

Recommended Changes to Arlington County's Proposed Behavioral Health Docket

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While the criminal justice system is increasingly being used to manage people with mental illness,¹ it was not designed for that purpose, and is ill-equipped to achieve optimal rehabilitative outcomes. Persons with mental illness present a unique challenge for our criminal justice system: they make up a substantial portion of the jail population and are more likely than others to face repeated incarceration. They are especially likely to violate the conditions of pretrial release and probation.² When we use the traditional criminal process of prosecution and incarceration rather than treatment and evidence-informed diversion practices, we fail to address the causes of criminal behavior for persons with mental illness. In fact, reliance on the traditional process likely increases future criminal involvement by subjecting an already vulnerable population to the destabilization and trauma associated with arrest and incarceration.

Recognizing that the traditional criminal process is does not reduce criminal contacts among the mentally ill and perpetuates a “revolving door of criminal justice involvement,”³ jurisdictions across the country have established mental health courts that seek to address the issues underlying criminal behavior among the mentally ill. Such programs have proven successful in both reducing recidivism in the target population and in reducing the high costs associated with the prosecution, supervision and incarceration of mentally ill people charged with crimes.⁴

Commendably, the Arlington County General District Court and Department of

¹ Indeed, more people suffering from mental illness are in this country's jails and prisons than hospitals. “More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States,” Treatment Advocacy Center, (May. 2010), available at

https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf

² Lange, Shannon, et al., “The Effectiveness of Criminal diversion Initiatives in North America: A Systematic Literature Review,” *International Journal of Forensic Mental Health* 10-200-214, 201 (2011).

³ Virginia Department of Behavioral Health and Developmental Services, “The Essential Elements of Mental Health Dockets in Virginia,” 1-2 (Dec. 2016) [hereinafter VADBHDS Report], available at

<http://www.dbhds.virginia.gov/library/forensics/fofo%20-%20mental%20health%20docket%20report%20final.pdf>.

⁴ *Id.* at 5-7. *See also*, Mental Health America, “Position Statement 52: In Support of Maximum Diversion of Persons with Serious Mental Illness from the Criminal Justice System,” (Sept. 2018), available at http://www.mhavalusia.org/_img/pdfs/policies/Position%20Statement%2052.pdf; National Alliance on Mental Illness-Virginia “Jail Diversion Program ‘A More Compassionate Way for Mental Health Treatment’” National Alliance on Mental Illness,” (Dec. 2016), available at <https://namivirginia.org/jail-diversion-program-compassionate-way-mental-health-treatment/>.

Human Services have drafted a proposal to establish a mental health docket and thereby join the many jurisdictions across the country that have taken a smarter approach to responding to criminal behavior by individuals suffering from mental illness. While the proposal would represent a positive step toward addressing the causes of criminal involvement in the target population, we are concerned that aspects of the proposal, as drafted, will prevent the program from being as robust and effective as possible.

We therefore submit this memorandum suggesting changes to the existing proposal; changes that will allow our mental health docket to better engage and enroll priority participants while also maximizing participation. It is only by involving the greatest number of target participants that the mental health docket will fully realize the optimal outcome of providing critical treatment services to all of the Arlington residents who need them the most. Given time constraints, and in consideration of the fact that much of the current proposal is well-designed, this memorandum is neither exhaustive in its recommendations, nor intended as a replacement for the existing draft. In each of the following two sections, we propose changes to the proposed program guidelines, followed by a discussion of why these changes are appropriate.⁵

Eligibility Requirements and Guidelines

Our proposed eligibility requirements primarily serve to expand the potential pool of eligible participants while ensuring that the docket's resources are used to help the population that would most benefit from a mental health docket, thus maximizing the return on Arlington's investment. In short, we believe it important to ensure that the docket does not primarily target and serve low-risk participants accused of committing the low-level crimes. Those individuals are best diverted earlier in the process, through either law enforcement, magistrate, or prosecutor-led diversion programs (i.e. intercepts 1 through 2.5).

Suggested Eligibility Requirements

In order to participate in the mental health docket, a defendant must:

- Be diagnosed with a serious mental illness⁶ (“SMI”) or dual-occurring

⁶ A “serious mental illness” is defined as having, at any time during the past year, a diagnosable mental, behavior or emotional disorder that causes serious functional impairment that substantially interfere with or limits one or more major life activities. VADBHDS Report at 3.

diagnosis, with a connection between the mental illness and past or present criminal behavior;

- Be assessed as a medium or high criminogenic risk according to the relevant risk assessment tool;
- Be competent to stand trial;
- Voluntarily participate in the program.

There are no disqualifying charges. Any defendant charged in criminal court, if deemed eligible at screening, can participate in the mental health docket, provided that:

- Defendants charged only with very low-level, “quality-of-life” offenses should not be treated in mental health court and should instead be diverted earlier in the criminal process, either through law enforcement, magistrate or prosecutor-led diversion programs;⁷
- Defendants charged with any misdemeanor or non-violent felony are presumptively eligible for mental health court, pending screening;
- Defendants charged with violent felonies are eligible for mental health court, subject to approval from the Commonwealth’s Attorney’s office.

There is no residency requirement for participation in the mental health docket.

Discussion

The requirements that the SMI relate to criminal activity and that the defendant have a medium or high risk score allows the court to use its resources most efficiently, targeting the populations that will most benefit from services and that society will most benefit from having treated in this setting.⁸ The Virginia Department of Behavioral Health and Developmental Services recommends that, resources permitting, mental health courts and dockets “target defendants of moderate to high risk (risk of failing to appear and incurring new charges while on release) as research has found those with moderate to high risk benefit most from dockets.”⁹ Indeed, lower-risk defendants are not an appropriate target population for this court as “[d]ata has shown that overprescribing services for

⁷ If a person has a persistent history of being arrested for such crimes and continues to do so despite receiving mental health services outside of the court system, he or she will likely be deemed “high risk” and therefore eligible for admission to the mental health docket.

⁸ See, e.g., VADBHDS Report at 23.

⁹ VADBHDS Report at 24.

low risk defendants may increase rather than decrease their risk[.]”¹⁰ Such lower-needs populations are more appropriately treated in non-criminal settings or through less-intensive diversion options.

Not only should the mental health docket focus on the most at-risk populations, it should also not be used for defendants accused of committing low-level “quality of life” offenses. Mental Health America notes that such crimes arise primarily from homelessness and “our society’s failure to provide decent housing, treatment for mental illnesses and supportive social services” and it “strongly opposes” using mental health courts to criminalize people “whose offenses flow from their troubled life on the street.”¹¹ Additionally, use of mental health diversion for low-level offenders can be an inefficient use of resources, as treating them does not deliver much, if any, reduction in jail time.¹² This docket should leave room for innovation with respect to law-enforcement- and prosecutor-led mental health diversion programs for lower-level offenses, each of which are more appropriate ways to respond to “quality of life” offenses than is a formal mental health docket.

As for offenses deemed more serious, excluding people from eligibility based only on their charges undermines the goals of a mental health program and limits its effectiveness, with little to no benefit to the community. The premise underlying the mental health docket is that, with treatment, the court can ensure that defendants avoid future criminal contacts and that it can do so at lower costs than traditional prosecutions. Those benefits apply to all defendants, irrespective of the crimes they are alleged to have committed,¹³ so those resources are best used to help keep those who have allegedly committed the most serious crimes from committing similar crimes in the future. Allowing for approved defendants to participate, irrespective of charge, will not create an undue risk of danger to

¹⁰ *Id.*

¹¹ Mental Health America, “Position Statement 53: Mental Health Courts,” (Jun. 2019) [hereinafter MHA 53], available at <https://www.mentalhealthamerica.net/positions/mental-health-courts>.

¹² *See, e.g.*, U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, “Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Abuse Disorders from the Criminal Justice System,” at 5 (2015) [hereinafter SAMHSA Report] available at <https://store.samhsa.gov/system/files/sma15-4929.pdf>.

¹³ McNeil, Dale E., Ph.D., and Binder, Renee, Ph.D., “Effectiveness of a Mental Health Court in reducing Criminal Recidivism and Violence,” *Am. J. of Psychiatry* 164:1395-1403, 1401-02 (2007) (“These findings provide evidence of the potential for mental health courts to achieve their goal of reducing recidivism among people with mental disorders who are in the criminal justice system. Moreover, since the mental health court participants in this study included a substantial proportion of individuals who had been charged with felonies or violent offenses, it appears possible to expand the mental health court model beyond its original clientele of persons charged with nonviolent misdemeanors in a way that public safety is enhanced rather than compromised.”)

the community because, first, “the comparative seriousness of a criminal charge is not a strong proxy for individual dangerousness,”¹⁴ and, second, individuals will be screened before being admitted to ensure that they are suitable candidates for the program.

The mental health docket should not be limited to Arlington residents. The program is completely voluntary and if participants are willing to be connected with service providers (either where they live or in Arlington) and comply with court obligations, there is no reason to prohibit them from participating. Regardless of where they live, all people criminally charged in Arlington have allegedly committed offenses in Arlington and could again in the future—the community has an incentive to reduce the likelihood of recidivism.

Procedures

We propose the following amendments to the current Arlington proposal. This is not intended as a full policy proposal but is instead a group of suggestions that, if adopted within the framework of the current proposal, we believe will result in a more effective mental health diversion court. With additional time, these recommendations could be refined or made more exhaustive.¹⁵

Suggested Procedures

Participants may be admitted to the docket in one of three ways, with a strong preference for the first:

- Immediate post-arrest referral based on an initial screening at the jail by mental health professionals;¹⁶
- Other pre-trial referral, by any actor in the system (including a defense attorney, pre-trial officer, mental health professional, judge or prosecutor), of a defendant who was not recommended at arrest;
- Post-conviction referral of a defendant on probation or under community supervision who is at risk of revocation or incarceration as a result of mental-health-related issues. Such a recommendation can be made by any

¹⁴ SAMHSA report at 3-4.

¹⁵ This is a first draft and has not been reviewed or vetted by other stakeholders. Like the existing GDC/DHS proposal, the recommendations contained in this memorandum could benefit from additional input from other stakeholders.

¹⁶ This should not be understood to supplant pre-booking diversion by police. This assumes that police have already decided to arrest a person according to established diversion procedures.

actor in the system, but must be approved by the trial judge.

The mental health docket should be primarily a pre-plea docket, subject to the following:

- Defendants charged with misdemeanors (all) and non-violent felonies (subject to exclusion¹⁷) are to enter the program pre-plea and at the earliest stage possible, with the case dismissed upon successful completion of the program;
- Eligible defendants charged with any non-violent felony subject to exclusion from the foregoing, *see* n. 17, may enter the program pre-plea without a promise or agreement as to disposition;¹⁸
- Defendants charged with other crimes may enter the mental health docket pre- or post-plea, according to terms negotiated by the Commonwealth and the defense, and may (or may not) have the case and charges dismissed or reduced upon successful completion of the program;
- Defendants referred post-conviction will have necessarily already been convicted before their cases are transferred over.

Treatment plans must be individualized and developed collaboratively with all members of the treatment team and the defendant him or herself. Plans should address all identified risk factors, not just those relating to mental health (e.g., a need for housing, employment or educational assistance)¹⁹ and may be modified by the court, if deemed necessary by a medical treatment professional.

The length of each plan term will vary by defendant but should be set for the least amount of time clinically necessary to carry out the treatment plan. A term can be extended, if necessary, but under no circumstances may the initially-set term exceed the possible period of incarceration for the lead charge against the defendant.²⁰

The case plan is the guide for determining compliance and non-compliance, with

¹⁷ This provision would require the input of the Commonwealth's Attorney and General District Court in order to identify exclusions. Exclusions should be minimal, however. Any felony petit larceny, grand larceny under \$2500, destruction of property under \$3500, identity theft, simple possession of narcotics, and most other non-violent felonies should be subject to automatic dismissal.

¹⁸ The purpose of this provision is to allow defendants who desire treatment services—regardless of whether they will receive a legal benefit—to enter the docket as soon as possible, and prior to the discovery and plea negotiation process.

¹⁹ VADBHDS Report at 26-27

²⁰ *See* SAMHSA Report at 10-12 (discussing the importance of a “proportional response”).

sanctions and incentives applied consistent with Element 11 of “The Essential Elements of Mental Health Dockets in Virginia,” as described in the DBHDS report,²¹ provided that:

- Sanctions are to be applied “judiciously,” conservatively and with input from treatment professionals, allowing for adjustment of terms of the initial plan, if necessary;²²
- Incarceration should not be used as a sanction, though a participant may be temporarily remanded into custody, preferably to a mental health treatment facility, if he or she is engaging in extremely high-risk behaviors and represents a specific and articulable risk to public safety. In the very rare event that the court wants to detain a participant, it must hold a hearing with his or her lawyer present.²³

Once treatment is complete and the participant is stabilized according to the treatment plan, the participant will graduate in a ceremony consistent with that described in Arlington’s mental health court proposal, with the case disposed of as follows:

- Referrals other than those transferred post-plea will have their cases dismissed with prejudice and without a conviction (unless negotiated otherwise, subject to the terms described *supra*); The court and Commonwealth Attorney will then assist the person in meeting the requirements for Virginia Code [19.2.392.2](#) to expunge all records of the arrest and charges.
- Post-plea participants will have their cases dismissed and probation terminated but will receive a conviction consistent with the terms of initial plea or trial.

All efforts should be made to help a participant successfully complete the program and removal should be a last resort, as setbacks are to be expected with this population. A participant should not be removed unless they have demonstrated a complete and sustained unwillingness to participate in treatment and all attempts at adjusting the treatment plan have been exhausted.

Additionally:

²¹ *Id.* at 27-28.

²² *Id.* at 27

²³ *See, e.g.*, MHA 53 (“Similarly, mental health courts were much less apt to use jails as a sanction for failure to comply with court-ordered treatment than were the drug courts after which they are modeled.”)

- Re-arrests should not necessarily result in removal from the program and will be considered on a case-by-case basis with a presumption that re-arrest will not result in removal from the program. All of a mental health participant's cases will be consolidated in the mental health docket;
- For a pre-plea referral, removal from the program will result in the case being transferred to a criminal docket to allow the prosecution to proceed as normal;²⁴
- Post-plea transfer cases will go back to the original judge for a revocation hearing.

Discussion

This program is designed to allow for immediate and successful engagement with mental health treatment and to provide incentive to as many participants as possible to take advantage of the program.

Immediate screening and engagement is crucial for participant success. Even short stays in jail can be extremely disruptive for people with mental illness, interrupting contact with treatment providers and access to medication and other services and can result in loss of housing or employment.²⁵ Compounding the harm, people with mental illness or substance abuse disorders are less likely to make bail and are more likely to experience significant delays in case processing.²⁶ By reviewing the cases and getting approved participants out of jail and connected to the mental health docket at the earliest possible point in the lifespan of the case, the court increases participants' likelihood of success.²⁷

Relatedly, allowing people to participate in the docket without first pleading guilty (unless otherwise negotiated²⁸) eliminates unnecessary delays that undermine treatment while serving no real purpose. Requiring a defendant to plead guilty before being allowed to participate in the mental health docket would require the defendant and his attorney to make a decision assessing the strength of the case, not the need for treatment, which would almost certainly involve the need for discovery, investigation and negotiation with the government. Over that

²⁴ If the participant enters the program pursuant to a plea agreement with the government, the terms of that plea will dictate the result of the case if the defendant is removed from the program.

²⁵ SAMHSA Report at 5.

²⁶ *Id.* at 3.

²⁷ *See also, e.g.*, VA report at 21-22 (recommending prompt enrollment decisions).

²⁸ As discussed, no participant is required to plead guilty and the preference is for pre-plea diversion.

time, a defendant may be incarcerated pre-trial, thus having his or her life disrupted and diminishing the likelihood of future success, even if they were to ultimately enter the program. Requiring a guilty plea would preclude diversion from the criminal justice system at the earliest point in time, further criminalizes a person because of his or her mental illness.²⁹

Not only would having a plea requirement undermine the prompt administering of services, it is coercive, antithetical to the purpose of the program, and disincentivizes participation. First, having a criminal conviction is stigmatizing and decreases the likelihood of future success by limiting employment, housing and even mental health treatment options.³⁰ Second, if the mental health court required a guilty plea for entry, a defendant who maintains his or her innocence but wants to take advantage of the services of mental health court faces the untenable choice of either foregoing the court's treatment or fighting the case against them, which conflicts with Mental Health America's recommendation that "a criminal record should never be the cost of getting mental health treatment."³¹ Finally, defendants must have an incentive to participate in the program.³² Few, if any people will subject themselves to a potentially longer and almost certainly more intensive period of supervision than they would face under a normal prosecution if they stand to end up with a criminal conviction in either instance.³³

²⁹ MHA 53

³⁰ *Id.* ("Adding the stigma of criminal charges and conviction makes it even harder for persons burdened with the substantial stigma of mental illness to find or maintain meaningful employment, find decent housing and pursue meaningful recovery. Unfortunately, even mental health providers often discriminate against persons with a criminal record.")

³¹ *Id.*

³² *See, e.g.*, SAMHSA Report at 10.

³³ For example, Arlington's post-plea drug court is under-utilized. As of mid-July 2019 it had 10 participants.