

# Pretrial Issues, Adjudication, and Sentencing

In jurisdictions where the law enforcement recommendations presented in the previous chapter are implemented, a great many people with mental illness who are currently brought to the court system for possible criminal prosecution will instead be diverted to an appropriate placement in the mental health system. For those who are referred for prosecution, the following policy statements and recommendations describe improvements courts can make that will assure that justice is served while meeting the needs of people with mental illness.

The extent to which these improvements can be made depends upon the level of services currently available in a jurisdiction. These policy statements and recommendations are written with two assumptions. The first is that the policy statements and recommendations contained elsewhere in this document pertaining to enhancements to mental health services are implemented (see Chapter I: Involvement with the Mental Health system and Chapter VII: Elements of an Effective Mental Health System). It would be counterproductive for

the court to enhance its referral capacities with no enhancements to existing mental health services. The second assumption is that the jurisdiction provides such services as early appointment of defense counsel; a victim assistance office; pretrial diversion through the prosecutor's office; and a pretrial services program that provides information and options to the court at the initial bail-setting hearing. Many jurisdictions do have all these services, and should be well positioned to take immediate advantage of the recommendations outlined here. Many other jurisdictions lack one or all of these services. Even in such jurisdictions, it would be possible to implement incremental change that could still have a dramatic impact on how the criminal justice system responds to people with mental illness.

The text includes many examples of initiatives jurisdictions have taken to improve the processing of people with mental illness through the courts. The inclusion of these examples is not meant to imply that jurisdictions need expensive new initiatives to make improvements. In many instances, simple adjustments to existing procedures can be very effective.

Several of the events discussed in this chapter—appointment of counsel, consultation with victims, prosecutorial review of charges, and pretrial release/detention hearing—all occur early in the life of a criminal court case. There is, however, no single process employed in all jurisdictions for when a criminal case is filed in court. In some, the defendant is appointed an attorney even before the prosecutor has reviewed the charges, or the two occur simultaneously. In others, the appointment of counsel does not occur until much later in the process. In some, the pretrial release/detention hearing occurs well before either appointment of counsel or prosecutorial review of charges. In yet others, contact with victims occurs even before any of these steps. The appointment of counsel is presented here first since so much of what is being recommended in this document depends on consent of the individual for the release of mental health information, and because consent should not be sought without first offering the person access to an attorney.

## 7

## Appointment of Counsel

## POLICY STATEMENT #7

**Make defense attorneys aware of the following: (a) the mental health condition, history and needs of their clients as early as possible in the court process; (b) the current availability of quality mental health resources in the community; and (c) current legislation and case law that might affect the use of mental health information in the resolution of their client's case.**

When a case is filed in court an inquiry is typically made regarding the defendant's financial ability to retain an attorney. If the defendant is found to be indigent, an attorney is provided. If the defendant is found to have sufficient financial resources, he or she is responsible for hiring his or her own attorney. Not surprisingly, most defendants in criminal cases are appointed counsel because they are found to be indigent.

The unique role that defense counsel plays for his or her client—spokesperson, translator, and court champion—becomes even more important when the client suffers from a mental illness. There are three key issues—all defense related—addressed in this policy statement. First, it is important that defense

counsel have speedy access to existing mental health information about the defendant. Information collected by law enforcement, pretrial services and other justice agencies, or from family members should be made available to the defense as soon as they are assigned or agree to represent a client. Second, attorneys have a responsibility to know about the mental health resources in the community—both their quality and their availability—that might be appropriate for clients with mental health issues, both pre- and post-adjudication. Third, the policy statement underscores the affirmative obligation of attorneys to be current as to laws that could affect their clients who have mental illness.

"Defense attorneys are often ill-equipped to represent people with mental illness. Training about mental illness and mental health resources in the community is a key means of ensuring that defendants with mental illness receive the best possible representation."

**JO-ANN WALLACE**  
*Vice President & Chief Counsel for Defender Operations, National Legal Aid & Defender Association*

**Source:** Personal correspondence

## RECOMMENDATIONS FOR IMPLEMENTATION

**a** **Ensure that defense counsel can identify the mental health status of their clients as soon as possible after appointment.**

The American Bar Association Standards Relating to Providing Defense Services state, "Counsel should be provided to the accused as soon as feasible

and, in any event, after custody begins, at appearance before a committing magistrate, or when charges are filed, whichever occurs earliest.”<sup>1</sup> One of the first actions of defense counsel after appointment should be to identify those clients with severe mental illness. This can be done by interviewing the defendant, and reviewing the police report and the information obtained by the pretrial services program. At least one state, Georgia, has a statute that allows defense attorneys access to state mental health records with the consent of the client.

It can also be done by listening to family members or others who may be in a position to provide useful information about the mental health status of the client. Attorneys should be careful, however, not to divulge information about a client’s mental health status to any of these parties without first obtaining the consent of the client.

**Example: Public Defender’s Office, Hamilton County (OH)**

In Hamilton County, a defense attorney is assigned to the case as soon as it is determined that the defendant may have a mental illness and the case is continued to a special afternoon calendar. The defense counsel consults with the defendant before a clinical assessment is conducted by a mental health clinician.

The mental health system should work with the defense counsel to assure that counsel has all the information needed to effectively represent a client.

**b**

**Ensure that defense counsel can identify alternatives to incarceration in appropriate cases for their clients with mental illness.**

In some jurisdictions it falls to a pretrial services program to identify and track programs in the community that could be used for referrals of defendants, and to probation departments to do the same for post-conviction alternatives. This recommendation calls for the defense to be equally familiar with mental health resources in the local community. Defense counsel should know program admission criteria and requirements; required lengths of stay; confidentiality rules imposed by the program; clinical capabilities; availability; and costs. Finally, defense counsel should be aware of the qualitative performance of such programs.

Obtaining this knowledge may require access by defenders to expert services. In many jurisdictions, the public defender’s office has staff who assist attorneys in finding appropriate alternatives.

**Example: Public Defender’s Office, King County (WA)**

In King County, social workers are assigned to the public defender’s office to help defense attorneys identify and develop mental health treatment alternatives to incarceration for defendants with mental illness.

“Defense attorneys aren’t thinking about me as an individual who has a mental illness. ...They are thinking about the short-term of this case. If they knew more about mental illness, they would do things differently.”

**CONSUMER**

**Source:** Derek Denckla and Greg Berman, *Rethinking the Revolving Door: A Look at Mental Illness in the Courts*, New York, Center for Court Innovation. 2001.

1. American Bar Association, *Standards for Criminal Justice: Providing Defense Services*, 3rd Edition, Washington, D.C., 1992, Standard 5-6.1, Initial Provision of Counsel.

In other jurisdictions—particularly small jurisdictions—defenders may have very limited resources. Yet even then, at least one state has taken on the responsibility of providing expert services to defenders in all parts of the state.

**Example: Georgia Indigent Defense Counsel**

In Georgia, much of the information regarding alternatives to incarceration for people with mental illness is catalogued by the Georgia Indigent Defense Counsel (GIDC), which serves as an information resource center for defense attorneys throughout the state. The GIDC provides defense attorneys with seminars and publications addressing the special needs of clients with mental illness. The GIDC is also available to defense counsel for telephone consultation on individual cases.

### Determining What Is in the Client's Best Interests

A defense attorney representing a defendant with a mental illness can face difficult decisions in trying to determine what advice to the defendant would be in the defendant's best interests. On the one hand, the attorney has an obligation to reduce the defendant's possible exposure to sanctioning by the criminal justice system by removing him or her as quickly as possible from its jurisdiction. To that end, the attorney may believe that the best resolution of a case where the evidence is strong is a quick plea of guilty and acceptance of a short jail term, perhaps even credit for any time served, and may make that recommendation to the court. On the other hand, the attorney may recognize that the defendant will continue to be rearrested if his or her mental health needs are not addressed and that having a criminal record may make it more difficult for the defendant to obtain a job and to receive such services as public housing. In that sense, the attorney may advise that the best course of action is to try to get the defendant accepted into a pretrial diversion program where he or she would be under the supervision of the criminal justice system while in mental health treatment, and where charges would be dropped upon successful completion.

There are no right or wrong answers to this issue. Defense attorneys should present all possible consequences to their clients when discussing options for the resolution of the case.

#### **c** Develop materials and training programs that cover recent legal holdings that might affect the client with a mental illness.

Defense counsel representing persons with mental illness must carefully consider how mental health information may potentially be used—not just in the instant circumstance but in future hearings involving the client as well. Counsel must also be aware of the potential ramifications of actions being considered. For example, advising a defendant to plead not guilty by reason of insanity to a relatively minor offense could expose the defendant to more extensive loss of liberty than in simply pleading guilty. (See Policy Statement 29: Training for Court Personnel.)

#### **d** Make resources available to the family members and friends of people with mental illness to help them navigate the criminal justice system.

When a person with mental illness becomes involved in the criminal justice system, his or her family, friends, mental health service providers, and other advocates may want to help in a variety of ways. Family members may want to inform the defense attorney about the defendant's mental health history, to advocate for the defendant's placement in a particular treatment program, or generally to help their loved one navigate the criminal justice system. Advocates in some communities have developed resources for such situations.

**Example: When a Person with Mental Illness is Arrested: How to Help, Urban Justice Center, New York City (NY)**

Staff at the Urban Justice Center's Mental Health Project have developed a practical handbook for supporters of people with mental illness who have become involved in the criminal justice system. The handbook provides general information about the criminal justice process (arrest, arraignment, meeting with counsel), relevant statutes, and advice for advocates on working with defense attorneys, as well as information specific to the New York City criminal justice system.



## 8

## Consultation with Victim

## POLICY STATEMENT #8

**Educate individuals who have been victimized by a defendant with a mental illness, or their survivors, about mental illness and how the criminal justice system deals with defendants with mental illness.**

Victims in most jurisdictions have constitutional or statutorily defined rights. Generally, these involve the right to be informed of key events in the processing of the case, including charging decisions, plea agreements, and release decisions.<sup>2</sup>

Prosecutors or their agents have traditionally played a key role in the provision of victim support services, including explaining the often complex court processes to the victims of crime. This provision of support—explanations and education—begins as the charges are reviewed and filed, and goes on throughout the court process. It is important to stress that the victim of a crime committed by a person with a mental illness has no more rights than

any other victim in a similar situation, but may have more needs. When the mental health status of the accused is relevant to the processing of the criminal case, the pain of the victim can be exacerbated by the even more confusing jargon, procedures, decisions, and even dispositions that might arise in the prosecution of that person.

It must be kept in mind that most crimes committed by people with mental illness are minor, and may involve no victim. Victims' issues, in general, are most relevant where the crime is a serious one, involving harm or risk of harm to the victim. The recommendation that follows is meant to address these types of crimes.

## RECOMMENDATIONS FOR IMPLEMENTATION

a

**Assure that victim assistance offices have the expertise to meet the special needs of people who have been victimized by someone with a severe mental illness.**

In recent years, great strides have been made in recognizing that victims of crime need assistance understanding both the legal process involved in the

2. See [www.ncvc.org](http://www.ncvc.org) for more on statutes concerning victims rights.

prosecution of their case and their rights as victims. Many jurisdictions have established victim assistance offices that provide services to victims of crime, usually violent crimes.<sup>3</sup> Staff from these offices typically act as a link between the prosecutor and victims, keep victims apprised of the status of the case, explain the court process to victims, and escort victims to court hearings.<sup>4</sup> This recommendation addresses how offices that provide victim assistance can better address the needs of persons who have been victimized by someone with a mental illness.

## Information

In cases where the accused person suffers from a mental illness the victim needs to be aware of the ways in which the criminal justice and mental health systems converge. Defendants with a mental illness may be subject to different legal procedures, such as a competency screening to determine their ability to understand the charges and their fitness to stand trial. In addition, victims may know little about mental illness—its causes, its impact on behavior, and how best to treat it. Providing such information should be viewed not as minimizing the victimization experienced, but as help for victims in understanding why they were victimized—an important part of the healing process.

## Confidentiality versus the Right to Know

The rights of victims to be informed about what is going on with their case must be balanced, however, against the medical privacy rights of the person with mental illness. It may be difficult for victims to understand that the privacy rights of the person who victimized them outweigh their rights to information. There are actions that should be taken, though, to assure that victims receive all the information to which they are entitled. Victims should be informed immediately and as a matter of routine of any actions taken that become part of the public record. These would include when the defendant is being released, whether on pretrial diversion, pretrial release, or as part of a sentence, with the condition to participate in mental health treatment; when a competency screening has been ordered; or when the defendant enters a plea of not guilty by reason of insanity.

In the overwhelming majority of victimizations caused by people with mental illness, however, releasing mental health information to the victim will not

"When someone is victimized by an individual with mental illness they have a huge learning curve. Explaining to victims how the criminal justice system works and what their rights are is one of our jobs. It gets really complicated for us to explain the role of the mental health system. We as advocates often don't understand how the two relate."

**ELLEN HALBERT**  
*Director, Victim Witness  
Division, District  
Attorney's Office,  
Travis County, TX*

**Source:** Personal  
correspondence

3. There are a number of different ways that victims can gain access to these services. The law enforcement agency investigating the crime should have referral information to victims' services. Listings for such services may appear in the telephone directory under either the local prosecutor's or the sheriff's office. These offices may also have web sites with information on how to access these services. The federal government also has taken steps to expand the availability of victims' services with the establishment of

the Office for Victims of Crime (OVC) within the Office of Justice Programs of the U.S. Department of Justice. OVC provides funding to state and local victim assistance programs. Information about OVC is available at: [www.ojp.usdoj.gov/ovc/](http://www.ojp.usdoj.gov/ovc/)

4. While many of these offices are administratively located in the prosecutor's office, they can also be found in the local department of corrections, sheriff's department, police department, or probation office.

be an issue because the victim is already aware of the situation. It is estimated that 85 percent of those victimized by a person with a mental illness are either family or friends of the perpetrator.<sup>5</sup> These victims need assistance at yet another level. A typical reaction of a loved one who has been victimized by a person with mental illness is to try to obtain help for that person. After perhaps experiencing numerous victimizations without pressing criminal charges, these victims ultimately may turn to the criminal justice system out of fear or frustration. When doing so, they may feel torn by being the complaining witness against a loved one. When they wish to do so, they should be advised on such issues as how to contact the defendant's attorney, how to assist in getting a signed consent to the release of the defendant's mental health information, and who to contact in the jail to make sure that the defendant is receiving his or her medications. They may also require additional supportive services to help resolve issues of guilt in reporting their loved one.

In short, in addition to the general role of victim assistance to explain how the criminal justice system works and what victims' legal rights are, when the alleged perpetrator has a mental illness victim assistance should also be prepared to do the following:

- explain the causes of mental illness and the impact it can have on a person's behavior;
- explain how the mental health system works, including confidentiality requirements;
- define terminology that the victim may encounter, such as "competency," "mental health court," and "Not Guilty by Reason of Insanity;" and
- help family members or others who have been victimized by a loved one with mental illness deal with issues of guilt.

### Victims with Mental Illness

It is important to note that, contrary to the public perception that people with mental illness are more likely to commit violent crimes, studies show that individuals with mental illness are actually more likely to be the victims of violent crimes than people without mental illness. Though this issue is, in large part, beyond the scope of this report, victims' assistance offices should consider developing the expertise to meet the special needs of victims who have mental illness. These crime victims often face a variety of challenges, including low employment, lack of affordable housing, and substance abuse.<sup>6</sup>

5. *Victims of Mentally Ill Offenders: Helping Family Caregivers and Strangers At Risk of Assault*, New York University, Ehrenkranz School of Social Work's Institute Against Violence, December 2000.

6. Hiday et al., "Criminal Victimization of Persons with Severe Mental Illness."



## 9

## Prosecutorial Review of Charges

## POLICY STATEMENT #9

**Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases involving people with a mental illness.**

As the representative of the state, the prosecutor is responsible for ensuring that criminal cases are resolved in the best interests of justice.<sup>7</sup> The best interests of justice can sometimes be served by extending to the individual the opportunity to address issues that may have led to the commission of the alleged offense without prosecuting the individual. When the case involves a minor offense or first-time offender, the prosecutor has the authority in many jurisdictions to provide that opportunity through pretrial diversion.

Authorizing which defendants will be offered pretrial diversion rests with the prosecutor and is addressed on a case-by-case basis in accordance with the laws of the jurisdiction authorizing diversion. Unlike the pretrial release/detention decision discussed in Policy Statement 11, the decision of whether to offer the defendant the opportunity to

participate in a pretrial diversion program is at the discretion of the prosecutor. Prosecutors typically rely on a number of criteria, including the potential danger to the community, the nature of the offense, the defendant's prior criminal record, and the wishes of the victim, in reaching a diversion decision. When faced with a defendant with a mental illness, prosecutors should also look at the relationship between the defendant's mental condition, whether the defendant was receiving adequate community treatment, and the behavior that led to the arrest.

Highlighting diversion programs designed especially for people with mental illness by no means suggests that these individuals should not have the same access to any diversion programs that are available in a jurisdiction to a person without mental illness.

7. "The prosecutor must seek justice. In doing so there is a need to balance the interests of *all* members of society, but when the balance cannot be struck in an individual case, the interest of society is *paramount* for the prosecutor," (emphasis in the original). National District Attorneys Association, *National Prosecution Standards*, Commentary to Standard 1, p. 11.

RECOMMENDATIONS FOR IMPLEMENTATION

**a Provide sufficient dispositional opportunities for people with mental illness for prosecutors to employ early in the court process.**

The crux of this recommendation is the need for more dispositional diversion programs for individuals with mental illness who come in contact with the criminal justice system. Pretrial diversion programs have been in existence in many jurisdictions for decades, serving mostly first-time offenders or those charged with minor offenses. The earliest diversion programs were based on the recognition that the justice process itself could be harmful—in some instances, criminogenic—and that for certain types of defendants, “diverting” them from the traditional process into a rehabilitative program and holding their charge in abeyance would reduce the likelihood of recidivism.<sup>9</sup> This same recognition surfaces when considering the person with a mental illness who is charged with a crime.

There are jurisdictions that provide pretrial diversion opportunities specifically for defendants with mental illness.

**Example: Mental Health Diversion Program, Jefferson County (KY)**

In Jefferson County, the Mental Health Diversion Program serves nonviolent defendants charged with either misdemeanors or felonies who suffer from chronic mental illness and have a history of treatment for mental illness. Defendants who are placed in pretrial diversion undergo intensive treatment for a period of six months to one year. Upon successful completion, the charges are dismissed.

Several jurisdictions have been developing models for community prosecution, in which prosecutors reach out to the community to seek input and assistance in both preventing and responding to crime. Community prosecution may be an effective vehicle for expanding the opportunities for diverting from prosecution people with mental illness.

**b Ensure that the defense and the mental health community work together to provide, in appropriate cases, mental health information to the prosecutor for use in pretrial diversion decisions.**

When an arresting officer brings a case to the prosecutor’s office, a prosecutor screens the case to determine whether to file criminal charges, and, if so, which charges.<sup>10</sup> The police report, which describes the circumstances that led

The use of the term “diversion” here employs the definition spelled out in the Diversion Standards of the National Association of Pretrial Services Agencies. “[A] dispositional practice is considered diversion if: (1) it offers persons charged with criminal offenses alternatives to traditional criminal justice or juvenile justice proceedings; and (2) it permits participation by the accused only on a voluntary basis; and (3) it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt; and (4) it results in a dismissal of charges, or its equivalent, if the diveree successfully completes the diversion process.”

8. National Association of Pretrial Services Agencies, *Performance Standards and Goals for Pretrial Release and Diversion*, August 1995, p. 1.

9. For an excellent review of the early years of diversion programming, see John P. Bellassai, “Pretrial Diversion: The First Decade in Retrospect,” *The Pretrial Services Annual Journal* 1, 1978, pp. 14-41.

10. According to the standards of the National District Attorneys Association, prosecutors should exercise that discretion using several criteria, including the strength of the evidence against the accused and the agreement of the victim to cooperate. Two other criteria are undue hardship caused to the accused and the availability of suitable diversion and rehabilitative programs. National District Attorneys Association, *National Prosecution Standards*, 1990.

to the arrest of the individual, might note any overt behaviors that are indicators of mental illness. (See Policy Statement 5: Incident Documentation.) That report usually is made available to prosecutors very early in the life of the case—sometimes within hours of arrest. Often, however, prosecutors may have no indication of possible mental health issues when reviewing the arrest information. The arrestee may not have exhibited symptoms of mental illness at the time of the incident, or the officer may have believed that the person was under the influence of drugs or alcohol. Without such information, the prosecutor cannot consider special accommodations that the defendant might need to be successful in pretrial diversion or any specialized mental health diversion program that might be appropriate. Procedures have been implemented in some jurisdictions to gather mental health information for the pretrial diversion decision.

**Example: Pretrial Services Program, Pima County (AZ)**

In Pima County, the prosecutor uses information collected by the pretrial services program for the pretrial release hearing to identify misdemeanor defendants who have a mental illness and who might be candidates for pretrial diversion. Those placed in the diversion program undergo a 180-day treatment program. Charges are dismissed upon successful completion of the program; prosecution resumes if the program is not completed.

In this example and others like it, the defendant has given prior written consent for the release of mental health information for the purpose of determining possible placement in a pretrial diversion program. The consent should be provided only after the defendant has consulted with his or her attorney. (See Policy Statement 7: Appointment of Counsel, for more on consent issues.) The consent provided should be in writing and explicitly specify what information the defendant is consenting to have released, who is being authorized to make the release, the parties to whom the information will be released, and the purposes for which the information is to be used. Finally, the release of mental health information should be consistent with all applicable confidentiality and ethical requirements, as well as conforming to the principle that the information released is the minimum necessary to make an informed pretrial diversion decision. All information collected through this process should also be made available to the defense attorney.

### Identifying the Sources of Mental Health Information for Court Officials

A key issue in the release of mental health information to criminal justice officials, regardless of the decision point, is identifying all the sources of this information in individual cases. This can be problematic, especially in larger jurisdictions where the individual may have received services at a number of different locations, or where the individual is transient, moving from one jurisdiction to another. Ideally, the individual's most recent clinician should have as up-to-date a history as exists.

Identifying the correct source of information requires that the individual cooperate, supplying the name of the attending clinician and providing consent to contact the clinician.

In cases where the individual has no prior history of receiving mental health services it may be necessary to have an assessment conducted by a mental health clinician before a decision — pretrial diversion, pretrial release, adjudication, or sentencing — is made. In such instances, the incident that led to the arrest may have been the individual's first indication that he or she may have a serious mental illness.

**C Expand the options available in rural areas to provide mental health services for people with mental illness who might be candidates for pretrial diversion.**

The opportunities for identifying or establishing the resources that would provide the range of options discussed here are much greater in urban and suburban areas than they are in rural areas. In fact, in many rural areas there may be no options at all. The chief problem that rural areas encounter as it relates to viable options for those with mental illness who are in the criminal justice system is the lack of mental health professionals. For example, more than half of the 3,075 counties in the United States—all of them rural—have no practicing psychiatrists, psychologists, or psychiatric social workers.<sup>11</sup>

The mobile units that law enforcement and mental health officials have teamed up in recent years to institute in many urban jurisdictions may hold clues for developing a model for options that can be used by courts to develop release alternatives in rural jurisdictions. These units are designed to respond rapidly to a person in a mental health crisis so that an arrest is avoided and the person is taken to an appropriate mental health facility. In rural areas, such mobile units may provide the courts with alternatives by bringing mental health treatment resources to those who need it. It may also be useful to make greater use of telemedicine, in which mental health professionals are available to conduct private telephone consultations with mental health patients from a remote location.

The federal government has been attempting to address the shortage of health care workers in rural areas since 1987, when the National Advisory Committee on Rural Health (NACRH) was established within the Department of Health and Human Services (HHS) to seek solutions to health care problems in rural areas. The committee has made several recommendations, such as: increase the awareness of health care opportunities in rural areas and ensure that students are academically prepared to take advantage of these opportunities; and create incentives for health care practitioners to practice there. Such incentives include financial support for students who will commit to service in rural areas, enhancement of Medicare reimbursements for rural providers, and granting tax credits to providers who serve rural areas. Many of these recommendations have been followed and have brought some relief to the health care shortages in rural areas.<sup>12</sup>

The U.S. Department of Justice, currently through its Bureau of Justice Assistance, also provides block grant funding to the states. In the past, block grant funds could be used for a number of different purposes, including to address alternatives to detention for those who pose no danger to the community.<sup>13</sup>

HHS has sought to address the mental health needs of rural residents through the Mental Health Block Grant program, which provides funding to states to improve access to mental health services.<sup>14</sup> More than \$350 million is allocated to this program annually. In order to receive their block grant funds, states must submit plans to address the mental health needs of various state subpopulations, including those who live in rural areas.<sup>15</sup>

State and local officials should work together to ensure a coordinated use of block grant funds from the Departments of Justice and HHS to address the mental health treatment needs of people who have been charged with criminal offenses in rural areas.

**11.** Georgine M. Pion and Harriet McCombs, *Mental Health Providers in Rural and Isolated Areas: Final Report of the Ad Hoc Rural Mental Health Provider Work Group*, Rockville, MD: The Center for Mental Health Services, 1997.

**12.** *National Rural Health Policy: Recommendations from the First Eight Years of the National Advisory Committee on Rural Health*, Rockville, MD: Of-

fice of Rural Health Policy, U.S. Department of Health and Human Services, 1997.

**13.** See the Web site of the Bureau of Justice Assistance at: [www.ojp.usdoj.gov/BJA](http://www.ojp.usdoj.gov/BJA) for the latest guidelines on the use of block grant funds.

**14.** *Ibid.*

**15.** *Ibid.*

## 10

## Modification of Pretrial Diversion Conditions

## POLICY STATEMENT #10

**Assist defendants with mental illness in complying with conditions of pretrial diversion.**

Once the prosecutor agrees to offer the defendant the opportunity to participate in pretrial diversion, the defendant is interviewed by a representative of the pretrial diversion program to determine the most appropriate conditions of diversion. These pretrial diversion programs, which also monitor compliance with diversion conditions, fall administratively either within the office of the prosecutor or report to the prosecutor.

A defendant should be informed of the specific program requirements, length of program duration, and sanctions for noncompliance. Because people with mental illnesses, in many instances, will have difficulty understanding this information and fol-

lowing through on their requirements, extra care is required to ensure that these defendants report for initial intake into the appropriate service and continue their participation.

Pretrial diversion programs that serve people with mental illness should recognize that this population often presents a range of problems that should be addressed in an integrated fashion. They may need assistance in locating affordable housing, in handling their finances, in traveling back and forth to diversion program appointments, or in obtaining employment or job training. All pretrial diversion programs that serve people with mental illness should be designed to address these problems.

## RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Ensure that interview protocols used by pretrial diversion staff on defendants with mental illness include questions to identify those with co-occurring substance abuse disorders.**

One way to assist defendants with mental illness in complying with conditions of pretrial diversion is to recognize that the majority also suffer from co-occurring substance abuse problems. According to several studies, rates of both mental health and substance abuse disorders are significantly higher in crimi-

nal justice populations than in the general population.<sup>16</sup> Individuals with co-occurring disorders present unique challenges that must be addressed by the mental health and substance abuse treatment communities. Individuals with co-occurring disorders, when compared to individuals with a single disorder, have heightened psychosocial difficulty, including an increased likelihood of problems with finances, social roles, education, housing, transportation, and marital stability.<sup>17</sup> In addition, people with co-occurring disorders experience more psychotic symptoms, have more severe depression and suicidality, have higher rates of incarceration, have more difficulty with daily living skills, are more noncompliant with treatment regimens, and are high service utilizers.<sup>18</sup>

## **b** Design pretrial diversion conditions to address individual issues presented by each defendant.

Conditions of pretrial diversion should be the least restrictive necessary and reasonably calculated to accomplish the goal of pretrial diversion, which is to reduce the likelihood that the person will recidivate. When a defendant is currently in mental health treatment and the treatment is helpful, it should be a requirement that he or she continue treatment as a condition of diversion. If the defendant expresses significant concern regarding the usefulness of that treatment, a mental health consultation may be needed to determine whether there are better alternatives available. When the defendant is not currently in treatment, an assessment should be conducted by a qualified mental health professional to determine the most appropriate treatment for the defendant, and then a referral should be made to begin that treatment. This assessment should be conducted on an outpatient basis.

Those with co-occurring substance abuse and mental health disorders should receive integrated treatment. Barriers to specialized treatment for this population include differing mental health and substance abuse treatment philosophies and practices, policies that exclude active substance abusers from mental health treatment, policies that exclude persons with active psychosis or other symptoms of mental illness from receiving substance abuse treatment, and separate local, state, and federal funding streams for mental health and substance abuse treatment.

**16.** S. Keith, D. Regier, D. Rae, and S. Matthews, "The prevalence of schizophrenia: Analysis of demographic features, symptom patterns, and course," *International Annals of Adolescent Psychiatry* 2, 1992, pp. 260-84; M. Weissman, M. Bruce, P. Leaf, L. Floria, and C. Holzer, "Affective Disorders" in *Psychiatric Disorders in America* edited by L. Robins and D. Reiger, New York, Macmillan, 1992; and L. Robins and D. Regier, *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*, New York, Free Press, 1991.

**17.** L. Pollack, G. Stuebben, K. Kouzekanani, and K. Krajewski, "Aftercare Compliance: Perceptions of People with Dual Diagnosis," *Substance Abuse* 19, 1998, pp. 33-44; A. Laudet, S. Magura, H. Vogel and E. Knight, "Recovery Challenges Among Dually Diagnosed Individuals," *Journal of Substance Abuse Treatment* 18, 2000, pp. 321-29.

**18.** F. Osher and R. Drake, "Reversing a History of Unmet Needs: Approaches to Care for Persons with Co-Occurring, Addictive and Mental Disorders," *American Journal of Orthopsychiatry* 66:1, 1996.

Treatment providers and the criminal justice community should be aware of the complexity involved in diagnosing co-occurring disorders and adapt professional practices accordingly. Identification of those with co-occurring disorders should occur in the early stages of criminal justice processing.

Research indicates that an integrated model of treatment is most effective for people with co-occurring mental and substance abuse disorders.<sup>19</sup> That is, both the mental disorder and substance abuse disorder are treated in the same service setting, using cross-trained staff proficient in both mental health and substance abuse disorder therapy. Too often, co-occurring disorders are treated sequentially — individuals receive treatment in one system first (either mental health or substance abuse) followed by treatment in the other—or concurrently—that is, individuals receive both mental health and substance abuse treatment at the same time, but with different therapists or at different agencies. In both of these models, the burden of coordinating or integrating treatment lies with the client. (See Policy Statement 37: Co-occurring Disorders.)

Boundary spanners—people who act as liaisons to bridge mental health, substance abuse and criminal justice systems—should be knowledgeable about both mental health and substance abuse disorders and provide such information to the courts. (See Policy Statement 26: Institutionalizing the Partnership, for more on boundary spanners.)

**Example: Drug Court, Lane County (OR)**

In Lane County, a mental health specialist trained to deal with co-occurring disorders is assigned to the jurisdiction's drug court in the dual role of case manager and court liaison to assist with people with co-occurring disorders who are placed in the drug court.

**C Develop guidelines on compliance and termination policies regarding defendants with pretrial diversion conditions that recognize the needs and capabilities of people with mental illness.**

The National Association of Pretrial Services Agencies (NAPSA) has standards for pretrial diversion that should prove useful in developing compliance and termination policies for defendants with mental illness who are placed in diversion programs.<sup>20</sup> Those standards state that diversion conditions should be clearly written in a service plan signed by the defendant and the diversion program representative. “Knowing exactly what is expected will decrease the likelihood of a participant’s being unsuccessful in treatment.”<sup>21</sup> The service plan should also detail what actions could be taken in response to the participant’s failure to comply with the conditions. The diversion program rep-

19. The National GAINS Center, *Treatment of people with co-occurring disorders in the justice system*, Delmar, New York, The National GAINS Center, 2000.

20. National Association of Pretrial Services Agencies, *Performance Standards and Goals for Pretrial Diversion*, August 1995.

21. *Ibid.*, Commentary to Standard 4.1, p. 20.

representative should explore any noncompliance with diversion conditions to determine whether the violation was willful, was a symptom of the mental illness, or was an indication of the need to change the treatment plan. It must be recognized that decompensation and other setbacks are common occurrences for people under treatment for mental illness as the attending mental health clinician seeks the most appropriate treatment.

Defendants who are terminated for unsuccessfully completing the program should have their cases returned, without prejudice, to the regular court calendar. Defendants should also be allowed to withdraw from diversion and have the prosecution of their cases resumed without prejudice.

# 11

## Pretrial Release/Detention Hearing

### POLICY STATEMENT #11

**Maximize the use of pretrial release options in appropriate cases of defendants with mental illness so that no person is detained pretrial solely for the lack of information or options to address the person's mental illness.**

Usually within a day of arrest, a defendant will appear in court where a judge or magistrate will determine whether or not the defendant should be released pending adjudication of the case, and if so under what conditions. In making that decision, the judicial officer weighs the risks posed by the defendant to fail to appear in court and the potential threat to the community's safety if the defendant is released.

Judges, like any decision maker, seek to make informed decisions and to have a range of options at their disposal. Armed with the kind of information outlined below and improved options, the courts

should be in a position to minimize the unnecessary pretrial detention of people with mental illness.

This is not to suggest that people with mental illness should never be detained. It is particularly important, though, that mental illness itself not be used as a reason to detain a defendant in a case where a defendant with no mental illness facing similar charges and with a similar criminal record would likely be released. In such cases where the criminal charges do not warrant detention and the judge's primary concern is the defendant's mental illness, facilitating access to services should be considered instead of resorting to criminal detention.

### RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Facilitate the release of mental health information where appropriate for use at the pretrial release hearing.**

Both mental health and criminal justice officials are bound by professional codes of ethics that define the doctor-patient, lawyer-client relationship. Communications between mental health providers and their clients, or attorneys and their clients, are protected from disclosure unless the client specifically

provides written consent for the release of information.<sup>22</sup> As in cases where pretrial diversion is being considered, the written consent should explicitly state what information the defendant is consenting to release, who is being authorized to make the release, the parties to whom the information will be released, and the purpose to which the information is to be used. Recognizing that the privacy rights of the individual with a mental illness must be balanced against the needs of the court to have all the information that might be relevant to assessing the defendant's risks to public safety and of failure to appear in court, the information released should be the minimum necessary to make an informed pretrial release decision. (See Policy Statement 25: Sharing Information, for more in-depth recommendations on information sharing.)

For the pretrial release decision, the defendant is under no obligation to provide the court with any private information, including mental health status. In many instances, though, it is in the defendant's best interests to do so since it might facilitate his or her release and allow for the continuation of existing treatment. Seeking consent for the release of information from an individual who may have a mental illness, however, must be done with extreme caution because the mental illness may impair the person's ability to give informed consent.

If the individual has provided consent to the release of the information, the next step is to gain access to that information. Jurisdictions have taken different approaches to obtaining mental health information for the pretrial release hearing.

**Example: Connecticut Mental Health Center**

Mental health staff from the Connecticut Mental Health Center receive each day a list from the court of all individuals just arrested that they cross-reference with their database to see who is currently in their system. Staff then interview the defendant and, in coordination with the public defender's and the pretrial services offices, develop a plan for release. This plan is then submitted to the court.

Two other issues that must be addressed in a discussion of obtaining mental health information are the ethical guidelines of mental health professionals and the timeliness of receiving that information. Mental health clinicians are prohibited from conducting a mental health assessment before the defendant has had an attorney assigned and has consulted with the attorney. Jurisdictions have addressed these ethical guidelines in a way that allows for a timely assessment of a defendant's mental health status.

22. Every state has either statutory or regulatory provisions that specify the confidentiality guidelines for the protection of mental health information, although the states vary greatly in the protections that are provided. Given the variance in state protections and concern about the growing ease of electronically exchanging private health information, in 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191), which,

among other things, directed the U.S. Department of Health and Human Services to establish regulations for the protection of all medical, including mental health, information. Those regulations, which supercede state laws that provide less protections, became effective on April 14, 2001. The regulations permit access to and dissemination of mental health information as outlined here.

**Example: Public Defender's Office, Broward County (FL)**

In Broward County, where mental health clinicians conduct an assessment before the pretrial release hearing, the clinicians are on the staff of the public defender's office. This expedites the process of conducting a mental health assessment while ensuring that the client has received appropriate consultation with an attorney.

It is also important to respect established boundaries when court and mental health professionals work together in these ways. Mental health clinicians should not make recommendations regarding whether the defendant should be released pretrial; they should limit their presentation to the court to the defendant's mental health condition, history, and needs and how those needs can be addressed.

**b** Ensure that a neutral entity is available to provide the pretrial release decision making officer with all the information relevant to that decision, including mental health status, and with viable options to address any identified mental health issues.

According to American Bar Association Standards, every jurisdiction should establish a neutral entity that gathers all the historical information that is relevant for the pretrial release decision.<sup>23</sup> In many jurisdictions, there is no designated agency that conducts these functions, particularly in nonmetropolitan areas. In those jurisdictions, the judicial officer presiding at the pretrial release hearing typically receives information directly from the defendant, from the arresting law enforcement agency, and, if present, from prosecution and defense.

In many other jurisdictions, pretrial services programs or their functional equivalent provide this information. When these programs interview a defendant, it is standard practice to inform the defendant of the purpose of the interview, how the information will be used, and of the defendant's right to refuse to answer any or all of the questions. The scope of services provided by these agencies, including the populations that they target, the information that they gather, and the options that they provide to the court, vary greatly across jurisdictions.

Since jurisdictions vary so widely in the mechanisms used to obtain and disseminate information relevant to pretrial release decision making, it is not possible to recommend a single approach to providing the court with the defendant's mental health information. However, several principles should be followed. First, jurisdictions should have some neutral entity that provides the pretrial release decision-making officer with all the information relevant to that decision. Second, defendants should be advised that they have the right to

23. American Bar Association, *Standards for Criminal Justice*, Chapter 10: Pretrial Release Standards, American Bar Association, 1989.

speak with an attorney before answering any questions, and that they have the right to refuse to answer any questions. Third, the neutral entity should provide the judicial officer with viable options to address identified mental health issues.

In its interview with the defendant, the neutral entity should ask whether the defendant has any mental health problems and whether he or she has ever been treated, either inpatient or outpatient, for a mental health problem. The entity should recognize, however, that a history of mental health treatment is not necessarily an indicator of higher risk of failure to appear or rearrest. For example, if a defendant reported having received mental health counseling after a traumatic event in the past, this information may not be relevant to the pretrial release decision and the interviewer should use discretion in recording that information. The interviewer should note behavior, such as the defendant seeing things or hearing voices that are not apparent to the interviewer.

In some instances, the pretrial interviewer will be unable to conduct an interview with the defendant because the defendant's mental condition precludes communication. This situation often can be resolved quickly once the defendant is reconnected with his or her mental health caseworker.

**Example: Data Link Project, Maricopa County (AZ)**

As part of the Maricopa County Data Link Project, the local behavioral health authority receives an automated list of every person booked into the local jail. The computer at the health authority seeks matches from the jail list with the list of more than 12,000 clients who receive mental health services in the area. When a match is found, the person's caseworker is notified and can intervene quickly to see that the person is receiving proper medications while in jail and to assist in discharge planning.

The discussion thus far makes an assumption about people who have been referred to the courts by law enforcement and who have been identified—by observations of third parties, from the results of a mental health screen, or by the person's own statements—as possibly suffering from mental illness. The assumption is that the person has a history with the mental health system and will direct court officials to the source of information about that history. In many cases, however, the incident that led to the instant arrest may have been the first manifestation of a mental illness. In other cases, the person may have had a history with the mental health system, but either out of mental impairment, deliberate deception, or a simple refusal to respond did not divulge that history when asked about it.

A particular problem arises for the pretrial release decision maker when a person is arrested on a charge that involves violence—even if just a simple assault—and there are clear indications that the person may be suffering from a mental illness, but the person denies any current or past mental health treatment. The person might also have no prior record of arrests or convictions that

could guide the pretrial release decision maker, who is required to weigh risk of future violence in making a release decision. The best course of action may be to have the court order a mental health assessment by a qualified mental health professional. That assessment should confirm whether there are mental health issues, including past police contacts with the defendant, that resulted in referrals to mental health facilities in lieu of arrest.

**Example: Pretrial Program, Hamilton County (OH)**

In Hamilton County, pretrial program staff team up with mental health professionals to have an assessment completed by a mental health clinician prior to the initial pretrial release hearing. All defendants who are identified by the pretrial services program during its early morning interviews as having possible mental health issues are then placed on an afternoon calendar for their pretrial release hearing. The program alerts the court's Psychiatric Clinic, and a clinician from that office conducts the assessment before the afternoon hearing. This approach provides an assessment by a trained mental health clinician with the results reported to the pretrial release decision maker without having to continue the case to another day.

**c** **Ensure that interview protocols used by pretrial services staff also include questions to identify those with co-occurring substance abuse disorders.**

This issue was described in the discussion earlier of pretrial diversion, and that discussion applies here. It is of even more importance, though, that screening by pretrial services staff for co-occurring disorders be conducted for the pretrial release/detention decision. While pretrial diversion may be offered to only a small percentage of persons with mental illness who have been arrested, all of them must have a pretrial release/detention hearing. (See Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 37: Co-occurring Disorders.)

**d** **Ensure that at the initial hearing defense counsel are prepared to offer, in appropriate cases, an alternative to pretrial detention for defendants with mental illness.**

Inherent in this recommendation is the support for the American Bar Association's call for defense to be present at the initial appearance of all defendants. The initial appearance is a critical juncture in all cases for all defendants. As stated by the American Bar Association, "[D]eterminations made in the course of first-appearance proceedings are the most important in the criminal process for many defendants." But the circumstances are hardly ideal: "Regrettably, these vital decisions often are reached under circumstances that would not be tolerated at trial. Courtrooms often are noisy and overcrowded,

cases are...treated hurriedly, and the entire process is motivated by the single aim of ‘moving the calendar.’ And as for the defendants, ‘...they are likely to be confused, exhausted, and frightened, particularly if they have had no earlier experience with the criminal justice system.’<sup>24</sup> Some defense attorneys have taken steps to be prepared.

**Example: Public Defender’s Office, Honolulu (HI)**

In Honolulu, by the time a defendant with mental illness appears in court at the initial hearing, usually the morning after arrest, the public defender will have discussed a release plan with the defendant and the mental health staff who work out of the jail.

One important issue that should be addressed in the context of the pretrial release decision is the release status of defendants who have been ordered to undergo a competency examination. The American Bar Association recommends that a defendant “otherwise entitled to pretrial release” should not be detained solely for the purpose of conducting the competency examination. According to the ABA, confinement for competency evaluation and pretrial release are two separate issues that courts should consider and rule on separately.<sup>25</sup>

e

**Ensure that mental health information presented to the presiding judicial officer at the pretrial release/detention hearing is limited to an indication of whether the defendant has a mental illness, and, if so, options for addressing it in the pretrial release decision.**

Mental health information is relevant to the pretrial release decision.<sup>26</sup> Therefore, a defendant’s mental health status should be reported to the judicial officer making a pretrial release decision—with the consent of the defendant. It is sufficient in most cases to report the information that there are mental health issues.

**Example: Jail Diversion Project, Connecticut Department of Mental Health and Addiction Services**

Under a program run by the Connecticut Department of Mental Health and Addiction Services, mental health clinicians conduct assessments of defendants with mental illness prior to the initial appearance in court. These clinicians are employed by the Department of Mental Health, and not the courts. The only information that they provide to the court is a treatment plan. The nature of the illness and any diagnoses are kept confidential. If the client agrees to allow the clinician to share more information with the court, it is sometimes easier to prepare a treatment plan.

24. American Bar Association, *Pretrial Release Standards*, Commentary to Standard 10-4.2(a), 1988.

25. American Bar Association, *Criminal Justice Mental Health Standards*, Standard 7-4.3 and accompanying commentary.

26. In 34 states and the District of Columbia, and in the federal system, the judicial officer is required to assess two types of risks: that the defendant will fail to appear in court and that the defendant will pose a risk to the safety of the community. In the remaining jurisdictions, only the risk of flight is examined. John Clark and D. Alan Henry,

“The Pretrial Release Decision,” *Judicature* 81:2, September/October 1997. Most state statutes require the judicial officer to consider a number of factors in assessing these risks, including: the nature of the current charge; strength of the evidence; prior criminal history; prior record of appearance in court; current probation, parole, or pretrial release status at the time of arrest; ties to the community; and the defendant’s character, reputation, and mental condition. John Goldkamp, “Danger and Detention: A Second Generation of Bail Reform,” *Journal of Criminal Law and Criminology*, Northwestern University School of Law, 76:1, 1985.

## f

### Establish programs that provide judges, prosecutors, and defense attorneys with options to address the mental health needs of people with mental illness.

Providing judicial officers with a defendant's mental health information at the pretrial release/detention hearing without presenting options to address the mental health needs of defendants would likely lead to more unnecessary pretrial detention of those with mental illness. Information and options must go hand-in-hand. Options that might be used include assertive community treatment or intensive case management; a rehabilitation program that offers assistance in finding, getting, and keeping housing, employment, and benefits; crisis residential services; and inpatient treatment. For the reasons noted earlier in the pretrial diversion discussion, it is also important that pretrial release options include a range of integrated services, including housing, financial assistance, transportation assistance, and employment counseling, and address the needs of defendants with co-occurring substance abuse and mental health disorders.

A specialized mental health program that is designed to meet the needs of people with serious mental illness who have come in contact with the criminal justice system can address this broad array of options.

#### Example: Community Support Program, Milwaukee (WI)

In Milwaukee, the Community Support Program (CSP) of the Wisconsin Correctional Service screens defendants identified at the pretrial release hearing as having possible mental health problems. If released with conditions, CSP develops an individualized treatment plan and assigns a caseworker to monitor the day-to-day implementation of the plan. Within CSP there are housing specialists available to assist those with housing needs, and medical and pharmacy services to prescribe and administer medications. The program also has the capability to offer financial services to help clients obtain and maintain both private and public health benefits.

It is also important to ensure that the treatment resources are available in the jurisdiction whenever needed.

#### Example: Pretrial Services, Tulsa County (OK)

In Tulsa County, the Tulsa Pretrial Services works closely with the local mental hospital, which is next door to the jail, to ensure that both inpatient and outpatient treatment is available.

"The ability to monitor people on release status is limited, especially for low level crimes. Many of these people need close supervision, which is just not available. Appropriate housing oftentimes is impossible. Without medication and proper supervision, few housing programs are willing to accept individuals with criminal charges and mental health problems. The result is that the defendant stays in jail."

#### HON. MICHAEL D. SCHRUNK

*District Attorney,  
Multnomah County, OR*

**Source:** U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21 2001

---

**g****Design pretrial release conditions to address individual risks and needs posed by each defendant.**

An important principle that should be followed in imposing conditions of pretrial release, particularly on the population of those suffering from mental illness, is that the conditions be the least restrictive necessary to ensure the safety of the public and appearance in court. Overburdening defendants with mental illness with extraneous conditions of release raises the possibility that they will be unable to handle them and will fail to meet their requirements.

---

**h****Expand the options available in rural areas to provide mental health services for people with mental illness who are charged with a criminal offense.**

Many pretrial services practitioners in rural jurisdictions admit that the typical action taken at a pretrial release hearing involving a defendant with mental illness is that a money bond is set. Few, if any, options exist for those requiring attention to their mental illness, and judges believe that they have no alternatives but to set a money bond. Most often that bond is unattainable for the defendant, who then spends the next several weeks or months in jail while the case is adjudicated. This is an outcome that satisfies no one—judge, prosecution, defense, or defendant. In fact, the person with mental illness in all likelihood will decompensate quickly. As noted in the discussion of expanding pretrial diversion options in rural areas, a possible approach to expanding mental health resources may be with the use of mobile units and telemedicine. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for more on telemedicine.)

# 12

## Modification of Pretrial Release Conditions

### POLICY STATEMENT #12

**Assist defendants with mental illness who are released pretrial in complying with conditions of pretrial release.**

Once conditions of pretrial release are set by the court they are monitored by a pretrial services program. If the defendant fails to comply with the conditions, the program notifies the court, after which the court can revoke the release, modify the conditions, or issue a warning to the defendant.

Conditions of pretrial release are set for the purpose of minimizing risks that the defendant will present a danger to the community or fail to appear in court. Defendants with a mental illness may have particular difficulty in understanding and fulfilling those conditions. In addition, an individual with mental illness who has been detained in jail—even for a very brief period following an arrest—can face tremendous obstacles upon his or her release. In many instances, the greatest challenge is to find a suitable, affordable place to live, or to identify a family member or friend with whom to reside. Other

challenges may include reestablishing eligibility for disability benefits under the federal Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicaid programs, getting back to work or other meaningful daytime activity, and establishing a connection with a provider of mental health services to ensure that appropriate treatment and support are provided in the community. Another challenge upon release may be that jail time has interrupted treatment or has altered the medication regimen, which may cause some post-release difficulties and adjustments. Thus, it is in the interests of both the defendant and the court that assistance be given to defendants in meeting the conditions of release. In addition, under the Americans with Disabilities Act, it may be required that people with mental illness be given the assistance they need to comply with pretrial release conditions.

## RECOMMENDATIONS FOR IMPLEMENTATION

- a** Streamline administrative procedures to ensure that federal and state benefits are reinstated immediately after a person with mental illness is released from jail.

People with mental illness who are unable to afford private insurance to help pay for treatment costs may be eligible for Medicaid. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more on detainees' Medicaid and Social Security eligibility.)

- b** Develop guidelines on compliance and termination policies regarding defendants with pretrial release conditions.

Placing court-ordered mental health conditions of pretrial release on those with mental illness must be accompanied by the ability to monitor compliance with those conditions. The judge and the defense attorney should make clear to the defendant the consequences for violating release conditions. The responses to condition violations should reflect the nature of the violation and should, unless the violations are severe, gradually escalate before imposition of the ultimate response—revocation of release.

It is important to have a written understanding regarding compliance and termination policies. When a court orders a defendant to enroll in or maintain treatment, whether it be for a mental illness, or for drug or alcohol abuse, deference must be paid to the treating clinician regarding the status of the person in treatment. Decomensation itself should not be considered a violation and the first response to noncompliance should be an attempt to adjust the treatment. Thus, the clinician or treatment program must assess the client's compliance with the order to participate in treatment on a case-by-case basis. However, the treatment program should provide the court and the referring agency with written guidelines outlining its general policy for determining whether a client is in compliance and when it is time to both successfully and unsuccessfully terminate a client from treatment.

When a violation of a pretrial release condition has been alleged, the court should hold a hearing looking into the circumstances of the alleged violation before taking action on the violation. Such circumstances should include attempts by the defendant to comply; reasons cited for noncompliance; and the nature of the violation. The court should consider that people with mental illness commonly experience relapses while in treatment, and that finding the most appropriate treatment is often a matter of trial and error for the treating

clinician. Before imposing punitive sanctions for noncompliance, the court should conclude that the defendant was capable of complying but chose not to.

Given the difficulties that defendants with mental illness may have in complying with conditions of pretrial release, it may be beneficial to have specially trained staff from pretrial release and diversion programs be responsible for supervising defendants with mental illness.

**Example: Pretrial Services Program, Bernalillo County (NM)**

In Bernalillo County, New Mexico, a team of three specialists from the pretrial services program supervises defendants with a mental health condition of release. These specialists work closely with a Forensic Case Manager who facilitates client treatment and acts as liaison between treatment services and the criminal justice system.

To protect the therapeutic/treatment relationship, mental health treatment programs should not report compliance and terminations directly to the court, but through the referring court entity—the pretrial services program or the pretrial diversion program. In most cases, it would be sufficient to provide compliance information in summary form. An exception would be if staff of the treatment program became aware of a specific threat that the client may pose. In that instance, the professional guidelines of the clinician should dictate the most appropriate method of response.



## 13

## Intake at County / Municipal Detention Facility

## POLICY STATEMENT #13

**Ensure that the mechanisms are in place to provide for screening and identification of mental illness, crisis intervention and short-term treatment, and discharge planning for defendants with mental illness who are held in jail pending the adjudication of their cases.**

Defendants not released at the pretrial release/detention hearing are booked into jail pending the posting of bail or the adjudication of the charges. Being jailed after arrest is a particularly critical period of time for a person with mental illness because the stress of incarceration can significantly raise the risk of decompensation. There are several important services that should be provided while the defendant is in custody, including identifying those detainees with mental health problems; addressing any immediate concerns about their men-

tal health; attending to their mental health needs while in custody; and planning for their transition back to the community.

Many of the recommendations below, while especially relevant to pretrial detainees, also apply to sentenced inmates, whether they are in jail or in prison. For a thorough review of the issues that should be addressed when a person with mental illness is incarcerated, see Chapter 4: Incarceration and Re-entry.

## RECOMMENDATIONS FOR IMPLEMENTATION

**a Screen all detainees for mental illness upon arrival at the facility.**

This recommendation calls for screening to be conducted on all detainees, regardless of their known history of mental illness and their presenting appearance. (See Policy Statement 17: Intake at Correctional Facility for Sentenced Inmates, for a more thorough discussion of screening procedures.)

In the majority of jails, staff immediately screen new admissions for basic issues that might affect housing assignment and safety, but many of these screens fail to address mental health issues. The screening should occur at the point of intake, before placement in a housing area. The screening should be done using a standardized instrument developed under the direction of a quali-

fied mental health professional. Booking staff should receive training in how to use the instrument and interpret the results. Several states, including Colorado and Montana, have statutes that require administrators of detention facilities to mandate screening for mental illness at the time of intake. In Montana, the screening is intended to identify misdemeanants who could be diverted from the detention facility into mental health services.

When the screen shows possible indications of mental illness, the screening officer should arrange for a more thorough examination by a qualified mental health professional. Some jurisdictions have developed a multitiered approach to identifying people with mental illness.

**Example: Screening, Summit County (OH) Jail**

The Summit County jail has a three-tiered approach that includes the initial screening by the booking officer, a cognitive function examination by a mental health worker, followed by an evaluation by a clinical psychologist.

Jails should also ensure that the screening protocol includes identification of suicide risk. Given the high rates of suicide in jail when compared to those occurring in the general population, it is important that great care be taken in identifying those at risk of suicide.

**Example: Suicide Screening Initiative, Montgomery County (MD) Detention Center**

In Montgomery County, detained inmates are screened at three points of intake using the same set of seven questions: at central processing, upon institutional intake, and as part of medical screening. When an inmate is first processed through the Central Processing Unit, an officer completes the Suicide Screening Form, comprising seven items relating to current suicidal ideation and past history of suicidal/self-destructive behavior. There are specific questions regarding mental health history and current psychiatric treatment. When inmates are processed through intake, the same form is completed a second time. Inmates answer the questions a third time when nurses at medical intake use the same questionnaire. The document first used at Central Processing follows the inmate throughout this process. If an inmate answers affirmatively to any of the questions at any point along this three-part process, a referral is generated to mental health services, who then conduct an assessment.

**Example: Suicide Prevention Screening Guidelines Tool (SPSG), New York State**

New York State has developed a Suicide Prevention Screening Guidelines (SPSG) tool that is used in all local lockups, county jails, and state prisons throughout the state. SPSG was developed and approved by the New York Commission of Correction and the Office of Mental Health and has been validated through numerous research projects. It consists of a structured interview conducted during the booking process by booking officers, and examines risk factors from past behavior, the inmate's current situation, and mental status. If there are indications that the inmate may be suicidal, the booking officer contacts the shift commander for immediate intervention, who arranges for increased supervision of the individual.

"Building internal jail mental health programs at the expense of community based treatment just doesn't make sense. We need to help people with mental illness in their communities, not wait until they arrive in jail to provide adequate treatment."

**ART WALLENSTEIN**  
*Director, Montgomery County Department of Corrections, MD*

**Source:** Personal correspondence

When resources do not allow for a timely, comprehensive, in-house follow-up assessment to a screen, such as may be the case in rural or remote settings and small facilities, creative alternatives should be found. These might include contracting for services with community mental health, or making provision for interns at local universities who might be available to conduct assessments on site on a part-time basis. Another option is telepsychiatry, where a qualified mental health professional is able to interview and examine the detainee through the use of telephone or closed-circuit television. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for examples of telepsychiatry and electronic communication arrangements in use in Texas and Alaska.) When a delay in providing a follow-up assessment is unavoidable, jail personnel must provide adequate supervision to ensure the physical safety of an inmate at risk of suicide until professional mental health services can be provided.

Individuals admitted to jail facilities may be withdrawing from a psychoactive drug, including both illicit substances and psychotropic medication. It is important that an observation period extend through the first 72 hours of detention and that the screening protocol be repeated if the detainee's behavior indicates the possibility of post-acute withdrawal or mental decompensation. Jail medical staff should also keep in mind that many psychotropic medications, particularly ones that are used in injectible forms, can take several weeks to clear a patient's system. Intake screeners and anyone reviewing medical records should look for indications of such long-lasting drugs and take steps to ensure that suicide screening and prevention measures are extended over several weeks in appropriate circumstances. This is particularly important in jails that have a limited pharmacy and may change the type of drug or form of administration.

**b** **Work with mental health service providers, pretrial service providers, and other partners to identify individuals in jail who may be eligible for diversion from the criminal justice system.**

The admission of an individual with mental illness into a county or municipal detention facility presents an opportunity to determine whether continued involvement with the criminal justice system is the most appropriate strategy to address that individual's situation. Once a detainee has been identified as having a mental illness, corrections officials can work with pretrial service programs, mental health service providers, and other partners to determine whether the detainee may be eligible for programs that provide an alternative to further detention. Some states, such as Montana, have passed legislation

## Steps in Suicide Prevention<sup>27</sup>

Eight essential steps for an institution suicide prevention plan:

- (1) Training of correctional staff, who are the primary observers of behavior when mental health staff are unavailable;
- (2) Immediate screening at intake and ongoing assessment;
- (3) Communication between transport officer and corrections officer, facility staff and mental health staff, and facility staff and inmate;
- (4) Placement in housing appropriate to the situation, emphasizing use of general population settings instead of isolation;
- (5) Establishing appropriate levels of supervision, including close and constant observation;
- (6) Rapid and correct response to suicide attempts;
- (7) Reporting of suicide attempts throughout the chain of command; and
- (8) Follow-up and administrative review, including attending to the effects of critical incidents on staff stress.

27. L.M. Hayes, *Prison suicide: An overview and guide to prevention*, Washington, D.C., U.S. Department of Justice, 1995.

requiring jail administrators to divert certain detainees to mental health services, either in the community or to inpatient hospitals.

Many programs use detention facilities as the first point of contact to identify a person with mental illness who may be eligible for diversion. Jail administrators who work closely with such programs will help individuals who would be better served by diversion from the criminal justice system while at the same time freeing jail beds for more appropriate purposes. It is essential that programs providing alternatives to further involvement with the criminal justice system for individuals with mental illness consider the multiple needs of these individuals, especially the need for adequate housing (see Policy Statement 38: Housing).

**Example: Thresholds Psychiatric Rehabilitation Centers Jail Program, Cook County (IL)**

The Thresholds Psychiatric Rehabilitation Centers Jail Program in Cook County provides intensive case management for individuals with mental illness who have become involved in the criminal justice system. Thresholds case managers work with individuals while they are still in jail, even accompanying them to court and often helping secure their early release. Once released, the case manager helps the individuals access mental health services, find employment, and locate housing. Threshold Jail Program members, as the program's clients are called, are usually housed in single-occupancy rooms in local hotels. Thresholds has developed relationships with landlords, guarantees the rent payment, and provides 24-hour on-call case managers in case of a crisis situation. Though Thresholds owns some 30 group homes and ten apartment houses, community and local government opposition prevents them from using these resources to house most individuals with mental illness who have been released from jail.

"If I had gotten into this [jail treatment] program in the beginning, things could have been different... I always wanted to excel, to do something good...I don't like the way my life has turned out, but I have the option to be someone."

**LEON**  
*consumer*

**Source:** William Branigan and Leef Smith, "Mentally Ill Need Care, Find Prison," *Washington Post*, Sunday, November 25, Section A, p. 1

**C**

**Facilitate the release of information to assist in the identification of need.**

While important in identifying people who might have a mental illness, a screen conducted at booking depends exclusively upon inmate self-reporting. Yet detainees, and particularly those with mental illness, are often unreliable reporters of factual information. It is important, therefore, to obtain information about a detainee that can shed light on his or her mental health history and help the facility to make appropriate decisions regarding classification and to ensure that those currently in treatment continue to receive it while in custody. In many instances the arresting officers may have input into classification decisions.

Several jails have also developed ways to alert the mental health community when a mental health client has been arrested so that mental health can respond immediately to the situation.

**Example: Cook County (IL) Jail**

Through an automated information system, the Cook County Jail electronically transfers its jail census on a daily basis to mental health clinics in the Chicago area. Clinic staff review the lists to see if they can identify any of their clients. The goal is to notify these clinics when one of their clients is in custody to aid in the continuation of treatment while in custody.

**Example: Montgomery County (MD) Detention Center**

The county detention center in Montgomery County each day posts the names of detainees who have entered the facility in the previous 24 hours, ensuring that a copy of the list is available to local mental health providers. Providers recognizing names of current or past clients on the detention center list may then, without breaching confidentiality, contact mental health staff at the detention center with information, including diagnosis and medication, that might help the detention center provide appropriate services or make decisions regarding placement or diversion. (See also Maricopa County Data Link Project, Policy Statement 11: Pretrial Release / Detention Hearing.)

Another way to facilitate the release of mental health information is to encourage individuals who are at risk of being arrested to provide their clinician with prior consent to discuss their mental health needs with jail officials if an arrest and detention occurs. (See Policy Statement 25: Sharing Information.)

Families can also provide more comprehensive information about the mental health history of a jail detainee. They should be encouraged to share any information that will result in delivery of appropriate mental health treatment in the jail setting.

## **d** Ensure that the capability exists to provide immediate crisis intervention and short term treatment.

People arriving at a jail may be in an active psychotic state or may decompensate to such a condition during the period of confinement. Jail staff must have the resources that they need to intervene effectively with detainees experiencing a crisis. The American Psychiatric Association has offered the following recommendations regarding crisis intervention in jails:

- Training of jail staff to recognize crisis situations;
- Around-the-clock availability of mental health professionals to provide evaluations;
- A special housing area for those requiring medical supervision; and
- Around-the-clock availability of a psychiatrist to prescribe emergency medications.

**28.** In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court addressed the medical needs of prisoners in the context of the Eighth Amendment. The court held that deliberate indifference to serious medical needs is prohibited “whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once

prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a [claim under the Constitution.] *Id.* at 104-105.” A prisoner must provide evidence of “acts or omissions sufficiently harmful” to show deliberate indifference in order to bring an Eighth Amendment claim.

Since *Estelle*, the Supreme Court has only refined the “deliberate indifference” standard once. In 1994 the Court

**Example: Summit County (OH) Jail**

At the jail in Summit County, one corrections officer is designated as the crisis intervention specialist and receives 40 hours of training each year from the jail's mental health coordinator.

The capability must also exist to meet the treatment needs of detainees. In larger jails, separate mental health units may be available. Often, however, there can be waiting periods to get into such a unit. In smaller jails, such units are typically not available, and the most severely ill inmates may need to be transferred to a state hospital or other secure facility. Regardless of where the individual is housed, there can be great benefit to ensuring that the clinician who was attending the individual before arrest continues to monitor the person's treatment while in custody.

e

**Facilitate a detainee's continued use of a medication prescribed prior to his or her admission into the jail.**

Inmates are usually prohibited from bringing their own medications into jail. Owing to formulary restrictions, prohibitive costs, limited inventories, or a combination of these factors, however, correctional health officials are often unable to fill a prescription prepared by a doctor outside the facility. Accordingly, the effect of the medications that detainees are taking at the time of their incarceration is likely to wear off soon after their arrival at the jail. The detainee's condition is thus likely to deteriorate, and he or she may commit disciplinary infractions that will lengthen his or her stay in jail.

Increasingly, offenders with mental illness are brought to jails with prescriptions for the newer, and considerably more expensive, psychotropic medications. In many cases, when facilities provide for the continuation of treatment, they substitute the medications the inmate has been taking with one on their formulary and readily available in their own pharmacy.

In some states, correctional health officials are required to adhere to the formulary, even if it is limited. Such policies can have negative consequences for inmates for whom medications on the formulary are either ineffective or cause harmful side effects. When a particular medication prescribed by a psychiatrist is not on an institution's formulary, corrections administrators should ensure that a mechanism is in place to enable access to the medication within 24 hours.<sup>28</sup>

"During a visit to South Carolina, I suffered the second manic episode of my life. When police were called, although I was exhibiting bizarre behavior and my wife desperately tried to advise them of my illness and show them the vial containing the medication that I should be taking, they took me to jail. At no time during my stay in the jail, even after the appearance before a magistrate, did I see any medical personnel or receive any medical treatment. If such experiences can happen to me, with a Ph.D. in criminology and my background and knowledge of the criminal justice system, they can happen to anyone."

**RISDON SLATE**

*Associate Professor of Criminology, Florida Southern College*

**Source:** U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21, 2001

said that deliberate indifference "... [lies] somewhere between the poles of negligence at one end and purpose or knowledge at the other;" (Farmer v. Brennan, 511 U.S. 825, 1994). The Court affirmed an "adequacy" standard stating that "prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care." (id. at 833), but went on to emphasize that "deliberate indifference" requires a culpable state of mind. Federal District Courts (the trial court in the federal system) may interpret

"adequate" with wide discretion. On appeal to the Federal Circuit Courts—the layer of the judiciary just below the U.S. Supreme Court—this has led to vastly varying law, especially in regards to the treatment of HIV. See *Psychiatric Services in Jails and Prisons: A Report of the American Psychiatric Association Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons*, second edition, p. 2.

Jail officials should understand that although there are often several medications that can be prescribed for the same diagnosed illness, the effectiveness and medical risks of different medications often varies considerably. The practice of switching medications can be particularly ineffective because many psychiatric medications take weeks to build up to therapeutic levels. Common drug interactions between different medications prescribed for the same problem can exacerbate the delay before the new medication becomes effective and can create serious medical risks for patients, and potential problems for the jail staff, if both medications are present in a patient's system at the same time.

Community mental health programs and service providers should be involved in medication issues for recently arrested and detained defendants. They can serve as a resource for detention-based health care officials in determining detainee medication needs, possibly assisting facilities with limited formularies to obtain and share the costs for less commonly prescribed and more expensive medications, if they are required for the detainee's well-being.

## f

**Suspend (as opposed to terminate) Medicaid benefits upon the detainee's admission to the facility to ensure swift restoration of the health coverage upon the detainee's release.<sup>29</sup>**

Enrolling a person who is eligible for Medicaid in this federal benefit program is a time-consuming process. Reinstating someone in Medicaid after their benefits have been terminated can take anywhere from 14 to 45 days (and sometimes longer), depending on the state.<sup>30</sup> Accordingly, when a detainee with mental illness enters jail, and he or she is already enrolled in Medicaid, staff should do everything possible to maintain that person's enrollment in the program. Suspending, instead of terminating, the detainee's enrollment in Medicaid enables staff to effect the reinstatement of the benefits immediately upon release, guaranteeing the individual access to the treatment and medications likely to keep him or her from coming into contact with the criminal justice system again.

A myth in many corrections, mental health, and public health agencies is that federal regulations require states to terminate a person's enrollment in Medicaid once he or she is incarcerated. In fact, federal law does not require states to terminate inmates' eligibility, and inmates may remain on the Medicaid rolls even though the services provided in jail are not covered. According to the US Secretary of Health and Human Services, "Federal policy permits, but does not require states to use administrative measures that include temporary

## Understanding Federal Benefits

Several federal benefit programs are particularly relevant for people with mental illness who will be released from a corrections facility: Supplemental Security Income (SSI) disability benefits; Social Security Disability Insurance (SSDI); Medicaid; Medicare; Temporary Assistance for Needy Families (TANF); Food Stamps; and Veterans Benefits. Understanding who is eligible to participate in these programs and how they qualify is extremely complex. Appendix C, a reprint of a policy brief that the Bazelon Center for Mental Health Law published, explains these program rules.

The recommendations in Policy Statement 13 addresses only those pretrial detainees who are enrolled in Medicaid immediately prior to their incarceration. Many detainees with mental illness are eligible for Medicaid but, for a variety of reasons, were not enrolled when they were admitted to jail. An essential component of planning the return of these inmates to the community is ensuring that they have some form of health coverage to continue their treatment plans after their release. Similarly, jail staff should facilitate inmates' access to other relevant federal and state benefit programs. The policies and procedures that should be in place to accomplish this for jail detainees are equally relevant to sentenced inmates, and they are therefore addressed in Policy Statement 21: Development of Transition Plan.

29. Much of this recommendation and the commentary below draws on an extremely useful and comprehensive review of jail detainees' Medicaid eligibility published by the Bazelon Center for Mental Health Law. Bazelon Center

for Mental Health Law, *Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules*, March 2001.

30. Ibid.

suspending an eligible individual.”<sup>31</sup> Thus, determining when a detainee’s enrollment in Medicaid should be terminated is, in some important respects, at the discretion of the state.<sup>32</sup>

Given these parameters, jail administrators should work with appropriate state and local social security administrators and state Medicaid administrators to develop policies and procedures to prevent the unnecessary termination of detainees who enter the facility on Medicaid. Ideally, for those detainees eligible for Medicaid by virtue of their enrollment in the Supplemental Security Income (SSI) program, authorities should terminate a detainee’s Medicaid coverage only when SSI eligibility is terminated. (This occurs after 12 consecutive months of SSI suspension.)

**Example: Interim Incarceration Disenrollment Policy, Lane County (OR)**

Officials in Lane County have confronted the barriers and disruption in continuity of care for people detained for a short time in jails. At the behest of the county, the state adopted the Interim Incarceration Disenrollment Policy. This policy specifies that individuals cannot be disenrolled from their health plan during their first 14 days of incarceration, during which the state makes the Medicaid payments. In addition, Lane County officials developed a relationship with the local application-processing agency for Medicaid and Social Security Insurance. Now, the application process for those individuals who did not have benefits prior to incarceration or whose incarceration period lasts longer than 14 days can begin while the detainee is still in custody.

When a detainee whose participation in Medicaid has been suspended, corrections administrators should work with health officials to authorize immediate coverage of the detainee upon his or her release. While the confirmation of a released detainee’s qualification of Medicaid is pending, federal rules permit the reinstatement of the benefits for six months. (This reinstatement may be terminated before six months have expired if state officials determine beforehand that the individual is no longer eligible for Medicaid). In those cases where a released detainee’s benefits are reinstated, and the person’s qualification for Medicaid is subsequently confirmed, officials should ensure that services already delivered are billed, retroactively, to the federal government.

**g**

**Commence discharge planning at the time of booking and continue the process throughout the period of detention.**

One reality for jail staff attempting to address the mental health needs of pretrial detainees is that a detainee may be released at any time with little or no warning to jail staff—the detainee may post the bail or plead guilty and be sentenced to time served, or the prosecutor may dismiss the charges. Given

**31.** See October 11, 2001 letter from Tommy Thompson, Secretary, US Department of Health and Human Services, to Congressman Charlie Rangel, confirming earlier written statements from DHHS Secretary Donna Shalala, April 6, 2000.

**32.** The Council of State Governments conducted a survey of state Medicaid agencies in 2001. All but one of the states responded. Each reported that they had a policy of terminating a person’s enrollment in Medicaid upon his or her incarceration. Collie Brown, “Jailing the Mentally Ill,” *State Government News*, April 2001, p. 28.

this situation, it is of little surprise that recidivism rates among people with mental illness released from jail are exceptionally high.<sup>33</sup> Thus, it is important that planning for the ultimate discharge of the individual be an ongoing process during the time the individual is detained. Such planning should include arranging for services immediately upon release; ensuring that there is no disruption in medications made available to the individual; and assisting with other needs, such as housing, food, clothing, and transportation.

**Example: Discharge Planning, Fairfax County (VA) Jail**

Discharge planning at the Fairfax County Jail is the responsibility of Offender Aid and Restoration (OAR), a nonprofit organization. OAR staff conduct weekly meetings with the jail's psychiatrist to set plans for release for all inmates with serious mental illness, and provide emergency services for those released before a plan is completed. Staff of OAR carry caseloads, and the same case manager works with an inmate with mental illness from the time of booking through discharge.

**Example: Case Management Services for Pretrial and Sentenced Offenders, Hampshire County (MA) Jail**

At the Hampshire County jail, all inmates, regardless of whether they have a mental illness, are assigned case managers, who have a typical caseload of approximately thirty detainees. Inmate treatment needs are assessed at intake, and the case manager then provides individual counseling, meets with the family, and makes referrals to appropriate resources both inside and outside the facility. Assignment of sentenced and pretrial inmates to a case manager facilitates the process from intake through discharge planning (and reentry, if applicable). A high level of contact between the client and the case manager ensures that inmates have access to services and that they do not slip through the cracks.<sup>34</sup>

One of the most pressing problems facing individuals with mental illness who have become involved in the criminal justice system is the lack of affordable housing. Housing for people with mental illness should be directly linked to other services, including mental health and substance abuse treatment, life skills, and job training. This model of "supportive housing" has been shown to have significantly higher retention rates than housing alone or housing that is not directly linked to services.<sup>35</sup> Long-term housing is crucial for helping individuals with mental illness maintain stability and avoid involvement in the criminal justice system. (See Policy Statement 38: Housing.)

"When I was arrested, I was living in subway stations. When I am released from jail, I will need Medicaid insurance so that I can go to a clinic and get medication and counseling so that I do not get sick again. I will also need to get my disability benefits again so that I can afford to buy food and get a place to live. If I do not get my medication, I will end up getting sick and living in subway stations again. I am intelligent and I am not all that crazy... I could have been somebody if I didn't spend my whole life in hospitals and jails."

**BRAD H.**  
*consumer*

**Source:** Affidavit of Brad H., exhibit to complaint in *Brad H. v. City of New York*, a class action lawsuit regarding discharge planning for people with mental illness being released from New York City jails

**33.** Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, pp. 1330-37. This study examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261 subjects (72 percent) were rearrested

**34.** As reported in H. Steadman and B. Veysey, "Providing Services for Jail Inmates with Mental Disorders," National Institute of Justice Research in Brief, National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, January 1997, p.4.

**35.** Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems," *Housing Policy Debate* 12, 2001.

**Example: Maryland Community Criminal Justice Treatment Program (MCCJTP)**

Through the Maryland Community Criminal Justice Treatment Program, staff in jails throughout the state work to provide treatment and aftercare plans for inmates with mental illness, and then provide community follow-up after their release. The MCCJTP has been widely recognized for impressive cross-system collaboration, focus on co-occurring disorders, transitional case management services, and attention to long-term housing needs. A \$5.5 million grant from the U.S. Department of Housing and Urban Development, complemented by matching local funds, allows MCCJTP case managers to help offenders with mental illness who qualify as homeless to become eligible for Shelter Care Plus housing funds.<sup>36</sup> Local service providers participating in MCCJTP support Shelter Care Plus recipients with vocational training, substance abuse treatment, and life-skills training to ensure that these individuals have access to meaningful daytime activity.

**Example: Conditional Community Release Program, Maricopa County (AZ) Adult Probation Department**

The Maricopa County Adult Probation Department has instituted a program called the Conditional Community Release Program, which is geared toward early jail release of offenders with mental health issues and provides appropriate treatment in the community at a reduced cost. This program utilizes a contract psychiatrist, probation officer, surveillance officer, and intake specialist to identify, diagnose, and supervise offenders with mental illness. Once referred, the inmate is evaluated within 72 hours by an intake specialist. If appropriate, the inmate is admitted to the program and jail release planning is undertaken. The psychiatrist will see the person in jail in order to ensure continuity of care once released, and the probation officer will see the client to complete all necessary paperwork.

Once released, the probationer may be placed in a housing facility funded by Adult Probation, or released to their home if appropriate. While in the community, the client is supervised by the probation officer and surveillance officer, and seen by the psychiatrist for follow-up treatment if not enrolled in community treatment. Using contracts with a local medical services agency, medication is provided at a reduced cost and necessary psychological testing is performed.

The program is 45 days in length, at which time the client is transferred back to his or her original probation officer, or referred to a specialized mental health caseload. In the event the client is not stabilized psychiatrically, the county will continue to serve the client until this is accomplished.

**36.** The McKinney Act of 1987 is the major federal housing program to support people who are homeless. This act defines a homeless individual as (1) “an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is— a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institu-

tion that provides a temporary residence for individuals intended to be institutionalized; or c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.” Technically, individuals coming out of detention facilities are not considered homeless until they have spent one night in a shelter or similar location. See [www.hud.gov/offices/cpd/homeless/rulesandregs/laws/index.cfm](http://www.hud.gov/offices/cpd/homeless/rulesandregs/laws/index.cfm)

## 14

## Adjudication

## POLICY STATEMENT #14

**Maximize the availability and use of dispositional alternatives in appropriate cases of people with mental illness.**

A criminal case can be adjudicated in several ways—the charges can be dismissed, the defendant can plead guilty or be found guilty in a trial, or the defendant can be found not guilty. The law provides several dispositional alternatives specifically for people with mental illness— i.e., incompetent to stand trial, not guilty by reason of insanity, guilty but insane.<sup>37</sup> This document does not make any recommendations regarding how these dispositions are used or the frequency of their use.<sup>38</sup>

Rather, the document addresses other dispositional alternatives to conviction and sentencing that are available under the law. Although known by different names, these alternatives are generally referred to as “adjudication withheld” or “deferred adjudication.”

Earlier, the pretrial diversion decision of the prosecutor was addressed. Under the pretrial diversion alternative, the prosecutor decides to hold the charges in abeyance while the defendant undergoes a program intervention. If successful, the charges are dismissed. If not, the case is placed on a court calendar for prosecution. The distinction

between that alternative and those discussed here is that in this instance it is a judicial, rather than prosecutorial, exercise of discretion.

There are variations in how jurisdictions make these alternatives available. For example, under Florida law, the court can withhold adjudication “if it appears to the court...that the defendant is not likely again to engage in a criminal course of conduct and that the ends of justice and the welfare of society do not require that the defendant presently suffer the penalty imposed by law.” The court then orders the defendant to participate in what is called a “community control” program. If the defendant successfully completes the program there is no conviction. Texas law has a “deferred adjudication” provision. Under this provision, once the defendant enters a guilty plea, the judge may defer the proceedings without entering the adjudication of guilt and order the defendant to abide by certain conditions if the judge finds that doing so “is in the best interests of the victim.” If the defendant successfully completes supervision, the charges are dismissed.

**37.** Some jurisdictions have replaced the “Not Guilty by Reason of Insanity” disposition with “Guilty but Insane,” or some similar variation.

**38.** For a discussion of these dispositions, see: American Bar Association, *ABA Criminal Justice Mental Health Standards*, 1989. Cases in which defendants plead Not Guilty by Reason of Insanity often receive significant publicity, which encourages the public impression that these pleas are commonly used. In actuality, use of the Not Guilty By Reason of Insanity plea is extremely rare. One study in Baltimore City of

the circuit and district courts found that of 60,432 indictments filed during one year, only eight defendants (.013 percent) ultimately pleaded not criminally responsible. All eight pleas were uncontested by the state. Jeffery S. Janofsky, Mitchell H. Dunn, Erik J. Roskes, Jonathan K. Briskin, and Maj-Stina Lunstrum Rudolph, “Insanity Defense Pleas in Baltimore City: An Analysis of Outcome,” *American Journal of Psychiatry* 153:11, November 1996, pp. 1464-68.

## RECOMMENDATIONS FOR IMPLEMENTATION

### **a** Provide sufficient dispositional alternatives for defendants with mental illness for courts to employ at any stage of the court process.

At least one jurisdiction has established a dispositional alternative for people charged with serious offenses.

**Example: The Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)**

The Nathaniel Project in New York, NY, run by the Center for Alternative Sentencing and Employment Services, is a two-year intensive case management and community supervision alternative-to-incarceration program for prison-bound defendants with serious mental illness. The program targets defendants who have been indicted on a felony, including violent offenses, most of whom are homeless and suffer from co-occurring substance abuse disorders. Forensic Clinical Coordinators, who are masters level mental health professionals and have expertise in negotiating the criminal justice system, create a comprehensive plan for community treatment. Starting work with participants prior to release, the project creates a seamless transition to community care. Once released, program participants are closely monitored and engaged in appropriate supervised community-based housing and treatment. Participants are required to attend periodic court progress dates. Charges are dismissed upon successful completion of the program.

Key to the success of individuals with mental illness who are diverted from jail or prison under the Nathaniel Project is their linkage to both temporary and long-term housing. The Nathaniel Project has developed relationships with housing providers to ensure that their clients will have shelter upon their release. Housing stabilizes the individual's life and enables the case manager to strengthen his or her relationship with the person with mental illness. Housing for individuals with mental illness should be integrated with support services including mental health, substance abuse, employment, and others.

Intensive case management is crucial in helping clients locate and flourish in supportive housing. Even when housing and services are integrated in a supportive model, many clients may need assistance in availing themselves of those services. A dedicated case manager, with small enough caseloads to devote significant energy to each client, is integral to making supportive housing, and diversion in general, a success.

The mental health courts that have been initiated in some jurisdictions often use dispositional alternatives. These courts focus specifically on cases involving defendants with mental illness, usually targeting only those charged with minor offenses. In some, the charges are dismissed upon successful completion of the program. In others, the defendant is required to plead guilty as a condition of participation but receives consideration at sentencing if the program is successfully completed.

Mental health courts vary greatly in the procedures that they employ, making it difficult to define “mental health court” or to present a mental health court model. It has been noted that “[a]ny similarities among current mental health courts occur more or less by chance at the implementation level and stem mostly from mirror-imaging by new jurisdictions seeking to replicate recently visited mental health courts or to duplicate drug courts.”<sup>39</sup> Some have argued against several elements of specialized mental health courts, including requiring the defendant to plead guilty first as a condition of participation, and requiring the defendant to spend a significant period of time under court supervision for a charge that might otherwise bring a very short sentence.<sup>40</sup> Others have argued that mental health courts can be defined as “almost any effort by the courts to better address the needs of persons with serious mental illness who engage with the criminal justice system.”<sup>41</sup>

Using that definition, the policy statements and recommendations presented in this document represent a model that does not necessarily require a specialized court and does not limit the population of those allowed to participate. Rather, the model envisions an integration of efforts into existing court practices to balance the needs of people with mental illness who are charged with a criminal offense with the needs of the courts to process the criminal case. If jurisdictions choose, however, to implement specialized mental health courts, then all parties, including the judge, prosecution, and defense, should receive training on available treatment resources and on how to choose which program or service is appropriate for each defendant. Furthermore, it is important that courts work closely with the relevant mental health professionals to ensure that treatment plans developed in the court are successfully fulfilled (see Policy Statement 29: Training for Court Personnel.)

"No judge wants to be faced with a defendant with mental illness without the knowledge, tools, and resources to properly and fairly handle the case."

**HON. TOMAR MASON**  
Superior Court Judge,  
County of San Francisco,  
CA

**Source:** Interview, January 11, 2002, Washington, DC.

## **b** Facilitate the release of mental health information where appropriate for use in a dispositional alternative.

When a case reaches a point where a judge is considering a dispositional alternative, it is likely that some information about the defendant’s mental health status will be available in the case file. This might include observations of the arresting officer as recorded in the police report and the information provided for the pretrial release/detention hearing. If the defendant’s competency was called into question, there may be a report in the file from a mental health clinician on the defendant’s mental health status. Several states have statutes

**39.** Henry Steadman et al., “Mental Health Courts: Their Promise and Unanswered Questions,” *Psychiatric Services*, April 2001, p. 457.

**40.** For more on the design and operation of four of the earliest mental health courts established in the United States, see John S. Goldkamp and Cheryl Irons-Guynn.

*Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.* Bureau of Justice Assistance. April 2000, available at: [www.ncjrs.org/pdffiles1/bja/182504.pdf](http://www.ncjrs.org/pdffiles1/bja/182504.pdf).

**41.** Henry Steadman et al., “Providing Services for Jail Inmates with Mental Disorders,” 1997.

that specifically allow for the disclosure of mental health records in court. In Georgia, records can be disclosed in response to a valid subpoena. In Illinois, a statute allows for the disclosure of mental health records once the recipient of mental health services introduces his or her mental condition as an element of the claim or defense.

Since a dispositional alternative will in many cases be a favorable outcome for the defendant, the defense attorney should carefully discuss with the defendant the advantages and disadvantages of the possible alternative before the defendant agrees to the release of any additional mental health information to the court. In some cases, the defense attorney may find it advantageous to request an assessment of the defendant and provide the full results to the court to facilitate a decision to offer a dispositional alternative. In these cases, release of the information would be with the consent of the defendant. (See Policy Statement 25: Sharing Information.)

**Example: Mental Health Court, Broward County (FL)**

For possible placement in the Broward County Mental Health Court, public defenders will often ask for an assessment that includes a listing of any medications that the defendant is taking, possible diagnosis, family support, social support, housing, and substance abuse issues. The assessment is done with the consent of the defendant.

# 15

## Sentencing

### POLICY STATEMENT #15

**Maximize the use of sentencing options in appropriate cases for offenders with mental illness.**

Several options are available to the court at sentencing. Generally, they can range from setting a fine, placing the offender on probation for a specified period, or imposing a period of incarceration in jail or prison. As the recommendations presented under the previous court events are implemented, by the time a case reaches the sentencing stage there may be information in the court file about the defendant's mental health status. The recommendations presented below describe how to build on

that information to ensure that the sentencing court has all the information it needs to make an informed sentencing decision. Consistent with earlier discussions, no offender with mental illness should be sentenced to incarceration in jail or prison due solely to the lack of information or options to address the mental illness. In addition, the court should never enhance a sentence solely because of the offender's mental illness. Rather, the sentence should be based on the behavior that brought the offender into court.

### RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Ensure that the capacity exists to complete presentence investigation reports in cases where there are indications that the offender may have a mental illness.**

The presentence investigation (PSI) report, prepared by the probation office, provides the sentencing judge with information about the offender so that an informed, individualized sentencing decision can be made. According to ABA standards, the court should order a PSI when it "lacks sufficient information to perform its sentencing responsibilities," or upon the motion of either the prosecution or defense.<sup>42</sup> In Washington, state law requires the court to order a

<sup>42</sup>. American Bar Association, *Standards for Criminal Justice: Sentencing*, 3rd Edition, 1994, Standard 18-5.2,

presentence report before imposing a sentence when the court determines that the defendant may have a mental illness.

A PSI can better inform the court of individual case nuances to be considered in ordering case-specific conditions of probation. The information presented in the PSI report should be neutral; that is, it should include both mitigating and aggravating factors. According to the American Probation and Parole Association (APPA), the PSI should cover the following items:

- a description of the offense and circumstances surrounding it;
- a description of the status of any victim, including the impact of the crime on the victim;
- the offender’s complete prior criminal record;
- the offender’s social history, including family status and residence history;
- the offender’s educational background and employment history; and
- the offender’s medical history.<sup>43</sup>

The ABA standards state that PSIs should not become part of the public record. Distribution of the reports should be limited to the sentencing court, the prosecution and defense, and to the entity (i.e., probation, jail, or prison) that will be responsible for supervising the offender.<sup>44</sup> Many states have statutes or court rules that specify that the contents of presentence reports, including any mental health information, are confidential and may be disclosed only to the court, prosecution, and defense. Most states permit the disclosure of their reports to correctional institutions that will be housing the offenders for use in classification.<sup>45</sup>

---

**b** Facilitate the release of mental health information for use at the sentencing hearing.

As noted earlier, communications between mental health providers and their clients are protected from disclosure without written consent from the client authorizing the release of information. Furthermore, the offender has the right to refuse to answer any or all of the questions asked by the probation officer during a PSI interview and offenders with a mental illness need to understand this right. Refusing to cooperate with a PSI interview, however, may be counterproductive, so the offender should obtain guidance from the defense attorney on how to proceed before the presentence investigation begins.

It is the obligation of the probation officer conducting the PSI to verify information contained in the report. As a result, if the offender indicates that

available at: [www.appa-net.org](http://www.appa-net.org).

**43.** Position Statement of the American Probation and Parole Association.

**44.** American Bar Association, *Standards for Criminal Justice: Sentencing*, Standard 18-5.6.

he or she is in mental health treatment, the probation officer must verify that with the treatment program. To do so, the offender must authorize the release of information to the probation officer. The probation officer and defense counsel should work together to assure that necessary written consents have been signed. The information the probation officer receives from a treatment program should include the offender's diagnosis, treatment recommendations of the attending clinician, and progress with treatment.

When an individual's mental illness is already known, these reports should include information about any diagnosis that has been made, current and past treatment, and the resources available in the community that can help the offender refrain from engaging in the same or similar conduct that led to the arrest. At least one jurisdiction assigns specially trained probation officers to these tasks.

**Example: Probation Department, Orange County (CA)**

In Orange County, probation officers specializing in mental health cases develop individualized integrated service plans and present them in the PSI that can include social services, housing, and medication as well as treatment for those with co-occurring mental health and substance abuse problems.

"The access to information will always be a provocative issue. We need to find common ground between the mental health community's need for confidentiality and the criminal justice system's need for information."

**HON. WILLIAM DRESSEL**  
President, National Judicial College

**Source:** Interview, January 11, 2002, Washington, DC.

**c** **Have a complete assessment conducted by a mental health clinician before sentencing when the mental health information contained in the pre-sentence investigation report is insufficient to make an informed sentencing decision.**

The capacity to have that assessment done in a timely manner by a qualified professional should be available. The assessment should be conducted on an outpatient basis whenever possible. An inpatient assessment should be necessary only when the person poses too great a risk of injury to others or to him or herself, or of failure to report to court or to the assessment. In determining whether such risks exist, the judge should consult the prosecutor, defense attorney, probation officer, and any available mental health records.

**d** **Ensure that interview protocols used by probation staff with offenders with mental illness include questions that enable staff to identify those with co-occurring substance abuse disorders.**

Just as identifying those with co-occurring disorders is important for other decisions in the court process, it should also be done at sentencing. See the discussions on this topic under Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 11: Pretrial Release/Detention Hearing (also Policy Statement 29: Training for Court Personnel).

**e****Establish programs that provide judges, prosecutors, and defense attorneys with options to address the mental health needs of the offender.**

Those people with mental illness who have been in pretrial detention throughout the processing of the case, assuming that the recommendations included in Chapter 4: Incarceration and Reentry of this document have been implemented, would have received mental health services while in jail. It is common for misdemeanants who have not been released pretrial (either by judicial decision or for inability to meet bail) to be found guilty of a crime and to be sentenced to time served. At this point, they will be released from custody and need have no more involvement with the criminal justice system regarding that particular offense. It is important that some discharge planning have been undertaken for such offenders, to ensure that their release will lead to a successful reintegration in the community with appropriate treatment and services. Without such discharge planning, the likelihood of their returning to the criminal justice system in short order is greatly increased.

Some of those who have been on pretrial release while the case was being adjudicated, assuming the implementation of the recommendations in this section, would have mental health conditions attached to their release. As a start, the same options that exist for the pretrial release decision should also exist for the sentencing decision. Additionally, once the individual has been convicted, the court has more authority to order mental health treatment.

**Example: Project Link, Monroe County (NY)**

In Monroe County, Project Link has developed a close working relationship with the probation department to identify offenders most in need of mental health services. It has a mobile treatment team, consisting of a psychiatrist, nurse practitioner, and five culturally diverse case workers, that is available 24 hours a day to focus on 40 of the most serious cases.

Before ordering treatment as a condition of the sentence, the judge should, as specified in ABA sentencing standards, determine that the offender “will participate in and benefit from” the treatment program.<sup>45</sup> The judge should also determine whether the offender needs mental health services.

**f****Expand the sentencing options available in rural areas to provide mental health services for people with mental illness.**

(See Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 11: Pretrial Release/Detention Hearing, for more on this topic.)

**45.** See, for example, Pennsylvania Rules of Criminal Procedure, Rule 703.

## 16

## Modification of Conditions of Probation/ Supervised Release

### POLICY STATEMENT #16

**Assist offenders with mental illness in complying with conditions of probation.**

If the offender is placed on probation with conditions, those conditions are supervised by a probation officer. If the probationer fails to comply with the conditions, the probation officer notifies the court. The court can revoke the probation, modify the conditions, or issue a warning.

Many of the same issues that were discussed under the Modification of Pretrial Release Conditions pertain here as well, including assisting the offender in getting reconnected to treatment and to financial and housing support after a period of incarceration, and establishing accountability in complying with the terms of release. There is an impor-

tant distinction, though, that has implications for treatment planning. Once the person has been convicted and sentenced, the length of time that the offender will be under supervision is known at the outset—six months, one year, 18 months, etc. While in the pretrial status, however, the duration of supervision lasts only as long as the case lasts, which cannot be known when the release conditions are set. This distinction makes it easier for mental health staff to develop an appropriate treatment plan for individuals who are on probation as opposed to those on pretrial release.

### RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Develop probation conditions that are realistic and address the relevant individual issues presented by the offender.**

Typically, when a judge sentences an offender to probation, the order may read that the offender is to participate in treatment, whether drug, alcohol, or mental health. It is up to the probation officer to identify the most appropriate treatment program for the offender, and then to monitor the offender's compliance. The key to successfully designing conditions of probation is to identify first the offender's individual needs and then identify the services in the com-

munity that can meet those needs. The information contained in the presentence investigation report, in addition to information taken at probation intake, should be very useful in identifying the needs of the individual offender.

### **b** Streamline administrative procedures to ensure that federal and state benefits are reinstated immediately after a person with mental illness is released from jail.

In instances when the person was on pretrial release while the case was pending there should have been no disruption in the receipt of benefits. When the person was held in jail pretrial, however, or where there was a split sentence—i.e., 30 days in jail followed by two years probation—benefits would have to be reinstated very soon after release so that the offender can begin to comply with the probation conditions. Probation officers should identify benefits for which an offender is eligible and assist the offender with the application or reinstatement process. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more on federal and state benefits.)

### **c** Assign offenders with mental health conditions on probation to probation officers with specialized training and small caseloads.

Most probation officers carry very high caseloads, making it very difficult to provide close supervision. Offenders with mental illness recidivate at a higher rate than those without mental illnesses, and they often do so within the first months of release. Close supervision by probation officers, including the time to attend to the individual needs of offenders with mental illness, will help to ensure compliance with conditions of release, and help to reduce recidivism. It is also important that these offenders be assigned to probation officers who have been specially trained to address the needs of offenders with mental illness. Such an approach has been used with success in at least one jurisdiction.

#### **Example: Adult Probation Department, Cook County (IL)**

The Mental Health Unit of the Cook County, Illinois, Adult Probation Department is comprised of probation officers with a background in mental health. These officers are qualified to perform the following functions:

- conduct clinical assessments
- make referrals
- develop supervision plans
- monitor compliance with probation conditions, medication requirements, and other treatment objectives

One important issue that should be addressed in any discussion of court referrals to mental health programs is the rejection of clients by programs that have restrictive admission criteria. A common frustration for courts is to identify a person with mental health needs, consult its inventory of programs, and be unable to find a program that, because of the person's charge, treatment history, or lack of insurance, is willing to accept the person. (See Policy Statement 1: Involvement with the Mental Health System.) One strategy to address this issue is the development of written agreements between the referring entity and mental health agencies.<sup>47</sup> (See Policy Statement 26: Institutionalizing the Partnership, for more on written agreements between criminal justice and mental health partners.)

46. American Bar Association, *Standards for Criminal Justice: Sentencing*, Standard 18-3.13.

47. "Repeated rejections of clients can be avoided if program administrators sign contractual agreements with local mental health agencies to ensure that clients will be

accepted for services," Arthur J. Lurigio and James A. Swartz, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons With Serious Mental Illness," in *Criminal Justice 2000, Volume 3: Policies, Processes, and Decisions of the Criminal Justice System*, edited by Julie Horney, Washington, D.C., National Institute of

- assist probationers in obtaining disability and other benefits
- serve as advocates for probationers in their efforts to obtain mental health treatment.

Mental health providers whose clients are on probation, while being careful not to become monitors of compliance, can also assist the individual to understand the consequences of their behavior in terms of sanctions and can build a collaborative relationship with the specialized probation officers that can benefit the individual. In this way, the probation officer can have more confidence when making decisions on how to respond to violations. For example, the officer and the provider can meet jointly with the individual to identify barriers to compliance and to make changes in the treatment plan or probation rules as necessary.

"You want [defendants] to think about the consequences—stay on track, you get a reward; mess up, you get punished. But what if they're confused and can't think straight because their medication is wrong? That's not their fault. It's not right to punish them then."

#### CONSUMER

Derek Denckla and Greg Berman,  
*Rethinking the Revolving Door:  
A Look at Mental Illness in  
the Courts.*

### d Develop guidelines on compliance and violation policies regarding offenders with mental illness.

It is important to establish incentives for probationers with mental illness to comply with conditions. Such incentives could include reducing the frequency of reporting after a period of compliance.

#### Example: Adult Probation Department, Cook County (IL)

The Mental Health Unit of the Cook County Adult Probation Department has three phases, each lasting a minimum of three months. The first phase is the most restrictive. Advancement to the next phases is contingent upon the probationer's compliance. Once advanced to a less restrictive phase, the probationer can be returned to the previous phase for noncompliance. Upon successful completion of all three phases, the probationer is placed in the standard probation supervision program for the remainder of his or her term.

Probation officers should be prepared to respond to offenders with mental illness who violate the conditions of probation in a way that recognizes that the violation may be a function of the offender's illness but that also holds the offender accountable. When a probationer commits a technical violation—for example, failure to report to treatment—probation officers should employ a graduated scheme of responses before employing the most serious response, that is, revocation of release. State law in Washington provides that, when an offender with a mental illness violates a condition of a release that involves failure to undergo mental status evaluation or treatment, the community corrections officer must consult with the treatment provider before taking action on the violation. Responding to minor technical violations early may obviate the need for revocation and may prevent more serious violations, such as reoffending. In developing intermediate responses, criminal justice officials should establish written agreements with mental health treatment programs

## Rearrest on New Charges

as to actions that will be taken for failure to participate in treatment. When a probationer's mental condition decompensates while under probation supervision, a more appropriate response would be to modify the treatment plan rather than to seek the revocation of probation.

At least one jurisdiction has developed a program that seeks to prevent a probation revocation by offering intensive treatment rather than incarceration for those who violate probation conditions.

**Example: The Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)**

Among the groups targeted by the Nathaniel Project in New York, New York, (mentioned earlier) run by the Center for Alternative Sentencing and Employment Services, are offenders with mental illness who have violated conditions of probation. Case managers are clinically trained professionals with caseloads of only ten. Staff assist participants in obtaining medication, housing, and other services, i.e., day treatment, psychosocial clubhouse, vocational training, and job placement. (See Policy Statement 14: Adjudication, for more on The Nathaniel Project.)

It is not uncommon for people under supervision for a current charge—whether pretrial diversion, pretrial release, or probation—to be rearrested on a new charge. A person with mental illness who is released from custody may need time to stabilize and rearrests may result during periods of decompensation. When rearrests occur, courts should treat them as they would other violations of the conditions of supervision, weighing the seriousness of the rearrest charge, and the person's compliance with other conditions of supervision. A rearrest on a new offense should not in and of itself be a reason for denying pretrial release in the new case or for revoking release in the first case.

## CONCLUSION

Leaders in jurisdictions able to implement the changes proposed in this chapter (along with those offered in the two preceding chapters, *Involvement with the Mental Health System* and *Contact with Law Enforcement*) will have gone a long way toward ensuring that persons with mental illness that come in contact with the criminal justice system will be treated fairly and appropriately. Improved collaboration with mental health providers, access to appropriate information, and increased awareness about mental illness will better prepare the courts to determine the proper resolution of cases involving defendants with mental illness. Sometimes, justice will be best served through diversion programs that help individuals with mental illness obtain treatment and support services. Many defendants with mental illness, however, will eventually be incarcerated.

The next chapter, *Chapter IV: Incarceration and Reentry*, focuses on an area of the criminal justice system that is too often overlooked—corrections. Correctional institutions are the ultimate destination for many individuals with mental illness who become involved with the criminal justice system; in many ways, they have become the country's new mental health institutions.

It is important for officials who focus on pretrial issues, adjudication, and sentencing to become familiar with the policies and programs that need to be in place to identify, treat, and prepare for release people with mental illness who are incarcerated. These are the issues that the subsequent set of policy statements address.

