CSG Justice Center Primer on Mental Health Courts

The Council of State Governments (CSG) Justice Center has released *Mental Health Courts: A Primer for Policymakers and Practitioners.* The primer provides the first comprehensive introduction to this increasingly popular specialty court model, in which individuals with mental illnesses are linked to treatment and receive treatment services while under court supervision. In the late 1990s only a handful of mental health courts were in operation. The Justice Center estimates that more than 200 such courts have now been established in large and small jurisdictions across the country, with many more in the planning phases. A 2007 survey found 18 mental health courts for juveniles in operation; 20 jurisdictions reported plans for such courts.

Mental health courts are one of many approaches taken to address the high level of justice system involvement in this population. Prevalence estimates of serious mental illness in jails range from 7% to 16%, four times the rate for men in the general population and eight times the rate for women. In addition, studies have found that people with mental illnesses are more likely to be arrested than those without mental illnesses when they commit similar crimes and are incarcerated longer than other inmates. These courts also address the consequences of justice system involvement for families and communities. As the authors note, "Like drug courts and other 'problem-solving courts,' 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."

The 25-page primer, which was supported by the Bureau of Justice Assistance of the Office of Justice Programs at the U.S. Department of Justice, provides an overview of this approach for policy makers, practitioners, and advocates. It describes mental health courts' goals and processes, summarizes research findings about their effectiveness, identifies issues to be considered in designing them, and lists resources for jurisdictions interested in starting a program, including sources of grants and other funding, training and technical support centers, written policy guides, and Web sites.

One chapter focuses on the differences between mental health courts and drug courts. More than 2,000 drug courts are in operation in the United States. In many jurisdictions, drug courts paved the way for mental health courts. Some of the earliest mental health courts were created when drug courts needed a more targeted approach to defendants with co-occurring substance use and mental disorders. However, mental illness, unlike illicit drug use, is not in itself a crime, and mental health courts admit participants with a wide range of charges, whereas drug courts focus on drug-related offenses.

Because the features and processes of mental health courts vary so greatly, some have commented, "If you've seen one mental health court, you've seen one mental health court." However, the primer describes a typical afternoon session held in a mental health court that has several features deemed essential to such courts. A 2008 companion publication, *Improving Responses to People With Mental Illnesses: The Essential Elements of a Mental Health Court,* describes ten core elements in more detail and is available for download along with the primer at consensusproject.org.

NEWS BRIEFS

Bazelon resources on mental health in health care reform: The Bazelon Center for Mental Health Law has prepared a series of seven issue briefs on critical areas affecting the integration of mental health services in health care reform. The seven titles are *Overview, Primary Care Providers' Role in Mental Health, Medical Homes and Integration of Mental Health, Improving Care for People With Severe Mental Illnesses, Integration of Mental Health in the Public Health System, Integration of Mental Health in Quality-Assurance Policies,* and *The Role of Federal Programs: Medicaid, SCHI, and Medicare.* Each of the four- to six-page briefs includes recommendations for reforming federal policies. For example, the brief on quality assurance calls for wider use of performance and outcomes measures for mental health services and continued research to refine these measures. It warns about any use of measures for people with serious mental illness that would hold providers accountable for the overall outcomes of these consumers because of the many factors that contribute to their recovery. However, it also notes that "the ultimate measure of services is how individuals are doing in their lives" and urges providers to focus on functioning and wellness. The Bazelon Center encourages advocates to download the briefs and use the policy recommendations in communications to federal and state officials. In particular, advocates are asked to post comments on change.gov, the Obama Administration's Web site for disseminating information and eliciting ideas for reform. The briefs can be downloaded at www.bazelon.org. The new administration's interactive site for health reform is at change.gov/agenda/health_care_agenda.

Kaiser Commission reports on economic turmoil and state Medicaid: As economic conditions worsen, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured has released new resources to provide information and guidance to practitioners, administrators, policy makers, and the pub-

lic. The materials examine the recession's impact on ordinary Americans and their health coverage and on state budgets and Medicaid programs. Because of the way Medicaid is financed, a recession means "double trouble": states have reduced revenue and less money to spend on Medicaid, but more people are losing jobs and health coverage and need the program. The resources include two policy briefs, a report, and a fact sheet, ranging from two to 14 pages. The titles are *Rising Unemployment: Medicaid and the Uninsured, Medicaid in a Crunch: A Mid–FY 2009 Update on State Medicaid Issues in a Recession, The Role of Medicaid in State Economies: A Look at the Research,* and *State Fiscal Conditions and Medicaid.* The materials also include a podcast and transcript of a panel discussion held in early January, "Medicaid as Stimulus: A Tonic for What Ails the Economy?" Six expert panelists examine the effectiveness of past federal increases in Medicaid funding during economic downturns. For example, in 2003–2004 the federal government temporarily increased its share of funding in exchange for states' agreeing not to cut eligibility. The panelists discuss whether such increases stimulate the economy and whether additional federal funding can be justified during a time of declining federal tax revenues and expanding deficits. The materials are available on the Kaiser Commission's Web site at www.kff.org/medicaid.

Practical Guide From APA's Committee on Patient Safety: Ensuring the delivery of safe psychiatric care is the objective of a new guide developed by the American Psychiatric Association's (APA's) Committee on Patient Safety. The 28-page guide was designed to be practical, brief, and to the point but also evidence based. *SAFE MD: Practical Applications and Approaches to Safe Psychiatric Practice* focuses on approaches to safe practice in six areas represented by the letters SAFE MD: suicide, aggression, falls, elopement, medical comorbidity, and drug-medication errors. Two approaches to designing a safe system are described: a proactive approach that involves multidisciplinary teamwork and uses failure mode and effectiveness analysis and a reactive approach that involves learning from mistakes through root cause analysis. Each chapter on a specific SAFE MD area includes one or more case descriptions that vividly describe scenarios in which caregivers failed to protect patients from harm. Summary tables with bulleted lists of risk factors and tips are provided, and key research articles and reviews are listed. The guide is available on APA's Web site at psych.org/safemd.

NSDUH data on serious psychological distress: The recent National Survey on Drug Use and Health (NSDUH) has found that in 2007 one in ten U.S. adults—or about 24.3 million people aged 18 years or older—experienced serious psychological distress in the past year. Forty-five percent of this group received mental health services (inpatient or outpatient care or prescription medication). Serious psychological distress is an overall indicator of past-year mental health problems, such as anxiety or mood disorders. In the NSDUH serious psychological distress is defined as having a score of 13 or higher on the K6 scale, which measures symptoms of distress during the one month in the past 12 in which a respondent was at his or her worst emotionally. The four-page report, *Serious Psychological Distress and Receipt of Mental Health Services,* highlights significant differences by demographic group. For example, the rate of distress was significantly higher among young adults aged 18 to 25 (18%) than among those aged 26 to 49 (12%) or aged 50 years and older (7%). The young adults were far less likely to receive mental health services than the other two groups (29%, 47%, and 54%, respectively). Less than 30% of blacks and Hispanics who experienced serious distress received services, compared with 51% of whites. NSDUH is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA). The most recent survey collected data from a representative sample of 45,000 civilian, noninstitutionalized adults. The report is available on the Web site of SAMHSA's Office of Applied Studies at oas.samhsa.gov.

NIDA report on comorbidity of addiction and other mental illnesses: The National Institute on Drug Abuse (NIDA) has released a research report, *Comorbidity: Addiction and Other Mental Illnesses,* that summarizes the state of the science regarding the complex relationship between substance abuse and other mental disorders. The 12-page report, which would be especially useful with trainees or others who need an introduction to this area of research, describes common factors that can lead to comorbidity, including genetic and gender vulnerabilities, involvement of certain brain regions, and the influence of developmental factors. Specific research areas discussed include childhood attention-deficit hyperactivity disorder and later substance use problems, smoking and schizophrenia, and adolescent marijuana use and psychosis. The report also discusses how comorbidity can be diagnosed and treated. Examples of effective behavioral therapies and potentially useful medications are described. The report is available on the NIDA Web site at www.drugabuse.gov.