Inclusion of Probationers in South Carolina Mental Health Courts

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Problem Statement

The Bureau of Justice Statistics published a Special Report: Mental Health and Treatment of Inmates and Probationers (BJA, 1999). In this report, they found that approximately 16% of all those incarcerated in local jails were mentally ill, significantly more than the estimated 5% for the general population, and that mentally ill offenders in state prisons averaged a sentence of 12 months longer than those without mental illness. The Bureau of Justice Statistics also reported that approximately 44% of all prisoners are rearrested within the first year of release, 59% at two years and 68% at three years (BJA, 2002). The number of people incarcerated in the Charleston County Detention Center is approximately 1,725 with a monthly average of 256 (15%) of these inmates being prescribed psychiatric medication during the last three months.

When the mentally ill are released from jail they often run into barriers that prohibit a successful community transition. Many have been released to discover they have lost their disability and insurance benefits as a result of being incarcerated. The mentally ill may leave jail with no medication, no income, no housing, no transportation and no connection with follow up treatment. In Charleston County, a person's criminal record can make them ineligible for public housing. These obstacles contribute to a cycle of untreated mental illness, personal crisis and re-incarceration.

Mental Health Courts were created as a response to the special needs of mentally ill offenders. In 2002, eight courts existed throughout the country (BJA,

2007). Today there are more than 150 Mental Health Courts around the nation. A Mental Health Court is defined as a court with a specialized docket for defendants with mental illness. In a 2005 survey of Mental Health Court grantees, 25% of these courts accepted offenders with pending violent criminal charges and 60% accepted participants with felonies (CSG and BJA, 2009). Numerous jurisdictions included probation officers as stakeholders and some programs made it a requirement that participants were placed on probation when starting the program (BJA, 2005). Various courts differ in the types of participants they accept but have the common elements of being judicially supervised, using a team approach, linking participants to community-based treatment, scheduling regular appearances before a judge and using rewards and sanctions during a specified period of participation.

In January 2003, the Charleston County Mental Health Court in SC accepted its first participant. After pleading guilty, participant's criminal charges are deferred and they are released from jail. They are transported to the local mental health center to begin outpatient treatment on an intensive case management team. If they are not successful in the program, they are returned to jail for traditional sentencing.

In July 2005, Mary Lynn's Law (MLL) was passed. Part of this law created legislation that defined which mentally ill defendants could be considered for diversion into Mental Health Courts. Charleston County Mental Health Court experienced changes that prohibited the acceptance of those who had a violent criminal conviction at any time in their past. This law also prohibited those who

were on probation from being considered for the program. Due to the legislation, some potential participants that would have previously been considered for diversion no longer qualify.

Alignment with Agency Goals

The mission of the South Carolina Department of Mental Health is to "support the recovery of people with mental illness" (SCDMH website). The S.C. Department of Mental Health gives priority to adults, children and families affected by serious mental illnesses and significant emotional disorders. The department is committed to eliminating stigma, promoting the philosophy of recovery and to achieving these goals in collaboration with stakeholders in order to assure the highest quality of culturally competent services possible.

The goals of the Charleston County Mental Health Court program are to engage mentally ill offenders in treatment in order to promote recovery and reduce recidivism. The program provides a "safety net" for non-violent mentally ill offenders, links participants to crisis support, therapy, medication management services and various community resources. On a larger scale, the program works in collaboration with its partners to be a model for the treatment of persons with mental illness who are overrepresented among the jail population. It also serves as an avenue for advocacy in reducing the stigma of mental illness so that this population will have access to recourses that can impact recovery.

Should mentally ill offenders on probation be eligible for inclusion in South Carolina Mental Health Courts? The project investigated whether participants who were on probation differed from non-probation participants in terms of

graduation rates, level of functioning and recidivism. It also investigated if there were a significant number of mentally ill offenders that no longer qualified for the program. If there were no differences observed between the probation versus non-probation group in terms of graduation rates, level of functioning and recidivism, findings would support the legitimacy of the current probation exclusion sited in the law. If there were observed differences between groups, this may support the inclusion of probationers and it could be beneficial to purse an amendment to the law so that more mentally ill offenders could benefit from the program.

Data Collection

1) I gathered two and a half years of data on graduation rates for probationers versus non-probationers from 1/2003 through 6/2005 (before the inception of MLL). I also gathered two and a half years of information on graduation rates from 7/2005 to 12/2007 (after passage of MLL). Graduation rates for various groups were calculated. These calculations Included rates for groups when those with prior violent convictions and/or probation were extrapolated out of the Pre-MLL group. Information was gathered from the court files of all participants and from Records of Arrests and Prosecution (RAP sheets). The purpose of gathering graduation data was to explore whether those on probation differed in terms of success in the program when compared to other participants.

2) The Global Assessment of Functioning Scale (GAF) Score was gathered at entry and exit of the program for all participants. The baseline and

exit scores for participants were averaged in order to identify if there was improvement in functioning while in the program and if there were any preexisting differences between groups.

3) The number of participant arrests was gathered from booking histories in the jail management computer system at the local detention center and from RAP sheets located in court files. The number of arrests the year prior to entry into the program, the year during the program and one year post program was calculated. The rates of the probation, versus non-probation group, were reviewed in order to investigate whether there was a difference in recidivism rates between the two.

4) The number of potential referrals to Mental Health Court was calculated in order to investigate how many participants could be included if probationers were considered eligible. Three samples, gathered approximately one month apart, was taken from all inmates receiving psychiatric medication at the local detention center. Each inmate's criminal charges and booking history was reviewed to see if they met legal inclusion criteria. If they had qualifying charges, they were cross referenced for probation status using the jail management computer system and probation/parole website. The three samples were averaged in order to identify the percentage of potential participants that would be on probation if they could be included in screening for the program.

Operational Definitions

GAF: A rating scale, based on clinical judgment, of a person's overall level of functioning used for the purpose of tracking clinical progress (APA, 2000; see

Appendix 2). Functioning is assessed in terms of symptom severity, social and occupational performance. Scores range from 0-100 divided into 10 point ranges. A score of zero represents inadequate information, a score of one represents the most dysfunction and a score of 100 indicates superior functioning.

Graduation Rate: Percentage of participants that successfully complete the mental health court program and are awarded a graduation certificate by the courts.

Pre MLL Group: Persons with a non-violent pending criminal charge (misdemeanor or felony), clinical mental health diagnosis, residing in Charleston County, at least 17 years old, competent to stand trail, no pending charges or convictions for lewd act on a minor, no pending criminal domestic violence charge.

Post MLL Group: The same as above with additional exclusions of: no prior conviction for violent crime, no pending charge of harassment or stalking, no current restraining order, victim consent required, not on probation.

Recidivism Rate: Comparison of the number of arrests one year before acceptance to the program to first year in the program and second year after the program. Arrests were counted for criminal charges resulting in incarceration regardless of conviction.

Violent crime: A crime defined as violent by the South Carolina Code of Laws Section 16-1-60. See Appendix 1 for list of violent crimes.

Data Analysis

Key findings: 1) The graduation rate for all those that entered the program prior to the change in legislation, the Pre MLL group, was 55% (see Table 1). The graduation rate for all those that entered the program after the change in law, the Post MLL group, was considerably higher at 69%. The graduation rate for the Pre MLL group was highest when those with a violent criminal history were excluded and probationers were included (67%). This rate was also the closest to the Post MLL graduation rate. When both probationers and those with a violent history were taken out of the equation, the graduation rate was less (64%) than when probationers were included. The lowest graduation rate was for those with a violent criminal history (46%). These findings support the idea that those with violent criminal histories may have had a bigger impact on lower graduation rates in the Pre MLL group than did probation status. Due to some continued variance in graduation rates, there may be other variables affecting differences between groups.

Table 1. Graduation Rates	Number Graduated	Number in Group	**Percentage of Participants Graduating**
Pre MLL total	44	80	55%
Probationers	12	24	50%
Non probationers	32	56	57%
Without violent offender history	44	66	67%
Violent offenders history only	6	13	46%
Without violent offenders and Probation	31	47	64%
Post MLL	51	74	69%

2) Global Assessment of Functioning Scale (GAF) scores indicated increases in functioning level across all groups (see Table 2). In the Pre MLL

group, there were virtually no differences between participants with the exception of a slightly greater change from baseline in the violent criminal history group. When comparing the Pre and Post MLL groups, observations indicated a smaller overall change in the Post MLL group and higher scores at entrance and exit from the program. The difference between entrance scores for the Pre and Post MLL groups may have had an impact on graduation rates as scores for those in the Post MLL were indicative of functioning better at baseline.

Table 2. GAF Scores	Entrance	Exit	**Percent Change in GAF Score**
Pre MLL total	51	64	20%
Probationers	51	64	20%
Non probationers	51	63	19%
Without violent offender history	51	64	20%
Violent offenders history only	50	65	23%
Post MLL	58	68	15%

3) Recidivism information indicated that the highest re-arrest rate was for the group with a violent offender history (see table 3). This information gives support to the idea that the program was least helpful in terms of recidivism for those with violent offender histories at both one and two years after release from jail into the program. All groups had a lower recidivism rate at year one, and an even great reduction at year two, in comparisons to the year prior to inclusion. This indicates a trend in decreasing recidivism continuing after graduation. The lowest recidivism rate at year one was observed for the group when excluding those with violent histories while including those on probation. The lowest recidivism rate at year two was for those who were on probation when entering the program.

Table 3. Recidivism	Total Arrests, Pre Program Year	Total Arrests, Year of Program	Total Arrests, Year Post Program	**Recidivism Rate Year One**	**Recidivism Rate Year Two**
Pre MLL Total Group	176	92	68	52%	39%
Probation	56	29	15	52%	27%
Non probation	120	63	53	53%	44%
Violent offenders only	31	18	15	58%	48%
Without violent offenders	142	72	51	51%	36%

4) Information concerning participant referrals indicated that approximately 60% of all potential participants were currently on probation (see Table 4). If those on probation could qualifying for screening, the total number of participants could be expected to increase an average of 1.5 times the current number while still excluding those with violent criminal histories.

Table 4. Potential Participants	12/1/2010	1/4/2010	2/1/2010	**Average**
Inmates On Psychotropic Medication	250	272	245	256
Excluded From Screening, Violent Charge	115	112	117	132
Excluded From Screening, Other Legal Issues	113	117	98	95
Qualify For Screening, No probation	8	17	13	13
Do Not Qualify For Screening, Probation	14	26	17	19
Non Probation and Probation Group Total	22	43	30	32
Percent of Potential Referrals On Probation	64%	60%	57%	60%

Potential Contributing Factors

Demographic information was collected from the court files of participants to investigate other factors that may have contributed to the variation in Pre and

Post MLL graduation rates (see Table 5 and Table 6). Pre-existing group differences that may have affected graduation rates include male/female ratio and homelessness. Participants who were homeless or male were the least likely to graduate from both groups. The Pre MLL group had more males and homeless participants which may account for some variance between Pre and Post MLL graduation rates. Groups were virtually identical in terms of age and education.

Table 5. Demographics	Pre MLL, N=82	**Percent Graduated**	Post MLL, N=77	**Percent Graduated**
Males	54	66%	45	58%
Female	28	34%	32	42%
Homeless	21	26%	13	17%
Age	40	*	40	*
Education	11.2	*	11.5	*

Table 6. Graduation Rates	Number Graduated	Total Number in Group	**Graduation Rate**
Pre MLL Group:			
Males	27	52	52%
Females	17	28	61%
Homeless	6	21	29%
Post MLL Group:			
Males	27	42	64%
Females	24	32	75%
Homeless	6	13	46%

Potential Solutions

Evidence seems to support the inclusion of probationers into South Carolina Mental health courts while continuing to exclude those with violent offender histories. In order for these findings to be put into practice, an amendment to

Mary Lynn's Law would need to be enacted. To have the law amended would require a change in legislation at the state level.

Implementation Plan

To change the law will require support for the change starting at the local level and expanding to the state level. The following will have to be done:

1) Information from this project will be distributed to stakeholders directly involved with Charleston County Mental Health Court. These persons/agencies will include the Charleston County Mental Health Court Judge, Charleston County Public Defender's Office, Charleston County Solicitor's Office and Charleston Mental Health Center.

2) If these immediate stakeholders are in support, the information will be distributed to other agencies for support including Charleston County Office of Probation, Parole and Pardon Services, the SC Prisoner Re-entry Initiative, Charleston County Detention Center, South Carolina Chapter of National Alliance for the Mentally Ill and the other four Mental Health Courts in South Carolina.

3) Letters of support for the change in law will be requested if stakeholders agree with the proposed plan. A written request will be sent to members of the Charleston Legislative Delegation with the hopes that a member will sponsor the proposed amendment. Letters may also be sent directly to members of the Legislative Council of the General Assembly. This five-member council is responsible for drafting and making recommendations concerning legislation when requested by committees or members of the General Assembly.

4) If the amendment is sponsored, it will be introduced by the House or Senate Judiciary committee for review and eventual approval or denial.

Time Frame/Costs

Information concerning this project's finding can be dispersed to immediate stakeholders in the month after completion. This will be done using a written summary of data and findings from the current project and an oral presentation during a weekly Mental Health Court staff meeting. Presentations will also be given to outside agencies that could be affected by the change during meetings as permission is granted. Requests for letters may be done after all stakeholders have had a chance to review and decide if they are in support. Letters of support should be received around September in order to prepare for submission to the Legislative Council well in advance of the January 2011 session.

Passing legislation is a lengthy process that involves numerous readings and drafting of bills. It is the hope that if the amendment is introduced in the January session, it will be passed by mid-year 2011. Monetary costs to carry out the action plan are minimal and would include printing and postage of letters. Time spent advocating for the amendment and speaking with stakeholders may consume a portion of work time.

Potential obstacles would occur if stakeholders are not in support of amending the law or if there are no legislative supporters willing to take on sponsoring the amendment. Information gathered in this project will be vital in advocating for support of the project. Letters of support from stakeholders will also be vital in creating a push for legislators to take on the project.

Potential resources include current stakeholders and other Mental Health Courts that have experience working with mentally ill offenders. Those immediately involved in Charleston County Mental Health Court have already verbally voiced support for the change and it is the hope that their agencies will put this support in writing.

Communication with stakeholders will be key in the process. The more supporters on the local and state level, the greater the likelihood of the amendment being sponsored and eventually passed. The inclusion of probationers could potentially affect many different agencies including legal entities that are struggling to find meaningful ways of reducing recidivism, increasing public safety, caring for the mentally ill and reducing costs to an overburdened system.

If non-violent mentally ill offenders on probation can be included in screening procedures for South Carolina Mental Health courts, this process can take effect immediately following the change. Processes are already set up for screening and treatment providers have capacity to take on the increased number of potential participants. Information regarding the change would need to be sent to stakeholders who make referrals to the program.

Evaluation Method

Information concerning participants will continue to be tracked in terms of graduation rates, GAF scores and recidivism rates. This information will be dispersed among stakeholders on a bi-annual basis. If including probationers in

Mental Health Courts later results in no advantage or reduction in recidivism, each court could then chose to exclude them from diversion.

Methods of collecting data will continue in the same fashion as they have thus far. Other courts in South Carolina will also be encouraged to collect data to monitor changes that may result if the amendment is passed.

Summary and Recommendations

In summary, data collected from the Charleston County Mental Health Court over a five-year period supports the exclusion of those with a violent criminal history and inclusion of those on probation into South Carolina Mental Health Courts. Evidence for this comes from findings that show the highest graduation rates and lowest recidivism rates were observed when excluding those with violent criminal histories while including those on probation in the Pre MLL group. This group also evidenced a 13 point increase in GAF scores from entrance to exit from the program and the probation group had the lowest recidivism rate at two years after inclusion. The number of mentally ill offenders that could potentially be screened for the program would be expected to more than double if probationers could be included. Inclusion of probationers could result in an increased number of mentally ill offenders having access to a valuable, treatment oriented jail diversion program. It is recommended that Mary Lynn's Law be amended to allow those on probation to be considered for the program if they meet all other inclusion criteria.

References

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South Carolina Department of Mental Health website. SCDMH.org

Appendix 1

From SC Code of Laws...

16-1-60. Violent Crimes Defined:

For the purposes of definition under South Carolina law, violent crime includes the offenses of: murder (Section 16-3-10); criminal sexual conduct in the first and second degree (Sections 16-3-652 and 16-3-653); criminal sexual conduct with minors, first and second degree (Section 16-3-655); assault with intent to commit criminal sexual conduct, first and second degree (Section 16-3-656); assault and battery with intent to kill (Section 16-3-620); kidnapping (Section 16-3-910); voluntary manslaughter (Section 16-3-50); armed robbery (Section 16-11-330(A)); attempted armed robbery (Section 16-11-330(B)); carjacking (Section 16-3-1075); drug trafficking as defined in Section 44-53-370(e); manufacturing or trafficking methamphetamine as defined in Section 44-53-375; arson in the first degree (Section 16-11-110(A)); arson in the second degree (Section 16-11-110(B)); burglary in the first degree (Section 16-11-311); burglary in the second degree (Section 16-11-312(B)); engaging a child for a sexual performance (Section 16-3-810); homicide by child abuse (Section 16-3-85(A)(1)); aiding and abetting homicide by child abuse (Section 16-3-85(A)(2)); inflicting great bodily injury upon a child (Section 16-3-95(A)); allowing great bodily injury to be inflicted upon a child (Section 16-3-95(B)); criminal domestic violence of a high and aggravated nature (Section 16-25-65); abuse or neglect of a vulnerable adult resulting in death (Section 43-35-85(F)); abuse or neglect of a vulnerable adult resulting in great bodily injury (Section 43-35-85(E)); accessory before the fact to commit any of the above offenses (Section 16-1-40); attempt to commit any of the above offenses (Section 16-1-80); and taking of a hostage by an inmate (Section 24-13-450). Only those offenses specifically enumerated in this section are considered violent offenses.

Appendix 2

Global Assessment of Functioning (GAF) Scale:

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms
81-90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members)
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
61-70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
41-50	Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).
31-40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21-30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
11-20	Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic

	excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
1-10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.0 Inadequate information