IMPROVING EFFECTIVE ADVOCACY
BY DEFENSE COUNSEL
OF DEFENDANTS WITH MENTAL ILLNESS
IN DISTRICT COURT CRIMINAL CASES

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Abstract

An intractable challenge in due process and fundamental fairness arises for mentally ill defendants in the criminal justice system. Practical and costly problems arise for defendants and public safety, as well as law enforcement, the courts, and corrections. Only the defense attorney has the legal duty to identify mental illness and zealously advocate: if counsel fails to identify mental illness and advocate appropriately, ineffective advocacy may occur.

Examination of arraignments and case outcomes in three Massachusetts district courts in 2009, indicate a significant under-identification of mental illness: fewer than 4% of the defendants had identified mental illness compared to approximately 8.3% of the U.S. adult population and 16.9% of the U.S. jail population. Cases involving mentally ill defendants took longer to resolve, resolved by plea agreement more often, have higher rates of guilty findings, and are more likely to serve periods of incarceration.

This implementation of a short screening instrument and increased attorney training would increase identification of mental illness in the criminal defendant population. This two-prong response would improve attorney advocacy, decrease defendant failures on community supervision and rates of recidivism, reduce costs in public safety, court, and correctional agencies, and improve public safety.
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1. Introduction

Serious mental illness is a problem for a growing number of defendants processed through the criminal courts in the United States every day. These defendants pose practical and immediate problems to themselves and to the efficiency, safety, and resources of the public, police, courthouse, and correctional staff, and remain a perplexing challenge to Constitutional concepts of due process and fundamental fairness. A range of problems means greater use of resources in all phases of the criminal justice system. There are already a limited number of resources allocated to cases involving seriously mentally ill individuals. Additional challenges include the poor identification of such cases in the criminal justice system, and the inability of all segments of the criminal justice system to address criminal cases with mental illness effectively rather than efficiently.

The prosecutor seeks out issues and facts to strengthen the state’s case against a criminal defendant. The defense attorney challenges those facts and brings others to light that bear on the state’s ability to prove each element of a crime beyond a reasonable doubt. In each case, the judge ensures that justice is properly administered, the prosecutor seeks justice for all parties, and the defense attorney advocates to minimize, mitigate, or avoid consequences for the acts alleged. Despite their respective roles, all parties are expected to help ensure a fair and impartial trial.

The mental health status of the defendant, whether mentally ill, developmentally delayed, or otherwise cognitively impaired, is important information for the judge, prosecutor, and defense attorney. As the mental health of the defendant can impair the defendant’s ability to properly interact with the judicial system or to understand the crimes alleged, there is significant
risk to the defendant’s procedural and substantive constitutional rights and may result in a trial that is neither fair nor impartial.

A. Meeting The Issue In Person and Finding Myself Lacking

My first experience with a mentally ill defendant was similar to those of countless other attorneys. I was the attorney provided at state expense to “Joe.” In the 1970s, surgeons implanted a plate in Joe’s skull to partially resolve a grievous injury. By the 1990s, Joe was well known to local police departments and the court for his long history of substance abuse and violent outbursts. One of Joe’s most common issues was that he smoked and drank and went out frequently for cigarettes and beer. In my case, Joe’s most recent ex-girlfriend lived on the direct path between Joe’s home and his supply of cigarettes and beer. The ex-girlfriend held a restraining order requiring Joe to stay a minimum distance away from her residence. Joe’s cognitive deficit prevented him from determining a different path to his local store or comprehending that his failure to re-route his travels was a crime. Upon his arrest, Joe understood nothing of my attempts to explain these offenses. I could see the issue and even begin to frame the scope of the issue, but I did not know how to define and present it in court as an effective advocate. Another attorney combined this case with Joe’s other open cases and worked out a plea agreement that involved a jail sentence. The period of incarceration did nothing to educate Joe, make the public safe, or modify Joe’s behavior. In my opinion, the plea agreement was poor advocacy but as a new attorney, I was not in a position to act on these perceptions. Through the intervening years, based on my efforts to educate myself on issues of mental health in criminal justice, I represented Joe several times with better results.
B. A Societal and Public Policy Challenge of Constitutional Dimension

Attorneys who cannot or do not screen for mental health issues, recognize mental health problems, or provide appropriate representation, face an enormous legal risk for the defendant, the attorney, and a failure of the Constitutional system of due process protections for criminal defendants.

Preparing for court, the attorney must consider that the defendant’s mental illness may have interfered with the ability to understand social cues or interactions escalating a situation, precluded the ability to understand or process instructions from police (including Miranda warnings), and diminished the ability to act in the defendant’s own interests regarding waivers of counsel, arraignment proceedings, jury trial rights, and plea negotiations (Shannon & Benson, 2005).

For the defendant whose case is resolved against him through a plea or trial, the defendant is under court supervision through probation or committed to jail (James & Glaze, 2006). Services provided through probation draw a disproportionate amount of the resources from the agency when a minor infraction, offense, or behavioral issue occurs due to an inability to control mental illness symptoms in public. The symptomatic behavior results in revocation of release and return to the locked facility – costing the public twice (Council of State Governments, 2009).

The mentally ill defendant entering jail faces physical and psychological attacks from detainees and inmates and tends to decompensate in confinement. In jail, problems arise including psychotic disorders, suicide attempts, insomnia, hypersomnia, and persistent anger. The combination of mental illness and decompensation place facility employees and officers in
greater danger, run up the costs of in-facility segregation, medical treatment, and draw officers away from issues of detainee, staff, and facility security and safety (James & Glaze, 2006).

Ineffective assistance of counsel, through a failure to identify the mental illness, increases costs for malpractice claims, especially as recent Supreme Court decisions expanded the scope of ineffective assistance of counsel for legal malpractice (Richards, 2011). Historically, appellate courts evaluated claims of ineffective assistance of counsel by whether the attorney’s defective performance deprived the defendant of a fair trial - but for counsel's poor conduct, the result of the trial would probably be different ("Strickland v. Washington," 1984). Even if no malpractice claim is pursued by an aggrieved defendant, there is a stigma upon counsel whose cases are brought back before the court on a claim of ineffective assistance of counsel, even if that allegation is not sustained by the reviewing court (Lucey, 1992-1993).

My representation of Joe was one case among the millions of criminal cases arraigned every year across the nation. In FY 2009, there were over 200,000 arraignments in Massachusetts alone (Trial Court of the Commonwealth, 2010). At the same time, experts estimate that serious mental health issues are present in approximately 8.3% of the U.S. adult population (Epstein, Barker, Vorburger, & Murtha, 2004). For adults entering jails on criminal charges, serious mental illness jumps to 16.9% of this population (Council of State Governments, 2009). Using these two metrics for the lower and upper bounds of the problem results in a prediction that 16,600 to 34,000 criminal defendants faced prosecution while suffering from serious mental illness in that fiscal year alone.

Of all the professions in the criminal justice system, only defense counsel are required by custom, practice, law, and Constitutional provision, to work on behalf of the defendant. The defense attorney has an obligation and duty to provide zealous advocacy to the defendant
Arriving in a Massachusetts court as a mentally ill criminal defendant, this defendant is represented in 90% of cases by an attorney provided at public expense (Saubermann & Spangenberg, 2006). The attorney received training in criminal defense but it is likely that the coverage of mental health issues was a brief lecture (Massachusetts Continuing Legal Education 2009) and a single chapter in a textbook (Massachusetts Continuing Legal Education 2010). The education and training in mental health matters received in law school is nearly non-existent (Redding, 2004).

The state and federal governments provide attorneys at government expense to indigent defendants in criminal matters as a Constitutional requirement under a sequence of Supreme Court decisions culminating with the Gideon ruling in 1963 (De Sario, 2003-2004). While the Supreme Court decisions require appointment of counsel, when counsel are not well trained in mental health matters or are inexperienced, it is unclear how effective or efficient these attorneys can be (Feeney & Jackson, 1990-1991).

There are compelling reasons to seek out the most effective and efficient attorneys for these cases. As a societal issue, persons who are seriously mentally ill should be offered relevant treatment. Research of differential case results supports the conclusion that the variation among case dispositions is heavily attributable to the offense charged, prior criminal history of the defendant, and bail status (Houlden & Balkin, 1985). Despite the competing case issues, all of the studies carry the premise that an attorney with more experience, more years of practice, and more issue-specific knowledge will perform more effectively, as measured by shorter sentences and fewer guilty dispositions, and more efficiently, as expressed in either or both of fewer hours spent on the case or a shorter time to case disposition (Cohen, 2011).
Prior research focuses on legitimate and pressing issues but entirely from a criminal justice system focus. Behind every data point is a human being facing the power of the government while struggling under the burden of a custodial arrest, lack of funds and other social resources, and mental illness. The obligation to provide effective services to these defendants and the failure to do so rises to a Constitutional defect in our justice system when considerations of state and federal disability protections are considered. While identification of mental illness in criminal defendants is the responsibility of all actors in the criminal justice system, only the defense attorney has the legal duty to the specific defendant to effectively identify any relevant mental health issues and zealously advocate for that client (De Sario, 2003-2004). By inference, for the attorney to fail in that identification and not advocate appropriately constitutes ineffective assistance of counsel.

I will argue that criminal defense attorneys with training and education relevant to mental health issues will be more effective and efficient by obtaining more advantageous dispositions with less time to resolution and / or shorter duration of incarceration pending disposition. From the body of research, more experienced attorneys are more effective and efficient than less experienced attorneys. It is reasonable to infer that attorneys with mental health training, knowledge, and resources will be more effective (in the Constitutional context) and efficient for their clients than attorneys untrained and unskilled in mental health matters.

One study examined a mental health public defender unit in Texas whose cases were assigned based on identification of defendant mental illness. The study concluded that mentally ill defendants spent greater periods of time in custody. This greater period of detention is due to inadequate identification of mental health needs early on in the cases. Referral to the mental
health public defender unit resulted in fewer guilty verdicts and, on guilty verdicts, more sentences to probation than locked facilities (Carmichael et al., 2010).

Mental health public defender units are uncommon and there is no such unit in Massachusetts. The issues of mentally ill defendants are wide-ranging and warrant a broad-based approach to provide competent and effective representation and more efficiently allocate resources throughout the criminal justice system in the processing of these defendants.

This study examines a sample of cases from three District Courts in Essex County, Massachusetts, to examine the rate at which counsel identify mental health issues and dispositions in such cases compared to cases without mental health issues. From there, the study considers training and mental health screening instruments for attorneys to identify and act on potential mental illness in new clients under the time and space constraints of district court defense practice.

Ultimately, through the combination of better-trained attorneys and effective identification of defendants with mental illness, defense counsel can more appropriately advocate for their clients, reduce the time these defendants spend in custody, and prompt more efficient allocation of scarce criminal justice system resources. Identification of and appropriate response to mental health issues in criminal defendants can avoid future criminal behavior, reduce future arrests and recidivism, diminish time in police or jail custody, and improve the lives of the defendants, their friends and families – all while improving public safety and reducing system-wide criminal justice costs.

C. Findings and Recommendations: The Leading Edge of a Solution

Research into the issues of mentally ill defendants in the courts, jails, and prisons of the nation has prompted a number of insights and discoveries about the scope of the issue and
potential responses. The first aspect of the expansive research into the scope of this issue is that the numbers of defendants facing prosecution, detained in jails, and ultimately incarcerated is exploding as it pushes up costs of police, courts, and correctional facilities. The aggregate costs grow at a greater-than-linear rate: doubling the number of mentally ill defendants does not merely double the costs. As the numbers of mentally ill defendants increases, the costs of arresting, prosecuting, defending, supervising, and frequently incarcerating grow at a disproportionate rate. This does not merely constitute one more arrest, one more defendant, one more prisoner. It involves added costs for the police (more officers, training, injuries, and liability), prosecutors and defense attorneys (more hours, investigation, research, psychological experts, and preparation), probation and parole (supervision ratios, time intensive cases, higher failure rates for non-compliance and re-arrest), and corrections (closer supervision, more training and liability, the increased costs of running de facto mental health facilities and the direct costs of mental health care and pharmaceutical needs) that drives a snowballing effect on tight government budgets.

By identifying the mentally ill in the defendant population, can policymakers find a solution. The extensive studies on mentally ill defendants in the criminal justice system have touted a number of screening instruments to identify the mentally ill in jail and police lockup populations (Ford, Trestman, Wiesbrock, & Wanli Zhang, 2007; Lurigio & Swartz, 2006). These are designed to screen recently arrested or arraigned defendants on entry to a detention facility (Baksheev, Ogloff, & Thomas, 2011). Use of these instruments by defense attorneys with the defendant at court is within the design parameters and would allow for attorneys untrained in mental health issues to effectively screen at a high level of accuracy. Screening early would increase identification of mental health issues in the defendant population and provide an
opportunity to marshal services and intervene at the first point in the criminal case process (Samuelson, 2000). Early intervention would provide defense counsel with insight not otherwise available. It would allow counsel to more effectively advocate for the client and develop strategies to resolve or address client mental health needs.

2. Literature Review: How the Issue Arose, Scope, and Costs

A. The History, Nature, and Extent of the Problem

Mental illness is defined as a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Serious mental illness encompasses that definition and extends it to a functional impairment that substantially interferes with or limits one or more of the activities of daily living (“ADLs”). These ADLs are grouped into basic daily skills (e.g. eating, bathing, dressing); instrumental skills (ex: maintaining a household, managing money, getting around the community, taking prescribed medication); and social, family, and vocational/educational contexts (Substance Abuse and Mental Health Services Administration, 2012).

Over the last several decades, societal decisions have contributed to the problem where hundreds of thousands of mentally ill individuals enter the criminal justice system and are often detained for lengthy periods of time. Made in the context of compassion, fairness, and financial considerations, these decisions cut the number of placements available to the seriously mentally ill who would receive mental health services on an in-patient basis (Markowitz, 2011).

The process of deinstitutionalization is a leading contributor to the criminalization of mentally ill individuals. In 1955, there were 559,000 beds in psychiatric facilities serving a national population of 165 million, providing one psychiatric bed for every 295 members of the
American population. (Keele, 2002-2003). Despite the intervening growth in the national population, by 2000, the number of psychiatric beds dropped to 55,000 for a national population of 275 million, or one psychiatric bed for every 5,000 of the populace; moreover, most of these beds are not available for treatment but are restricted for forensic use (Lamb, Weinberger, & Gross, 2004). Trends show that a stable proportion of society are confined at any given time and that their number is divided between criminal justice confinement and mental health facilities. A decrease in the proportion of confined people in one facility type is shortly reflected by an increase in population of the other facility type (Lamb et al., 2004). Many individuals with mental illness find themselves without treatment and drawn into the criminal justice system as a result of aberrant behavior or some minor infraction. Then, instead of diversion to mental health facilities and programs, the mentally ill are arrested, prosecuted, and detained or returned to the streets where the cycle will repeat itself until proper treatment is found or more serious offenses prompt higher level criminal justice intervention (Perez, Leifman, & Estrada, 2003).

Another societal decision was to “raise the bar” on the standard for civil commitment to a mental health facility. During the ten years beginning in 1970, legislatures raised the standards of proof and individual need for involuntary commitment to a mental health facility from a minimal standard of ‘mentally ill’ to more specific criteria of ‘danger to self or others’, the maximum period of involuntary commitment was decreased, and individual due process rights were increased in commitment proceedings such that the numbers committed and the length of commitment dropped dramatically (Lamb et al., 2004). These changes, reflecting the trend of expanding due process rights of the era could be found in every state within a few years. New civil commitment laws resulted in three major changes: 1) the substantive criteria for commitment went from general concepts of mental illness and treatment to specifics of danger or
incapacity to care for oneself, 2) the duration of commitment from indeterminate to determinate and brief periods, and 3) explicitly guarantees that those civilly committed have rapid access to the courts, counsel, and trials. These new due process guarantees for the civilly committed echoed those obtained by criminal defendants over the prior ten years. These procedural safeguards and commitment standards meant fewer and shorter commitments. Many mentally ill individuals who would be committed under the old standards remained in the community, leaving large numbers of mentally ill persons committing crimes and drawn into the criminal justice system (Lamb et al., 2004).

The deinstitutionalization process was further spurred along by federal court holdings that the mentally ill were constitutionally entitled to treatment for their mental illness rather mere storage in state hospitals and limited custodial care. This sudden burden on the states prompted large-scale discharges from state hospitals to the care of community-based programs. However, the states did not use the cost-savings from these waves of wholesale discharges to improve outpatient care and left thousands of former mental health inpatients to fend for themselves in the community without meaningful support (Perez et al., 2003).

Between emerging due process protections and court decisions mandating discharge from state hospitals, these factors left many more mentally ill persons in the community without a mechanism to compel treatment or resolve problems. Another factor is the diminishing range of social services and resources, social workers, community housing and mental health facilities, that would otherwise work supporting and protecting persons with less severe mental illness to minimize their drift into activity that prompts criminal justice intervention (Lamb et al., 2004).

Aggravating the issue of diminishing resources, the police mandate to protect the welfare and safety of the community expanded. The police are the direct arm of the state’s historical
‘police powers’ to protect and care for those who cannot protect themselves (Lamb et al., 2004). When police are called to a disturbance involving the mentally ill, arrest is the immediate solution available to a police officer (Lamb et al., 2004). That arrest is a direct path to court and all of the criminal justice system. In their respective states, the Cook County Jail (IL) and Riker’s Island (NY) each hold the largest number of diagnosed mentally individuals of any facility and the Los Angeles County Jail holds a similar status in both California and the nation (Keele, 2002-2003). The result of these policies, at least in New York City, is that police are dispatched approximately every 6.5 minutes to incidents involving persons with serious mental illness and the calls have their own acronym: ‘PSMI’ (Lurigio & Harris, 2008). This arises from the 150,000 interactions annually between officers of the NYPD and these mentally ill individuals (Waldman, 2004).

Aside from the population of the mentally ill in the criminal justice system, the Substance Abuse and Mental Health Services Administration’s report in October, 2011 advises that some form of mental illness is found in 19.7% of adults in the United States (Substance Abuse and Mental Health Services Administration, 2012). When the SAMHSA data are examined, the population suffering from mental illness closely describes the population coming before the criminal courts of the country or already is that population:

- 7.7% of adults aged 18 to 25 have serious mental illness,
- 7.8% of unemployed adults have a serious mental illness compared with 3.5% among those employed full-time,
- 9.1% of adults with serious mental illness had a family income that fell below Federal poverty guidelines,
- 12.9% of adults having serious mental illness were on probation in the prior twelve months,
• 12.3% of adults having serious mental illness were on parole or supervised release from incarceration in the prior twelve months (Substance Abuse and Mental Health Services Administration, 2012).

Researchers, using rigorous methods of assessment (relying on objective data over self-reporting) found serious mental illness in 14.5% of male inmates and 31.0% of female inmates in the jails holding the new arrests, detainees, and some inmates (Steadman, Osher, Robbins, Case, & Samuels, 2009).

For all of these facts and issues, the criminal justice system deals with the mentally ill when all other societal safety nets fail. At that point, the police, courts, attorneys, and correctional systems are the social service providers to which all other problems flow (White, Goldkamp, & Campbell, 2006).

B. Mentally Ill Individuals and Police - Response and Resources

The mentally ill have greater contact with law enforcement for a variety of reasons. Aberrant behavior that would justify treatment in a psychiatric unit is viewed as a public disturbance and prompts a police response to criminal activity (Markowitz, 2011). Police officers respond to calls involving mentally ill individuals, are unaware of circumstances, and employ trained responses. The immediate objective for police is to control the situation: this requires compliance with police commands. Police seek compliance through loud commands and exhibiting force; resistance to commands prompts an escalation of force. On many occasions, non-compliance is a psychiatric crisis from a failure to use prescribed medications and may trigger a paranoid response (Miami-Dade County Grand Jury, 2005).

Two types of encounters between police and mentally ill persons prompt arrest and entry to the criminal justice process. The first type of encounter involves zero tolerance enforcement of
laws criminalizing minor offenses in an effort to reduce street crime. When police arrest individuals for infractions commonly associated with the homeless population (ex: panhandling, sleeping in parks and other forms of loitering, urinating in public), this brings in many defendants with untreated mental illness. However, the practice of arresting for low level offenses brings mentally ill defendants into court at a greater pace than relevant services can absorb (Lurigio, Rollins, & Fallon, 2004). The second type of encounter is entirely different: a person that, when medication compliant, is calm and poses no hazard, is now a danger to himself and others once the medications stop. Under these circumstances, loud police orders, escalation of force, and close confrontation aggravate the paranoia and the likelihood of violent confrontation. The costs commonly arising from this escalation include medical care and lost work time for police. For the arrested mentally ill person, there are costs of medical care, legal costs and consequences from the arrest, and potential litigation against the police. The immediate costs are frequently at public expense, and almost all of the litigation costs are borne by the public. The direct costs of litigation alone adds up to millions of dollars per year (Miami-Dade County Grand Jury, 2005).

Even in the absence of such an escalation and violent encounter, the aberrations of mental illness prompt police to make an arrest as an act of concern and mercy to protect the individual from harm that may arise. The arrest is a mechanism to bring the individual into mental health treatment and off the streets. The nature of police, serving as protection for society as a whole, is to use the coercive power of law to provide such protection. Use of arrest powers grants police the authority to resolve an unruly situation before escalation even if the result is that mentally ill individuals are much more likely to be arrested than the non-mentally ill under similar circumstances.
C. Counsel Representing Mentally Ill Defendants

Representing a criminal defendant is not casually undertaken by attorneys: the defendant’s liberty and life are placed in the hands of defense counsel. There are countless details, deadlines, procedures, legal and factual issues in flux throughout the entire case. Defense attorneys in Massachusetts who represent indigent criminal defendants receive, at their own expense, five days of training in substantive law and procedure on criminal matters and only a small portion of the training concerns mental health issues of defendants (Massachusetts Continuing Legal Education 2009). The schedule for the five days of training, a listing of each lecture and subject matter, does not cover mental health issues. There are sixteen chapters in the text provided in the Zealous Advocacy course to the attorneys attending training, the one chapter on mental health is sandwiched between Detention Hearings (chapter 6) and Pretrial Conferences (chapter 8). Although it is substantively covered in the text, it is only one of sixteen chapters and there is no expressly scheduled training on the matter.

In many cases, attorneys confuse mental health issues for defendant behavioral and personality issues. If defendants act in an aggressive, confrontational, otherwise argumentative manner, counsel may interpret this as an angry and uncooperative client and decline to invest themselves in the case. Failing to build a rapport and relationship with the client precludes an understanding of the client and case and eliminates any opportunity to examine and raise mental health issues as mitigation or defense of the case. Poor attorney-client relations fostered by a failure to visit the client in custody, lack of resources, training, and experience are more likely to predict adverse results when the clients are mentally ill, especially when the existence or extent of the mental illness is not known to counsel (MacLean, 2008-2009).
The next problem involves client competency and whether to raise it with the court. If the attorney raises the issue, counsel may anger and alienate the client. If the defense attorney raises the issue without consent of the client, the attorney usurps the client’s basic rights of self-determination and imposes the attorney’s judgment on the client. A failure to raise the issue risks even greater issues including malpractice and ineffective assistance of counsel (Davoli, 2009-2010). These decisions are evaluated by counsel on the basis of five days of training, a chapter of training materials, and any intervening experience and education (Massachusetts Continuing Legal Education 2009).

Once attorneys resolve the competency issues, they must ultimately advise and represent the client through pretrial processes that will result in dismissal, plea, or trial. Mental health issues that bear on defense tactics impose a burden on counsel to raise the issues as an effective advocate on the specifics of mental health and defendant culpability. Improper handling of these issues and decisions leads to potential ineffective assistance of counsel claims (Covarrubias, 2008-2009).

Tactical choices by defense attorneys are based on the relative strengths of the state’s case compared to the defendant’s, the skills of the prosecutor and defense counsel, the prevailing norms of case disposition of the court, and the ability of defense counsel to evaluate all of these and other factors. The defendant’s serious mental illness is a key factor in this calculation. The defense attorney has a legal duty to identify and investigate mental health defenses to mitigate or avoid criminal liability. Unfortunately, unidentified mental health issues do not become part of the case investigation or advocacy and that omission constitutes ineffective assistance of counsel (Covarrubias, 2008-2009).
Counsel’s failure to identify serious mental illness in defendants results from several common issues. These individuals often develop coping and masking skills to overcome the stigma of serious mental illness and cloak their symptoms in a variety of adaptations to their environment. Further, serious mental illness is an issue of variable presentation. It is rarely florid and interfering with the defendant’s ability to function in society. Issues of mental illness are concealed by the defendant and hamper the attorney’s efforts to investigate mitigating factors to the charges. Even if observed, counsel frequently lack the resources to identify the mental illness, experts to assess the defendant, or how to present the issues to the court (Covarrubias, 2008-2009). Serious mental illness does not always present visible and easy to identify symptoms. The extent of mental illness, signs, and symptoms vary over time, with stress, medication, and environment, and counsel is likely to overlook client mental illness (Covarrubias, 2008-2009).

If any clinician or screening tool identifies mental illness in the client, the defense attorney faces a difficult choice. The mentally ill client, like every other defendant, wants to get out of court and custody as fast as possible with some certainty in the case resolution. However, serving the mentally ill client’s immediate wish conflicts with his long term best interests. Disposing of the case quickly and with certainty through a plea precludes consideration of mental health issues and potential defenses. If the client pleads guilty and is placed on probation or obligated to pay fines, the client’s immediate wishes are served (Laberge & Morin, 1998). The attorney can plead the client out and wash his hands of the later consequences of the guilty plea.

However, the attorney is legally required to consider client's ability to evaluate the risks and benefits of an immediate plea. The attorney must weigh the client’s ability to make choices, communicate choices to counsel, allow counsel to act on those choices, and the client’s potential
to testify in court with decorum. The conflict between the obligation of counsel to consider the client’s wishes and the long and short-term results of those choices arises numerous times during the representation. Every occasion of this conflict and the choices made by the defense attorney results in differing outcomes in each case (Laberge & Morin, 1998).

Over 94% of felony cases prosecuted in the United States are resolved through plea agreements (Cohen & Kyckelhahn, 2010). A plea agreement requires that the defendant waive trial rights in exchange for concessions by the prosecution – commonly reductions of charges, penalties, or sentencing. The likelihood of a plea is strong and factors considered by defense attorneys weighing against a trial involve concerns about how the judge and jury perceive the mental health status of the defendant, strength of evidence of serious mental illness, severity of charges and penalties, and the ability of the defendant to testify in a coherent manner. Also filtered into the decision and advice to the defendant are the attorney’s skill and confidence as an advocate, the ability to skillfully examine expert witnesses in the defendant’s case, cross examine police and other witnesses.

Into this mix comes the case of Lafler v. Cooper, 132 S.Ct. 1376 (2012). The Supreme Court ruled that ineffective advice by counsel prompted the defendant to unwisely reject an advantageous plea offer. The decision significantly extends the concept of ineffective assistance in that the standard for many years was measured by trial outcome. This case asserted that the prejudice to the defendant was not an unfair trial but of actually going to trial. The court held that, but for the ineffective advice of the attorney, there is a reasonable probability that the plea offer would have been made, presented, and accepted by the court and that the conviction, sentence, or both, under the offer’s terms would have been less severe than under the actual judgment and sentence imposed after trial. The decision, written by Justice Kennedy, finding that
counsel was ineffective, looked back to earlier cases of grossly ineffective counsel and reconsidered the scope of the critical stages of criminal proceedings ("Lafler v. Cooper," 2012).

This case and issue flow from the premise that the option and opportunity to resolve a criminal case short of trial is both the critical stage of a case and at the heart of the criminal justice system. Effective analysis and decision making hinges on the importance of competent counsel ("Lafler v. Cooper," 2012).

This holding reflects the prevailing views of practitioners in the prosecution and defense roles, that there is an ethical and enforceable obligation upon counsel to relay all offers to plead out a case extended by the prosecution to the defendant. This duty of counsel is coupled with an obligation by defense counsel to provide competent and factual legal advice to the defendant whenever such an offer is made (Gideon, 2012).

The leading case cited in the Lafler decision is Strickland v. Washington, 466 U.S. 668 (2004). The key holdings of the Strickland case were:

- the Sixth Amendment guarantees the right to the effective assistance of counsel;
- this right is measured by whether counsel's conduct sufficiently undermined the functioning of the adversarial process that the trial cannot be relied on as having produced a just result;
- a claim that counsel's assistance was so defective must show that counsel's performance was both deficient and deprived the defendant of a fair trial;
- the deprivation of a fair trial is determined by a two-prong test for evaluating ineffectiveness claims:
first, that counsel's representation fell below an objective standard of reasonableness according to prevailing professional norms; the inquiry is case specific and context driven, taking into account all the circumstances, and

second, the defendant must demonstrate prejudice that there is a reasonable probability, but for counsel's unprofessional errors, the result of the proceeding would have been different ("Strickland v. Washington," 1984).

*Strickland v. Washington* was the leading case on attorney performance and framed the issues in a specific manner for several decades. The *Lafler* case presented a different issue – that counsel deficiencies in the pretrial stages lead to a fair trial, but that the trial would not have occurred but for the incompetent counsel and advice given ("Lafler v. Cooper," 2012). When you measure the case result’s prejudice and deficiency of counsel by the fairness of the trial, the issue of competent pretrial practice and effective advocacy is lost. The *Lafler* case presented issues that evaded review under *Strickland*: pretrial advocacy and advising when trial is not the anticipated result.

**D. Correctional System Resources and the Mentally Ill**

Many people who were placed in psychiatric treatment in prior decades are now behind bars into jails and prisons. At least one report estimates that 24% of inmates in state facilities are mentally ill and 16% had serious mental illness. Other reports claim that this underreports the real figures on the projection that many offenders with mental illness remain unidentified at the time of entry to the facility (O'Keefe & Schnell, 2007).

Due to the high number of mentally ill persons held by jails and prisons, identified and unidentified, and inadequate budgets, the resources and treatment programs are stretched thin when additional inmates need mental health treatment. Budget constraints, limited staff, and
shortages of mental health workers means that many prisoners in need of mental health treatment do not receive services. This compounds the problem by providing less treatment and services to those identified and no meaningful treatment to those later identified (O'Keefe & Schnell, 2007).

The end result of the inadequate or lack of treatment compounds and aggravates nearly all aspects of the serious mental illness (White et al., 2006). The combination of a failure to provide treatment and the nature of correctional environments is a substantial factor in the cycle of re-arrest and recidivism and many of mentally ill become an ever greater burden on the physical, organizational, and financial resources of the criminal justice system (White et al., 2006).

E. Resource and Dollar Costs

Using the criminal justice system to provide services to mentally ill persons is both expensive and draws resources away from the primary mission of each agency involved. In Florida alone, transporting the tens of thousands of mentally ill to psychiatric facilities for evaluation requires at least two police officers and one vehicle on each occasion. The annual count of individuals transported for evaluation exceeds the arrests for many serious offenses. Further, in many cases where psychiatric resources and evaluations are not available, the only option for officers is a custodial criminal arrest in the absence of other less restrictive or effective solutions (Lurigio & Harris, 2008).

Resolving incidents of the mentally ill through arrest, in Florida and elsewhere, triggers a long sequence of actions throughout the criminal justice system. Each arrest requires processing by the local police station or jail, holding and transport of the person (perhaps overnight), processing by the local criminal court through the probation and criminal clerk’s offices, and thereafter into a court session with court officers, prosecuting and defense attorneys, and a judge
(Lurigio & Harris, 2008). The individual case does not burden these systems any more than a grain of sand makes a beach. In the aggregate, hundreds of thousands of arrests passing through the criminal justice system daily and the proportional resources that these cases draw is significant. In the 1980s, Los Angeles police officers spent almost 20,000 hours on a monthly basis responding to calls involving the mentally ill. Similarly, people brought into emergency rooms by the police represented more than 30% of the psychiatric admissions in New York and Los Angeles (Lurigio & Swartz, 2000).

In the correctional system, where pretrial detainees and convicted offenders are held, the costs of both management and treatment of mentally detainees add up rapidly. In Miami-Dade County alone, police spent almost $4 million annually on overtime to manage mentally ill detainees (Perez et al., 2003). A study of the Santa Fe Police Department per prisoner expenses reported mentally ill detainees accounted for 95.6% and 87.1% of the detention expenditures in the two years studied (White et al., 2006). For better allocation of public resources, efficient use of jail and prison budgets, and therapeutic efficacy, the high number of seriously mental ill prisoners and the expanding costs of detention and treatment warrant action (Steadman et al., 2009).

F. Indirect Costs

Mentally ill defendants cause resource allocation responses on the basis of the problems presented. Police departments shift resources through the dispatch process and respond to exigent mental health issues every 6.5 minutes (Lurigio & Harris, 2008). These allocations are within existing resources and each crisis diverts officers from other needs. However, the problem of mentally ill offenders does not drive a change in manpower allocation or staffing levels. The
costs remain, but they are not distinguished from the overall task of policing all problems that arise.

For probation agencies, rising numbers of mentally ill probationers has prompted change in recognition of the issue. Many probation departments created specialty caseloads with an altered ‘model’ of probation supervision, specialized training for the officers, community and agency resources are integrated into supervision plans, and the caseloads are cut in half. The results demonstrate more effective supervision of the mentally disordered probationers (Louden, Skeem, Camp, & Christensen, 2008). Study of these specialty caseloads supports their use but ignores the economic impact of their adoption. In an office shifting from traditional supervision caseloads to specialized caseloads, the average probation caseload could easily be 100 cases per officer. If there are ten probation officers handling 1,000 cases, when five transition to the altered model, those officers have fifty cases each and supervise 250 probationers total. The officers that remain with the traditional supervision model have an average of 150 cases each – there is no change in resources allocated to the department, only within the department. The change within the department decreases the supervision resources available to serve the other 750 cases supervised by the five officers using traditional supervision methods. Little speculation is needed to predict a decrease in effective case supervision of the larger number of cases.

G. Non-Compliance with the Americans with Disabilities Act

In 1999, the United States Supreme Court held that the Americans with Disabilities Act (ADA) covered mental illness and developmental delay as a disability and that no individual with a disability could be excluded from programs or benefits provided by a public entity on the basis of that disability. Beyond forbidding discrimination in the services provided by a public entity, the Supreme Court further held that the ADA requires public entities to make reasonable
modifications when necessary to avoid discrimination as long as these accommodations do not alter the services in a fundamental manner ("Olmstead v. L.C.," 1999).

Despite the ruling above, courts routinely violate the ADA because mental health disabilities are not readily observed compared to physical obstacles.

Following from the Olmstead decision, the Supreme Court specifically held that the ADA requires that all judicial facilities and services, including the provision of counsel to the indigent, be accessible to all without regard to disability in accord with the Supreme Court decision in Tennessee v. Lane, 541 U.S. 509 (2004)("Tennessee v. Lane," 2004). This case, interpreting both the ADA and the 14th Amendment [sections 1 (due process clause) and section 5 (Congressional power to enforce 14th Amendment through legislation)], incorporates provisions of the 1st Amendment (meaningful access to criminal proceedings) and the 6th Amendment (confrontation clause) (Cress, Grindstaff, & Malloy, 2006). The judicial process meant is to administer justice, not merely determine guilt and punishment. The ADA is part of the legislative environment giving rise to mental health courts and other specialized services for mentally ill defendants. When defendants do not receive equal access to and administration of justice through the court system, an ADA violation occurs (Cress et al., 2006).

Under the ADA, mental illness falls within the definition of disability and requires accommodation of those brought before the court, detained, or sentenced in criminal cases. The ADA does not require complete accommodation of all disabilities but requires that public entities, including courts and judicial processes, identify and remove barriers that interfere with or preclude provision of and access to public services (Rubin & McCampbell, 1995). While common application of the ADA is that screening processes and criteria cannot bar those entitled to services without ADA-compliant justification, the inverse situation arises: the failure to screen
for mental health disabilities in the defendant population means that the appropriately tailored
counsel services for indigent mentally ill defendants are not provided by the courts in the
administration of justice or appointment of counsel.

The Supreme Court’s decision in *Tennessee v. Lane*, 541 U.S. 509 (2004), does not
require that all means available be used to resolve access to justice by the disabled("Tennessee v.
Lane," 2004). The Court held that the ADA requires courts to make reasonable modifications
that do not otherwise fundamentally alter the nature of services provided or incur undue financial
or administrative burdens so that judicial services and the benefits thereof are made available to
the disabled (Cress et al., 2006). It is insufficient to merely provide counsel to an indigent
defendant identified as mentally ill. The ADA requires that no one be denied the benefits of the
services, programs, or activities of a public entity by reason of the disability. Once a mental
health disability is identified in a defendant, the ADA requires that a defense attorney qualified
to help deliver accessible judicial and defense services be appointed (Cress et al., 2006).
However, this obligation is only realized through screening practices implemented prior to
arraignment and appointment of counsel. In the absence of any screening process, there is no
obligation to provide accommodation to would both assure equal access to justice and the
services of counsel required under the Constitution (Cress et al., 2006).

An issue emerges from a conflict between the *Olmstead* decision and earlier decisions of
the Supreme Court permitting defendants acquitted by reason of mental illness and held in
locked psychiatric facilities for periods for beyond the maximum penalty if found guilty of the
underlying offense. *Olmstead*’s holding required discharge of institutionalized persons, as a
qualified right under the ADA, to community treatment and services rather than ongoing
hospitalization in a state hospital. Application of “least restrictive alternative” principles to these
indefinitely detained acquitted defendants held in maximum security psychiatric facilities appears to mandate discharge of those originally charged with misdemeanors and non-violent felonies. Read in conjunction, the *Olmstead* decision appears to invalidate the statutes and court practices that mandate unending detention of non-violent and lower risk defendants. *Olmstead* does not preclude application to acquitted or untried mentally ill individuals committed under the color of criminal law to psychiatric facilities (Perlin, 2000).

Some reasoning of this nature exists and predates *Olmstead*. In, Jackson v. Indiana, 406 U.S. 715 (1972), the U.S. Supreme Court held that indefinite detention of criminal defendants lacking competence to stand trial violates the equal protection and due process clauses of the 14th Amendment of the Constitution. Comparing civil and criminal commitment statutes, as applied to untried criminal defendants who stood unconvicted of the underlying offense, prompted a finding that a defendant cannot be held more than a reasonable period to determine whether it is likely that he will attain competency. If the defendant will not attain competency in that reasonable period, the State must release the defendant or commence civil commitment proceedings (Kaufman, Way, & Suardi, 2013). While this provides some measure protection and relief for mentally ill defendants who have not been convicted of their underlying offenses – it provides no immediate relief for defendants indefinitely detained after acquittal by reason of insanity.

**H. Efficacy of Mental Health Treatment for Criminal Defendants**

For many defendants identified and diagnosed with serious mental illness, a pretrial order or the resolution of the case requires that the defendant receive mental health treatment. Numerous studies demonstrate reduced recidivism based on effective treatment interventions for offenders remaining in the community. Beyond the reduction in recidivism, defendants in
treatment achieved higher levels of independent functioning, increased quality of life, and decreased their psychological distress and substance abuse (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005).

**I. The Vicious Cycle**

Many defendants are placed on community supervision, either probation or parole supervision, as part of the case. Nationwide, probation and parole supervision carries standard conditions of supervision (ex: maintain or obtain employment, no further criminal offenses) as well as ‘special’ terms directly related to the defendant or offense involved (ex: remain free of illegal drugs and/or alcohol, remain medication and treatment compliant, ‘stay away,’ ‘do not drive’). Violation of any term of community supervision triggers revocation proceedings and the risk of incarceration. Defendants with mental illness fail to meet the terms of community supervision at much higher rates than those without such disorders (Feucht & Gfroerer, 2011). This only triggers a re-cycle through the police, court, counsel, corrections and/or community supervision.

Judges and probation staff struggle with limited dispositional options for defendants who fall between the categories of seriously mentally ill and not mentally ill. Many defendants are not mentally ill enough to compel court action for services but remain too ill to ignore. The court and probation staff have few community resources to draw upon and those that exist are over-taxed. Attempts to fit these mid- and low-range mentally ill defendants into standard supervision models and programs commonly results in complications in the mental health disorders, failed compliance with community supervision rules, and a return to court for further or increased sanctions (Lurigio & Snowden, 2009).
For the mentally ill defendant who avoids incarceration or is released from custody, compliance with community supervision (probation or parole) terms present the next obstacle to disentangling from the court system. Untreated or inadequately treated mental health issues are an effective predictor of recidivism (Rich, 2009). When combined with a substance abuse disorder, the existing mental health issues nearly guarantee arrest for a new offense or terms-of-supervision violation. Compliance with supervision terms are difficult for many probationers. A combination of factors conspire against the mentally ill probationer / parolee: supervising officers unable to distinguish symptoms of mental illness from criminal behavior, reentry to the community from incarceration and the changes in routine and structure, and the interruption of stabilizing medications provided either through care prior to arrest or during custody, among others. The opportunities for failure are frequently too much to avoid. While these stressors alone may not lead directly to probation / parole revocation, it is almost certain to exacerbate stress that will cause revocation as a secondary consequence (Rich, 2009).

Even for those defendants released from incarceration without parole or probation supervision, in the absence of meaningful mental health treatment or post-release aftercare (assuming some treatment was provided while incarcerated), mentally ill offenders routinely return to incarceration in only half of the time that other offenders do. This process of re-institutionalization, cycling from incarceration to the community and back again is a significant draw upon the publicly funded police, courts, prosecution and defense functions, and jails without any proportional benefit. Further, of those offenders released with community supervision, the majority will return to incarceration on a technical violation (a violation of release terms that is not a new criminal offense) without committing any new crimes (Cloyes, Wong, Latimer, & Abarca, 2010).
Many of the mentally ill are re-arrested for their behaviors and end up warehoused in city and county jails on a recurring basis (Markowitz, 2011). This is a non-trivial consideration. In an analysis of Washington state adult prison releases, new charges and probation / parole violations occurred among 70% of people with serious mental illness after leaving prison; similarly, analysis of Maryland adult prison releases showed 73.3% of mentally ill offenders were rearrested in a 5 year period both in statistically significant contrast to the non-mentally ill release population rearrest rate of 65.4% (Wilson, Draine, Hadley, Metraux, & Evans, 2011).

Despite the distressing paths to re-offense and recidivism described above, administration of a screening process and mental health treatment intervention administered through court supervised processes is effective in two ways. Upon screening and identification of defendants with mental illness, directing the defendant into specialized court processes reduced rates of re-offense. Additionally, for those defendants that do re-offend after screening and specialized adjudication, it led to longer times between adjudication and new offenses (McNiel & Binder, 2007). In contrast, mentally ill offenders receiving sentences to jail or prison reoffend at higher rates and much sooner than those receiving treatment while on community supervision (Castillo & Alarid, 2011).

J. Opportunities

Early identification of mentally ill offenders and intervention through mental health treatment demonstrates that public interest and therapeutic objectives can be achieved without compromising each other. Mental health courts, which are premised on early identification of the mentally ill offenders for proper case assignment, were created to address court inefficiencies arising from this population. The targeted issues of reducing detention time for defendants and
providing access to mental health treatment were balanced against public safety concerns (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005).

A program targeting unnecessary periods of detention for mentally ill offenders reduced detention days in Broward County by almost 90% (from an average of 23 days prior to program intervention to an average 3 days post-program intervention) and decreased the incidence of arrests for the target group compared to other arrestee populations. Applying the results to the samples listed in the study shows the pre-intervention sample as 116 defendants were detained an average of 23 days each while the test sample of 101 defendants were detained only three days on average (Christy et al., 2005). Data presented by the Broward County Sheriff’s Department listed cost per offender in Broward County as $113/day and $41,425/year per as July, 2012 (Ludwig, 2012). Extrapolation of the days saved through program intervention (101 defendants * 20 days saved) equals 2,020 offender days (approximately 5.53 years) or, at the rates listed, a savings of $228,260 through that program alone.

The basic analysis of these findings are that intervention based on early identification of mentally ill offenders saved unknown expenses and hours in reduced court and jail time, unnecessary days of detention, reduced recidivism for defendants, decreased rearrest by police, all while not depriving defendants of constitutional rights or harming public safety (Christy et al., 2005).

Understating a significant problem with mental health courts and jurisdictions with programs for diverting offenders with mental health issues out of the criminal justice system is the same fundamental issue that drives this research – the failure to identify those defendants with mental illness. As with the discussion of ADA issues as applied to programs and services for the mentally ill, there is no uniform identifying factor for mental illness. Mental illness
cannot be readily identified in the manner to that of physical disabilities. A physical disability is identified by the difficulty encountered in the face of physical obstacles and barriers to action. Such disabilities are consistent and commonly seen in casual observation. Mental illness carries a stigma that encourages concealment and denial.

Even when mental illness is identified and attempts are made to divert defendants into mental health courts, there exists no model for procedures and adjudication. Individual courts set differing policies for acceptance into an alternate judicial process and provide varying levels of executive power over acceptance and adjudicatory procedures. Additionally, the mental health courts rarely have any ability to reach outside the court process to address social service policies and failures that place the mentally ill at risk of arrest (Bernstein & Seltzer, 2003).

The variations between mental health courts include rejection of defendants charged with certain offenses (e.g., felonies, sex offenses, weapons offenses), some accept mentally ill offenders while rejecting defendants with head trauma or developmental delays. Training of judicial staff, prosecutors, and defense counsel varies widely. There are implied and potential Constitutional violations arising from the partial or lack of competency of many mentally ill defendants who lack meaningful understanding of the voluntary transfer issues, procedural and due process differences of the mental health court. In many cases, the courts lack defined standards for the scope and length of supervision, what supervision by the court requires of the defendant, and the range of sanctions for non-compliance with court orders, programs, and services. There remains conflicts inherent to the required disclosures of medical and psychiatric treatment of the defendant and the range of disclosures and information-sharing conducted by the court of this personal data (Bernstein & Seltzer, 2003).
Despite this discussion of issues and opportunities, at least in Massachusetts, the mental health session in the one of the busiest courts in the Commonwealth diverts far less than one percent of the arraigned cases. The Annual Report on the State Of The Massachusetts Court System describes the operation of “voluntary Mental Health Diversion Initiative in operation since 2007” at the Central Division of the Boston Municipal Court. This session is limited to defendants charged with misdemeanors or non-violent felonies (Commonwealth of Massachusetts, 2013a). This selection criteria, the voluntary nature of transfer, and the low rates at which mental illness is identified in the defendant population severely restricts the rates of diversion from the criminal session into the mental health court.

In the three most recent Annual reports (the method of reporting this data changed in the FY 2010 to reflect diversion transfers; prior reports only listed the number of current cases without reporting the number of transfers), the rate of diversion of criminal cases into the mental health session fell consistently below one percent of criminal cases handled.

<table>
<thead>
<tr>
<th>Year</th>
<th>Criminal Cases</th>
<th>Diverted to Mental Health Court</th>
<th>Percentage Diverted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12,587 (Commonwealth of Massachusetts, 2011b)</td>
<td>82 (Commonwealth of Massachusetts, 2011a)</td>
<td>0.65%</td>
</tr>
<tr>
<td>2011</td>
<td>13,348 (Commonwealth of Massachusetts, 2012b)</td>
<td>86 (Commonwealth of Massachusetts, 2012a)</td>
<td>0.58%</td>
</tr>
<tr>
<td>2012</td>
<td>13,488 (Commonwealth of Massachusetts, 2013b)</td>
<td>79 (Commonwealth of Massachusetts, 2013a)</td>
<td>0.58%</td>
</tr>
</tbody>
</table>

K. Summary

Drug courts were the first model for judicial response to defendants with serious mental illness. However, as successful as drug courts are, they work because of the factual underpinning of drug-involved individuals. When a defendant is arrested and brought before the court for a
drug offense, the substance abuse problem is documented by the nature of charge. There is no analogous crime of mental illness. The ability to make a prompt identification of mentally ill defendants and make rapid placement for services is absent due to numerous factors discussed in the preceding pages (Lurigio & Snowden, 2009).

Mental health issues are present in the national population and pervasive in many sub-populations. Research by the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that in 2010, 20% of the adult population of the United States (age 18 or older) had some form of mental illness (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria and 5% had serious mental illness. A serious mental illness is defined by its sufficient duration to meet diagnostic criteria and has resulted in serious functional impairment which substantially interferes with or limits one or more major life activities (Substance Abuse and Mental Health Services Administration, 2012).

Despite the large percentages of the population with mental illness, the extent of these issues in many identified sub-populations is much greater. One group likely to have a disproportionately high level of interaction with the criminal justice system are the homeless population. Florida highlights the nature of this issue. Following the documented trend that correctional facilities hold more mentally ill individuals than hospitals, Florida jails hold more than 10,000 mentally ill inmates – five times the number of people in Florida’s psychiatric hospitals. While Miami-Dade County has the highest percentage of people with mental illness of any urban area in the United States, approximately 9% of the total population in Miami-Dade suffers from a mental illness it is markedly worse for the homeless. Nationally, 33% to 50% of the homeless suffer from serious mental illness, while 45% of the homeless in Miami-Dade
region suffer from some sort of chronic mental illness or dual diagnosis of mental health and
substance abuse (Perez et al., 2003).

The presence of mental health issues is an effective predictor of problems encountered
with the criminal justice system. For the adult population of the United States (age 18 or older),
individuals with serious mental illness are imprisoned approximately eight times more frequently
than they are admitted to state mental hospitals; if incarcerated, it is for significantly longer
periods than other inmates without serious mental illness (Ascher-Svanum, Nyhuis, Faries, Ball,
& Kinon, 2010). Applying that predictive power to Miami-Dade County, where nearly 200,000
people (9% of the population of approximately 2 million) reportedly suffer from a mental illness,
prompts the observation that the resources consumed through incarceration and hospitalization
are enormous (Perez et al., 2003).

Examining the presence of mental health issues in criminal justice populations yields
distressing values that explain the high costs of police, courts, and corrections. Of the individuals
arrested in Brooklyn, NY, 22.1% had serious to moderately serious mental health disorders
(Redding, 2004). Yet, in the next step of the criminal justice process, arraignment, defense
attorneys stated significant concerns about client competence in only 8% to 15% of cases
(Redding, 2004).

In local jails, housing pretrial detainees and defendants on non-prison sentences, mental
health issues are greater still:

- Riker’s Island, NY: 34-40% of daily population has serious mental illness (Kerle, 2012);
- Miami-Dade County jail: 20% of inmate population receives psychiatric medication (Perez et
  al., 2003);
- Florida jails: Florida jails hold five times as many mentally ill inmates as there are occupants in all Florida psychiatric hospitals (Perez et al., 2003);

- Jail and prison inmates (nationally): 35% have mental health disorder ranging from serious mental illness to less serious disorders (Redding, 2004), over 50% of inmates reported symptoms that met the criteria for serious psychiatric disorder (Rich, 2009).

  In prisons, where all individuals held are sentenced on felony level offenses which carry longer terms of incarceration, the trend shown in the jails continues:

- Massachusetts adult correctional facilities: As of June 30, 2000, 3% of inmates are in 24-hour psychiatric units (309), 21.8% are receiving mental health therapy (2271), 12.7% are receiving psychotropic medications (1331) out of a correctional population of 10500 (Beck & Maruschak, 2001);

- New York (state) prisons: Sampling of over 3000 prisoners found that 80% had disorders requiring treatment (Redding, 2004);

- Michigan prisons: 31% of prison population requires psychiatric care (Redding, 2004);

- State adult correctional facilities of Hawaii, Maine, Montana, Nebraska, and Oregon: 20% of inmates receiving psychotropic medications (Beck & Maruschak, 2001);

- State adult correctional facilities of Louisiana, Nebraska, Maine, and Wyoming: 25% of inmates receiving psychotropic medications (Beck & Maruschak, 2001);

- All adult correctional facilities (pretrial detainees and sentenced): approximately 70% of commitments have active symptoms of serious mental illness (Redding, 2004) while 40% of inmates reported symptoms that met the criteria for serious psychiatric disorder (Rich, 2009).

  As an overview of the criminal justice system, when adults in state criminal justice systems (defendants, probationers, parolees, incarcerated, detained) are considered, meta-
analysis reports that 6.4% to 14.5% of men and 12.2% to 31.0% of women have a serious mental illness (Beck & Maruschak, 2001). Consideration of these same issues of inmates in federal correctional facilities shows that 20.2% to 25.1% of inmates have serious mental illness (17.6% to 21.2% of males; 29.2% to 38.6% of females) and approximately 1 in 7 new male prisoners and 1 in 4 new female prisoners are expected to meet serious mental illness criteria (Magaletta, Diamond, Faust, Daggett, & Camp, 2009).

3. Methodology

A. Hypothesis

Are mentally ill defendants under-identified and underserved by their counsel in the district court compared to the incidence of mental illness in the American adult and correctional populations? If they are under-identified, this failure of counsel to identify defendant mental health issues hinders the effective assistance of counsel. The unidentified issue fails to trigger the needed response: effective advocacy to resolve the problem or accommodate it in a criminal case disposition.

In short, the defendants with mental illness are under-identified, their needs relevant to the criminal justice system are underserved, and adverse outcomes are more likely (Lurigio, 2001). It is a logical conclusion that, for those defendants who remain unidentified as mentally ill, their needs go totally unserved. Further, for the defendants who are identified as having mental illness, the absence of effective screening and response mechanisms, means that full service of their needs will similarly be underserved.

I. Hypothesis: Mentally Ill Defendants Are Under-identified

This research arises out of personal observations and anecdotes related by judges, attorneys, and defendants of the representation provided to mentally ill district court criminal
defendants. The observations and anecdotal reports support the conclusions that attorneys appear unable to identify mental health issues in their clients and, even after identifying such issues, have difficulty providing effective representation. Thus stated, this research focuses on a primary question: compared to the rate of mental illness found in the American populace and American jail population, to what extent are criminal defense attorneys able to identify mental health issues in their clients?

II. Hypothesis: Mentally Ill Defendants Are Harmed By Defense Attorneys Lacking Training and Skills

On the assumption that defense attorneys lack the training and skills to identify mental health issues in their clients, the question arises, what harms occur from this lack of training and skills when a defense attorney is faced with a client with mental health issues? To what extent do such defendants suffer from this lack of training and skills? Compared to defendants without mental health issues:

- Are there delays in resolving the cases?
- Are these cases resolved in a similar manner?
- Are these cases reaching the same dispositions?
- Are these defendants received similar sentences?

The answer to the primary question, the extent to which mental illness is identified by attorneys in their clients, is resolved through a combined qualitative / quantitative analysis of district court criminal dockets and reference to mental health issues in the arraignment, pretrial events, motion practice, and dispositional terms of each case. The results of that sampling and evaluative process are compared to national averages.
The answers to questions about the cases where mental health issues are identified is resolved through a quantitative analysis of case details (offense data, case events, resolution, disposition, sentence, etc.) from the district court criminal cases used to resolve the primary question.

**B. Data Gathering**

The data gathered to address these questions comes from three district courts in Essex County, Massachusetts. These district courts, which hear misdemeanor cases and minor felony cases through their conclusion, in Salem, Peabody, and Haverhill, process approximately 9000 cases annually. The selection of these courts is based on the proximity of the courts to the researcher and that these courts reflect diverse populations by range of ethnicities, geographic characteristics, and court staffing composition. It is anticipated that, due to the number of cases retrieved, different populations represented by each court’s geographic jurisdiction, the samples are from three of the county’s eight district courts, and high sampling rate from these courts, that these results are generalizable to both the Essex County population and the state’s overall population as well.

Cases are from those filed in calendar year 2009 as they likely resolved through to a final disposition by the time of this study. The sampling method is a systematic selection (Levin, Fox, & Forde, 2010). The specific method retrieved every fifth case in sequence for a sample rate of 20% of the population of cases.

The specific detail data is not stored in a central or public repository other than in paper form at each courthouse. This required manual selection and retrieval of 1,842 files for review.

From the 1,842 cases, a variety of data was gathered (see data gathering instrument at Appendix 1). For each case, notation was made of the court, docket number, attorney, key dates
(offense, complaint, disposition), specific charges, details of case disposition, disposing judge, charging police department, and whether the charges filed fell into certain statutory categories, involved allegations of domestic violence, and whether there were any indications of any mental health issue identified. For each case, the data gathered included the defendant’s hometown, date of birth, and gender.

Of the 1,842 cases from which data was gathered, 1,101 were valid cases for purposes of this study (represented by counsel). This research used no surveys or questionnaires, as the objective data available from official records of cases is empirical compared to subjective perceptions of attorneys on their performance in the process of identifying mental health issues and providing effective representation.

The specific data gathered and the collection instrument were designed to gather information related to the nature of the case, representation provided, potential mental health issues, and dispositional possibilities.

Most of the data gathered are independent variables unrelated to the direct area of study but included for points of analysis of issues collateral to the cases (ex: defendant hometown). Several of the fields have no bearing on the research but were included for purposes of data verification in the event of data anomaly or data entry error (ex: defendant name, docket number). The key dependent variables are the indications of mental health issues and the dispositional data. These mental health variables are driven by events in the case that highlight the potential for the existence of mental health issues (ex: does the attorney or anyone else identify behavior indicative of mental health issues?); the dispositional variable can be influenced by almost all of the independent variables and numerous other factors for which data could not be gathered (ex: defendant’s race is not stored in public records).
Upon gathering the information, one person reviewed and entered all data to assure minimal variance in interpretation of the data gathering instrument. Testing of the data by direct review and sort processes verified the ranges of data collected (ex1: by law, defendant’s age cannot be less than 17 for adult jurisdiction; a calculated age of less than 17 indicated a data collection or entry error; ex2: certain charges are outside the final jurisdiction of the district courts, sorting by chapter and section of the charges alleged highlighted those offenses not within district court authority).

C. Site and participants

As this is a collection of data from public records continuously maintained and stored as the official records of criminal proceedings, there are no participants in this study. Although this involves a retrospective analysis of public proceedings in criminal matters of the district courts, the potential for embarrassment or perceptions of confidentiality is significant. For this reason, the names of the people whose cases were systematically selected were never stored in the dataset. Further, prior to subjecting the dataset to statistical analysis and reporting, the data were reduced to partial anonymity by eliminating any reference to docket number as that is the only uniquely identifiable attribute to a specific case.

As discussed above, the district courts selected for this study were chosen for their relatively high volumes of cases processed (over 9000 cases annually) and their diverse nature. The selection criteria was based on the calculations of a high confidence level and the known population of approximately 9000 cases. Oversampling at a rate of 1:5 was expected to provide both a statistically valid sample and increase the likelihood of sampling-in those cases with identified mental illness for use in quantitative analysis. As performed, a population of 9000 (all
criminal cases in these three district courts in 2009) and a sample size of 1,842 is a sampling rate at a 99% confidence level, and a confidence interval of approximately 2.14.

Analyses on the basis of case and defendant factors are pre-defined by the case or defendant characteristics; there is no analysis based on researcher-based arbitrary designations.

**D. Data Collection: Procedures and instruments for data collection**

In addition to the issues and factors discussed above, the remaining issue involves concern for protection of confidentiality in these records. Although the records reviewed are public records (open to public inspection and view during regular business hours) there is the potential for stigma or embarrassment arising out of the study. As this study focuses on criminal defendants who are mentally ill, both designations (as mentally ill and criminal defendants) carry substantial public stigma, careless disclosure of public records addressing either issue was avoided. To that end, data used in the analysis omits the name of each defendant and analysis of these records results only in aggregated information from which no individual can be identified. Further, in accord with the Northeastern University Institutional Research Board approval (IRB #12-03-16, approved as Exempt, Category #44), upon completion of this research and any audits or review of the raw data, the original data gathering instruments will be destroyed. Any resulting publication or dissemination of this research will not uniquely identify any individual directly or through any combination of factors.

**E. Data Analysis: Procedures and models for data analysis**

Due to the nature of the data collected, there is no subjective or evaluative event that is subject to interpretation. The event of being charged with a crime makes each individual in this population and sample a defendant. The charges filed designate the classification of the offense
(ex: all Chapter 265 offenses are crimes against persons, all Chapter 94C offenses are controlled substances crimes). The one area that outwardly appears subjective is the existence of a mental illness. Using objective factors for the “identification” of a mental illness in these records indicates that there were flags of the issue but is neither conclusive to its actual existence nor a reliable indicator of the original reporter. There will be some false positives identified in these “flags” of mental illness. The accuracy and source of those flags is irrelevant to this study as it is assumed that all factors are identified by the defense attorney. The existence of such flags is only an indication that an issue was observed and not that a mental health issue was considered and validated by a qualified clinician. As this study focuses on the ability of counsel to identify these issues, false positives indicate that counsel are watching for these issues, regardless of their ability to spot or respond to them. The “flags” for mental health issues are docketed events of motions for funds for related issues, commitments to mental health facilities, and dispositional terms or references to mental health treatment. The existence, or lack, of these docketed conditions is not subjective and no judgment of the merits of these docket entries was made. Based on the primary and non-subjective nature of the data collected, coding of the data into other subjective variables was unnecessary.

The quantitative analysis of valid cases examines the identification by counsel of mental health issues in the defendants represented. Comparison of the rates of identification of mental health issues in the defendant sample is to national rates of reported mental health issues of 8.3% (Epstein et al., 2004), up to 35% in custodial corrections (Redding, 2004) among others. Additional analysis of the data sought correlations between the existence of mental health issues and offenses of violence and/or drugs, as well as the possibility of additional unforeseen
relationships between charging data, dispositional times, and other demographic aspects of the samples.

The specific mechanism of statistical testing employed was correlation and chi square analysis. The $t$ ratio testing is a comparison between two mean values for samples and assumes normal distributions within the data and that data are presented in an interval format, rather than the types of data collected in this study. The dominant forms of data gathered for analysis were either nominal or aggregated into nominal values and do not lend themselves to meaningful numeric coding. Interval coding, as would work in $t$ ratio testing, would cause a complete loss of meaning (ex: where interval value 1 equals guilty or incarcerated and 2 equals not guilty or not incarcerated, 2 does not represent a value that is “twice” that of the other value). Any $t$ ratio testing would create false conclusions rejecting or affirming the null hypothesis without validity for either conclusion. The chi square analysis is well suited to this study as the data do not have a normal distribution in the population sampled, the data are represented in nominal or cardinal forms, and the chi square analysis, as used in SPSS, using observed frequencies rather than expected frequencies and avoids either expecting or requiring a “normal” distribution for effective analysis. The weakness of chi square testing in this study is that the analytical power is impaired by small cell frequencies. When it was possible to aggregate cells for greater values to overcome this weakness without defeating the purpose of the analysis, such aggregation was performed.

**F. Validity and Reliability**

The limitations of this study are multiple. Most notably, this is a sample from three of eight courts of one county of one state. Due to the large sample gathered and methods of gathering and analysis, the study has internal validity. Despite this, the limited size, compared to
greater geographic regions available (other courts within the county, state, nation), the results
cannot be directly applied to the national population of criminal defendants or court processes.

Further, for purposes of this study, all points in the criminal justice system at which the
issues of mental health in a defendant could be flagged are attributed to the defense attorney.
This is likely to inaccurately give credit to the attorney when the issues may have been identified
by another party (victim, witness, police officer, probation officer, court officer, or judge). This
inaccuracy is irrelevant because the rate of identification is low despite these potential false
credits. The more pressing concern for the validity of the study is that, even at the rates of mental
health issues found in the American public (Epstein et al., 2004) and custodial corrections
populations (Redding, 2004), a sample of these cases at 20% (1:5) may miss some of the small
number of cases where mental health issues are reported. In the absence of ability and resources
to retrieve these records electronically or sample at a higher rate, there is no mechanism to
resolve this potential error.

Through analysis and examination of the data, it is expected that other potential
weaknesses in the sampling method or analytical constructs may be exposed and resolved. The
primary threat to the reliability of this study is that this researcher, as an attorney among the
attorneys that are the indirect subjects of this study, would be viewed as sympathetic or biased in
favor of his fellow counsel. In response to that potential criticism, it is observed that the title and
focus of this research is critical and seeks to improve the practices employed by these same
attorneys and emerges from a perspective critical of the current practices to identify and provide
representation to mentally ill criminal defendants.
G. Public Policy Advocacy

Any solution must address the identification and advocacy issues. The task of identifying mental illness in defendants should fall on the defense attorney to ensure their legal advocacy complies with Constitutional provisions, professional, and ethical standards. Early identification of a defendant’s mental illness would increase the quality of legal advocacy while decreasing direct and indirect costs, inappropriate dispositions, and eliminate the vicious cycle of returning to court for probation violation or re-arrest.

The solution to this problem is to choose, deploy, and use an effective and time-efficient screening instrument to identify the mentally ill defendants while concurrently implementing greater training and certification requirements on the counsel providing representation to all defendants. In this manner, counsel improve their abilities to identify and respond to the advocacy needs of defendants with mental health issues.

The opportunity to reduce the delays and excess costs that are burdens upon both society and the defendant, as well as the substantive harms suffered primarily by the defendant, could be addressed in many forms and at many points in the criminal justice system. The Committee for Public Counsel Services (CPCS), under the supervision of the Supreme Judicial Court of Massachusetts, provides counsel for indigent defendants in Massachusetts ("Committee for Public Counsel Services," 2011). Approximately 90% of the criminal defendants in Massachusetts are indigent and receive their representation through CPCS (Commonwealth of Massachusetts State Auditor, 2007). In this context, the burden and constitutional duty of the defense attorney is to effectively identify relevant mental health issues and zealously advocate for that client (De Sario, 2003-2004).
As the agency that provides counsel to indigent defendants, CPCS controls the training, standards, and supervision of defense counsel ("Committee for Public Counsel Services," 2011). This market power, combined with sole regulatory control under its enabling legislation, makes CPCS the only body in the state with the authority and resources to effect change in the training, skills, and resource materials of the attorneys who provide the representation ("Committee for Public Counsel Services," 2011).

The policy opportunity presented by this research is to provide feedback to the governmental agency that provides the programs, budgets and expends funds, and has the legislative authority to implement and require training. The conclusions reached by this analysis brings a specific problem to the attention of the agency, that a program in place has unidentified problems and requires a remedy. In the circumstances analyzed herein, there are conditions that resulted in problems – conditions becomes problems when there are needs identified that can or should to be solved (Kingdon, 2003).

The circumstances and immediate need for policy making in this analysis is that the problems presented, in this case of defendants with mental illness, are among a range of available alternatives to resolve. CPCS, as a government agency tasked with specific responsibilities, has numerous competing practical and policy issues to address. The issues in this research present problems of great personal and financial cost to the defendants and the state. The chances for a problem to move forward within an agency’s decision agenda improve significantly if solutions are readily available with smaller requirements for political capital or taxpayer expense (Kingdon, 2003).

Additional policy factors to consider are that CPCS is a small agency with a modest and comparatively flat administrative structure with short organizational distances between the chief
counsel’s office and the lawyers providing direct representation of defendants (Committee for Public Counsel Services, 2013a). Such a small administrative structure diminishes control loss and increases the ability of CPCS administrators to involve agency and other government stakeholders and build consensus to resolve such issues with a small number of decision-making participants without a significant need to accommodate other points of view. Most, if not all, of the decisions to implement solutions to problems can be resolved in a core group (Moran, Rein, & Goodin, 2008).

While there are numerous advocacy groups for specific segments of society that overlap the subject matter of this research, there is no effective advocacy for mentally ill offenders. There is advocacy for the mentally ill (National Alliance on Mental Illness, www.nami.org), the incarcerated (The Sentencing Project, www.sentencingproject.org), and even on the subject of mental illness and criminal justice but from the point of view of state governments seeking to reduce costs of prisons and courts (Consensus Project, www.consensusproject.org). There is no broad support or advocacy for indigent criminal offenders. These offenders are not typically voting, organizing advocacy efforts, or contributing to political campaigns. They commit crimes that victimize the members of society that vote, organize advocacy efforts, and contribute to political campaigns. The advocacy that exists is commonly person- or incident-based by family or friends of a specific mentally ill offender or arising from a recent incident or tragedy.

In Massachusetts, advocacy to identify solutions and implement them falls upon CPCS as the agency’s duties are to provide zealous advocacy to secure equal justice for the indigent people of Massachusetts (Committee for Public Counsel Services, 2011). Through the years of CPCS’ existence, the organization has been a significant advocate and organizational litigant on areas of criminal justice as those topics affect the population served including issues of funding
and compensation for indigent defense, regulation of sex offenders, and capital punishment (Committee for Public Counsel Services, 2013b).

4. Findings

Based on the data gathered, a number of analyses were performed to identify aspects of the sample population. The basic descriptive statistics for the data were that, of the 1,842 cases examined, only 1,101 were valid for purposes of the study.

The results of the analyses are compelling. Before a defendant with mental health issues steps into court to face the charges alleged, these defendants have statistically significant and greater delays in the number of days from offense to complaint, face higher maximum penalties, are charged with a greater number of offenses that carry a jail term, and are more likely charged with offenses of violence and public order violations.

Already dealt a variety of factual and procedural setbacks, mentally ill defendants are under-identified for their mental health issues compared to both civilian and incarcerated populations. The cases of defendants with mental health issues take longer to resolve, are more likely to violate court case processing time standards, more likely to resolve through a plea agreement, result in a Guilty finding, and receive a sentence that includes incarceration.

A. Research Questions and Analysis

I. Finding: Mentally Ill Defendants Are Substantially Under-identified

Based on comparative levels of mental illness found in the American populace and American incarcerated population, criminal defense attorneys representing the defendants in the study population were not successful in identifying mental health issues in their clients. Frequency analysis, shown in Table 1, of the sample data is that, of the 1,101 cases where a
defendant was represented by counsel, only 39 were identified to have any mental health issue (3.5%).

<table>
<thead>
<tr>
<th>Mental Health Issue</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>39</td>
<td>3.5</td>
</tr>
<tr>
<td>No</td>
<td>1,062</td>
<td>96.5</td>
</tr>
<tr>
<td>Total</td>
<td>1,101</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 1. Frequency of Mental Health Issue

It is unlikely that this populace and the findings made herein could be analogized to all defendants, attorneys, and courts in the United States, or even Massachusetts. However, these other populations are unlikely to be substantially different in that the United States and Massachusetts are relatively homogenous. While minor differences are likely in any regional comparison, the defendants, attorneys, and courts across Massachusetts and the United States are likely to be substantially similar except in those areas where significant efforts are already underway to identify and serve defendants with mental health issues.
<table>
<thead>
<tr>
<th>Reference Population</th>
<th>Identified mental health issues</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami-Dade County populace</td>
<td>9%</td>
<td>Perez et al., 2003</td>
</tr>
<tr>
<td>Miami-Dade County jail</td>
<td>20%</td>
<td>Perez et al., 2003</td>
</tr>
<tr>
<td>Brooklyn, NY arrests</td>
<td>22.1%</td>
<td>Redding, 2004</td>
</tr>
<tr>
<td>Brooklyn, NY arraignments</td>
<td>8 to 15%</td>
<td>Redding, 2004</td>
</tr>
<tr>
<td>Riker’s Island, NY</td>
<td>34 to 40%</td>
<td>Kerle, 2012</td>
</tr>
<tr>
<td>National jail &amp; prison inmates</td>
<td>35%</td>
<td>Redding, 2004</td>
</tr>
<tr>
<td>Massachusetts adult inmates</td>
<td>21.8%</td>
<td>Beck &amp; Maruschak, 2001</td>
</tr>
<tr>
<td>Federal corrections inmates</td>
<td>20.2% to 25.1%</td>
<td>Magaletta et al., 2009</td>
</tr>
<tr>
<td>State-level criminal justice systems</td>
<td>6.4% to 14.5% of men, 12.2% to 31.0% of women</td>
<td>Beck &amp; Maruschak, 2001</td>
</tr>
</tbody>
</table>

Table 2. Other Populations With Specific Identified Mental Health Issues

In comparison, as discussed in the literature review, other regions and jurisdictions using additional or different methods to identify mental health issues in their respective populations identify mental health issues at much higher rates. Clearly, the systems and methods used in the courts sampled lack the level of analytical power implemented in other locations, courts, and aspects of the criminal justice system. The populations listed in Table 2 that most closely compare to the data sampled in this research are the Miami-Dade County populace as it is an estimate of mental health issues in the entire regional population; Brooklyn, NY arrests as that is one of the most common points of entry to the criminal justice system and 67.6% of this study’s sample population entered the criminal justice system by arrest; and Brooklyn, NY arraignments as this this study’s sample population is comprised entirely of arraigned defendants and the analysis of case data follows from it.
II. Finding: Mentally Ill Defendants Are Significantly Harmed By Defense Attorneys Lacking Training and Skills

Based on the findings that defendants with mental illness are under-identified in the courts sampled, the analysis turns to the remaining questions. To what extent do defendants with mental health issues suffer because the attorneys lack of training and skills in representing such defendants?

There are two metrics for analyzing whether cases are resolved in a timely manner and move appropriately through the court system. First is to measure the cases with and without mental illness against each other. Second is to measure these cases against the time standards for case processing set by the district court.

Table 3 sets forth the analysis of cases with and without mental illness against each other. The “days to disposition” describes the length of time between filing of a criminal complaint and resolving the case (without regard to method of disposition) and the presence of mental illness. The case duration, or “days to disposition,” is grouped into 0 days (those cases resolved on arraignment date) and 30 day intervals for the first year and grouped into a single unit for cases where the disposition exceeds the year. The time intervals were analyzed against the presence of a mental health issue and chi square analysis showed statistical significance (p=.009). The result is that over 16% of the mental health criminal cases took more than a year to reach resolution. While a total of 55.7% of non-mental health issue cases are resolved in less than 120 days; 67.5% of cases with mental health issues are resolved in more than 90 days, 35.1% more than six months, and still 16.2% exceeded one year.
The second method, measuring the cases against the time standards set by the district court for case processing is determined by the maximum sentence that can be imposed in each case. There are two track designations for criminal cases in the District Court. “Track A” sets a standard that all criminal offenses punishable by no more than six months incarceration should be resolved within five months (150 days). “Track B” is for criminal offenses punishable by more than six months of incarceration and should be resolved within twelve months (365 days) (Trial Court of the Commonwealth, 2004). Analysis of the cases sampled, broken out by mental

<table>
<thead>
<tr>
<th>Days to Disposition</th>
<th>MH ISSUE</th>
<th>Y</th>
<th>N</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Count</td>
<td>0</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.0%</td>
<td>2.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>1-30</td>
<td>Count</td>
<td>4</td>
<td>120</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>10.8%</td>
<td>11.6%</td>
<td>11.6%</td>
</tr>
<tr>
<td>31-60</td>
<td>Count</td>
<td>2</td>
<td>162</td>
<td>164</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.4%</td>
<td>15.6%</td>
<td>15.3%</td>
</tr>
<tr>
<td>61-90</td>
<td>Count</td>
<td>6</td>
<td>141</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>16.2%</td>
<td>13.6%</td>
<td>13.7%</td>
</tr>
<tr>
<td>91-120</td>
<td>Count</td>
<td>10</td>
<td>127</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>27.0%</td>
<td>12.3%</td>
<td>12.8%</td>
</tr>
<tr>
<td>121-150</td>
<td>Count</td>
<td>2</td>
<td>97</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.4%</td>
<td>9.4%</td>
<td>9.2%</td>
</tr>
<tr>
<td>151-180</td>
<td>Count</td>
<td>0</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.0%</td>
<td>7.5%</td>
<td>7.3%</td>
</tr>
<tr>
<td>181-360</td>
<td>Count</td>
<td>7</td>
<td>227</td>
<td>234</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>18.9%</td>
<td>21.9%</td>
<td>21.8%</td>
</tr>
<tr>
<td>361 or more</td>
<td>Count</td>
<td>6</td>
<td>57</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>16.2%</td>
<td>5.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>37</td>
<td>1036</td>
<td>1073</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 3. Disposition Day Group by Mental Health Issue.
health status, demonstrates that the criminal cases with mental illness fail to meet the District Court Time Standards at a statistically significant (p=.024) and higher rate than other cases. Specifically, 16.2% of cases with mental health issues failed to meet District Court time standards compared to only 6.6% of other cases.

<table>
<thead>
<tr>
<th>Crosstabulation of Time Standard Compliance by Mental Health Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Time Standard</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

Table 4. Time Standard Compliance by Mental Health Issue.

Additionally, when the mechanism of case disposition is analyzed with consideration of mental illness, further issues emerge. This analysis, shown in Table 5, demonstrates that the defendants with mental health issues receive disproportionately more guilty findings compared to cases where the result entered is a CWOF (Continued Without a Finding, meaning that after the defendant makes an admission to the facts alleged, the case is left open for a period of time while the defendant is on probation), PTP (the case is left open for a period of time without the defendant’s requirement to make an admission), Dism/Decrim (the case was dismissed or decriminalized to a civil infraction), and Not Guilty.
The adverse findings of Guilty and CWOF, findings that require admissions by the defendant to the facts of the case or adverse trial results, occur at a disproportionately high rate for the defendants with mental health issues. Logically, there are disproportionately lower favorable dispositions (pretrial probation, dismissal, decriminalization, not guilty). This higher proportion of adverse findings and lower proportion of favorable findings for the defendants with mental health issues is statistically significant (p=.000). More specifically, 72.3% of the defendants with mental health issues received adverse dispositions while only 63.3% of the other defendants received such dispositions. Of greatest concern is the marked disparity that 55.6% of the defendants with mental health issues entered into guilty pleas compared to only 38.2% of the other defendants.
The most notable variation by ratio in Table 5 is found in the examination of the “not guilty” dispositions as only 0.8% of the defendants without mental health issues received such results while 8.3% of the defendants with mental health issues were found not guilty.

Examining this issue of disparate case disposition in greater detail is a similar review that explains much of the detail of Table 5. Resolution of the cases that leads to the specific dispositions listed above could be achieved in a limited number of ways. The startling result, read from Tables 5 and 6, defendants with mental health issues electing trials (two bench, one jury), were found not guilty. In contrast, only 72.7% of the 22 non-mental health issue defendants were found not guilty (despite this disparity, there is no statistical significance, $p=.299$). Aside from those results, two-thirds (66.7%) of the mental health criminal cases were resolved by plea agreements while only 57.3% of the non-mental health cases were similarly resolved. The combination of the various modes of resolving the cases demonstrated statistical significance based on the mental health issue ($p=.024$).

<table>
<thead>
<tr>
<th>Resolution Mode</th>
<th>MH ISSUE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Plea</td>
<td>26</td>
<td>608</td>
</tr>
<tr>
<td>%</td>
<td>66.7%</td>
<td>57.3%</td>
</tr>
<tr>
<td>Bench</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>%</td>
<td>5.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Jury</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>%</td>
<td>2.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>432</td>
</tr>
<tr>
<td>%</td>
<td>25.6%</td>
<td>40.7%</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>1,062</td>
</tr>
<tr>
<td>%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 6. Case Resolution Mode by Mental Health Issue
In light of the data presented in Table 6, it comes as no surprise that the rate at which defendants with mental health issues seek trial is statistically significant (p=.021) and higher – if only individual defendants were aware of these results and confident of the ability to replicate them.

<table>
<thead>
<tr>
<th>Crosstabulation of Defendant Committed by Mental Health Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defendant Status</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Committed</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Not Committed</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Table 7. Rate of Incarceration (Committed) by Mental Health Issue</td>
</tr>
</tbody>
</table>

Analysis of defendant incarceration reinforces the data in Tables 5 and 6. Table 7 provides the comparative rates for incarceration of defendants with mental illness following their case dispositions at a statistically significant (p=.031) and higher rate than the other defendants. In comparison, the extent to which both groups of defendants were placed on probation were not statistically significant (p=.097).

<table>
<thead>
<tr>
<th>Crosstabulation of Jail Potential by Mental Health Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does at least one charge carry jail sentence</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>N</td>
</tr>
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<tr>
<td>Total</td>
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<tr>
<td>Table 8. Potential for Incarceration by Mental Health Issue</td>
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Of concern is that the comparative rates at which these two groups of defendants could be incarcerated was not statistically significant (p=.229) as demonstrated in Table 8.

There are numerous factors that a defense attorney must consider in defense representation independent of the defendant’s mental health status. Factors that a defense attorney would consider with regard to a specific defendant or case include some of the factors addressed in the preceding tables. The most notable consideration listed above is if the charges carry the potential for incarceration, as in Table 8. Other factors that merit consideration are listed below with the statistical significance of their respective relationships to the mental health status of the defendant.

<table>
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<tr>
<th>Defense Factors to Consider and their Relationship (Statistical Significance) to Mental health Issue</th>
<th>“p” value</th>
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<tr>
<td>Number of days from offense to complaint</td>
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<tr>
<td>Maximum penalty carried by charges</td>
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<tr>
<td>Charges include offense against a person</td>
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<td>Charges include a public order or health offense</td>
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<tr>
<td>Number of “jailable” offenses</td>
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<td>Charges include a motor vehicle offense</td>
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<td>Charges include a drug offense</td>
<td>.080</td>
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<tr>
<td>Distance defendant traveled to offense</td>
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<td>Charges include offense against property</td>
<td>.119</td>
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<tr>
<td>Defendant’s Gender</td>
<td>.182</td>
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<tr>
<td>Charges include a “domestic” offense</td>
<td>.203</td>
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</table>

Table 9. Other Defense Factors and their Relationship (Statistical Significance) to Mental health Issue

As shown in Table 9, five of the factors meet the threshold for statistical significance (where p < .05). While these factors are considered by defense counsel in case analysis and
preparation, no single factor or combination thereof is sufficient to explain the disparities highlighted in the preceding tables. They are listed here to provide a more complete picture of the issues confronting defense attorneys. Despite their statistical significance, their weight in case analysis and preparation varies widely with the defendant, defense attorney, court, defendant’s criminal history, publicity of the case, and much more.

Of the analyses listed in the preceding pages, two conclusions emerge. First, defendants in these courts suffering from mental illness are unlikely to be identified anywhere in the court system. Second, in the absence of effective identification, defense attorneys are unable to advocate relevant to mental health issues.

Defendants who are identified as mentally ill are likely to suffer greater delay in resolving their cases when measured against other defendants without mental health issues or by time standards set by the court for handling of criminal cases. Upon resolution of these cases, the defendants with mental health issues will receive more frequent adverse case resolutions (guilty finding or continued without a finding), by plea agreements (rather than trial), and are more likely to be incarcerated (even though they faced no greater jeopardy than other defendants).

5. Recommendations

With these results identified, there is a clear need for action. The best route for action is through advocacy designed to engage the Committee for Public Counsel Services (CPCS) in drafting new standards and practices for the identification and representation of defendants with mental health issues. While it is not the only route, one effective mechanism to open a policy window is to couple the available solutions with the problems identified (Kingdon, 2003). Coupling the data of the costly problems that exist throughout the criminal justice system arising
from the under-identified mentally ill defendants with solutions that require only modest efforts by CPCS will get these issues on agency and political agendas. If key stakeholders view this as a policy window opportunity during state and agency budget planning cycles this increases the likelihood that positive action will occur. The burden to develop and implement training programs for defense attorneys and deploy screening instruments falls lightly on CPCS and more heavily on the attorneys themselves. CPCS can mandate, without regard to a requirement of proportional benefit to the defense attorneys, that the attorneys attend and complete training on the representation of the mentally ill defendants through an agency mandate as was done when CPCS needed more counsel to accept other types of cases (Committee for Public Counsel Services, 2012b). Coupling an inexpensive solution for the agency to a costly problem will likely see favorable review in light of the potential cost benefits of lowered costs throughout the criminal justice system. An inexpensive solution that provides spillover benefits to other elements of the state and related agencies provides opportunities for credit claiming by CPCS (Kingdon, 2003).

Compared to funding of prosecution and indigent defense, the states allocates substantial resources to reducing crime and costs in law enforcement and corrections (Frank & McGuire, 2010). The modest funding, meager wages paid to, and administrative burdens upon counsel for indigent defendants provides limited incentives and resources for these attorneys to seek skills, training, and education relevant to mental health issues (Committee for Public Counsel Services, 2006). Any additional education, resources, or continuing legal education are at the time and expense of the defense counsel.

On the basis of the Constitutional mandate, chronic government budget and funding issues, and fiscal realities facing counsel for indigent defendants, there are few practical
solutions available to remedy the shortage of counsel knowledgeable in the combined areas of criminal defense and mental health law. The quick resolution would be an increase in hourly wages for counsel holding dual certifications in criminal defense and mental health practice from the Committee for Public Counsel Services (Committee for Public Counsel Services, 2011); in the current economic climate, this is unavailable. Three solutions that are least burdensome to the Committee for Public Counsel Services remain: 1) create a hybrid certification for criminal defense attorneys with mental health training and limit appointments in such cases to the certified attorneys; 2) require mental health training for all criminal defense attorneys as a condition of continuing certification; 3) deploy a screening instrument for attorneys to use in identifying mental health issues in clients.

Each of these three solutions carries a burden of policy making and enforcement, variable costs, and difficulties in implementation. This comes back to the issues at hand – how to prepare attorneys to provide effective advocacy and advice in a time of limited resources for mentally ill criminal defendants. There are issues with each of the possible solutions.

Solution I: Deploy A Screening Instrument To Identify Mental Illness

This solution appears, on its face, to be the most readily deployed and simple solution in time and cost. There are a number of screening instruments in development and use in the criminal justice field to identify people with mental illness. The most common area to catch and identify such issues is at the point of transfer or admission of a prisoner to a jail (Ford et al., 2007). Many instruments in current use require little or no training for the person to administer the screen and identify mental health issues quantitatively. The emphasis at the screening stage is on quantitative identification with qualitative analysis arising through a properly trained and credentialed clinician (Ford et al., 2007)
The positive aspect of these screening instruments is the ease of use and the absence of training needed for effective use (Lurigio & Swartz, 2006). The screening process usually involves fewer than a dozen “yes/no” questions for the defendant. Upon receiving answers, the screener counts the positive responses and, if the number is above a set threshold, referral to a clinician is warranted (Ford et al., 2007).

The negative aspect is that the screening process ignores the realities of a busy attorney preparing for bail arguments and arraignment. In a busy court, the attorney must meet with a new defendant, perform a quick assessment of the facts of the case, establish issues of the defendant’s information, identity, case perceptions, review a criminal record, and meet with the prosecutor. There is very little time to add another dozen questions to this process and potentially create an interruption in the court’s case flow while finding a court clinician. The simple nature of the screening instrument is also the simple way that a busy attorney discards an extra task for which there is no apparent immediate benefit. While it is easily carried and used, it is also easily ignored and overlooked.

The direct benefit of attorney-performed screening is threefold. First, the attorney providing representation derives immediate and significant information regarding the client’s mental status and can advocate more effectively on those issues with regard to bail, detention, or the relevance of mental health issues to the acts alleged. Second, the knowledge provided to the attorney enhances the ability to make early decisions in the defense of the client to seek out additional mental health resources including experts and defense materials. Third, conduct of the screening by the attorney keeps all initial materials and information within the scope of the attorney-client privilege which provides a range of protections for both attorney and client.
Solution II: Require Mental Health Training For All Criminal Defense Attorneys

This solution has the advantage of an existing model. When the Sex Offender Registry Board ("SORB") was established, a need to train attorneys for that area of representation arose. Attorneys were initially unmotivated to take on a new area of practice, expend the time and expense of training, and CPCS resolved this shortage of counsel by requiring SORB Training for all attorneys to maintain their annual certification requirements as criminal defense counsel (Committee for Public Counsel Services, 2012b). While attorneys complained, the choices were clear: take the training or relinquish this aspect of your livelihood. Within one year of the requirement, all attorneys that wished to remain certified for representation in criminal matters were trained to provide representation in SORB cases and the panel of attorneys for SORB matters was fully populated.

As with the training in SORB matters, counsel were required to attend a multi-day training at their own expense, both in tuition and lost time from the practice (Committee for Public Counsel Services, 2012b). The burden fell on the attorney and not on the agency (other than provision of training). The costs to the agency were minimal; most of the cost and time burdens were spread among thousands of attorneys at no meaningful cost to the state.

Mandatory mental health training for all criminal defense attorneys would significantly increase the number of attorneys familiar with and comfortable in the mental health law field and more attorneys would be able to effectively identify and provide representation to mentally ill defendants. The current requirement for continuing legal education for the two panels, criminal and mental health, is eight hours annually for each panel; however, this is on top of the initial
training requirements of approximately five days for criminal matters and four days for mental health matters (Committee for Public Counsel Services, 2011)

**Solution III: Hybrid Certification**

It could be an effective solution to limit the appointment of counsel in cases with mentally ill defendants to those with appropriate training and skills. The issue is that such appointment presupposes the successful identification of mental health issues in the criminal defendant population. The failure of counsel to identify these issues is where the deficiency arises. In the absence of identification, there is no perceived need to appoint a dual certification attorney. It is the same issue again, if counsel does not recognize a mental health issue, there are no skills or training sought, developed, or enhanced to deploy against an unidentified problem.

Additionally, there are administrative headaches in that the number of attorneys carrying mental health and criminal defense certifications is small and finding counsel for criminal mental health cases would be difficult. The training requirements for the combined panel, assuming it would be a merger of the training requirements for the mental health and criminal panels, would be burdensome in time and cost as it is double the existing obligations for either panel of attorneys (Committee for Public Counsel Services, 2012a).

**Optimal Solution**

Based on the legal, economic, and human realities of the large and growing problem of mentally ill criminal defendants, it appears that the better solution is a two-pronged approach. First, select and implement widescale use of a mental health screening instrument for attorneys to use with their clients. Second, while information is gathered about the utility and benefit of the screening instrument with the attorney and defendant populations, develop a training program to add mental health skills to the population of the criminal defense practitioners with the objective
of providing a shorter-than-four-day training that provides counsel with the skills and resources necessary to identify the problems so that it can be handed off to more appropriately trained and skilled counsel.

**Implementation, Follow Up, and Evaluation**

Upon implementation of any or all of the solutions proposed, there should be specific follow up by CPCS during and after the implementation process.

Evaluation of the use and efficacy of the screening instrument should be monitored to confirm both actual and proper use by attorneys in defendant interviews. If early phases of instrument use do not indicate greater identification of mental illness among the defendants, review and/or modification of the specific instrument or use in the field may be necessary.

Evaluation of attorney training efforts will take longer. Effective measurement of the impact on case dispositions requires both the effective identification of defendants with mental illness as well as time to gather the cases of the mentally ill defendants that came into court and resolved in the time since completion of attorney training.

**Conclusions and Recommendations for Further Research**

Under the doctrine of “parens patriae,” the government, inclusive of the courts and criminal justice system, has an obligation to act as a caretaker for those who cannot survive or protect themselves within their abilities (Stavis, 2000).

This responsibility, when applied to this research, carries multiple imperatives. First, we must act to carry out one or more of the proposed solutions in the preceding pages such that we improve how we identify and provide legal representation to mentally ill defendants. Initial expenditures under all of the proposals are modest and all carry substantial benefits in costs,
administration of justice, and for the individual defendants who are identified earlier and more effectively represented.

Second, further research is necessary in multiple related directions. This study should be replicated with another population both by timeframe (different years, multiple years) and geography (different and additional courts). Any further research should attempt to control the resulting case dispositions for the influence of defendant criminal history. The criminal history of a defendant is a substantial influence on the prosecutor, defense counsel, and judge. Criminal history is factored into all phases of case analysis and preparation, plea negotiations, trial decision and planning, and sentencing. It was impractical to control for the criminal history factors in this study due to a time constraints and statutory limits on access to criminal history data. Already in progress, a study announced in 2013 notes the limited research on the challenges appointed counsel face representing mentally ill defendants and cites the significant number of defendants with mental health issues and counsel’s vexing legal and ethical issues, lack of funding, and near complete absence of expertise or training provided to such counsel. The study focuses on relationships between representation and case outcomes, counsel’s understanding of client needs, among other issues (Sideman, 2013).

Third, extension of this research into the field testing of and analysis of new research in mental health screening instruments will likely enhance the ability of defense counsel to make the earliest possible identification of mental health issues in their clients. While there are a range of instruments currently available, work in the mental health field continues and the development of instruments that are both quantitatively and qualitatively more effective is informed by ongoing experience and research insights.
Replication and extension of this research in these forms, verifying the methods of research and conclusions reached, enhancing and optimizing screening instruments, and controlling for the influence of criminal history will assist in refining and improving the identification, representation, and care of mentally ill criminal defendants.

Mental illness should deny no defendant effective representation in criminal matters. It is a serious injustice, a gross waste of public resources, and an individual tragedy that many defendants are only identified as suffering from mental illness upon their incarceration – long after the opportunity to effectively assert their rights have passed. As a society, we must both empower and demand that our justice system and the attorneys therein do a better job to avoid the damaged lives, lost years, and wasted public dollars.
Appendix 1: Data Collection Instrument

**Court:** Salem Lynn Lawrence Newburyport Ipswich Haverhill Peabody

Docket ________________________ Attorney ________________________

(4 digits CR 4 digits) Last Name only

Defendant Name ________________________ Last Name, First Name

Defendant Hometown □ same as court □ same as police

Check box if the defendant’s home is in the same town / city as either the court or the arresting police department

Defendant Date of Birth ________________ Gender M F

Month / Day / Year circle one

Arresting Police Department □ same as court

Check box if the arresting police department is the same town / city as the court

Offense Date ________________ Complaint Date ________________

Month / Day / Year Month / Day / Year

Disposition Date ________________ Disposition Judge ________________________

Month / Day / Year Last Name

If this is an offense under Chapter 209A, 265, or 268? N Y

Is this a “Domestic?” N Y

1) Are the defendant and victim of the same last name?
2) Is the complaint or docket stamped “DOMESTIC” anywhere?
3) Is there any indication that the defendant and victim live together or are related?

Is there any indication of mental health issues? N Y

1) Is there a referral to the court clinic?
2) Is there a motion for funds for psychiatric evaluation or similar?
3) Is there a commitment (for any reason) to a state hospital (Lowell, Taunton, Worcester, Bridgewater)?
4) Are there dispositional terms or reference to mental health treatment?
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