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CRIMINALIZATION OF PEOPLE WITH MENTAL ILLNESSES: THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM

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Preamble

This document examines the use of mental health courts in the United States as a response by communities to the increasingly common arrest and incarceration of people with serious mental illnesses. Based on analysis of 20 existing mental health courts' operation, it is the product of much discussion among the Bazelon Center's legal and policy staff. All are concerned about the potential of mental health courts to encourage arrest as a strategy for accessing mental health services that are not otherwise available. Some members of the staff perceive adjudication by a mental health court to be unduly coercive, stigmatizing and discriminatory, and to reflect mental health systems' shameful tendency to shift the responsibility for people they see as hard to serve to other serve systems. Others believe that, with efforts to address the most serious defects—spelled out in the paper—and when used only for offenders charged with serious felonies, mental health courts may have a place in a broader system of diversion from the criminal justice system for people with serious mental illnesses. The document therefore presents the many reservations we have about the creation and operation of mental health courts while acknowledging their existence and the likelihood of their continued expansion. With unanimity, however, we urge that any mental health court be initiated, if at all, only as one aspect of a complete overhaul of public mental health systems. Such a reform is desperately needed to address the current lack of access to voluntary services and supports that promote recovery and self-sufficiency—a deficit that we believe is the primary factor placing people with serious mental illnesses at risk of arrest, incarceration, punishment and coercion.

Introduction

In a recent report based on two years of study and meetings of hundreds of individuals involved in criminal justice or mental health systems at the state and local levels, the Council of State Governments found that "people with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate." It reported that many people with mental illnesses are "overlooked, turned away or intimidated by the mental health system," and "end up disconnected from community supports." As a result, "not surprisingly, officials in the criminal justice system have encountered people with mental illness with increasing frequency."(1)

Contact with the criminal and juvenile justice systems obviously has significant negative consequences for those who are subject to arrest, booking and incarceration. Its increasing frequency among people with serious mental illnesses is generating increased concern among policymakers, criminal and juvenile justice administrators, families and advocates. A great many of the individuals arrested are charged with only minor offenses; for most, the underlying issue is their need for basic services and supports that public systems have failed to deliver in meaningful ways.

No rational purpose is served by the current system. Public safety is not protected when people who have mental illnesses are needlessly arrested for nuisance crimes, or if the mental illness at the root of a criminal act is exacerbated by a system designed for punishment, not treatment. (2) Individual rights are violated when people with mental illnesses are denied treatment and subjected to more frequent arrests and harsher sentences than other offenders. And beyond the trauma of arrest and incarceration are the unintended collateral consequences, such as social stigmatization based on a criminal record and the resulting denial of housing or employment or treatment services—even if charges are dropped.

The criminal and juvenile justice systems are not the appropriate "front door" to access mental health care. The factors that determine whether someone who has demonstrated problematic

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behavior enters the criminal justice system or the mental health system are often capricious rather than objective. For example, police officers may find it easier to process someone through the criminal justice system than to navigate the hurdles that consumers routinely face to obtain services through the public mental health system. Ironically, community mental health programs often refuse to serve the very individuals who are most likely to benefit from their intervention and who are least appropriate for prosecution— those who have engaged in misdemeanors and who have low priority within mental health systems because they are not at risk of involuntary psychiatric hospitalization.

Perversely, the drift of people with mental illnesses into criminal justice has benefited public mental health systems by shifting their financial burden for "hard to serve" groups to the budgets of state corrections departments. As a result, taxpayers' resources are wasted on expensive and counterproductive incarceration instead of financing more appropriate and effective community mental health and supportive services. Police, court and jail personnel are forced to devote inordinate amounts of time to arresting, processing and incarcerating individuals with mental illnesses—a process that also diverts their attention from more serious crimes, defendants and inmates.

As communities grapple with this fallout from unresponsive mental health and social services systems, reforms are being proposed. In large measure these proposals come from the criminal justice sector, which finds itself both ill-equipped to address the needs of people with mental illnesses and alarmed about the de facto role of jails and prisons as today's psychiatric institutions. Mental health systems, even while attempting to address the criminalization of the populations they are charged with serving, have not typically originated reform efforts. For this reason, it is important to build any reforms in such a way as not to bypass the mental health and other service systems or allow them to shirk their responsibilities. Every effort should be made to assist people with serious mental illnesses before they come to the attention of law enforcement and to identify and address system failures that result in their inappropriate arrest or incarceration for minor offenses.

Certainly, not every crime committed by an individual diagnosed with a mental illness is attributable to disability or to the failure of public mental health. But homelessness, unemployment and a lack of access to meaningful treatment services have clearly put many people with mental illnesses at risk of arrest. The Bazelon Center for Mental Health Law strongly endorses efforts to address these root causes of criminalization, recognizing at the same time that this will require a fundamental change in the mental health systems that have so tragically deviated from their goal of promoting community living with dignity. This paper examines efforts in a growing number of concerned communities to respond to the immediate problem by establishing mental health courts to promote court-imposed treatment as a substitute for incarceration. It presents issues that arise when a mental health court is being contemplated—issues that apply, for the most part, to all courts because all courts share an obligation under the Americans with Disabilities Act to accommodate individuals with mental illnesses.

The Bazelon Center has reviewed information relating to 20 mental health courts around the country and, through interviews with judges, public defenders and other stakeholders, has studied a dozen more intensively. We have reached the following conclusions:

- There is no single "model" of a mental health court; each court operates under its own, mostly unwritten, rules and procedures and has its own way of addressing service issues.

- Many of the existing courts include practices that are unnecessarily burdensome to defendants, that make it harder for them to reintegrate into the community and that may compromise their rights.

- Few of the courts are part of any comprehensive plan to address the underlying failure of the service system to reach and address effectively the needs of people at risk of arrest. Substantial numbers of mental health court participants are people who should not have been arrested in the first place, although some courts are beginning to accept defendants who are more appropriate for such a program—e.g., people who have committed serious felonies.

- Addressing the issues raised by the escalating number of contacts between individuals with serious mental illnesses and the criminal justice system requires a broad and comprehensive approach that should include mechanisms giving all police, prosecutors and judges effective options for alternatives to incarceration. These options should be available to offenders with mental illnesses just as they are available to all other offenders, with reasonable accommodations provided as necessary to ensure fair access and improve opportunities for their successful completion when deciding these cases.

- No program of alternative disposition—whether prosecutor-driven, court-based, within law enforcement or jail-based —can be effective unless the essential services and supports that individuals with serious mental illnesses need to live in the community are available. Moreover, it is critical that these services exist in the community for everyone, not just offenders, and that supports not be withdrawn from others in need and merely redirected to those who have come in contact with the criminal justice system. Additional, specialized resources and programs are needed to reduce the risk of arrest for people with mental illnesses and the recidivism of those who have come into contact with the criminal justice system.

This paper reflects these assessments and highlights issues for communities to consider if choosing to implement a mental health court. It also encourages a broader range of diversion programs as alternatives or supplements to mental health courts. Our recommendations are designed to ensure that if mental health

courts are used, they are part of a broad-based approach and they operate with policies and procedures that protect the individual rights of defendants who come before them.

The best approach to the problem of criminalization is to create a comprehensive system of prevention and intervention. Mental health courts may provide immediate relief to criminal justice institutions, but alone they cannot solve the underlying systemic problems that cause people with mental illnesses to be arrested and incarcerated in disproportionate numbers. Furthermore, without careful consideration of several factors discussed in this report, reliance on mental health courts carries significant risks for individuals with mental illnesses.

The Scope of the Problem

Policymakers' concern stems from the shockingly high percentage of jail and prison inmates who have mental illnesses, the fact that people with mental illnesses typically are incarcerated for much longer periods than offenders who do not have mental illnesses, that while incarcerated they become especially vulnerable to assault and other forms of intimidation by other inmates (4), and that mental health treatment in prison is rarely successful and usually not even adequate to combat the worsening of psychiatric conditions caused by incarceration itself. The following statistics illustrate the scope of the problem that needs to be addressed:

- Approximately 600,000 to 700,000 individuals with severe mental illnesses are jailed every year, most of them arrested for non-violent offenses, such as trespassing or disorderly conduct.(5)

- Sixteen percent of state and local inmates suffer from a mental illness and most receive no treatment at all.(6)

- During street encounters, police officers are almost twice as likely to arrest someone who appears to have a mental illness. A Chicago study of thousands of police encounters found that 47 percent of people with a mental illness were arrested, while only 28 percent of individuals without a mental illness were arrested for the same behavior.(7)

Under the Americans with Disabilities Act, states and municipalities cannot discriminate against people with disabilities and must make reasonable accommodations in their programs and services. These legal obligations apply to courts as well as to diversion and alternative sentencing programs and practices administered by law enforcement, prosecutors and pretrial services.

All jurisdictions have some ability to divert offenders from the criminal justice system—either by exercising discretion not to arrest or prosecute, or by providing formal diversion programs or alternative sentencing. However, in practice many do not even consider such options for people with mental illnesses. This may occur because of stereotypes about mental illness, such as the erroneous belief that people with mental illnesses are more dangerous than others, or for lack of information about how people with mental illnesses could be successfully accommodated in these programs. Some judges, prosecutors and defense attorneys have observed that defendants with mental illnesses are treated more harshly in court—that they are more likely to be remanded without the opportunity to post bail or given harsher sentences. According to the Council of State Governments' (CSG) Criminal Justice/ Mental Health Consensus Project—a nationwide effort to find agreement between representatives of law enforcement, courts, corrections and mental health system stakeholders—"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 to court."

South Carolina

In May 2003, the Richland County Probate Court received a $135,000 grant from the U.S. Justice Department's Bureau of Justice Assistance to establish a mental health court. "Mental health courts are a very important program to keep people with mental illness from becoming criminalized," Dave Almeida, executive director of the National Alliance for the Mentally Ill-South Carolina, told *The State*. "This is good news in a very bleak year." By providing more appropriate treatment, the number of mentally ill people in jail and in hospital emergency rooms could be reduced, saving the state money, said Shirley Furtick, director of forensic services for the state Department of Mental Health.

The first phase of the program will involve arrestees coming through the Columbia Municipal Court who have been arrested and charged with a non-violent misdemeanor. They can be referred to the program by a judge or jail staff. The arrestee, who would be screened by a social worker, must agree to follow the treatment plan recommended by the mental health court, said Amy McCulloch, the Richland County Probate Court judge who will preside over the program. Each program participant will have a different treatment plan, determined by a team that will include mental health professionals and family members. In addition to the provision of mental health treatment services, assistance with housing, education, and employment will be provided.

According to Dave Almeida, the mental health court will succeed only if Judge McCulloch has a string network of treatment options available, which could be threatened if the General Assembly does not fully fund the necessary community resources. "If we're not careful, it could be a recipe for disaster," he told *The State*.

The Role of Mental Health Courts

In the past few years, more than 25 communities have established some form of mental health court to process cases involving people with serious mental illnesses. These specialty courts strive to reduce the incarceration and recidivism of people with mental illnesses. They typically involve judges, prosecutors, defense attorneys and other court personnel who have expressed an interest in or possess particular mental health expertise.

From the criminal law perspective, two rationales underlie the therapeutic court approach: First, to protect the public by addressing the mental illness that contributed to the criminal act, thereby reducing recidivism, and second, to recognize that criminal sanctions, whether intended as punishments or deterrents, are neither effective nor morally appropriate when mental illness is a significant cause of the criminal act. The goals of these mental health courts, then, are 1) to break the cycle of worsening mental illness and criminal behavior that begins with the failure of the community health system and is accelerated by the inadequacy of treatment in prisons and jails and 2) to provide effective treatment options instead of the usual criminal sanctions for offenders with mental illnesses.

Effectively breaking the cycle of repeated contact with the criminal or juvenile justice systems must start with expanded and more focused community-based services and supports. As currently configured in many communities, public mental health services are substantially targeted at prioritized populations —people exiting state psychiatric institutions, people regarded as being at risk of admission to these facilities, people in crisis and people whose treatment is governed by court orders. Individuals not falling into a defined priority group may find very limited services available to them. Improving access to meaningful services and supports will inevitably reduce the number of incidents between individuals with mental illnesses and the law enforcement and justice systems; furthermore, it is critical to the effectiveness of any diversion program directed toward people who have mental illnesses, including mental health courts. (8)

Communities should ensure that criminal justice systems have a range of choices for disposition. Effective police diversion programs that prevent arrest for minor offenses and lead instead to services and supports are the first step in such a continuum. Various effective strategies then exist for people who have committed more serious offenses, including programs to reintegrate into the community those who have served time in jail or prison. The proper role of courts in this continuum is to address the needs of those who cannot, because of the nature of their offense, be diverted without arrest or at pre-booking or arraignment but for whom punishment through incarceration is not appropriate.

While most specialty mental health courts handle only defendants charged with minor offenses, several court-based alternative disposition programs exist that focus on individuals with serious felony charges—sometimes individuals who have already received a sentence to jail or prison but who are offered mental health services as a likely more effective option.

The Bazelon Center strongly believes that courts —including mental health courts— following the approaches outlined can be successful in final outcomes without compromising public safety if they are part of a broader program of system reform. (9) All of these approaches can be effectively implemented by any court to fulfill its obligation to accommodate people with mental disabilities, with or without the creation of a formal mental health court. Nonetheless, it is crucial for communities to develop a comprehensive approach to the criminalization of people who have mental illnesses

The Operation of Mental Health Courts

Today there are 25 to 30 mental health courts, depending on the definition used, and more are being planned. Congress addressed the issue in 2000, passing America's Law Enforcement and Mental Health Project Act, (10) which makes federal funds available to local jurisdictions seeking to establish or expand mental health specialty courts and diversion programs.

Some of the courts have a single judge who presides over a mental health court held once or twice a week or as often as necessary. Eligible defendants usually include people who appear to have a mental illness; some courts also include people with developmental disabilities or head injuries.(11) The courts typically have special court or pretrial-services personnel, who are responsible for developing treatment plans, and probation officers, who monitor defendants' compliance with the plans once incorporated into court orders.

From the earliest stages of its development and continuing through implementation, a mental health court must coordinate not only with police, sheriff and prosecution but also with state and local service systems. Only thus can a comprehensive—and realistic—picture be developed of how and why people with mental illnesses fall through the cracks, come in contact with law enforcement and get processed through the criminal justice system. Understanding the gaps and the reasons for these individuals' behaviors can lead to better targeted alternatives. In this regard, the participation of mental health consumers is critical. People who have "been there" can offer the most relevant perspective on how systems fail and what meaningful alternative(s) should be in place.

Of particular note to jurisdictions planning to apply for federal funds, Congress viewed coordination of services as crucial to the success of any mental health court. Specifically, in section 2203(d)(5), which lays out minimum requirements for all applications, Congress required both initial consultation and ongoing coordination during implementation with "all affected agencies... including the State mental health authority."

Three critical elements are needed in communities considering the establishment of mental health courts:

- there must be treatment and service resources in the programs to which offenders will be referred;
- there must be diversion programs at the time of arrest, at jail before booking and at arraignment

to keep the court from being overwhelmed by individuals whose offenses are minor and to prevent its becoming a routine point of entry to mental health services for individuals whose real problem is the limited availability of help through more appropriate channels; and

- the court's procedures should not have the effect of making a mental health court more coercive than a standard criminal court and more damaging to a defendant's future prospects for housing, employment and health care.

Mental Health Court Procedures

Mental health courts have a separate docket with a judge, prosecutors and defense attorneys who all have training on dealing with defendants with mental illnesses, who are familiar with existing service resources, and who are willing to work together with defendants and service providers to get the proper services for each defendant. Beyond these basic principles, every mental health court needs to put a number of procedures in place to ensure a fair balance between defendants' constitutional rights to trial and legal counsel and the protection of public safety and public health. Even existing mental health courts are not static; procedures and practices tend to be modified over time. The Bazelon Center compiled information on 20 mental health courts and undertook a more extensive examination of 12 of them, including interviews with judges and other key stakeholders. While the small number of mental health courts and their evolving nature preclude definitive conclusions, our examination does provide a glimpse of significant factors and trends relating to important procedural issues that any community will need to address if it chooses to establish a mental health court:

Voluntary Transfer into the Mental Health Court. It is crucial from the outset that transfer to the mental health court be entirely voluntary. Otherwise, singling out defendants with mental illnesses for separate and different treatment by the courts would violate the equal protection guarantee of the 14th Amendment and would likely violate the 6th Amendment's right to a trial by jury and the prohibition against discrimination by a state program found in the Americans with Disabilities Act.

Truly voluntary transfers to mental health courts entail much more than a simple declaration by the defendant. On its face, a defendant's selection of a therapeutic court over one structured around determining guilt and meting out punishment would appear an obvious choice. In fact, as explained in this report, mental health courts have their own risks, sometimes subtle, that a defendant needs to understand in order to make an informed decision. According to the CSG report, "Defense attorneys should present all possible consequences to their clients when discussing options for the resolution of the case."

For example, a mental health court may function as a coercive agent —in many ways similar to the controversial intervention, outpatient commitment—compelling an individual to participate in treatment under threat of court sanctions. However, the services available to the individual may be only those offered by a system that has already failed to help. Too many public mental health systems offer little more than medication and very occasional therapy. As with outpatient commitment, almost all mental health court orders include medication or an order to "follow the treatment plan," which includes medication; in fact, medication is the most likely "service" received. Obviously, a defendant should be fully informed of such factors and, in the alternative, of the potential outcomes of a conventional criminal hearing.

Some defendants, and their attorneys, may feel it would be more in the person's interest to go before a conventional criminal hearing. These situations should be assessed on an individual basis. According to the CSG report, "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.... 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."

Further complicating the voluntary election of mental health court involvement is the fact that such decisions are made when the defendant is likely to be under considerable stress, having been arrested and taken into custody, and perhaps having spent some time in a jail cell, often without treatment of any kind.

Right to Withdraw. Defendants in mental health courts have come to the attention of the legal system because they have been charged with criminal conduct, not because they have met criteria for involuntary treatment. To ensure that mental health courts and the services they may initiate are truly voluntary, it is important for defendants to be allowed to withdraw and have their cases heard in criminal court without prejudice. In some courts, a defendant pleading guilty knows ahead of time what his or her sentence would be before choosing whether to participate in a mental health court. While the defendant's decision to opt for a hearing in a mental health court, as described above, is more complex than might first appear and has some attendant risks, 56 percent of the courts providing information on this factor do not allow a defendant to reverse his or her decision and to withdraw from the mental health court program without prejudice. Of the courts that do permit this option, about half impose some restriction—for example, making withdrawal without prejudice available only with a 30-day time limit or only when program participation is not a condition of probation. The other half employ an approach supported by the Bazelon Center; they provide an unrestricted right for defendants to have their cases re-heard in criminal court without prejudice. It has also been suggested that people who voluntarily withdraw or "fail" in treatment monitored by mental health courts should be given credit for time served;(12) no court in the survey reported that it was utilizing this approach.

Appointment of Counsel. As a practical matter, mental health courts provide a form of pretrial diversion, most likely at or soon after the arraignment stage. A defendant who accepts transfer into a mental health court will be effectively waiving the right to a trial. It is the court's responsibility to ensure that the waiver of such a basic right is both voluntary and chosen with a realistic understanding of the legal consequences of the decision. The most reliable way to ensure that the waiver is both voluntary and informed is to provide defense counsel as soon as the defendant

is identified as a candidate for the mental health court. The American Bar Association Standards Relating to Providing Defense Services state that "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."

Missouri

In March 2003, Boone County received a $142,000 grant from the U.S. Justice Department's Bureau of Justice Assistance to establish a mental health court. "It is essential for Missouri to adequately treat these offenders and do everything possible to keep them from violating the law in the future," U.S. Senator Kit Bond said in a prepared statement that announced the grant. Bob Perry, court services administrator for Boone County, said that the primary focus of the program would be to offer help to people diagnosed with a serious mental illness, such as bipolar disorder, schizophrenia or major depression, who are charged with misdemeanor offenses or non-violent felonies. People could either participate to avoid prosecution or as a condition of their probation.

Kathryn Benson, district defender for the Boone County Public Defender's Office, said there is definitely a need for a mental health court. "For a multitude of other people there is no satisfactory way of dealing with their problems, she told the *Columbia Daily Tribune*. "You're talking about people who could easily function in society with a little help."

Behavioral Health Concepts, which provides screening and assessment services for the Boone County Jail, would act as a primary source of referrals. According to Court Services Administrator Perry, "That will be an important connection with the mental health court effort." The program would be funded with the federal grant and by proceeds from Proposition L, the law enforcement sales tax voters approved in August 2002.

Boone County Prosecuting Attorney Kevin Crane said officials have been discussing establishing a mental health court for quite awhile. "This is a very progressive option to use in lieu of incarceration," he said. Mr. Crane said the court would be designed to intervene with individuals who continually commit infractions of law because of their mental illness, including people who have not been diagnosed, as well as those who have but do not have enough structure in their lives to get necessary treatment. "There are some people who are just below the radar except for the criminal justice system," Mr. Crane told the *Columbia Daily Tribune*. "It's a cycle that they're in. You don't want to institutionalize them — they're not at that level — yet you keep having them commit these violations of law." He cautioned, however, that the mental health court would exclude individuals charged with serious and/or violent offenders.

It is particularly important for an individual with a mental illness to have access to such an advocate. Knowing that his or her advocate is participating in each step of the legal process can significantly improve the defendant's understanding of the process and the chance of success in the diversion program. The presence of defense counsel also helps with a number of court procedures, including obtaining authorization from the defendant to make available privileged information that may be used for a more positive outcome and limiting disclosure of private treatment information about the defendant. All of the courts on which we have information provide for defense counsel and at least one of the courts ensures that trained clinicians from the public defenders office assess offenders at the time of the bail hearing to determine whether they should be considered for the mental health court. For representation to be meaningful, though, defense counsel must have a background in mental health issues and in communicating with individuals who may be in crisis, an understanding of how the jurisdiction's public mental health system operates, resources that enable the attorney to actively participate in or challenge development of a treatment plan, and enough time to spend with the defendant.

No Guilty Plea. Of the courts studied, approximately half require guilty or no contest pleas as a condition of participation. Some courts utilize a preadjudication model, whereby charges are suspended or held in abeyance as the individual participates in treatment. Over a third of the courts surveyed allow for dismissal of the charges or expungement after successful completion of treatment. In most cases, dismissal of charges is not automatic and an individual must request expungement of the record, which is at best a cumbersome and difficult process. Furthermore, it is unclear what "successful completion of treatment" means, given that serious mental illnesses, by definition, are long term and often require many years of services and supports. Moreover, several courts retain participants' record of conviction.

The argument put forward by those who favor requiring a plea is that it is an effective form of coercion to increase treatment compliance. Beyond the irony of requiring an individual to follow a treatment plan developed by a mental health system with its own history of failures—and which indeed may have placed the individual at risk of arrest in the first place (13)— there are important reasons not to require a guilty plea:

- A guilty plea adds a conviction to the individual's record, making it harder to get or keep the housing and employment that are so crucial to effective mental health treatment, community tenure and management of a long-term psychiatric disability. Twenty-seven percent of the courts surveyed report that the individual will have a record of conviction even if the course of court supervision is successfully completed.

- Pressuring a defendant with a mental illness into a guilty plea continues (and even exacerbates) the existing disparities between arrest rates and subsequent jail time for individuals with mental illnesses compared to other defendants.

- If a defendant without a mental illness would typically have charges dismissed, it is discriminatory to require a person with a mental illness to plead guilty in order to access services and supports.

Mental health courts are intended as an alternative to a traditional trial, but they should not be more punitive. If a guilty plea is required, a defendant should be given information that would allow him or her to weigh the likely jail or prison time associated with a conviction against the scope and duration of treatment that would be monitored by a mental health court. For individuals opting for mental health court, a guilty plea should be dismissed upon successful completion of a defined period of monitoring by the court.

Types of Offenses Covered. Most arrests of people with mental illnesses are for non-violent crimes, such as trespassing or disorderly conduct.(14) While it would appear reasonable and fair to divert the least serious offenses before reaching the court, most of the early mental health courts focus primarily on misdemeanor cases.(15) It is important to divert such cases, both to avoid overwhelming the criminal justice system and so that arrest does not become the pathway to services, (16) for example, for people who are homeless or temporarily incapacitated and in need of treatment.

Mental health courts should focus their resources on individuals who are not considered appropriate for other types of diversion, either pre-booking or at arraignment.

- Of the courts studied, half limit eligibility to defendants with misdemeanor charges and half accept people charged with felonies, at least under certain circumstances.

- Eighty percent of the courts allow for cases involving violent acts, although 40 percent require some special process before these cases are accepted—for example, the victim's consent or a review of the specific charges.

- Twenty percent of the courts studied apply a blanket exclusion of defendants who have a history of violent behavior.

Based on our interviews with court personnel, mental health courts appear to be gradually expanding their jurisdiction to accept people charged with more serious offenses. This is a positive trend, reflecting the most appropriate use of mental health courts. Individuals with mental illnesses who are charged with more serious offenses are likely to be the least suited to the pre-booking diversion programs we recommend as companions to mental health courts. To avoid becoming the entry point for people abandoned by the mental health system, mental health courts should close their doors to people charged with minor misdemeanors. We found no court doing that.

Avoiding Court Involvement Through Services. Many encounters between people with serious mental illnesses and the police should not result in arrest, let alone court appearance and detention. For example, homeless people engaging in minor "crimes of survival' associated with living on the streets should not be arrested. According to the CSG report, "It is particularly important... 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."

Accomplishing this will require collaboration between law enforcement and the mental health system. A far more effective solution for many is a law enforcement diversion program, using trained officers backed up by readily accessible mental health services and coupled with a deliberate effort to address mental health system reform. However, 50 percent of the courts included in our survey operate in isolation without any defined pre-booking diversion program.

The CSG report includes examples of post-booking diversion programs and practices that do not utilize the mental health court model:

- The Mental Health Diversion Program, Jefferson County (KY), serves nonviolent defendants charged with either misdemeanors or felonies who suffer from chronic mental illnesses 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.

- In the Lane County (OR) drug court, a mental health specialist trained to deal with co-occurring disorders is assigned to the drug court in the dual role of case manager and court liaison to assist with defendants who have co-occurring disorders.

- Project Link, Monroe County (NY), 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.

- The Nathaniel Project in New York, NY, run by the Center for Alternative Sentencing and Employment Services, has established a dispositional alternative for people charged with serious offenses. The project is a two-year intensive case management and community supervision alternative-to-incarceration program for prison-bound defendants with serious mental illnesses. It 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.

- The Nathaniel Project has also developed a program that seeks to prevent a probation revocation by offering intensive treatment rather than incarceration for those who violate probation conditions. It targets offenders with mental illnesses who have violated conditions of probation. Case managers are clinically trained professionals with caseloads of only 10. Staff assist participants in obtaining medication, housing and other services, including day treatment, psychosocial clubhouse, vocational training and job placement.

Scope and Length of Judicial Supervision. One of the fundamental aspects of a mental health court is that the court maintains jurisdiction over the defendant while in services. Usually, mental health courts require the individual to "complete" a period of treatment. Our study found that the scope and duration of mental health courts' supervision varied from court to court. Even within a court, though, there may be significant variation.(17)

- Most courts lack any written procedures, so uncertainty is great and the outcome depends on the judge's decision. In several courts the length of supervision is not specified, but is decided on a case-by-case basis. However, several courts place specific limits, generally from one to two years.

- In at least 40 percent of the courts reporting, the limits of court supervision significantly exceed the possible length of incarceration or probation for the offense. Such policies likely discourage many individuals with mental illnesses from transferring their cases to the mental health court.

The duration of the court's supervision of treatment should be based on the individual's treatment plan, but should never exceed the typical sentence and probationary period for the underlying criminal charge. To do so would compound the discriminatory inequities people with mental illnesses already face in the criminal justice system. While individuals with mental illnesses may require long-term services and supports, it is unnecessary and inappropriate for the court to continue to supervise such services beyond the typical period of court supervision for the underlying offense. It is the task of the mental health system to engage its clients in needed service programs, not to relinquish this function to criminal courts.

Accordingly, the court should carefully limit the scope and duration of its supervision. Conditions of release should be individualized, the least restrictive necessary and reasonably calculated to accomplish the goal, which is to reduce the likelihood that the person will recidivate. It is inappropriate and demeaning for the court to maintain protracted supervision based on the individual's mental illness, not on alleged criminal activity.

Sanctions for Non-Compliance. The performance standards of the National Association of Pretrial Services Agencies state that diversion conditions should be clearly written in a service plan signed by the defendant. This plan should detail what action could be taken in response to the individual's failure to comply with conditions, so that individuals know exactly what is expected of them. At the same time, the plan must consider the nature of serious mental illness. According to the CSG report, "it must be recognized that decompensation and other setbacks are common occurrences for people under treatment for mental illness as the attending mental health clinicians seeks the most appropriate treatment." Moreover, "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." We found that courts use an array of mechanisms as sanctions for non-compliance with a service plan:

- Thirty-six percent of the courts reported that non-compliance is handled via adjustments in services.

- At least 27 percent try lectures, more frequent court appearances and increased judicial persuasion.

- Sixty-four percent (18) of mental health courts reporting, however, use jail time as a sanction and 18 percent reported that the individual may be dropped from the program —actions that may be particularly unhelpful if the issue is one of normal relapse and the ups and downs of recovery from mental illness.

If the goal is to lessen the incarceration of people with mental illnesses, then using incarceration as punishment is a perversion of whole idea of mental health courts. According to the CSG report: "Before imposing punitive sanctions for non-compliance, the court should conclude that the defendant was capable of complying but chose not to." This finding requires careful investigation. Mental health treatment is much more difficult to quantify than drug abuse treatment, which has easily defined measures of compliance and where non-compliance itself is a crime. The success of mental health services is gauged in outcomes, not adherence to a specific plan of care. Setbacks may have no relation to the individual's desire to comply with court orders or adherence with a treatment program. In fact, for many individuals with mental illnesses, various treatment and service options must be tried before an appropriate and effective service plan is established. In fact, "the key...is to identify first the offender's individual needs and then identify the services in the community that can meet those needs."(19)

When individuals run into difficulties while in a services program operating in collaboration with the court, the court should explore the causes. Noncompliance should be assessed in order to determine "whether any noncompliance with diversion

California

Leland Siegal was "on the street" doing drugs and suffering from an undiagnosed bipolar mental disorder for years. In and out of jail, he managed to "clean up" for about two years by relocating to Florida, but quickly returned to his bad habits when he moved back to his Oroville hometown last year. On April 23, 2003, the 40-year-old defendant became the latest to graduate from an innovative court research project called "the mentally ill offender crime reduction" program.

Butte is one of 14 counties in California participating in a three-year pilot study to test whether getting specialized treatment through the courts for people with mental problems is more cost-effective than simply locking them up. (See ***Jail Suicide/Mental Health Update***, Volume 11, Number 1, Spring 2002, pp. 17-20.)

Using the county's highly successful drug court as its model, volunteers accepted into the program get "enhanced" treatment, supervised by a special team that randomly tests them to ensure they are not using drugs or alcohol and are staying on their psychiatric medication. They are then compared against a like number of defendants with similar mental and substance abuse problems who do not receive the specialized treatment.

At a celebration marking the one-year anniversary of the "FOREST" (Forensic Research Team) court, Superior Court Judge Stephen Benson said early indications are that the program is working. He said the first-year statistics show that those not getting the enhanced treatment spent four times more time in the local jail than those who did.

In a more measured response, Sheriff Perry Reniff said, "we won't know for another year how successful we'll be" in saving money and reducing crime. If nothing else, though, the 38 current participants in the pilot project have freed up badly-needed bed space in the overcrowded county jail. "I have long been opposed to jailing the mentally ill," said the sheriff. But he said that until now, there was not a suitable alternative.

The $2.8 million research grant, which is funded through the state Department of Corrections, is due to run out in July 2004. Judge Benson, who had lobbied hard to include Butte in the research project, said he hopes to have enough statistical data to convince the Legislature to continue it. To qualify for the state grant, Butte originally had to come up with a 99 percent matching grant of nearly $1.4 million in goods and services. But the sheriff said that thanks to the court's program manager, Pamela Hospers, the local share has now been cut in half, saving Butte taxpayers about $800,000.

Like Leland Siegal, participants in the pilot study must have a diagnosed mental disorder and currently be in jail or recently have served time in custody for a broad range of felony and misdemeanor primarily non-violent offenses. After a careful screening process - which among other things examines the level of risk to the public - they are released on probation on their promise to abide with a course of treatment. A special team drawn from the Butte County Behavioral Health Department, Probation Department, Sheriff's Office, District Attorney's Office and the public defender then monitor the offender's treatment and test them regularly for substance abuse. The participants are brought back into court on a regular basis to assess their progress, reprimand them when they are not complying with treatment and to reward them when they are.

Cathy Cooper wept as she recounted how after successfully going through "detox," she had ingested methamphetamine recently. Turning to people in the courtroom, including the media, she pleaded: "I don't want to be one of those people institutionalized the rest of my life." The judge consoled her by noting that just by coming to court, she had showed "the heart" necessary to overcome her dual drug and mental health problems. "I have confidence you'll make it," he added.

Program Manager Hospers noted privately that many of the mentally ill offenders in the program became addicted to drugs when they attempted to "self-medicate…Some said it (drugs) helps them not to hear voices."

To acknowledge them remaining drug-free and following their required course of treatment, the judge handed out coupons for free pizza to two others taking part in the court research project: Emily Burke, 40 and Christine Sartin, 25, both of Oroville. "If it hadn't been for FOREST court, I wouldn't have made it," Ms. Sartin told a reporter later. "I was a real relapser ... But I've been clean 80 days now and I don't ever want to use again," she said.

Leland Siegal, the fourth person to successfully complete the county's mentally ill offender program, celebrated not only his release from court supervision, but his and his wife's four-month "anniversary." "When I first started, I thought I had no chance of success," Mr. Siegal told those in the courtroom. "The FOREST team brought me back to life. If I had a problem, they talked me through it and helped to keep me together." His wife, Kay Siegal, said that in many ways the court program was even tougher on her. "They went through me to get at him," she said, pointing at her husband. But she said she is grateful for the court's assistance. "He could have stayed in jail and gotten nowhere," she observed.

Public defender Steve King, who represents those going through the special court, said he has seen "a big difference" after his clients are "stabilized and have someone to talk to….On the average, I'm very pleased. They do a good job; the team is very dedicated."

Before San Bernardino became the first county to launch a mentally ill offender court in the state, Judge Benson said it was spending up to $6.2 million annually just in jail medication costs. One of the first graduates from Butte's FOREST court, the judge noted, suffered from a bipolar disorder and was re-arrested for repeatedly violating a restraining order sought by his girlfriend. The county spent money not only to re-arrest and incarcerate him, but to transport him to and from court and to a psychiatric unit in Chico. "Jails and prisons were simply not designed to serve as the last resort for the mentally ill in our communities ... and the Legislature wanted to know whether there was a better, more cost-effective way," the judge said of the pilot project.

FOREST is one of several so-called "collaborative" or problem courts in Butte County, which utilize the same team approach to help criminal offenders deal with everything from substance abuse to domestic violence. Asked if she felt the court should take on such a social service role, assistant district attorney Helen Harberts replied: "The goal of these (collaborative) courts is to reduce crime. Anything that achieves that goal is not being soft on crime, it's being smart on crime."

The above article — "Mental Health Court Marks First Birthday" — was written by Terry Vau Dell, a staff writer for the ***Chico Enterprise Record****. It appeared in the April 24, 2003 edition of the newspaper and is reprinted with permission of the* ***Chico Enterprise Record.***

conditions...was willful, was a symptom of the mental health illness or was an indication of the need to change the treatment plan."(20) These factors should be carefully considered before any sanctions are contemplated. Often, "a more appropriate response would be to modify the treatment plan rather than to seek the revocation of (diversion)."(21)

Case managers or social workers can be particularly helpful in monitoring treatment and coordinating services across various providers and systems, especially if they take a proactive approach, rather than just reacting to compliance problems.

Accountability of Mental Health Providers. Too often, the criminalization of defendants with mental illnesses begins with the failure of mental health programs to meet these individuals' needs or to accept them into services because they have difficult problems (such as co-occurring substance abuse) or because they already have a criminal record. Solving the problem, in the context of a mental health court, should begin with service providers' active participation in the mental health court plan and in the processing of individual cases moving through the court. This should include conducting assessments, designing person-centered service plans that seek to engage people in treatment that encompasses their own life goals (e.g., employment), and accepting responsibility for implementing the plan, in collaboration with the individual, once the defendant is referred by the court.

If the court is to be responsible for continuing supervision of the offender, including the possibility of applying sanctions for any type of noncompliance with the service plan, the court must also have the power to ensure that service providers are delivering appropriate services to defendants who are making a genuine effort to participate in their service plan. However, 63 percent of the courts reporting indicated that they have no authority to hold mental health providers accountable. The best ways to exercise this authority will depend on local circumstances, but may include the court's contempt powers, writs of mandamus or control over funds targeted toward service diversion plans.

Seventy percent of the courts reporting indicated that they have access to some, albeit limited, services beyond what the mental health system customarily offers. Vastly preferable would be better services integrated in the mainstream mental health system, rather than court oversight of a parallel system for offenders.(22) Mental health systems should not be allowed to abdicate their role and their responsibilities on behalf of people with mental health care needs.

Medical Privacy. To work effectively, mental health courts often require medical and psychiatric treatment information about defendants, both as part of the disposition of a case and for ongoing monitoring. All of the courts surveyed reported some provisions to safeguard the privacy of information about defendants—for example, limiting discussion of clinical information in open court or delegating maintenance of clinical information to case managers and keeping the court record to a minimum. Use of treatment information in a criminal proceeding raises questions of doctor-patient privilege and disclosing medical information in open court raises serious privacy concerns. Ensuring the early appointment of defense counsel can help to solve some of these problems by using defense counsel as a filter or reporting point for any potentially privileged treatment information. Mental health courts can address the privacy concern with rules that keep the medical information out of the public record of the proceedings and through sidebar or chamber conversations for sensitive discussions. They can also protect individual privacy with rules that limit judges' and prosecutors' access to only the specific information they need to know to make their decisions.

Intended and Unintended Consequences. Typically, the genesis of mental health courts can be traced to concerns by local judges, attorneys and criminal justice personnel that people with mental illnesses were being wrongly subjected to arrest and incarceration. Their goal is to ensure not only that these individuals are diverted from the correctional system, but also that beneficial services are made available. Mental health courts should be evaluated carefully to determine whether these objectives are, in fact, being met. For example, courts should ascertain whether individuals under their supervision are being rearrested and whether services are working to improve the individual's quality of life. Furthermore, given that mental health courts are largely reactive to failing mental health systems, the evaluation should also consider whether reform efforts are underway by the public mental health system toward identifying and making services available to people with mental illnesses who are at risk of arrest. There is an inherent risk that any court-based diversion program, if not accompanied by such reforms and an effective pre-booking diversion program, might lead law enforcement officers to arrest someone with a mental illness in the expectation that this will lead to the provision of services. However, as stated above (and by the Council of State Governments), individuals with mental illnesses should not be arrested in situations where someone without a mental illness would not be. It is therefore important to also include arrest data in these evaluations. Finally, the court should create a mechanism for stakeholders, including people with mental illnesses, to have a say about its operations and to play an active role in the evaluation process.

Conclusion

Court-based diversion—whether through speciality mental health courts or through regular criminal courts—is not a panacea for addressing the needs of the growing number of people with mental illnesses who come in contact with the criminal justice system. Rather, court-based diversion should be seen as but one part of the solution. A broader effort at system reform is needed; indeed, without such broader efforts courts can have only limited success. Specialty mental health courts, when used for more serious offenses and responsive to the issues raised in this paper, can play a productive role in a comprehensive strategy to break the cycle of poor treatment, worsening mental illness, escalating criminal behavior and increasing arrest and incarceration.

To eliminate the unnecessary and harmful criminalization of people with mental illnesses, communities must address the

causes of the problem, not just its symptoms. The substantial gaps in effective community services are the root of the problem and addressing them must be the first step toward its solution. Training court personnel and law enforcement officers to enable them to make better informed decisions about people with mental illnesses and about new and existing treatment resources is also critical. Both of these steps can have a major impact on the presence of people with mental illnesses in the criminal justice system, even without creating a formal mental health court. Communities looking to create or expand court-based diversion programs should consider the wide range of existing programs, such as the examples listed above. Jurisdictions that do create specialized mental health courts will have far more success and will better serve the cause of justice if they include treatment and diversion programs as part of a broad package of systemic reform.

If communities do choose to set up mental health courts, they should be aware of the need to focus on the final outcome—successful reintegration into the community and reduced recidivism—when establishing the court's procedures. This outcome is more likely to be achieved if the court focuses on ensuring the success of community services and avoids actions that hinder reintegration, such as insisting on guilty pleas that lead to denial of housing or employment.

Innovation and, above all, a dedication to reform are necessary to address the growing problem of criminalization from both a public safety and a public health point of view. Communities that are committed to change, where mental health and criminal justice interests work collaboratively on solutions, can find cost-effective and just ways to reverse the present trend of neglected lives and wasted resources.

Footnotes

(1) Council of State Governments (June 2002), *Criminal Justice/Mental Health Consensus Project*, New York: Council of State Governments, Eastern Regional Office.
(2) Center for Court Innovation (2001), *Rethinking the Revolving Door: A Look a Mental Illness in the Courts*, New York: Author.
(3) Council of State Governments (June 2002), *Criminal Justice/Mental Health Consensus Project*, p. 9
(4) Council of State Governments (June 2002), *Criminal Justice/Mental Health Consensus Project*, p. 5, citing testimony of Reginald Wilkinson, then Vice President, Association of State Correctional Administrators and Director, Ohio Department of Rehabilitation and Correction, before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, oversight hearing on "The Impact of the Mentally Ill on the Criminal Justice System," September 21, 2000.
(5) Bureau of Justice Statistics (July 1999), *Special Report: Mental Health and Treatment of Inmates and Probationers* (NCJ 174463), Washington, D.C.: U.S. Department of Justice.
(6) Id.
(7) Teplin, Linda A. (July 2000), "Keeping the Peace: Police Discretion and Mentally Ill Persons, *National Institute of Justice Journal*.
(8) Trupin, E.; Richards, H.; Lucenko, B. and Wood, P (undated), *King County District Court Mental Health Court Phase I Process Evaluation Report*. Seattle, WA: The Washington Institute for Mental Illness Research & Training, University of Washington.
(9) See Bazelon Center for Mental Health Law (2000), *A New Vision of Public Mental Health*, including model law, An Act Providing Recovery-Oriented Mental Health Services and Supports, Washington, D.C.: Author.
(10) P.L. 106-515.
(11) Not all courts require proof that the person has been diagnosed with a mental illness. See, for example, King County District Court, Washington. For some, the first time a mental illness is recognized by the family or the individual is when the person is arrested for bizarre or unusual behavior.
(12) Center for Court Innovation (2001), *Rethinking the Revolving Door: A Look a Mental Illness in the Courts*, New York: Author, p. 19.
(13) Bazelon Center for Mental Health Law (2001), *Disintegrating Systems: The State of States' Public Mental Health Systems*, Washington, D.C.: Author; also see Bazelon Center position on outpatient commitment at www.bazelon.org/issues/committment/ioc/index. htm.
(14) Bureau of Justice Statistics (July 1999), *Special Report: Mental Health and Treatment of Inmates and Probationers* (NCJ 174463), Washington, D.C.: U.S. Department of Justice.
(15) Griffin, P; Steadman H.; and Petrila, J. (October 2002), "The Use of Criminal Charges and Sanctions in Mental Health Courts," *Psychiatric Services*, 53 (10):1285-1289.
(16) Petrila, J.; Poythress, N.; McGaha, A. and Boothroyd, R. (undated), *Preliminary Observations From an Evaluation of the Broward County, Florida Mental Health Court*.
(17) Trupin, E.; Richards, H.; Wertheimer, D. and Bruschi, C. (2001), *Mental Health Court Evaluation Report, City of Seattle Municipal Court*.
(18) Numbers exceed 100 percent because several courts reported more than one strategy.
(19) Council of State Governments (June 2002), *Criminal Justice/Mental Health Consensus Project*, New York: Council of State Governments, Eastern Regional Office.
(20) Id.
(21) Id.
(22) See Bazelon Center for Mental Health Law (2000), *A New Vision of Public Mental Health*, including model law, An Act Providing Recovery-Oriented Mental Health Services and Supports, Washington, D.C.: Author.

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Commentary on Mental Health Courts: Reframing the Problem From a Jail-Center Perspective

by
Margaret Severson, J.D., M.S.W.

Introduction

The very informative and admirably balanced article in this edition of the *Jail Suicide/Mental Health Update* by the Bazelon Center for Mental Health Law will do much to further inform our community of practitioners, scholars, and policy makers about the advantages, disadvantages and unknowns of mental health courts. Insightful comments on the many reservations about mental health courts will be especially useful as more communities consider developing a mental health court — a phenomenon Bazelon notes is likely to continue, despite these serious reservations.

There is something very seductive about this relatively new concept, one where jails hand over their (ever diminishing) power to a judge who, from all appearances, has political pressures, time management challenges, and to top it off, constitutional mandates to steer clear of legislative and executive areas of control. Hmmm, exactly how *does* this or how *is it* supposed to work? Again, the authors point to some of the ways that these courts can indeed "work." Still, the question remains, *is this really the work that needs to be done*?

As I contemplated writing this commentary, read the Bazelon article, considered my own experiences witnessing the operations of certain mental health courts and recalled the excitement and then disappointment that some jail administrators and clinical directors have experienced with this promising new invention, I could not help but think that we have once again been seduced by the power of systems that still don't quite understand what jails face when called upon to care for persons with mental illnesses. The point is missed if we only lament the failure of the mental health system to perform. For jails, the focus should always be on the demands on it to perform in ways it was never intended to perform.

Well-intentioned though they may be, mental health courts contribute to the criminalization and may well worsen the stigma that persons with mental illnesses face every day of their lives. True, these courts *are* trying to help the detainee access needed services, trying to influence the mental health system to get involved and trying to offer families hope for a better, healthier outcome when someone's illness has been criminalized. These are all admirable accomplishments, true, but it is easy to get confused amidst the feel-good rhythms coming out of these courts. In the end, there is no evidence that these accomplishments benefit jail systems; they only make us think that they might. And "might" is simply not good enough.

So, it seems very important to build on Bazelon's work by examining this whole mental health court - court entanglement thing from a jail-centered perspective. In fact, it is time to do some critical thinking, find our power and perhaps then quickly set about doing something about the problem itself in a jail-centered way. The good folks at Bazelon started us down the road of critical thinking…and the humbly submitted and intentionally jarring ideas that follow are intended to further it.

What's Wrong With This Picture?

At first glance, the idea of mental health courts seems reasonable in the effort to seek a solution for the burgeoning population of offenders with mental illnesses. Feeling otherwise powerless to effect change, it is normal to turn to the entity — and to the person who represents it — that seems to hold the kind of power jails need in order to solve the problems of overcrowding, understaffing, over-housing (of certain categories of special needs populations) and under-responding. But in the clarity of the Bazelon article, we begin to see that mental health courts are not the ultimate solution we have all been searching for after all and further, that this handing over of power to yet another substantially uninvolved entity is filled with risks. One such risk is that we will see these same defendants incarcerated repeatedly on even more serious charges. In the end, it seems important to ask *why exactly we think that someone with a mental illness who doesn't want to follow his/her treatment plan devised with a mental health professional will suddenly want to do so just because a judge is involved*?

Those at the Judge David L. Bazelon Center for Mental Health Law have addressed many of the relevant legal and ethical issues in their excellent article. They stop short at suggesting alternative methods that jails might use to deal with this ongoing problem of having to safely house persons with mental illnesses. While acknowledging that the mental health systems responsible for caring for persons with mental illnesses have failed to do so, jail systems are still left holding the bag for their actual custody and care. Consequently, the objective in the paragraphs that follow is to present some useful, albeit provocative ideas about what jails can do as an alternative to climbing on the mental health court bandwagon.

In the final analysis, each jail must decide if such a court is right for them. But first, the following bears some thought.

Judges should not be front and center in the world of mental health decision-making … and neither should jails.

Judges have their own set of professional responsibilities and they go about carrying those out based on a body of knowledge that is all about the law. Jail administrators, officers and other personnel have their own set of professional responsibilities as well and those, too, are based on a special body of knowledge that is part law, part administrative and personnel management, part human services and part communications. While persons with mental illnesses may come to the attention of both judges and corrections professionals, their presence alone does not somehow infuse the judge or the correctional administrator and officer with a special knowledge about their illness; nor should it. That knowledge is the purview of the mental health professions. There is always a danger that when one inserts oneself into the business of another,

as these courts and jails have done, some responsibility for that business is likely to be assumed by those intruders. Welcome to the 21st century. The real question is not how to get more into that business; it is how to get out of that business.

One answer? Disengage. Do not get into the business of trying to make the public mental health system do what it is supposed to do and instead, start work now to get yourself out of it. More on that later.

A person is a person is a person … unless s/he has a mental illness.

What is wrong with this picture? A person with a physical illness, let's say lung cancer, is charged with a crime. Perhaps the crime is a nuisance charge; perhaps it is something more aggressive, but in any case, it is a misdemeanor offense. That person is identified at arrest, at booking, prior to court, after court or sometime during his/her jail stay as being someone with lung cancer. A flurry of activity begins. The person's doctor is consulted, the family is contacted, medications may be started, his/her attorney is called, the jail medical staff sees the inmate/client, a case manager is contacted to work on a discharge plan, the community health center is consulted about what services might be available to help this person, probation is called in and the inmate's case is discussed and finally, they all meet up in court along with the offender. A plan for the offender's medical care has been or is created. The offender is offered a "deal" … go get this health intervention and your case will be disposed of in some way that gets you out of doing jail time.

What is wrong with this picture? Chances are you said to yourself, why all the activity about this offender? I would go to the courthouse, talk to the judge and the attorneys, say this is the problem and here is what it will cost the jail to keep this person and either provide or otherwise arrange for all the treatment, and you would ask for the person's release. Right? The total outlay in energy and money is simply the sum of your time, the Judge's time, and the attorneys' time and whatever medical treatment you rendered in the interim.

Now consider what is wrong with *this picture*? A person with a mental illness is charged with a crime, perhaps some nuisance charge; perhaps something more aggressive, but in any case, a misdemeanor offense. That person is identified at arrest, at booking, prior to court, after court or sometime during his/her jail stay as being someone with a mental illness. A flurry of activity begins. The attorneys meet, the evaluator sees the inmate/client, the case manager is contacted, community mental health center is consulted regarding available services, probation is called in and they all meet up in the mental health court along with the offender. A plan has been or is created. In fact, this group of people has been meeting regularly about many similar defendants who have seen the inside of your jail. Some of those defendants actually spent more time in your jail that their counterparts who only had physical illnesses. Imagine that? In any case, this defendant is ultimately offered a "deal" … accept this mental health intervention and your case will be disposed of in some way that gets you out of doing more jail time.

What is wrong with this picture? The very fact that judges, health systems, attorneys and other service providers are approached differently, more expediently in the case of the person with a physical illness tells the story. We *do* treat people with mental illnesses differently than other people. The stigma of mental illness motivates us to treat people differentially. Society's reactions to people with mental illness means that they are more likely to be locked up and locked up for longer periods of time than others who do not have a mental illness. Further, we treat their conditions differently even though there is no reason to believe that the person with a mental illness is any more likely to commit the misdemeanor than the person with lung cancer.

One answer? Protection of the jail's interests should be the same for all incarcerated within its walls. We owe no special duty to the courts or to others in the criminal justice system to plan more for the person with the mental illness.

There are some very good reasons for the constitutional principle that mandates the separation of powers … and jail management is one.

There is a good reason why the three specific powers are executive, legislative and judicial. For one, if one or another branch could broadly and legitimately exercise power over another branch well, we would all be answering to a judge. Thankfully, that is not the case. Curiously, the Bazelon Center suggests that courts must "have the power to ensure that service providers are delivering appropriate services to defendants who are making a genuine effort to participate in their service plans," and suggest that courts should exercise contempt powers, writs of mandamus and/or control over the funding of diversion programs. Aside from the fact that judges are not the front-line providers of mental health care and are not generally willing to act as mental health experts, what would happen if these extraordinary powers were used? Would the mental health professionals be sent to jail? Would diversion programs be terminated? Would our appellate processes be even further burdened?

Actually, aside from all those questions is the very fundamental issue of the separation of powers. In fact, the Bazelon Center reports that 63 percent of the reporting mental health courts acknowledged they had "no authority to hold mental health providers accountable." To this I can only say, hallelujah — and let's keep it that way. If the courts get that involved in making providers provide services — our jails will be filled with clients *and* their providers.

One answer? Take a lesson from the mental health professionals — without something more, simply wearing a robe does not mean that a judge can always tell you what to do and back it up.

The national, state and community mental health systems, no matter how well intentioned, have abdicated their responsibilities to help persons with mental illnesses who find themselves entangled in the web of the criminal justice system. Jails are not going to change the mental health systems; jails must not function as the primary mental health system.

The Bazelon Center did an excellent job pointing out how the mental health system has abdicated its responsibility to persons with mental illnesses — and even to persons who have what are

frequently referred to as sub-clinical disorders, but who cause much disruption in the jail setting. While of course we all want the mental health system to step up to the plate and take over the game, we simply are not the ones to make this happen. Jails will not change the mental health system. What jails can change is how they respond to the failure of the mental health system to take charge.

One answer? Take a lesson from the mental health system which has good, bad or otherwise, redefined itself. Refuse to be the default mental health system by your own default. Get tough with those who by way of their actions, insist that having a mental illness is a criminal offense.

In truth, there are already mental health "courts" or "judges" in many jurisdictions; they just are not defined in quite the same way as these new-fangled versions.

Many court districts have a designated mental health judge. Sometimes this responsibility rotates among all the judges in a particular district. Generally, this is the judge who hears the civil actions that involve persons with mental illnesses. Typically, involuntary commitment proceedings, guardianships and petitions to find someone incompetent to manage some or all of their own personal affairs (among other actions) are issues heard in this court. If you must have a mental health court, why not use the same judge who has been hearing these related matters and who hopefully already has a good knowledge base regarding the services available to the person in both the law and in the community, as well as the particular rights the person has when brought in front of the court.

There is an important historical context to all this, one we should pay attention to and integrate into our planning efforts. In fact, there is precedent to remind us what happens when we isolate problems in a problem-focused place. Inevitably the result is more stigma; more isolation. Homeless shelters, co-located service centers, housing projects … come to think of it, jails; all are good examples of what happens when we move the problem out of the community and into its own special, read desolate, place.

Finally, in truth, most courts systems are already overburdened, especially with criminal dockets. How can it be argued that more judges are needed and at the same time, tie one up — no matter how committed to the cause — to manage an issue that ought to be managed by other entities and by other people — those who actually understand the problems experienced by persons with mental illnesses and who, if given the legitimate authority to do so, have the most opportunity to make things happen for them.

One answer? If you have to have one, why reinvent the wheel?

The money going into the creation of mental health courts might be better spent elsewhere.

So far, the work of these existing mental health courts has been largely limited to those charged with misdemeanors, though this appears to be slowly changing. At the same time, state hospital systems continue to not only downsize but also narrow their eligibility requirements, making it difficult to access beds for those charged with felonies and/or crimes involving assaultive behaviors. Also at the same time, access to local and/or private inpatient psychiatric care for one who is uninsured is nearly impossible. And, what about all those felons out there in our jail systems who, by virtue of their crimes, have ever diminishing opportunities to gain access into a hospital system?

Though the money invested in mental health courts is, in the grand scheme of criminal justice funding, thus far minimal, it just might be better spent elsewhere. In truth, what is being spent to run mental health courts would not pay for four months of psychiatric hospitalization … but it just might pay for a year or two of a case manager who, working collaboratively in the community with the community systems that were designed and funded to serve persons with mental illnesses, could conceivably accomplish a lot more for a lot more people.

One answer? Invest in the knowledge of the mental health profession who can act as the service broker.

There are serious privacy and self-determination issues that exist in the case of the defendant who is compelled to appear in front of the mental health judge … and the jail should refuse to join in.

The Bazelon article touches on the issue of privacy, but much more needs to be said. This country was built on the right of people to both be and act differently from anyone else. It is tolerated (and in many cases encouraged) in entrepreneurial endeavors, in the boardrooms of major corporations, in educational systems and in the arts. When a person is charged with a crime because of his or her mental illness, this right to be and act differently is

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.performancebasedstandards.org
www.gainsctr.com

summarily denied and often for no clear reason. If the shopkeeper is annoyed, if the police are bothered or if the mental health professionals just think it is time that their client learn a lesson, the criminalization of persons who, but for their mental illnesses, would not be charged is a method of endangering all persons' rights to self-determination, to dignity and to just "be."

Of course, this doesn't mean that we should not incarcerate the violent offender who has a mental illness, especially to protect the safety of the community. But, it does mean that no person who has a mental illness should be incarcerated solely for his/her own safety or merely for the convenience of any one segment of the community. Hospitalized, maybe; jailed definitely not.

One answer? Exercise discretion at the front door of the jail.

We should never assume that our doing something for someone's mental health is a supreme and noble endeavor.

In fact, as the Bazelon Center points out, when the person with the mental health challenge is arrested and brought in front of the mental health court, his/her illness has been criminalized. There is no getting around it — there are court records; legal processes; adversarial stances; and substituted judgments that leave an enduring history that such is the case. Unless you can say with certainty that this person will be better *and* better off by your taking matters (treatment decisions in particular) out of his/her hands and becoming the administrator of treatment, we simply do not have the right to do it.

When thinking of exercising control over the decisions of another, caution and humility are in order. In fact, some people fare worse in mental health treatment. We ought to be mindful of the inexactness of this science and open to new ways of helping people manage their own illnesses. That will not happen when life-altering orders are issued from the bench.

One answer? Be humble. Keep looking for a better set of solutions.

What Can The Jail Do?

The Bazelon Center suggests that "any mental health court be initiated, if at all, only as one aspect of a complete overhaul of public mental health systems." But if this is about the exercise of power over one's own destiny, then it is the jail system that requires the overhaul. We simply do not have the time to wait for the public mental health system to reinvent itself. If it ever does happen, it is unlikely that those persons we have housed, treated, released and re-booked will be the first in line to be served by a revamped community mental health system.

So, what can the jail do?

First, beware the seductive power of the panacea. Success is a destination; it starts with a concept and at least one person and it is continually infused with energy, authority, determination and feedback. If you don't have the person, the idea, and the infusion, or if you don't have someone you have recognized as having all three and in whom you are willing to vest the power to think about new ways of managing this problem and to pursue

Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

meaningful solutions to the problems currently sent before the mental health courts, read no further. If you rely on someone else to solve these problems you can count on being the front line provider of mental health services in your community.

Recognize, own and use responsibly, your power and the power vested in you by virtue of your position as a change agent. Power in and of itself is neither good nor bad; it is simply an abstraction. Power is only something experienced and used in relation to something else. The question is how does the jail have power in caring for persons with mental illnesses and how should the jail wield this power?

Chances are some of you will balk at these suggestions — and while you may not like them at first glance, consider the alternative. Reinventing your institution means getting a picture of what the jail should be used for and defining what needs to happen to make it so. Sheriffs and jail administrators, think about refusing to book into your facility persons with mental illnesses who are charged with anything other than the most serious misdemeanors (driving while intoxicated and domestic violence, for example). Sheriffs, police chiefs and highway patrol commanders, consider more training for your officers in the areas of identification of mental illnesses and crisis intervention. Instruct them to transport people suspected of having a mental health condition to a social service agency in the nearest community. Think about empowering your officers to contact family members for assistance instead of or at least before making an arrest.

Be not only the change agent but the agent of reality for those who advance solutions that do not put the jail in the center of the solutioning process. While cooperation and collaboration in problem solving processes are essential, be careful not to confuse cooperation with cooptation. If you believe it will not work for your system, you must say it and be prepared to stand firm in that resolve. Standing firm may in fact mean refusing to accept certain people; refusing to accept certain people unless certain conditions are met (a pre-admission psychiatric evaluation); refusing to open yet one more mental health unit or pod in your facility because these special needs people keep being sent to you for their service needs.

We could not ask for better networks in which to do this reinventing work. I was working with a jail not long ago and a member of the security staff asked me if I thought the public mental health system could or would ever turn this whole thing around. Without much thought I said I didn't think so. Even if the funding for community mental health magically appears on October 1, 2003, mental health systems have been so under-funded for so many years that the costs of building the infrastructure necessary to do business — computers, office space, hospital beds, personnel, record keeping systems — make it hard to believe that they could then afford to pick up all the jailed clients we have been dealing with these many years.

So what are we going to do, this officer asked. As a corrections practitioner, mental health professional, lawyer and social work educator, it is hard for me to suggest that we stop rescuing the mental health system, but I am convinced that it is in fact what needs to happen. We should take a lesson from mental health — we must prioritize who we will detain and determine who we will not. Like mental health systems who, in accord with public policy and as a requirement of funding, must identify their target populations and create plans to serve them, we must do the same. We must listen to the crime experts and to the public about who they believe should be at the top of the list of those needing to be incarcerated. We must base decisions about this on facts — on the data regarding criminogenic risk factors and recidivism and not on the public's discomfort with people who are different because of an illness for which they did not ask and over which they have limited control. We must insist on fair media coverage to persons with mental illnesses who come to the attention of law enforcement and who might make a "good story." Their stories should be balanced against all the brutal acts of criminals who do not have a mental illness … and they far outnumber the ones who do. We must work in our communities to educate them about the numbers of people who are in our jails who have serious mental illnesses and who have those other sub-clinical conditions that, without intervention, might well end in a disorder that will be far more difficult and must more expensive to treat.

So it is the jail which needs to reinvent itself — rediscover its power — understand and indeed live its critical role in the criminal justice system. The power that the jail has is inherent and immutable: The criminal justice system cannot function without the jail. Where else would the defendants and the convicted go? Including all the lock-ups, pretrial detention facilities, and state prisons, we number 16,000 institutions located in virtually every city, county, and region of these United States. You will not find anywhere a more ready-made national (and for that matter, international) web of power. Exercise it.

The Bazelon Center encourages consideration of a "broader range of diversion programs …," but there is little evidence that diversion programming actually works over the long haul for people with mental illnesses. If nothing else, diversion programming is not something around which communities have enthusiastically rallied. Why? In part it is because we continue to view diversion as a program rather than a policy. As a program it will always be susceptible to the whims of administrators, lawmakers and funders. The program is only as good as it supported by the very few that make it happen. On the other hand, people announce and laws are enacted to carry out public policy and thus public policy is something generally built on consensus and dependent on the wider public forum for its life and its death. Mental health courts, crisis response programs, community corrections — while all can be useful in some configurations — are programs and they may or may not have the weight of public policy. In the end, when we talk about diversion programming it must be understood that absent a clear public policy to the contrary, people with mental illnesses who have an encounter with law enforcement will likely be taken to the nearest jail instead of being seen at or by the nearest crisis intervention service.

How can this public policy be made a reality? Take a lesson from the National Alliance for the Mentally Ill (NAMI). A powerful advocacy organization with chapters in every state, NAMI has put mental health and mental illness on the plate of nearly every state and the national legislature. Think what sheriffs and jail system administrators and police chiefs who represent these

16,000 institutions located in every small and large town in the country could do, if organized. We have learned that *if* we build it, they in fact *will* come. There are new lessons to be learned and one is that *if* we resist, some *will* still come and more will be *diverted* elsewhere.

You must eat, sleep, and dream jail-centered wielding of that power. You cannot turn it over to a judge, an attorney, a mental health agency — anyone. Your responsibility is to realize and stay focused on having it, using it, and giving it up only when it works for you and for others in your community.

The Resolve

So, indulge yourself here a bit and visualize a reinvented system. What would it look like? Who would you hold in your facility? What would you tell your officers to do when they respond to the call from the local merchant or the mental health center? What would you say to the committee that is looking at creating a mental health court in your community? Perhaps you will consider the ideas above and these as well:

1) Any mental health court must be subservient to the jail. Be jail-centered.

2) Be a nuisance … ask questions. Who will provide services to this person? Who will not be served because of the structure of this system or because of the costs of this system?

3) Pick up the phone or go for a walk and see your institutional attorney. Ask her/him to check into using the 1999 U.S. Supreme Court decision announced in *Olmstead v. L.C., 527 US 581; 119 S.Ct. 2176; 144 Led.2d 540 (1999)* as a foundation for legal action against the agencies who must serve all persons with mental illnesses but who do not serve those persons simply because they are incarcerated.

4) Pick up the phone or go for a walk and see your county manager. Check out the contract that the county signs with the area community mental health provider. Check out who is to be served under that contract and where they will be served. Chances are the jail is listed in the contract … and if not, make sure it is when the contract comes up for renewal.

5) Contact your local government agencies — your Medicaid eligibility people and your social security office. Find out if and how your inmates can continue receiving Medicaid benefits while incarcerated; how their applications for SSI can be completed while incarcerated; and how these systems can help plug people into other community service organizations.

6) Provide some limited in-house mental health services. We are way beyond the point where one can righteously argue doing nothing. Take a lesson from mental health: set priorities in client populations (suicidal, serious mental disorder, emergent mental illness, situation crisis) and in service delivery strategies (identification, brief intervention, community connection). Use your mandate to do something to make things happen in your community.

7) Put your money where you need it — not in the courts. You probably need it for in-house services, for the contemporary psychotropic medications and for case management that has the potential to create and sustain service linkages in the community.

8) Get the players around the table so that *you* can facilitate the process. Don't ask a judge to do it; don't ask an attorney to do it. We live in the land of status; of hierarchy; of the power of prestigious positions. *You* can tap those any time you want and you can *not* tap those anytime you want as well. Tap them when you need help; leave them be when you want to assert yourself.

9) Recognize mental health courts as being the most recent interesting idea but not the last great idea — and resolve to use it as the foundation for a new method of evaluating concepts with a critical thinking and critical investigation approach. Do so before jumping on an idea. Do so before being seduced. You'll save time, money and energy.

10) And, if your community and your court system are intent on developing or continuing a mental health court, think about proposing a restructuring of this entity. Suggest the court become the "community mental health center court," its only subject being the constant monitoring of the community mental health center operation. Insist that the court call mental health representatives in front of the bench to grill them about how they will care for the defendant who is sitting in your jail. If a "deal" is to be made, it should probably be with that system and not with the defendant — since in reality, it is that system which has victimized and continues to victimize the defendant. Suggest the court direct its efforts to the real perpetrators, those who commit the crimes of neglect and abandonment.

The Bazelon Center opines that there are three critical elements needed when a community establishes a mental health court: treatment resources, diversion programs, and court procedures which are not unduly coercive.

In the end, for all those to work we must add a fourth critical element: A jail that will just say "no."

About the Author

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She started her career in corrections in 1983 by developing a comprehensive suicide prevention and mental health program for the El Paso County Jail in Colorado Springs, Colorado. From 1991 through 1994, Ms. Severson worked as the court-appointed mental health expert in *Williams v. McKeithen*, a long-standing consent decree involving Louisiana's jails and prisons, and later served as the court-appointed expert in monitoring the overall operations and programming of all the facilities. She also provides consultation and training services in the areas of mental health and suicide prevention throughout the country. Correspondence should be addressed to Margaret Severson, Associate Professor, University of Kansas, 1545 Lilac Lane, Room 303, Lawrence, Kansas 66044, (785) 864-5277 or e-mail: mseverson@ku.edu ❑

News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Connecticut

On April 6, 1996, William Dumais, 19-years-old, committed suicide in the Corrigan Correctional Institution in Uncasville. In April 2003, seven years after the death, his family reached a $500,000 settlement with the state to resolve a pending lawsuit.

William Dumais had an extensive history of depression and suicidal behavior. In 1982 at the age of 5, he suffered a traumatic brain injury and severe seizures when struck by a car. At the age of 14, he started becoming depressed and suicidal, resulting in intentionally driving the family car into a tree. In December 1995, Mr. Dumais was arrested on fourth-degree larceny charges and sent to the Corrigan Correctional Institution. He was screened by an intake nurse and found to be "crying and talking about killing himself." Mr. Dumais was placed on medication and suicide precautions. While in the facility, he continued to display self-injurious behavior, including cutting himself with a sharp object and telling another inmate that he was either going to poison himself or jump off the second-story balcony in the housing unit. Mr. Dumais was eventually released on bond in February 1996.

In early April 1996, Mr. Dumais was re-incarcerated at Corrigan after he arrived late for a court hearing. He was again assessed by an intake nurse who apparently was unaware of his medical history and recent prior suicidal behavior in the facility. He was not placed on suicide precautions and hanged himself two days later on April 6.

Since the death, the state Department of Corrections revised its procedures to require health care personnel to obtain and review the entire medical chart from an inmate's prior confinement in the correctional system and incorporate those records into the current intake screening records.

Virginia

For the third time in eight months, and the second time during a recent two-week span, an inmate committed suicide by hanging at the Rappahannock Regional Jail in Stafford. In April 2003, a fourth inmate died of an apparent heart failure after suffering alcohol withdrawal in his cell.

Following the suicide of 27-year-old Philip K. Kristoffersen on June 8, jail officials contacted the U.S. Department of Justice's National Institute of Corrections (Jails Division) and asked for an independent assessment of the facility's suicide prevention practices (see a summary of NIC's services offered on page 15). Jail Superintendent Larry Hamilton told the *Washington Post* that he and his staff are very upset about the recent deaths. "It's a depressing event.…These are things we try to avoid."

Mr. Kristoffersen had been in the facility since May 23 on bad check charges. He was housed in general population and had not given staff any indication that he might be suicidal. "We can't read minds," the superintendent stated. According to jail officials, none of the other recent suicide victims had been identified as potentially suicidal. Earl D. Rose, Jr., 25-years-old and serving a short sentence for malicious wounding, was found hanging in his cell on October 4, 2002. On May 25, 2003, William T. Chittum, Jr., 19-years-old and only two days from release on a reckless driving conviction, was found hanging in his cell. Ironically, Mr. Chillum's father also died in the jail in March 2000 following complications attributed to alcohol withdrawal. The Chittum family, as well as other victims' families, have been vocal in their suspicions regarding the recent jail deaths. As a result, the Virginia State Police and Stafford County Sheriff's Department are investigating all the deaths.

According to Superintendent Hamilton, the Rappahannock Regional Jail already had an "aggressive" suicide prevention policy. During a recent six-week period, 90 inmates had been put on suicide watch, which involved being separated from other inmates and observed at 15-minute intervals. An additional 30 inmates had been placed on suicide precaution status, where they were restrained for varying periods of time for potentially self-injurious behavior. In addition, there were several serious suicide attempts during that period. The regional jail, designed to house approximately 550 inmates, serves the counties of Stafford, Spotsylvania, Fredericksburg and King George. "I don't know what else we can do (to prevent future suicides) and neither does my staff," Superintendent Hamilton recently told the *Free-Lance Star*. "That's why we're seeking outside assistance."

Georgia

A terminally ill inmate who hanged himself in the Richland County Jail in Augusta on June 6, 2003 had recently been discharged from suicide precautions despite two recent suicide attempts. John Orestes Johnson, 43-years-old, had been placed back in the general population at the facility a week after he tried to strangle himself with a shoestring on May 19. Sheriff Ronnie Strength, however, defended his staff's decision to remove him from suicide precautions, stating that a privately-contracted psychiatrist told them that Mr. Johnson was no longer a suicide

risk. "The psychiatrist said he was fine, and that's what we go by," Sheriff Strength told the *Augusta Chronicle*.

Mr. Johnson had been arrested in May 2003 for a string of restaurant and bank robberies. Police tracked him down to a local hotel where he was found smoking crack cocaine purchased with the stolen money. On the night of his arrest, Mr. Johnson told Investigator Jo Ann Nutter that he was depressed because he had terminal cancer. "He said he wanted to smoke enough crack cocaine to make his heart explode," she said. Investigator Nutter said she entered an interrogation room and found the suspect with a shoestring tied around his neck. His face was blue. As paramedics treated him, Mr. Johnson then tried to swallow a pulse and oxygen sensor that was on his finger. He was placed on suicide watch and remained on precautions until May 27.

"You have to take into consideration, many, many folks who are arrested and are taken to jail say they are going to kill themselves," Sheriff Strength stated. "We take them all seriously, but that's why we have psychiatrists." He has asked the Georgia Bureau of Investigation to look into the death, as well as Correctional Medical Services (CMS), the private contractor that provides mental health services to the Richland County Jail. "We are participating in a thorough review of this situation and will take appropriate action based on the findings," a CMS spokesperson told the *Augusta Chronicle*.

Wisconsin

In February 2003, a $600,000 settlement was negotiated in the case of a 21-year-old inmate who died at the Green Bay Correctional Institution while correctional officers allegedly ignored his repeated seizures. A petition for approval of the settlement was filed by inmate Kelvin Jackson's mother, Dorothy Brooks, and her attorney, Willie Nunnery. The settlement was reached after interviewing witnesses and reviewing a videotape of the day Mr. Jackson died. "We believe this settlement is reasonable," Mr. Nunnery told the *Journal Times* on February 1, 2003. "It is probably in excess of the average of settlements for individuals who have died here in prison, and it allows Dorothy Brooks to move on."

Kelvin Jackson, 21-years-old, had mental retardation, mental illness and epilepsy. In a videotape made the day he died on July 12, 2001, other inmates were heard screaming from nearby isolation cells that Mr. Jackson was being ignored while he had three seizures over a 24-hour period. According to Attorney Nunnery, Mr. Jackson was left naked and unobserved for over three hours and rigor mortis had already set in by the time emergency medical personnel arrived.

A plaintiff's expert opined that Mr. Jackson was kept naked in his cell, denied palatable food, and provided grossly inadequate mental health treatment. According to a Department of Corrections spokesperson, Mr. Jackson had been provided with "nutri-loaf" that is taste-tested by nutritionists and given to inmates who cannot be trusted with utensils. Attorney Nunnery, however, argued that Mr. Jackson was unable to keep the loaf in his stomach, and his inability to eat prevented him from swallowing his seizure medication. Mr. Jackson's inability to take his medication appeared to have led to his death, the attorney stated. It was also alleged that Mr. Jackson and another inmate hit their emergency response buttons in their cells to request medical assistance. They were reportedly ignored, with a correctional officer commenting that Mr. Jackson was "faking again so he can get his clothes back." According to the plaintiff's expert, "He died because the security staff failed to listen to the cries for help of the other prisoners in the segregation unit, who were aware that he had not taken his medication because he was vomiting and could not tolerate the anti-seizure drugs prescribed him." The Department of Corrections declined further comment.

Arkansas

In March 2003, the Civil Rights Division of the U.S. Justice Department reached a settlement agreement with the state regarding various conditions of confinement for juveniles held within the Alexander Youth Services Center. The facility, operated by Cornell Companies, Inc., through a contract with the state Division of Youth Services, houses approximately 140 youth. The Justice Department had initiated its investigation in June 2002 following allegations of abuse and mismanagement at the facility, as well as two youth suicides within five months of each other. In May 2001, a 16-year-old youth hanged himself from a fire sprinkler in a room within the high risk offender unit at the facility. In September 2001, a second youth committed suicide in the same room (see ***Jail Suicide/Mental Health Update***, Volume 10, Number 4, Fall 2001, pp. 19-20). In November 2002, the Justice Department notified the state that certain conditions at the Alexander Youth Services Center violated the constitutional and/or statutory rights of juveniles confined in the facility.

Under terms of the settlement, the state and Cornell Companies agreed to improvements in various areas, including mental health, education, religious freedom, and fire safety. With regard to suicide prevention, the defendants agreed to the following corrective measures:

- Develop and implement an effective protocol to ensure that direct care staff have all relevant mental health information about the juveniles, including instructions regarding any required suicide precautions and information about critical incidents in which juveniles are involved;

- Develop and implement an effective quality assurance system regarding implementation of, and adherence to, Alexander's suicide prevention policy;

- Revise Alexander's current suicide prevention policy to appropriately clarify what type of staff can place juveniles on suicide precautions, specify what type of staff can remove a juvenile from such precautions, and provide sufficient and appropriate daily interaction between a qualified mental health professional and every juvenile on juvenile precautions;

- Provide staff with sufficient training (including both initial training for new employees and on-going ❑

training for experienced employees) on Alexander's revised suicide prevention policy; and

- Ensure (through hiring additional qualified mental health personnel) that mental health staff has sufficient daily interaction with juveniles on suicide precautions and sufficient weekly interaction with any juvenile who needs such treatment.

The settlement agreement will end in March 2005 if the state substantially complies through both development and maintenance of the corrective measures outlined in the agreement.

New Mexico

The mother of a man who hanged himself at the Santa Fe County Jail last year plans to file a lawsuit against the private company that manages the jail because she feels her son's death was preventable. Suzan Garcia, mother of 27-year-old Tyson Johnson, claims that she called Management and Training Corporation (MTC) officials almost every day during her son's 17-day confinement to try to get him mental health treatment. "I knew every day he needed help," Ms. Garcia told *The New Mexican* in April 2003. "He needed someone to talk to, but there was no one to talk to." Mr. Johnson was found hanging in his cell on January 12, 2002.

Despite her telephone calls, Mr. Johnson's two suicide attempts in the jail, as well as repeated threats that he was going to kill himself, jail officials did not get her son the help he needed, Ms. Garcia said. Instead, inmates who were housed near Tyson Johnson when he died contacted his mother following the death and told her that jail staff allegedly taunted her son, saying things such as — "Is that the best you can do?" — after he unsuccessfully tried to kill himself by cutting his wrists.

In May 2002, the Civil Rights Division of the U.S. Justice Department initiated an investigation into conditions of confinement at the Santa Fe County Jail. In March 2003, a scathing report was issued that cited numerous deficiencies in the facility. A Justice Department consultant that reviewed Mr. Johnson's death concluded that he had died after a weekend of inadequate mental health intervention at the facility. For example, although required to be observed on suicide precautions at 15-minute intervals, Mr. Johnson was found hanging in his cell at approximately 9:40am on January 12, 2002, with his observation log not containing any entries past 6:15am. In addition, contrary to standard correctional practice, Mr. Johnson was issued a blanket and housed in a cell with poor visibility for staff observation, as well as containing a light fixture, sprinkler head and grate — all of which could have been utilized in a hanging attempt. In fact, Mr. Johnson ripped his blanket into pieces and tied it around the exposed sprinkler head. His cell, deemed "wholly unsafe and inappropriate for that purpose" by the U.S. Justice Department, is apparently no longer used to house suicidal inmates.

Attorneys representing Mr. Johnson's family contend that the Justice Department findings support their contention that MTC officials and jail staff could have prevented the suicide. A spokesperson for MTC declined to comment on the pending litigation.

Jail Suicide/Mental Health Update

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

Available Jail/Prison Suicide Prevention Materials

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Jail Suicide/Mental Health Update (Volumes 1 through 11)

For more information regarding the availability and cost of the above publications, contact either:

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