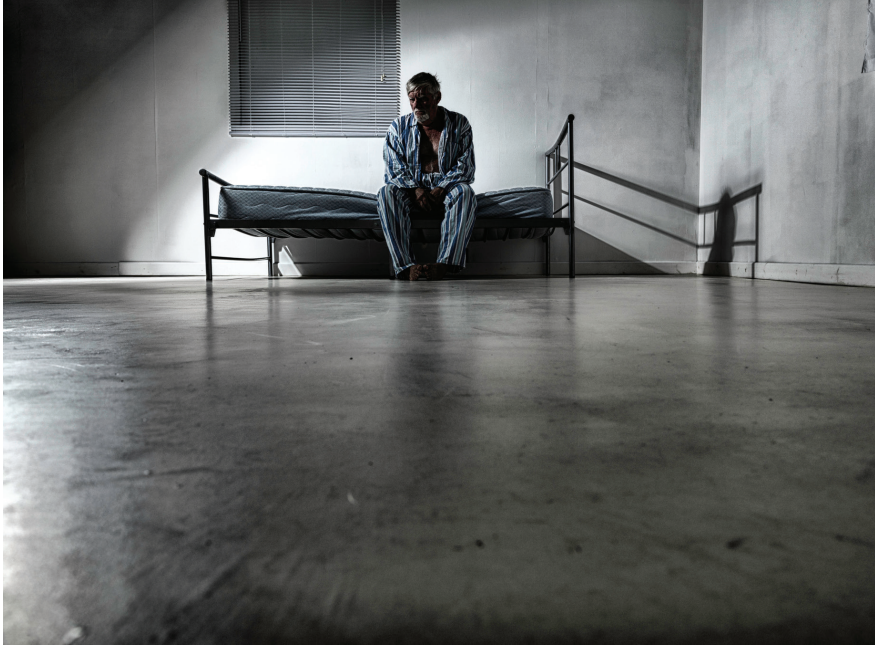
Improving the Courts' Response to People with Mental Illnesses



BY JUDGE STEVE LEIFMAN AND HALLIE FADER-TOWE

Our justice system often finds itself handling not just individual cases but also the complex outcomes of other areas of social policy. Whether in Judge Leifman's courtroom in Miami or in thousands of courtrooms around the country, legal professionals come face-to-face with individuals who likely would not be involved with the courts were it not for untreated or undertreated mental illnesses or substance use disorders ("behavioral health" needs). Although the legal options may be clear, they often seem inadequate.

Judge Leifman realized the critical role that mental health plays in the work of a judge one morning when he was about to take the bench:

> I was approached by the assistant state's attorney and the assistant public defender, who asked me to speak to a couple whose son was in jail on a low-level misdemeanor charge. After speaking to the couple, I learned that their Ivy League son had a late onset of schizophrenia. As a result of religious ideations, he cashed in his life insurance policy and flew to Israel, where his behavior became bizarre. Within weeks, he was deported back to Miami where he became homeless and started to cycle through the criminal justice system. I also learned that he was a licensed psychiatrist who worked at our public hospital.
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> I took the bench determined to get this man help. I assumed there must be a mental health treatment program in our jail to help treat him. I called his case, and we began a wonderful conversation. While he insisted he didn't have a mental illness, he was thoughtful, respectful, and every bit the brilliant Harvard-educated psychiatrist his parents told me he was. He was also extremely knowledgeable about Florida's mental health laws regarding individuals charged with misdemeanors.
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> At the time, judges in Florida had no training on how to identify or deal with people with mental illnesses. As a result, I decided to confront him about his illness, which caused him to have a full-blown psychotic episode in the courtroom. I immediately realized that I had made a mistake. He screamed that his real parents had died in the Holocaust and that the couple in court were imposters sent from the CIA to kill him. My only option at the time was to order three psychological evaluations to determine if he was competent to stand trial. After spending a much longer period in jail than anyone would normally spend on this charge, he was adjudicated incompetent to stand trial. Because he was charged with only a misdemeanor, once he was found incompetent, my only option in Florida was to release him. Not surprisingly, he never returned to court. It's been almost 20 years, and I have no idea if he's still alive.

To better equip attorneys and judges in this area, the American Bar Association (ABA) adopted new Criminal

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Justice Standards on Mental Health in 2016. In 2018, the Conference of Chief Justices and Conference of State Court Administrators (CCJ/COSCA) passed Resolution 6: Improving the Justice System Response to Mental Illness. This spring, CCJ/COSCA and the National Center for State Courts hosted a first regional summit in the West bringing together state court leadership teams from 12 states to learn about this issue and develop strategies for their states; additional regional events are planned through 2020. At a time when an increasing number of judicial and legal leaders are recognizing the crisis we collectively face in addressing behavioral health needs in the justice system, we write today to describe how we got here and what leaders around the country are doing and can do going forward to improve justice in their own communities.

Overview

Each year, more than 15 million criminal cases enter our nation's state courts. Of the approximately 10 million jail admissions each year, approximately 20 percent are people with serious mental illnesses (SMI). That means that about two million people enter jails annually with a significant level of impairment due to a mental illness, and many more have mental health needs that have not reached that level of severity. About three-quarters of people with SMI also have co-occurring substance use disorders. According to the Bureau of Justice Statistics, just over 60 percent of people in jails meet the criteria for drug abuse or dependence.

Attorneys, judges, and court administrators rarely anticipate that they will be at the frontlines of addressing mental illnesses and substance use; yet their decisions are critical to giving people the best chance of successful recovery and productive engagement with society. As Judge Leifman has learned, by failing to recognize the unique needs of this population, we often inadvertently sentence people with serious mental illnesses to a lifetime of trauma, homelessness, and cycling through the criminal justice system.

It should come as no surprise that our court procedures and processes, which are often confusing to a well-informed public, struggle to do justice for people with behavioral health needs. Indeed, analyses in multiple diverse jurisdictions have shown that people with mental illnesses are often less likely to be released pretrial and often stay longer in jail pretrial than those with similar charges and histories of criminal justice involvement who do not have mental health needs. While pretrial detention for anyone is now known to be associated with a higher likelihood of a conviction, longer post-adjudication detention, and even higher future recidivism, for people with behavioral health needs, jail time often means disruption in treatment and separation from family and other social supports, including the risk of losing housing and eligibility for health care. (For additional details on these conclusions, see Hallie Fader-Towe & Fred C. Osher, Council of State Gov'ts Justice Ctr., *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements* (2017).)

A Simplified History

A recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA) traces trends in how Western European and then US governments approached mental illness and the role of the state in providing treatment. (Substance Abuse & Mental Health Servs. Admin., *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice* (2019).) In this account, the English colonists to North America left behind a system that relied on the monarch to fund and care for certain people with mental illnesses. No equivalent "public" system was developed in what became the United States until the early 1800s. Until then, individuals with behavioral health needs in the US relied on family and community for care, with jail as a frequent result when these supports failed.

As always, variation evolved across the states. In the early 1800s, Quakers in Pennsylvania were bringing the French "moral treatment" approach to the US, with its focus on creating an atmosphere that would be conducive to recovery. At the same time, Florida paid for people with SMI to be cared for in Georgia and South Carolina. Around 1840, the American activist Dorothea Dix was visiting a Boston jail when she came across several men segregated in the jail who were freezing to death. Their crime? Mental illness. She was so horrified by what she saw that she mobilized what became a national movement for moral treatment in the form of state "asylums." The idea was to place people with mental illnesses in small 120-bed asylums where they would have greater freedom of movement and receive more rehabilitation, rather than incarceration. (For additional historical details, including specifics from Florida, see Supreme Court of Florida, *Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development* (2007).)

By 1900, every state had a psychiatric hospital. These hospitals grew rapidly and often housed tens of thousands of individuals, ignoring the original intent to keep them appropriately small. The abuses that occurred in too many of these institutions are well known, from deplorable living conditions to unproven treatments to nonconsensual human experimentation.

A number of events converged after World War II that brought us to the often-fragmented system of care that we have today. In the early 1950s, the first antipsychotic medication, Thorazine, was developed. Oversold as a "cure," it led many to believe that

institutionalization was no longer necessary.

In 1963, in his last public bill signing, President Kennedy signed a $3 billion authorization to create a national network of community mental health facilities that would enable people to be released from state asylums and returned to their communities, where they would receive the newly developed medications. Tragically, with President Kennedy's assassination and the escalation of the Vietnam War, the promise of a well-funded community mental health system did not come to fruition.

At the same time, litigation proceeded against a number of states for the subpar operation of their state hospitals. In 1971, the first major case, *Wyatt v. Stickney*, was decided in the federal court and set such strict obligations for the appropriate operation of state hospitals that use of them plummeted, leading to "deinstitutionalization."

Unfortunately, there was no national network of community mental health facilities to absorb these new patients. Continued deinstitutionalization, combined with changes in Medicaid funding to encourage deinstitutionalization, left a fragmented system of care that is not accessed by many who need it. Simultaneously, changes to housing policy and an affordable housing crisis have pushed many Americans out of stable housing. Finally, waves of "tough on crime" policies have made the criminal justice system a de facto system of both first response and last resort for many. According to studies cited by COSCA in their 2016–2017 policy paper, 25–40 percent of individuals with SMI have been in jail or prison at some point in their lives. (Milton L. Mack, *Decriminalization of Mental Illness: Fixing a Broken System* 3 (2017).)

Debunking Common Misunderstandings

Given the danger of living on the street while experiencing delusions or emotional turbulence, it is not difficult to think that a jail's roof, meals, and access to health care would be a benefit to people with behavioral health needs. Uniquely, incarcerated people in the US have a constitutional right to adequate health care, including mental health care. However, we know from local data analyses that, when compared to the general population, incarcerated people who have behavioral health needs often cost more within a correctional facility, have longer lengths of stay, and may be difficult to supervise or cause disturbances while in custody, exacting a toll on correctional officers. Time in custody often leads to disruption in continuity of care through missed treatment appointments or changed prescriptions, as well as jeopardizes a person's access to benefits, housing, and employment. Detention often comes at a high price both for public coffers and individual lives, so its use must be weighed carefully.

The other "institutional" option, state hospitals, also presents a complicated reality. Anecdotally, many judges or attorneys report raising a defendant's competency to stand trial in the hope that the competency evaluation will connect the person to needed mental health care. This has led many states to experience surges in the percentage of state hospital beds that are occupied for forensic cases, leading to backlogs of individuals waiting in jails and the community for needed hospital beds. As we have learned from conversations with forensic psychiatrists, competency restoration treatment is not designed to set an individual on the path to recovery in the community; it is designed to fulfill the constitutional legal requirement of positioning an individual to ably assist in his or her own defense. New programs, notably in California and Florida, are reexamining this paradigm and exploring ways to "divert" individuals out of the criminal justice system, when appropriate, and into community-based treatment focused on recovery in the community, rather than competency restoration and a return to court and jail.

Finally, judges and attorneys should learn that media coverage does not do justice to the complex relationship between mental illness and risk of violence. Degree of severity of mental illness, co-occurrence of substance use, current treatment, and any history of violence all impact this relationship.

> "Officials throughout the criminal justice system should recognize that people with mental disorders have special needs that must be reconciled with the goals of ensuring accountability for conduct, respect for civil liberties, and public safety."
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> —ABA Criminal Justice Standards for Mental Health, Standard 7-1.2(a)

What We Can Do

The new ABA Criminal Justice Standards for Mental Health were developed to clearly articulate how actors in each part of the criminal justice system can work productively with mental health and other partners in the interests of accountability, respect for civil liberties, public safety, and public health. Facing a social structure that has failed many defendants struggling with mental illnesses and/or substance use disorders, judges, attorneys, and court administrators can use the tools they do have and take the following steps to pursue justice for individuals with behavioral health needs.

Commit to understanding what mental illnesses and substance use disorders are and aren't. We all walk around with some idea about what these illnesses mean, and we owe it to ourselves and our communities to make sure our understanding of these illnesses is as well informed as possible. We should know that mental illnesses

are rarely correlated with increased risk of violence. We should know that there are different levels of care for substance use disorders, and not all individuals need residential treatment. We should know that these are often lifelong conditions that will include decompensation but also plenty of reasons for hope; there are medications and therapeutic interventions that do work, and more are being developed.

Develop skills for working with defendants who have behavioral health needs. Our tone of voice, our word choice, the pace of our speech, and our body language can make a significant difference in whether our words are heard and understood as we wish them to be by defendants with behavioral health needs. We can talk with colleagues, especially our partners on the clinical side, to get coaching on how to ensure our message is heard as intended and learn how to understand those who may struggle to express themselves. Cultural competency is a critical piece of this.

Establish working relationships with colleagues who specialize in community-based treatment and supports. Local behavioral health administrators, operators of community-based treatment programs, housing advocates, and leaders of housing continuums of care are critical allies in achieving positive outcomes for the individuals coming to the courts. Schools are essential partners in identifying and addressing early trauma. Strong relationships with these local partners will help you identify additional ways to help the people who are involved with multiple public systems and identify where there are gaps in connections to care that should be filled.

Get good information to inform your decisions. Research in behavioral health and criminology emphasizes the importance of understanding individual "risks" (across numerous dimensions, such as suicide, violence, and future justice involvement) and "needs" (also across numerous dimensions, such as needs associated with future justice involvement, mental health care, or housing) to determine appropriate interventions. This aligns with our legal obligations of individualized considerations and decisions. Increasingly, national initiatives like Stepping Up are directing local leaders to ensure that uniform mental health screens and assessments are conducted as well as assessments of risk across several dimensions. Consider what information is critical to *your role* and *your decisions* at different points in a case. For example, a defense attorney does not need to know a client's prescription history, but knowing that mental health is a factor may help the attorney decide to engage a social worker early on to identify appropriate potential community-based placements. When considering a diversion to community-based care and supports, there are obvious questions related to accountability and public safety. Will a diversion satisfy someone who has been victimized by the individual? Will it satisfy police who see that person back on the streets? What can be done to mitigate the risk of a tragic headline? Attorneys and judges still must decide in each case how to weigh information about behavioral health needs against our societal interests in fairness, accountability, and public safety. With additional training and information from their colleagues in the behavioral health field, however, they can make better decisions. The Judges' and Psychiatrists' Leadership Initiative, which we both participate in, has developed numerous resources on this.

Use this knowledge to make decisions. Whether through a diversion or reentry from jail and prison, almost everyone who is coming through the courts will return to the community. The courts can provide an opportunity to connect someone with the community-based supports they need. You can truly achieve justice and accountability and protect public safety by applying the best available social science and the individualized information you have collected at each key process point:

- Charging/filing
- Pretrial release
- Diversion
- Alternatives to incarceration
- Minimizing collateral consequences
- Reentry

Promote data collection and analysis to determine what's working. While many of us may have chosen the law to avoid numbers and statistics, aggregate data can help us develop better court strategies and policies to reduce the over-representation of people with mental illnesses in the criminal justice system. For instance, a study by the Florida Mental Health Institute at the University of South Florida found that 97 individuals in Miami-Dade, mostly men diagnosed with a schizoaffective disorder, were arrested almost 2,200 times over five years, spent 27,000 days in the Miami-Dade County Jail, spent 13,000 days at a state-funded psychiatric facility, and cost taxpayers $14.7 million during that time with no clear benefit to the individuals or the community.

Consider stepping into a leadership role to promote better cross-system collaboration. Hundreds of judges nationwide have recognized the critical role they can play as conveners of the cross-system partners that are necessary to reduce the involvement of people with behavioral health needs in the criminal justice system. As the saying goes, "when a judge calls a meeting, people come." Recognizing this, CCJ/COSCA have called upon chief justices and others to take on this leadership role, either locally or at the state level. (*See* CCJ/COSCA, Resolution 11: In Support of the Judicial Criminal Justice/Mental Health Leadership Initiative (2006).) This summer, the National Center for State Courts released a guide called *Leading Change: Improving the Court and Community's Response to Mental Health and Co-occurring Disorders*. The Judges' and Psychiatrists' Leadership Initiative is

another way that hundreds of like-minded judges and attorneys are learning from one another and developing new ways to lead in this area. Programs such as the Eleventh Judicial Circuit of Florida's Criminal Mental Health Project—a pre- and post-arrest diversion program for people with SMI—have shown significant reductions in arrests and recidivism rates along with improved public safety and recovery rates.

Promote self-care for yourselves and your colleagues. The well-educated and professionally accomplished are not immune to mental illnesses and addiction. Attorneys, judges, and others also have behavioral health needs and may struggle to identify and connect with care providers and treatment approaches that work for them. The work we do is inherently stressful and can often be traumatic for those on the frontlines. As employers and colleagues, we should all work to reduce the stigma associated with seeking treatment and promote self-care within our professional communities.

Our courts do not choose the societal challenges that make their way through the doors, but judges, attorneys, and court administrators can certainly make sure we have the best available tools to handle those challenges when we see them. ■

Places to Learn More

- ABA Criminal Justice Section: https://www.americanbar.org/groups/criminal_justice
- The Council of State Governments Justice Center: https://csgjusticecenter.org
- The Judges' and Psychiatrists' Leadership Initiative: https://csgjusticecenter.org/courts/judges-leadership-initiative
- The National Center for State Courts: https://www.ncsc.org/mentalhealth
- Policy Research Associates: https://www.prainc.com
- The Stepping Up Initiative: https://stepuptogether.org
- Funders for Local Initiatives
- Arnold Ventures
- Bureau of Justice Assistance, US Department of Justice
- Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services
- John D. and Catherine T. MacArthur Foundation's Safety and Justice Challenge

Racial Profiling: Past, Present, and Future?

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or are afraid that refusing the request will make them "look guilty." The racially skewed statistics on who ends up being searched pursuant to consent, in study after study, show just how important consent searches have become to this pernicious practice. Taking away the ability to search, absent probable cause or reasonable suspicion to believe an offense has been committed, would go a long way toward curtailing these practices. The US Supreme Court has made clear that it has no interest in reexamining the constitutionality of so-called consent searches. *(See, e.g.*, *Ohio v. Robinette*, 519 U.S. 33 (1996), *reaff'g Schneckloth v. Bustamonte*, 412 U.S. 218 (1973).) But eliminating this tool, except in the presence of evidence that would support a finding of probable cause, would not require a change in constitutional law. State lawmakers can make this happen with the passage of statutes that prohibit police searches or requests to search without probable cause; law enforcement leaders can do it themselves, by creating police department rules and regulations that do the same thing. We need not wait for the US Supreme Court to act.

Second, every police department must keep data on all traffic stops, including not just who is stopped and appropriate demographic data on each person but also on post-stop activity such as searches and recovery of contraband. The same must be done for all other types of routine enforcement that results in searches, such as stop and frisk activity. As discussed earlier, Missouri and North Carolina have such statutes; in Illinois, which had a law passed 15 years ago (sponsored by then state senator Barak Obama) that would expire June 30, 2019, the legislature passed a new law that will make data collection an ongoing obligation. Illinois House Bill 1613 passed both houses of the state legislature on May 21, 2019 (*available at* https://bit.ly/31aLFVr). (At this writing, the governor has not yet signed the bill.) Every state must pass such a law. And with those data, supervisors and all police commanders must analyze them to see whether racially skewed patterns of enforcement, with no explanation other than racial discrimination, emerge. If and when those patterns become evident, the responsible officers, units, precinct commanders—everyone—must be held accountable. ■