

Mental Health: Scratching the Surface in Arizona's Limited Jurisdiction Courts



**Institute for Court Management
ICM Fellows Program
2013-2014 Court Project Phase
May 2014**

**Dyani Juarez
Court Administrator
Casa Grande Municipal Courts
Casa Grande, Arizona**

Acknowledgments

I would like to take this moment to thank those who played a crucial role in my success in the Institute for Court Management. First of all, I would like to thank Judge Judy Ferguson for believing and supporting me throughout ALL of my educational endeavors. I have not forgotten the conversation we had in 2010, when you gave me that push (or forced me) to finish the Certified Court Manager Program. Here we are in 2014... in the Fellows Program!

I would like to thank the staff at the National Center for State Courts: Dan Straub, Amy McDowell, Nicole Waters, Scott Graves, and everyone else who works to make this program a success. Thank you for the time you have invested into this program, into the students, and the video modules! I have watched the videos (and certain sections of the webcasts) countless times to ensure that I produce work that will not be laughed at. I am sure that I missed something, and my hysterical graph(s) will be used as an example in webcasts in the years to come!

I would like to thank my fellow students, especially the Arizona clan. We have spent countless hours offering support and encouragement to each other.

My data collection would not have been successful without the help of Raquel Ortega, Honorable Mattias Tafoya, Rockne Anderson, Al Kuffner and court personnel who took the time to complete the survey. Raquel was my guinea pig taking the survey many times to check for errors, ease of use, etc. Matt, Rockne and Al made sure that the survey was distributed, and their colleagues completed it! Thanks, it is NOT easy getting completed surveys!

I would like to thank those who I have bugged to review and help edit this master piece: My project supervisor Scott Graves, Christopher O'Neil, and Sonya Wilkins.

A special thank you to Dianna Kalandros: Dianna's hard work and dedication to serving the mentally ill and their families is unparalleled to anyone that I know. You do not have to be involved in the criminal justice system for Dianna to help. She always goes above and beyond to point those in need into the right direction. I have expressed great disappointment over the years with my frustration dealing with the mental health agencies/system and their status quo. One would think that I would lower my expectation, but when I work with Dianna I know that my expectation is not too much, and is attainable with a competent and dedicated workforce. Last but not least, all of my family and friends who have been neglected over the past year. The paper is finally completed, and I have no more excuses.

Table of Contents

Acknowledgments	iii
Table of Contents	v
List of Figures	ix
Abstract	xi
Introduction	1
Literature Review	6
Chlorpromazine (Thorazine)	6
Deinstitutionalization	7
Assertive Community Treatment (ACT)	7
Diagnosing Mental Illness	9
Implications for the Criminal Justice System	10
Methods	11
Survey	11
Case Tracking	13
Findings	14
Finding Number 1: Attorneys and Courts are Generally Aware of the Concept of Seriously Mentally Ill (SMI), but Courts are Less Familiar with the Concept Than Practicing Attorneys	14
Finding Number 2: Large Jurisdictions are More Likely Than Smaller Jurisdictions to Implement Mental Health Courts	14
Finding Number 3: Of Courts With No Mental Health Court, Half Have No Mental Health Policy at All	15

Finding Number 4: In Most Courts, SMI defendants Represent a Small Minority of the Total Caseload	15
Finding Number 5: Courts Know and Utilize Rule 11 Proceedings for Defendants Who Are Seriously Mentally Ill	16
Finding Number 6: Arizonas Limited Jurisdiction Courts Typically Do Not Utilize Mental Health Screening Tools to Identify Potentially Mentally Ill Defendants	17
Finding Number 7: Courts Do Not Appear to Consider Cost as a Factor in the Decision to Initiate Rule 11 Proceedings	17
Finding Number 8: SMI Offenders Follow the Same Case Flow as Non SMI Offenders, but are Appointed Attorney’s Without Regard to Financial Status	18
Finding Number 9: Court Practices Vary as to the Manner In Which They Identify Individuals Who May Suffer From a Mental Illness	19
Finding Number 10: Many Cases Against SMI Defendants are Dismissed Without a Rule 11 Evaluatioin On a Motion By the Prosecutor	20
Conclusions and Recommendations	23
Conclusion Number 1: As a Result of Deinstitutionalization, Many Individuals Suffering From Serious Mental Illness Do Not Receive Regular Treatment	23
Recommendation Number 1: Education Should Be Mandated For Mental Healthcare Workers and Law Enforcement	24
Conclusion Number 2: Even With Proper Funding, Treating Mental Illness is a Serious Challenge	25
Recommendation Number 2: Mental Healthcare Providers Should Be Held to a Higher Standard	26
Conclusion Number 3: Arizona Limited Jurisdiction Courts are Uniquely Impacted By SMI Offenders	28

Conclusion Number 3A: Arizona Limited Jurisdiction Courts Struggle to Properly Identify Mentally Ill Offenders	29
Conclusion Number 3B: HIPAA Poses an Additional Challenge for Identifying Offenders Who Have an SMI Designation	30
Recommendation Number 3: Court Personnel Should Be Trained to Identify and Take Appropriate Action Related to Offenders With Mental Health Issues	30
Conclusion Number 4: Arizona Rule 11 and A.R.S. 13-4501 Et Seq. Provide Procedures Related to Competency, But the Procedures Are Costly and Do Not Address All Mental Health Issues	31
Recommendation Number 4: Mental Health Courts Are an Effective Solution to the Problem	33
Conclusion Number 5: Mental Health Courts Are Often Prohibitively Expensive in Limited Jurisdiction Courts Relying On Local Funding	34
Conclusion Number 5A: Qualified Mental Health Professionals Are Scarce In Rural Arizona.....	35
Recommendation Number 5: Regional Mental Health Courts Are An Ideal Solution For Limited Jurisdiction Courts With Scarce Resources ..	35
Summary.....	37
References	39
Appendix A: Survey For Court Staff	41
Appendix B: Questions For Interviews	44
Appendix C: Number of Mental Health Courts Per State	46
Appendix D: Log of Known SMI Defendants in the Casa Grande City Court From January 2013 Through Novmeber 2013	48

Appendix E: Log of Known SMI Defendants Who Committed New Offenses in the Casa Grande City Court From January 2013 Through November 2013	51
Appendix F: Jurisdictions With Mental Health Courts	53
Appendix G: Courts With a Policy and Procedure for SMI Defendants.....	54
Appendix H: Respondents Familiar With The Concept of SMI	55
Appendix I: Court Staff Familiar With the Rule 11 Process.....	56
Appendix J: Number of Potentially Mentally Ill Defendants Visiting Arizona Limited Jurisdiction Courts Monthly	57
Appendix K: Rule 11 Proceedings Initiated in Limited Jurisdiction Courts in the Past Year	58
Appendix L: Criminal Justice Employees Aware Of or Familiar With Mental Health Screening Tools.....	59

List of Figures

Figure 1: Survey Respondents	13
Figure 2: Percentage of Monthly Caseload Involving Potentially Mental Ill Defendants.....	16
Figure 3: The Impact of Cost on Initiating and Processing Rule 11 Proceedings	18
Figure 4: Disposition of Cases	22

Mental Health: Scratching the Surface in Arizona's Limited Jurisdiction Courts
Dyani Juarez
Abstract

Deinstitutionalization shifted mentally ill patients from mental institutions into local communities, but failed to ensure that patients continued receiving treatment. The result is an influx of mental health patients now navigating the criminal justice system, especially in limited jurisdiction courts dealing with minor offenses. Historically, limited jurisdiction courts have processed all cases in the same manner. There is no separate set of laws or procedures designed to ensure treatment and reduce recidivism for the mentally ill. The Arizona Revised Statutes and Arizona Rules of Criminal Procedure offer protections for individuals who are incompetent to stand trial, but do not address those multitudes of seriously mentally ill individuals who do not qualify as incompetent according to the legal standard.

This paper investigates how limited jurisdiction courts identify and process offenders who may be mentally ill, the impact of competent Seriously Mentally Ill (SMI) offenders on Arizona limited jurisdiction courts, the challenges of treating mental illness, obstacles such as HIPAA, and what limited jurisdiction courts in Arizona are doing to reduce a mentally ill offender's likelihood of reoffending. While courts nationwide are trending toward innovative specialty court models for mental health issues, such models may be unworkable for smaller and more rural limited jurisdiction courts. This paper discusses the unique challenges faced by courts in rural areas and offers a Regional Mental Health Court Model as a potential solution.

Introduction

B. Jones moved to Casa Grande, Arizona from Chicago, Illinois. Her family members knew about her illness, but because of the tension it caused within the family, they were unwilling or unable to be her caretakers. Ms. Jones was cited into the Casa Grande City Court for trespassing some time after moving into the city. It seems she had refused to exit the Burger King drive-through when her debit card was declined. When Ms. Jones appeared for court, she was clearly disoriented: She refused to talk to court staff, the city prosecutor, the judge, or the public defender appointed to represent her.

Eventually, the city prosecutor filed a motion to dismiss the case against Ms. Jones case. Rule 11 proceedings would be costly to the city, and the prosecutor determined that pursuing the case would not be in the interest of justice. Ms. Jones' father travelled to Casa Grande and took his daughter, Ms. Jones, back to Chicago.

On February 28, 2013, L. Smith was charged with criminal damage and disorderly conduct. Mr. Smith entered into a plea agreement in May 2013 and pled guilty to criminal damage. He was sentenced to a term of unsupervised probation, a fine, and anger management counseling.

When Mr. Smith failed to make payments on his fines, the Casa Grande City Court issued an order to show cause. Upon receiving this order, J. Lloyd of the Coconino County Public Fiduciary's Office contacted the court to raise an objection to Mr. Smith's conviction. Mr. Smith had a history of mental illness. He was diagnosed with manic depressive disorder, post-traumatic stress disorder, Tourette's syndrome, mental retardation, and schizophrenia. The Superior Court

in Coconino County had previously ruled Mr. Smith mentally incapacitated, and Mr. Lloyd was appointed as his guardian and conservator. At the time of the offense, Mr. Smith was living in a “Community Provider of Enrichment Services” (CPES), a group home. The home is for mentally disabled individuals.

Mr. Smith appeared in court twice. Each time, he was accompanied by a person named Priscilla from CPES. At no time did Priscilla notify either the Court or the prosecutor of Mr. Smith’s mental incapacitation. Neither did CPES notify Mr. Lloyd of Mr. Smith’s charges. Unlike Ms. Jones, Mr. Smith showed no signs of mental illness or comprehension difficulties when he spoke with the prosecutor and the judge. There was one person, however, who possessed all of the necessary information regarding the defendant’s deficiencies, and she was in the courtroom: Priscilla never said a word.

When Mr. Lloyd brought Mr. Smith’s condition to light, the court appointed a public defender to represent Mr. Smith. The public defender filed a motion to set aside the judgment and order a Rule 11 prescreen. The court granted the motion, and the resultant prescreen concluded that Mr. Smith is incompetent. As in the case of Ms. Jones, the prosecutor filed a motion to dismiss the case against Mr. Smith in the interest of justice.

Ms. Jones and Mr. Smith represent a growing issue in limited jurisdiction courts like the Casa Grande City Court. Courts perceive an increase in the number of defendants who suffer from mental illness. Many of these defendants are repeat offenders. Courts, in general, have struggled to identify an appropriate remedy.

While it was obvious that Ms. Jones suffered from a mental defect, Mr. Smith's case shows that properly identifying defendants suffering from mental illness can be difficult. There is no easy screening tool to assist courts in identifying potentially Seriously Mentally Ill (SMI) offenders. Arizona's limited jurisdiction courts do not share a database that would allow them to know when another court has determined that a defendant is SMI. HIPAA Regulations prohibit the release of an individual's medical information without the proper authorization, such that mental health professionals are unable to communicate with the criminal justice system that an offender has been diagnosed as SMI.

Rule 11 of the Arizona Rules of Criminal Procedure establishes a procedure for courts in Arizona to process cases involving defendants who might suffer from mental illness. However, before a court can even consider initiating Rule 11 proceedings, the court must be able to identify the defendant as possibly suffering from a mental illness. Courts often rely on jail staff, caseworkers, or the offender's family members to notify the court that a mental defect may exist.

Further, Rule 11 is not a complete solution to the mental health issue. Rule 11 proceedings only seek to determine whether or not a Defendant is competent to stand trial, and fails to provide a solution to help an SMI individual to become independent and productive in the community.

Processing Rule 11 cases in limited jurisdiction courts in Arizona can be very expensive. Initially, upon recognizing a possible mental health issue, the judge will appoint a public defender to assist the offender with the case. The public defender will then file a request for a Rule 11 Prescreen, and the judge will issue an order appointing a doctor to perform the

prescreen. If the doctor finds that the offender is incompetent, the limited jurisdiction transfers the case to the Superior Court, which is the general jurisdiction court. If the Doctor finds that the offender is competent, the case will follow the normal process at the limited jurisdiction level.

The prosecutor and public defender assigned to the case continue to work on Rule 11 cases that have been transferred to the general jurisdiction. The Superior Court has the jurisdiction to appoint the offender a guardian, order in-patient treatment, order commitment to the Arizona State Hospital (ASH), or dismiss the case. The limited jurisdiction court is responsible for paying the public defender, jail expenses if the offender is incarcerated, and the doctor's fees for the evaluations and any other bills incurred as a result of the pending case. The notion that properly processing Rule 11 cases could cost limited jurisdiction courts thousands of dollars often means that potential Rule 11 cases are simply dismissed. It could also result in SMI offenders failing to be properly identified, not receiving help, and committing additional offenses in the future.

Larger limited jurisdiction courts have innovated specialty courts designed specifically for mentally ill defendants as a possible solution. These specialty courts are known as mental health courts. These courts cater to Defendants who suffer from mental illness, but are not incompetent to stand trial under Arizona's Rule 11 standard. Mental health courts offer specialized sanctions in an effort to reduce recidivism by requiring offenders to regularly seek mental health treatment and participate in other programs deemed necessary by the court. Upon successful completion of the mental health court program, the court dismisses the case against the offender. These mental health courts have become more and more common nationwide.

Smaller limited jurisdiction courts are struggling to identify plausible solutions to address repeat offenders who suffer from mental illness. While implementing their own mental health courts would be a logical answer, courts located in rural areas may lack ready access to qualified mental healthcare professionals. Further, these smaller courts often lack an adequate caseload to sufficiently support a continuing Mental Health Court.

Mental health courts generally must limit access according to a set of predefined qualifications, resulting in some seriously mentally ill (SMI) defendants being ineligible to participate in the program. This can make it even more difficult for small courts to identify a sufficient number of participants to justify a program. The lack of qualified healthcare professionals and an inadequate caseload makes it difficult for many small courts to justify funding and implementing a mental health court.

This paper will examine the problem posed by SMI individuals in Arizona's limited jurisdiction courts, review the existing standards in Arizona for processing SMI defendants, and examine practices for identifying individuals who potentially have mental health issues. This paper will also investigate methods to assist individuals who potentially suffer from mental health issues, but do not necessarily meet the Rule 11 criteria. The paper will identify what resources are available and used, and what limited jurisdiction courts in Arizona are doing in an attempt to help these individuals to reduce their likelihood of reoffending in the future. The paper will focus especially on the practices of limited jurisdiction courts for which a mental health court model is not ideal, and will propose a regional mental health court as a potential solution.

Literature Review

The mental health industry has changed drastically over the past century. The early 1900s offered state hospitals and other institutions to house millions of mentally ill patients at the federal government's expense, and against the patients' will. In the 1950s, legislation passed that called for deinstitutionalization as a result of the development of antipsychotic drugs (Brown, 1988).

Chlorpromazine (Thorazine)

The world changed on December 11, 1951, when Paul Carpentier developed chlorpromazine, the first antipsychotic drug, in a French laboratory. The drug was shown to relieve symptoms of agitation, delusions, and hallucinations. Mental health professionals began prescribing chlorpromazine to treat schizophrenia. While many were skeptical regarding its effectiveness, mental health workers regarded it as a miracle drug. Chlorpromazine's commercial success resulted in the search for additional antipsychotic formulas (Ban, 2007).

Chlorpromazine changed the way mental health conditions are treated in the United States. Before the innovation of chlorpromazine and other antipsychotic drugs to treat mental illness, typical treatment consisted of institutionalization, electroconvulsive therapy, and psychosurgery (NAMI, 2013). The introduction of drug therapy as an effective alternative treatment paved the way for a massive cultural, political, and legal shift away from institutionalization in mental hospitals as a solution for mental health problems (Torrey, 1997).

Deinstitutionalization

President Kennedy played a key role in the process of deinstitutionalization through his involvement in passing the Community Mental Health Act of 1963. The Act was supposed to support prevention and community-based outpatient treatment programs for the mentally ill through Federal startup grant opportunities, and to reduce reliance on mental health institutions. The movement toward deinstitutionalization resulted in the closing of many mental institutions, the creation of community-based treatment settings, and patients either moving in with relatives or becoming homeless. The administration for treating the mentally ill shifted to the state and local levels from the federal government (Goldman, Foley and Sharfstein, 1983).

However, many patients were transferred to communities that lacked the resources to properly care for the mentally ill, resulting in insufficient treatment and homelessness (Elpers, 1989). Many SMI patients were released into society without adequate treatment and support, making it more likely that they will commit crime or become homeless (Ribeiro, 2006).

Assertive Community Treatment (ACT)

During the 1960s, employees at the research ward of Mendota State Hospital in Madison, Wisconsin became frustrated at their limited success in dealing with these issues (Test, 1998). They worked hard preparing patients to be released into the community, only for the patients to return to inpatient treatment in mere weeks or months (Test, 1998). They noticed, however, that the patients of one coworker, Barb Lontz, seemed far less likely to relapse and return to the facility (Test, 1998). Assertive Community Treatment (ACT) is a mental healthcare treatment

model that evolved out of these employees' attempts to replicate Barb Lontz's success (Test, 1998).

The group discovered that Ms. Lontz intensively planned each patient's discharge (Test, 1998). If a patient needed transportation, Ms. Lontz often drove the patient home from the mental hospital personally (Test, 1998). Barb Lontz helped patients move into their residences, and put sheets on the bed if need be (Test, 1998). Ms. Lontz taught clients how to use the laundromat and other simple tasks that are imperative to daily life (Test, 1998). Ms. Lontz showed clients how to use the bus to get to doctor appointments or the pharmacy for medication by riding the bus with them as many times as it took (Test, 1998). Ms. Lontz called clients to assist with problem solving or to provide emotional support (Test, 1998). Ms. Lontz provided clients, family members, and landlords her personal telephone number to call if assistance was needed (Test, 1998). Barb Lontz made herself available 24 hours a day and 7 days a week to help her patients live successfully in the community (Test, 1998).

The Mendota State Hospital crafted ACT as an evidence-based model that relies on principles of community as opposed to institutions. Instead of one Barb Lontz, the model comprises a team of professionals. Case managers ensure that patients are cared for, receive ongoing assessments, and have access to a psychiatrist if needed. The case manager also assists individuals in seeking housing and employment if appropriate. The ACT model makes available resources including education services, substance abuse services, and other services deemed necessary. ACT services are available to a patient 24 hours per day and 7 days a week (ACTA, 2013).

Assertive Community Treatment (ACT) is an alternative for effective mental health treatment. Additional research has shown that the model is effective and cost efficient. Patients most successfully treated with the ACT Model usually have co-existing problems or substance abuse issues, or are involved in the criminal justice system (ACTA, 2013).

Diagnosing Mental Illness

As communities struggle to care for individuals diagnosed with mental illnesses, the healthcare profession struggles to define and diagnose these illnesses. The American Psychiatric Association (APA), issues the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM standardizes the classification of mental disorders and is accepted and used by mental health professionals nationwide (APA, 2014). However, each new version has stirred controversy as the healthcare profession's definitions of mental illnesses change and expand (Parry, 2013).

The APA's latest version, DSM-5, released in 2013, reclassified many disorders and lowered the standards to qualify for diagnosis (Parry, 2013). This means that many individuals may now be diagnosed with a mental disorder that will qualify them for special programs, even while program funding continues to be cut. The result could be that the individuals who most need the services will be unable to receive them (Parry, 2013). Courts face a similar challenge: as the healthcare profession's understanding of mental illnesses changes, courts must identify which individuals do and do not meet the standards set for procedures like Rule 11 and other programs designed for the mentally ill.

Implication for the Criminal Justice System

Limited jurisdiction courts have recognized that normal court proceedings, including Rule 11 proceedings, are inadequate to address the issues raised in cases involving SMI defendants. Many courts have created specialized court systems to address the instability of defendants dealing with mental health issues. The 17th Circuit in Broward County, Florida launched the first nationally-recognized mental health court in 1997 (Redlich, 2005). Many courts followed, and today several hundred mental health courts exist nationwide.

Methods

This paper will investigate the process and procedures currently used in limited jurisdiction courts in Arizona that address Defendants suffering from mental illnesses. To that end, I collected data by means of a survey and by tracking cases involving individuals known to suffer from mental illness. I have set out to identify inefficiencies and explore possible solutions.

The Survey

I developed 19 survey questions and had Scott Graves, project supervisor with the National Center for State Courts, edit, revise, and make suggestions. I then entered the survey questions into an online survey template provided by Toluna Quick Surveys.

Toluna Quick surveys is tricky to use, but allows an unlimited amount of questions for free. Once I completed the template, I sent the survey to a fellow court employee to review, test, and make suggestions.

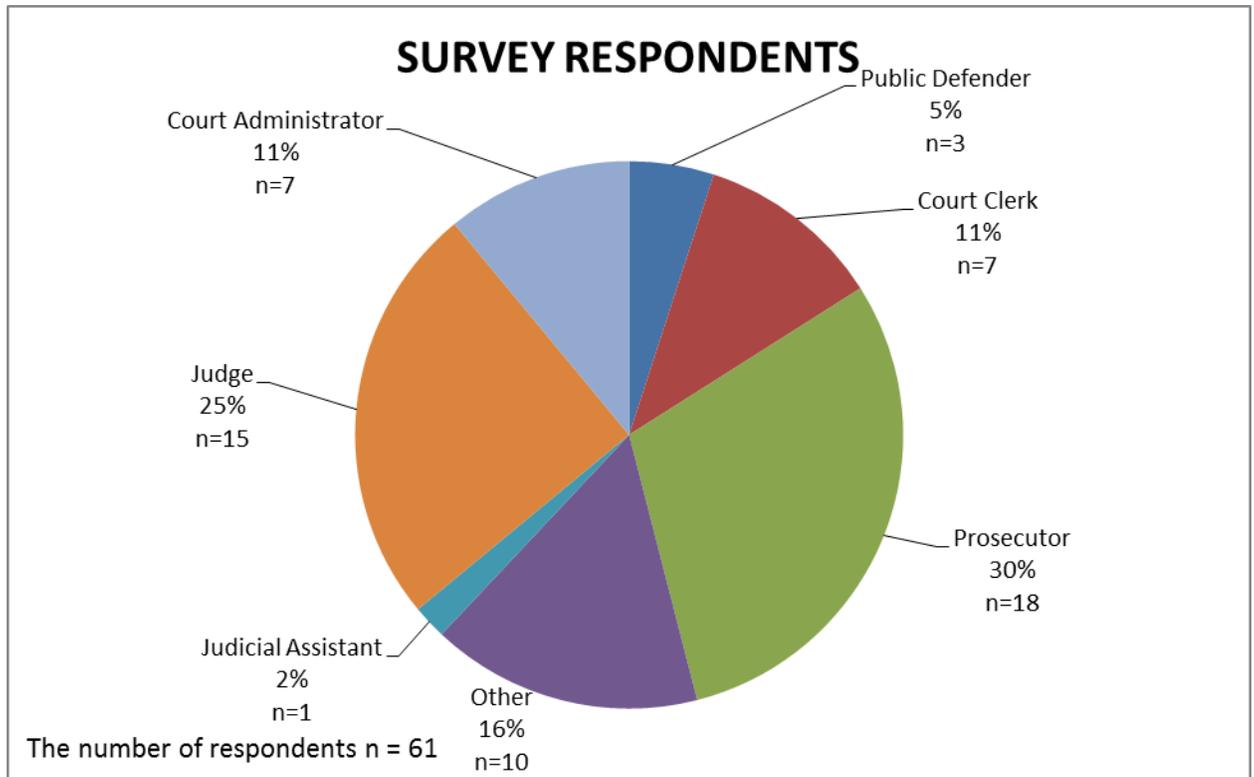
Once I completed the rest of the survey, I launched it to targeted groups. The first group to receive the survey was Pinal County's limited jurisdiction court employees. I distributed the survey via a link within an email. I then networked with other contacts outside of Pinal County, such as the Mesa Municipal Court. I sent the link to the survey via email with a message describing the purpose of the survey as well as identifying the target audience (court employees, judges, and lawyers within limited jurisdiction courts). I then asked the contacts to complete the survey and distribute it to other criminal justice counterparts who are knowledgeable and deal with SMI issues in Arizona courts. The targeted individuals included court staff, judges,

prosecutors, and public defenders assigned to limited jurisdiction courts. I also distributed the survey to attorneys for completion, and also asked them to forward the survey to fellow prosecutors and defense attorneys.

The survey consisted of 19 questions, and I distributed it via email to 300 court employees, prosecutors, and public defenders. I received a total of 84 completed surveys for a response rate of 28%. I reviewed the completed surveys and eliminated 23 because the individuals who completed them work in general jurisdiction courts. The remaining 61 completed surveys came from respondents working in limited jurisdiction courts. These 61 completed surveys formed the sample population.

There are 163 limited jurisdiction courts in Arizona, including 80 justice of the peace courts and 83 municipal courts. The sample population of 61 completed surveys represents 41 limited jurisdiction courts in Arizona. Of these 41 courts, 15, or 37%, of the completed surveys were from justice of the peace courts; and 26, or 63%, represent municipal courts.

Figure 1: Survey Respondents



Case Tracking

I tracked cases filed in the Casa Grande City Court from January 1, 2013, through November 30, 2013. I compiled a list of offenders known to suffer from mental disorders: The list totaled 31 defendants. I then checked the court’s database to determine whether any offenses had been committed or charges filed during the prescribed period of time. Eleven offenders had charges filed and became the sample size. I tracked each of the cases involving these offenders and logged the disposition of each case.

Findings

Finding 1: Attorneys and courts are generally aware of the concept of Seriously Mentally Ill (SMI), but courts are less familiar with the concept than practicing attorneys.

Of the 61 surveys completed by individuals working in or assigned to limited jurisdiction courts, 49 responded that they know what SMI or Seriously Mentally Ill is. A total of twelve individuals working within limited jurisdiction courts do not know what SMI is. Of the respondents who do not know what SMI is, four are judges, representing 27% of the respondent judges. The eight remaining respondents who were unfamiliar with the concept of SMI were nonjudicial staff members, representing 32% of that group. All of the attorneys responded that they do know what SMI is. Overall, 80% of court personnel know what SMI is, and 20% do not.

Finding 2: Larger jurisdictions are more likely than smaller jurisdictions to implement mental health courts.

Of the 61 respondents, 15 work for jurisdictions that offer a Mental Health Court, 45 do not, and one respondent was not sure. The 15 respondents who work for a jurisdiction with a mental health court represent nine Arizona limited jurisdiction courts: Phoenix Municipal Court, Mesa Municipal Court, Carefree Municipal Court, Pima County Consolidate Justice Court, Glendale City Court, Sierra Vista Justice Court, Flagstaff Justice Court, Marana Municipal Court and Tucson City Court. With the exception of the Flagstaff Justice Court, these courts are all located in or around Phoenix and Tucson, Arizona's two largest cities. These results may suggest that that cost or other factors involved in mental health courts may be prohibitive for smaller

limited jurisdiction courts. Notably, out of the twelve respondents who answered that they do not know what SMI is, two indicated that their jurisdiction has a mental health court.

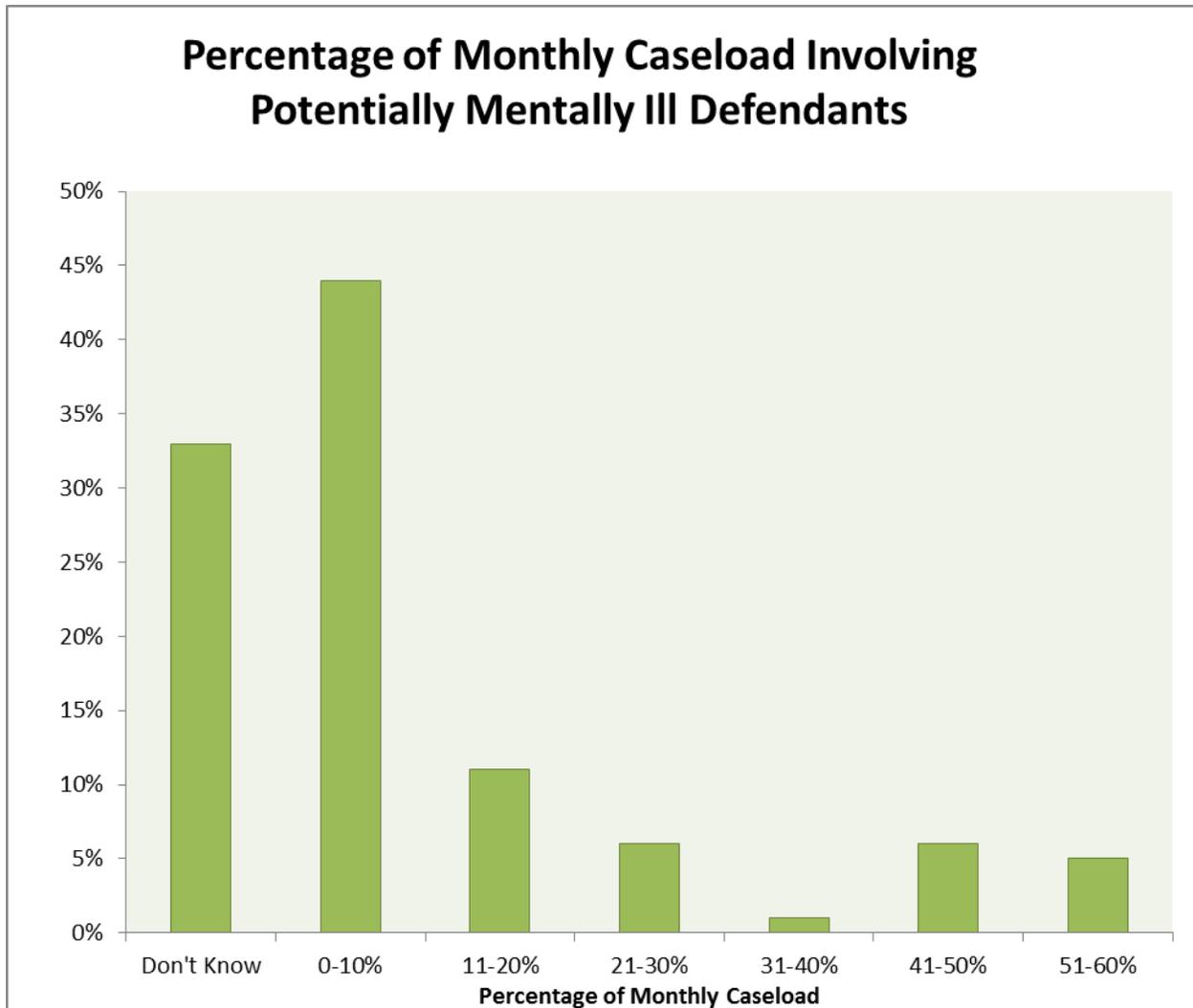
Finding 3: Of courts with no mental health court, half have no mental health policy at all.

Survey participants from jurisdictions lacking a mental health court were asked whether their jurisdictions have a policy and procedure in place to identify and deal with individuals who may suffer from a mental illness. There were 46 respondents to this question: a slight minority of 22 responded that they do have a policy, 19 indicated that they do not, and 5 were unsure.

Finding 4: In most courts, SMI defendants represent a small minority of the total caseload.

The survey asked respondents how many individuals visit their jurisdictions each month who could possibly suffer from a mental illness, and what percentage of the court's overall caseload is made up of potentially SMI defendants. The respondents reporting that more than 10% of their caseloads could represent defendants suffering from mental illness represent eight limited jurisdictions. These courts include Mesa Municipal Court, Pima County Consolidated Justice Court, Sierra Vista Justice Court, Holbrook Justice Court, Marana Municipal Court, Peoria City Court, Avondale City Court and Phoenix Municipal Court. Five of these jurisdictions reported that they have mental health court programs: Mesa Municipal Court, Pima County Consolidated Justice Court, Marana Municipal Court, Sierra Vista Justice Court, and Phoenix Municipal Court.

Figure 2: Percentage of Monthly Caseload Involving Potentially Mentally Ill Defendants



Finding 5: Courts know and utilize Rule 11 proceedings for defendants who are seriously mentally ill.

The survey asked respondents whether they are familiar with Rule 11 of the Arizona Rules of Criminal Procedure. Of the 61 respondents, 55 answered that they are familiar with Rule 11, and six responded that they are not familiar with the rule. While a large percentage of

respondents were not sure how many Rule 11 proceedings had been processed through their courts in the past year, the majority of respondents indicated that Rule 11 proceedings are being initiated.

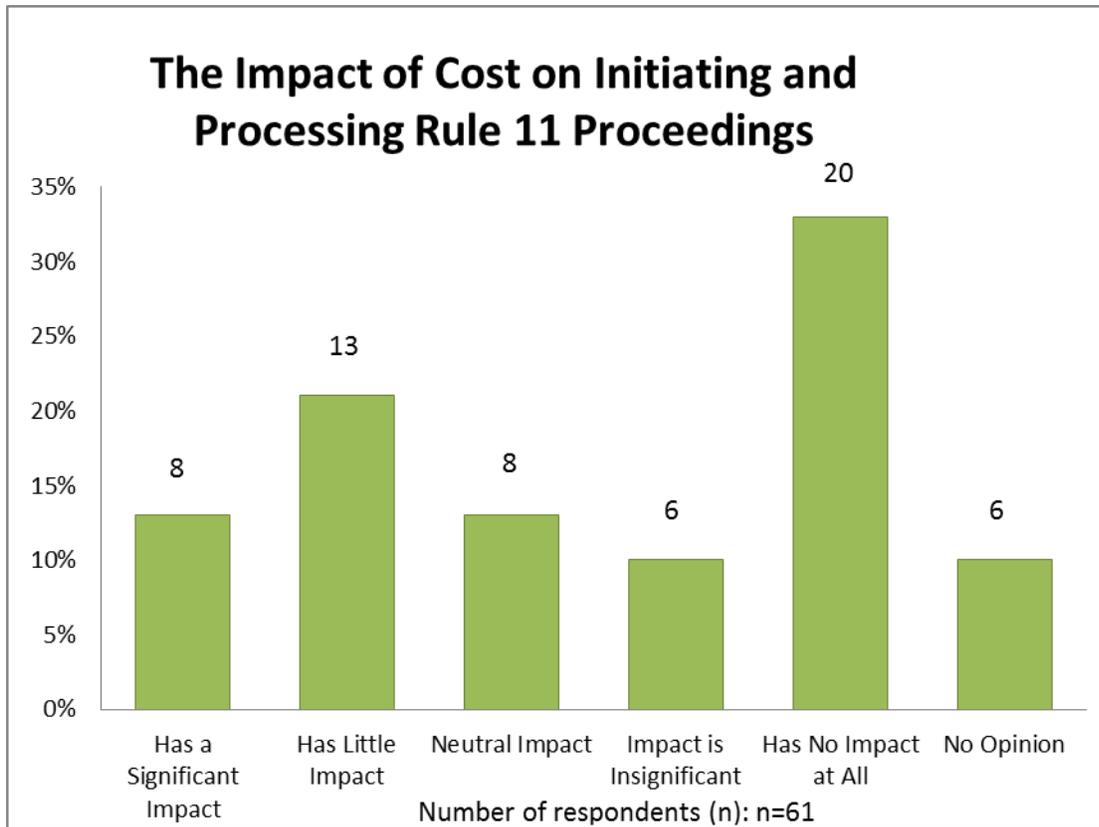
Finding 6: Arizona’s limited jurisdiction courts typically do not utilize mental health screening tools to identify potentially mentally ill defendants.

The survey asked respondents if they are familiar with screening tools that assist in the identification of a person who may suffer from mental illness. Only five respondents reported that they have personally used a mental health screening tool and they are very easy to use.

Finding 7: Courts do not appear to consider cost as a factor in the decision to initiate Rule 11 proceedings.

Over 50 of the respondents feel that money is not a concern when processing or initiating Rule 11 proceedings. There does not appear to be any correlation between those who reported that the cost weighs in on the decision and the size of the jurisdiction (whether rural, suburban, or metropolitan). Some respondents who reported that cost is a factor also work in jurisdictions that offer a Mental Health Court Program.

Figure 3: The Impact of Cost on Initiating and Processing Rule 11 Proceedings



Finding 8: SMI offenders follow the same case flow as non SMI offenders, but are appointed attorneys without regard to financial status.

Respondents described their courts' processes and procedures for adjudicating cases that involve defendants who appear to suffer from mental illness, but fail to meet Arizona's Rule 11 requirements. Of the 61 completed surveys, 53 responded to this question. Two respondents indicated that their courts have partnered with local mental health agencies to assist in identifying SMI defendants. Another 14 responded that their judges will appoint an attorney without the offender filing any affidavit to show that they financially qualify for court-appointed counsel.

Court-appointed counsel can ensure that the Defendant understands the proceedings, and may also recommend whether or not a Rule 11 prescreen should be conducted. Ten respondents work for jurisdictions that offer a mental health court. One respondent indicated that the prosecutor will offer a mental health diversion program, and dismiss the case upon successful completion. One respondent stated that the prosecutor will file a motion to dismiss without any type of Rule 11 prescreen or assessment. Two respondents indicated that their court will start the Rule 11 prescreen process to determine if the defendant is competent or not competent to stand trial. If the individual is found competent, then the case will follow the normal procedure. Eighteen respondents indicated that the proceedings follow the normal process regardless of the offender's mental state, and twelve respondents indicated that they do not know. Finally, one person voiced frustrated with the system and is currently investigating the development and implementation of a mental health court.

Finding 9: Court practices vary as to the manner in which they identify individuals who may suffer from a mental illness.

Most mental health court models identify potential program participants as anyone who “appears to suffer from a mental illness.” Survey respondents describe what this means to them. Five respondents answered that they do not know what it means. Respondents identified that the following signs and symptoms help them identify a potential mental illness: incoherence, inability to function rationally or care for oneself, inability to understand or comprehend, a feeling that something is “off” with the individual, failure to comprehend release conditions such that a defendant is arrested for the same offense immediately after being released, suspicious and

defensive behavior, an uncooperative nature, extended pauses before answering questions, failure to understanding the process or his or her rights, inability to answer simple questions, an appearance that the individual is out of touch with reality, blank stares, and unusual body language. Some respondents indicated that they rely on observations that the defendant deviates from a normal cognitive ability or some other otherwise displays diminished mental capacity.

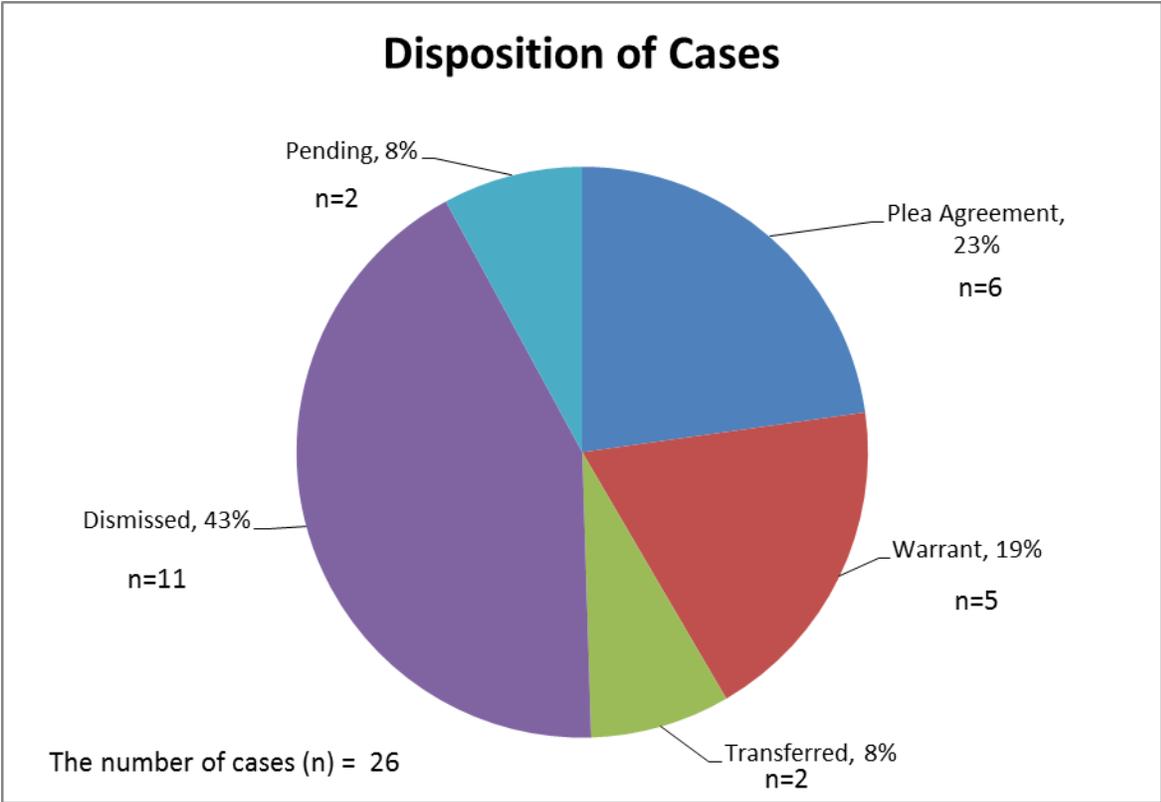
Other respondents indicated that it is not the court's responsibly to identify mentally ill defendants. Some explained that the court is not the agency that identifies or diagnoses individuals; the public defender in their jurisdiction employs a certified mental health counselor who will go to the courtroom or jail to evaluate defendants. In these jurisdictions, based on the counselor's training and education, the counselor will make an appropriate recommendation to the court if the person should be allowed to participate in a mental health court.

Finding 10: Many cases against SMI defendants are dismissed without a Rule 11 evaluation on a motion by the prosecutor.

Based on an analysis of 31 known SMI defendants in the Casa Grande City Court, eleven had new charges filed from January 2013 through November 2013. These eleven individuals were involved in a total of 26 separate cases during the sample period. Their charges included assault, shoplifting, criminal damage, disorderly conduct, trespassing, public consumption of alcohol, theft, resisting arrest, and interference with a judicial proceeding. Four of the individuals were charged with two new cases, two had three new cases, one had four new cases, and one had five new cases.

The disposition of these 26 new cases would cause alarm to any concerned citizen who is unfamiliar with the Rules which govern the proceedings in cases where the Defendant possibly suffers mental illness. Six of the cases have active warrants for failure to appear and consequently have yet to be adjudicated. Two cases are still pending at the Casa Grande City Court. While five cases resulted in plea agreements, two have been transferred to the Superior Court in Pinal County for full Rule 11 proceedings, and the remaining eight cases were dismissed. In these latter eight cases, which involved six different offenders, not only were the offenders essentially not held accountable; they failed to receive any services or help that might reduce the possibility that they might reoffend or commit a more serious crime in the future.

Figure 4: Disposition of Cases



Conclusions and Recommendations

Conclusion 1: As a result of deinstitutionalization, many individuals suffering from serious mental illness do not receive regular treatment.

Deinstitutionalization was one of the largest social experiments in American history (Torrey, 1997). President Jimmy Carter's Commission on Mental Health defined deinstitutionalization's goal as maintaining "the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receive services." But when institutions released individuals into society, society failed to ensure that these individuals received the medication and the rehabilitation services necessary for them to survive and function within the community (Torrey, 1997). Furthermore, the treatment of mental illness usually is not covered by health insurance, which makes it difficult for those who need this kind of medical attention to receive it (Ribeiro, 2006). Roughly 2.2 million SMI patients fail to receive any psychiatric treatment at all (Torrey, 1997). Mental health patients who lack treatment are more likely to commit petty crimes and misdemeanors. Now, the criminal justice system is attempting to identify SMI patients and take measures to prevent recidivism.

Limited jurisdiction courts in Arizona, like other courts across the country dealing with petty crimes and misdemeanors, have seen an increase in offenders who suffer from mental illness. Often, the same mentally ill offenders are seen appearing in court time and time again with new cases. Because these offenders' mental illnesses often factor into their proclivity toward committing minor offenses, it can be assumed that regular treatment for their mental illnesses

would drastically reduce the likelihood that they will continue to reoffend. Such treatment, however, is not readily available to mentally ill individuals without income or financial support.

Recommendation 1: Education should be mandated for mental healthcare workers and law enforcement.

Education is not a comprehensive solution to the mental health crisis faced by limited jurisdiction courts. However, data in this report indicate that it is critical. The story of L. Smith is a clear illustration of this necessity. Mr. Smith lived in a group home with staff who were fully aware of his condition, including the fact that he had an SMI designation and a guardian appointed by a court. Mr. Smith was one of those rare mental health patients with access to care and insurance that could pay for his treatment. Even then, the personnel charged with his care failed to provide the treatment he needed.

Mr. Smith was charged with a crime following an incident that occurred at the residential treatment facility where he lived. Properly trained staff should be able to identify and handle situations prior to them arising. However, if a resident needs help that a staff member cannot offer, 24-hour crisis hotlines are available to help. Crisis teams can assist in these types of situations without involving the police. If patients should find themselves involved in the criminal justice system, treatment facilities should be required to notify the court immediately.

Instead of utilizing these resources, when the staff assigned to Mr. Smith felt they could no longer handle him, they called the local police department and he was charged with a misdemeanor. The group home failed Mr. Smith again when he appeared for court and their staff failed to notify the court that Mr. Smith had an SMI designation. Training and education of

mental healthcare workers cannot solve every mental health issue, but it would help ensure that workers are equipped to utilize every resource available to them and avoid cases like Mr. Smith's.

Education can also benefit police departments. Law enforcement needs to be educated about the resources available to assist a person suffering from a mental episode. Crisis teams are often a superior alternative to arresting and filing criminal charges against a person suffering from mental illness.

Conclusion 2: Even with proper funding, treating mental illness is a serious challenge.

The National Alliance on Mental Illness provides the following staggering statistics regarding mental health in the United States:

- One in four adults suffer from a mental illness annually.
- 20% of youth ages 13 to 18 experience a severe mental disorder in a given year.
- 2.6 million Americans live with schizophrenia.
- 14.8 million Americans live with major depression.
- 42 million Americans suffer from anxiety disorders.
- 9.2 million Americans suffer from more than one mental disorder (NAMI, 2013).

Mental illness includes any medical condition that alters an individual's feeling, thinking, mood, daily functioning and ability to relate or understand others. The result of an individual's mental illness is diminished capacity to cope with normal day to day activities. Serious mental illnesses include depression, schizophrenia, bipolar, obsessive compulsive disorder (OCD), panic

disorder, posttraumatic stress disorder (PTSD) and personality disorders (Duckworth, 2013).

Those suffering or diagnosed with a mental illness, are said to be seriously mentally ill.

There is no cure for mental illness. However individuals suffering from mental illness can identify the unique signs and symptoms of their condition and seek timely care in an attempt to prevent relapse. Ultimately, those suffering mental illness can obtain treatment resulting their ability to lead productive lives. Since there is not a cure for mental illness, treatment must be continuous and from time to time, medications will need to be adjusted (Duckworth, 2013).

Treating mental illness is a collaborative effort: an individual needs to seek treatment in order to receive it. While half of all chronic mental illnesses commence by the age of 14, treatment is rarely sought right away. In some instances, decades pass before an individual presents for treatment (NAMI, 2013). According to NAMI, approximately 60% of Americans suffering from mental illness have failed to receive mental health services in the past year. Currently, there are 41 antipsychotic medications available for the treatment of mental illness, as well as long active injectable antipsychotic medications (NAMI, 2013).

Recommendation 2: Mental healthcare providers should be held to a higher standard.

The National Alliance on Mental Illness (NAMI), has generated two reports grading states on how effectively they deal with their SMI population. The first report, issued in 2006, graded the United States as a whole with a “D” average (Aron, 2009). NAMI reports that deinstitutionalization has resulted in emergency rooms, courts, and families being left to deal with the burden once borne by institutions (Aron, 2009). These entities have proven insufficient

to the task. NAMI's 2006 report issued the State of Arizona grade of "D." This grade improved to a "C" in the 2009 report (Aron, 2009).

The NAMI report asks governors and legislators of the federal government to take action in five key areas to reform the mental health care system: 1) increase public funding for mental health care services; 2) improve data collection, outcome measurements, and accountability; 3) integrate mental and physical health care; 4) promote recovery and respect; and 5) increase services available for those who suffer SMI who are at risk (Aron, 2009).

Mental health patients often require adjustments to their medication. Even when proper medication is prescribed, patients frequently fail to take it. SMI individuals who fail to receive medication often are unable to care for themselves. The agencies responsible for their care are in the best position to ensure that these patients are receiving the care they need. These agencies should be held accountable, and should be required to follow through with periodic home visits, mandatory home visits when patients miss scheduled appointments, attendance at any court proceedings, notification to the court of the status of a patient involved in a case, confirmation that the patient attends all medical appointments, and accommodations for SMI patients who lack the ability to pay. In addition, agencies should maintain appointments with patients who are incarcerated even if it means traveling to a jail, and should arrange for transportation for SMI clients who need it, such as for trips home from a jail.

Currently, rural Arizona courts rely on their own intuition, jail staff, and the offenders themselves to report that a mental illness may exist. Oftentimes, SMI offenders find themselves in the criminal justice system after they quit taking medication or their medication needs to be

adjusted. Court staff are not required to ensure that SMI offenders are receiving treatment, but on occasion do contact treatment providers to inquire as to whether treatment has been regular or is current. The treatment provider often puts the responsibility of treatment on the patients, but many of these patients are incapable of caring for themselves. A patient who lacks even the capacity to remember an appointment cannot be expected to take personal responsibility for treatment. Mental healthcare providers should be required to accept a heightened level of responsibility for the patients they serve.

Conclusion 3: Arizona limited jurisdiction courts are uniquely impacted by SMI offenders.

Limited jurisdiction courts have been uniquely impacted by deinstitutionalization. SMI individuals who are held involuntarily and receiving treatment in institutions do not commit criminal offenses in the community. But now that these individuals have been released from institutions and are no longer receiving treatment, they are entering the criminal justice system after committing misdemeanors and petty offenses. The courts are struggling to identify offenders who potentially suffer from mental illness, and in fact 30% of Arizona court employees reported that they do not know what Seriously Mentally Ill (SMI) is. Further, 50% of Arizona court employees reported that their court lacks a protocol for handling SMI defendants.

Courts of limited jurisdiction lack the authority to commit an offender against his will, require mental health treatment, or even appoint a legal guardian. Although these courts can order treatment as part of a sentence upon entry of a judgment of guilty, SMI offenders usually lack the financial ability to pay for the services.

Options for courts of limited jurisdiction to address offenders suffering from mental defect are few and far between. In order to adapt to this growing problem, many limited jurisdiction courts are implementing mental health courts and other solutions to address their increasing caseloads of mentally ill offenders. The fact that so many SMI offenders in so many jurisdictions continue reoffending suggests that many limited jurisdiction courts are struggling to solve the problem.

Conclusion 3A: Arizona limited jurisdiction courts struggle to properly identify mentally ill offenders.

Properly identifying mentally ill defendants and identifying an effective sentence to prevent recidivism is a challenge in limited jurisdiction courts. The standard for referral to many mental health courts is that a defendant “appears to suffer from a mental illness.” But even under a broad definition like this one, the L. Smith case proves that even defendants who are so seriously mentally ill that they lack the ability to understand the proceedings can make it to the post-adjudication stage without displaying any apparent defect. Without adequate training and expertise to identify mental illnesses, limited jurisdiction courts often rely on jails, family members, or case workers to notify the court of a mental defect. This approach is not sufficient. Mr. Smith appeared with a case worker who failed to notify the court of Mr. Smith’s previous diagnosis.

Conclusion 3B: HIPAA poses an additional challenge for identifying offenders who have an SMI designation.

The United States Department of Health & Human Services issued the Privacy Rule to ensure compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA established federal guidelines for healthcare providers, employers and insurance companies to follow regarding the collection, release, and sharing of information regarding patients. Prior to HIPAA, standards failed to exist to protect individuals from personal health and medical records from being disclosed.

The Department of Health & Human Services Office of Civil Rights (OCR) has the authority for enforcing voluntary compliance, and civil monetary penalties with covered entities that fail to comply. Covered entities are those establishments who offer health care services, health care plans, and health care clearing houses (USDHH, 2013). While the covered entities can share the information amongst each other, medical data is prohibited from being released to other parties. Medical information can be released if the patient authorized the release via a written consent form, or all identifiable information is removed from the record prior to being released (USDHH, 2013).

Recommendation 3: Court personnel should be trained to identify and take appropriate action related to offenders with mental health issues.

All criminal justice employees, including prosecutors, defense attorneys, and public defenders, should receive thorough training focusing on seriously mentally ill offenders. This training should, at a minimum, include an in depth analysis of the following areas:

- What is SMI and what disorders it encompasses
- How a person receives an SMI designation
- Identifying potentially SMI individuals/offenders
- How to effectively deal with, and communicate with SMI individuals/offenders
- Local resources available to SMI patients and their families
- Alternative sentences for SMI offenders in an effort to reduce recidivism
- Rule 11 process in Limited Jurisdiction Courts

It is important for all court staff to receive mental health training. Based on the survey results, there are varying opinions regarding what it means that a defendant “appears to suffer from a mental illness.” Training all staff to recognize and identify potentially mentally ill offenders will increase the offender’s likelihood of receiving fair treatment within the criminal justice process. If court staff assisting an offender believe that the offender could have a comprehension issue, staff should report the matter to the appropriate authority within the court. This ensures that the judge is aware of the issue and can take appropriate action to ensure that the case is handled appropriately and to safeguard the integrity of the court.

Conclusion 4: Arizona Rule 11 and A.R.S. 13-4501 et seq. provide procedures related to competency, but these procedures are costly and do not address all mental health issues.

Competency proceedings in Arizona are governed by Rule 11 of the Arizona Rules of Criminal Procedure, in conjunction with Title 13, Chapter 41 of the Arizona Revised Statutes. Rule 11.1 states that “a person shall not be tried, convicted, sentenced or punished for a public offense if the court determines that the person is incompetent to stand trial.” The Rule further

defines incompetency as a mental illness, defect, or developmental disability such that the individual is unable to comprehend the proceedings and is unable to assist in his or her own defense. The mere presence of a defect alone fails to meet the standard of incompetence.

Arizona Rules of Criminal Procedure 11.2 outlines the examination of mental conditions. After a complaint has been filed, any party, or the court itself, may request an examination to determine a defendant's competency to stand trial or the defendant's mental state at the time of the offense. In a limited jurisdiction court, the court will issue an order appointing a doctor to perform a Rule 11 prescreen. Pursuant to Rule 11.2(d), if further competency proceedings are necessary, the limited jurisdiction court loses jurisdiction and is required to transfer the case to the Superior Court for further examination. In accordance with A.R.S. 13-4504(c), "if the case is referred by a municipal court judge, the court shall order the city to pay the costs of the examination."

Proceedings under Rule 11.3 are conducted at the Superior Court level. The Superior Court will appoint two new mental health experts. These experts are different from the expert who conducted the Rule 11 prescreen at the limited jurisdiction level. In accordance with Rule 11.4, the mental health experts appointed to perform the evaluations must submit their reports within ten working days from the completion of the examination. The Court will then hold a competency hearing within 30 days of receiving the experts' reports (Rule 11.5(a)). Upon finding a defendant competent, the case is remanded back to the lower court for adjudication. Defendants found incompetent may be remanded to the Department of Health Services for civil commitment proceedings under Title 36 of the Arizona Revised Statutes. If the case originated from a limited

jurisdiction court, that jurisdiction may be held financially responsible for restoration costs. However, in such cases prosecutors will typically file a motion to dismiss the charges without prejudice under A.R.S. 13-4504(a).

Recommendation 4: Mental health courts are an effective solution to the problem.

While courts are generally not subject to regulations requiring them to ensure that SMI offenders receive treatment, they do have a responsibility to take reasonable measures to reduce the likelihood that SMI offenders will continue committing new crimes. There is no cure for mental illness; however, proper treatment improves the ability of a person suffering from mental illness to function in society. Beyond ordering treatment for the offenders who appear before them, courts can take steps to ensure that these offenders are placed in environments where they can benefit from proven methods such as those utilized in the ACT model, including home visits by case workers, periods of observation to identify when medications should be adjusted, the active involvement of family members, and the assistance of trained and dedicated treatment staff. Mental health courts are an ideal venue for ensuring that offenders receive the support they need.

Limited jurisdiction courts have identified mental health courts as an effective method to address the instability of defendants dealing with mental health issues. Rule 11 proceedings only address Defendants who are incompetent, and do little to assist defendants with mental health issues who are not necessarily incompetent under the Rule 11 standard. Mental health courts are

structured specifically to help defendants suffering from mental illness and reduce the risk for recidivism.

Although mental health court models vary from jurisdiction to jurisdiction, they share several common characteristics. Most courts allow potential participants to be referred to a mental health court program at any point during the process of adjudication. Participation is voluntary, and defendants can transfer to the traditional courtroom at any time. Social workers are present in the courtroom to offer their opinions and expertise. A defendant's participation in the program usually lasts one year. Participants in mental health court programs are sentenced to treatment instead of jail; however, defendants who fail to comply with their treatment plan may be referred back to traditional court or sentenced to a jail term (Stodola, 2004). Upon successful completion of the program, the mental health court will give a participant a certificate of completion and dismiss the case.

The success of existing mental health courts has created a growing trend. The Substance Abuse and Mental Health Services Administration (SAMHSA) launched a database in 2012 to identify mental health courts that exist in the United States. As of August 2013 SAMHSA reports that there are 343 mental health courts in the United States. Arizona has five mental health courts and counting.

Conclusion 5: Mental health courts are often prohibitively expensive in limited jurisdiction courts relying on local funding.

Unfortunately, courts lack programs and resources even for those offenders who are properly identified. Specialized court programs can be expensive. Mental health courts require

dedicated staff, preferably with special expertise in the area of mental health: the court must employ a judge, court staff, and counselors. This dedicated staff is expensive, and funding must generally be secured from local government. Failure to secure local funding means a court must find other funding sources, such as grants, or abandon any plans for a mental health court altogether. Grants are often short-term solutions, however; and if ongoing costs like wages are paid out of grants, the program could end once the grant monies run out.

Conclusion 5A: Qualified mental health professionals are scarce in rural Arizona.

Counseling and treatment services are an essential resource for the mentally ill to thrive in the community. They are also an essential component of any mental health court program. But while counseling agencies are everywhere, they often lack the qualified personnel to offer mental health treatment. Mental health patients need to be evaluated regularly, and they often require adjustments to their medications. To adequately serve mentally ill patients, treatment facilities must have psychologists who are licensed to write prescriptions. Often, rural areas lack qualified treatment facilities, which hampers a court's effort to establish a mental health court or any other treatment-related solution to offenders who suffer from mental illness.

Recommendation 5: Regional mental health courts are an ideal solution for limited jurisdiction courts with scarce resources.

Phoenix and Tucson are the two largest cities in Arizona and, with the exception of Flagstaff, every mental health court in the state is located in or near one of those two metropolitan areas. Offenders in rural areas could benefit from mental health court models no

less than offenders in big cities, but the absence of qualified mental health treatment agencies, an inadequate number of potential program participants, and a lack of funding pose debilitating obstacles.

Smaller jurisdictions lacking the resources and the caseload to establish their own mental health courts should investigate the establishment of a regional mental health court model. James “Marty” Vance, Limited Jurisdiction Court Administrator for Maricopa County, has proposed just such a model for the Justice Courts of Maricopa County. A regional mental health court would be a cooperative effort of some number of smaller courts to pool their resources and create a mental health court serving multiple jurisdictions simultaneously.

The benefits of this model are numerous. Participating courts would be able to pool their budget dollars, thus increasing the available funds to operate the program. This would reduce the amount that it would cost each individual jurisdiction to operate the mental health court. Cases would be transferred to the jurisdiction where the mental health court is held, a single judge would be assigned to the mental health court docket, and court hearings would be held at a central location. At the same time, individual courts would maintain the ability to decide which cases and which defendants would be eligible for referral to the program. The participating jurisdictions would enter into a single contract with a treatment service provider to be involved in the process, and that provider would only need to attend a single court in a single location. The combined mental health court could require, as a part of the contract, that the treatment service provider arrange for the transportation of offenders to court and to treatment sessions. The court may also make arrangements in the contract for treatment of indigent offenders.

Summary

Limited jurisdiction courts in Arizona have seen an increase in cases involving offenders who possibly suffer from mental illness. The development and implementation of mental health courts are a viable solution. However, most limited jurisdiction courts in Arizona lack the essential resources required to operate a successful program. Smaller jurisdiction lack local resources to provide mental health services, qualified mental health professionals, funding, prosecutors and public defenders, and a quotient of participants large enough to ensure a mental health court program's sustainability.

Further research should address several issues. This case study showed that 20 of 31 prior offenders known to suffer mental illness did not reoffend in the Casa Grande City Court during the eleven-month sample period. This calls for additional research as to what might have happened to the individuals who did not reoffend. Are they back in treatment? Was their medication adjusted? Did they move out of the court's jurisdiction and reoffended elsewhere? At least one individual out of these 20 is currently at the State hospital. Details regarding the whereabouts and conditions of prior SMI offenders who have not reoffended could provide insight to assist a court in implementing a successful program to address the needs of SMI offenders.

Mental health professionals need proper training to effectively work with SMI patients. Professionals like Priscilla, who appeared with L. Smith in Court on two separate occasions, should understand the need to notify the court of their patient's condition and key information

such as previous findings regarding the patient's competency. Mental health training would also be beneficial to law enforcement and court staff.

I am truly intrigued by the concept of a regional mental health court. This is a model that calls for additional investigation and innovation. A regional mental health court could solve a great many of the barriers which prevent smaller jurisdictions from establishing mental health courts by pooling the essential resources required to successfully operate such a program. Limited jurisdiction courts should continue investigating and identify intuitive solutions for addressing the needs of the mentally ill, in an effort to reduce the likelihood that they will reoffend.

References

- ACTA, (2013). *ACT model*. Assertive community treatment association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Arlington VA. American Psychiatric Publishing.
- Aron, L., Honberg, K. Duckworth et al., (2009) *Grading the states 2009: A report on America's health care*. Arlington VA: National Alliance on Mental Illness (NAMI).
- Ban, Thomas, (2007). *Fifty years chlorpromazine: A historical perspective*. *Neuropsychiatry Dis Treat*. August; 3 (4): 495-500.
- Brown, P (1988). *The transfer of care: Psychiatric deinstitutionalization and its aftermath*. New York: Routledge.
- Duckworth, K. (2013). *Mental health: What you need to know*. National Alliance on Mental Illness.
- Elpers, J.R. (1989). *Public mental health funding in California, 1959 to 1989*. *Hospital and Community Psychiatry*, 799-804.
- Goldman, W., H.A. Foley, & S.S. Sharfstein (1985). *Madness and government: Who cares for the mentally ill?* *American Journal of Orthopsychiatry*, 55(1): 151-152.
- LexisNexis, 2014. *Arizona criminal and traffic law manual*. Matthew Bender & Company, Virginia.
- National Alliance on Mental Illness, (2013). *Mental illness: Facts and numbers*.
- Parry, Wynne. (2013). Normal or nuts? New psychiatric manual stirs controversy. *Livescience*. May 19, 2013.

Redlich, Allison D. et al. (2005). *The second generation of mental health courts*. Psychology, Public Policy, and Law, Dec Vol 11(4) 527-538.

Ribeiro, C. (August, 2006). *Deinstitutionalization of the mentally ill: Overview and research on United States deinstitutionalization*.

SAMHSA, (2013). *Mental health treatment courts*. Center for Behavioral Health and Justice Transformation.

Stodola, Mark (2004). *An assessment and evaluation of mental health courts in maricopa county Arizona*. National Center for State Courts: Institute for Court Management.

Test, Mary (1998). *The origins of PACT as told by Mary Ann Test*. The Journal, Vol. 9, Iss. 1. Sacramento, CA.

Torrey, F., (1997). *Out of the shadows: Confronting America's mental illness crisis*. New York; John Wiley & Sons.

USDHH, (2013). *OCR privacy brief: Summary of the HIPAA privacy rule*. HIPAA Compliance Assistance.

Appendix A: Survey for Court Staff

1. Do you know what SMI is?

Yes No

2. Is your Court of Limited or General Jurisdiction?

Limited General Don't Know

3. Does your Court have a Mental Health Court Program? If yes, proceed to question 5.

Yes No Don't Know

4. If your Court does NOT have a Mental Health Court Program, is there a policy and procedure for identifying/dealing with parties who suffer or may suffer from a mental illness?

Yes No Don't Know

5. How Many people visit your Court on a monthly basis that could possibly suffer from mental illness?

a.0-4 b. 5-9 c. 10-15 d. 16-19 e. 20-24 f. 25+ g. Don't Know

6. Based on your answer to question 5, what percentage of your courts overall caseload is this number?

a. 0-10% b. 11-20% c. 21-30% d.31-40% e. 41-50% f.51-60% g. 61-70% h. 71-80%

i. 81-90% j. 91-100% k. Don't Know

7. Of your Courts offenders suffering from mental illness, on average, how many new cases are these individuals charged with on an annual basis?
- a. 1-3 b.4-6 c.7-9 d.10-12 e.13-15 f.16+ g. Don't Know
8. Are you familiar with Arizona's Rule 11 process? If no, please proceed to question 12.
- Yes No
9. How many Rule 11 Prescreens has your Court ordered in the past year?
- a. 1-3 b. 4-6 c.7-9 d.10-12 e.13+ f. Don't Know
10. How much does the cost of a Rule 11 proceedings factor into the Judges/Prosecutors decision on whether or not to initiate Rule 11 proceedings?
- a. Has a significant impact b. Has a little impact c. Neutral impact
- c. Impact is insignificant d. Has no impact at all
11. In your own words, describe your courts process for dealing with litigants that suffer from mental illness, but do not meet the Rule 11 criteria.
12. Most Mental Health Court Models describe potential participants as "appearing to suffer from a mental illness." In your opinion, what does "appear to suffer from a mental illness" mean to you for purposes of identifying an individual?
13. Are you aware of any form, tool, assessment, or instrument that your Court or another Court uses in an effort to determine if an individual may suffer from a mental illness?
- Yes No

14. Are you familiar with the following, or any other mental health screening instruments such as Brief Jail Mental Health Screen, GAIN-SS, MHSF-III or MINI-Screen? If “no”, please proceed to question 17. If “yes”, please list instruments with which you are familiar.

Yes No If, Yes state which ones: _____

15. Of the mental health screening instruments that you are familiar with, have you personally used any of them and identify which ones? If “yes” please proceed to the next question, if “no” please proceed to question 17.

Yes No

16. How would you rate the ease of use of the screening instruments that you have personally used on a scale of 1 to 10, with 1 being really easy to use and 10 being very difficult to use?

1 2 3 4 5 6 7 8 9 10

17. How many years have your worked in the Courts?

a. 1-5 b.6-10 c.11-15 d.16-20 e.) 21+

18. What is the name of the Court you currently work for or assigned to?

19. What best describes your current job title?

a. Clerk b. Judicial Assistant c. Bailiff d. Court Administration e. Judge

f. Other _____

Appendix B: Questions for Interviews

- 1.) What is your job title and describe what you do?
- 2.) How long have you worked in this field?
- 3.) What resources are available to friends/family members of individuals suffering from mental illness?
- 4.) Do you believe that precautions can be taken to help prevent SMI patients from entering the criminal justice arena? If yes, please describe?
- 5.) Do you believe that SMI patients receive fair treatment within the criminal justice system? Why or why not?
- 6.) Do you believe that there are alternatives to arresting SMI patients and if yes, what are they?
- 7.) What, if any, assistance could government agency (i.e. Court, Police Department, Probation Department, etc.) personnel provide you, that would either assist you in the essential functions of your job, or assist in providing SMI patients treatment that they need?
- 8.) Are you aware of a form or tool that Courts or another criminal justice agency uses to attempt to determine if an individual may suffer from a mental illness?
- 9.) If yes to #8, what is the instrument and what is your opinion as to the usefulness of the assessment as it relates to the Criminal Justice System?
- 10.) How would you describe a person who “appears to suffer from a mental illness”?

11.) In your opinion, what are some physical signs that a person is suffering from a mental illness?

12.) Are there governmental law, rules, statutes, etc. that interfere with you effectively performing essential functions of your job as it relates to mental health issues and the Courts?

If yes, please describe the limitations.

Appendix C: Number of Mental Health Courts Per State

Number of Mental Health Courts Per State			
State	MHC's	State	MHC's
California	33	Delaware	3
New York	28	Indiana	3
Florida	25	Kentucky	3
Ohio	25	Louisiana	3
Illinois	21	Maryland	3
Georgia	17	Massachusetts	3
Oklahoma	14	Montana	3
Pennsylvania	14	Tennessee	3
Idaho	13	Hawaii	2
Michigan	12	Iowa	2
New Hampshire	12	Kansas	2
Texas	11	Maine	2
Washington	10	Minnesota	2
Oregon	8	Nevada	2
Utah	8	Vermont	2
West Virginia	8	Wisconsin	2
Alabama	7	Mississippi	1

Missouri	6	North Dakota	1
North Carolina	6	Arkansas	0
Arizona	5	Connecticut	0
New Mexico	4	Nebraska	0
South Carolina	4	New Jersey	0
Virginia	4	Rhode Island	0
Alaska	3	South Dakota	0
Colorado	3	Wyoming	0
Source: SAMHSA, 2013			

Appendix D: Log of Known SMI Defendants in the Casa Grande City Court From January 2013 Through November 2013

Casa Grande City Court Known SMI Offenders					
	Name	Offenses	Dates	Charges	Disposition
Subject 1	AA	0			
Subject 2	DA	0			
Subject 3	RA	0			
Subject 4	JB	3	1.)1/27/13 2.)5/13/13 3.)6/26/13	1.)assault, disorderly conduct 2.) assault, criminal damage, disorderly conduct 3.) assault, disorderly conduct x2	1.) plea agreement 2.) warrant 3.) warrant
Subject 5	AC	0			
Subject 6	AC	2	1.)2/6/13 2.)6/25/13	1.) disorderly conduct 2.) trespassing	1.) transferred 2.) warrant
Subject 7	JD	0			
Subject 8	JG	0			
Subject 9	RJ	0			
Subject 10	TJ	2	1.)1/9/13 2.)3/14/13	1.) shoplifting 2.) shoplifting	1.) dismissed 2.) dismissed
Subject 11	CL	3	1.)3/8/13	1.) drinking in public	1.) dismissed

			2.)10/2/13	2.) drinking in public	2.) case pending
			3.)11/15/13	3.) drinking in public	3.) case pending
Subject 12	JA	0			
Subject 13	JL	0			
Subject 14	WL	0			
Subject 15	RM	0			
Subject 16	JM	0			
Subject 17	AM	0			
Subject 18	JM	0			
Subject 19	RM	1	1.)2/14/13	1.)disorderly conduct and trespassing	1.)plea agreement
Subject 20	SO	0			
Subject 21	AO	2	1.)3/16/13	1.)assault x 2, and disorderly conduct	1.)dismissed
			2.)8/13/13	2.)theft	2.)warrant
Subject 22	BP	0			
Subject 23	FR	2	1.)12/27/12	1.)disorderly conduct	1.)dismissed
			2.)6/16/13	2.)assault	2.)dismissed
Subject 24	JS	4	1.)6/1/13	1.)trespassing	1.)dismissed
			2.)7/6/13	2.)trespassing	2.)dismissed
			3.)7/31/13	3.)trespassing	3.)dismissed
			4.)8/5/13	4.)trespassing	4.)dismissed

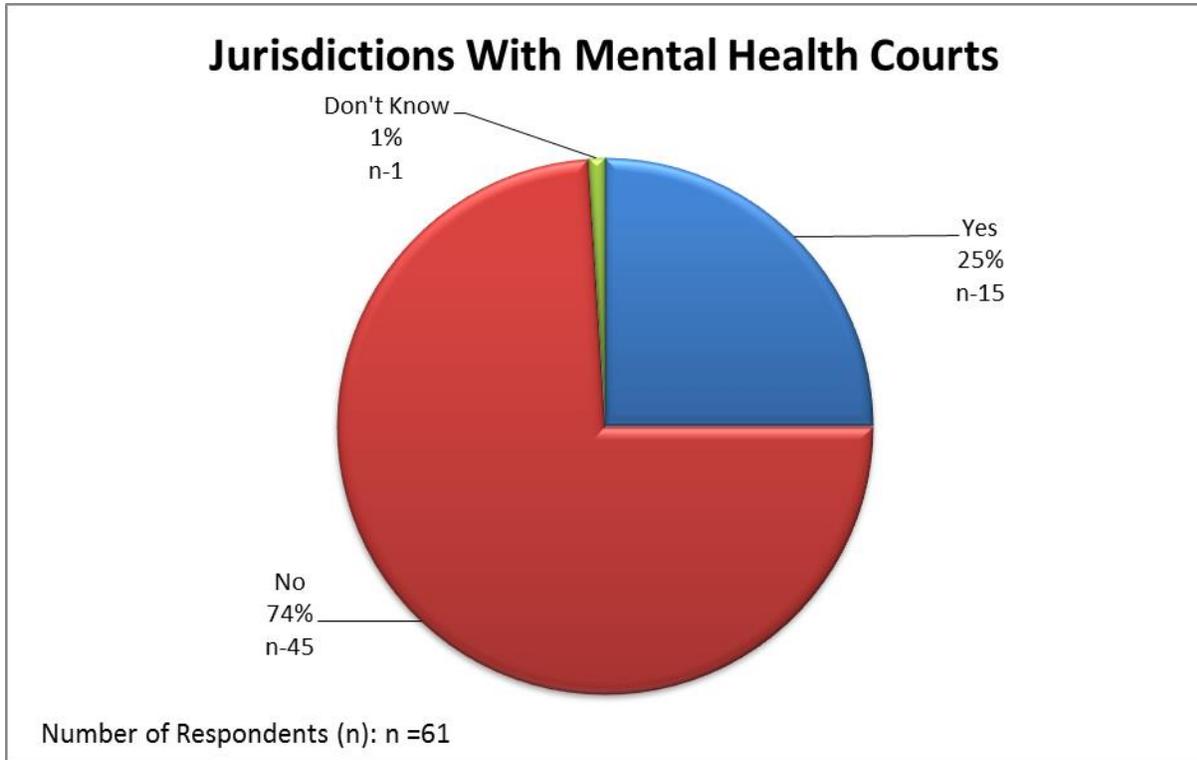
Subject 25	JS	0			
Subject 26	MS	0			
Subject 27	JS	1	1.)5/21/13	1.)drinking in public	1.)Rule 11
Subject 28	KS	1	1.)3/24/13	1.)assault, resisting arrest, disorderly conduct	1.)dismissed
Subject 29	DT	0			
Subject 30	IV	5	1.)3/30/13 2.)4/16/13 3.)5/1/13 4.)5/2/13 5.)6/11/13	1.) assault, threatening and intimidating, disorderly conduct x3 2.) criminal damage and disorderly conduct 3.) violation of a court order 4.) violation of a court order 5.) violation of a court order	1.)plea agreement 2.)plea agreement 3.)plea agreement 4.)plea agreement 5.)warrant
Subject 31	CV	0			

Appendix E: Log of Known SMI Defendants Who Committed New Offenses in the Casa Grande City Court From January 2013 Through November 2013

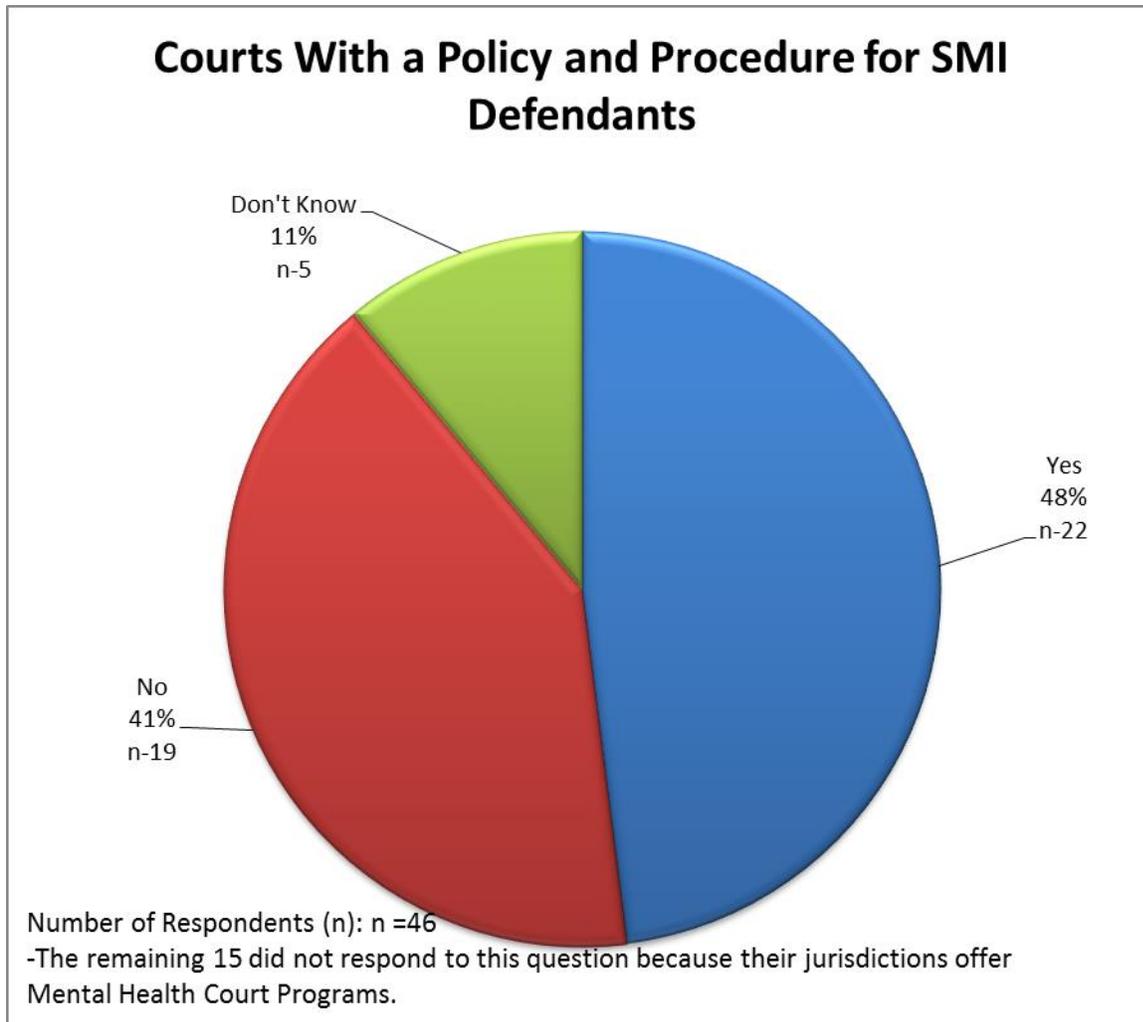
Casa Grande City Court Known SMI Offenders					
	Name	Offenses	Dates	Charges	Disposition
Subject 4	JB	3	1.)1/27/13 2.)5/13/13 3.)6/26/13	1.)assault, disorderly conduct 2.) assault, criminal damage, disorderly conduct 3.) assault, disorderly conduct x2	1.) plea agreement 2.) warrant 3.) warrant
Subject 6	AC	2	1.)2/6/13 2.)6/25/13	1.) disorderly conduct 2.) trespassing	1.) transferred 2.) warrant
Subject 10	TJ	2	1.)1/9/13 2.)3/14/13	1.) shoplifting 2.) shoplifting	1.) dismissed 2.) dismissed
Subject 11	CL	3	1.)3/8/13 2.)10/2/13 3.)11/15/13	1.) drinking in public 2.) drinking in public 3.) drinking in public	1.) dismissed 2.) case pending 3.) case pending
Subject 19	RM	1	1.)2/14/13	1.)disorderly conduct and trespassing	1.)plea agreement
Subject 21	AO	2	1.)3/16/13 2.)8/13/13	1.)assault x 2, and disorderly conduct 2.)theft	1.)dismissed 2.)warrant
Subject 23	FR	2	1.)12/27/12 2.)6/16/13	1.)disorderly conduct 2.)assault	1.)dismissed 2.)dismissed
Subject 24	JS	4	1.)6/1/13	1.)trespassing	1.)dismissed

			2.)7/6/13	2.)trespassing	2.)dismissed
			3.)7/31/13	3.)trespassing	3.)dismissed
			4.)8/5/13	4.)trespassing	4.)dismissed
Subject 27	JS	1	1.)5/21/13	1.)drinking in public	1.)Rule 11
Subject 28	KS	1	1.)3/24/13	1.)assault, resisting arrest, disorderly conduct	1.)dismissed
Subject 30	IV	5	1.)3/30/13	1.) assault, threatening and intimidating, disorderly conduct x3	1.)plea agreement
			2.)4/16/13	2.) criminal damage and disorderly conduct	2.)plea agreement
			3.)5/1/13	3.) violation court order	3.)plea agreement
			4.)5/2/13	4.) violation court order	4.)plea agreement
			5.)6/11/13	5.) violation court order	5.)warrant

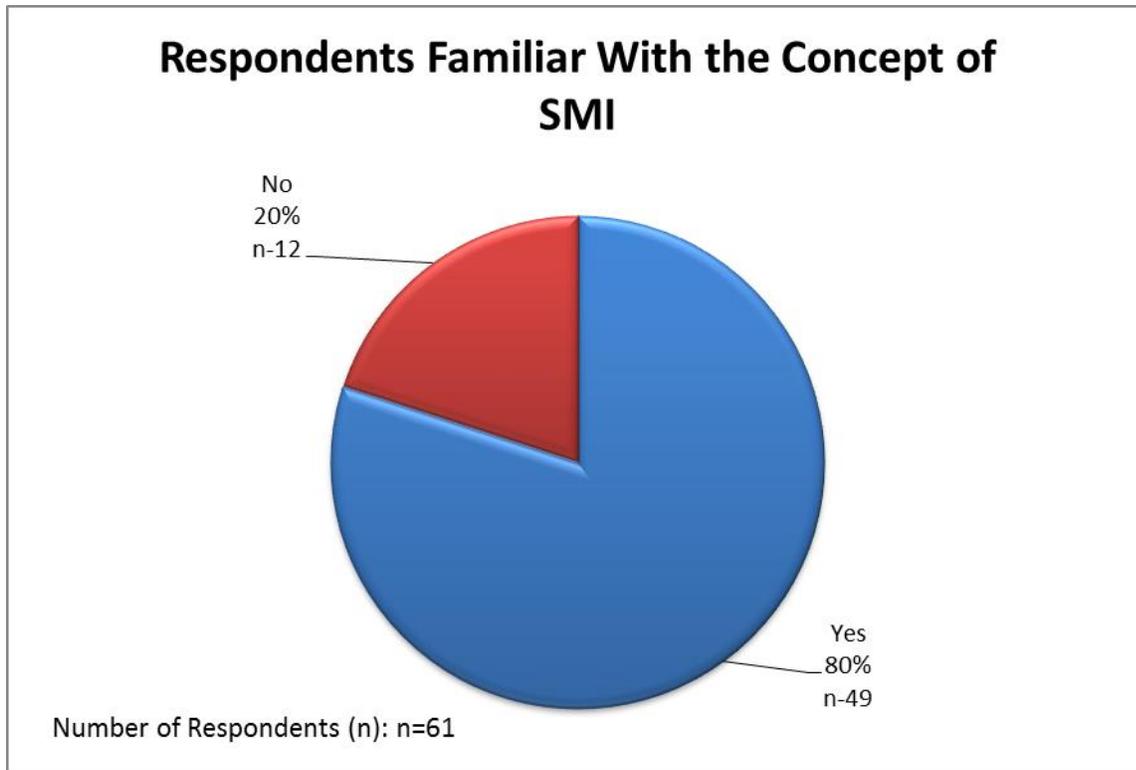
Appendix F: Jurisdiction With Mental Health Courts



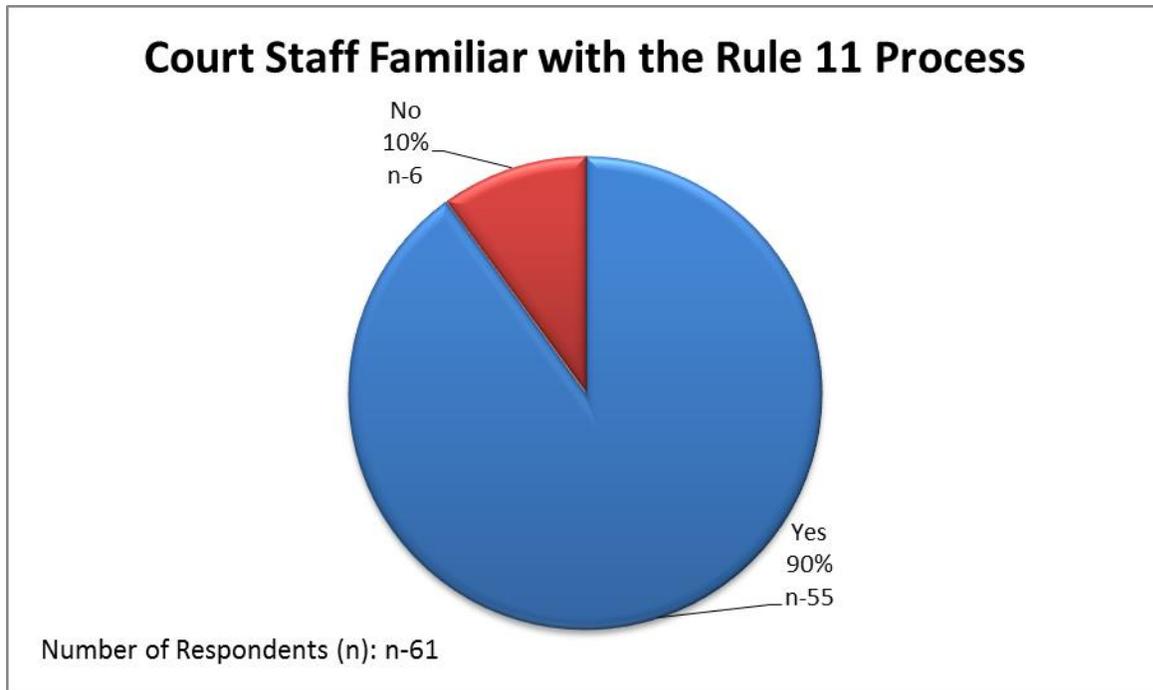
Appendix G: Courts With a Policy and Procedure For SMI Defendants



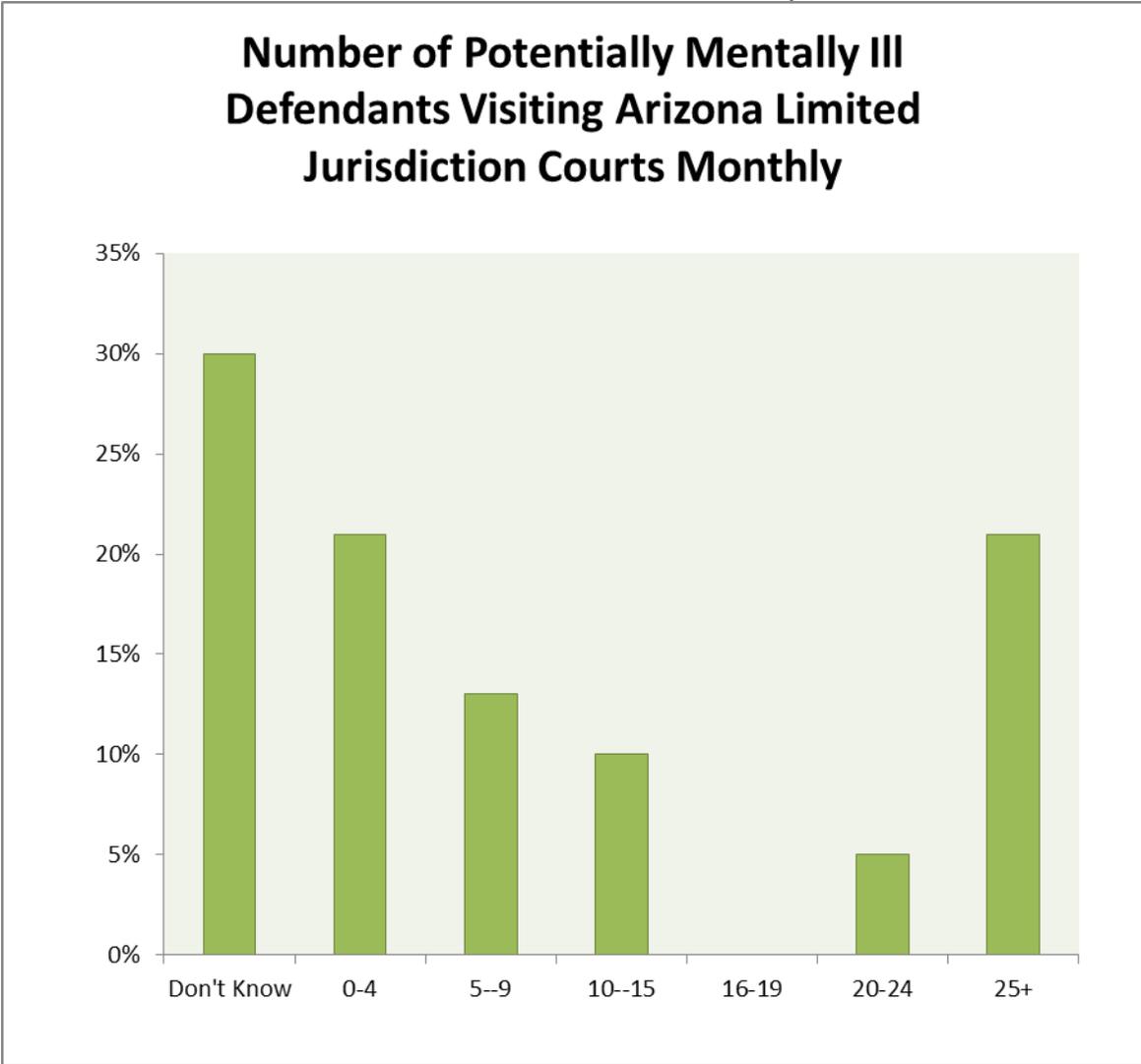
Appendix H: Respondents Familiar With the Concept of SMI



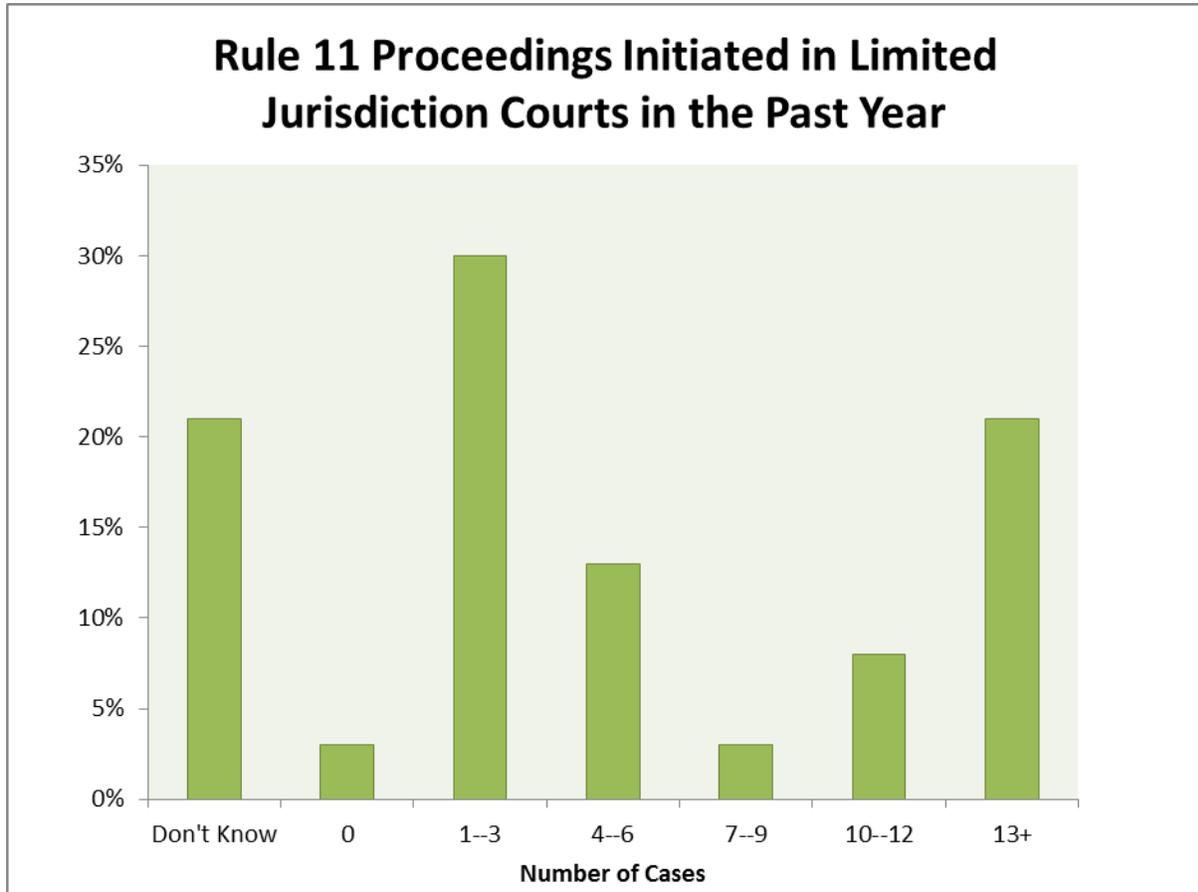
Appendix I: Court Staff Familiar With the Rule 11 Process



Appendix J: Number of Potentially Mentally Ill Defendants Visiting Arizona Limited Jurisdiction Courts Monthly



Appendix K: Rule 11 Proceedings Initiated in Limited Jurisdiction Courts in the Past Year



Appendix L: Criminal Justice Employees Aware Of or Familiar With Mental Health Screening Tools

