Mental Health Court Referral Packet

If there are ANY competency concerns do not proceed unless a competency evaluation has been completed.

- Referrals from any source will be considered.
- If a Defendant meets Mental Health Court Eligibility and SMI Criteria described below, the State Attorney's Office may extend a written plea offer with the option to apply to Mental Health Court.
- The Mental Health Court team will assess each applicant through a mental health evaluation, a Level of Services Inventory-Revised (LSI-R), and a Pre-Sentence Investigation (PSI).
- Defendants who apply to Mental Health Court are considered for the program on a case-by-case basis. The Mental Health Court Judge decides whether to accept or deny all pending applications.
- If a Defendant is accepted into Mental Health Court, the Mental Health Court team will develop a treatment program. The Defendant will be required to follow the program which usually takes 1-2 years to complete.

Mental Health Court services will include:

- ❖ Comprehensive Community Based Mental Health Services to include:
  - Medication support
  - Case management
  - Therapy (Dialectical Behavioral Therapy, family therapy and/or other therapy)
- ❖ Substance abuse treatment
- ❖ One-on-one judicial review
- ❖ Intensive probation supervision
- ❖ Random drug and alcohol testing

BEFORE SUBMITTING THIS REFERRAL PACKET —

Make sure the following documents are completed:

☐**Mental Health Court Referral Sheet**

☐**ALL supporting documentation is attached**

☐**Mental Health Court Consent for Disclosure of Confidential Information**

☐**Mental Health Court Application**

ALL PAGES of this COMPLETED packet should be returned to:
Mental Health Court Coordinator Rick Olauson
Richard.Olauson@ujs.state.sd.us or the Pennington County Court Services Office

Mental Health Court Eligibility

To ensure the treatment services are appropriate for the individual being considered for the Mental Health Court, the following criteria have been established:

INCLUSION CRITERIA:

1. Client meets SMI criteria
2. Client is diagnosed with a thought or mood disorder, which may include Schizophrenia, Schizoaffective Disorder, or Mood Disorder
3. Client would benefit from medication stabilization as one of the primary treatment interventions because of the diagnosed serious mental illness
4. Client is at least 18 years of age
5. Client is facing Criminal Charges and is eligible for probation
6. Client is willing to live where the mental health team can supervise them

EXCLUSION CRITERIA

1. Client has a Developmental Disability
2. Client's primary diagnosis is Personality Disorder

SMI CRITERIA

Has a severe mental disability: The individual's severe and persistent emotional, behavioral, or psychological disorder has resulted in at least one of the following:

- A single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis
- Frequent crisis contacts with community resources for more than six months as a result of severe and persistent psychiatric symptomology
- Receive psychiatric treatment more intensive than outpatient care (e.g.: emergency services, alternative residential living or inpatient hospitalization)
- Maintained with psychotropic medication for at least one year

Has impaired role functioning: The individual's severe and persistent emotional, behavioral or psychological disorder has resulted in at least three of the following:

- Exhibits inappropriate social behavior which results in concern by the community and/or requests for mental health services by the judicial/legal systems
- Inability to procure appropriate public support services without assistance
- Is employed in a sheltered setting
- Is unable to perform basic living skills without assistance
- Is unemployed or has markedly limited job skills and/or poor work history
- Lack of social support systems in a natural environment (e.g. no close friends, lives alone, isolated)
- Requires public financial assistance for out of hospital maintenance

Mental Health Court Referral Sheet

Date:	Referral Source:		
Client's Full Name:			DOB:
Address:			
City:	County:	State:	Zip Code:
Cell Phone:	Home Phone:		
Pending Criminal Files: ☐No ☐Yes—LIST:			
Information dating back three years:			
Mental Health Assessment: ☐No ☐Yes—ATTACH COPY			
Treatment Needs Assessment: ☐No ☐Yes—ATTACH COPY			
Psychiatric Assessment: ☐No ☐Yes—ATTACH COPY			
Prior Mental Health Care: ☐No ☐Yes—PROVIDE SUPPORTING DOCUMENTS			
Mental Health Diagnosis: ☐No ☐Yes—ATTACH COPY			
Current prescriptions of Psychotropic Medications: ☐No ☐Yes—LIST:			
Are you currently working with a Case Manager: ☐No ☐Yes—PROVIDE NAME & CONTACT INFORMATION:			
** ALL referrals must include a **Consent for Disclosure of Confidential Information** signed by the client			
*** All of the above answered "YES" **MUST HAVE** supporting documentation attached with the referral packet.			

Mental Health Court Consent for Disclosure of Confidential Information

I, _____, hereby acknowledge that treatment information normally is confidential under federal law. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient (or client) records, and Part 164 of Title 45 of the CFR, which governs the confidentiality of mental and physical health records generally. I also understand that it is unlawful to violate these confidentiality requirements, but that both requirements permit me to voluntarily consent to permit disclosure of my health and substance abuse treatment information from the following entities:

1. Pennington County Jail
2. Mental Health Treatment Providers at: _____
3. Substance Use Disorder Treatment Providers at: _____

Therefore, I, _____, consent to allow the release of employment, medical, psychiatric, treatment, educational, mental health, or other documents and records which are deemed necessary for Mental Health Court purposes concerning Case No(s). _____. I also consent to the disclosure of on-going communications about my diagnosis, prognosis and compliance status, which includes, but is not limited to, the following:

- Assessment results pertaining to Mental Health Court eligibility, treatment needs, and supervision needs;
- Attendance at scheduled appointments;
- Drug and alcohol test results, including efforts to defraud or invalidate drug or alcohol tests;
- Attainment of treatment plan goals, such as completion of a required counseling regimen;
- Evidence of symptom resolution, such as reductions in drug cravings or withdrawal symptoms;
- Evidence of treatment-related attitudinal improvements, such as increased insight or motivation for change;
- Attainment of Mental Health Court phase requirements, such as obtaining and maintaining employment or enrolling in an educational program;
- Compliance with electronic monitoring, home curfews, travel limitations, and geographic or association restrictions;
- Adherence to legally prescribed and authorized medically assisted treatments;
- Procurement of unauthorized prescriptions for addictive or intoxicating medications;
- Commission of or arrests for new offenses; and
- Menacing, threatening, or disruptive behavior with staff members, fellow Participants or other persons.
- Current list of medications and history of compliance in taking them.

These communications may be disclosed among the following parties or agencies involved in the Mental Health Court Program: the Mental Health Court judge, the Mental Health Court team members, the employees engaged in the Mental Health Court operations and administration, court services officers in the Mental Health Court Program, treatment providers utilized by me during the Mental Health Court Program,

the Mental Health Court defense attorney, and/or other referring or treating agencies involved in the direct delivery of services through the Mental Health Court Program.

I understand that the purpose of and the need for this disclosure is to: inform the court and the other above-specified agencies of my eligibility and/or acceptability for substance abuse treatment services; to report on and adequately monitor my treatment, attendance, prognosis, and compliance with the terms and conditions of the program; to discuss and assess my status as a Participant in the Mental Health Court Program; and, to assess and comment on my progress in accordance with the Mental Health Court reporting and monitoring criteria.

I agree to permit the disclosure of this confidential information only as necessary for, and pertinent to, hearings, and/or reports concerning the status of my participation and compliance with the conditions of my probation as defined by the Mental Health Court. I understand that information about my medical status, mental health and/or drug treatment status, my arrest history, my levels of compliance or non-compliance with the conditions of my Mental Health Court participation (including the results of urinalysis or other drug screening tools,) and other material information will be discussed and shared among members of the Mental Health Court team.

I further understand that as an essential component of the Mental Health Court Program summary information about my compliance or non-compliance will be discussed in an open and public courtroom, including but not limited to, whether I have attended all meetings, treatment sessions, the results of urinalysis or other drug testing as required, and the disclosure of my compliance or noncompliance with the terms and conditions of the Program as defined by the Court. It is entirely possible that third parties will attend these court sessions and will hear these discussions. This process will require the re-disclose of confidential treatment information to individuals who have not been individually and specifically authorized to receive such information. Therefore, I hereby specifically consent to any potential re-disclose to third persons who may be in attendance at any of my Mental Health Court sessions.

I further understand that if I re-disclose confidential information of any other Participant to another party, I expose myself to legal liability for unauthorized disclosure of confidential information.

Recipients of this confidential information may re-disclose it only in connection with their official duties. I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Mental Health Court for the case named above such as the discontinuation of all court-ordered supervision or probation upon my successful completion of the Mental Health Court requirements, or upon sentencing for violating the terms of my Mental Health Court involvement.

_____ _____

Mental Health Court Referral Date

_____ _____

Witness Date

Unified Judicial System

Pennington County Mental Health Court Application

Return to: Treatment Court Coordinator Rick Olauson at Richard.Olauson@ujs.state.sd.us or the Pennington County Court Services Office

Date of Application:	Referring Party:
Disability accommodations? ☐No ☐Yes	Accommodations Needed:
Interpreter needed? ☐No ☐Yes	Language Needed:
Full Name:	Date of Birth:
Other Names Used:	Gender:
Race:	Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown
Phone Number:	Email Address:
Current living arrangements: ☐Own ☐Rent ☐Hotel/Motel ☐With Friend/Family ☐Jail ☐Homeless	
Address:	
City:	State: / Zip Code:
Emergency Contact:	Relationship:
Address:	Phone Number:
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Co-Habitating	
Significant Other:	
Address:	Phone Number:
Pregnant: ☐No ☐Yes ☐Yes-Significant Other	Paying Child Support: ☐N/A ☐No ☐Yes
Number of Children Under Age 18:	Number of Children Over Age 18:

Children

Full Name:	Date of Birth:	Full Name:	Date of Birth:

Other Members of the Household

Full Name:	Full Name:	Full Name:

Driver's License Status: ☐None ☐Expired ☐Revoked ☐Suspended ☐Valid ☐ID ONLY	
Driver's License Number:	State:
State ID Number:	State:

Highest Grade Completed:	☐ High School Diploma ☐ GED ☐ College Degree
Service the Military or Armed Forces? ☐ No ☐ Yes	Received Veterans Services? ☐ No ☐ Yes
Branch:	Discharge Date:
Rank at Discharge:	Discharge Reason:

Primary Source of Income:	Monthly Income: $
Employer:	Supervisor:
Address:	Phone Number:
Assistance/Benefits: ☐ None ☐ WIC ☐ TANF ☐ VA ☐ LIEAP ☐ Child Support ☐ SSI SSD ☐ Voc Rehab ☐ Unemployment ☐ Food Stamps ☐ Medicaid ☐ Housing Assistance ☐ Other	

Drugs of Choice: 1)	2)	3)
Current IV Drug Use: ☐ No ☐ Yes	History of IV Drug Use: ☐ No ☐ Yes	
History of Overdose: ☐ No ☐ Yes	Drug of Overdose:	Date of Overdose:
Previous Treatment: ☐ None ☐ Detox ☐ Inpatient ☐ IOP ☐ Outpatient ☐ Jail-Based ☐ Individual ☐ Co-Occurring ☐ Inpatient Mental Health ☐ Outpatient Mental Health		
Currently in Treatment: ☐ No ☐ Yes	Where:	

Treatment Needs Assessment completed within the past 6 months: ☐ No ☐ Yes

If YES — Provide a copy to the Treatment Court Coordinator

Medical Insurance: ☐ None ☐ Medicaid ☐ Medicare ☐ VA ☐ Federal ☐ State ☐ Private

Mental Health Provider:	**Medical Provider:**
List all MENTAL HEALTH diagnoses:	List all MEDICAL conditions:
List all MENTAL HEALTH medications:	List all MEDICAL medications:

Number of Law Enforcement Contacts:	Age of First Arrest:	
Current Charges:		BAC, if applicable:
Defense Attorney:		
Are you currently on probation? ☐ No ☐ Yes	Probation Officer:	
Previous **Treatment Court** Participation? ☐ No ☐ Yes	Court:	When:
Have you ever been sentenced to prison: ☐ No ☐ Yes	When:	

The Treatment Court Team will determine whether you are eligible for the program. **By signing this application, you agree to allow court services officers, treatment providers and mental health providers to conduct necessary interviews to determine eligibility and share that information with the rest of the team.** By signing below, the applicant acknowledges that she/he has had an opportunity to discuss this matter with counsel and that she/he understands her/his Boykin rights, and freely and voluntarily agrees to participate in the process required to create the Level of Service Inventory (LSI) and to that end waives his/her Boykin rights for the purpose of completing the LSI.

Applicant Signature	Date	Defense Attorney Signature	Date