



—PROBLEM SOLVING—
COURTS
WORK
MAKING A DIFFERENCE

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 SPMI 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

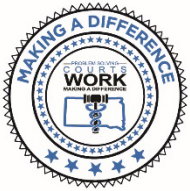
BEFORE SUBMITTING THIS REFERRAL PACKET —

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 Sean Ireland

Sean.Ireland@ujs.state.sd.us or 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 SPMI 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

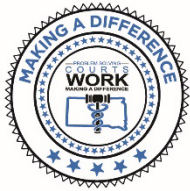
SPMI CRITERIA

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

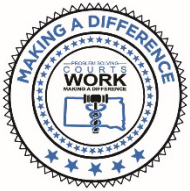
Has impaired role functioning: The individual's severe and persistent emotional, behavioral or psychological disorder has resulted in at least three of the following:

- 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: <input type="checkbox"/> No <input type="checkbox"/> Yes—LIST:					
Information dating back three years:					
Mental Health Assessment: <input type="checkbox"/> No <input type="checkbox"/> Yes—ATTACH COPY					
Treatment Needs Assessment: <input type="checkbox"/> No <input type="checkbox"/> Yes—ATTACH COPY					
Psychiatric Assessment: <input type="checkbox"/> No <input type="checkbox"/> Yes—ATTACH COPY					
Prior Mental Health Care: <input type="checkbox"/> No <input type="checkbox"/> Yes—PROVIDE SUPPORTING DOCUMENTS					
Mental Health Diagnosis: <input type="checkbox"/> No <input type="checkbox"/> Yes—ATTACH COPY					
Current prescriptions of Psychotropic Medications: <input type="checkbox"/> No <input type="checkbox"/> Yes—LIST:					
Are you currently working with a Case Manager: <input type="checkbox"/> No <input type="checkbox"/> 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					



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:

- Pennington County Jail
- Mental Health Treatment Providers at: _____
- 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.

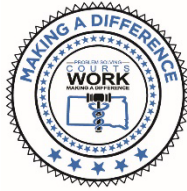
Recipients of this confidential information may re-disclose it only in connection with their official duties. I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Mental Health Court for the 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: Mental Health Court Coordinator Sean Ireland
Sean.Ireland@ujs.state.sd.us or Pennington County Court Services Office

Date of Application:		Referring Party:	
Disability accommodations? <input type="checkbox"/> No <input type="checkbox"/> Yes		Accommodations Needed:	
Interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes		Language Needed:	
Full Name:		Date of Birth:	
Other Names Used:		Gender:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Phone Number:		Email Address:	
Current living arrangements: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> With Friend/Family <input type="checkbox"/> Jail <input type="checkbox"/> Homeless			
Address:			
City:		State:	Zip Code:
Next of Kin:		Relationship:	
Address:		Phone Number:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Co-Habiting			
Significant Other:			
Address:		Phone Number:	
Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes-Significant Other		Paying Child Support: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended <input type="checkbox"/> Valid <input type="checkbox"/> ID ONLY			
Driver's License Number:		State:	
State ID Number:		State:	
Highest Grade Completed:		<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> College Degree	

Service the Military or Armed Forces? <input type="checkbox"/> No <input type="checkbox"/> Yes		Received Veterans Services? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Branch:		Discharge Date:	
Rank at Discharge:		Discharge Reason:	
Primary Source of Income:		Monthly Income: \$	
Employer:		Supervisor:	
Address:		Phone Number:	
Assistance/Benefits: <input type="checkbox"/> None <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> VA <input type="checkbox"/> LIEAP <input type="checkbox"/> Child Support <input type="checkbox"/> SSI SSD <input type="checkbox"/> Voc Rehab <input type="checkbox"/> Unemployment <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Other			
Drugs of Choice: 1) _____ 2) _____ 3) _____			
Current IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes		History of IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes	
History of Overdose: <input type="checkbox"/> No <input type="checkbox"/> Yes		Drug of Overdose: _____	Date of Overdose: _____
Previous Treatment:		<input type="checkbox"/> None <input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient <input type="checkbox"/> Jail-Based <input type="checkbox"/> Individual <input type="checkbox"/> Co-Occurring <input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Outpatient Mental Health	
Currently in Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes		Where: _____	
Treatment Needs Assessment completed within the past 6 months: <input type="checkbox"/> No <input type="checkbox"/> Yes If YES — Provide a copy to the Mental Health Court Coordinator			
Mental Health Provider:		Medical Provider:	
List all MENTAL HEALTH diagnoses:		List all MEDICAL conditions:	
List all MENTAL HEALTH medications:		List all MEDICAL medications:	
Age of First Arrest: _____		Gang Affiliation: _____	
Number of lifetime MISDEMEANOR arrests: _____		Number of lifetime FELONY arrests: _____	
Number of lifetime MISDEMEANOR convictions: _____		Number of lifetime FELONY convictions: _____	
Current Charges: _____			
Defense Attorney: _____		Probation Officer: _____	
Previous Problem-Solving Court Participation: <input type="checkbox"/> No <input type="checkbox"/> Yes		Court: _____	When: _____
Have you ever been sentenced to prison: <input type="checkbox"/> No <input type="checkbox"/> Yes		When: _____	
The Mental Health Court Team needs to figure out whether you are eligible for the Mental Health Court program. By signing this application, you agree to let team members share your information before you plead guilty. The information shared will include Application information, your LSI-R (risk assessment) score, Mental Health records, and Treatment Needs Assessment.			
Applicant Signature _____		Defense Attorney Signature _____	
Date _____		Date _____	