, uncertainty and embarrassment all contributed to this. However, a direct question tended to evoke a truthful response. This demonstrated the importance of ensuring points of contact at which professionals had this opportunity, and guidance for the use of these.

Experiences of support

Protocols and systems for support in criminal courts meant that court users were more content with the level of information and support offered than in civil and family proceedings. These provisions included explanations of court proceedings through pre-trial visits. However, no such provision was generally available in civil and family courts. Practitioners supported court users most effectively where individuals within agencies were personally

familiar, and in sufficiently regular contact, with court users to facilitate appropriate referrals. Building multi-agency teams between voluntary sector organisations, public sector services and the courts is recommended to improve co-ordination of support.

Implementation of special measures

The use of special measures in criminal cases helped court users to give evidence. However, a lack of clarity over responsibility for arranging meetings, and delays in making applications, could hamper their implementation. Practitioners gave a range of reasons for not using special measures which demonstrated some inconsistencies in application and uncertainty as to responsibility for provision. Training for police and court staff on the role of special measures and provisions available is therefore recommended. They should also be clearly explained to court users, in order to manage expectations.

Access to support in civil proceedings

Practitioners working in civil courts felt that many cases go unidentified and unsupported, due to the lack of contact and dependence on legal representatives for support. A low awareness of advocacy services among participants also contributes to this. Guidance from charities or existing support networks on choices of solicitors improved court users' chances of securing legal representation in civil cases. It is recommended that guidance and information on advocacy services are made available to legal representatives and court staff.

Routine offers of assistance

Findings showed that court users with difficulties may not seek support because they did not think of asking, or were afraid to. To improve information and access to assistance in civil and family cases, there is a need to introduce routine, proactive offers of assistance, as well as disseminating tailored information to improve understanding of the court process. An equivalent to the 'Going to Court' DVD used in criminal cases would be very helpful.

1. Introduction

People with mental health conditions and learning disabilities tend to experience greater difficulties in accessing justice than other groups, and also to experience greater discrimination and disadvantage (Mind, 2001). Current government policy aims to meet the needs of victims, witnesses and users of the justice system more effectively and to improve access to justice, particularly for vulnerable people.

The 'Court Experience of Vulnerable People' Research Programme helps deliver this aim by providing evidence to facilitate improvement in Ministry of Justice (MoJ) services. As part of this programme, the MoJ commissioned BMRB and Professor Roger Evans of Liverpool John Moores University to undertake research into the experiences of court users with mental health conditions, learning disabilities and limited mental capacity.

Overall, the research aimed to determine how the court system (and all other agencies involved throughout case progress) supports the complex and specific needs of adults with mental health conditions, learning disabilities and limited mental capacity. The study placed a strong emphasis on the direct experiences of court users in criminal (excluding defendants and young witnesses), civil and family courts.

This is the second in a series of six reports presenting the findings from the research. Reports 3 and 4 discuss the experiences of court users while at court and after their court appearance. This report deals with experiences from initial involvement with the justice system until the court date. It begins with a discussion of court users' experiences of the processes before court, from reporting the crime to being kept up to date with progress. This is followed by an outline of the support provided and needed at this stage, as well as an account of the experience of support received. The report discusses barriers to and facilitators of support prior to court, followed by examples of good practice and recommendations for improvements. The findings presented in this report are based on the research conducted in Phases 1 and 2 of the study with key stakeholders, practitioners, court users and their carers.

1.1 Methodology

Research design

The research comprised two phases: a scoping study (Phase 1) and data gathering and analysis (Phase 2). Phase 1 consisted of desk research, mapping the range of policies and structures in place to support people with mental health conditions, learning disabilities and mental capacity issues within the court system. Twenty-seven interviews with key stakeholders (including court staff and agency representatives), and email consultations with 25 Area Directors for Her Majesty's Court Service were also undertaken, between January and April 2008.

The primary focus of Phase 2 was on the experience of court users with mental health conditions, learning disabilities and limited mental capacity. A range of methods and approaches were used to explore this, including:

- **court familiarisation visits;**
- **in-depth interviews with practitioners:**143 interviews with practitioners in London and the north east of England were carried out between December 2008 and May 2009. Interviewees were court staff (27), legal representatives (34), staff from in-court support organisations (17), public agency staff (26), and staff from voluntary support organisations (27); and
- **in-depth interviews with court users and carers:** 61 interviews with court users and 23 interviews with carers were carried out between December 2008 and May 2009. Of the court users interviewed, 26 self-identified as having experience of a mental health condition, 20 as having a learning disability, and five as having limited mental capacity. Initially it was planned to conduct these interviews **only** in the same case study areas as the interviews with practitioners. However, due to recruitment challenges the sample area was extended to cover all of England.

The two case study areas were not intended to be representative of the UK as a whole. Rather, they were selected as regions in which good practice was in place, and where the courts carried large caseloads.

Court users

In this report series, the term 'court user' refers **only** to court users with mental health conditions, learning disabilities and limited mental capacity, and **only** to people who use the court in a non-professional capacity (e.g. not lawyers) and as case participants (i.e. not as jurors). In addition, defendants were excluded from the sample. All court users in the sample had been involved in a justice process within the last three years; those currently involved in 'live' cases were excluded.

Twenty-six of the court users interviewed had been victims or witnesses in criminal cases (three of whom were defence witnesses), ten had been involved in civil cases, and 25 in family cases. Because court users involved in civil proceedings typically had a relatively low level of contact with the courts or related support services, this participant group was particularly difficult to recruit.

No specific legal definitions of 'learning disabilities' and 'mental health conditions' are used in relation to the court setting. Consequently, court users who took part in the study self-identified as having one or more of these conditions, in response to open questions and examples of conditions. They were also asked whether they required any support in their day-to-day life (e.g. from social services, counsellors, advocates, key workers, psychiatric nurses, or friends and family).

For the purposes of this study, 'carers' were defined as relatives, friends or other unpaid individuals who had supported a court user through the process. Eleven carers had supported court users through criminal cases, eight through civil cases and four through family cases.

The target population for this study constitutes a particularly 'hard-to-reach' group for social researchers, and recruitment presented a number of challenges. Various recruitment methods were employed to achieve quotas and access the widest range of individual experience. The most successful of these was through individual staff from local support organisations and advocacy centres. These individuals had an interest in and commitment to the study. As well as identifying users, they acted as local conduits within and between organisations, gaining the support of other practitioners working in the field. This motivation helped to overcome time and resource pressures for voluntary organisations. The time taken to build a network of organisations and establish co-operative, trusting relationships with individual staff posed the greatest barrier to achieving quotas within the time frame.

Informed consent

Given the highly sensitive nature of the research study, an extremely thorough process was required to ensure that court users gave informed consent. The process was tailored to meet individual needs, and to ensure that participants fully understood what they were consenting to.

Informed consent was gained directly from participants at the point of interview. In order to aid communication, the researcher explained the details of the research verbally, and used leaflets written in an easy-to-read style specifically for the project (including information in written and picture format). Where present, carers and support workers were encouraged to assist in explanations, but consent was always gained from the participant themselves rather than a third party. Researchers also led participants through a consent form which checked their comprehension of the subject of research and the nature of the interview.

Fieldwork and data

Court users chose the interview locations which they felt would provide the most comfortable and secure environment. Researchers guided interviews using a topic guide which allowed questioning to be responsive to the issues arising. Interviews with court users also included a 'journey-mapping' exercise as a facilitating tool to explore experiences of the court system.

Due to the variation in participants' competencies and the sensitive nature of the subject area, researchers adopted a flexible approach to interviews in response to participant need. The time required with participants ranged from 20 minutes to two hours, often with frequent breaks. Some court users requested the presence of carers or support workers, to provide moral support or assist communication.

The detail and coherence with which court users were able to recount their experiences varied a great deal. Memory lapses, communication difficulties and challenges in recalling events in a linear fashion all affected participants to a greater or lesser extent.

Analysis

In the fieldwork and analysis for this project, a qualitative approach was adopted, in order to allow attitudes and experiences to be explored in depth. It should be noted that qualitative methods neither seek nor allow the quantification of data; for example, the number of people who hold a particular view or underwent a particular experience would not be included in any discussions.

An analytical procedure called 'Matrix Mapping' was used to analyse interview data. In Matrix Mapping, researchers work from verbatim transcripts of data to identify key issues and themes. On the basis of this, a **thematic framework** is constructed. This provides a grid into which qualitative material is summarised. On the basis of the thematic matrices generated, key features of the data are identified, and individual accounts are turned into a thematic story. Concepts are defined, typologies created, associations identified and explanations advanced.

Alongside the main analysis, some of the 'journey maps' generated during interviews were chosen for inclusion in the final report. Examples were selected which reflect the full range of user experience in a 'snapshot'. Journey maps were produced by presenting court users with a plain graph on which to map the events and key junctures in their experience. This was used to produce a visual chart of varying levels of satisfaction through the process.

2. The pre-court process

This chapter of the report outlines the experiences of court users before their attendance at court. It focuses on reporting the offence in criminal cases, finding out about court attendance in all cases, and the information and updates received from the courts.

2.1 Reporting the offence (criminal cases)

Court users tended to report crimes directly to the police by telephone. After this, a police officer would usually visit their home or attend the scene of the crime. Experience of this stage in the case varied greatly between court users, depending on:

- the actions and behaviour of the police;
- whether the police were aware of their condition; and
- the availability of and access to specialist support, such as specialist police officers and court users' own carers or support workers.

Support is discussed in more detail in section 3.2 below.

Police actions and behaviour

Court users' perceptions of their treatment at this initial stage varied, and usually related to whether they felt the officer believed them or showed genuine interest and empathy. Many court users were concerned that the police would not trust their stories, and a few found officers unfriendly or sceptical when called to their homes after the initial phone call. However, they felt that officers' attitudes seemed to change and become warmer when the court user brought a family member or carer with them when they made their statement.

'You feel you have to prove yourself a lot to them. In some respects I felt they didn't believe me at first ... so that kind of upset me a bit.'
(Female court user, criminal case, mental health condition, North)

Court users whose victimisation was immediately obvious (for example, if they were physically injured), found police were extremely kind and understanding from the outset.

Court users generally found that once police were aware of their condition, they were attentive, helpful and reassuring. They demonstrated this by offering support from special needs trained police officers, or offering court users the option of making a statement in their home rather than at the police station. Advocates and support workers also found that the police readily adapted their behaviour once they were aware of a condition.

'The police wanted to talk to me further, just to clarify that he had a learning disability, and then they would offer more sort of, a different sort of support and it was very good ... I just think they then explained things differently and there was more, they took things at a slower pace with him, but not, they never belittled him actually, they were, the police were very good about it, I have to say.'
(Advocate for court user with learning disabilities, South)

In contrast, where the police were not aware of a condition or vulnerability, their support was often more limited. Court users also suggested that occasionally the police did not provide support even after the court user had disclosed their condition. This was noted particularly by those with depression and anxiety issues.

Nature of the offence

Another issue influencing court users' experiences of the police was the nature of the offence reported. Court users reporting domestic violence incidents praised the police for their quick response and the emotional support they provided. In these cases, participants did not think the police were aware of their mental health condition or learning disability. However, they had felt able to describe their anxiety and receive support without formally disclosing their condition.

Presence of a carer or support worker

Court users found it useful for their support worker or carer to be present when they reported a crime. Having a familiar person involved in the process made them feel less intimidated and anxious. It also meant their vulnerability was flagged up to the police at this early stage, prompting the police to ask whether they needed any further support, such as a social worker.

'It did help a lot, to know that there was somebody in the next room, while I was being interviewed in the other room, who's not a member of the police ... Because to me, that person had feelings, the police seemed a bit cold. I suppose they are only doing their job.'
(Female court user, learning difficulties, criminal case, North)

Case study:

Nicola was seriously sexually assaulted in the street, and sought help from a supermarket close by. There she made a 999 call to report the incident, which she found easy despite her significant learning disabilities. The police came to the scene immediately, but despite her obvious distress and learning disabilities, simply returned her to her flat and left her there without offering any support. She found it hard to communicate with them and they appeared to disbelieve her. Nicola called her support worker, who saw her injuries and called the police back, but no statement or medical examination for evidence was taken. Nicola went to the police station a few days later accompanied by her social worker, and this time police officers were a lot more supportive, encouraging her to give her statement in a video interview.

2.2 Making a statement (criminal cases)

Following the initial reporting of a crime, court users had to make a statement. They usually did this at the police station or in their own home. However, in rare instances, if they had been transferred to hospital or a safe house, they could make their statement there. Court users generally found the process of making a statement a stressful experience, mainly because recounting the experience of the crime reawakened or intensified feelings of fear and distress. In cases where the court user experienced severe anxiety they often took

several attempts (on different occasions) before they were able to provide a full statement. Importantly, when this happened, court users found the police very patient and reassuring. In some cases they would even arrange visits to the court user's house between attempts, to maintain contact and help them feel more at ease.

The police made a range of provisions to accommodate court users when giving their statement, including in-home or safe-house video interviews. Occasionally a special needs trained police officer or an intermediary was present (see 'specialist support', section 3.2). This support benefited court users both emotionally and practically, primarily by aiding communication. Court users often suggested they would have been unable to provide a statement without it. For example, court users with communication difficulties felt that police officers with training in special needs were able to communicate with them more effectively than other police officers and this helped them to perceive the process more positively.

'If there was any words what I didn't understand she used to just explain it to me and then I was alright then. I have just got to have someone to help me and then I am fit as a fiddle.'
(Female court user, learning disabilities, criminal case, North)

2.3 Finding out about going to court

Criminal cases

Victims and witnesses were generally informed whether or not a case would go to court via a letter or telephone call from the police or Witness Care Unit (see section 3.1). Letters were often read to the court user by their carer or support worker, but both the court users and their carers or support workers often found the language hard to understand. In certain cases court users (or their carers) sought clarification about the content of the letter by telephoning the detective or Witness Service. They valued having a point of contact whom they knew they could call.

'We knew that we had to go to Court, we knew that part of it, but when it come to more stronger words, we had to ring up and ask what it was all about ... I think he did keep us up to date yes, you know to let us know what was going on and that. I asked him, I said I want to keep up to date.'
(Female court user, mental health problems and learning disabilities, criminal case, South)

In serious criminal cases, court users received details of their appearance at court from a Family Liaison Officer, detective or police officer (see section 3.1) who maintained contact throughout the duration of the case. Court users praised this contact, as they felt they were treated sympathetically and that the officer shared their interests, which raised their confidence about appearing in court.

'He wanted to make sure I could do this and be able to face court and stuff and tell them like different things'.
(Female court user, mental health condition, criminal case, North)

When cases did not reach a trial, solicitors or barristers occasionally offered a follow-up explanation. This was considered good practice by court users and legal representatives. However, it was not standard, despite requests for meetings and further information by court users who had the confidence to ask. Practitioners could be unavailable or otherwise occupied, and did not always consider another meeting to be their responsibility after trials.

'It hasn't actually gone to court, but why can't something still be done and for someone else to tell me why or if not why can't it be done or ... It will be better than just being right okay, you can't go.'
(Male court user, mental health condition, criminal case, North)

Civil cases

The way in which court users found out about going to court was different for those with legal representation and those who undertook litigation in person.

In civil cases with legal representation, the solicitor tended to relay information about the case and court appearances by telephone or letter, or in face-to-face meetings. In exceptional cases of severe learning disabilities, solicitors suggested that they were unable to communicate this information because the court user's condition was so severe. Generally, these court users relied on a carer, advocate (see support, section 3.1) or support worker to mediate this contact, reading letters or making arrangements to attend meetings.

Those with milder conditions could engage with the solicitor either directly or through their supporter. This varied with the court user's capabilities, and also with day-to-day variations in their condition, particularly for court users with bi-polar disorder, whose capacity and feelings were prone to fluctuate. Court users and carers found it helpful when solicitors gave a detailed, step-by-step breakdown of what would happen and what their client would be required to do in court. Court users felt more confident when they knew what they would have to do than if they felt unprepared. For example, one court user was unsure whether the case opponent would be in the courtroom with them, which made them more nervous.

Carers and advocates felt that they relied on legal professionals' ability to explain details of the case, so that they could then relay this information to the court user effectively. They were unlikely to have any experience of court cases themselves, so were rarely able to provide court users with any information without this support.

'We weren't sure where we were going to have to go and what it actually involved. We didn't have any clear instructions or ... written brief on what to expect. So it was quite a surprise, whatever we got when we got there.'
(Carer, civil case, North)

Where the participant was litigating in person, a letter with a court summons was often the first they heard of their involvement in proceedings. Receiving such a letter caused great distress, frustration and uncertainty about the right course of action. Where the participant

was unable to fully comprehend the summons due to literacy issues or an emotional state which temporarily impeded their capacity to function, the presence of a carer or advocate was important. They could explain the letter and seek further information if necessary.

Court users without access to a carer or advocate often felt scared and helpless. Unsupported court users also often suggested they were unaware of the legal services or pastoral support available to them when preparing for their appearance at court, and did not believe this information had been given to them. Occasionally, the stress of going through proceedings alone caused participants to discontinue proceedings altogether.

'I've just thought the best thing was to walk away from the whole thing ... During the run-up to it I got lots of pains ... It became so stressful, because I realised it was just such a waste of time ... I just thought the best thing was to walk away from the whole thing'.

(Female court user, mental health condition, civil case, South)

Family cases

There was no established process for informing court users of their court appearance in public law cases. Findings across the study sample showed solicitors and social workers tended to mediate all information relating to the court appearance. In the few instances where the court user had a Litigation Friend or advocate, the solicitors and social workers would communicate with them.

In private law cases, as in the civil courts, communications were sent via solicitors, usually as written correspondence. Court users' experiences of this time were strongly influenced by their relationship with their solicitor and the communication they received from them. They found it helpful when solicitors arranged a face–to-face meeting to explain what would happen prior to their appearance in court. However, receiving this information by letter often left court users feeling distressed, as they felt that the letter did not provide enough information to help them understand the process. For example, one party in a child custody case did not learn of the court hearing until their solicitor wrote them a letter, and had no further opportunities to learn about their appearance until they met on the day of the hearing.

'It was the solicitor that sent a letter saying that there was going to be a family court case which I found bad. Really when you go to family court your solicitor just meets you there. You have got to shut up and not say anything ... Her solicitor, my solicitor, the wife and myself and you have just got to sit there.'

(Male court user, learning disabilities, family case)

In exceptional cases where parents were not already involved in child protection proceedings, court users said they were unaware their children were being held in care. Receiving this information at the same time as learning of their court appearance came as a shock. Unless court users already had a good support system in place, such as a relationship with an advocacy service, they were often unsure where to go for advice.

'Nobody really said much about it to me until I had got my solicitors.'
(Female court user, mental health condition, family case, North)

2.4 Information and updates from the courts

Criminal cases

In criminal cases, court users had mixed experiences of contact by telephone and letter from the Witness Care Unit. Not all participants recalled being contacted. However, they acknowledged that they might have forgotten, or ignored the contact because they wanted to avoid thinking about the case. This was particularly likely among interviewees who suffered depression. Participants were also uncertain about **which** agency had contacted them, and consequently were unsure where they would have gone to access support should they have needed it.

A few participants recalled receiving the DVD, 'Going to Court'. This DVD is prepared by HMCS for victims and witnesses in criminal cases. It explains the court process and guides the viewer through the various stages. The DVD was accompanied by a letter with a telephone contact number. It explained the role of the Witness Care Unit and explained that members of the service would be available to offer personal support at the court hearing if required. Court users found the DVD informative, particularly because it showed the order of events and who would be present in the courtroom. This reassured court users about attending court and increased their confidence.

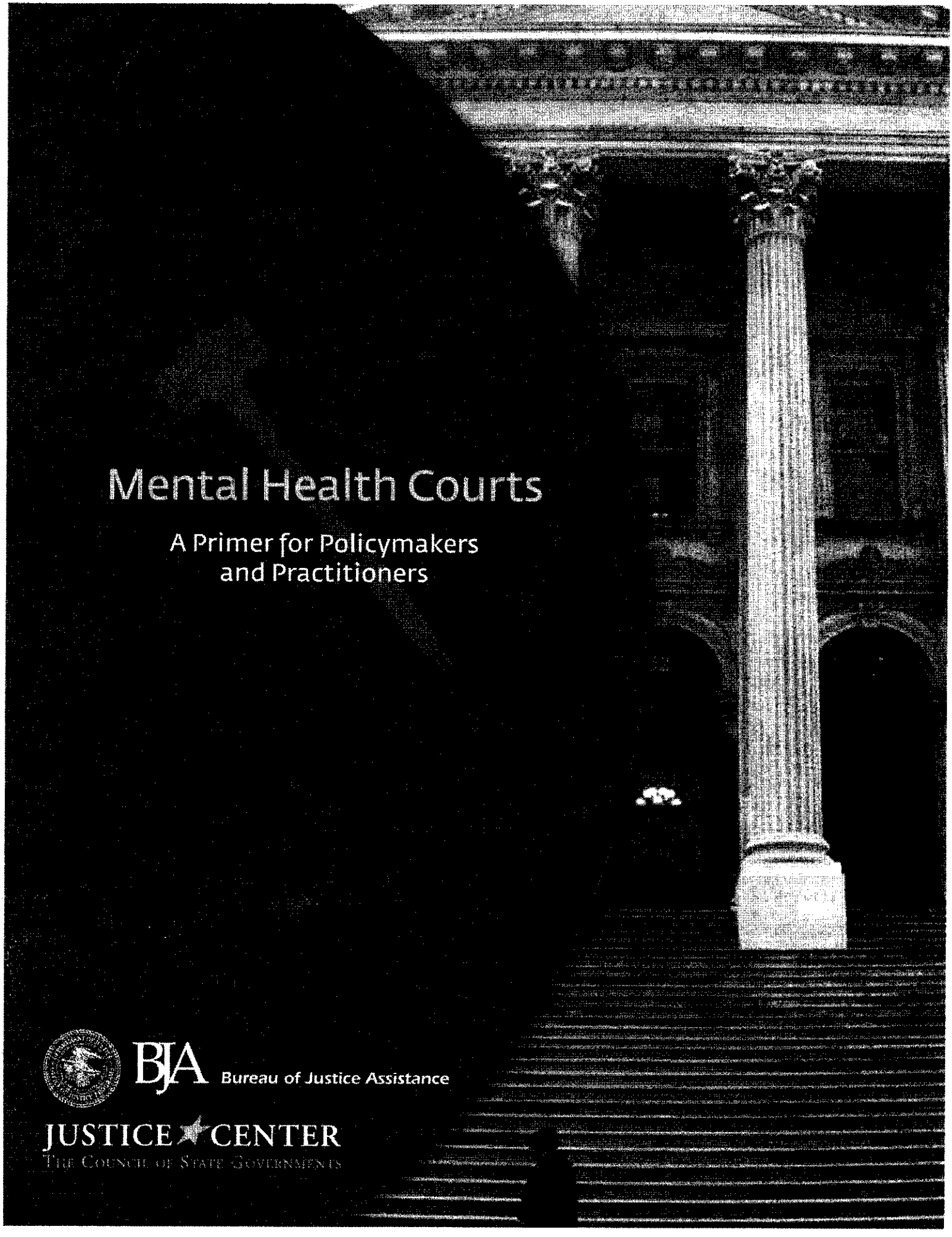
'It was pretty informative really all in all. Everything in there, that was put in there was made to make you feel, that this was not such a, you know, although it's quite a hard thing you know, everything would be, I got the impression everything would be, you know, that the forms and the CD, everything would be there to help you, in strange surroundings if you like.'
(Male court user, criminal case, mental health problems, North)

In a few cases, court users also recalled receiving a letter from the Witness Service. A number of participants took the opportunity to contact either the Witness Care Unit or the Witness Service. Where court users did not have access to alternative forms of support, they found this mechanism centrally important. They could telephone for reassurance and also ask staff to liaise with the police on some occasions. This eased anxiety and made them feel less daunted. However, if court users already had care and support in place they relied heavily on this, rather than taking up Witness Care Unit or Witness Service support.

Civil and family cases

In civil and family cases, the courts did not provide information. In these instances, court users depended on their solicitor for information about the case. Court users' views on this aspect of their experience therefore depended upon the effectiveness of their relationship with their solicitor (see 'Experience of support', section 3.2).

Most litigants in person had difficulty in accessing any information or assistance when preparing for their court appearance. As a result they felt very unsure about what they were



Mental Health Courts

A Primer for Policymakers and Practitioners

BJA Bureau of Justice Assistance

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Mental Health Courts

A Primer for Policymakers and Practitioners

A report prepared by the
Council of State Governments Justice Center
Criminal Justice/Mental Health Consensus Project
New York, New York

for the

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Contents

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Introduction

Mental health courts have spread rapidly across the country in the few years since their emergence. In the late 1990s only a handful of such courts were in operation; as of 2007, there were more than 175 in both large and small jurisdictions.[1]

If this recent surge in popularity is any indicator, many more communities will consider developing a mental health court in the coming years. This guide is intended to provide an introductory overview of this approach for policymakers, practitioners, and advocates, and to link interested readers to additional resources.

The guide addresses a series of commonly asked questions about mental health courts:

- Why mental health courts?
- What is a mental health court?
- What types of individuals participate in mental health courts?
- What does a mental health court look like?
- What are the goals of mental health courts?
- How are mental health courts different from drug courts?
- Are there any mental health courts for juveniles?
- What does the research say about mental health courts?
- What issues should be considered when planning or designing a mental health court?
- What resources can help communities develop mental health courts?

Why Mental Health Courts?

Mental health courts are one of many initiatives launched in the past two decades to address the large numbers of people with mental illnesses involved in the criminal justice system. While the factors contributing to this problem are complicated and beyond the scope of this guide, the over-representation of people with mental illnesses in the criminal justice system has been well documented:[2]

- Prevalence estimates of serious mental illness in jails range from 7 to 16 percent, or rates four times higher for men and eight times higher for women than found in the general population.[3]
- A U.S. Department of Justice study from 1999 found that half of the inmates with mental illnesses reported three or more prior sentences.[4] Other research indicates that people with mental illnesses are more likely to be arrested than those without mental illnesses for similar crimes and stay in jail and prison longer than other inmates.[5]
- In 1999, the Los Angeles County Jail and New York's Rikers Island jail held more people with mental illnesses than the largest psychiatric inpatient facilities in the United States.[6]
- Nearly two-thirds of boys and three-quarters of girls detained in juvenile facilities were found to have at least one psychiatric disorder, with approximately 25 percent of these juveniles experiencing disorders so severe that their ability to function was significantly impaired.[7]

Without adequate treatment while incarcerated or linkage to community services upon release, many people with mental illnesses may cycle repeatedly through the justice system. This frequent involvement with the criminal justice system can be devastating for these individuals and their families and can also impact public safety and government spending. In response, jurisdictions have begun to explore a number of ways to address criminal justice/mental health issues, including mental health courts, law enforcement–based specialized response programs, postbooking jail diversion initiatives, specialized mental health probation and parole caseloads, and improved jail and prison transition planning protocols. All of these approaches rely on

extensive collaboration among criminal justice, mental health, substance abuse, and related agencies to ensure public safety and public health goals.

Mental health courts serve a significant role within this collection of responses to the disproportionate number of people with mental illnesses in the justice system. Like drug courts and other "problem-solving courts," after which they are modeled, mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court.* They work to improve outcomes for all parties, including individuals charged with crimes, victims, and communities.

*Drug courts have been particularly instrumental in paving the way for mental health courts. Some of the earliest mental health courts arose from drug courts seeking a more targeted approach to defendants with co-occurring substance use and mental health disorders.

Mental Health in Tennessee's Courts

A Procedural Manual for Judges, Defense Attorneys and District Attorneys

July 2006

Tennessee Department of Mental Health and Developmental Disabilities

Table of Contents

Juvenile Services

What Can Be Done?

Resources

Introduction

This manual is intended as an introductory guide to assist legal and judicial personnel with developing fair and effective adjudication of defendants with mental illness. Basic information is provided with sources for further investigation.

Information is provided on recognizing mental illness and on types of mental health services available in Tennessee. Principles and methods are explored regarding misdemeanor, felony and juvenile cases involving defendants with mental illness. Considerations for capital cases involving mentally ill defendants are briefly reviewed.

Title 33, Tennessee Code Annotated, the mental health code in Tennessee, stipulates legal procedures for forensic evaluation, mandatory outpatient treatment (MOT) and psychiatric hospitalization. These procedures are described to assist counsel and the court with appropriate usage in legal proceedings.

Mental health care in jails is described to provide an overview of treatment that is, and is not available for those who are incarcerated, realizing that services in Tennessee jails vary considerably from county to county. Components and challenges of release planning, probation and parole for this population are described with the intent of encouraging realistic release planning and community supervision in accordance with accepted best practices.

The Problem

The Problem: Criminalization of Mental Illness

There are more than four times as many individuals with mental illness in the Tennessee county jails (19.1%)[1] as in the general population (5%) (Kessler et al, 1999)[2]. On any given day in Tennessee there is an average of 3339 jail inmates with a diagnosis of serious mental illness, while there are 942 in state psychiatric institutions. Reduction in the size of state psychiatric institutions is generally regarded as having an overall positive effect, giving many individuals the opportunity to live productively in the community[3]. Unfortunately, increase in community-based mental health treatment has not grown as psychiatric inpatient beds were reduced[4] leaving individuals with severe mental illness underserved. Nationally, almost a quarter (23.2%) of the jail inmates with mental illness are arrested and incarcerated for public order offenses that could be connected to symptoms of untreated mental illness[5].

The public perception is that most individuals with mental illness are prone to violence. Research has repeatedly shown that, when treated, individuals with mental illness are no more likely to commit a violent act than the average person. When not in treatment and when abusing substances, individuals with mental illness do commit more acts of violence[6]. Conversely, individuals with mental illness are at increased risk of crime victimization[7].

Encounters between law enforcement and individuals with mental illness are frequent. The National Consensus Project (Council of State Governments) reports, "In the police departments of the U.S. with populations over 100,000, approximately 7 percent of all police contacts, both investigations and complaints, involve a person believed to have mental illness"[8]. Despite the frequency of contact, it is by no means standard for law enforcement agencies to

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[1] Department of Mental Health and Developmental Disabilities, (2004, January 8). Survey of County Jails in Tennessee: One Year Follow Up. Retrieved June 1, 2006 from http://www.state.tn.us/mental/cj/cj6.html.

[2] Kessler, RC (1999) *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness*, In Mental Health United States 1999, Manderscheid, RW and Henderson MJ eds., Rockville, MD, Center for Mental Health Services.

[3] Lamb, R.H. & Bachrach, L.L (2001) Some Perspectives on Deinstitutionalization. *Psychiatric Services,* American Psychiatric Association, *Vol.* 52, August, 2001 pp.1039-1045.Rothbard, A.B., Kuno, E. (2000) The Success of Deinstitutionalization Empirical findings from Case Studies on State Hospital Closures. *International Journal of Law and Psychiatry*, Vol 23 (3-4), pp. 329-344.

[4] Council of State Governments, (2002). Criminal Justice / Mental Health Consensus Project. New York: Council of State Governments.

[5] Ditton, PM (1999) *Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers.* Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[6] Steadman, H.; et al (1998) Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods, Archives of General Psychiatry 55, pp. 393-401.

[7] Virginia Hiday, et al., "Criminal Victimization of Persons with Severe Mental Illness," pp. 62-68; also J.A. Marley and S. Buila, "When violence happens to people with mental illness: Disclosing victimization," American Journal of Orthopsychiatry, 69:3, 1999, pp. 398-402.

[8] Dean et al (1999) Emerging Partnerships between Mental Health and Law Enforcement. *Psychiatric Services,* 50(1) pp. 99-101.

have specialized response procedures for calls involving an individual with mental illness[9]. The result is that individuals with mental illness are frequently arrested and incarcerated when diversion to mental health treatment may be a viable option.

The county detention facility is an inappropriate setting for most individuals with mental illness who are convicted of misdemeanors. While incarcerated, jail inmates with mental illness are less likely to receive appropriate treatment or rehabilitation, more likely to decompensate, more likely to misbehave and more likely to be victimized by other inmates[10]. Detention facilities are also negatively impacted by the requirement to house this population. Research has shown that inmates with mental illness are more costly and troublesome than other types of inmates due to needs for psychiatric treatment and high surveillance[11]. Correctional personnel typically receive little training in recognition of psychiatric symptoms or methods for effective de-escalation of psychiatric disturbances.

Prisons face similar supervisory and budgetary challenges in housing an increasing number of mentally ill inmates. The Bureau of Justice Statistics reported that one in 10 state inmates received psychotropic medications while 1 in 8 participated in therapy or counseling[12]. Annual spending for mental health services in Georgia's prisons rose from $2.6 million in 1991 to $24.1 million in 2001 with $6.6 million for psychiatric medications alone. In Pennsylvania, lack of community services raised barriers to release so that inmates with mental illness were denied parole at a higher rate (27%) than the inmate population as a whole (16%)[13].

The Court may have difficulty obtaining determination of mental illness in defendants. Forensic Evaluation in Tennessee (T.C.A. § 33-7-301a) has specific and narrow purposes and is not appropriate for simply preparing to divert the defendant to community treatment. Purposes and procedures for Forensic Evaluation are described in this manual, as are alternative methods of obtaining psychiatric evaluation.

Legal remedies and service models exist to divert defendants with mental illness into treatment in the pretrial or post-conviction level of court proceedings. Community services are described in this manual to acquaint counsel and the court with possible alternatives to incarceration. In order to implement diversion remedies, Counsel and the court will need assistance to develop viable psychiatric treatment alternatives.

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[9] Ibid

[10] Roy, B.; Ruddell, R.; Diehl, S (2004) Diverting Persons with Mental Illness from Jail: A tale of two states. *Corrections Compendium*, 29, 1- 5, 38 – 42.

[11] Roy, B.; Ruddell, R. (2004) Diverting mentally ill inmates from California Jails. *American Jails*, 18, 14 - 18

[12] Bureau of Justice Statistics (2001) *Mental Health Treatment in State Prisons, 2000.* US Department of Justice, NCJ 188215.

[13] Couturier, L. (2002) Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation and Co-Occurring Disorders. IN: *The Consensus Project Report,* Council of State Governments.

Understanding Mental Illness

"Mental health" is a relative term. It can mean many things to many people. Generally, mentally healthy people have a positive self-image and can relate successfully to others. Mental health is the ability to integrate one's self with one's environment.

Serious mental illnesses are brain disorders that impair thinking, feeling, and behavior. These disorders disrupt a person's ability to function in activities of daily living such as social interaction, employment, education, and self-care. Mental illness can be caused or triggered by genetic transmission, biochemicals in the brain, prolonged or very intense social stress, alcohol and drug use, and environmental toxins.

Jackie Massaro, MSW, in the Overview of the Mental Health Service System for Criminal Justice Professionals, published by the Technical Assistance and Policy Analysis Center, states the following:

> People with mental illness become involved with the criminal justice system for a variety of reasons. The symptoms of mental illness may result in bizarre or unusual behaviors that are disturbing to other people and result in complaints to law enforcement. A lack of understanding on the part of the general public about mental illness often leads people to perceive behaviors associated with mental illness as frightening or threatening. Individuals with mental illness in the community may display these disconcerting symptoms if they are not receiving any treatment or if they are not participating fully in treatment (e.g., not attending therapy, not taking medications). For a variety of reasons, people with mental illness are not always willing to participate in treatment. The illness itself may make some people fearful of authority figures or of being controlled; others may object to the treatments offered. Mental health providers are challenged to find ways to engage these individuals and to create (or adjust) treatment plans that keep people involved in treatment.

People with mental illness may also become involved with the criminal justice system due to aggressive behavior. To date, research concludes that only a weak association exists between mental illness and violence in the community (MacArthur Research Network on Mental Health and the Law, 2004). However, under certain circumstances, a person with mental illness may be at greater risk for exhibiting aggressive or violent behavior that must be sanctioned. The symptoms of mental illness alone do not necessarily increase risk; however risk increases with the presence of certain other factors, the most significant being the use of alcohol or other drugs. Other factors that increase risk include a history of violence, anger, violent fantasy, and psychopathy, which is a disorder characterized by the lack of concern for other people and impulsive behavior (Monahan et al., 2001).

Of course for some people, mental illness is secondary to involvement in criminal behavior. For example, co-occurring substance use disorders may result in illegal activities such as possession or sale of controlled substances or crimes of opportunity of support substance abuse.

The presence of a mental illness does not necessarily prevent people from acting in a responsible and socially adaptive manner. However, the symptoms of mental illness may interfere with social functioning. Treatment of these symptoms can help to restore responsible social behavior. Responsibility for criminal behavior should not be automatically excused due to the presence of mental illness (Rotter al., 1999).

Types of Mental Disorders

These are the most common disorders of mental illness and severe emotional disturbance found among both adults and children in this country. For more in depth and specific information, please consult the Diagnostic and Statistical Manual, Fourth Edition.

Psychotic Disorders

Psychotic disorders are a condition where malfunctions in the brain cause the person to be to be overwhelmed by inner perceptions and thoughts that they lose contact with reality. Classical characteristics of psychosis include hallucinations (alterations in sensory perception, usually involving hearing voices or seeing images that do not exist) and delusions (beliefs about events or circumstances that have no basis in reality). Schizophrenia is one of the most disabling mental disorders. In the past, it was thought that people with schizophrenia and other psychotic disorders could not function normally in their families or communities. With new, effective medications and services, many people with psychotic disorders are able to live and work productively in the community. Some people who need the new medications and services don't get them due to a variety of reasons and end up in the criminal justice system for behaviors that could be attributed to untreated psychosis.

Mood Disorders

Mood or Affective Disorders are a group of clinical conditions characterized by a disturbance of mood (the internal emotional state of an individual), a loss of sense of control, and a subjective experience of great distress; mood disorders include depression and mania. Depression is a serious medical illness and is the most recognizable mental illness in the community. Untreated depression may lead to suicide and law enforcement is frequently called when an individual has made a suicide attempt. Risk of suicide is also higher for persons who are incarcerated, estimated at ten times that of the general population.

Bipolar Disorder is a mood disorder; it is also known as manic depression. It is a biologically based mental illness. Manic symptoms include mood swings from an intense high of excitement, irritability and inflated sense of self-importance, while depression is characterized by intense lows of sadness, hopelessness and lethargy. Bipolar Disorder can vary from mild to severe and can involve only a

few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

There is an increased risk of suicide in individuals with Bipolar Disorder who are experiencing the depressive cycle. In a manic phase, the individual is more likely to engage in violence or high-risk behavior such as truancy or occupational absenteeism, substance abuse, spending sprees or sexual promiscuity. At either of these extremes, individuals' behavior may bring them into contact with the criminal justice system.

Anxiety Disorders

Anxiety disorders are conditions in which anxiety and extreme worry/nervousness disrupt ordinary functioning or cause significant distress to the sufferer. "Anxiety" refers to one's response to any perceived threat of danger (real or imagined), and includes physical (such as increased heart rate and shortness of breath), mental (attention drawn to the perceived threat), and behavioral (avoidance or escape) components. Anxiety itself is a normal and healthy part of human experience that signals a need to protect oneself from potential dangers; it only becomes dysfunctional when it is overly frequent or intense, occurs repeatedly in response to situations that are not really dangerous, and/or disrupts the ordinary functioning and enjoyment of one's life.

Personality Disorders

Personality disorders are groups of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment.

Substance Abuse Disorders

There are a multitude of substance abuse diagnoses, ranging from Alcohol Abuse to Hallucinogen Dependence. Abuse indicates the person is misusing the substance and may be suffering ill effects from the substance, and dependence indicates more serious consequences exist due to the use, including addiction, problems at work, in home life and interpersonally. Substance abuse disorders can be difficult to distinguish from mental illnesses, because the symptoms can present in similar ways. It is important to note that substance abuse disorders are not considered mental illnesses and are treated with very different methods.

Co-Occurring Disorders

Co-occurring disorders refers to two disorders in the same individual. The most common co-occurring disorders for individuals with mental illness are substance abuse disorders, mental retardation, and physical disabilities such as traumatic brain injury. In the criminal justice system, the most common is the co-

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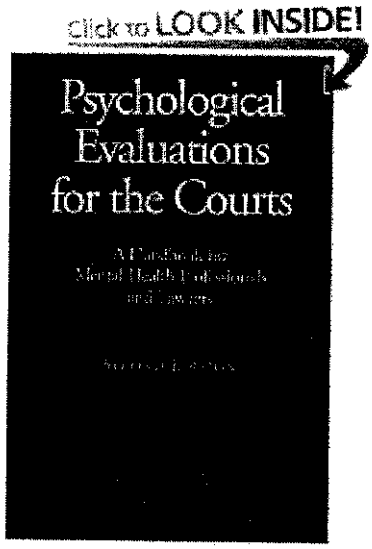

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Psychological Evaluations for the Courts, Second Edition: A Handbook for Mental Health Professionals and Lawyers

[Hardcover]

Gary B. Melton PhD (Author), John Petrila JD LLM (Author), PhD Norman G. Poythress (Author), Christopher Slobogin JD LLM (Author)

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Review

"*Psychological Evaluation for the Courts* is a splendid resource for mental health professionals who come into contact with the legal system. Relevant law is presented concisely, and its application illustrated with thorough reviews of empirical research. Clinicians are guided carefully through the essentials of the evaluation process. This second edition is even more comprehensive than its excellent predecessor. It is an indispensable aid for all forensic evaluators, and an indispensable tool for students in forensic training programs from the undergraduate to the postgraduate levels." --Paul Appelbaum, MD, Department of Psychiatry, University of Massachusetts Medical Center

"This is a brilliant synthesis of law, policy, theory, practical wisdom, and clinical knowledge, integrated in such a way as to make this book absolutely essential reading for any forensic evaluator or examiner working today. It is a tour de force of law and the behavioral sciences, and will set the standard against which other efforts in this area will be assessed for the indefinite future. The authors' treatment of the insanity defense is, simply, the best that I have ever seen in this type of context." --Michael Perlin, JD, Professor of Law, The New York Law School

"This is a brilliant synthesis of law, policy, theory, practical wisdom, and clinical knowledge, integrated in such a way as to make this book absolutely essential reading for any professor of, or student in, forensic mental health law. It is a tour de force of law and the behavioral sciences, and will set the standard against which other efforts in this area will be assessed for the indefinite future. The authors' treatment of the insanity defense is, simply, the best that I have ever seen in this type of context." --Michael Perlin, JD, Professor of Law, The New York Law School

"With this fresh edition, Melton, Petrila, Pythress, and Slobogin have made another landmark contribution to forensic practice. Comprehensive in legal coverage and rigorously empirical in analytic approach, this lucidly written book is packed with astute suggestions for conducting clinical assessments. Any psychologist or psychiatrist who gets on the witness stand without carefully having read *Psychological Evaluations for the Courts, Second Edition* should be committed as 'dangerous to self.' This is an immensely impressive work, one of the few in the field that deserve to be called authoritative." --John Monahan, PhD, Doherty Professor of Law, Professor of Psychology and Legal Medicine, University of Virginia

"This book is a valuable guide for the mental health professional anxiously preparing to testify for the first time and for the seasoned forensic psychologist or attorney....The authors provide guidelines on how mental health professionals can conduct themselves ethically, cautiously, and effectively....a comprehensive, clearly written, and interesting reference text. Fine-tuning, updating, and expanding on the first edition, which was itself a well respected guide to forensic work, this book is an indispensable asset to the library of any professional who practices in the forensic arena. It can also serve as a textbook for graduate courses and training courses for forensic evaluators." --*Criminal Justice Review*

"This is an exceptionally good handbook for mental health professionals, lawyers, and other practitioners who work within, for, or in conjunction with the courts. Two populations will likely benefit from this book, the legal representation and clinical evaluators involved in civil or criminal matters....This book is very informative and undoubtedly would be an extremely useful teaching text. It includes case studies and practical tips for clinicians. I strongly recommend it to clinicians writing examinations for the court. It would be a superb resource for school counselors, social service workers, attorneys and others working within the court system to use in working with agencies in a effort to sort fact from inference." --*The Masters Advocate*

"The book provides comprehensive guidance on both substantive and procedural law as well as their application. The contents are accessible, practicable and enlightening....The book is an invaluable referral source for American practitioners, whose work concerns mental health issues. Its use, however, extends to other professionals, such as doctors, social workers, etc., who would find the book a readable and informative practical guide in the daily course of their work....this book is highly recommended for both its essence and its exemplification of the complementary, and not conflicting combination of legal academia and practice. There should be a copy of it in every legal, medical and health authority library." --*Social Welfare Law Quarterly*

"Given our litigious society, every client should be viewed as a potential litigant; and consequently, every mental health practitioner, regardless of type of practice, can expect to be called into a legal case involving a client....Self-study of professional books and articles is the most common way of meeting the challenge to be adequately prepared for forensic services....Psychologists can gain a wealth of knowledge and skills from the contents of *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (2nd ed.)....[It] should be on every pracitioner's bookshelf....Suitable for graduate training, especially for students in clinical, counseling, and school psychology....The excellent contents...effectively blend research and practice that call for supplemental lectures and seminar discussions." --*Contemporary Psychology*

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Michael Perlin, JD, Professor of Law, The New York Law School

This is a brilliant synthesis of law, policy, theory, practical wisdom, and clinical knowledge, integrated in such a way as to make this book absolutely essential reading for any forensic evaluator

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR®

AMERICAN PSYCHIATRIC ASSOCIATION

DSM-IV-TR Classification

NOS = Not Otherwise Specified.

An *x* appearing in a diagnostic code indicates that a specific code number is required.

An ellipsis (. . .) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., 293.0 Delirium Due to Hypothyroidism).

Numbers in parentheses are page numbers.

If criteria are currently met, one of the following severity specifiers may be noted after the diagnosis:

Mild
Moderate
Severe

If criteria are no longer met, one of the following specifiers may be noted:

In Partial Remission
In Full Remission
Prior History

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (39)

MENTAL RETARDATION (41)

Note: *These are coded on Axis II.*

317 Mild Mental Retardation (43)
318.0 Moderate Mental Retardation (43)
318.1 Severe Mental Retardation (43)
318.2 Profound Mental Retardation (44)
319 Mental Retardation, Severity Unspecified (44)

LEARNING DISORDERS (49)

315.00 Reading Disorder (51)
315.1 Mathematics Disorder (53)
315.2 Disorder of Written Expression (54)
315.9 Learning Disorder NOS (56)

MOTOR SKILLS DISORDER (56)

315.4 Developmental Coordination Disorder (56)

COMMUNICATION DISORDERS (58)

315.31 Expressive Language Disorder (58)
315.32 Mixed Receptive-Expressive Language Disorder (62)
315.39 Phonological Disorder (65)
307.0 Stuttering (67)
307.9 Communication Disorder NOS (69)

—.– Delirium Due to Multiple Etiologies *(code each of the specific etiologies)* (146)
780.09 Delirium NOS (147)

DEMENTIA (147)
294.xx Dementia of the Alzheimer's Type, With Early Onset *(also code 331.0 Alzheimer's disease on Axis III)* (154)
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
294.xx Dementia of the Alzheimer's Type, With Late Onset *(also code 331.0 Alzheimer's disease on Axis III)* (154)
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
290.xx Vascular Dementia (158)
.40 Uncomplicated
.41 With Delirium
.42 With Delusions
.43 With Depressed Mood
Specify if: With Behavioral Disturbance

Code presence or absence of a behavioral disturbance in the fifth digit for Dementia Due to a General Medical Condition:

0 = Without Behavioral Disturbance
1 = With Behavioral Disturbance

294.1x Dementia Due to HIV Disease *(also code 042 HIV on Axis III)* (163)
294.1x Dementia Due to Head Trauma *(also code 854.00 head injury on Axis III)* (164)
294.1x Dementia Due to Parkinson's Disease *(also code 331.82 Dementia with Lewy bodies on Axis III)* (164)
294.1x Dementia Due to Huntington's Disease *(also code 333.4 Huntington's disease on Axis III)* (165)
294.1x Dementia Due to Pick's Disease *(also code 331.11 Pick's disease on Axis III)* (165)
294.1x Dementia Due to Creutzfeldt-Jakob Disease *(also code 046.1 Creutzfeldt-Jakob disease on Axis III)* (166)
294.1x Dementia Due to . . . *[Indicate the General Medical Condition not listed above] (also code the general medical condition on Axis III)* (167)
—.— Substance-Induced Persisting Dementia *(refer to Substance-Related Disorders for substance-specific codes)* (168)
—.— Dementia Due to Multiple Etiologies *(code each of the specific etiologies)* (170)
294.8 Dementia NOS (171)

AMNESTIC DISORDERS (172)
294.0 Amnestic Disorder Due to . . . *[Indicate the General Medical Condition]* (175)
Specify if: Transient/Chronic
—.– Substance-Induced Persisting Amnestic Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (177)
294.8 Amnestic Disorder NOS (179)

OTHER COGNITIVE DISORDERS (179)
294.9 Cognitive Disorder NOS (179)

Mental Disorders Due to a General Medical Condition Not Elsewhere Classified (181)

293.89 Catatonic Disorder Due to . . . *[Indicate the General Medical Condition]* (185)
310.1 Personality Change Due to . . . *[Indicate the General Medical Condition]* (187)

Specify type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type

293.9 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]* (190)

Substance-Related Disorders (191)

The following specifiers apply to Substance Dependence as noted:

[a]With Physiological Dependence/Without Physiological Dependence

[b]Early Full Remission/Early Partial Remission/Sustained Full Remission/Sustained Partial Remission

[c]In a Controlled Environment

[d]On Agonist Therapy

The following specifiers apply to Substance-Induced Disorders as noted:

[I]With Onset During Intoxication/[W]With Onset During Withdrawal

ALCOHOL-RELATED DISORDERS (212)

Alcohol Use Disorders (213)

303.90 Alcohol Dependence[a,b,c] (213)
305.00 Alcohol Abuse (214)

Alcohol-Induced Disorders (214)

303.00 Alcohol Intoxication (214)
291.81 Alcohol Withdrawal (215)
Specify if: With Perceptual Disturbances
291.0 Alcohol Intoxication Delirium (143)
291.0 Alcohol Withdrawal Delirium (143)
291.2 Alcohol-Induced Persisting Dementia (168)
291.1 Alcohol-Induced Persisting Amnestic Disorder (177)
291.x Alcohol-Induced Psychotic Disorder (338)
.5 With Delusions[I,W]
.3 With Hallucinations[I,W]
291.89 Alcohol-Induced Mood Disorder[I,W] (405)
291.89 Alcohol-Induced Anxiety Disorder[I,W] (479)
291.89 Alcohol-Induced Sexual Dysfunction[I] (562)
291.82 Alcohol-Induced Sleep Disorder[I,W] (655)
291.9 Alcohol-Related Disorder NOS (223)

AMPHETAMINE (OR AMPHETAMINE-LIKE)–RELATED DISORDERS (223)

Amphetamine Use Disorders (224)

304.40 Amphetamine Dependence[a,b,c] (224)
305.70 Amphetamine Abuse (225)

Amphetamine-Induced Disorders (226)

292.89 Amphetamine Intoxication (226)
Specify if: With Perceptual Disturbances
292.0 Amphetamine Withdrawal (227)
292.81 Amphetamine Intoxication Delirium (143)
292.xx Amphetamine-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Amphetamine-Induced Mood Disorder[I,W] (405)
292.89 Amphetamine-Induced Anxiety Disorder[I] (479)
292.89 Amphetamine-Induced Sexual Dysfunction[I] (562)
292.85 Amphetamine-Induced Sleep Disorder[I,W] (655)
292.9 Amphetamine-Related Disorder NOS (231)

CAFFEINE-RELATED DISORDERS (231)

Caffeine-Induced Disorders (232)
305.90 Caffeine Intoxication (232)
292.89 Caffeine-Induced Anxiety Disorder[I] (479)
292.85 Caffeine-Induced Sleep Disorder[I] (655)
292.9 Caffeine-Related Disorder NOS (234)

CANNABIS-RELATED DISORDERS (234)

Cannabis Use Disorders (236)
304.30 Cannabis Dependence[a,b,c] (236)
305.20 Cannabis Abuse (236)

Cannabis-Induced Disorders (237)
292.89 Cannabis Intoxication (237)
Specify if: With Perceptual Disturbances
292.81 Cannabis Intoxication Delirium (143)
292.xx Cannabis-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.89 Cannabis-Induced Anxiety Disorder[I] (479)
292.9 Cannabis-Related Disorder NOS (241)

COCAINE-RELATED DISORDERS (241)

Cocaine Use Disorders (242)
304.20 Cocaine Dependence[a,b,c] (242)
305.60 Cocaine Abuse (243)

Cocaine-Induced Disorders (244)
292.89 Cocaine Intoxication (244)
Specify if: With Perceptual Disturbances
292.0 Cocaine Withdrawal (245)
292.81 Cocaine Intoxication Delirium (143)
292.xx Cocaine-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Cocaine-Induced Mood Disorder[I,W] (405)
292.89 Cocaine-Induced Anxiety Disorder[I,W] (479)
292.89 Cocaine-Induced Sexual Dysfunction[I] (562)
292.85 Cocaine-Induced Sleep Disorder[I,W] (655)
292.9 Cocaine-Related Disorder NOS (250)

HALLUCINOGEN-RELATED DISORDERS (250)

Hallucinogen Use Disorders (251)
304.50 Hallucinogen Dependence[b,c] (251)
305.30 Hallucinogen Abuse (252)

Hallucinogen-Induced Disorders (252)
292.89 Hallucinogen Intoxication (252)
292.89 Hallucinogen Persisting Perception Disorder (Flashbacks) (253)
292.81 Hallucinogen Intoxication Delirium (143)
292.xx Hallucinogen-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Hallucinogen-Induced Mood Disorder[I] (405)
292.89 Hallucinogen-Induced Anxiety Disorder[I] (479)
292.9 Hallucinogen-Related Disorder NOS (256)

INHALANT-RELATED DISORDERS (257)

Inhalant Use Disorders (258)
304.60 Inhalant Dependence[b,c] (258)
305.90 Inhalant Abuse (259)

Inhalant-Induced Disorders (259)
292.89 Inhalant Intoxication (259)
292.81 Inhalant Intoxication Delirium (143)

292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (168)
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder (177)
292.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W] (405)
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W] (479)
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I] (562)
292.85 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W] (655)
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (293)

POLYSUBSTANCE-RELATED DISORDER (293)

304.80 Polysubstance Dependence[a,b,c,d] (293)

OTHER (OR UNKNOWN) SUBSTANCE–RELATED DISORDERS (294)

Other (or Unknown) Substance Use Disorders (295)

304.90 Other (or Unknown) Substance Dependence[a,b,c,d] (192)
305.90 Other (or Unknown) Substance Abuse (198)

Other (or Unknown) Substance–Induced Disorders (295)

292.89 Other (or Unknown) Substance Intoxication (199)
Specify if: With Perceptual Disturbances
292.0 Other (or Unknown) Substance Withdrawal (201)
Specify if: With Perceptual Disturbances
292.81 Other (or Unknown) Substance–Induced Delirium (143)
292.82 Other (or Unknown) Substance–Induced Persisting Dementia (168)
292.83 Other (or Unknown) Substance–Induced Persisting Amnestic Disorder (177)
292.xx Other (or Unknown) Substance–Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Other (or Unknown) Substance–Induced Mood Disorder[I,W] (405)
292.89 Other (or Unknown) Substance–Induced Anxiety Disorder[I,W] (479)
292.89 Other (or Unknown) Substance–Induced Sexual Dysfunction[I] (562)
292.85 Other (or Unknown) Substance–Induced Sleep Disorder[I,W] (655)
292.9 Other (or Unknown) Substance–Related Disorder NOS (295)

Schizophrenia and Other Psychotic Disorders (297)

295.xx Schizophrenia (298)
The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia:

Episodic With Interepisode Residual Symptoms (*specify if:* With Prominent Negative Symptoms)/Episodic With No Interepisode Residual Symptoms

Continuous (*specify if:* With Prominent Negative Symptoms)
Single Episode In Partial Remission (*specify if:* With Prominent Negative Symptoms)/ Single Episode In Full Remission
Other or Unspecified Pattern

.30 Paranoid Type (313)
.10 Disorganized Type (314)
.20 Catatonic Type (315)
.90 Undifferentiated Type (316)
.60 Residual Type (316)

295.40 Schizophreniform Disorder (317)
Specify if: Without Good Prognostic Features/With Good Prognostic Features

295.70 Schizoaffective Disorder (319)
Specify type: Bipolar Type/Depressive Type

297.1 Delusional Disorder (323)
Specify type: Erotomanic Type/ Grandiose Type/Jealous Type/ Persecutory Type/Somatic Type/ Mixed Type/Unspecified Type

298.8 Brief Psychotic Disorder (329)
Specify if: With Marked Stressor(s)/ Without Marked Stressor(s)/With Postpartum Onset

297.3 Shared Psychotic Disorder (332)

293.xx Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]* (334)
.81 With Delusions
.82 With Hallucinations

—.— Substance-Induced Psychotic Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (338)
Specify if: With Onset During Intoxication/With Onset During Withdrawal

298.9 Psychotic Disorder NOS (343)

Mood Disorders (345)

Code current state of Major Depressive Disorder or Bipolar I Disorder in fifth digit:

1 = Mild
2 = Moderate
3 = Severe Without Psychotic Features
4 = Severe With Psychotic Features
Specify: Mood-Congruent Psychotic Features/Mood-Incongruent Psychotic Features
5 = In Partial Remission
6 = In Full Remission
0 = Unspecified

The following specifiers apply (for current or most recent episode) to Mood Disorders as noted:

[a]Severity/Psychotic/Remission Specifiers/ [b]Chronic/[c]With Catatonic Features/[d]With Melancholic Features/[e]With Atypical Features/[f]With Postpartum Onset

The following specifiers apply to Mood Disorders as noted:

[g]With or Without Full Interepisode Recovery/ [h]With Seasonal Pattern/[i]With Rapid Cycling

DEPRESSIVE DISORDERS (369)

296.xx Major Depressive Disorder (369)
.2x Single Episode[a,b,c,d,e,f]
.3x Recurrent[a,b,c,d,e,f,g,h]

300.4 Dysthymic Disorder (376)
Specify if: Early Onset/Late Onset
Specify: With Atypical Features

311 Depressive Disorder NOS (381)

BIPOLAR DISORDERS (382)

296.xx Bipolar I Disorder (382)
.0x Single Manic Episode[a,c,f]
Specify if: Mixed
.40 Most Recent Episode Hypomanic[g,h,i]
.4x Most Recent Episode Manic[a,c,f,g,h,i]

.6x Most Recent Episode Mixed[a,c,f,g,h,i]

.5x Most Recent Episode Depressed[a,b,c,d,e,f,g,h,i]

.7 Most Recent Episode Unspecified[g,h,i]

296.89 Bipolar II Disorder[a,b,c,d,e,f,g,h,i] (392)
Specify (current or most recent episode): Hypomanic/Depressed

301.13 Cyclothymic Disorder (398)

296.80 Bipolar Disorder NOS (400)

293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition]* (401)
Specify type: With Depressive Features/With Major Depressive–Like Episode/With Manic Features/With Mixed Features

—.— Substance-Induced Mood Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (405)
Specify type: With Depressive Features/With Manic Features/With Mixed Features
Specify if: With Onset During Intoxication/With Onset During Withdrawal

296.90 Mood Disorder NOS (410)

Anxiety Disorders (429)

300.01 Panic Disorder Without Agoraphobia (433)

300.21 Panic Disorder With Agoraphobia (433)

300.22 Agoraphobia Without History of Panic Disorder (441)

300.29 Specific Phobia (443)
Specify type: Animal Type/Natural Environment Type/Blood-Injection-Injury Type/Situational Type/Other Type

300.23 Social Phobia (450)
Specify if: Generalized

300.3 Obsessive-Compulsive Disorder (456)
Specify if: With Poor Insight

309.81 Posttraumatic Stress Disorder (463)
Specify if: Acute/Chronic
Specify if: With Delayed Onset

308.3 Acute Stress Disorder (469)

300.02 Generalized Anxiety Disorder (472)

293.84 Anxiety Disorder Due to . . . *[Indicate the General Medical Condition]* (476)
Specify if: With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms

—.— Substance-Induced Anxiety Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (479)
Specify if: With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/With Phobic Symptoms
Specify if: With Onset During Intoxication/With Onset During Withdrawal

300.00 Anxiety Disorder NOS (484)

Somatoform Disorders (485)

300.81 Somatization Disorder (486)

300.82 Undifferentiated Somatoform Disorder (490)

300.11 Conversion Disorder (492)
Specify type: With Motor Symptom or Deficit/With Sensory Symptom or Deficit/With Seizures or Convulsions/With Mixed Presentation

307.xx Pain Disorder (498)
.80 Associated With Psychological Factors
.89 Associated With Both Psychological Factors and a General Medical Condition
Specify if: Acute/Chronic

300.7 Hypochondriasis (504)
Specify if: With Poor Insight
300.7 Body Dysmorphic Disorder (507)
300.82 Somatoform Disorder NOS (511)

Factitious Disorders (513)

300.xx Factitious Disorder (513)
.16 With Predominantly Psychological Signs and Symptoms
.19 With Predominantly Physical Signs and Symptoms
.19 With Combined Psychological and Physical Signs and Symptoms
300.19 Factitious Disorder NOS (517)

Dissociative Disorders (519)

300.12 Dissociative Amnesia (520)
300.13 Dissociative Fugue (523)
300.14 Dissociative Identity Disorder (526)
300.6 Depersonalization Disorder (530)
300.15 Dissociative Disorder NOS (532)

Sexual and Gender Identity Disorders (535)

SEXUAL DYSFUNCTIONS (535)

The following specifiers apply to all primary Sexual Dysfunctions:

Lifelong Type/Acquired Type

Generalized Type/Situational Type

Due to Psychological Factors/Due to Combined Factors

Sexual Desire Disorders (539)

302.71 Hypoactive Sexual Desire Disorder (539)
302.79 Sexual Aversion Disorder (541)

Sexual Arousal Disorders (543)

302.72 Female Sexual Arousal Disorder (543)
302.72 Male Erectile Disorder (545)

Orgasmic Disorders (547)

302.73 Female Orgasmic Disorder (547)
302.74 Male Orgasmic Disorder (550)
302.75 Premature Ejaculation (552)

Sexual Pain Disorders (554)

302.76 Dyspareunia (Not Due to a General Medical Condition) (554)
306.51 Vaginismus (Not Due to a General Medical Condition) (556)

Sexual Dysfunction Due to a General Medical Condition (558)

625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]* (558)
608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]* (558)
607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition]* (558)
625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]* (558)
608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]* (558)

625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]* (558)

608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]* (558)

—.— Substance-Induced Sexual Dysfunction *(refer to Substance-Related Disorders for substance-specific codes)* (562)
Specify if: With Impaired Desire/With Impaired Arousal/With Impaired Orgasm/With Sexual Pain
Specify if: With Onset During Intoxication

302.70 Sexual Dysfunction NOS (565)

PARAPHILIAS (566)

302.4 Exhibitionism (569)

302.81 Fetishism (569)

302.89 Frotteurism (570)

302.2 Pedophilia (571)
Specify if: Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both
Specify if: Limited to Incest
Specify type: Exclusive Type/Nonexclusive Type

302.83 Sexual Masochism (572)

302.84 Sexual Sadism (573)

302.3 Transvestic Fetishism (574)
Specify if: With Gender Dysphoria

302.82 Voyeurism (575)

302.9 Paraphilia NOS (576)

GENDER IDENTITY DISORDERS (576)

302.xx Gender Identity Disorder (576)
.6 in Children
.85 in Adolescents or Adults
Specify if: Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both/Sexually Attracted to Neither

302.6 Gender Identity Disorder NOS (582)

302.9 Sexual Disorder NOS (582)

Eating Disorders (583)

307.1 Anorexia Nervosa (583)
Specify type: Restricting Type; Binge-Eating/Purging Type

307.51 Bulimia Nervosa (589)
Specify type: Purging Type/Nonpurging Type

307.50 Eating Disorder NOS (594)

Sleep Disorders (597)

PRIMARY SLEEP DISORDERS (598)

Dyssomnias (598)

307.42 Primary Insomnia (599)

307.44 Primary Hypersomnia (604)
Specify if: Recurrent

347.00 Narcolepsy (609)

780.57 Breathing-Related Sleep Disorder (615)

327.3x Circadian Rhythm Sleep Disorder (622)
.31 Delayed Sleep Phase Type
.35 Jet Lag Type
.36 Shift Work Type
.30 Unspecified Type

307.47 Dyssomnia NOS (629)

Parasomnias (630)

307.47 Nightmare Disorder (631)

307.46 Sleep Terror Disorder (634)

307.46 Sleepwalking Disorder (639)

307.47 Parasomnia NOS (644)

SLEEP DISORDERS RELATED TO ANOTHER MENTAL DISORDER (645)

327.02 Insomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]* (645)

327.15 Hypersomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]* (645)

OTHER SLEEP DISORDERS (651)

327.xx Sleep Disorder Due to . . . *[Indicate the General Medical Condition]* (651)
- .01 Insomnia Type
- .14 Hypersomnia Type
- .44 Parasomnia Type
- .8 Mixed Type

—.— Substance-Induced Sleep Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (655)

Specify type: Insomnia Type/Hypersomnia Type/Parasomnia Type/Mixed Type
Specify if: With Onset During Intoxication/With Onset During Withdrawal

Impulse-Control Disorders Not Elsewhere Classified (663)

312.34 Intermittent Explosive Disorder (663)
312.32 Kleptomania (667)
312.33 Pyromania (669)
312.31 Pathological Gambling (671)
312.39 Trichotillomania (674)
312.30 Impulse-Control Disorder NOS (677)

Adjustment Disorders (679)

309.xx Adjustment Disorder (679)
- .0 With Depressed Mood
- .24 With Anxiety
- .28 With Mixed Anxiety and Depressed Mood
- .3 With Disturbance of Conduct
- .4 With Mixed Disturbance of Emotions and Conduct
- .9 Unspecified

Specify if: Acute/Chronic

Personality Disorders (685)

Note: *These are coded on Axis II.*

301.0 Paranoid Personality Disorder (690)
301.20 Schizoid Personality Disorder (694)
301.22 Schizotypal Personality Disorder (697)
301.7 Antisocial Personality Disorder (701)
301.83 Borderline Personality Disorder (706)
301.50 Histrionic Personality Disorder (711)
301.81 Narcissistic Personality Disorder (714)
301.82 Avoidant Personality Disorder (718)
301.6 Dependent Personality Disorder (721)
301.4 Obsessive-Compulsive Personality Disorder (725)
301.9 Personality Disorder NOS (729)

Other Conditions That May Be a Focus of Clinical Attention (731)

PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION (731)

316 . . . *[Specified Psychological Factor] Affecting . . . [Indicate the General Medical Condition]* (731)
Choose name based on nature of factors:
Mental Disorder Affecting Medical Condition
Psychological Symptoms Affecting Medical Condition

Personality Traits or Coping Style Affecting Medical Condition
Maladaptive Health Behaviors Affecting Medical Condition
Stress-Related Physiological Response Affecting Medical Condition
Other or Unspecified Psychological Factors Affecting Medical Condition

MEDICATION-INDUCED MOVEMENT DISORDERS (734)

332.1 Neuroleptic-Induced Parkinsonism (735)
333.92 Neuroleptic Malignant Syndrome (735)
333.7 Neuroleptic-Induced Acute Dystonia (735)
333.99 Neuroleptic-Induced Acute Akathisia (735)
333.82 Neuroleptic-Induced Tardive Dyskinesia (736)
333.1 Medication-Induced Postural Tremor (736)
333.90 Medication-Induced Movement Disorder NOS (736)

OTHER MEDICATION-INDUCED DISORDER (736)

995.2 Adverse Effects of Medication NOS (736)

RELATIONAL PROBLEMS (736)

V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition (737)
V61.20 Parent-Child Relational Problem (737)
V61.10 Partner Relational Problem (737)
V61.8 Sibling Relational Problem (737)
V62.81 Relational Problem NOS (737)

PROBLEMS RELATED TO ABUSE OR NEGLECT (738)

V61.21 Physical Abuse of Child (738) *(code 995.54 if focus of attention is on victim)*
V61.21 Sexual Abuse of Child (738) *(code 995.53 if focus of attention is on victim)*
V61.21 Neglect of Child (738) *(code 995.52 if focus of attention is on victim)*
—.— Physical Abuse of Adult (738)
V61.12 (if by partner)
V62.83 (if by person other than partner) *(code 995.81 if focus of attention is on victim)*
—.— Sexual Abuse of Adult (738)
V61.12 (if by partner)
V62.83 (if by person other than partner) *(code 995.83 if focus of attention is on victim)*

ADDITIONAL CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION (739)

V15.81 Noncompliance With Treatment (739)
V65.2 Malingering (739)
V71.01 Adult Antisocial Behavior (740)
V71.02 Child or Adolescent Antisocial Behavior (740)
V62.89 Borderline Intellectual Functioning (740)
Note: This is coded on Axis II.
780.93 Age-Related Cognitive Decline (740)
V62.82 Bereavement (740)
V62.3 Academic Problem (741)
V62.2 Occupational Problem (741)
313.82 Identity Problem (741)
V62.89 Religious or Spiritual Problem (741)
V62.4 Acculturation Problem (741)
V62.89 Phase of Life Problem (742)

Additional Codes (743)

300.9 Unspecified Mental Disorder (nonpsychotic) (743)
V71.09 No Diagnosis or Condition on Axis I (743)
799.9 Diagnosis or Condition Deferred on Axis I (743)
V71.09 No Diagnosis on Axis II (743)
799.9 Diagnosis Deferred on Axis II (743)

Multiaxial System

Axis I Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention
Axis II Personality Disorders
Mental Retardation
Axis III General Medical Conditions
Axis IV Psychosocial and Environmental Problems
Axis V Global Assessment of Functioning