Hagen Stauffer:

All right, good afternoon, everyone, and welcome. I am Hagen Stauffer, the communications manager here at NAMI, and the producer for NAMI Webinars. We're very excited to have you join us for today's presentation, NAMI Virtual Town Hall: Mental Health Treatment and the Court System with Aaron Arnold, the Chief Development Officer of All Rise. Just a couple housekeeping items before we begin. All callers are muted. Only presenters can turn their microphone on and off. You can enable closed captions by clicking the CC button and choosing View Subtitle. Chat is disabled to reduce distraction due to the large number of attendees, so please use the Q&A button to submit any questions you have for our presenters. If you'd like to ask a question anonymously, you can check the Send Anonymously button before pressing send. This call is being recorded and will be posted online within a week following the webinar. So, those who register in advance will receive a follow-up email containing a link to view the recording, a PDF of the presentation slides, a certificate of participation, and any additional resources shared by one week from today.

And finally, when you exit the webinar, a brief survey will pop up on the screen. Please do take a moment to share your feedback, as we'd love to hear your thoughts. We'd also like to highlight our NAMI helpline contact info. If you ever need to talk to someone, this line is available 10 a.m. through 10 p.m. Monday through Friday at 1-800-950-NAMI. It's staffed by around 180 volunteers with lived experience who are ready and able to help. And please also remember that you can always call 988 24/7 for crisis service. And with that I'm going to go ahead and hand it over to today's moderator, NAMI, director of Justice Policy and Initiatives, Shannon Scully.

Shannon Scully:

Thanks so much, Hagen, for that great introduction to our webinar. And I want to thank the over 1,000 people who have decided to take time off from their afternoon and join us for this incredible and incredibly important conversation. I just want to take a minute to really ground us in why it's important to continue to have this discussion about the court's role in mental health treatment and diversion of people from the criminal justice system. There's been a lot of recent attention paid to how the courts can play this role in the national policy discussion. And I'm really thrilled to have our partners at All Rise, formerly known as the National Association of Drug Court Professionals on this webinar here today to talk about the work that they've really been doing, leveraging the evidence and the research around recovery and engagement and the use of the court system to support people with substance use disorder and mental illness who become engaged in the criminal justice system.

And so, I'm really thrilled to, I'm not going to spend any more time chatting here. We're going to get onto the substance that you all are here for. I am pleased to introduce Aaron Arnold, who is the Chief Development Officer at All Rise, where he works to develop new initiatives to strengthen justice system responses to substance use and mental health disorders. Prior to joining All Rise he spent 15 years at the Center for Court Innovation, overseeing the center's national work in the areas of treatment courts, community justice, alternatives to incarceration, and more. Aaron has served as a prosecutor with the Maricopa County Attorney's Office in Phoenix, Arizona where he gained firsthand experience working in several problem-solving courts. He's a graduate of Cornell University and the University of Arizona College of Law. So Aaron, I'm going to hand over this presentation to you to get started.

Aaron Arnold:

Thank you so much, Shannon and Hagen. Let me just share my screen real quick so we can move on with this presentation. All right, hopefully you're all seeing that, somebody holler at me if you're not. Again, thanks for having me here. I asked Hagen before today's presentation who all would be in the audience. And what I've been told is that most of you, and this is a good thing for me, is that you are not primarily people who work in the justice system. So we spend a lot of our time at All Rise presenting to judges and prosecutors and court staff and probation officers and things like that, and really kind of help them

improve the way they do business, particularly to help people with substance use and mental health disorders. But it's much more rare for us to be able to talk to an audience that's made up of mental health professionals, individuals who live with mental illness, or those who have loved ones who live with mental illness, and other folks who aren't necessarily immersed in the justice system each and every day.

And so, it's a real pleasure for me to be able to come and talk to you and hopefully give you some valuable information about how the justice system operates and what some of the most promising practices are for doing a better job addressing mental health and the issues that all of you care so much about.

So, with that being said, let's just jump right in. Some of these statistics may be familiar to you, but it's worth reminding ourselves that more than one third of adults who are arrested in the United States have some kind of underlying mental health condition. So, a third of all arrestees, and there are millions of arrests every year, so a third of all those people. And 44% of individuals being held in jails and 37% of those being held in prisons have a mental health condition compared to 18% of the general population.

For those of you who don't know, jails are run by localities, by cities or counties, and therefore short-term stays under a year prisons are run by states or the federal government and the for longer stays over a year. So, adults with co-occurring mental health and substance use disorders make up 15% of RSDs. So, there's a significant number of individuals struggling with both mental health and substance use disorders at the same time, compared to just 2% of the general population. We'll spend a lot of time talking about that overlap later on in this presentation. And finally, more than one in nine adults with a co-occurring substance use and mental health disorder are arrested annually. That's 12 times more than the general population. So, what does that mean for the justice system? What it means for the justice system is that there are an awful lot of individuals coming in the door, if you will, to the justice system who are struggling with mental illness or with substance use or with both.

And quite frankly, between you and me speaking as a former prosecutor and someone who works each and every day with judges and attorneys, like I mentioned, the justice system really does not do a good job handling these issues, and they don't even really have a great understanding of the issues or what their options are. So, one of the things I'm really going to try to talk about today is some of the promising practices that are available for justice systems to seize on and really try to implement in their own jurisdictions. And try to encourage you to speak with folks in your circle who may be able to kind of prevail upon your elected officials, your court administrators, your judges and others to try to adopt some of these kinds of practices so that we can all do a better job.

Now, it's important to point out, as you probably know, that mental illness by itself is not a risk factor for crime. I'm sure you all know that, but when we speak with folks in the justice system we often have to really spend time stressing this, that just because someone has a mental illness or mental health condition does not make it more likely that they will be violent or that they will commit a crime.

There is still, sad to say, a lot of misinformation and false beliefs about what it means to have a mental illness. It is not a risk factor for crime. However, it is well known that there are certain crimes, like the ones listed here on the slide, disorderly conduct, trespassing, shoplifting, and other kinds of quality of life, lower level kinds of crimes that do have a mental health nexus. And that's often because a larger percentage of individuals with mental health conditions may also be suffering from things like being unhoused or other kinds of issues that make it more likely that they will end up getting ensnared in the law with the law for things like trespassing or shoplifting or disorderly conduct.

So, that's one of the reasons why there's so many cases coming into the system through arrest and through charging and prosecution with people who have these issues. So, let's just jump right in. We're going to go through chronologically beginning with the point of arrest or even pre-arrest all the way through the court process. And I'll walk you through some promising practices at each phase. We'll begin with pre-arrest, meaning we're talking about folks who are just out in the community, they have a mental health condition, but they have not yet been arrested and brought into the system. Some of the things that you've

probably heard of, and I'm going to go quickly through these first few ones, because the meat of the presentation is really going to be about courts, but I wanted to give at least some acknowledgement that there are promising practices available before someone gets that deep into the system.

So, one thing that I'm sure most of you are familiar with are crisis call centers. The 988 line that most jurisdictions are standing up now is a good example of that. There is a document that I've linked here on the bottom of the slide. It's really great. It's put out by SAMHSA, federal government, that's about best practices for crisis call centers. And if you read that it says they should be open 24/7. They should be staffed by clinicians, people with clinical expertise. You should be able to communicate with the call center either by traditional telephone but also by text and chat. And they should be able to coordinate a response quickly with the right folks, not just law enforcement, but also clinicians who can come help out in crisis teams and things like that.

Another approach that can be available on the pre-arrest stage is a co-responder crisis response model. Co-responder refers to essentially an approach where law enforcement officers, police officers go out in response to crisis calls with mental health professionals and clinicians. And in many of the models it's really the mental health professionals who are sort of in the lead, with the police officers playing more of a supporting role. And just in case there happens to be an emergency or a flare up that needs a police response. But in the best models the mental health professionals will be allowed to take the lead and engage with people who are having a crisis and in a therapeutic way and not in a way that will lead to escalation or to violence or for god forbid, a death on the scene.

When these programs are implemented well police get extra training in crisis response. They get training in mental illness, they get training in substance use and overdose reversal and overdose prevention, all those kinds of things. It's important that police are not simply sent out in crisis response without having training in the issues that they're going to be facing. And also, their role in a co-responder team and how to be supportive to the mental health professionals. And just one example I picked out of many, many that are available online is a study out of Boston that saw a total of just nine arrests out of more than 1,000 mental health crisis calls in just, this study was from a few years ago. But over a one-year period, there were nine arrests out of a total of 1,000 mental health crisis calls. That's a pretty astounding result and a real change from the status quo from just a decade or two ago. And I got that from the Center for State Governments Justice Center link there at the bottom of the slide, so you can check out that study yourself.

Police deflection programs are a model that we're very supportive of and are really spreading like wildfire around the country. And this is starting to get into that stage where there is going to be, there's potentially going to be an arrest, right? So, the police have been called, maybe they've been called to a shoplifting, maybe they've been called to a disorderly conduct or a trespassing like I talked about before. So, the police are out there on the scene. Many times it's just the police, they're not with mental health professionals, it's not a co-responder model, this is pure law enforcement response. But in jurisdictions where they've developed police deflection programs, what the police have been authorized to do, oftentimes by law or by department policy, is not to arrest people and charge them and bring them to jail for booking, but rather to divert them to services in lieu of an arrest.

This is a huge change in the field. Because again, just not that long ago, if police are out for a call and they see evidence of a crime being committed, they didn't really have too many options in their tool belt or any tools in their tool belt. They really just had to make the arrest book people into jail. These programs, again, they allow police officers at the point where an arrest would traditionally be made to use their judgment and to decide. In this case, there's really no need to bring the person into custody. There's no immediate threat to public safety. And so, instead of making that arrest and bringing someone deeper into the system, we're either going to bring them to somewhere where they can receive services. We're going to give them a referral to somewhere where they can get services, and we'll let them know that if they agree to access services that they need, that they can avoid the arrests and the consequences of arrest.

The original program, the original police deflection program was called the LEAD program, L-E-A-D, Law Enforcement Assisted Diversion. That was started in Seattle, but since then it's spread around to hundreds of communities. You can find out more at the National Lead Bureau or at the PTACC collaborative that's cited at the bottom of the slide. A really exciting and encouraging model. If your community doesn't have a police deflection program. Again, if you're a person who knows how to pick up the phone and knows who to call, I encourage you to sort of get the word out that this is a model that your community should take a closer look at.

And then finally, I think this is the last slide in this section is crisis stabilization centers. Crisis stabilization centers are facilities that provide short-term intensive behavioral health services, both mental health and substance use, overdose reversal, things like that. They take lots of forms. There's no one cookie cutter approach to a crisis stabilization center. They can be in a hospital, they can be in a community clinic, they can be somewhere else. There's a wide range of kind of services that they provide in different communities. But the idea is that there's somewhere that police or family members or others can take people who are in the midst of a crisis that's not jail and that's not going to draw them deeper into the justice system. So again, if your community doesn't have a crisis stabilization center, there's information here on the slide where you can go learn more and see about what you can do to create one in your community.

The research on these models suggests that they do help to reduce jail bookings, which is really kind of what we all want. We know that jail is harmful and traumatic and anti-therapeutic for everyone, but particularly folks who are dealing with mental health conditions.

All right, so that was sort of all preludes to what the meat of the presentation is about, and that is what happens after someone's arrested. Because as we said in those first couple of slides, if you look at the millions of arrests that happen in the United States every year, and you consider that 15% of those people have a mental illness, or you look at the jails and you think 40% of the people held in jails have a mental illness, we're talking on the aggregate about tens of thousands, hundreds of thousands of people who really need services and need new and creative approaches after arrest so that they're not simply incarcerated or led further down into the justice system.

As I was just alluding to, the impact of arrest and jail is increasingly clear from the research, jail is an anti-therapeutic environment. Here at All Rise we are not an advocacy organization per se. We don't take positions because we think that they're philosophically attractive or politically attractive. We are an evidence-based organization, we follow the evidence. So when I stand here in front of you and I say, "Jail is an anti-therapeutic environment," that's not me coming at you as an anti-jail advocate or anything like that. This is what the research says, and the research is voluminous and it's really unambiguous, is that jail is a harmful place to be. It increases suicide risk, it increases overdose risk for people with drug use problems. It causes trauma. And in fact, it increases the risk that someone will commit a future crime, not decrease. And that again, that's even though we work with folks like judges and prosecutors who are working in the system every day, this is news to them. And sometimes it's hard for them to accept the idea that jail actually makes it more likely that someone will re-offend not less.

Despite the fact that the research is very, very clear on that there's still a lot of misinformation or incorrect beliefs about what the effects of jail are. We know that it's destabilizing and harmful, and we know that it's particularly bad for people with mental health disorders. So we really want to try to find ways to keep people out of jail whenever possible. And I can tell you, again, I keep saying it, I was a prosecutor. I have been working with courts for 20 years in this role as kind of a technical assistance provider trainer, that kind of thing. And so, I've worked with courts in almost every state, hundreds of if not thousands, of judges and prosecutors. And I can tell you without any hesitation, at the top of the list for just about everyone we work with in terms of the challenges that they face day to day is mental illness.

The simple fact is that judges and attorneys, probation departments, they struggle mightily with understanding what mental illness is and understanding what their options are for helping people,

connecting people with the treatment that they need, and diverting them away from jail and into options that are better for them and better for the community. It is a massive struggle to help these justice system players, these justice system decision makers to come up with better approaches. As an attorney, I can tell you we get no training, unless we proactively seek it out we get no training and understanding mental illness or what possible responses are. We don't know how to screen for mental illness. We don't even know how to identify the people who have mental health conditions and need extra help or a different approach. And even if we could identify people regularly, consistently, there's very few evidence-based diversion programs that are out there.

So, what do we do? Well, when you break it down it's really, we want three simple things to happen. And this is what we're working day to day to help courts do. One, if you want to help people who have mental health conditions, you have to know who they are. So, courts have to have the tools and the procedures in place to identify individuals who have mental health conditions. That's basic step one. If you don't know who needs help, you can't help them, right? So you have to identify the people who have the conditions.

Second, you have to be able to match these individuals with appropriate treatment and supervision. We're going to talk in depth about what that means.

And third, at the end of the day, what we want to do both for the betterment of the people who we're serving, as well as the community, is to avoid unnecessary jail. Because again, it's simply going to destabilize the individual who's been arrested. It will increase their risk of committing crimes in the future, and it'll put the public in more jackery, not less. So, we want to do better than jail.

That's everything I'm going to talk about for the rest of this presentation is really aimed at accomplishing these three goals. All right, so talking about post-arrest. What are some evidence-based approaches that we can talk about? Now, what you're seeing on the screen here is a document called the Adult Treatment Court Best Practice Standards. This is a document that our organization, All Rise puts out. I have been working with my colleagues. I know my colleague Megan Wheeler is here with us today. Megan and I have been working non-stop for the last few years on updating and revising the best practice standards. I doubt frankly, that many of you are going to go read this document, because it's very lengthy and it's very technical, but I can tell you this is a landmark achievement in the history of the criminal justice system. This is approximately, I don't know, close to 300 pages of evidence-based, research-based best practices for courts to respond to substance use and mental illness and other treatment needs.

It's based on 30 or more years of research, thousands and thousands of studies. And so, it really distills down what works in the justice system for getting better results in cases where people have mental illness or substance use disorders, or both. So, everything that I'm going to talk about in terms of best practices at the court level is really rooted in this research, and that's why I am pointing it out. Even though it's called the Adult Treatment Court Best Practice Standards, the principles and the practices that it outlines are really applicable, not just to specialized treatment courts, but they can be implemented sort of all throughout the justice system. So, this is the research we're going to be based on. And if you are interested in learning more about it, by all means I encourage you to download it. It's free to download it on our website, it's allrise.org/standards. Again, allrise.org/standards. Go check it out.

PART 1 OF 4 ENDS [00:23:04]

Aaron Arnold:

It's, again, allrise.org/standards. Go check it out. It's free. There's no reason not to dig in and learn more. So one of the things that the standards talk about is what you're seeing here on your screen, and that is, we call this the quadrant model. This is the point in the presentation where I will get a little technical. I'll try to make it as digestible as possible for folks who are not necessarily used to these concepts.

But it does get a little technical, and this is actually really important for understanding how the justice system should be approaching these issues. So what you're seeing, again, this is the quadrant model, and

what we're going to be talking about in the next few slides is understanding how to take a person who's been arrested and assess them using validated assessment tools, which we will talk about in a minute, and determining two things.

One, their risk level, and two, their needs. And based on the assessments that we do, people fall into one of four categories. People are either high risk and high need. That's the red. They're high risk, but low need. That's the orange. They can be low risk, high need. That's the blue. And they can be low risk, low need. That's the green. We're going to talk ad nauseum about what all this means.

So if you feel a little confused at this point, just hang tight, we're going to get to it. So what does risk mean? Again, I said for courts to do a better job responding to the needs of people with mental health conditions, they need to understand their risk level and their needs. What does it mean to understand their risk level? What we're talking about here is the risk that that person is going to commit a future crime.

Not the risk that they're going to be violent, not the risk that they're dangerous or anything like that, but simply the risk that they're going to get arrested in the future basically. And I don't know if you know this, but we actually have tools that can predict with pretty good accuracy the risk factors for being rearrested. Just so you know, the most powerful risk factor for being arrested in the future is having been arrested in the past, but there are lots of other risk factors as well.

So when we're talking about risk, we basically just sit the person down, ask them a series of questions. These questions have been proven through research to be predictive about whether a person is going to be a low, medium, or high risk of being arrested again in the future. So that's the first thing we're looking at is, is this person likely or not likely to be arrested in the future?

And that's important information because prosecutors need to know that, right? Their primary job is to protect public safety. And so they need to know if a person is very likely to commit a new crime, moderately likely, or not very likely at all. And judges are going to want to know that too when they're deciding what to do with a case. So that's the first component is risk.

The second is needs. So I told you that quadrant model is looking at both risks and needs. The needs refers to several things. Basically, you can think about it though is a person's need for treatment, their need for mental health treatment, their need for substance use treatment, their need for trauma treatment, and other kinds of treatment. If you want to look at it very technically, we're talking about things like what they call criminogenic needs.

That's things like having peers who commit crimes or peers who engage in antisocial behavior. What they call antisocial thinking patterns or criminal thinking patterns, those are ways of thinking that are basically like, "The law doesn't apply to me. The law isn't important. I don't need to respect social norms. I can kind of do whatever I want." Substance use is a criminogenic need. That means it's associated with committing crimes.

So when we're talking about needs, we're talking about those things, but we're also talking about mental health, housing, literacy, employment, having pro-social activities to engage in, having peers that can support you and help you when you're feeling like you're in need. So the needs assessment is looking at all of these factors and essentially looking at ways in which people can benefit from getting treatment or other kinds of supports.

So again, just to go back for a second, we're talking about risks and we're talking about needs. How do we measure those things? Again, we're talking about when someone gets arrested, when they're brought into the system, in order for the courts to do a better job meeting their needs and getting good results, they need to understand what their risk is and what their need are.

How do we answer those questions? What we do is we use a risk assessment tool and a clinical assessment tool. So every jurisdiction hopefully we'll be using two tool, a risk assessment tool and a clinical assessment tool. The risk assessment tool obviously measures their risk of being rearrested, and the clinical assessment tool evaluates their treatment needs and their other kinds of needs.

Like I said, things like housing and work and all that kind of stuff here. I'm definitely not going to go through this in this presentation, but if you're really interested, what you see here is a sampling of evidence-based or validated assessment tools. The ones on the left are validated tools that measure risk, and the ones on the right are validated tools that assess needs.

We are available to provide more guided assistance if anybody on this presentation wants to follow up about what their jurisdiction can do to adopt one of these tools. But the point that I'm trying to leave you with here is identifying people who need help is not simply a matter of looking at them or sitting down and talking to them. There are validated evidence-based tools that are used to measure risk and need, and that's what courts need to be doing in order to make good evidence-based decisions about how to handle the cases that are in front of them.

So back to the quadrants. Now we've talked about what risk means, risk of committing a future crime. We've talked about what need means, need for substance use treatment, mental health treatment, housing assistance, building a better pro-social peer network, so on and so forth. We've talked about how to measure those things through validated tools.

And now if the jurisdiction is doing their job right, they're doing those assessments with everyone who gets arrested, and now they know, this person in front of me is high risk, high need, high risk, low need, low risk, high need, or low risk, low need. Those quadrants are really where the rubber hits the road, because the response that you want to use as a court is different depending on what quadrant you're in.

In other words, the approach that's going to work for a person in the red box, the high risk, high need box, is very, very different than the approach that's going to work with someone in the green box who's low risk, low need. And if you mess up and you give the low risk, low need person the kind of response that's designed for the high risk, high need person, you're just going to have terrible, terrible results, disastrous results.

Because what you're going to do is you're going to actually do harm to the person and make it more likely that they're going to have problems down the road, both problems in terms of their condition, their mental health condition, as well as problems being rearrested or having trouble with the justice system down the road. So we want to figure out for each person who comes in the system which box do they fall into, and based on that, what is the best response for that person.

And so here is where we're going to talk about the responses. So if a person is high risk and high need, that's the red box. And again, that means they're much more likely than others to be rearrested in the future and they have a lot of treatment needs. So if someone fits that description, what the evidence shows us is the best way we can support that person and put them on a trajectory for long-term success is by giving them lots of supervision and lots of treatment and supportive services.

For the high risk, low need person, that's the orange box, so they're at high risk of committing another crime, but they don't really have a lot of treatment needs. And there are lots of people like this. For those people, you want to keep the intensive supervision so that you can make sure that they're not committing new crimes, but you don't really need to give them a lot of treatment because they don't need it.

And we don't give people treatment that they don't need, because that has the reverse effect and it has a deleterious effect on people. It actually makes them worse. So for those people, lots of supervision, very little treatment on other services. For the blue box, people who are low risk, but have a lot of treatment needs, we don't want to overdo the supervision. We go light on supervision, but lots of intensive treatment and social services to meet their needs.

And then finally, for the green box where someone's both low risk and low need, basically we just want to leave them alone. And what happens too often in the justice system is when we get people who are low risk and low need, and there's lots of those people too, the players in the justice system, the prosecutors, the judges, the probation officers, they all too often have a tendency to want to intervene too much.

They have a hard time accepting the fact that the best thing we can do for this kind of individual is leave them alone. Because if we just leave them alone, they're very likely to get into trouble in the future. So we need to resist the urge to do too much for those people. So I've told you with these four boxes what the approach should look like in terms of how much supervision and how much treatment.

On the next slide, I'm going to show you specific programs that work with each kind of person. So for high risk, high need people, the best approach we have available are specialized treatment courts. So that includes mental health courts, drug courts, veterans treatment courts that are focused on veterans who often have mental health issues that they bring to court, impaired driving courts, co-occurring disorder courts specifically for people with both mental health disorders and substance use disorders.

And we're going to talk about this a lot in a moment, but treatment courts are by far the best, most effective approach we have for people who are both high risk and high need. For people who are high risk and low need, that's the orange box, we want to do diversion. Diversion means not jail. So we want to find a way to divert people away from jail with a heavy focus on supervision, not on treatment.

For the blue box, low risk, high need, we want to do, again, diversion, but this time we want to do it with a focus on treatment, not on supervision. And then finally, in that green box, like I said before, the name of the game here is light touch. Do not over treat or over supervise these people. To the extent that you can, leave them alone. So the rest of the presentation what I'm going to do is talk in a little bit more detail about, well, particularly the three interventions that are listed here on the screen, the red, the orange, and the blue.

So again, high risk, high need, the evidence shows us that the most effective approach we have are treatment courts. And the reason why is because treatment courts effectively combine intensive supervision with intensive treatment in a way that's designed to support and help the person's long-term success. When done properly, treatment courts are extremely effective, and they are not designed to be a punitive model. There's a thousand plus people watching today.

I would not be surprised if there are people out there who've had maybe a bad experience with the treatment court or you know someone who's had a bad experience with the treatment court. It's not to say that all treatment courts get it right all the time. But when treatment courts follow those best practice standards that I showed you on a previous screen, when they follow those standards, they get really, really good results, and they do it in a non-punitive, very supportive, therapeutic manner.

So again, as I've been saying, the research is consistent. They're the most effective approach we know of for high risk, high need individuals. That's after 30 years of experience implementing treatment courts, and it's compared to every other approach that's been studied. They are more effective than anything we know. Whoops, let me go back.

When done properly, they avoid prison, they avoid jail, and they focus primarily on treatment and support and getting people into long-term either recovery from substance use or stability and quality of life if they have mental health conditions. In many, many treatment courts, the way they're built is that if you successfully complete the program, at a minimum, you can avoid jail, prison, but in many cases, you can also have your charges dismissed or reduced.

So even though we're dealing with folks who are high risk and high need and often have very serious charges, the programs are built so that you can avoid the punitive impacts of the justice system and really focus on getting better and having success in the future. I'm just going to go through some of the main features that make treatment courts unique, different than other approaches and that make them effective.

So the first thing that's really groundbreaking about treatment courts is that they're multidisciplinary in nature, so they take a team approach. That's a huge change from traditional justice system practice. Going back 30 years, it was unheard of for prosecutors and defense attorneys to work collaboratively for the success of the defendant, of the person who's been arrested.

And it was unheard of for judges to interact directly with defendants. They always want to talk to the defense attorneys, right? In fact, I've been in court numerous times when I was a prosecutor where the judge would stop the defendant from talking. They would say, "Sir or Ma'am, please don't talk. Let your attorney talk." So everything is done through the attorney.

In a treatment court approach, that's not the case. The judge is encouraged and trained in how to engage directly with the participant. And the team works all together to keep really close tabs on how people are doing, not to catch them in wrongdoing, not to punish them when they mess up, but to make sure that they know if the treatment is working and to make adjustments when it's not, so they can really help support people in their success.

The team includes all the people listed on the screen here. Another thing that the team does is they bring people back to court very frequently. So a new treatment court participant who's just entered the program will come to court every week or every two weeks. That can be reduced later on in the program, but it starts off being weekly for most people.

So very intensive, coming to court all the time, interacting directly with the judge, meeting with the team, reviewing how you're doing, and taking steps to course-correct if someone is, for instance, not showing up at their treatment program or not meeting with their probation officer, or not taking advantage of the services they're being offered, finding out ways to really work with people to make sure they're getting the benefit of the services they're being offered.

The judge and the participant build a supportive alliance. The participant also builds a supportive alliance with their treatment provider, with their case manager, with peers that they may be working with, peers being individuals with lived experience who can help support them through the process. So there's the team approach, frequent meetings, frequent meetings also outside the courtroom with probation and with treatment.

The team meets even before court to really talk in depth about how a person's doing. They get reports from the treatment providers. They get reports from the probation officers. They get reports from other folks who've been interacting with the participants, and they talk about what's working, what's not working, and what steps do we need to take to really...

Again, if there's instances where the person's either not getting the benefit of the services or they're not showing up or they're resisting, what can we do to help steer people in the right direction and get the results that we want? And the nice thing about treatment courts is they are designed specifically so that they can take the tough cases. The standards say and the research supports, treatment courts should be taking violent cases when they can do so safely.

They should be taking cases where people are engaged in drug sales, because we know that lots of people who are in crisis, who have substance use disorders themselves, have mental illness themselves, they're oftentimes out selling drugs and order just to make ends meet or to support their own addiction. Treatment courts are supposed to have broad eligibility criteria.

They're supposed to be taking the tough, tough cases, because we want to take people who are really headed for prison or people who are headed for jail and use treatment court as a way to steer them in another direction and get them away from that path. The next thing to mention about this is when it comes to treatment... I mean, these are treatment courts.

So at their center, they are intended to connect people with the kinds of treatment that they need. So each individual's needs, again, are assessed clinically. We find out exactly what the person's dealing with, whether it's a standalone mental illness, it's co-occurring disorder, whatever the case may be, get them connected with the appropriate kinds of treatment, and to do so in a way that's collaborative and person-centered. This is really important to stress.

There's a misnomer in some circles that treatment courts are very dictatorial about telling people what treatment they're going to get, forcing people to get treatment. By and large, treatment courts are directed

to work collaboratively with the participants to talk about what their treatment goals are, to talk about what kinds of treatment they're open to and receptive to, what treatment providers they're comfortable with, and they come up with a treatment plan that everybody feels good about.

Of course, this is a criminal justice setting and the alternative for a lot of folks who are offered a treatment court option is prison. If they don't want to do treatment court, the option for them is prison. So there is some level of incentive, shall we say, that kind of pushes people toward treatment. We can't shy away from that. But once someone's decided they want to go down this road, the treatment court works with them as much as possible to come up with a treatment plan that everyone can get behind.

There's a lot of supervision, but the supervision is done with a helping lens. The technical term in our field is called core correctional practices. This is essentially a framework for supervision that is not the old school law enforcement catch people in wrongdoing and punish them kind of approach. It's the opposite. It's building an alliance. It's building trust. It's supporting people when they mess up, treating people with respect and dignity.

Really making it clear that even though we sometimes have to let people know that we disapprove of their conduct and that we need to take steps to sanction or punish certain conduct, we're doing so in the spirit of guiding people in the longterm toward success. Again, we're trying not to send people to jail as a sanction. We're trying to figure out what the barriers are and help people overcome them.

The supervision is there, it's intensive, but it's done with a lens of support. I'll skip over that. Treatment courts have a robust system of incentives, that means rewards, sanctions, meaning punishments, and service adjustments to guide people's behavior. So incentives are rewards that the court gives people when they're doing things that are desired, like attending treatment, showing up for their drug testing if they're ordered to drug test, working on getting a job, all the kinds of stuff that they're expected to do in the program.

When they do it, they get copious amounts of incentives and rewards. When they're not doing things they're supposed to be doing or when they're doing things they're not supposed to be doing, there are sanctions, there are consequences, punishments, but those punishments, again, the treatment courts are designed to be therapeutic. And so they're instructed not to send people to jail unless they've tried everything else in their power first.

So they're going to try all kinds of lower-level sanctions, such as making people come to court more often, making people sit in court all day before their case is heard, having people do community service if that's something they're capable of doing, and lots of other lower-level sanctions to help steer people toward correct behavior in the program.

What treatment courts really focus on doing more than anything else is when people are having trouble using service adjustments, changing up their treatment or changing up their supervision to better support them in their long-term success. That's really even more than sanctions is service adjustments are really there to give people better support and better meet their needs.

These programs are long. They tend to be a year or more in length, sometimes two years. And so the courts work with them over time, even through hiccups and through setbacks, to work toward their long-term success. And one thing that treatment courts are instructed very, very strongly to do in the new standards is to avoid the use of jail. So they make it clear through the research that jail has serious negative consequences.

They instruct treatment courts not to use jail unless several less severe sanctions have been tried unsuccessfully. We do not sanction people to jail for ongoing substance use until they are psychosocially stable. And when we do use jail, even though we don't want to, sometimes we have to, when we do, we keep it no more than six days in length.

Because research shows that after that, we begin to have deleterious effects on people in terms of making them more likely to offend in the future and at poorer health effects as well. So there are really strict

guardrails governing how jail is used in these programs. It is used at times when other options aren't working, but it's not the first or the second or the third option.

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Aaron Arnold:

Those aren't working, but it's not the first or the second or the third option. They do do drug and alcohol testing and they do drug and alcohol testing even in mental health courts where there's not necessarily an indication that the individual participant has a substance use disorder. And the reason they do that is because they want to just be sure, because we know that the use of drugs and alcohol can exacerbate mental health symptoms. And so even if there's not an indication that the person has an active addiction or anything like that, they do require drug and alcohol testing just to make sure that nothing's happening that's going to undermine the overall success of the person. And when someone does test positive for drugs or alcohol, again, the knee-jerk reaction is not to send people to jail. It's to figure out why is the treatment not really working the way we want it to, and how can we adjust it in order to get better results?

Okay. So that is wrapping up this section on treatment courts for high-risk, high-need people. Now we're going to talk about the other quadrants pretty quickly and then we'll wrap it up and we'll open it up for questions. So we covered the red box, high-risk, high-need. That was treatment courts. We're now going to talk about out the high-risk, low-need, the orange box, and the low-risk, high-need, the blue box. So in either both of those cases, what we're trying to do is use what we call pre-trial diversion, basically. Okay, so someone's been arrested. Most often, they've been booked in jail, hopefully they've been released on bail or on their own recognizance, and their case is basically pending. They're awaiting trial, they're awaiting resolution of their case. So what we're trying to get courts and their partners to do for those people in the orange quadrant and the blue quadrant is to basically say, "How can we divert them away from prison? What other options do we have?"

And there are lots of jurisdictions, in fact, I'd probably say most jurisdictions in the country that have some kind of diversion program. The problem though is that the details matter. You can't just say, "Oh, sure, we have a diversion program. It looks like this, or it looks like that." Too many of those programs are not really rooted in evidence and therefore they're not really super effective. And so we want to make sure that diversion programs look at the individual. They don't impose cookie cutter requirements across the board. They look at the individual, and like we've been saying throughout, they assess the person's risk level and their specific individualized needs, and they craft a diversion, a path that really fits that person's risk and need and is not sort of just a cookie cutter approach. That's not going to work. So each diversion kind of program will have a supervision component, a treatment component, and social services that are sort of tailored to each individual person's risk and needs.

For people who are in that low-risk high-need quadrant, we want to make sure, again, low risk means if you leave them alone, they're not likely to commit a future crime. So if you have a person who's low risk, not likely to commit a future crime, you don't want to saddle them with a lot of supervision, that's just going to get in the way and make things worse for them. But this person in the blue box has a high need, so we want to make sure that we're giving them plenty of treatment and services. Who is that person in the real world? Who we're talking about here is someone who has minimal criminal history, so few arrests in the past, but they have really significant treatment needs, meaning they got a serious mental health condition or a serious addiction or both. For those people, again, light supervision, but intensive treatment and supportive services. There's a million different ways that could look down on the ground.

But what prosecutor's offices and courts really need to be aware of when they're offering people these diversion programs is that if I have someone who fits this description, it's got to be light on supervision, heavy on the tailored treatment services for that person. If a person doesn't have an addiction, we don't send them to substance use treatment. If a person has a mental health condition, we send them to specialized services that are targeted for that condition. And so that's kind of how we want to design

programs for pretrial diversion. For folks in the orange quadrant who are high risk and low need, again, these are people who are at a high risk for being re-arrested, committing a new crime, but they don't have a lot of treatment needs. So for these people, we want to make sure they're supervised very closely, and we're not giving them treatment that they don't need.

So who is this person in the real world? These are people, sorry, there's an error on this slide. I just realized. I guess I didn't update it. So what the who should say is someone with significant criminal history, someone who has committed crimes in the past and is therefore likely to commit crimes in the future, and minimal treatment needs. So I apologize for that error on the slide, but a high-risk, low-need person is someone with a lot of criminal history and very few treatment needs. And so what we want to do for that person is diversion again, but with a supervision focus, not a treatment focus. So you want to make sure that, for instance, they are required to be supervised by a probation officer to do frequent check-ins with the probation officer at the office, that the probation officer's out doing home visits and visits to their employer and things like that.

They may need to have GPS monitoring if they're serious risk for going out and getting into trouble. They may be on home confinement if they're on a really serious risk of getting into trouble. They're going to be on drug testing probably, but we're not going to make them go to treatment. We're going to make them go to services that they don't need because again, that's really just going to have the opposite effect of what we want. It's not going to help them. It's going to undermine their long-term success. And finally, for that low-risk, low-need box, I'll repeat myself because it's really important. These people don't need anything. They don't need much. Okay, so we're talking about people who have minimal criminal history and minimal treatment needs. These people do get into trouble. If you're a person watching now and you're like, I've never been arrested and I don't really have any serious mental health or substance use needs that require treatment, you could still get arrested tomorrow.

Let's say, people get arrested because they go out to a party, they have too much to drink, and they get a DWI, right? They're not a person who has a substance use disorder. They're not likely to ever get in this problem again, but people do slip up. So you could be arrested even though you are low-risk and low-need, or there's a misunderstanding, you get into an argument with someone at a store or at a park and it escalates and someone calls the cops and you get arrested for disorderly conduct. These things happen. There's a lot of people who get swept into the system even though they're really low-risk and they're low-need. And again, too often what courts and prosecutors and probation like to do is give these people supervision and support and treatment that they don't need, and that is going to make things worse in the long run.

So we want to make sure that we're either leaving these folks alone, just giving them an outright dismissal, letting them go on with their lives, or doing something that's very light touch. I used to live in upstate New York, and one of the things they would do in upstate New York was what was called an adjournment in contemplation of dismissal. So they would basically say, "Look, we're going to let you go today. If you stay out of trouble for six months, your case is going to get dismissed. You don't have to go to any treatment, you don't have to report to anybody. We're not going to be actively supervising you. If you get re-arrested, that's going to be a problem, but as long as you stay out of trouble, you'll never have to worry about us again." And there's lots of other variations of that too, but basically giving people a chance to go on with their lives without a lot of intervention.

Okay, so again, let me go back because we are sort of at the end here. I just want to go back to, sorry, this is probably a little dizzying for you. I'm sorry. I just want to go back to this. Okay? Because this is probably new for almost everyone watching today. So I just want to very quickly recap. The only way, I mean, our goal, as I said before, is we want to identify people who are coming into the court system who have a mental health disorder or substance use disorder or both. We want to figure out who are these people, where are they? And then we want to give them the services that they need and avoid jail. That's the name of the game.

And what I'm suggesting to you here in our presentation today is that decades of research indicate to us that the best way to accomplish those three goals is to assess people's risk, assess their needs, figure out which quadrant they're in, and then tailor your responses appropriately. The high-risk, high-need people should be going to treatment court. The people in the orange and blue boxes should be getting diversion with supervision and services that are tailored to their risk and need levels. And the people in the green quadrant should really be getting very little and mostly allowed to go on with their lives.

Conceptually, this is, I mean, it's a little complicated, but hopefully this is basically straightforward. If we can do this, we can put people in the right box. We can connect them with the right services. We can maximize chances of success for everybody. It's pretty straightforward conceptually. I can tell you from 20 years of helping to do this in the field, it's difficult for justice systems to do. It requires training. It requires hands-on advice and support, and it requires, frankly, people like you who are community members being vocal and demanding that their justice system build better options and not just go through the motions of arresting people, convicting them, and sending them to jail or putting them on probation.

There are better ways. There are evidence-based approaches that courts can use. We've talked about them today, and it's our goal as we go out in our work and as we partner with NAMI and with folks like you in the community to help courts really understand this message and to take the steps that they need to take to build these kinds of evidence-based approaches. So that went by fairly quickly, but we're just at about an hour and we've got plenty of time for questions, and I want to thank you all for your attention and I hope that this has been useful for you.

Shannon Scully:

Thank you so much, Aaron. And do we ever have questions for you? So get ready, because we are going to enter into what I think is going to be a really great Q&A session, lots of engagement here from folks. I think they're really receptive. Based on my reading of the Q&A, folks are really receptive to this idea, really excited about what you guys have to offer. And so first up, I think a lot of people just had this general question, what is the best way for me even to know if there is a treatment court in my area that is available either to myself or my loved one?

Aaron Arnold:

The first thing I would suggest, I guess, and my colleague Megan is on the meeting here too, so if she has answers that I don't, I encourage her to jump in. What I would say is, number one, go to your court's website. A lot of courts have decent websites where they would want to let the public know that we have a treatment court. So try that first. If you can't find anything on your local court's website, I would call the court clerk's office. They probably get a lot of calls. I wouldn't be surprised if these are burned out civil servants, and so they're probably not super eager to answer your questions.

But if you're polite and you call them and you say, "Hey, listen, I just want to know does your court system have a drug court or a mental health court or another kind of treatment court?" I'm sure they can at least say yes or no and point you in the right direction. And if you get really stuck and you can't figure out an answer, you can always call us and we can do a little digging for you and figure it out. But hopefully by either just looking on the court website or calling the court clerk, you can get a straight answer.

Megan:

In addition, you can also go to the National Treatment Court Resource Center. They have an active map and locator for treatment courts nationwide, and you can go on that map that should identify the coordinator of that treatment court in that jurisdiction.

Shannon Scully:

Great. And so here's our other most common question that I think we tend to get when we are learning about best practices and models is if our community doesn't have one, how can we get one started? And what do you think are some of the greatest barriers to getting these started as well as having them available in every community?

Aaron Arnold:

So fortunately, there are over 4,500 treatment courts in the country today. So 4,500 treatment courts spread around the country means that a lot of counties and cities have them. I believe that every state at this point has at least one. So no matter where you are, there's one or more counties or cities in your state that have one up and running. So it's not a totally foreign concept. Your elected prosecutor is likely to at least be familiar with the concept and maybe have experienced or knows people who work in a treatment court in your state. Same thing with your judges. They probably are at least familiar with the concept. They might know a judge in your state who runs a treatment court. So that's the good news is you're not likely to suggest it and get met with glassy eyes or something. People are going to kind of be familiar with the concept, hopefully.

What it takes to get the push to really get it started, the issue is that it's, as I just discussed in the slides, it's a team-based model. So in order to make it work, you've got to get lots of people on board. You've got to get the judges on board, you've got to get the prosecutors on board. You've got to get the public defenders on board, probation department, treatment providers, law enforcement. You can't run an effective treatment court unless you have all of those team members bought in. So there is some hurdle, right? You have to get those people bought in.

There's lots of ways I can think of to do that, everything from going to public meetings and standing up and demanding that your jurisdiction create one if they don't have one, to again, if you have any kinds of connections at all to folks who work in the justice system, picking up the phone, asking for a meeting, sitting down and talking to people and saying, "Can you explain to me why don't we have this program? I understand that their evidence shows they're very effective. They actually reduce costs in the long-term. So help me understand why we don't have one." It's really just about relationships and advocacy and really being heard and letting people know that this is important to the community, and it's something that you want.

You will in some places find resistance. So there are prosecutor's offices that are even today still resistant to the idea of treatment courts. If that's the situation for you, you're in a tough boat. It's hard to start a treatment court without the prosecutor's office. So I won't lie to you. There are barriers in some locations, but by and large, we have found that if we make people familiar with the model, we train them, we make them familiar with the research and their support among the public, then the pieces are in place to make it happen.

Shannon Scully:

Megan, anything you would add to that?

Megan:

No, thank you. Aaron did a fabulous job at explaining that.

Shannon Scully:

I would also say-

Aaron Arnold:

I will say this though. There are federal, well, I don't know these days. For the last 30 years, there have been federal grants available to jurisdictions that want to start treatment courts, and hopefully with the new administration right now, the grants, the federal grants haven't really been released yet, and it's a little unclear what's going to be released. But we're very hopeful that that pattern will continue. And so that's something to make people aware of in your jurisdiction that says, if you're interested in starting something, you don't have to just do it on your own and magically come up with all the resources. There are grants that are available. The grants come with free training and technical assistance. So that's a way to maybe spur people into action.

Shannon Scully:

I was going to say, if you are on this call and you are connected to your local NAMI, a lot of our NAMIs do this advocacy work. This is where some of our great partnership with All Rise comes in. They come in with some of the best practices. We come in with the willingness to bang down any door we possibly can to get some of those best practices available in communities. And to that point around resources and technical assistance, what kind of resources can All Rise provide folks either in starting up a treatment court? Or if they have a treatment court and they're not working in the way that you're kind of presenting to folks here, or folks are feeling like there's just something off because folks aren't succeeding when they engage with that court. What kind of resources can All Rise provide to communities?

Aaron Arnold:

I mean, the short answer is this is our bread and butter. Our whole reason for being is providing that kind of support, helping to launch new treatment courts, and in some cases even more importantly, supporting the treatment courts that already exist to make sure that they're good treatment courts, that they're following the evidence-based practices. So we've got about 60 people on staff, and that's what all of us are doing all day every day is working out in the field with courts. Megan and I and all of us, we're on airplanes all the time, flying to different jurisdictions, offering trainings, doing webinars, going on site, and sort of steering people in the right direction. So we do that with federal grant money primarily. We also do it on a fee for service basis. So if you're in a jurisdiction where there's interest in improving the drug court, your treatment court that you have or launching a new one, we can talk to folks and try to figure out a way to come and help them.

But basically, we use every resource we can get our hands on to offer the support that you're talking about. And we do it through, we have trainings for new treatment court teams where we do intensive, they're like a week long, intensive trainings to help new treatment courts launch and be good from the get go. We have trainings for existing treatment court teams to make sure that they are doing things properly and that they're aware of the latest research. We have trainings specifically for roles. So we have trainings that are just for judges. We have trainings that are just for prosecutors and so on and so forth. We have an online learning system where people can go get free trainings online. That's easily found through our website. So this is what we do, and we try to stretch our money as best we can to help as many people as possible.

Megan:

And you can reach out to us directly, right from our website. There's a contact form that you can fill out, and again, that would be allrise.org/contact, where you can then provide your name and information and we can get back with you.

Shannon Scully:

I'll also do a shameless plug for them. They host a really excellent conference every year, which will be taking place this coming July 20th through the 23rd. Nashville, right, you guys? NAMI has been there the

last three or four years, and when we've had folks from our field attend and staff, it's been really fruitful. So if you have those resources, definitely check it out. It's a worthwhile conference to really kind of go and dig into the folks and hear from folks who are really doing this work and doing it successfully. The next question I have is we had a couple questions about the role that peers and peer support specialists can play in the treatment team. Can you speak to a little bit of that role they can play and how you've seen that contribute to the success in the treatment court space?

Aaron Arnold:

Yeah, a hundred percent. So all the evidence we have to date is that peers can be an incredibly powerful factor in the treatment court model. It is different for every participant, but I mean, there are participants who will openly say, "The most impactful part of this program for me was the peer." Peers really have become central to the model. The research is still evolving a little bit in terms of specifically kind of what the role and responsibility of the peer is. At this stage, the recommendation from All Rise is that courts use peers, they use peers liberally, but that they don't consider the peer to be one of those team members. You may remember there was a slide that listed the team members, judge, prosecutor, defense attorney, community supervision officer, law enforcement officer, treatment provider. As of now, the research doesn't support having the peer serve on the team. And the reason for that is not because they're not important, but rather because the-

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Aaron Arnold:

... reason for that is not because they're not important, but rather because the relationship that they have with the client is so personal and intimate that we don't want to muddy the waters by having them participating in the team meetings and talking about their relationship with the client and the things that the client tells them, that needs to be protected. Anyway, the short answer is we love peers. We think all courts should be using peers. Hopefully your state has a peer certification or training process so that they've gone through some steps to make sure that they understand ethics and professional boundaries and all this kind of stuff. But yes, we love peers. The only caveat we'd like to say is we don't want peers in the team meetings disclosing things that the participants are telling them.

Shannon Scully:

And to that, obviously we are NAMI, we are rooted in the history of families and families of people who are impacted by mental illness and substance use disorder. And so what kind of role can families play in the court process? Do they play a role in the core process? How do you see them fitting in and being involved in this model that you're building?

Aaron Arnold:

Families? That's a great question. I'm going to address that in two seconds. I just want to point out something I forgot. We have a special publication that just came out a year, year and a half ago about peers. And I can't remember the exact title, but it's basically the role of peers in treatment courts, something like that. You can find it on our website. If Meghan is feeling very ambitious, she might be able to find it and put a link into the chat while I'm talking. But there is a good publication on that. Anyway, onto the question about families. Yeah, families can be really critically important in the treatment court model.

If a treatment court is doing its job properly, part of the services that they're offering is family engagement, particularly if the participant is living with family. If you've got a younger participant who is living with parents, if you've got a participant who has a spouse and children, you want to make sure that

the entire family unit is participating in family counseling, that the family is educated about mental health, about substance use, that they understand treatment and recovery, that they can be supportive of the participant. Yes, basically a good well-run treatment court will definitely be including family in the equation and including them in the services so that they're addressing those needs.

Shannon Scully:

We did also have some questions about cultural competency and the evaluation and consideration of either adverse childhood experiences or complex post-traumatic stress disorder. Can you talk about how the standards either do or do not weave in those considerations in the model and maybe why or why not?

Aaron Arnold:

Yeah, I'm very pleased to say that, so the way the standards rolled out is the original standards came out a decade ago and we just basically, in the last year, have issued version two or the second edition of the standards, so they've gone through a full rewrite based on emerging research and stuff. And one of the things that's new in the second edition of the standards is that the standard on treatment used to be called, I think it was just called substance use treatment. It's now been expanded, it's called substance use mental health and trauma treatment and recovery management services. And it's stressed throughout that standard as well as the other standards that it's incumbent upon treatment courts to assess every single participant for potential exposure to trauma or trauma related symptoms or disorders to provide treatment for those disorders and to make sure that every aspect of the program is trauma informed. And that has implications for everything from the way supervision is done, the way home visits are conducted, the way searches are conducted, the way drug testing is done.

There's even guidance for treatment courts now that if you have a participant who's experienced childhood sexual trauma or has sexual assault as an adult, that you consider making adjustments to the drug testing protocol. Because normally in the treatment court we want people to be providing urine specimens and they're observed while they're providing the urine specimens and there's strong science-based reasons why we do it that way. But the new standards, they give guidance that says if you have a client or participant who has exposure to significant trauma and is likely to be retraumatized by providing an observed urine specimen, that you allow them to be tested a different way to avoid retraumatization. And that's just one example. The theme of trauma is woven throughout the standards so that courts are... They're really called upon to understand trauma and to make sure that they're providing treatment and modifying their program to avoid retraumatizing people.

Shannon Scully:

Great. And then we had a couple questions about children and youth and knowing that there is this increasing rise in the number of children and youth who experience mental health conditions, who are becoming involved in the justice system, who at very young ages are engaging in risky substance use behavior. Is there work being done or considerations given to creating these types of models for, I'll say, youth and young adults? Just because children gets into probably a whole different category, but looking at really youth and young adults and how this can apply or maybe shouldn't apply.

Aaron Arnold:

There are actually lots of juvenile treatment courts in the country already. There's a separate set of guidelines for juvenile treatment courts that are also being updated right now. We have, not a division, but we have a team here at All Rise that focuses on these issues for youth. And so yes, the short answer is yes, there are treatment courts for juveniles and what we call emerging adults, so it'd be like 18 to 25 as well as teens and younger. And they present special challenges and considerations. One being trying to determine when a young person meets the criteria for an addiction is more complicated than it is for an

adult, but the models are there, the guidelines are there. It's our job as All Rise to really spread that model and encourage more jurisdictions to take it up and offer these services for youth.

Shannon Scully:

Great. There's also been a number of questions throughout your presentation about the existence of anosognosia in people who are coming into contact with the court system, people who maybe either don't want to engage in treatment, might be in denial that they need to engage in treatment. And so I'll ask maybe a two-fold question. What are courts doing to try to engage these folks, especially since some of them are going to be what we've, I think the friendly term, they're becoming familiar faces with our court system? What are courts doing to try to engage these folks and can they engage in a treatment court even though they may not think that they need to be there or they need that type of care?

Aaron Arnold:

I'm going to give you my best answer with the caveat that I'm just a dumb attorney and I'm not a clinician, so there are people who know a lot more about this than I do. But my understanding, and I understand that anosognosia was recently added to the international, I forgot what the title is, but to the international diagnosis standards and that it is in the DSM-5, not as a diagnosis, but as a factor. I'm going to be very honest with you. This is where the coercive power of the court system can come into play. I know that probably most of the people watching today are probably not super comfortable with the coercive power of the justice system, but it could be argued, and I would argue that the coercive power of the justice system can have a beneficial effect in some cases when used properly.

If a person has a mental health disorder and they have anosognosia and they're in denial or whatever, if they have committed a serious offense and the justice system is prepared to send them to prison, which is where people end up, even if today they're in the system because they're there for some low-level misdemeanor or something, if they're not treated they may work themselves up into a more serious charge simply by the fact that they've been convicted several times. Those people are eventually going to get to the point where they're facing prison. And what the justice system can do at that point is to say, "You are now at the point where you have a decision to make. You can go to prison for five years or you can go to this treatment program. We don't care sitting here today, whether you believe you need treatment or not, we can deal with that in the program."

And frankly, we do that all the time even with people with substance use disorders, forget anosognosia as it pertains to mental health conditions, there's lots of people who have substance use disorders who are in denial about that. And we send them off to treatment court even though they're resistant. On day one they don't think they have a problem, they don't want treatment. They're only going because they want to avoid prison. And the thing that's really interesting is that the research supports this approach. There's this misnomer, this outdated view that a person has to want treatment in order to benefit from it, or they have to hit rock bottom in order to know that they want... This is inaccurate, outdated information. What the research says is that if a person has an external motivating force, even if they're not internally motivated, they don't personally feel that they want treatment or that they need help.

If there's a significant external motivator, and that could be prison, the prospect of prison, it could also be the prospect that your spouse is going to leave you. It could also be the prospect that you're going to lose your job. External forces can give us the motivation we need to get started in a treatment. And then once the treatment has a chance to take hold over a long period of time, the person can really thrive and get all the benefits of treatment even though they weren't interested on day one. I would say the same thing about mental health and anosognosia, which is the coercive power of the justice system can be the kick in the pants that people sometimes need to get into treatment, even if they are resistant. And once we have them in the treatment, if we can keep them in the treatment over the period of months and a year or more, they can have really good outcomes.

Shannon Scully:

Great. And so stemming a little bit from there, we had a question about obviously a court program provides a lot of really great structure and sometimes that structure can be really helpful to someone staying engaged, staying involved in treatment. Can you speak to how courts and for lack of a better term, almost wean people off of that instead of sending someone into just no structure at all, what are ways that courts are working with people to make sure that when they're out of that court program, that they're still being successful in doing what they need to do to stay away from the justice system?

Aaron Arnold:

These are really fantastic questions. They're very sophisticated questions, but I have a good answer for you, I think. A treatment court program generally is structured in phases, generally four phases or five phases. And in short, the way it works is the early phase is the crisis management phase where you're just trying to make sure people are safe and aren't going to die or have some horrible impact. The middle phases are when you're really deep into treatment, you're dealing with people's symptoms, you're dealing with teaching them either how to not to use drugs or to manage their mental health symptoms. As you get into the final phases of the program, those phases are designed specifically to accomplish what you're talking about. In other words, to prepare people for leaving the program and going back to the real world. And the way they do that is that as people obtain the benefits of treatment and build their capacity to function, the treatment court reduces its services slowly and very deliberately.

They will reduce how often you have to meet with your supervision officer. They'll reduce how often you have to drug test. They'll reduce the intensity of the treatment services. And they're doing that slowly ratcheting down specifically to see if you have the ability to continue to succeed as the services are reduced and taken away. And if you make it all the way to the end of phase five, basically what you have shown is you are ready now to take that step out of the program and you have enough internal capacity that you are likely to be able to continue to thrive. The other thing that some courts are starting to do really well is to have aftercare programs where people can actually come back to the court on a voluntary basis and still obtain some services if they want. There are alumni groups where people who have graduated from the program can get together to support each other and to support current participants, so there's a whole system of tools and steps that treatment courts take to prepare people for re-entry into the community and to support them after they leave.

Shannon Scully:

Great. And I do want to just... And I'll respond for both Aaron and I. We do know that anosognosia is a condition, it is in the most recent edition of DSM, but there is a variety of folks that may not have anosognosia, but also maybe more in a level of denial of just what it is that is happening to them or what is... I just wanted to acknowledge to folks, yes to anosognosia, yes to the fact that some people just don't want to engage, but I think that to Aaron's point, you can still leverage... There is still a way in which the court can leverage them, can engage them in services. There can be that kind of outside force that can lead people into that success of engaging in treatment and recovery. I did want to just acknowledge that for folks that... Because there were a couple of comments about just making sure we knew that anosognosia is yes, absolutely a condition where people really don't have a sense of their mental health condition.

I did want to make sure I address this because we are actually getting down low on time. This has been a great discussion and a great presentation, but people really wanted to hear more about both incentives and sanctions. You talked about this, what do you see courts using as incentives and sanctions for folks in the court system? And one example that someone brought up was like, what if someone is not medication compliant? What if someone's found to be... I think that tends to be the big concern within our community, so what kind of incentives and, what did I say, sanctions are you seeing courts leveraging use in this system?

Aaron Arnold:

There's a ton of discussion in the standards about the proper use of incentives and sanctions and service adjustments I should add because those are the three things that go together. In all treatment court programs, but particularly in mental health court programs, the guidance that the standards give is that we really need to focus on incentives more so than sanctions. The research shows that the best ratio of incentives to sanctions is four to one. In other words, you want to give a person four incentives for every sanction that they get. Lesson number one for treatment courts is resist the urge to punish people into compliance and understand that behavioral science shows that people respond much better to incentives, so we're pushing treatment courts toward focusing on rewarding behaviors that are desired, so that's thing number one. Thing number two is sanctions are appropriate and required and can be effective in changing people's behavior when used appropriately.

The thing that treatment courts sometimes don't do appropriately is they use sanctions that are too intense, so they'll use jail or they'll use other kinds of sanctions that are more... The magnitude of the sanction is too high for the behavior. When sanctions are used, again, we want people to do things like, just off the top of my head, and Meghan probably has a better handle on this than I do because she used to be a supervision officer, making people sit in court all day long as a sanction and watch the treatment court docket all the way through, making people wait till go last. We used to say that writing an essay is a thing, but that's really more of a learning assignment, that's not really a sanction. But making people do community service. Again, if that's something that they can do, that's not going to be too onerous for them given their condition. Meghan, what other kinds of sanctions that are like low magnitude sanctions?

Megan:

That's a great question. I'm going to put in the chat, we have a sample list of incentive sanctions and service adjustments that are identified by low, moderate, and high and magnitude of responses. And so it provides you with a tremendous amount of recommendations and examples. When we look at those low magnitude sanctions, we're looking at those verbal warnings, court observation, instruction, what we call instructive community service, traveler association restrictions. There's a number of things on our list that not only list them, but we go into further explanation and further depth of how you would deliver that response or the importance of associating the response to the actual behavior that they're seeing. There's a number of resources. I will put those into the chat here just in a moment.

Aaron Arnold:

Perfect. Thanks so much, Meghan.

Shannon Scully:

Great. Thank you guys. And we will make sure that we get some of these resources that are being dropped into the chat out in our follow-up materials. We are at time. This has been such a great discussion. I really want to thank our partners at All Rise, Aaron and Meghan, this has been wonderful. We will have to have you back again for more content because this was just not enough time and obviously a topic that our audience really, really is interested in engaging more in. Again, thank you so much for your work. Thank you so much for your time. And thank you all audience members for joining us today. We will be sending out follow-up materials, but feel free to reach out to us at NAMI if you have any follow-up questions. Thanks again. Take care.

Aaron Arnold:

Thanks everyone.

PART 4 OF 4 ENDS [01:30:16]